NHS England report on Tinkers Lane Surgery, Royal Wootton Bassett

12 November 2013
Contents

1. NHS England (Bath, Gloucestershire, Swindon and Wiltshire) report          Page 3
2. Tinkers Lane Surgery overview report (NHS Wiltshire)                        Page 7
3. Tinkers Lane Surgery overview report, Appendix 1 (NHS Wiltshire)           Page 27
4. NHS England (Bath, Gloucestershire, Swindon and Wiltshire) action plan     Page 33
5. Addendum                                                                 Page 36
NHS England (Bath, Gloucestershire, Swindon and Wiltshire) report

Background
In June 2012, Davinderjit Bains of Tinkers Lane Surgery, Royal Wootton Bassett, was arrested on suspicion of sexual assault and voyeurism. In March 2013, he was charged with 39 offences affecting 32 patients and subsequently sentenced to 12 years imprisonment in May 2013.

NHS England came into being on 1 April 2013 and assumed responsibility for any legacy primary care issues from former Primary Care Trusts. The NHS England Area Team for Bath, Gloucestershire, Swindon and Wiltshire (hereafter referred to as the Area Team) inherited this case and as a result has taken the lead in ensuring that the appropriate action has been taken to safeguard and protect patients.

Tinkers Lane Surgery overview report
Following the arrest of Davinderjit Bains, NHS Wiltshire (Wiltshire Primary Care Trust) worked with Tinkers Lane Surgery to appraise and strengthen the governance arrangements at the practice. A key part of this work included a review of the surgery’s arrangements for the safeguarding of children and vulnerable adults to help inform recommendations and actions.

The review identified that improvements should be made in relation to keeping children and vulnerable adults safe and the implementing of policies for:
- complaints
- chaperoning patients for intimate examinations
- reporting and investigating serious incidents of concern
- supporting and protecting staff who wish to raise concerns.

It was also recognised that staff training should be provided in a number of these areas.

The Tinkers Lane Surgery overview report (attached at page seven) describes the findings of the review, which were considered by the Board of the former NHS Bath and North East Somerset and NHS Wiltshire cluster on 27 February 2013. This report was subsequently received as a legacy document by the Area Team.

The surgery has confirmed that all identified actions have been undertaken and have provided evidence to demonstrate this. The Area Team continues to monitor these changes to ensure standards are maintained and that patients can continue to be cared for in a safe environment.
Actions taken by the NHS England Area Team for Bath, Gloucestershire, Swindon and Wiltshire

Since assuming responsibility for this case, the Area Team has worked closely with Tinkers Lane Surgery to provide ongoing support and advice and ensure all required actions are undertaken. This work is outlined in the action plan on page 33, along with details of monitoring arrangements.

The Area Team has reviewed all aspects of keeping children and vulnerable adults safe at Tinkers Lane Surgery, including the handling of complaints and concerns, incident reporting and the use of chaperones for intimate examinations. The appropriate policies and procedures have been updated and implemented and all staff have been familiarised with these to ensure they are adhered to. Additional staff training has also been provided where required.

Regular meetings are held with the practice GPs as part of the on-going assurance and monitoring process, to ensure that the required systems and professional practices are in place and being followed. The Area Team has also worked with the practice GPs to ensure that they are confident and supported in raising concerns about colleagues in line with General Medical Council (GMC) guidance.

In any serious incident, it is vital that lessons learnt are shared widely. The Area Team is therefore working with colleagues across NHS England (South) through the Regional Head of Public Health and Primary Care to share key learning and recommendations across the region. These in turn are being shared nationally with Directors of Commissioning, Directors of Nursing and Medical Directors.

This has included sharing best practice in the use of chaperone policies within GP practices for the benefit of patients and as a safeguarding measure for practice staff. As part of this process, the Area Team has written to all GP practices within Bath, Gloucestershire, Swindon and Wiltshire alerting them to the GMC guidelines on chaperones (http://www.gmc-uk.org/static/documents/content/Intimate_examinations_and_chaperones.pdf) and encouraging the use of a chaperone policy as best practice and having it clearly displayed for patients to see.

The Area Team Director and Medical Director have also met with a number of patients who made a request through their solicitor to speak to the team to discuss their experiences. This provided an opportunity to raise any questions and concerns and share thoughts and ideas on protecting patients. The Area Team very much appreciated being able to have an open and frank discussion with some of the affected patients, which provided a stark insight on the personal impact of these horrendous crimes.
Key points from this meeting include:

- ensuring the appropriate counselling and support services are available to victims and information is provided on how to access them
- recognising that not all female patients will want to see a male GP and ensuring provision is in place to accommodate this as far as possible
- ensuring that patients are aware of how to take complaints further should they feel that their initial complaint has not been dealt with adequately
- being accommodating of patients who wish to have a chaperone for intimate examinations.

The Area Team is working on the specific points raised at this meeting, which have been shared and discussed with the GPs at Tinkers Lane Surgery. The practice has now recruited a female GP who will join the surgery in the new year and arrangements are in place to recruit another female GP on a part-time basis who will start soon after.

The meeting has reaffirmed the Area Team’s resolve to ensure that crimes of this nature are not allowed to happen and in doing so, rebuild the trust of patients registered at Tinkers Lane Surgery.

**Care Quality Commission inspection**
In addition to the actions taken by the Area Team, the Care Quality Commission (CQC) has asked the practice to address a number of areas, following an inspection on 5 September 2013. For a copy of the inspection report, visit [http://www.cqc.org.uk/directory/1-587569635](http://www.cqc.org.uk/directory/1-587569635).

The CQC report states that patients said they are treated with respect and involved in making decisions about their care and treatment. However, the CQC found that the following standards required action, as highlighted in the following extracts from the report:

- **Safeguarding people who use services from abuse (minor impact)**
  We found that the practice had worked to improve safeguarding awareness, training and protocols in the practice. However, at this inspection we found there were still concerns around safeguarding awareness and staff’s knowledge of safeguarding principles.

- **Cleanliness and infection control (moderate impact)**
  There were no effective systems in place to reduce the risk and spread of infection. The practice also failed to implement systems that monitored and maintained an appropriate level of cleanliness and hygiene.

- **Management of medicines (minor impact)**
  People were not always protected against the risks associated with
medicines because the provider did not have appropriate arrangements in place to manage and store medicines.

As a result, the CQC asked the practice to submit a report by 1 November 2013, setting out the action they will take to meet these three standards. The practice has already made improvements in the areas highlighted and the Area Team continues to work with them and provide support and assistance as necessary to ensure they are compliant.

Next steps
The Area Team is working with the practice to monitor and ensure that all changes are sustained and the actions required following the CQC visit are implemented.

As part of this process, the Area Team has asked the CQC to review the implementation and use of chaperone policies in all GP inspections.

For people in Swindon and Wiltshire affected by sexual assault, free and confidential help and support is available from SARC (sexual assault referral centre). For further information, please contact the counselling line on 01793 835757.

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NHS England
# TLS Overview Report

30\textsuperscript{th} January 2013

<table>
<thead>
<tr>
<th>Section</th>
<th>Section Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Introduction, methodology and context</td>
<td>8</td>
</tr>
<tr>
<td>2</td>
<td>Safeguarding Children and Vulnerable Adults</td>
<td>10</td>
</tr>
<tr>
<td>3</td>
<td>Incident reporting</td>
<td>16</td>
</tr>
<tr>
<td>4</td>
<td>Handling of complaints and concerns</td>
<td>18</td>
</tr>
<tr>
<td>5</td>
<td>Intimate examinations and chaperones</td>
<td>23</td>
</tr>
<tr>
<td>6</td>
<td>Outstanding matters and closing comments</td>
<td>26</td>
</tr>
</tbody>
</table>
Section 1  Introduction, methodology and context

Introduction
This report was commissioned by Banes and Wiltshire PCT Cluster in the light of serious allegations against a GP employed at Tinkers Lane Surgery (thereafter, “the practice”). There is now a criminal investigation in relation to that individual GP. The criminal process is on-going.

Throughout this review caution has been exercised at all times to ensure that the criminal process is not prejudiced in any way. This review was essentially commissioned by the PCT to obtain a more informed understanding of how the practice conduct their governance arrangements across a number of key areas and enquire whether there is any learning that may emanate out of recent events. The PCT have a duty to seek such assurance. The Terms of reference for the review are found at Appendix 1.

Methodology
The methodology of choice for this review is an appreciative inquiry, with quantitative and qualitative elements.

Clinical governance at the practice has been reviewed in accordance with the Terms of Reference which are specific but also where relevant expanded upon to capture a whole service perspective and provide context.

Sources
Data that has informed this review have come from various sources:-

1. Interviews with the practice manager, GPs, a selection of administrative staff and practice nurses.
2. A review of relevant current policies, procedures, and protocols in existence at the practice.
3. A review of historic complaints and incidents going back three years.
4. Considerations of appraisal, education and training logs of clinical staff.
5. QOF documentation
6. CQC registration requirements and essential standards documentation.
7. Management documents pertaining to the daily operation of the practice and key meeting minutes.
8. Relevant PCT management documents.

As well as the above there has been a consideration of current legislation; health guidance; evidence based practice standards and the incoming regulatory regime in terms of the essential standards.
While the patient perspective is often helpful in reviews of this nature this has not formed part of this review as this would risk crossing over into the criminal investigation.

**Context**
Currently the PCT manages this particular practice under a PMS Agreement working to the PCT. The overall health landscape however is changing radically in April 2013 with the abolition of PCTs and SHAs to a system of Clinical Commissioning Groups and Local Area Teams under the NHS Commissioning Board.

Another major change impacting upon practices and staff is the requirement by April 2013, to become registered with the Care Quality Commission, (CQC). The CQC is the main regulator for health and social care in England.

Revalidation will also have an impact on how GPs evidence their professional development and performance.

Historically, GPs have managed their practices as businesses using a partnership model in the main. While generally the CQC will be registering primary service providers, rather than individual GPs, the partners of the practice will have agreed to accept joint or several liability for the way regulated activity is carried out. This is a prerequisite for registration under the partnership model.

Although primary care is delivered under a different model to secondary care or other more specialist services, the requirement for governance and patient safety is as important in primary care as it is across the rest of the NHS. Indeed this principle is embedded in legislation including the Health and Social Care Act 2008 as well as professional standards guidance for General Practitioners.

In the historic absence of a national regulator for primary care, PCTs have acted as quasi regulators. However, it is fair to say that generally practices and GP partners have enjoyed many freedoms to manage their businesses but in accordance with meeting the health needs of the local population.

Given this context and the common business model used by practices, some practices have perhaps historically operated outside mainstream governance developments in health, particularly in terms of safeguarding, patient experience and performance management. This context is important to note as the findings and applicable recommendations in this report are likely to apply to other practices reflecting the different levels of governance that currently prevail. What regulation will bring is some uniformity across the essential standards and the scrutiny that formal regulation brings will mean that many practices will need to rethink their governance systems and perhaps even redesign the way GPs operate to meet these challenges in terms of management and leadership.
Section 2  Safeguarding Children and Vulnerable Adults

This review looks at the practice’s arrangements for the safeguarding of children and vulnerable adults. This section will look at children and adult safeguarding separately.

Safeguarding children

The national framework for safeguarding children is comprehensive, underpinned by legislation but layered with an extensive network of secondary source material, guidance and professional standards. There are also local Safeguarding and Child Protection Protocols. (http://www.online-procedures.co.uk/swcpp/) All staff working with children are subject to mandatory training at varying levels depending on roles and responsibilities for working with children. There are specialist professionals who are specifically designated for safeguarding children and they are an important source of advice and support.

See also NICE Guideline 89 – “When to Suspect Child Maltreatment” (http://www.nice.org.uk/nicemedia/pdf/CG89NICEGuideline.pdf)

There has been a wealth of reports and guidance in recent years around children safeguarding. The most recent, the Munro Report, July 2012. (www.official-documents.gov.uk/document/cm80/8062/8062pdf) emphasised a whole systems approach to children safeguarding to ensure the multi-agency system is more child centred. Many of the recommendations of this report have been accepted by government and has also triggered consultation and a review of some aspects of the safeguarding process.

“Working Together to Safeguarding Children- A guide to Inter-agency Working to Safeguard and promote the Welfare of Children” remains a primary source. The statutory obligations are contained in Part 1 and the non statutory guidance in Part 2.

Safeguarding and promoting the welfare of children is defined as:-

- Promoting children from maltreatment
- Preventing impairment of children’s health or development
- Ensuring children are growing up in circumstances consistent with the provision of safe and effective care.

Child protection is part of safeguarding and promoting welfare. It refers to activity that is undertaken to protect specific children who are suffering, or are likely to suffer, significant harm.
“Working Together” makes clear that protecting children from harm and promoting their welfare depends upon a shared responsibility and effective working between the agencies. For health, of which there are many components this can be a challenge. The lead agency for children safeguarding is the local authority but health is a “duty to co-operate” agency.

S47 of the Children Act 1989 underpins the decision making process and the inter-agency collaboration to safeguard children.

Chapter 5 of “Working Together” provides guidance on what should happen if there are concerns about the safety and welfare of a child. There are four key processes—assessment, planning, intervention and reviewing. There is a clear step by step process set out in “Working Together” including how to escalate concerns.

In terms of training, all professionals working with children are expected to have a foundation understanding of safeguarding children processes via mandatory training. Those who are specialists in the field will require more in depth knowledge. Each level has specific competencies. There are 8 target groups. GPs fall into target group 3, as professionals who regularly work with children.

The training content includes, “identifying, assessing and meeting the needs of children where there are safeguarding concerns.” In practice, professionals often start off with level 1 training to gain the foundation understanding of what to do in response to concerns and signs and indicators of abuse and neglect. GPs should also be aware of the guidance in the RCPCH Intercollegiate document—“Safeguarding Children and Young People: roles and competencies for Healthcare Staff” -September 2010. (See above web reference.) The most basic level is that professional staff should be able to recognise potential indicators of child maltreatment and take appropriate action if they have concerns including appropriately reporting those concerns and seeking advice.


Appendix 5 of “Working Together” sets out procedures for managing allegations against people who work with children. This should be used in all cases where it is alleged that a person who works with children has:

- behaved in a way that has harmed a child, or may have harmed a child;
- possibly committed a criminal offence against or related to a child or;
- behaved towards a child or children in a way that indicates she/he is unsuitable to work with children.

There may be three strands of consideration for an allegation:-

- a police investigation of a possible criminal offence
- enquiries and assessment by children’s social care about whether a child is in need of protection or in need of services; and
consideration by an employer of disciplinary action in respect of the individual.

The possible risk of harm posed by an accused person needs to be quickly and effectively managed. This will include a consideration of an immediate suspension. Information should be shared with other agencies as required, ie the police and social care in the first instance.

Actions on the conclusion of a case, are dependent on whether the allegations are substantiated or not but if substantiated, consideration needs to be given to referring to a professional body, eg GMC.

Recommendations- Safeguarding Children
1. Safeguarding children policy-In relation to the practice, there is a children’s safeguarding policy. This was revised in February 2012. This relates to QUOF Indicator management 1. The policy is adequate but could be improved upon by the addition of a simple flowchart which can be replicated from “Working Together” in relation to the process if there are concerns and what happens thereafter. It would also be helpful to insert the procedure contained in Appendix 5 as set out above.

2. Practice Staff understanding of safeguarding children- staff at all levels at the practice do appear to be aware of the policy but there are certain complaints that have come to light concerning children that demonstrate that the GPs are unclear on how to apply the policy and their safeguarding training. This perhaps reflects the fact that training is rarely scenario based. It would be inappropriate to go into detail around specific complaints as the cases in question will be part of the on-going criminal investigation but there is sound evidence that indicates a real lack of clarity for the GPs and the practice manager around the application of process. That being said the practice have not resisted the suggestion of additional safeguarding children training and this has now been delivered.

3. Concerns about another professional- the senior partner at the practice had on-going concerns in relation to his colleague GP around his attitude to patients. However that GP was providing what seemed to be plausible explanations. The senior partner was unclear where to take the professional concerns in terms of basic line management as well as safeguarding. The senior partner did raise this at an appraisal and discussed the concerns around the GP colleague but the advice given was inconclusive as to how to take matters further. The partners need clarity and a system on to whom to seek advice if such concerns arise. This could involve the medical director of the CCG to support, and any GP can always seek advice from the GMC on an anonymised basis. It was not until the police became involved following a complaint from an individual outside the practice that the practice became aware of allegations against the GP. It is not possible to say whether the GP’s alleged conduct would have been detected in some other way at the practice.
Certainly, all those interviewed for this review, apart from the senior GP partner did not have any concerns. The individual concerned was considered to be personable, popular within the practice and actively sought to socialise with staff.

4. **Children safeguarding lead** - the partners state that they are clear as to whom is the named children safeguarding lead under their policy. However, on documents reviewed another GP is also mentioned. In any event, all the GPs in the practice need to have a good understanding of the safeguarding process but this could be better championed by the lead.

5. **Attending Safeguarding meetings** - an important part of children safeguarding is the input into strategy meetings. Many GPs report that due to time pressures and the fact they are often asked to attend at short notice, generally they do not attend. This is a problem experienced by many practices. However, in some cases the attendance of a GP is key and a solution must be found to secure co-operation and input even if this via a telecon or by providing a report. The GPs at the practice also report that sometimes they are asked to attend when they may not have had any real involvement with the child or family. One of the GPs at the practice suggested offering up the practice as a venue for relevant safeguarding meetings. As well as making logistics easier for attendance this would also assist the practice in building inter-agency relationships and becoming more familiar with the designated nurses and doctors.

6. **Whistle blowing policy** - there is a whistle blowing policy at the practice but this is inadequate. There needs to be comprehensive policy document which reflects the legislative protection for whistleblowing and the procedures to be followed when there is a whistle blower. This is governed by 5 pieces of legislation in all. Staff interviewed know what whistle blowing is but did not understand the legal duty to a whistle blower and how to manage this. Having reviewed what policies the practice does have there are several gaps in terms of HR policies though this is probably the situation across other practices too. This relates to escalation procedures for dealing with serious concerns, suspension guidance and disciplinary investigations. This does need to be remedied however to align the practice with current employment law principles, modern NHS governance, contractual obligations and the incoming regulatory regime. There are pre appraisal guidelines at the practice which are helpful but these will need to be revised to take into account the revalidation regime.

7. **Children safeguarding training** - this has been attended within the required timescale but knowledge needs understood with a scenario based approach and context so that the procedures can be identified as applicable and then applied with confidence. The practice has had some further training but this should be on-going. This will stand them in good stead for outcome 7 for CQC which concerns the positive duty of those registered to safeguard patients (children and adults) from abuse.
Safeguarding Adults.
There is no overarching legislative framework concerning vulnerable adults as is in place for safeguarding children. The “Statement of Government Policy on Adult Safeguarding”- May 2011 sets out expectations of principles for all agencies concerning vulnerable adults from the Department of Health and there is a real driver now for the law in this area to be more defined post Winterbourne. The initial guidance “No Secrets”-2000, (http://www.dh.gov.uk/en/Publications/PublicationsPolicyAndGuidance/DH_4008486) was taken to consultation in 2010, particularly around the interface with the Mental Capacity Act 2005 which sets out the duty to act in the best interests of those who lack mental capacity. The Deprivation of Liberty Standards is another important aspect has to how the law has developed in this area. “No Secrets” sets out the categories of abuse and the process by which professionals should respond.

The categories are:-
- Psychological
- Physical
- Sexual
- Neglect
- Financial
- Discrimination
- Institutional

“No Secrets” also includes guidance on information sharing and the lead agency is adult social care within the local authority. Health (all its components) have a duty to cooperate. The process of dealing with concerns is not unlike the children process of early assessment, gathering information via a case conference and a Chair running the process of defining a protection plan with evaluation. Safeguarding alerts can require an urgent response but a referral can be across a spectrum of concerns but all of which meet the threshold. As with children safeguarding, there are those specialist professionals, who can give advice and support to other professionals where required. These roles are not as uniform as those of say, a designated nurse or doctor but nevertheless there are professionals who deal with safeguarding vulnerable adults on a daily basis and lead in this area.

Post Winterbourne, the safeguarding agenda has become even more prominent. As indicated above safeguarding adults is recognised as a compliance indicator under the regulatory regime for the CQC of which practices will be subject from April 2013.

Recommendations- safeguarding adults
1. Baseline knowledge of safeguarding adults- the review found that the practice has an extremely limited understanding of safeguarding vulnerable adults and what is expected if there are concerns. By baseline what is meant, is an understanding of what constitute a vulnerable adult as set out in the “No
Secrets” guidance, and how to escalate this if there are concerns about abuse of an adult. This was identified as an immediate training need and an introductory session has now been delivered to personnel across the practice. This has yet to be evaluated fully and there will be a requirement for follow up training on the Mental Capacity Act and the formal processes for assessing mental capacity and best interests. That is not to say that the GPs concerned do not assess mental capacity when needed, but the legal framework and formal tests are not fully understood. There is a distinction between the best interest process and safeguarding and that requires further understanding. There is a readiness to learn in this area and that is positive. The practice needs to further familiarise with governmental policy on safeguarding now the introductory training has been delivered. The practice would also benefit from a flowchart setting out the procedure for raising concerns around a vulnerable adult and to whom to seek advice and what other agencies to involve.

2. Safeguarding policy - This practice does not have a safeguarding vulnerable adults policy. This needs to be remedied incorporating the Mental Capacity Act and escalation procedures for safeguarding adults.

3. Nominated safeguarding lead - there is no formally nominated professional at the practice for safeguarding adults. This needs to be agreed between the partners and that nominated professional develop skills and knowledge further. It is often the case that the same professional who is responsible for safeguarding children also takes on responsibility for safeguarding adults too but that is a matter of internal management for the practice.
The practice are currently obliged to demonstrate compliance with QOF Education 7 and 10, and ensure a positive reporting culture to the PCT in terms of reporting and learning from significant untoward events. The PCT monitor this and it represents important data for the PCT in cross referencing risk profiles across primary care. A summary sheet is produced by the practice which sets out SIRIs over a given timescale; what learning has been identified and what will be done differently. The summary sheets were considered in the review but also specific SIRIs and the SIRI policy. The SIRI process, reports and specific management and investigation is overseen by the practice manager who then reports at intervals to the GP partners and the PCT. The current approach is that the senior partner would oversee adverse incidents as a serious untoward event (SUE). All SUEs are presented at the practice meeting – if there is a clinical matter this would be presented by the GP concerned.

As with other members of the clinical team, eg nurses, they do not attend this meeting. A GP may present issues raised at the 6 week clinical meeting to discuss in a wider clinical group. However, in terms of the SIRI reporting cycle this approach does need to be improved as the timescales for action and resolution are too extended.

Patient safety is a fundamental cornerstone of health governance and the expectation is always that when things do go wrong that this is analysed accordingly to ensure that the learning emanating is fed back into the organisation to improve future outcomes.

For many years this element of governance was driven by the National Patient Safety Agency (NPSA) which has informed both national guidance and professional standards. As part of the current health reforms this organisation has reached its demise, though elements of its function remain in other health bodies and some of the principles and templates emanating out of the NPSA still stand good. Providers of secondary care in particular use the NPSA templates around SUIs as well as the methodology to investigate SUIs (now called Serious Incidents-SIs). This methodology is called root cause analysis. It should however be stated that there are now other methodologies emerging such as “appreciative inquiry” and “systems learning”. All methodology in this area, seeks to capture learning and assist organisations to be a learning organisation. There should also be sound linkage between SUEs, complaints and safeguarding.

**Recommendations upon Incident management**

1. **SUE/SIRI policy**- the relevant policy at the practice is the “Incident management policy”. The fact that the practice does have a policy is positive. However, the current policy does need to be reviewed to bring it into line with modern governance principles and set out more clearly and in more detail, the process and methodology. The NPSA SUI framework (2010) is a good starting point and provides a useful template that is acceptable to the CQC. The policy
should also include the expectation around an audit trail of any SUI/SUE investigation. There was a lack of audit trail within the SUEs considered for the review. The policy should allow trend analysis to pick up patterns and themes. The practice manager notes that other than the annual audit of complaints and SUE handling, the practice does need a more sophisticated system for developing this process into the future.

2. **Accountability**- it is apparent that in the main the practice manager oversees the identification, investigation and reporting of SUEs/ SIRIs. While it is understandable that the practice manager has developed this role, the GPs appear to have stepped back from this element of governance. The GPs, as clinical leads and should be more engaged in the process. The senior partner should have the overview assisted by the practice manager. The current disjoint has been compounded by decreased communication between the GP partners and the practice manager. Historically, a weekly meeting would take place with one of the GPs which afforded the practice manager the opportunity to speak to events on a regular basis and allow the GP to input more actively. It is recommended that the regular meetings with the practice manager should be re-instated with a nominated GP who can then be kept abreast more closely around SUEs (and complaints) and agree levels of input rather than at the shared learning stage which is generally at partners meetings. The GPs should also be more proactive on the evaluation of any actions plans emanating out of a SUE/SIRI and trend analysis. All sign off of SUE/SIRI reports should lie explicitly with the senior partner.

3. **Linkage with other processes**- The linkage between complaints and SUIs needs to be strengthened. They are not mutually exclusive. There are certain perceptions that if there is a formal complaint that this precludes a SUI. The two and indeed safeguarding are not mutually exclusive. As part of risk management in the practice there needs to be a system and mechanism that marries up the processes. Many providers achieve this with an IT solution using a risk matrix based approach. Some events can legitimately be an SUI, a complaint and a safeguarding matter.
Section 4 Handling of complaints and concerns

Most complaints into the NHS are written complaints but many are more informal, ie via telephone, or verbally face to face. Some complaints come through a third party.

The Department of Health has responded to NHS complaints by putting in place a national process for dealing with complaints and new regulations came into force in April 2009. This was to streamline the complaints process, to reduce the bureaucratic burden and improve complaints handling. The Local Authority Social Services and NHS Complaints (England) Regulations 2009 revoked earlier regulations concerning NHS complaints. (http://www.dh.gov.uk/health/complaints/)

The regulations stipulate that each organisation must designate a complaints manager and a “responsible manager” to ensure compliance. If a complaint is made to a PCT, the PCT can pass the complaint to the provider (primary or secondary care) or the PCT can deal. In practice, providers tend to investigate their own complaints. Generally, any complaint should be made within 12 months and there is a defined process under the regulations in terms of how a complaint must be managed and timescales. If a response is not sent within 6 months the complainant must be notified in writing why there is a delay and a full response must be provided as soon as is reasonably practicable thereafter.

The emphasis is upon local resolution but the Health Ombudsman can still become involved if the complainant remains dissatisfied. The Health Ombudsman uses “Principles of Good Complaint Handling” which sets out the following principles:-

- Getting it right
- Being customer focussed
- Being open and accountable
- Acting fairly and proportionately
- Putting things right
- Seeking continuous improvement

In essence, the current regulations are less prescriptive on deadlines, but more focussed upon liaising with the complainant during the complaints process and streamlining of process across public services providers.

There is an on-going debate nationally whether health organisations, including GP practices should investigate their own complaints. There are concerns in some quarters as to the quality of complaints management and investigations and some would argue that complaints are best dealt with externally to promote independence and fairness.

In other regions different arrangements exist where health complaints are investigated by the local authority and vice versa. It is too soon to evaluate the impact of this but it
does indicate that there may be a move away from self regulation on complaints and a move toward a different model.

A practice will be accountable under the PMS to the PCT not only to report complaint profiles but also to demonstrate what learning has occurred.

As indicated above complaints can be incoming in different ways and routes. Each practice must have a uniform system to manage complaints and it is not unusual for the practice manager to oversee complaints. However, complaints are often clinical in nature and therefore there is no substitute for hands on management from a clinical professional. A senior partner in a GP practice should be well engaged with the complaints profile of the practice in any event, as part of his managerial and governance duties

At times, particularly when a complaint comes in less formally there can be subtleties that need consideration and sensitive decision making. This is best placed with a clinical colleague rather than the practice manager and in any event accountability lies with the GPs. That is not to say that the practice manager cannot assist in complaint management. That is a practical necessity, but the GPs should be involved in consideration at the outset rather than be presented with a response letter to merely sign off. This early consideration can also serve to consider other processes that may be triggered such as safeguarding, the serious incident process or whether the complaint should be classed as vexatious or habitual.

Any complaints policy should be aligned with removal of patients from the list and also patient choice. The fact is some patients do ask to register elsewhere even though a complainant may have had the fullest response from the practice. Conversely, there will be other occasions where a patient may use the complaints process in a more ill intended or vexatious way that heralds a breakdown in the therapeutic relationship and the GP may consider that the patient staying with the practice is not a feasible option.

There is a specific procedure under regulation where a GP wishes to remove a patient from the list because of threatening or abusive behaviour and that is not considered in detail here as outside the terms of reference. Obviously it is not appropriate for a GP to seek removal solely on grounds that a patient has complained though sadly this has been known to happen. There is no evidence that this is the case at this practice.

It should also be further noted that the NHS complaints process is underpinned by the NHS constitution concerning patient rights and the need to ensure that the patient fully understands the basis and rationale of his/her medical care.

When considering the complaints process and the individual complaints files back over previous years, it is apparent that the complaints system being used at the practice has been too informal in a number of ways:-

- GPs and others can intercept complaint letters (this is a feature with regard to the current GP subject to the current criminal investigation).
• There is an over reliance upon the practice manager to manage and investigate all complaints.
• The audit trail of the complaint investigation is weak.
• The practice manager in general, drafts the response letter after discussion with the GP if the complaint is clinical in nature, for the relevant GP to sign off. When this is discussed beforehand with the GP in question this is not fully documented.
• There is no real consideration of what other processes may be triggered at the outset of the complaints process.
• Verbal or lower level complaints appear to be dealt with differently than written complaints. By that what is meant that no written complaints appear to be dealt with less formally though the overall process generally lacks a robustness.
• When GPs are involved in the process (usually to discuss with a colleague this is not documented contemporaneously).
• On discussion at the partners meetings, there is an over reliance on the practice manager to present the findings and action plan. This dynamic is tending to obviate the leadership role of the senior GP partner who should be driving forward learning and improved outcomes as the head of the practice.
• There is a lack of communication between the practice manager and GPs along the pathway of some complaints.
• There are clear steps being taken to locally resolve and some meetings do take place with patients though these are not well audit trailed.
• Action plans being presented at partners meeting have no evaluation date so it is difficult to assess if past learning has been embedded.

This lack of formality and more in depth understanding of complaints has meant that there are a number of complaints relating to current events that arose but were not managed as formally as they should have been, though it is important not to apply a hindsight bias. The difficult issue is that the GP involved gave what seemed a plausible rationale at the time around the way he interacted and treated those particular patients who complained. However, two of the complaints should have been considered in safeguarding terms. One was in relation to a minor and another related to a vulnerable adult. It is not appropriate to detail those complaints in this report as they may well form part of the criminal investigation and charges.

The GPs state that they are actively involved in all clinical complaints but do rely upon the practice manager to draft initial responses. Having reviewed the complaints files there is poor audit trail of this. There are of course different categories of complaint and there is a division of labour on that in that it is expected that the practice manager deal with complaints relating to environment, access, process and procedure.
Recommendations for Complaint Handling

1. Realignment of accountability and responsibilities - As an overarching measure, it is recommended that there be a realignment of duties and responsibilities for the investigation and management of complaints as between the GPs and the practice manager. The practice does have a nominated clinical governance lead and it is perhaps he would be best placed to manage complaints with the practice manager. Alternatively the senior partner. This is likely to require awareness training for the GPs to enable them to better understand professional duties in this regard, the current regulations and the expectations apparent under the PMS and CQC. This will build clinical leadership and support the practice in evidencing it is compliant with Outcome 16 which incorporates complaints handling to assess and monitor the quality of the service provision. The CQC expect to see this as well as trend analysis across complaint and serious incidents as well as a system of clinical audit. It would be helpful for the practice to have a link person at the PCT and subsequently within the CCG to act as an advice point where more senior input is required around difficult complaints which carry sensitivity. In this context it would be helpful to redefine the role of the GP governance role so that he can build appropriate skills going into the future.

2. Complaint policy - The practice has a complaint policy not unlike that used at many other practices. This includes an appropriate leaflet for patients and also an internal flowchart for process. The flowchart does indicate that the practice manager is the main decision maker and lead for complaints. It is recommended that the practice review this and develop a more comprehensive complaints policy to bring more GP leadership, formalise the process and align the process more closely to the regulatory regime. The policy can also give clarity around linkage to the other processes as well as performance management.

3. Centralised complaint log - all written complaints should come direct to the practice manager in the first instance to be logged and recorded. Verbal complaints should be logged in the same manner and this will be the start of the audit trail for each individual complaint. GPs nor other staff should never circumvent or intercept complaints. The review cannot be sure that all complaints over the said period have been considered or indeed have reached the practice manager as it has become apparent that a number have been intercepted by the GP subject to the criminal investigation. It is impossible to say if any others have also been intercepted by other staff.

4. Weekly governance meeting - the practice manager should meet with the nominated GP governance lead or senior GP partner weekly to review active complaints, serious incidents or any other matters pertaining to governance at the practice. The meetings are not likely to be lengthy but need to be factored in around the clinical commitments.

The above actions will enable the practice to best meet up to date national guidance, improve their governance structure overall and best meet section 23 of the PMS agreement.
From the review of complaints seen there does not appear to be any other complaints, other than stated above whereby the safeguarding process would be triggered but as indicated it cannot be guaranteed that all complaints have been captured.

It is important to note that the practice staff at all levels do have an insight that these processes need significant improvement and there is a commitment to do that. One suspects that some of the themes here are echoed in other practices in the region but have not attracted scrutiny. With the advent of formal regulation all practices are going to need to be more sophisticated in their governance systems and with appropriate support this practice could become a strong template for that.
Section 5  Intimate examinations and chaperones

The use of chaperones for intimate examinations can be a controversial area with the research demonstrating that there is a spectrum of viewpoints as to whether it is always in the best interest of the patient to have a chaperone present. Numerous factors come into play, the age of the patient; the gender of the doctor and patient; familiarity between doctor and patient; trust; situational awareness; professional judgement; patient embarrassment and wishes; previous training and practice; chaperone availability; cost and convention for the therapeutic setting to name a few.

An intimate examination may involve examination of the breasts, genitalia or rectal examination. Gloves should always be worn.

There is no mandatory legal requirement to have a chaperone present at such examinations but there is a professional code of guidance around professional boundaries set in the core guidance for good practice set out by the GMC.

This states that sensitivity and dignity must be shown at all times toward a patient for whom an intimate examination is required and this must be done with informed consent. The advice within this guidance states:-

“Wherever possible, you should offer the patient the security of having an impartial observer (a chaperone) present during an intimate examination. This applies whether or not you are the same gender as the patient.”

It goes on to state:-

“A chaperone does not have to be medically qualified but will ideally:

- Be sensitive, and respectful of the patient’s dignity and confidentiality
- Be prepared to reassure the patient if they show signs of distress or discomfort
- Be familiar with the procedures involved in a routine intimate examination
- Be prepared to raise concerns about a doctor if misconduct occurs.

In some circumstances, a member of practice staff, or a relative or friend of the patient may be an acceptable chaperone.

If either you or the patient does not wish the examination to proceed without a chaperone present, or if either is uncomfortable with the choice of chaperone, you may offer to delay the examination to a later date when a chaperone (or an alternative chaperone) will be available, if this is compatible with the patients best interests.

You should record any discussion about chaperones and its outcome. If a chaperone is present you should record that fact and make a note of their identity. If the patient does not want a chaperone you should record that the offer was made and declined”
There are situations where using a chaperone is simply not feasible, eg home visits where the patient is alone but requires an intimate examination.

The discussion with the patient about a chaperone needs to take place fully and before the examination takes place. Full consent should be obtained and recorded. The patient should be given privacy to undress and kept covered as much as possible during the examination to maintain dignity. The doctor should not assist the patient in removing clothing unless it has been clarified that they require assistance. With or without an examination the doctor must be prepared to stop at any time if the patient becomes uncomfortable or distressed.

While there is no uniformity on the use of chaperones in general practice, many practices have moved to a position that chaperones are used routinely. This does not denote a lack of trust in the patient–doctor relationship but merely seeks to protect the patient and the doctor. There are varying practices as to whether the chaperone is another professional (eg a nurse).

Where younger children are concerned the chaperone tends to be a parent or other adult responsible for the child. Teenage girls and boys requiring intimate examinations represent a difficult group as they can be particularly vulnerable and the observed convention is that they should be examined with a chaperone present. In many practices, given that an intimate examination for women is often in relation to gynaecological checks or procedures specialist practice nurses often conduct the examination.

This area is not research rich in the UK or indeed internationally. The latest research found is a small study conducted in Australia and reported in August 2012 that reflects that different health systems approach this issue in different ways. (The Attitudes and Practices of General Practitioners about the use of Chaperones in Melbourne, Australia- Int J Family Med 2012 768461)

The study looked at a small group of GPs and attitudes to the use of chaperones. The study reinforces the many considerations of using a chaperone and that some doctors consider that offering a chaperone in some way contaminates the assumption of trust as between doctor and patient. The study notes that:-

“one of the most important components of the doctor-patient relationship is trust and respect for a patient’s autonomy, and these can be expressed in different ways. The power differentials that exist between doctors and their patients can be subtle, as can the vulnerability patients may feel. Thus using a chaperone is both an added layer of protection and acknowledgement of a patient’s vulnerability.”

The need for a strict professional boundary where intimate examinations are required is crucial as any misinterpretation of the boundary can have devastating effect upon the doctor’s reputation and the patient’s health. Unfortunately as the media has exposed and GMC data indicates, a small number of doctors do cross professional boundaries and as result become criminally culpable for their actions where
allegations are founded. Further, doctors who behave in this way can go to extreme lengths to conceal their misconduct and criminal behaviour.

Complaints were patients allege something untoward has happened during an intimate examination can present a difficult evidential problem where a chaperone has not been present or there has been a chaperone in the room but not actually behind the curtain in close proximity to the patient. Patients who consider they have been assaulted, sexually or otherwise during an intimate examination should be seen as vulnerable in safeguarding terms and also there should be appropriate support for an accused doctor as the investigation progresses. Where the most serious allegations are made, the police will investigate as a criminal investigation.

GMC guidance is clear that if there is any suspicion about a doctor’s performance in this regard by another professional and/or colleague that has to be reported immediately whether the patient seeks to take matters forward or not. Patient safety and safeguarding is paramount despite what may seem a patient’s reluctance to take the matter forward.

Findings and recommendations-Intimate examination and chaperones

1. **Chaperone policy** – at present the practice subject to this review does not have a chaperone policy and the GPs use their professional judgement for the requirement of an intimate examination and then the need for a chaperone accordingly. The senior partner is more inclined not to use chaperones as he has known his patients for many years and also his practice historically has not been to use chaperones. Another partner rarely conducts any intimate examinations preferring to refer patients to qualified nursing staff. It would be helpful for clarity for there to be a defined policy on chaperoning at the practice reflecting the GMC guidance. Many practices have moved toward using chaperones as routine and the GPs state this could probably be accommodated in terms of logistics using nursing or administrative staff. The partners need to debate openly with other staff in the practice and risk assess as against the benefits and disadvantages of using chaperones and in what circumstances. It would be difficult and perhaps inappropriate for the PCT to impose the use of chaperones upon the practice but there does need to be an open and full debate as indicated as the move to using chaperones as a matter of course for intimate examinations has gained momentum for obvious reasons and is now convention and seen as best practice in other areas of healthcare. The GPs at this practice are not unlike many other practices and would not as a matter of practice use gloves for a breast examination.

2. **Policy for managing concerns about primary care practitioners and intimate examinations**- the PCT has a policy on this but it is not widely known at the practice. When looking at the overall complaints relating to the doctor subject to the criminal investigation, a picture does build of a poor attitude towards patients. Some complaints however relate to examinations which appear to be more intimate than was required. The senior partner had discussed those concerns with the doctor in question but the responses were
calm and very plausible. It would be unfair to say that anyone in the practice could have foreseen what was to follow in terms of allegations against the GP and even now there is still a sense of disbelief amongst some staff. The practice manager and the senior partners do, however, require further training and support in relation to the management of concerns about primary care practitioners as indicated elsewhere in this report. There is a wealth of material on this and also the National Clinical Assessment service still has helpful materials on this, on line. It should be absolutely clear to all staff at the practice, that even if the patient does not feel they can go through a complaint process or report the matter to the police, once they have made the disclosure, if there are concerns of this nature, action must be taken. Patients are vulnerable in this situation and need to be supported but at the same time allegations of this nature must be investigated robustly.

6. Outstanding matters and closing comments
The terms of reference refers to a separate medicines management review by the Medicines Governance Lead pharmacist for the PCT. Apparently this has not been possible to pursue due to a recent Prescribing Authority decision to destroy prescription evidence after 15 months. It should be noted in this review that the use of prescription sheets and their security has been seen as something that needs to be incorporated into the medicines review. At present, while the main stock of prescription pads are locked away, a pad of prescription sheets is kept in reception in an open drawer, easily accessible for all staff. All prescription pads should be under lock and key.

It was also surprising that the GP subject to the current allegations had a high number of prescriptions sheets and this fact has been reported on to the police.

Number 8 of the Terms of reference concerns consideration of this report as Head of Primary Care.

This completes the review in accordance with the relevant Terms of Reference. As indicated above it should be appreciated that in terms of benchmarking some of the weaknesses in governance and processes in this report may be replicated in other practices. Those practices also will have similar challenges to face in meeting the requirements of modern clinical governance, the regulatory regime under the CQC and the demands of revalidation, all set in the changing landscape toward CCGs.

ENDS
Appendix 1

TERMS OF REFERENCE FOR GOVERNANCE AND SAFEGUARDING FACT FINDING REVIEW AT TINKERS LANE SURGERY ROYAL WOOTTON BASSETT

1. Introduction

1.1 These Terms of Reference for Governance and Safeguarding fact finding Review at Tinkers Lane Surgery Royal Wootton Bassett are intended to respond to the initial police investigation following the arrest of Dr DB and the subsequent initial Complex Case Strategy Meeting and safeguarding concerns arising from case consideration to date.

1.2 It is intended that the review will provide evidence and assurance to both the practice and the responsible commissioners which will both assist in preparing the Practice to respond to the findings of the likely criminal case, and to also assure commissioners and patients that remedial action has been taken if required and provide a basis for establishing, if required, additional training and support is required by the practice going forward in relation to safeguarding and clinical governance.

1.3 The initial review will be undertaken by an independent investigator with a clinical background with considerable experience at both national and regional level in the legal and policy framework and application of Adult and Children’s Safeguarding mechanism in both Health and Social care and who has wide experience as the independent chair of a number of Serious Case Review panels.

1.4 The overarching senior lead at the PCT supporting this work will be Deborah Gray, Acting Director of Nursing and Patient Safety for Banes and Wiltshire PCT Cluster, with effect from August 2012.

1.5 The investigation will be supported by a short life steering group. The membership of this group will include:
- Acting Director of Nursing and Patient Safety [Chair]
- Head of Primary Care
- Designated Nurse Safeguarding Children
- Head of Adult Safeguarding Wiltshire Council
1.6 The investigation will be carried out with full co-operation from the Practice and the key point of contact for the practice will be the senior partner Dr Peter Fudge.

2. **Key lines of Enquiry for Review**

2.1 The review and report will consider five key lines of enquiry:
- Safeguarding arrangements for both Children and Adults;
- Serious untoward event reporting and management;
- Handling of complaints and concerns;
- Professional performance issues [including management of intimate examination and chaperoning arrangement];
- Medicines Governance.

2.2 Each key line of enquiry is considered in more detail in Section three to Section seven below but other supporting records should be considered in conjunction with these terms of reference.

2.3 In addition the reviewer will consider the practice compliance with Legislation, PMS Agreement and Guidance including GMC Ethical Guidance.

3. **Safeguarding arrangements for both Children and Adults**

3.1 Local Safeguarding and allied Policies and Implementation throughout the practice

**Issues**
Identification of potential safeguarding concerns and escalation to appropriate safeguarding professionals and other agencies e.g. LADO and Police

**Initial lines of enquiry**
- Is there a policy for Safeguarding children that is fit for purpose?
- Is the process understood by staff at all levels in the practice?
- Is there a policy and understanding of the processes for identifying and managing concerns related to Safeguarding vulnerable adults that is fit for purpose?
- Is there a Whistle blowing procedure in the practice?
- Is this understood by staff and does it require review
3.2 Child Protection Training

Issues
The GP lead indicated that the training he had accessed did not provide sufficient information in terms of allegations management and LADO processes.

Initial lines of enquiry
- Availability and appropriateness of training;
- Evidence of Practice training records.

3.3 Role of the lead GP for safeguarding children and for Vulnerable Adults

Initial lines of Enquiry
- Does the practice have a Nominated GP lead for both Safeguarding Adults and Children?
- Is this clearly identified in the Practice Policy and made known throughout the Practice premises?
- Are the practice staff clear how and when to report Safeguarding concerns to the Lead GP

3.4 The Practice’s management of complaints - See Section five below

4. Serious untoward event reporting and management

Did the practice report and discuss any of the initial patient concerns/complaints in 2011 as a Serious Untoward Event?

- Are the Practice compliant with QOF: Education 8 and 10 – significant events?
- Is there a policy for reporting and learning from Significant untoward Events?
- Is there a process that involves all disciplines within the practice to consider and share learning from consideration of Significant untoward events?
5. Handling of complaints and concerns

Issues

5.1 There appears to have been up to three reported complaints concerns known to the practice in 2011 which were not escalated through appropriate safeguarding arrangements i.e. it appears that the Practice did not seek expert advice.

5.3 The senior partner reported he had received a number of seemingly unrelated concerns from patients which he has noted but had sought advice through discussion at his annual appraisal session.

5.4 Despite being the named GP for Safeguarding children, the nominated GP lead indicated he had not been consulted about all potential cases raised of a safeguarding nature.

Initial lines of enquiry

- Is there an up to date policy for handling complaints and concerns?
- Does it comply with current national guidance?
- Does the Practice comply with Section 23 of the PMS Agreement; Complaints Sections 464 and 465? - See Annex 1.
- Is there a clear process understood by all practice staff?
- Is there appropriate record keeping and learning following complaints resolution?
- Does a clinician review and formally sign off clinical complaints?
- Does a detailed review of complaints handled since early 2008 to date provide assurance re the proper management of complaints and;
- Does this review identify any further safeguarding concerns not yet identified in initial discussions with the practice?
- Are complaints/ concerns which have a potential safeguarding concern identified/ reviewed by the designated GP lead for children
- Is there a similar arrangement for vulnerable adults?
6. Professional performance issues including management of intimate examination and Chaperoning arrangements

Issues
6.1. The practice does not appear to have implemented a policy that supports safe practice when undertaking an intimate examination of minors or indeed consent for such in adults.

6.2. The procedure for undertaking intimate examinations and the chaperone requirements may require review.

6.3. Does the Practice have access to and follow the ‘Policy for managing concerns about primary care practitioners’?
http://nww.wiltshire.nhs.uk/policiesandprocedures/PrimaryCare/PC305_Performance_Concerns_Policy_v2.pdf

Initial lines of enquiry
• Does the practice fulfil the requirements of GMC Good Medical Practice: Treat patients as individuals and respect their dignity with reference to Section 10 on Chaperones;
• Does the Practice adhere to the GMC Ethical Guidance on Maintaining Boundaries?
http://www.gmcuk.org/guidance/ethical_guidance/maintaining_boundaries.asp

7. Medicines Governance

Issues
7.1. The police initial investigation and seizure of evidence indicated that Dr DB was holding a wide range of individual patient named drugs, in addition to a range of other pharmaceutical stock.

Initial lines of enquiry
7.2. A separate medicines governance review will be carried out by the Medicines Governance Lead Pharmacist for Wiltshire PCT with particular emphasis on the practice arrangements for the receipt and disposal of unused / returned named patient medications.
8. Other compliance with Legislation, PMS Agreement and Guidance including GMC Ethical Guidance will be assessed by the Head of Primary Care.

Following the initial review the practice will have the evidence to demonstrate that it complies with legislation and, in particular, satisfy the terms of its PMS agreement including

- Does the practice comply with **Part 22 of PMS Agreement**
  **Compliance with Legislation and Guidance** in particular section 463;

  ‘The Contractor shall comply with all relevant legislation and have regard to all relevant guidance issued by the relevant Strategic Health Authority or the Secretary of State.’?

- Does the practice comply with **Part 19 of PMS Agreement clinical**

  ‘The Contractor shall have an effective system of clinical governance. The Contractor shall nominate a person who will have responsibility for ensuring the effective operation of the system of clinical governance. The person nominated shall be a person who performs or manages services under the agreement.’?

9. Conclusion

9.1 It is anticipated that the initial review process will take place in the last week in July and that this will include review of agreed documents and records on the practice premises.

9.2 The reviewer[s] will also have access to the PCT website to access policy documents and to the QOF evidence submitted by the practice.

9.3 It is anticipated that an early draft report will be available to both the Senior Partner and the Steering Group in late August at a date to be agreed and certainly prior to the next court hearing of 8 September 2012.

Mary C Monnington  
Director of Nursing and Patient Safety  
Lead Director for Safeguarding  
July 2012
<table>
<thead>
<tr>
<th>Item</th>
<th>Detail</th>
<th>Responsible Director</th>
<th>Target date</th>
<th>Progress</th>
<th>Monitoring arrangements</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Performers list</td>
<td>Ensure GPs within the practice are confident and supported in raising concerns about colleagues in line with GMC guidance</td>
<td>Medical Director</td>
<td>29/11/2013</td>
<td>Meeting arranged with GPs and Area Team Investigating Officer to report back to Medical Director in November 2013</td>
</tr>
<tr>
<td>2</td>
<td>On-going assurance</td>
<td>Regular meetings with GPs regarding the implementation of good practice</td>
<td>1. Medical Director 2. Director of Nursing 3. Director of Commissioning</td>
<td>On-going</td>
<td>Initial meeting 16/7/13, followed by monthly meeting between Area Team representative and Practice Manager</td>
</tr>
<tr>
<td>3</td>
<td>Enhance support to primary care for safeguarding across Bath, Gloucestershire, Swindon and Wiltshire</td>
<td>The Area Team will access specialist safeguarding advice as required; either from designated posts or alternative sources</td>
<td>Director of Nursing</td>
<td>End of September 2013</td>
<td>Appropriate levels of safeguarding training, both children and adults, undertaken by all practice staff, including on the Mental Capacity Act</td>
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NHS England (Bath, Gloucestershire, Swindon and Wiltshire) action plan

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<tr>
<th>Item</th>
<th>Item</th>
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<th>Responsible Director</th>
<th>Target date</th>
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<th>Monitoring arrangements</th>
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<tr>
<td>4</td>
<td>Oversight of practice action plan</td>
<td>Need for assurance that actions are sufficient and completed in a timely manner with a focus on: 1. chaperoning of patients for intimate examinations 2. complaints 3. supporting and protecting staff who wish to raise concerns 4. reporting and investigating serious incidents of concern</td>
<td>Director of Nursing</td>
<td>End of November 2013</td>
<td>Practice action plan drafted and progress made on all items. Monthly meeting between Area Team representative and Practice Manager to monitor progress to completion of plan</td>
<td>On-going: completed action plan to be signed off by Area Team by the end of November 2013</td>
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<tr>
<td>5</td>
<td>Ensure lessons learnt are shared widely and implemented across Bath, Gloucestershire, Swindon and Wiltshire</td>
<td>Process will be through: 1. local NHS England Safeguarding Forums 2. discussion with Local Medical Committees regarding setting up twice yearly workshops on Patient Safety and Quality issues that will include learning from Tinkers Lane Surgery 3. report to Wiltshire Safeguarding Board</td>
<td>Director of Nursing</td>
<td>End of November 2013</td>
<td>Brief Safeguarding Forums and Safeguarding Board by the end of November 2013 (to include briefing to Safeguarding Board Chairs)</td>
<td>Area Team</td>
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<tr>
<td>6</td>
<td>Ensure lessons learnt are shared across the region and nationally</td>
<td>Liaison with Regional Head of Public Health and Primary Care who will disseminate learning regionally and</td>
<td>Director of Nursing</td>
<td>31/01/2014</td>
<td>Presentation to NHS England (South) Medical and Nursing Directors in January 2014</td>
<td>NHS England (South)</td>
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<tr>
<td>Item</td>
<td>Detail</td>
<td>Responsible</td>
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<td>7</td>
<td>Meeting with affected patients</td>
<td>nationally</td>
<td>Area Team Director</td>
<td>03/10/2013</td>
<td>The Area Team Director and Medical Director met with those individuals who requested a meeting on 3/10/13. A list of actions has been drawn up and discussed with GPs at the practice</td>
<td>Area Team</td>
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</table>

**NB:** For the purposes of this action plan, NHS England (Bath, Gloucestershire, Swindon and Wiltshire) is referred to as Area Team.
Addendum

Some of the documents and reports referenced in the Tinkers Lane Surgery overview report and Terms of Reference are now accessible via different URL addresses, which are provided below.

Munro Review of Child Protection: emerging findings from the trials, July 2012

Safeguarding children and young people: roles and competences for health care staff, intercollegiate document, September 2010

No Secrets: guidance on protecting vulnerable adults in care, March 2000

The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009

General Medical Council, Maintaining boundaries, guidance for doctors, November 2006
http://www.gmc-uk.org/mobile/maintaining_boundaries