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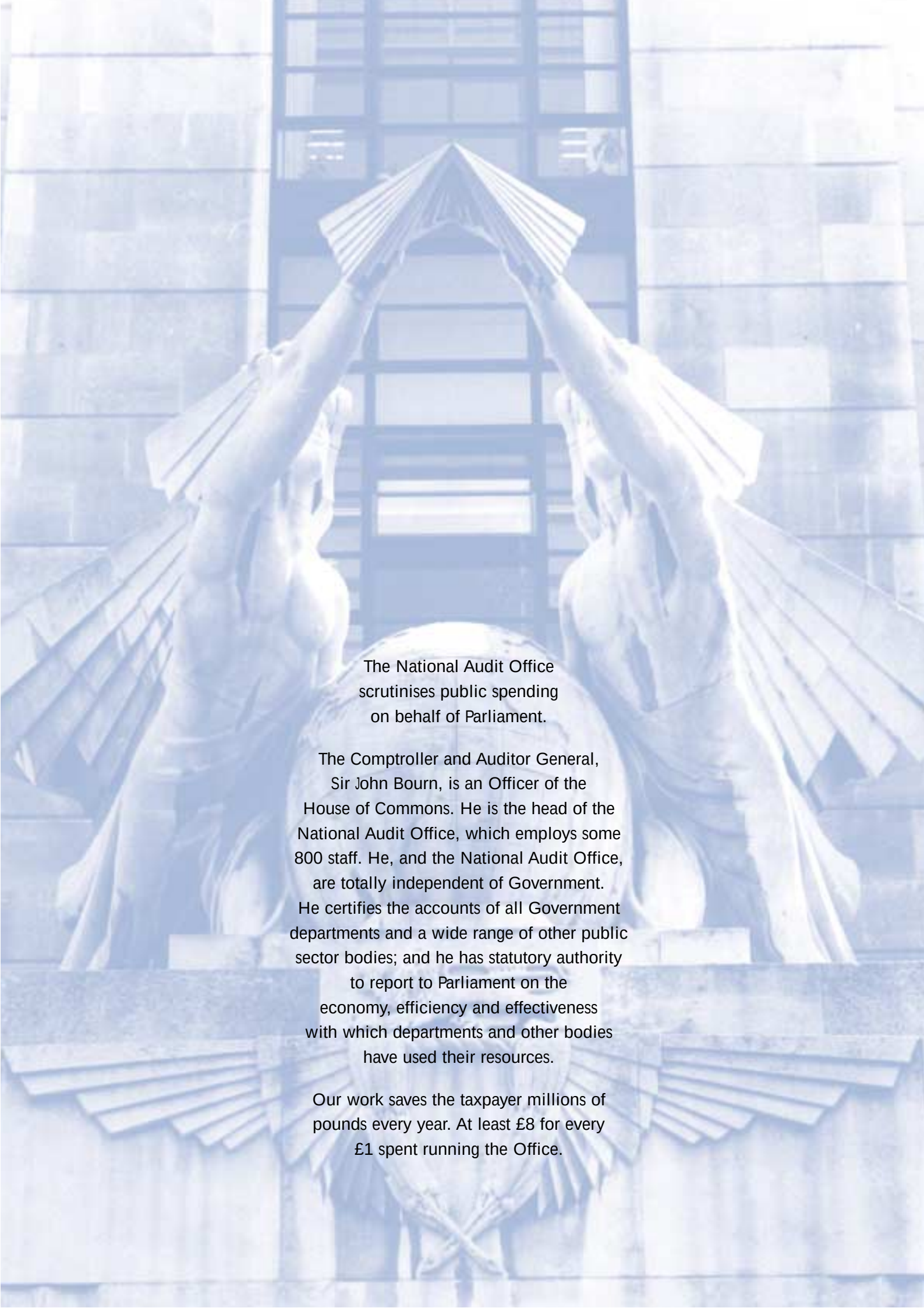
The Management of Suspensions of Clinical Staff in NHS Hospital and Ambulance Trusts in England

REPORT BY THE COMPTROLLER AND AUDITOR GENERAL
HC 1143 Session 2002-2003: 6 November 2003



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John Bourn
Comptroller and Auditor General

National Audit Office
3 November 2003

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Executive Summary

1 There are 700,000 clinical staff providing direct care to patients in NHS hospital and ambulance trusts in England, 75,000 consultants, doctors and dentists (referred to as 'doctors' in this report) and 625,000 other clinical staff, such as nurses, midwives and other health professionals. From our survey of these trusts we found over 1,000 clinical staff were excluded for more than one month between April 2001 and July 2002 and we estimated annual additional costs to the NHS of £29 million, covering the costs incurred on staff cover to replace the excluded clinician, management time related to the administration of the exclusion, and legal costs. The £11 million employment costs of the excluded clinicians are not included as these costs would be incurred in any event. NHS spending in 2002-03 was almost £55 billion and if exclusions were managed more effectively, for example if all exclusions were concluded within six months, additional resources worth some £14 million a year would be available. **Figure 1** presents our key findings and Appendix 1 describes our methodology.

1 Key findings

Extent of exclusions

- Between April 2001 and July 2002 over 1,000 clinical staff were excluded from NHS Hospital and Ambulance Trusts in England.
- Exclusions averaged 47 weeks for doctors and 19 weeks for other clinical staff.
- Doctors made up one fifth of all exclusions.
- 40% of doctors and 44% of other clinical staff returned to work.

The cost of exclusion

- The annual additional cost of exclusion is £29 million.
- The annual employment cost of excluded clinicians is £11 million.
- If exclusions were completed within six months additional resources worth £14 million a year would be available.
- The average cost of excluding a doctor is £188,000.
- The average cost of excluding other clinical staff is £21,400.
- Doctor exclusions account for three quarters of all costs.

Types of exclusions

- Formal suspensions - 88% of exclusions in our survey.
- Other exclusions, sometimes referred to as 'gardening leave', cover special leave, and extended sick leave.
- Restrictions on practice where a clinician may be prevented from undertaking certain types of clinical work.
- For all exclusions, the clinician receives full pay.

Reasons for exclusion

- Professional competence, where there are concerns about clinical performance - 44% of doctor cases and 19% of other clinical staff in our survey.
- Professional conduct, where there are concerns about the clinician's professional relations with patients.
- Personal conduct, where there are concerns which are not related to undertaking clinical duties.

2 While the cost of excluding clinicians is significant, there is also a loss of clinical skills as a result of the enforced absence, with staff being paid to stay at home and not normally allowed to treat patients. For the clinician, exclusion can result in reduced self-esteem and depression, and in some cases, the clinician may feel suicidal. The clinician's family can also be adversely affected. A number of clinicians never work again, even if they are exonerated by enquiries. Clinical staff may well have undertaken expensive training and, with shortages of many staff across the NHS, unnecessary exclusions or cases where clinicians consider they have been driven out of the health service are of concern, both in terms of personal fairness and equity, and waste of scarce resources.

Professor Wendy Savage

"The loss of my job was like a bereavement. Powerful, confusing and shifting emotions swept over me - disbelief (can this really be happening?), sadness, guilt, self-doubt and anger."

Source: Wendy Savage 'A Savage Enquiry' Virago Press Ltd 1986

3 Trusts may exclude clinical staff from work where there are concerns about patient safety or where there are allegations of gross misconduct to enable them to undertake investigations. Exclusions may be done to protect the interests of patients, other staff, or the clinician concerned until the outcome of an investigation is known. Formal suspension is deemed in law a 'neutral act' but in practice it is rarely perceived as neutral by NHS staff, patients or the wider public.

4 On the other hand patient safety is paramount and highly publicised incidents such as those which occurred over children's heart surgery in Bristol[1], where poorly performing doctors continued to practice, highlight the importance of effective arrangements for investigating allegations. Where patient safety is at risk, the opportunity to exclude staff from work or restrict their activities so that the situation can be defused and investigated at the earliest opportunity is vitally important. But all parties need to be confident that the process is fair, open and transparent, and the Department of Health (the Department) has a key role to play in encouraging local trust management to establish an open culture for reporting and examining clinical incidents and promoting organisational learning.

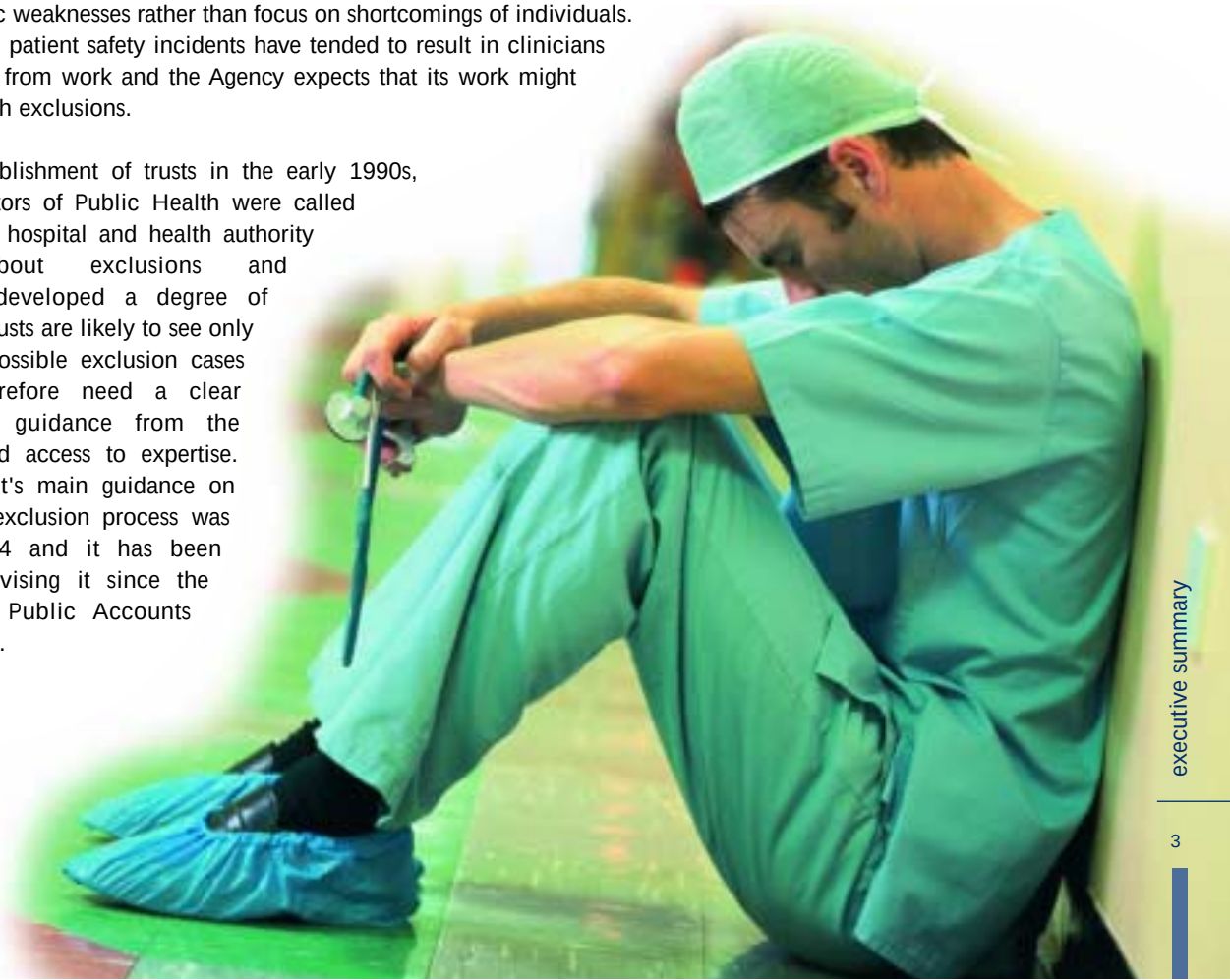
5 Cases are often high profile and the Committee of Public Accounts examined the case of Dr O'Connell, who was suspended for more than 11 years, in its 1995 report.[2] Since then there have been a number of cases of doctors being excluded for many months and sometimes years. This report examines the extent and costs of exclusions, the management of the process by trusts and the effectiveness of arrangements to protect patients where staff are excluded. Whilst it tends to focus on doctors because of the costs and high profile of such cases, it includes data on the exclusion of all clinical staff and draws on recent research on nurse suspensions. We have also published a complementary report *'Achieving Improvements through Clinical Governance'* (HC 1055, Session 2002-03) which examines the wider aspects of improving clinical quality and safeguarding high standards of care.[3]

6 A number of organisations are involved in managing the exclusion of clinical staff and supporting poorly performing clinicians:

- The Department provides central guidance and monitors suspensions of doctors lasting more than six months. In April 2001 it established the National Clinical Assessment Authority to provide an expert advice and assessment service where there are concerns about a doctor's performance.
- Trusts as employers are responsible for instigating all exclusions and their management, with chief executives ultimately accountable for decisions. Some consultants who were in post before 1990 retain national contracts and have a right of appeal to the Secretary of State if dismissed on grounds of professional competence or conduct. Under the Department's proposals for new contracts, those consultants would no longer have such a right of appeal to the Secretary of State.
- Professional regulatory bodies such as the General Medical Council and the Nursing and Midwifery Council are responsible for maintaining professional registers and conducting disciplinary investigations which can result in clinicians being struck off the professional register. They also encourage staff to undertake appropriate continuing professional development.
- The professional Royal Colleges provide external expertise. Trusts may invite rapid response teams from the Royal Colleges to carry out an independent assessment of a clinician and make recommendations for future training and employment.
- Professional associations and trades unions provide support to excluded clinical staff. Also the medical defence organisations and their lawyers represent many doctors in investigations.

7 In July 2001 the Department established the National Patient Safety Agency to encourage the reporting of patient safety incidents and to learn from analyses of such incidents. Its work promotes an open culture where trusts look to identify systemic weaknesses rather than focus on shortcomings of individuals. In the past such patient safety incidents have tended to result in clinicians being excluded from work and the Agency expects that its work might help reduce such exclusions.

8 Before the establishment of trusts in the early 1990s, Regional Directors of Public Health were called upon to advise hospital and health authority managers about exclusions and subsequently developed a degree of expertise. But trusts are likely to see only a handful of possible exclusion cases and they therefore need a clear framework of guidance from the Department and access to expertise. The Department's main guidance on managing the exclusion process was issued in 1994 and it has been working on revising it since the Committee of Public Accounts hearing in 1995.



9 More progress has been made in providing access to expertise. Since his appointment in 1999, the Chief Medical Officer, Sir Liam Donaldson, has taken a close interest in long term cases of doctor suspensions. Following consultation on *'Supporting Doctors, Protecting Patients'*,[4] in April 2001 the Department established the National Clinical Assessment Authority to provide expert advice to trusts and doctors (Appendix 3). In its first two years of prototype operations it received 500 requests from trusts and dealt with most of these through advice and support, and in 10 per cent of cases it has needed to carry out a full clinical performance assessment of the doctor. The Authority has helped prevent a number of suspensions. For example it analysed a sample of 36 referrals and in 30 cases identified alternatives to suspension. The Authority has developed targets for dealing with enquiries, ranging from a 24 hour emergency service to completing detailed assessments in three months. It has not proved possible to achieve all turnaround targets as in part the Authority is dependent on cooperation with a number of organisations and people - trusts and other organisations referring doctors to it, Royal Colleges, the General Medical Council and doctors. In December 2001 the Chief Medical Officer wrote to all trusts, emphasising the need for them to consult the Authority prior to suspending a doctor but our survey found that a number of trusts had not contacted the Authority.

10 Some doctors who have gone through the assessment process told us of their concerns, pointing to an overall lack of transparency. There was uncertainty about timetables and who was to be interviewed, and it was not clear how doctors' comments on draft reports were to be incorporated.

11 In addition to the National Clinical Assessment Authority, in 2002 the Chief Medical Officer appointed a former human resources director, as a special adviser, to review suspension cases lasting more than six months and advise trusts. By April 2003 he had reviewed over 50 cases and helped resolve two thirds of them. The Chief Medical Officer has also undertaken a special exercise to identify the extent of informal suspensions, sometimes referred to as 'gardening leave', amongst doctors. Since June 2003 the Chief Medical Officer's adviser transferred to the National Clinical Assessment Authority to take forward the review of long term exclusions whilst continuing to provide direct advice to the Chief Medical Officer.

12 As demonstrated by the establishment of the National Clinical Assessment Authority and the appointment of the Chief Medical Officer's special adviser, the Department's focus has been on doctors and there are no similar arrangements for other clinical staff. The Department's Clinical Governance Support Team, part of the Modernisation Agency, has a role to play in promoting effective team working. As part of *Shifting the Balance of Power*,[5] the Strategic Health Authorities' performance management role should include effective scrutiny of trusts' management of exclusions and they may be able to provide external advice.

13 A key objective in managing exclusions is to ensure that suspension is only used as a last resort as once suspension has been embarked upon, it can prove very difficult to resolve. There are various alternatives to suspension which trusts need to consider at the outset. It may be possible to restrict some clinical activities, avoiding certain procedures or types of patient, whilst enabling an investigation to be conducted. Clinical staff may be able to undertake clinical audit or research activities, or attend training courses. From discussions with clinicians and our expert panel, there is concern that in some instances trusts rush to exclude staff without considering alternatives. A number of exclusions occur as a result of a breakdown in team working or personality clashes where there appears to be no risk to patients. Where there have been patient safety incidents, trusts have sometimes excluded clinicians despite evidence of systemic failures rather than individual shortcomings. The work of the National Patient Safety Agency and others in developing a decision tool to assist trusts to examine such incidents should help reduce the number of unnecessary and inappropriate exclusions (Appendix 4).

14 Where exclusions are required good practice includes: timely investigations, reviewing the need to continue exclusions, identification of alternatives and drawing up effective management plans for exclusions. Most trusts recognise the need for these processes to be in place but the evidence from the numbers and length of exclusions identified in our survey suggests that basic management principles are not being followed in a number of cases. Cases can drag on for months and years with delays occurring at all stages: in informing clinicians of the allegations to be investigated, providing the required documentation, undertaking investigations and clinical assessments, and implementing recommendations. We also found many of the problems identified in the 1995 Dr O'Connell case were still prevalent: a failure to follow guidelines, continued use of confidentiality clauses in settlements, and poor cost information. There is therefore a pressing need for the Department, Strategic Health Authorities, and trusts to improve their management.

15 Clinical audits, which are a key component of clinical governance, should provide a barometer of clinical staff performance but audits are often underdeveloped or non-existent, and their patchiness contributes to delay in investigating exclusions.[3] Had clinicians carried out audits of their work, there would have been a much clearer picture of relative clinical performance, and where there was evidence of shortcomings, it would have been easier to provide support and training. In the absence of clinical audit information, external assessors from the Royal Colleges and, more recently, the National Clinical Assessment Authority have to undertake their own assessments from case notes. Judgements may not be clear cut and there can be considerable disagreement on the findings between the clinician and assessment team.

16 The professional bodies for clinical staff encourage their members to undertake continuing professional development. Increasing attention is being paid to professional development. For example as part of revalidation from 2005 continuing professional development will be a requirement for doctors to maintain their registration. When clinicians are excluded there is a risk that they will not be able to continue their training and development. Trusts therefore need to support excluded clinical staff to enable them to progress their continuing professional development.

17 A number of doctors who contacted us raised concerns that ethnicity and gender might be factors in doctor exclusion cases.[6] Our survey of all doctor exclusions lasting more than six months showed that while a slightly higher proportion of ethnic minority doctors were excluded, the difference was not statistically significant. When looking at consultants, however, a significantly higher proportion of ethnic minority consultants are excluded. As regards gender, significantly more men are excluded than women. The overall position though may mask some types of surgery where there are very small numbers of women surgeons and where one or two exclusions can result in a very high proportion being excluded.

18 Where staff are excluded there are important implications for patient safety. There is a need to: inform other employers of concerns, carry out proper employment checks, including registration and criminal bureau checks, and conclude investigations quickly.

- In cases where there are patient risks and the clinician is likely to seek other employment, trusts are required to inform potential employers of their concerns. For doctors there is a long established system of alert letters and from January 2003 the Department extended a similar system for other clinical staff. Up to then procedures for clinical staff other than doctors relied on action being taken by the professional regulatory bodies but from our survey only one third of trusts advised the regulatory body of problems regarding such staff.
- As part of their pre-employment checks most trusts review alert letters but trusts are concerned whether they hold complete sets of alert letters and whether letters have been rescinded. Trusts consider that a web-based database would be more effective. There are also weaknesses in other pre-employment checks, in particular obtaining declarations from clinical staff of their fitness to practice, and in obtaining assurance for overseas qualifications, locum and agency staff.
- When staff resign during an investigation one fifth of trusts do not conclude the investigation, and this means it may not be possible to alert prospective employers of any concerns about the clinician.

19 The Department has emphasised the need to look beyond the shortcomings of individuals. The National Patient Safety Agency encourages the reporting of patient safety incidents and examination of these to determine underlying systemic weaknesses. We plan to report on these wider issues of patient safety in 2004.

Recommendations

20 There are a number of steps that need to be taken to improve the whole management of exclusion of clinical staff. The Department needs to:

Develop better guidance, enhance expertise and promote organisational learning

- Update guidance on the exclusion process to take account of the National Clinical Assessment Authority, the National Patient Safety Agency's work and the findings from this report;
- Extend its monitoring to all long term exclusions of clinical staff, not just formal suspensions of doctors;
- Require Strategic Health Authorities to scrutinise the length and costs of exclusions as part of their performance management work;
- Hold the National Clinical Assessment Authority accountable for achieving its various response times for referrals set out in its business plans, including completion of assessments;
- Encourage the National Patient Safety Agency in its evaluation of its decision tool for examining patient safety incidents and the implications for staff exclusions where patient safety is a factor and, if deemed successful, promote its use across the NHS;
- Encourage trusts to make more use of Clinical Governance Support Teams in working with poorly performing teams;
- Encourage trusts to improve the extent and coverage of clinical audit through working with Clinical Governance Support Teams, the Modernisation Agency, and the proposed Commission for Healthcare Audit and Inspection so that staff regularly assess their clinical performance against peers to ensure improvements in patient care;
- Encourage trusts to support excluded clinical staff in their continuing professional development;
- Clarify the roles and responsibilities of host organisations providing retraining and employing trusts where staff require external training;
- Taking account of human rights legislation and other legal issues, consider the feasibility of establishing a national web-based database for alert letters for all clinical staff, which is regularly maintained;
- Keep ethnicity and gender of exclusions under review through the National Clinical Assessment Authority's monitoring of referrals to it and ensuring that trusts have effective diversity programmes raising awareness of ethnicity issues and robust monitoring systems; and
- Encourage the promotion of an open and fair culture where all learn from patient safety incidents and near misses, through systematic analysis of root causes, and through the work of the National Patient Safety Agency and others.

21 In managing exclusions trusts need to:

Initial investigations

- Inform staff of any investigation at the earliest opportunity;
- Undertake a rapid investigation within two weeks to determine if there is any case, including obtaining an independent view and discussion with staff against whom allegations are made;
- Adopt a systematic approach to reviewing incidents, through analysis of root causes, to ensure that contributory systems weaknesses are examined and that the focus is not just on individual error or blame;

- Ensure that they seek advice from the National Clinical Assessment Authority for all doctor cases;
- Ensure the initial investigation results in clear identification of what the allegations are and that these are communicated to all parties in writing;
- Only use suspension where there is a risk to patient safety, the member of staff or colleagues, or to ensure an investigation is unhindered. Where there is clear evidence of gross misconduct disciplinary procedures should apply;
- Consider alternatives to suspension such as restrictions on practice, retraining or moving post; and
- Limit the initial investigation to a maximum of two weeks, after which staff would return to work unless formally suspended.

Case management

- Ensure there is an effective management plan, with named managers for each case, clear timetables set in line with guidance and achieved, and costs monitored;
- Ensure trust boards are appraised of the duration and forecast costs of each exclusion and that they review progress as part of their board meetings;
- Nominate a non executive director to scrutinise exclusions and encourage expeditious management and resolution of cases;
- Ensure external advice is sought and acted upon, including clinical assessments by the National Clinical Assessment Authority and the Royal Colleges;
- Where staff return to work, ensure systems are in place to provide support to staff so that they are successfully integrated back into clinical work;
- Strengthen investigations training for staff involved in managing exclusions, including root cause analysis; and
- Provide a support system for excluded staff which includes regular contact with a mentor to ensure their psychological well being is monitored and they have access to continuing professional development so their skill base is maintained.

Protecting patients

- Where there are concerns about a doctor's performance, NHS bodies should contact the National Clinical Assessment Authority at the earliest opportunity, engage constructively with the Authority, respond speedily to its recommendations and implement action plans;
- Ensure professional regulatory bodies and other potential employers, including private sector hospitals and locum agencies, are informed where there are concerns for patient safety;
- Ensure that investigations are properly completed when staff resign during investigations;
- Ensure pre-employment checks are properly carried out, particularly for locums and overseas qualifications, and ensure they obtain fitness to practice declarations as required by the Department;
- Ensure there are effective systems in place for identifying and examining patient safety incidents, including the promotion of an open and fair culture and effective 'whistle blowing' procedures; and
- Require all staff to participate in clinical audits through the Commission for Healthcare Audit and Inspection's clinical national audit programmes and though extending local clinical audit arrangements.

Part 1

The scale and costs of exclusions

1.1 The Department requires trusts to collect data on doctors who have been suspended for more than six months but it does not monitor informal procedures such as 'gardening leave', nor does it monitor exclusions of other clinical staff. This Part examines the extent and costs of exclusions based on our survey of all NHS hospital and ambulance trusts in England.

1.2 In summary our survey shows that just over 1,000 clinical staff were excluded for at least one month between April 2001 and July 2002, and we estimate annual gross costs of some £40 million. While doctors make up one fifth of all cases, they account for three quarters of the costs. The average length of doctor exclusions was 47 weeks and in 40 per cent of cases the doctor returned to work. For other clinical staff exclusions averaged 19 weeks and 44 per cent returned to work.

Why clinical staff may be excluded from work

1.3 Although the NHS can normally rely on the dedication and professionalism of its staff, on occasion it becomes necessary to exclude clinical staff from the work place. Indeed the ability of a trust to exclude a staff member as a precautionary measure where there is evidence or suspicion of patient risk is an important management tool. For the purpose of this report, we have used the term 'clinical staff' or 'clinicians' to comprise all healthcare professionals involved in patients' treatment. We present analysis for two groups: consultants, doctors and dentists (referred to as 'doctors' in this report) and 'other clinical staff' **(Figure 2)**.

2 The main groups covered by the term 'Clinical Staff'

Consultants, Doctors and Dentists (1)	Physiotherapists
Nurses	Occupational Therapists
Midwives	Arts, Speech & Language Therapists
Health Visitors	Dieticians
Radiographers	Orthoptists
Clinical Scientists	Prosthetists & Orthotists
Pharmacists	Chiropodists/Podiatrists
Clinical Psychologists	Paramedics

NOTE

1. The report includes analyses for this group, referred to as 'Doctors', and all other groups, referred to as 'Other Clinical Staff'.

1.4 Exclusions take two main forms: informal arrangements where clinical staff agree to stay away from work, sometimes referred to as 'gardening leave'; and formal suspensions. Throughout the duration of their exclusion, staff receive their full salary. Suspensions arise from questions of personal conduct, professional conduct, or professional competence. Suspension is not an end in itself but is used to enable trusts to investigate concerns about an individual's conduct or capability. It is deemed in law to be a neutral act intended to protect the interests of patients, other staff, or the practitioner concerned, until the outcome of an investigation is known. In practice, however, it is rarely perceived as neutral, and can adversely affect a practitioner's career and reputation, even when exonerated. When staff are excluded they are often prohibited from entering the work place. This may impact on their continuing professional development, an increasingly important component of continued professional registration and revalidation.

3 Key Stakeholders

Trusts are responsible for managing exclusions. There are a number of departmental bodies (blue), non-departmental bodies (yellow), which trusts may call upon for assistance or advice, as well as clinical staff advisors (green).

Source: National Audit Office

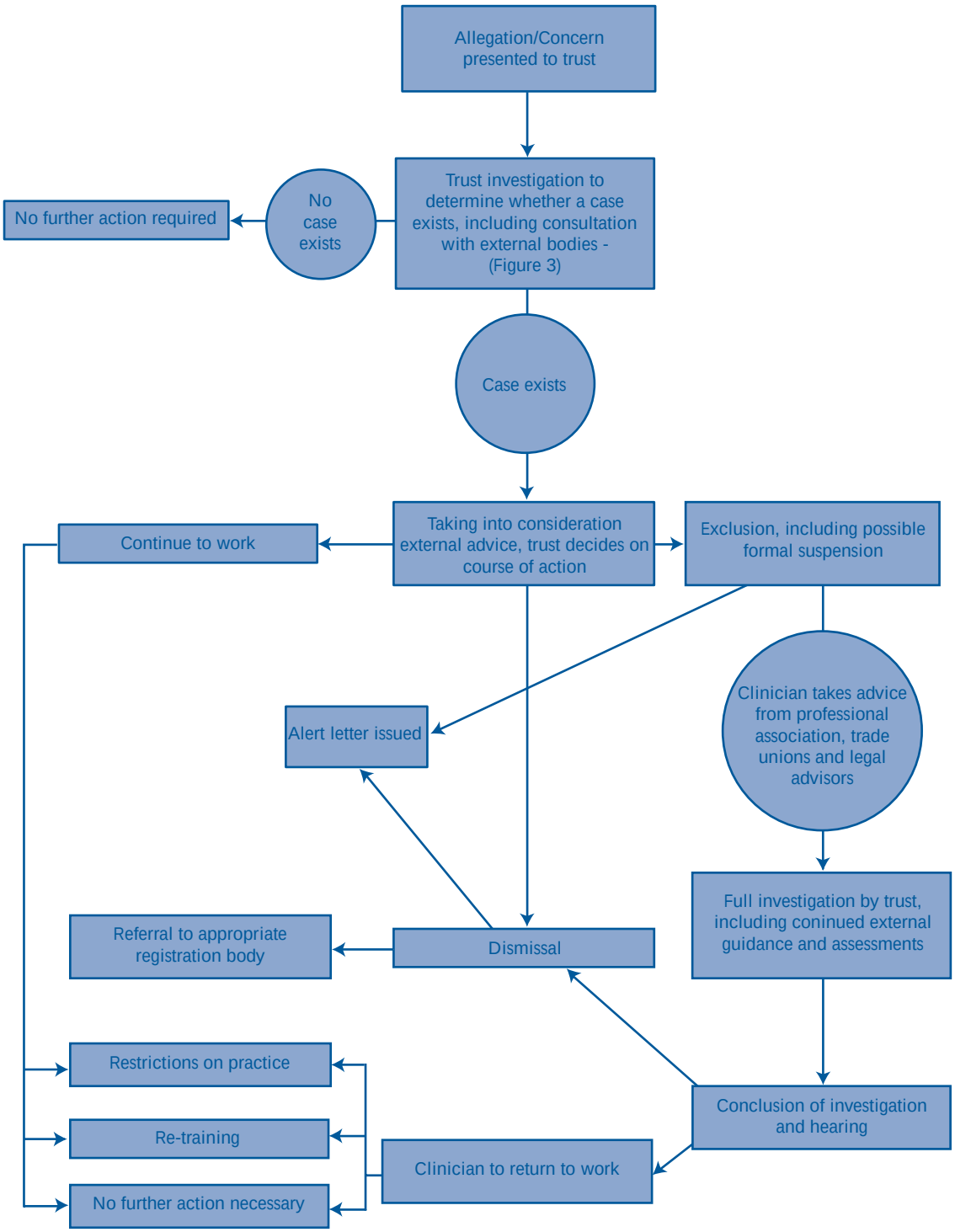
1.5 Since the early 1990s NHS trusts, as separate legal bodies, have been responsible for setting employment conditions for their staff, including exclusions in relation to employment. In addition professional regulatory bodies have powers to restrict or suspend a clinician's registration and hence a clinician's ability to practice in any health care environment. Trusts can refer their concerns about a Clinician's conduct and competence to the relevant regulatory body and, as part of an investigation, can seek advice from experts from the Royal Colleges. In 2001 the Chief Medical Officer wrote to trusts, encouraging them to contact the National Clinical Assessment Authority in all circumstances where there are concerns about a doctor's or dentist's performance. In addition, clinical staff are normally supported by their professional associations and trades unions, and can call upon the services of medical defence organisations, including legal representative. **Figure 3** shows the main bodies involved and **Figure 4** presents a flow chart of the process.

Committee of Public Accounts hearing on *The Suspension of Dr O'Connell*

1.6 The Committee of Public Accounts examined the suspension of Dr Bridget O'Connell in 1995 (Appendix 2).[2] The Committee criticised North East Thames Regional Health Authority for failing to confront the problem of resolving the suspension which continued for 11 years and was only brought to a head by the doctor's legal action. It was concerned that no manager had been disciplined and that the Department was slow to become involved. The Committee was disturbed at the costs of £600,000 (plus the legal costs of the then regional health authority) and found it unacceptable that the figures in the eventual settlement were intended to remain confidential. It noted that trusts were not compelled to follow new (October 1994)

4 The exclusion process for clinical staff

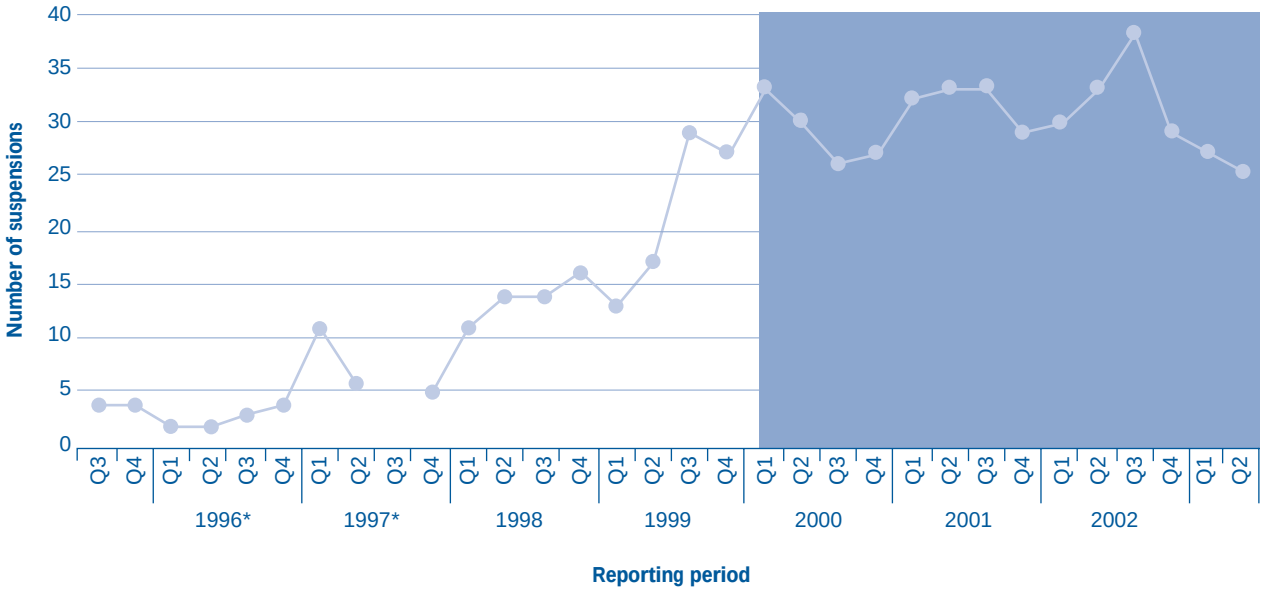
The exclusion process varies in complexity. While some exclusions are straightforward others can involve detailed investigations with trusts and clinicians represented by lawyers.



Source: National Audit Office

5 Number of doctors suspended for longer than six months

The Department considers that data are only reliable from 2000 and since then, at any one time, some 30 doctors have been suspended for more than six months.



Source: Department of Health

guidelines on suspensions and the Department did not monitor compliance; and that individual trusts might lack the expertise to deal with complex clinical and legal issues that could arise with suspensions. The Committee looked to the Department to develop expertise to which the trusts could turn for support.

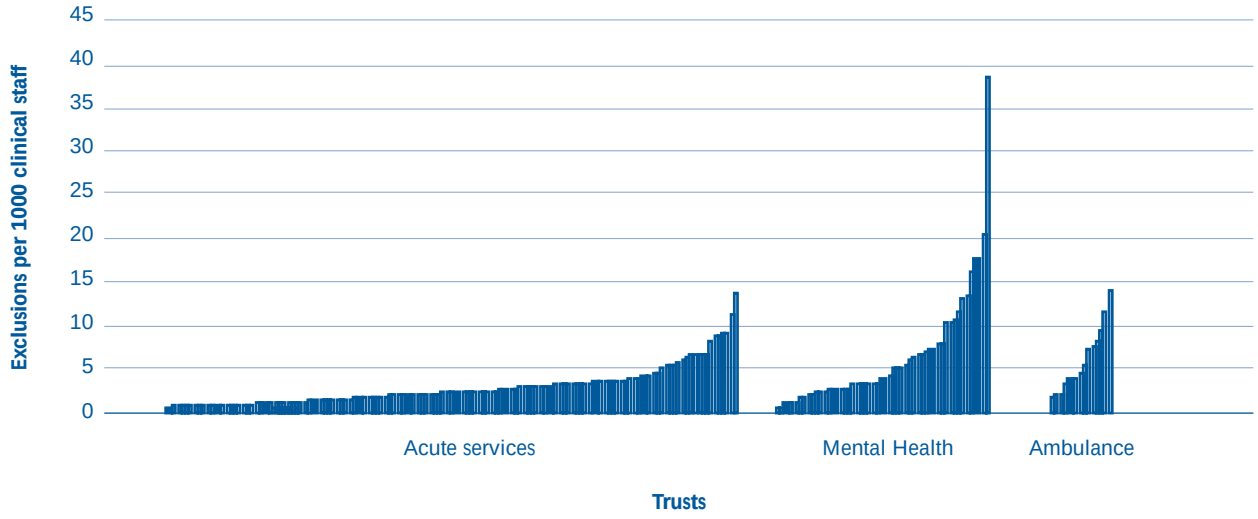
1.7 The responding Treasury Minute covered the management of the individual case and, more generally, reported that new guidance issued to NHS employers made trust chief executives responsible for doctor suspensions. The Department was confident this and new monitoring arrangements would prompt quick resolution of cases by bringing in earlier central intervention. The Department undertook to provide details of suspensions exceeding six months in October 1996 (which it did in December 1996); and to review the guidelines by October 1997. The Department's review was subsumed into the Chief Medical Officer's consultation document *Supporting Doctors, Protecting Patients*[7] which is discussed in Part 3 of this report, but the Department has not issued further guidance on exclusions.

The Department's monitoring of the cost and duration of exclusions

1.8 The Department monitors long term formal suspensions of doctors but not informal suspensions such as 'gardening leave', nor does it collect information on other clinical staff. In response to the Committee of Public Accounts' 1995 report, every three months the Department collects data from trusts on all suspensions of doctors which have lasted more than six months. In the first years reporting was not properly established and the Department considers that its monitoring has only been accurate since 2000. Since then at any one time some 30 doctors have been suspended for six months or more **(Figure 5)**. While the Department does not routinely publish its figures on long term suspensions, it regularly provides the information in response to parliamentary questions. The Chief Medical Officer also included an analysis of the data in his 2002 annual report, commenting on the relatively constant number of cases and their stable turnover - a steady number of cases being resolved but being replaced by new cases.[8]

6 Number of exclusions by trust

Two fifths of mental health trusts and a quarter of ambulance trusts had more than 5 exclusions per 1,000 clinical staff, compared with one tenth of acute trusts.



NOTE

The '5 exclusions per 1,000 clinical staff' figures are used purely for comparisons.

Source: National Audit Office survey

1.9 As a result of concerns about the increasing numbers of long term suspensions, in 2002 the Chief Medical Officer appointed a former human resource director to examine all long term doctor exclusions. He has visited all trusts with long standing exclusions to help see if resolutions can be found and in the last 12 months has reviewed some 50 cases, assisting in the resolution of two thirds of them. He has also carried out a one-off special exercise to review cases of informal suspensions, which identified some 35 doctors excluded from work but not formally suspended.

Our survey of trusts and methodology

1.10 As the Department only has data on long term doctor suspensions, we surveyed all NHS hospital and ambulance trusts in England to collect data on the numbers of exclusions of clinical staff lasting more than one month from April 2001 to July 2002. We covered all clinical staff, not just doctors, and collected data on the duration of exclusions, their estimated costs and the management processes. In addition we visited a number of trusts to discuss their responses and validate the data given to us. Some 50 excluded clinicians also contacted us and provided us with information about their experiences. Appendix 1 gives details of our methodology.

The numbers of excluded clinical staff

1.11 Trusts reported that 1,063 clinicians were excluded from work for at least one month during the period April 2001 to July 2002. Of these, 206 (20 per cent) were consultants/doctors, 567 (53 per cent) were nursing staff and midwives, and the remaining 290 (27 per cent) consisted of allied health professionals.

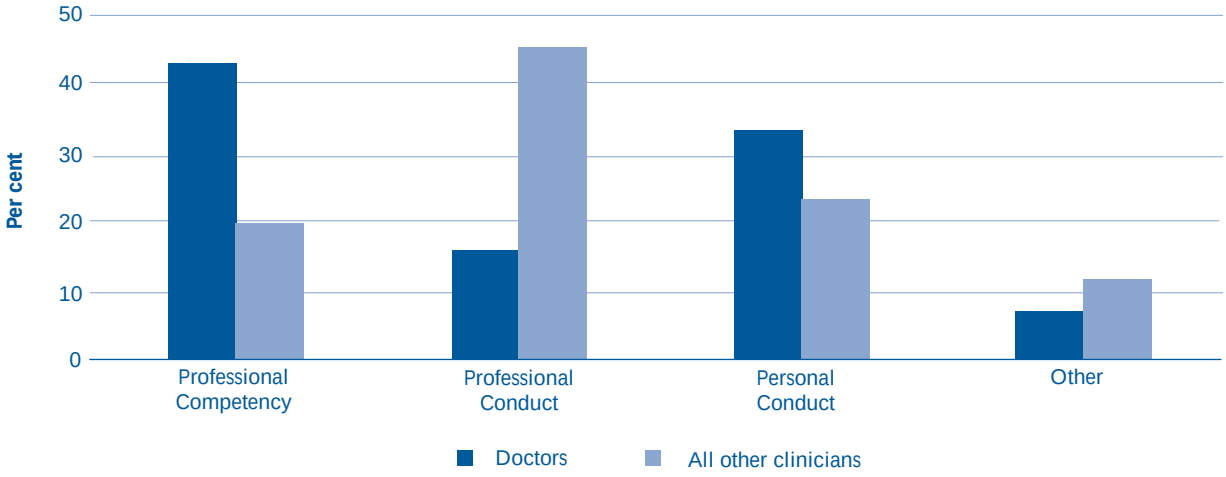
1.12 The number of exclusions per 1,000 clinicians varies across trusts **(Figure 6)**. One quarter of trusts reported no cases and the majority (60 per cent) had between 1 and 5 cases. The 15 per cent of trusts with more than 5 cases tended to be mental health and ambulance trusts, where the nature of the clinical work may generate a disproportionate number of allegations from patients.

Reasons given by trusts for excluding clinical staff from work

1.13 Reasons for exclusions vary, and professional competence was cited in just under a quarter (23 per cent) of all cases. There is, however, a marked difference in the reasons given for excluding doctors and other clinical staff **(Figure 7 overleaf)**. For example, trusts identified concerns about professional competence in 44 per cent of doctor cases but this fell to 19 per cent for other clinical staff.

7 Reason for exclusion of clinicians

Where staff were excluded, doctors were excluded on professional competence grounds more than twice as often as other clinical staff, although only a third as often for professional conduct.



NOTE

While there can be considerable debate on categorisation, **professional conduct** covers physical assault/abuse of patients or inappropriate behaviour to patients while **personal conduct** includes theft, fraud and alcohol use.

Source: National Audit Office survey

8 The different types of exclusions

While formal suspension is the most common type, compared with other clinical staff, doctors are less likely to be formally suspended and are placed on special leave five times more frequently.

Source: National Audit Office survey

Types of exclusions

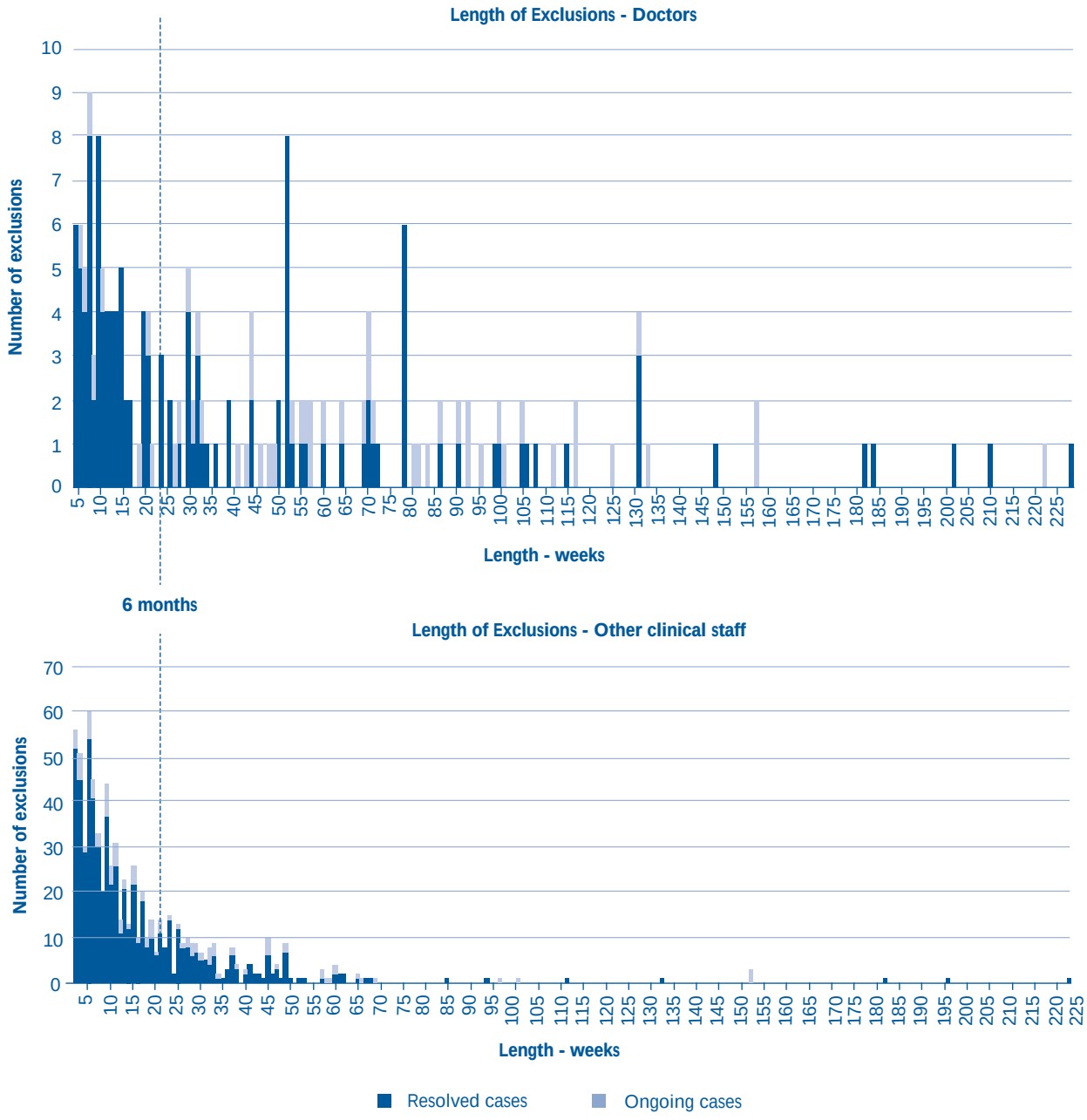
1.14 Formal suspensions accounted for 88 per cent of the 1,063 cases. Again there were differences between doctors, where one fifth were excluded without being formally suspended, and other clinical staff, who were more likely to be suspended **(Figure 8)**.

The length of exclusions

1.15 The average length of exclusion is more than twice as long for doctors (47 weeks) as it is for other clinicians (19 weeks). **Figure 9** shows that just over half of doctor cases (55 per cent) lasted more than six months compared with under a quarter of other clinical staff cases (23 per cent). Trusts told us that it is particularly difficult to deal quickly with excluded doctors as their agreed terms of employment afford them considerable protection which for some includes retaining a right of appeal to the Secretary of State.

9 Length of exclusions for doctors and other clinical staff

Doctors are excluded longer than other clinical staff and proportionately more doctors are excluded for longer than six months at which point cases are reported to the Department.



Source: National Audit Office survey

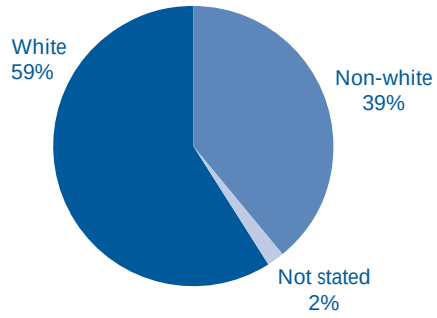
1.16 Of the 1,063 exclusions in our survey, 874 cases had been concluded but 189 cases were continuing at the time of survey. One third of doctor cases (63) were ongoing, of which 46 were already ongoing for at least six months. For other clinical staff 15 per cent of cases (126) were ongoing. Doctor cases took twice as long as cases involving other clinical staff: 38 weeks compared to 18 weeks for resolved cases and 68 weeks compared to 28 weeks where cases were still ongoing.

1.17 During the course of our work, a number of clinicians raised concerns about possible bias as regards ethnicity and gender. We therefore collected additional data on all doctor exclusions which had lasted more than six months. **Figure 10 overleaf** shows a higher proportion of ethnic minority doctors were excluded compared with the proportion of ethnic minority doctors working in trusts, but the difference is not statistically significant. This picture is similar to the

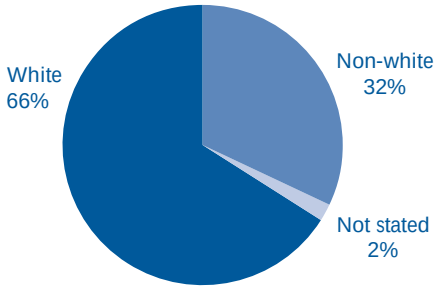
10 Ethnicity and gender in long term exclusions

A higher proportion of ethnic minority doctors are excluded, but the numbers are significant only as regards consultants. Significantly more men than women are excluded.

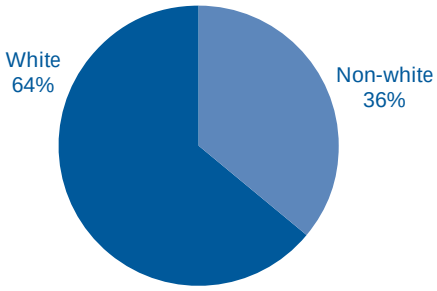
Doctors excluded longer than six months



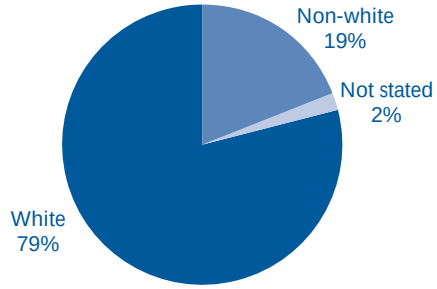
Doctors in hospital and ambulance trusts in England



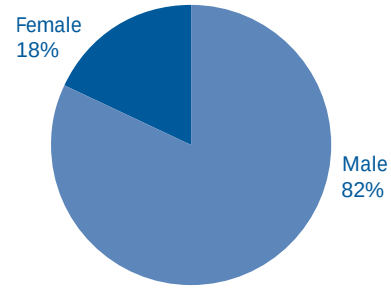
Consultants excluded longer than six months



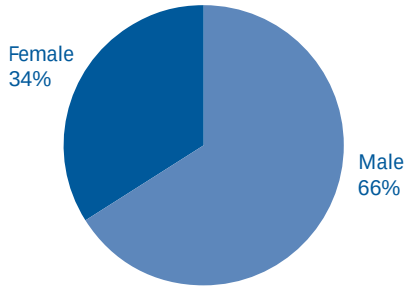
Consultants in hospital and ambulance trusts in England



Doctors excluded longer than six months



Doctors in hospital and ambulance trusts in England



NOTE

The charts on the left show proportions of doctors excluded and the charts on the right show the overall population.

Source: National Audit Office survey and Department of Health statistics

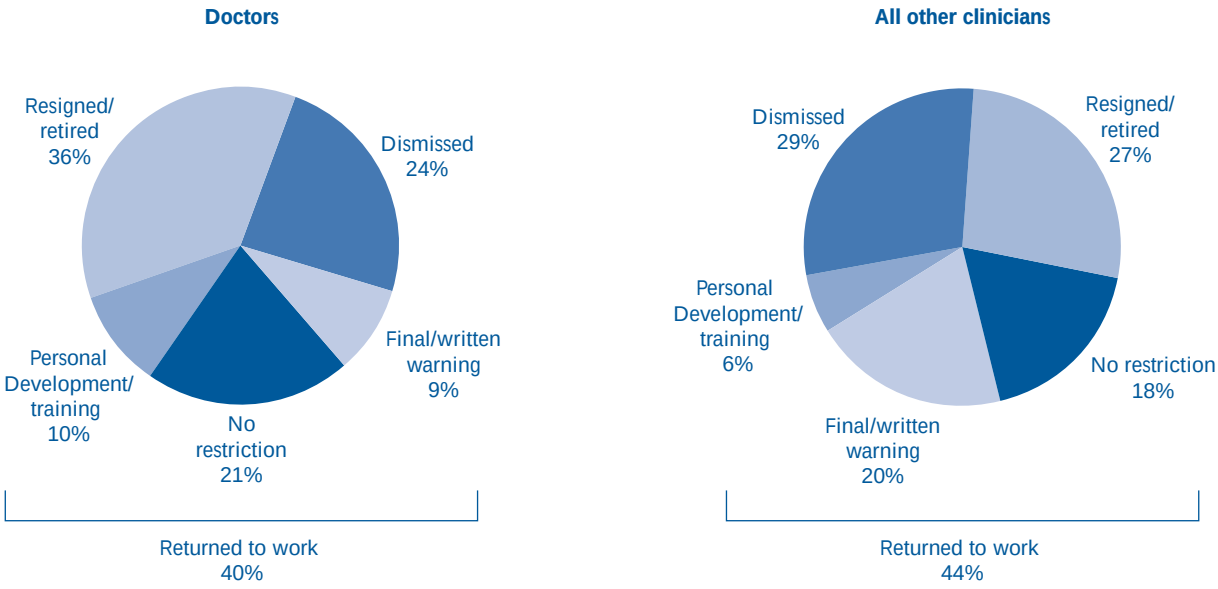
National Clinical Assessment Authority's monitoring of referrals to it. However, when we looked just at consultants we found that a significantly higher proportion of ethnic minority consultants were excluded compared with the proportion of ethnic minority consultants working in trusts. As regards gender, significantly more men are excluded than women. The overall position may hide some areas where gender may well be an issue and in some specialities, for example breast and plastic surgery, a handful of exclusions can result in a high proportion of women being excluded, given the small numbers of women surgeons.[9]

The outcomes of exclusions

1.18 In over half of the 874 resolved cases, clinical staff did not return to the trusts where they worked before exclusion **(Figure 11)**. Over a quarter of all cases resulted in the dismissal or termination of employment of the clinician (24 per cent of cases involving doctors and 29 per cent of other clinicians). Doctors were more likely to resign (20 per cent of cases involving doctors compared with 16 per cent of other clinical staff resigned). Where staff did return to work, doctors were more likely to undertake personal development or retraining while other clinicians were twice as likely to receive final or written warnings.

11 Outcome of exclusions

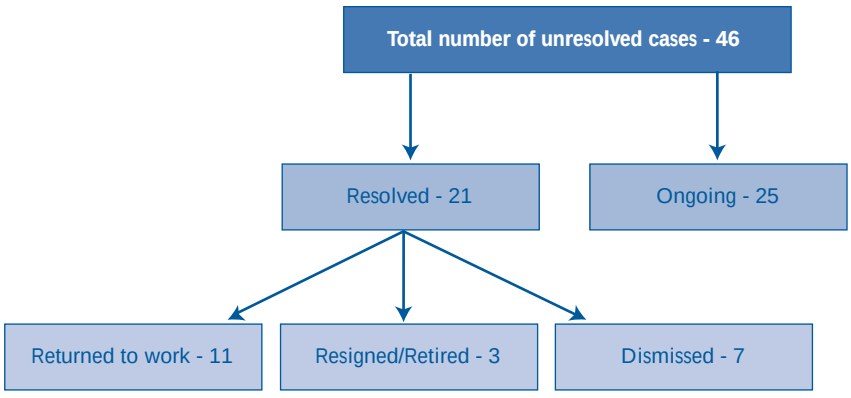
More than two-fifths of doctors and other clinicians returned to work, although significant numbers of clinicians were subject to disciplinary proceedings and trusts required some clinicians to undertake retraining.



Source: National Audit Office survey

12 Follow up survey of doctor cases which were ongoing in July 2002

In June 2003 just over half of the doctor cases ongoing at the time of our original survey were still unresolved.



Source: National Audit Office survey

1.19 As part of our follow up work, in June 2003 we re-surveyed the 46 doctor cases that were ongoing for longer than six months at the time of our original survey (paragraph 1.16). Our results show that 25 cases were still ongoing and 21 were resolved, with half of these cases ending in dismissal **(Figure 12)**. Trusts were reluctant to seek assistance from external bodies. For example trusts highlighted the role of the National Clinical Assessment Authority in seven of the resolved cases and in eleven of the ongoing cases.

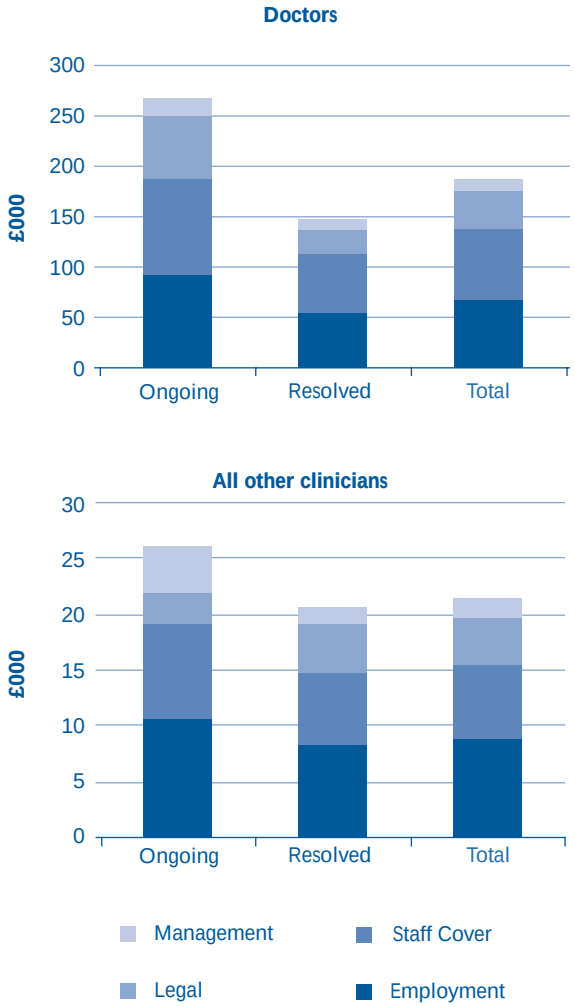
The cost of exclusions

1.20 In estimating the cost of exclusions, our starting point was to collect data from trusts on the gross costs associated with exclusions - the employment costs of the excluded clinician, costs incurred on staff cover to replace the excluded clinician, management time related to the administration of the exclusion, including investigations of allegations or events leading to the exclusion, and legal costs. The additional costs of

exclusion are lower as the excluded clinician's salary would be incurred in any event. Trusts provided cost estimates in 758 cases (71 per cent of all cases) totalling £29 million. While some trusts provided estimates for all categories of cost many provided data in only one or two categories and some were unable to provide any information. Using average weekly costs **(Figure 13)** and extrapolating across cases where we did not have full data, we estimated that the total gross costs of exclusion across all cases could be £57 million. The doctor exclusions made up 74 per cent of all reported costs but only 20 per cent of cases. As some cases last considerably longer than 12 months, we further estimated the **annual** gross cost associated with excluding clinicians based on average weekly costs and the average numbers of excluded clinicians, at £30 million **(Figure 14)**.

13 Average costs of exclusions

Doctor exclusions are up to ten times more costly than exclusions of other clinical staff, in part because of the length of time of doctor exclusions and higher salaries and legal costs.



Source: National Audit Office analysis

1.21 These estimates do not include the costs of any settlements and retraining. Such cases are limited, but costs can be significant:

- Some cases are concluded with trusts and clinicians agreeing a settlement whereby the clinician receives a payment and agrees to resign. Trusts reported 18 cases at a cost to the NHS of £670,000. The average settlement in the ten doctor cases was £62,000.
- Where clinicians are excluded, they may well require retraining before returning to work. The longer the exclusion, the greater the requirement for retraining. Retraining can be costly, particularly for consultants, and trusts may have to continue employing locum cover.

1.22 Our estimates are likely to be understated as trusts had considerable difficulty in estimating costs. In our visits to validate the data in some trusts we found that cost estimates were at best patchy, despite the Department's 1994 guidance calling on trusts to provide them to their boards. For example in one case the trust reported 60 per cent of the employment costs and staff cover and excluded legal costs of £31,000, an overall understatement of 50 per cent. A second trust provided data for our survey period but not for the first 18 months of the exclusion. A third trust provided details of a doctor on long term sick leave only after we had been contacted by the doctor. In other cases trusts understated management and legal costs by 50 per cent.

1.23 Trusts identified settlement costs in less than 10 per cent of the 230 cases which ended in resignation, retirement or mutual agreement. Not all of these cases would have included a settlement but we identified two cases where trusts excluded settlement costs from their estimates. Where there had been settlements, in two cases we identified confidentiality clauses. The Committee of Public Accounts has criticised the use of such confidentiality clauses in the Dr O'Connell case and more recently when reporting on 'Inappropriate Adjustments to Waiting Lists'.[10] The Department accepted that confidentiality clauses should not prevent trusts disclosing a settlement's circumstances to potential employers.[11] In following up the 46 long term doctor exclusions (paragraph 1.19), we identified two further cases where trusts had agreed confidentiality clauses in negotiating settlements with the excluded doctors.

14 The costs of exclusions

The gross annual costs of exclusions are some £40 million, comprising £11 million for the employment costs of the excluded clinicians and £29 million additional costs.

	April 2001 to July 2002		Annual cost of exclusions	
	Actual costs reported by trusts for 70 per cent of exclusions(1, 2, 3) £m	Extrapolated costs for all exclusions, covering all cost elements(2, 3) £m	Extrapolated costs for all exclusions, covering all cost elements (3) £m	Cost of exclusions, given level of under reporting of costs and allowing for settlement costs (4) £m
Employment costs of excluded clinicians	**8**	**16**	**9**	**11**
Additional Costs				
Staff Cover	*10*	*19*	*10*	*13*
Legal	*9*	*18*	*9*	*13*
Management	*2*	*3*	*2*	*3*
Additional Costs Sub-total	**21**	**41**	**21**	**29**
Total	**29**	**57**	**30**	**40**

NOTES

1. While trusts provided cost estimates for 70 per cent of all exclusions, many of these estimates did not cover all the cost elements - employment costs, cost of staff cover, management costs, and legal costs.
2. Costs estimates in the first two boxes cover exclusions which were current for one month between April 2001 and July 2002. A number of exclusions were already in place before the start of the period and the cost estimates cover the full duration of these exclusions. For example if an exclusion started in April 1998 but ended in April 2001, the whole cost of that four year exclusion would be reported.
3. Cost estimates in the first three boxes exclude the costs of settlements as these tend to be 'lumpy' - a small number of high costs cases.
4. Our validation work at trusts identified significant under-reporting of costs (paragraph 1.22).

Source: National Audit Office survey

1.24 Although negligence costs are not a direct cost of exclusion, where trusts undertake investigations of clinicians it can be difficult for them to defend negligence cases. We therefore asked trusts to provide details of resolved claims for clinical negligence cases associated with exclusion. Trusts reported 19 resolved claims of clinical negligence at a cost of £4.2 million: sixteen involved doctors and only three involved other clinicians. Cases can take many years to conclude and a number are unresolved. In our validation work we found that one trust excluded clinical negligence costs of more than £1 million.

1.25 Given the scale of under reporting in trust returns, the annual gross cost associated with clinical exclusions may be £40 million rather than £30 million (paragraph 1.22). Taking out the employment costs of the excluded clinician (paragraph 1.20), we estimate an annual additional cost of £29 million. If all cases were resolved within six months, staff cover and other resources would be available to provide additional services, worth some £14 million a year. In Part 2 we examine the scope for improving the management of exclusions which should lead to speedier resolutions of exclusions and significant cost savings.

Part 2

The efficiency of the exclusion process

2.1 Good practice in managing the exclusion process includes: timely investigations, identification of alternatives to exclusion, and project management. Timely external expert advice and examination of systems weaknesses through analysis of root causes, rather than focusing on individual blame, may help avoid exclusion in the first place. In this Part we examine how well trusts manage the process. In brief most trusts recognise the need for proper processes to be in place but the evidence from the numbers and length of exclusions suggests that basic management principles are ignored and many cases drift.

The Department's guidance on the suspension process

2.2 The Department's main guidance on doctor suspensions was issued in 1994,[12] around the time of the Committee of Public Accounts' enquiry into the suspension of Dr O'Connell. It aims to ensure that avoidable suspensions of doctors and dentists do not happen and that, if clinicians are suspended, it is for the minimum length of time. It operates alongside 1990 guidance on disciplinary procedures,[13] which in turn derives from guidance issued in 1961. The guidelines are for suspensions of doctors and do not deal with nurses, therapists, or other clinical staff who are subject to the local procedures adopted by their employing trust. As the guidelines incorporate good practices, however, trusts should find them helpful in managing other clinical staff.

2.3 Taken together the guidance describes a complex process which was designed when the NHS had a different organisational structure and employment pattern. For example, in 1990 hospital consultants were employed by the 14 Regional Health Authorities; they are now employed by any one of 270 NHS hospital trusts, or by primary care trusts. One consequence is a dissipation of expertise and experience in managing exclusions. As a result, trusts do not have the same familiarity with the process as their Regional Health Authority predecessors, which affects the way exclusions are managed. Under *Shifting the Balance of Power*, the Department has established Strategic Health Authorities. As part of their oversight and performance management work, they should scrutinise trusts' management of exclusions and may develop a useful source of expertise and advice for trusts.

2.4 The Department's guidance stresses that suspension should be seen as a neutral act. Suspension may be considered when a member of staff needs to be removed as a matter of patient or staff safety, or to aid the investigation. Any suspension should be for a limited time whilst further action is agreed. In recognition of this all suspensions should be on full pay. The procedures that should then be followed are:

- Trusts should identify a manager who would carry out the suspension, which should be done in a formal meeting, with a witness present.
- Any suspension should be immediately confirmed in writing.
- Details of allegations should be clarified and put in writing within ten days.
- Suspensions should be reviewed every two weeks and clinicians should be informed of the result of each review.
- Any investigations that are not completed within three months should be reported to the trust board, outlining reasons for the delay.
- Should the suspension continue, progress reports should be made to the board.
- If investigation shows that the allegations are without foundation or that the clinician can return to work while the investigation is completed, the suspension should be lifted.

2.5 The guidance provides a timetable for managing the process and encourages employers to adopt this but as Part 1 shows, these timescales are often missed **(Figure 15 overleaf)**.

15 The Department's recommended timetable for doctor exclusions

The timeline helps to establish milestones for trusts in the management of suspensions.

	Two Weeks	Three Months	Six Months
Decision to suspend	Case reviewed - then again every two weeks thereafter. Practitioner informed of results in writing following each review.	Case reported to the Trust Board, and updates given at all subsequent meetings of Board or Authority until resolved.	Case reported to the Regional office of NHS Executive, including actual and anticipated costs, reasons for delay and anticipated completion date.

Source: Department of Health HSG (94) 49[12]

2.6 The Department recognises that the existing procedures are unsatisfactory. The main problem is that they make professional conduct a disciplinary matter from the outset, whereas employers should ideally have recourse to disciplinary procedures only after more constructive approaches have been exhausted. Where there are questions of professional competence, a disciplinary procedure is not appropriate at the outset. Rather trusts should explore how to improve professional competence, although clinicians may have to leave if their competence cannot be improved. Other criticisms are:

- There are often protracted legal disputes over what constitutes 'personal', as distinct from 'professional', misconduct.[14] The practice is for trusts to deal with allegations of personal misconduct using their own procedures as for all other staff. But, where they relate to professional conduct or competence, many doctors must be dealt with under the nationally agreed procedures. This affords them greater protection than is given to other clinicians.
- Hospital doctors whose contracts have not been updated since 1990 have the right to appeal directly to the Secretary of State if they feel their appointment is being unfairly terminated with notice on grounds of professional misconduct or incompetence. This is seen as a deterrent to trusts taking action.
- The part of the disciplinary procedures used in serious cases of professional misconduct or incompetence is daunting and legalistic. As a result, NHS employers are reluctant to use it, thus failing to address doctors whose practice is giving concern.

2.7 The Department has proposed introducing national standards and a pro forma for local contracts for consultants which would see the establishment of a new disciplinary framework on a national basis, including the removal of the appeal process to the Secretary of State. In September 2003 the Department and the British Medical Association reached an agreement on introducing the new consultants' contract, which retains the key principles of the initial framework agreement. In October 2003 consultants in England voted in favour of accepting the new contract.

Trusts' exclusion policies

2.8 Trusts have developed local disciplinary procedures for all staff, including exclusions. Two thirds use the Department's guidance as a base for their local procedures and for developing guidelines and a third of trust chief executives felt that following the external guidance was the main factor contributing to successful management of the suspension process. However, a quarter of trusts felt that the Department's guidance was of little use. Common criticisms from these trusts were that the guidance was too lengthy, complex, legalistic and difficult to follow, and that these factors contributed to delays in progressing cases. A number of trusts cited the nature of the guidance as a key reason for prolonging exclusions.

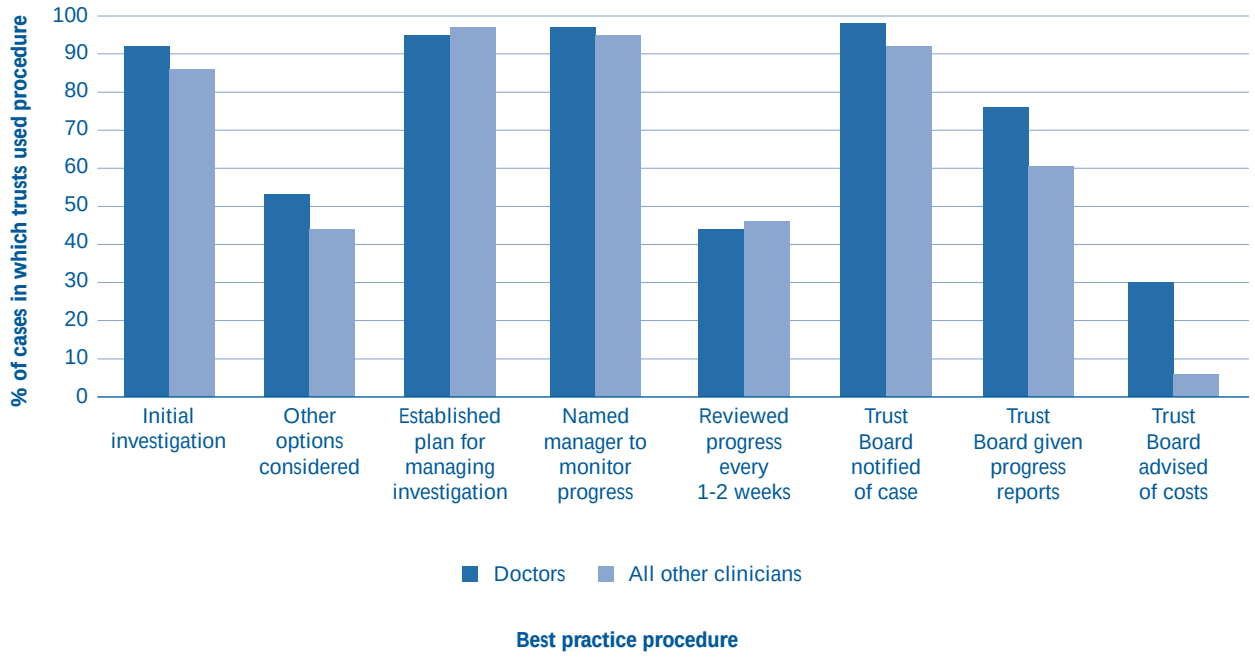
2.9 Trusts use other sources of guidance to help draw up disciplinary polices and manage exclusions. More than half see the Advisory, Conciliation and Arbitration Service (ACAS) as a valuable source in framing exclusion policies. ACAS recommends that suspensions be as short as possible, that employees are informed of the reason and that suspensions should not be used as a sanction prior to a proper disciplinary hearing and decision. The Department is seeking to follow such principles in revising its guidance.

The effectiveness of trusts' procedures

2.10 While most trusts appear to be aware of best practice, the length of many exclusions and discussions with numbers of excluded clinicians indicate that many trusts are not following best practice **(Figure 16)**. As a result suspensions last longer than they should do and are more costly to the NHS and damaging to the excluded clinician. The following paragraphs look more closely at aspects of performance.

16 Trust's adherence to best practice

In many cases best practice is not followed, particularly relating to consideration of alternative options to suspension, regular progress reviews and reporting to the trust board.



Source: National Audit Office survey

Initial investigations and consideration of options

2.11 It is vital that trusts undertake effective initial investigations, giving them high priority, and that they fully consider options. In this regard a number of trusts have developed guidance and Leeds Teaching Hospitals NHS Trusts provides a useful example **(Guidance 1)**.

2.12 Most trusts (86 per cent) carried out an initial investigation before excluding a clinician but the quality and rigour of these varied, with initial investigations continuing following decisions to suspend staff. Where patient safety is at risk swift suspension may be appropriate, but in the majority of cases reported to us by trusts, patient safety was not an issue (paragraph 1.13), and the decision to exclude is sometimes a knee-jerk reaction made by trusts without sufficient investigation.

2.13 The majority of the 50 clinicians who contacted us considered that initial investigations are often not thorough enough. While these clinicians were self selecting as they chose to contact us, we were struck by the similarities of experiences. Common themes were the delays in clarifying what allegations were being investigated, continually shifting goal posts with new claims being added, and the limited opportunities clinicians were given to rebut allegations **(Case 1 overleaf)**.

GUIDANCE 1

Leeds Teaching Hospitals NHS Trust - initial investigations

The Trust has developed guidance that emphasises the importance of initial investigations prior to formal processes being invoked. Where there are patient safety incidents the Trust examines individual and systemic weaknesses. It encourages consideration of alternatives to suspension such as restriction on certain clinical practices. For minor breaches of discipline the Trust recommends informal procedures as set in guidance notes and will use its disciplinary procedures where there is evidence of serious misconduct. Where there appears to be a breakdown in interpersonal relations the Trust seeks to resolve the issues through mediation. It encourages close working with clinical staff and their representatives, personnel staff and external organisations to resolve problems.

CASE 1

Delays in clarifying allegations and involving the clinician

Dr Ben Green and the Five Boroughs NHS Trust

In July 2002 Dr Green, a consultant psychiatrist, was suspended by the Trust and was asked to leave the building immediately. He was told a police doctor had complained that he had not admitted a dangerous patient. In September 2002 the Trust provided written details following reports from Occupational Health that Dr Green was competent to engage in the investigative process. In addition to the police doctor complaint, the letter also included allegations that Dr Green had taken an offensive weapon onto Trust property - a pepper spray. The Trust states that it raised the issue of the offensive weapon at the time of Dr Green's suspension, but Dr Green has no recollection of such a discussion and the Trust made no reference to the pepper spray in correspondence with Dr Green during August. Dr Green acknowledged that in March 2002 he had brought the pepper spray on to Trust property on one occasion to show the clinical director, confirmed by the clinical director in a statement in August 2002. Dr Green had acquired the pepper spray because of serious concerns about his and other staffs' safety following attacks on him and continued threats by a patient. In February 2003 the Crown Prosecution Service concluded that it would not support a prosecution for an offensive weapon. The same month the external assessor concluded that Dr Green had looked after the patient triggering the police doctor complaint well for a number of years but criticised the absence of a contingency plan. In April 2003 the Trust concluded that there was no disciplinary case against Dr Green and advised Dr Green's solicitors that the suspension would be ended, with Dr Green giving an undertaking not to carry a pepper spray on Trust premises and noting the point on contingency planning. Dr Green stated that he had not been aware of the external assessor's report and could not therefore comment on the point about contingency planning. In welcoming Dr Green back to work, the associate medical director stated that he was pleased Dr Green's name had been exonerated. Dr Green is resigning from the NHS to work in the private sector. Estimated gross costs are £250,000.

2.14 One option short of exclusion from all clinical practice is to restrict some of the clinician's activities, an option made clear in the Department's 1994 guidance. This could mean restricting the type of patient a clinician sees, only allowing the clinician to carry out certain designated procedures, or ensuring that a clinician is supervised. **Case 2** illustrates the use of such restrictions for doctors following advice from the National Clinical Assessment Authority and how all parties worked to resolve problems without recourse to suspension.

2.15 The National Patient Safety Agency's decision tool emphasises the options that are available to trusts when considering patient safety incidents (Appendix 4). Trusts considered options other than suspension in 45 per cent of cases, most commonly restrictions on the clinician's work, moving them to another post, additional supervision and retraining. However, formal suspensions accounted for most exclusions - more than three quarters of doctor exclusions and more than nine in ten other clinical staff (paragraph 1.14).

Detailed investigations

2.16 When carrying out investigations where there are concerns about a clinician's professional competence or conduct, trusts may arrange for external experts to make an assessment. For doctors, these include the Royal Colleges and their rapid response teams, the regulatory bodies and since April 2001 trusts have been encouraged to consult the National Clinical Assessment Authority. A quarter of trusts had referred a member of staff to the Authority, including attempts to resolve current suspensions. In December 2001 the Chief Medical Officer recommended trusts to consult the Authority on all suspensions (and were issued with a reminder in June 2002),[14] but in its prototype early operations, the Authority had had no contact with half of all trusts during its first two years and trusts had limited contact regarding the 46 ongoing doctor exclusions in our survey (paragraph 1.19).

2.17 Trusts rated advice from other trusts and Regional Directors of Public Health more highly than the bodies providing external assessments of clinical staff **(Figure 17)**. Critical comments included concerns about the length of time organisations took to respond and the helpfulness of the advice.

2.18 Trusts are not obliged to accept the recommendations of external assessors. From case studies we saw evidence of trusts rejecting a number of reports from external bodies, and in one instance the trust rejected an external assessment from the General Medical Council **(Case 3 overleaf)**.

CASE 2

National Clinical Assessment Authority intervention to avoid suspension

Note: this is a composite case drawn from a number of real cases

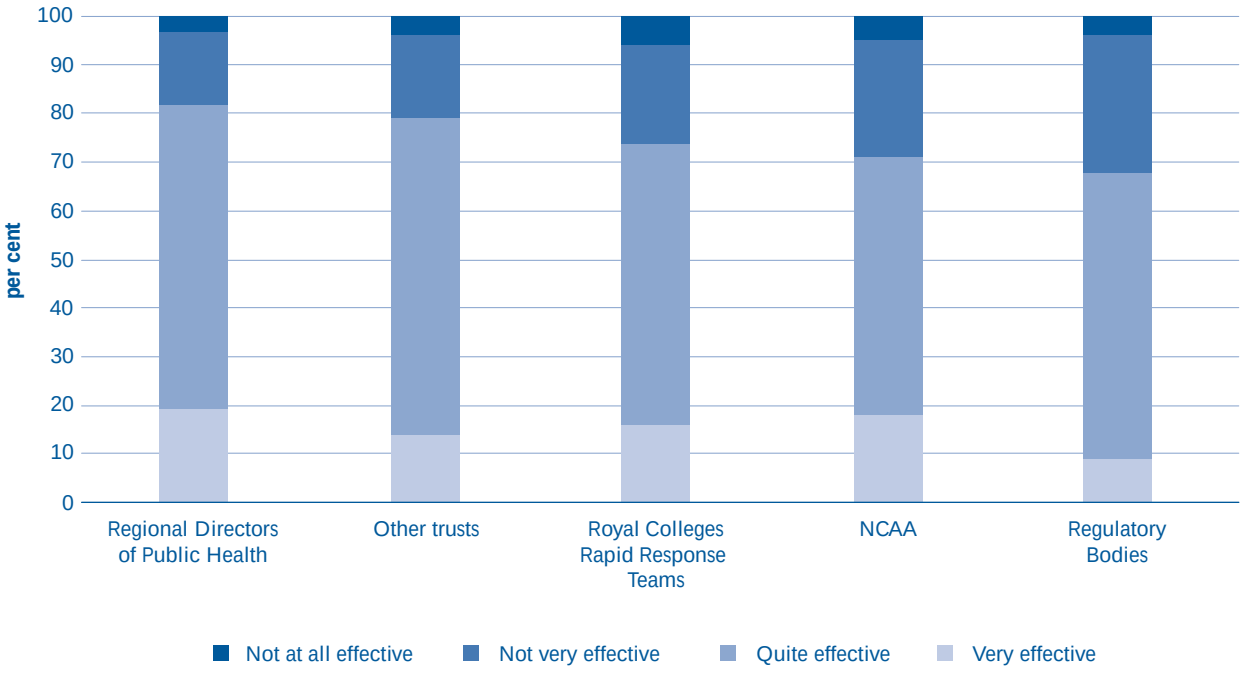
During the investigation of a patient safety incident, the trust identified a number of concerns about a doctor's performance. The doctor took some leave as a result of the distress caused by the incident. After taking advice from the Authority it decided on the following course of action:

- the medical director would see the doctor himself to explain the proposed course of action;
- the trust would arrange for an audit of outcomes and complication rates for all members of the department;
- occupational health would assess the severity of the doctor's stress and ability to work;
- if fit, the doctor would return to work under restricted practice;
- the Authority would undertake a full assessment.

The Authority assessment concluded that the doctor was generally clinically competent but required retraining in laparoscopic surgery. The Authority was able to facilitate retraining through discussion with the local postgraduate dean and a consultant in another trust. There was also a need to improve organisational skills and relationships with colleagues. Both the doctor and the trust accepted the report and agreed an action plan. The doctor's colleagues needed to be persuaded of the value of the recommendations and agreed to participate in team-building.

17 Trust opinions on the effectiveness of advisory organisations

Trusts rate the advice of the regional directors of public health and other trusts above those organisations which assess clinical performance.



Source: National Audit Office survey

CASE 3

Rejection of external assessments

Miss Briony Ackroyd and University Hospitals Coventry and Warwickshire NHS Trust

In February 2000 the Trust suspended Miss Ackroyd, a consultant breast surgeon, following concerns about her professional competence and reported her to the General Medical Council. Over the next two years the General Medical Council undertook a performance assessment. In March 2002 Miss Ackroyd agreed a Statement of Requirements whereby her performance would be regularly appraised by a consultant colleague. The General Medical Council would monitor the case and arrange for a reassessment after 12 months. The Trust did not, however, reinstate Miss Ackroyd and continued to consider using its disciplinary procedures. In April 2002 Miss Ackroyd asked the Chief Medical Officer to help and he asked the National Clinical Assessment Authority to assist in finding a way forward. With the Authority's support, in January 2003 some three years after the original suspension, the Trust and Miss Ackroyd reached an agreement whereby Miss Ackroyd resigned. She is now successfully retraining as a general practitioner. Costs are estimated at £825,000.

CASE 4

Time taken to demonstrate inadequacy of initial investigations

Dr Martin Samuels, Professor David Southall and University Hospital of North Staffordshire NHS Trust

In February 1999 the Trust received a serious complaint from a member of the public who was neither a patient nor a parent of a patient about the work of Dr Samuels and Prof Southall, both paediatricians. The complainant provided no specific evidence but because of the potentially serious nature of the allegations and their wide scale reporting, the Trust began an investigation. The Trust commissioned an external preliminary inquiry which concluded in November 1999 that the doctors should be suspended. The doctors were not invited to respond to the allegations and they had to wait seven weeks for a copy of the report. The Trust considered that a more detailed internal inquiry was needed to establish the full facts and to inform future decisions. The Trust began its internal investigation, appointing an external expert to review one aspect affecting one doctor. In a second area because of difficulties in establishing terms of reference, the investigation had been ongoing for one year before the case notes were sent for expert review. The main inquiry exonerated both doctors concluding they should be re-instated as there was no case against them. The suspensions lasted 20 months and 27 months respectively and estimated costs are £750,000.

2.19 Our discussions with excluded clinicians, largely doctors, raised concerns about the thoroughness and rigour of some external assessments. Common themes were that external assessors did not give clinicians the opportunity to respond to concerns raised, that evidence presented by the excluded clinicians was often ignored, that supporting colleagues nominated by the clinician were not interviewed, and that analysis of case evidence was open to considerable interpretation. This last point raises the importance of clinical audit. As part of clinical governance arrangements the Department has emphasised the need for effective clinical audit. Clinicians are expected to undertake audits, comparing their performance outcomes with peers as part of their continuing professional development. However, our report on clinical governance shows that clinical audit remains under developed.[3] Excluded clinicians recognised that had they undertaken their own clinical audit, then there would have been a common starting point for any external assessment of their performance.

2.20 As regards the National Clinical Assessment Authority, some doctors who have gone through the assessment process told us of their concerns about the transparency of the process. There was a lack of clarity about the timetable for the process; which doctors were to be interviewed, particularly those nominated by the doctor; and what cases were to be reviewed. Some doctors commented on the critical attitude of the assessment team and its objectivity in weighing evidence. While the process allowed for doctors to comment on the assessment teams' reports, in practice any criticisms of reports, even factual corrections, could delay implementation of action plans which were themselves time critical, being dependent on the availability of senior doctors to supervise training and development.

2.21 As we have seen in Part 1, many investigations can take many months and raise questions about the thoroughness of the initial investigation **(Case 4)**.

CASE 5

Allegations and counter allegations

Dr Judy Evans and Plymouth Hospitals NHS Trust

In August 1999 Dr Judy Evans, a consultant plastic surgeon in Plymouth since 1986, supported a black female junior plastic surgeon who had complained of racial abuse by another consultant in February 1999. Within weeks, after clinical complaints from the alleged abuser and a newly appointed colleague, Dr Evans was sent on 'gardening leave'. A Royal College of Surgeons rapid response team recommended her return to work with limited restrictions on her practice and mediators to work in the department. The General Medical Council performance assessment found 'no serious deficiency' in her practice. No detailed audit was undertaken and Dr Evans took the Trust to a Tribunal. The Trust settled out of court but Dr Evans had to agree to resign. She has not been able to work in the NHS since and now works privately. Estimated costs are £500,000.

2.22 Some of the most complex cases are not about professional competence but occur where there are professional disagreements between colleagues and where there is a breakdown of relations. A number of cases appear to result from a breakdown in inter-personal relations between a clinician and colleagues or managers, often characterised by allegation and counter allegation which adds to the complexity of the investigation **(Case 5)**. In these circumstances clinicians consider that it was because they were 'whistle blowers' that they were excluded. Of the 50 clinicians who contacted us after being excluded half claimed that their 'whistle blowing' was a factor in their exclusion. We were also told of cases where it was alleged that trusts had threatened staff with suspension if they spoke out against trust practices and saw documentary evidence in one case.

2.23 We found that there are continuing problems in managing exclusions. In one recent case, anonymised because of pending legal action, the Trust attempted to contact the National Clinical Assessment Authority at a very late stage but could not talk to the Authority until after it had suspended the doctor. It had received written allegations about the doctor some weeks earlier but complaints from a senior colleague required prompt action. The Authority agreed that suspension was appropriate. The Trust arranged for an independent investigation of the doctor's work but the doctor was not interviewed as part of the investigation. Early discussions with the National Clinical Assessment Authority and ensuring the doctor is involved in the investigation are important lessons. With clinical audit becoming better established, trusts should have earlier warning of potential problems and there is scope to make more use of clinical audit data during investigations.

2.24 As most of the clinicians who contacted us were doctors, we invited the Royal College of Nursing to provide a nursing perspective. One of the College's counsellors is completing doctoral research which shows that nurses who have been excluded from work were in some cases critical of the processes and that these reflected the criticisms voiced by doctors who contacted us **(Case 6 overleaf)**.

Reintegration and retraining

2.25 When trusts complete their investigations and conclude that the clinician should return to work, it can take considerable time to arrange this. Delay can be a result of the tensions that build up between trusts, clinicians and their colleagues during the exclusion. Also where clinical staff have been excluded from clinical practice, wholly or in part, for a long period, they may well require retraining and reorientation before returning to clinical work. In one case a consultant surgeon did not work for more than two years and has undertaken nine months' retraining at an external trust. He will undertake further training at his employer trust and be reassessed before being reintegrated into the service. Trusts have experienced difficulties in finding host organisations to provide retraining and there needs to be a clearer understanding of roles and responsibilities. In addition the clinician has to be comfortable with the host organisation and we found cases where it has proved difficult to arrange mutually acceptable training **(Case 7 overleaf)**.

2.26 The National Clinical Assessment Authority has helped broker retraining as part of implementing action plans. In one case a doctor had been suspended for more than two years following concerns about his practice. The Trust had employed a senior, recently retired consultant to look at how the doctor was working but was unsure about how to act on the consultant's findings. The Authority worked with the Trust to develop a programme which included a placement at another trust. After six months the doctor was able to return to his original Trust with the full support of his colleagues.

CASE 6

Ms Rachel Murray's research findings, The University of Manchester

The research was undertaken between 2000 and 2003 and included interviews with suspended nurses and Royal College of Nursing staff. Trust managers who have suspended nurses, Royal College of Nursing activists and suspended nurses came to focus groups. The number of research participants was 75 and grounded theory analysis was undertaken. In 2002 some 200 members of the Royal College of Nursing were newly suspended and contacted the College. Around 100 cases were resolved, taking three months on average.

Immediate suspensions Many nurses felt that trusts are quick to suspend staff as soon as they receive a complaint without any preliminary investigation.

The inherent message of suspension Despite being told that they were being suspended without prejudice, nurses perceived suspension as a punishment, and that there was a presumption of guilt.

The manner of suspension Many nurses complained about how they were informed of the suspension. Some were not told about the nature of the allegations. Most were told to go straight home and were escorted off trust premises, were banned from the premises and prohibited from contacting colleagues. Many felt that they were not provided with adequate support and some considered that they were not in a fit state to go home by themselves.

The length of suspensions Nurses were concerned by the time they were suspended. In many cases trusts had not followed guidelines, and had not met the timetable. While the majority of nurse suspensions lasted less than 12 weeks, a significant minority lasted longer, some for more than a year. The uncertainty of the outcome, combined with the long wait, resulted in nurses experiencing significant trauma related health issues, often needing medical and counselling interventions.

Unfairness within and between trusts Some nurses spoke of perceived inconsistencies, where nurses in similar circumstances were not suspended.

Source: Rachel Murray, The University of Manchester PhD research supervised by Dr William West

CASE 7

Difficulties in arranging retraining

Dr Ahmed Sadiq and the Central Manchester and Manchester Children's University Hospitals NHS Trust

In November 2000 the Trust placed Dr Sadiq, a consultant ophthalmologist, on special leave, following concerns raised about his clinical performance. In March 2001 an external assessment team reviewed Dr Sadiq's work and completed its report in May 2001. The report recommended further training in two areas of his clinical practice, one of which was highly specialised. Very few centres are able to provide the appropriate training. However, in November 2001 a trust did offer to provide the training but due to a number of difficulties withdrew the offer. It took a further 12 months to November 2002 to arrange further training which commenced in February 2003 and which is expected to be completed at the end of 2003. Estimated costs are £260,000.

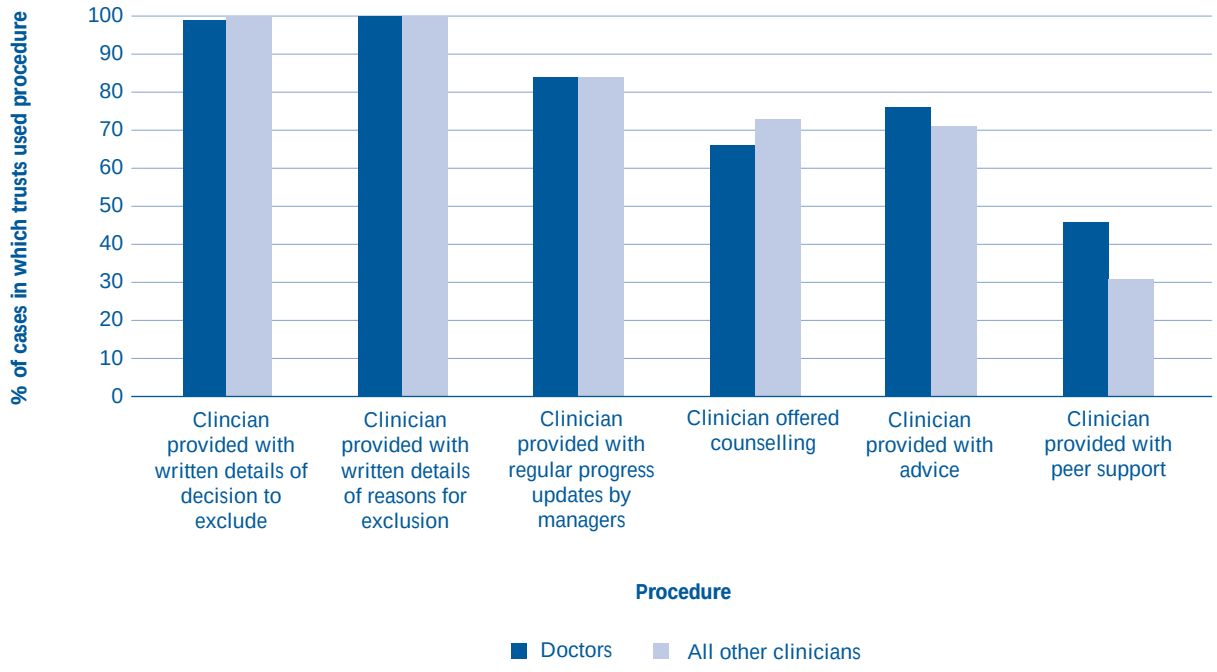
Communication with excluded clinicians

2.27 Trusts told us that they provided clinicians with details of the decision to exclude them and the reasons for exclusions in the vast majority of cases **(Figure 18)**. But of the 50 clinicians who spoke to us, there was unanimity that trusts communicated poorly with them, particularly as regards the timeliness of communications:

- Guidance states that trusts should provide details of allegations within ten days, but clinicians told us that they had to wait several weeks to obtain clear details of the allegations against them.
- Departmental guidance states that the suspension should be reviewed every two weeks, and in 84 per cent of cases trusts told us that they provide regular progress updates to the suspended member of staff. Again Leeds Teaching Hospitals NHS Trust has developed useful guidance **(Guidance 2)**. However, from the detailed case information, only 45 per cent of trusts reviewed cases fortnightly and 20 per cent reviewed progress monthly at best. Evidence from the 50 clinicians who spoke to us suggests that trusts were often poor in keeping them informed.

18 Trusts' adherence to best communications practice

While trusts reported high levels of adherence to best communications practice for certain key aspects, provision of counselling, advice and peer support was much more limited.



Source: National Audit Office survey

GUIDANCE 2

Leeds Teaching Hospitals NHS Trust - formal suspension

The Trust makes it clear that suspension is only to be used when there is a risk to patients or staff, in cases of gross misconduct, or where the presence of the staff member would impede the investigation. Even in such cases, suspension will only be used if any concerns cannot be addressed by other reasonable means such as restrictions on clinical practice. The purpose of investigations is to establish the facts, not prove cases. Cases are to be reviewed fortnightly and managers have to set milestones to help resolve the case. Where there are professional competence issues, the disciplinary board's composition and responsibilities are made clear. Clinical staff are to be given copies of all relevant documentation and counselling support is made available.

- While trusts told us that they provided excluded clinicians with details of their planned course of action, earlier case studies show that there is often a long delay between the exclusion and provision of detailed written information. In one case we were told that full documentation was not provided some 30 months after the suspension.

Overall management arrangements

2.28 The Committee of Public Accounts was critical of the management arrangements in the Dr O'Connell case and accountability for dealing expeditiously with disciplinary proceedings for medical staff (Appendix 2). From our survey, just over half of the trusts place the responsibility for managing the exclusion process for doctors and dentists with the medical director, 26 per cent with the human resources director and 14 per cent with the chief executive. The human resource director is most commonly responsible for other clinicians. With long running, high profile exclusions, chief executives are very likely to be heavily involved, and ultimately are accountable for the exclusion process. In practice, however, we found little evidence of chief executives or medical and human resource directors being held accountable for the management of long running exclusion cases. In one case, however, the management of suspensions was a factor in the breakdown of relationships between the management of the Trust and a number of consultants. Following critical reports from the Commission for Health Improvement, the Trust received no stars and was franchised, the Chairman, Chief Executive, and Director of Personnel all resigning **(Case 8)**.

2.29 The Chief Medical Officer's special adviser has reviewed all long term exclusions (paragraph 1.9) and has highlighted a number of features which aid resolution of cases **(Guidance 3)**.

2.30 The vast majority of trusts reported that they project managed clinical exclusions. Trusts formulated a project plan in 97 per cent of exclusions, and in 95 per cent a named case manager was appointed. A number of chief executives cited the setting of milestones as an important part of the process.

2.31 In exclusion cases, particularly lengthy ones, greater board knowledge of the details and scale of the case should increase the onus on trusts to help expedite matters. Under the Department's guidance, trusts should advise their boards of doctor exclusions lasting more than three months and provide progress reports. Trusts did this in 76 per cent of cases. However, contrary to guidance, trusts told boards the costs in only 31 per cent of cases and Part 1 showed that costs estimates were often under stated (paragraph1.22).

CASE 8

University Hospitals Coventry and Warwickshire NHS Trust

In recent years the Trust suspended three consultants, including Miss Ackroyd (Case 3). The two other consultants were suspended because of allegations of bullying and harassment of junior staff, not their clinical practice. Both consultants had previously raised concerns about clinical practices in the Trust. One consultant was suspended for nearly three years before being reinstated following High Court and Court of Appeal rulings in support of the consultant. The independent panel which investigated the suspension concluded that the consultant had oppressed a junior doctor but recommended that he should be reinstated. The other suspension has lasted 20 months and was ongoing in October 2003. In addition the Commission for Health Improvement's clinical governance review (September 2001) highlighted deep concern that medical staff felt "bullied, intimidated, threatened and oppressed by senior managers when raising concerns about clinical care or conditions. Some consultant staff reported fear of speaking out for fear of being victimised, following occasions where they believed their colleagues had been victimised." CHI's follow up report (March 2002) concluded that "limited progress had been made by the Trust to build effective working relationships between doctors and managers…Relationships had broken down between some consultant medical staff and senior managers. In particular some doctors did not feel safe to raise concerns about clinical risk." The Trust lost its star rating and was franchised. The Chairman, Chief Executive, and Director of Personnel resigned, with the Chief Executive working his six month period of notice to provide continuity in implementing an action plan. The Medical Director resigned partly because of his concerns over the way that suspensions were being managed. Following franchising, a virtually new Trust Board was appointed during the second half of 2002. In June 2003 CHI undertook a further review against the action plan and advised that "the CHI clinical governance report should not prevent the Trust from receiving three stars". CHI awarded the Trust two stars in the 2003 overall assessments. The costs of the suspensions for the two bullying and harassment cases are estimated at £600,000.

GUIDANCE 3

Good practice management of exclusions

Chief Medical Officer's review of long term exclusions

Draw up a case management plan, including appointing a case manager A number of cases have been resolved where trusts drew up and maintained full case management plans, including estimated timetables for each stage of the process, clear allocation of responsibility and identification of risks and possible challenges to the plan. Plans were regularly reviewed, and modified and updated as necessary until satisfactory resolutions were reached.

Maintain tight control of the case It is vital that the case manager does not allow others to take over, slowing the pace or progress of the case. The manager will need to ensure that any blockage to progress is dealt with and the blockage removed so that the case does not get bogged down.

Seek and use advice To maintain momentum and avoid cases getting bogged down, it is important to seek advice from experts and know how to utilise that advice. It is essential that medical directors receive top level human resource advice a well as clinical advice. Telephone advice may not be sufficient and meetings with advisers can improve the quality of the support available.

Make effective use of lawyers and other specialists Ensure lawyers and other specialists are only asked to undertake those specialised matters which managers in trusts cannot do for themselves. Writing letters, chairing meetings and general communications should remain a responsibility of local managers.

Make effective referrals to occupational health Where there may be a question of ill health about the excluded clinician, ask tightly focused and specific questions of the occupational health adviser that will enable management to make a decision about progressing the case.

Ensure full support for the excluded clinician It is essential that trusts ensure that excluded staff are fully supported and looked after and that there is regular liaison with management.

Part 3

Protecting patients and other staff where clinical staff are excluded

3.1 This Part examines the effectiveness of the NHS's arrangements for protecting patients and other staff in cases where clinicians have been excluded and concludes by reviewing some of the broader issues around *'Supporting Doctors, Protecting Patients'*. In brief trusts work to protect patients by carrying out pre-employment checks, undertaking investigations when patient safety incidents occur and informing other trusts and potential employers, the regulatory bodies and the Department where there are problems. However, there are weaknesses in pre-employment checks, such as obtaining declarations from clinicians of their fitness to practice, and for overseas qualifications, locums and agency staff, and some investigations are not concluded when staff resign, presenting a risk that clinicians could move to other posts.

3.2 While our report concentrates on the performance of the Department and NHS trusts, other bodies also have important roles to play. The regulatory bodies, such as the General Medical Council, the Nursing and Midwifery Council and the Health Professions Council, maintain registers of all clinicians. They require clinicians to meet training standards before admitting them to the register, encourage continuing professional development, operate disciplinary procedures in serious cases of poor performance by clinicians, and ultimately can suspend a clinician from the professional register. The medical Royal Colleges too have a role in encouraging best professional practice through setting requirements for continuing professional development. They also undertake assessments of clinical performance. The nursing and midwifery Royal Colleges also support continuing professional development whilst representing their members in cases of exclusion. While we have not examined the activities of these bodies, we have discussed their role in relation to the exclusion of clinicians by NHS trusts with them and our expert panel included representatives from these organisations (Appendix 1 paragraph 7).

Use of alert letters

3.3 The key procedure used by trusts to warn employers about clinical staff who have been dismissed or are under suspension, or where serious doubts have been raised, is the system of alert letters. Regional Directors of Public Health notify trusts of the names of doctors who have been dismissed, or who are under suspension by their employer, or where there are sufficient reasonable grounds to consider them a potential danger to the safety of patients, other staff, or themselves; and where there is reason to believe they may seek work elsewhere be it in the NHS or the private sector. In 1997, the Department issued guidelines requiring NHS chief executives to ensure that systems were put in place to consider whether action should be taken:

- To alert other NHS employers to the dismissal or suspension of a member of their medical staff;
- To retain alert letters so that human resources staff are aware of all current warnings; and
- To withdraw and formally cancel alert letters if the doctor is exonerated.

3.4 With restrictions on employment and rights of appeal, a system of alert letters raises human rights and natural justice issues. The Department's current rationale for alert letters is that they are in the public interest as they help protect patient safety. The system is also proportionate as letters are restricted to senior staff in personnel departments.

3.5 Alert letters have been long established for doctors, and in January 2003 the Department extended the system for other clinical staff. Up till then procedures for other staff were less robust, relying on action being taken by the regulatory bodies for the profession (for example by the Nursing and Midwifery Council and the Health Professions Council). Our survey showed that only one third of trusts advise the regulatory body of any problems they have with members of staff other than doctors.

3.6 Employing trusts have a responsibility to assure themselves of the suitability of a potential employee. As part of their employment checks most trusts (84 per cent) told us that they review current alert letters. While trusts consider that alert letters are useful, there were concerns about the completeness of records, with 27 trusts (12 per cent) stating that they find it hard to keep track of all alert letters that have been issued and whether letters have been rescinded. Trusts feel that a national, web-based database would be more effective. Establishing such a web-based database would need to take account of human rights legislation and other legal issues.

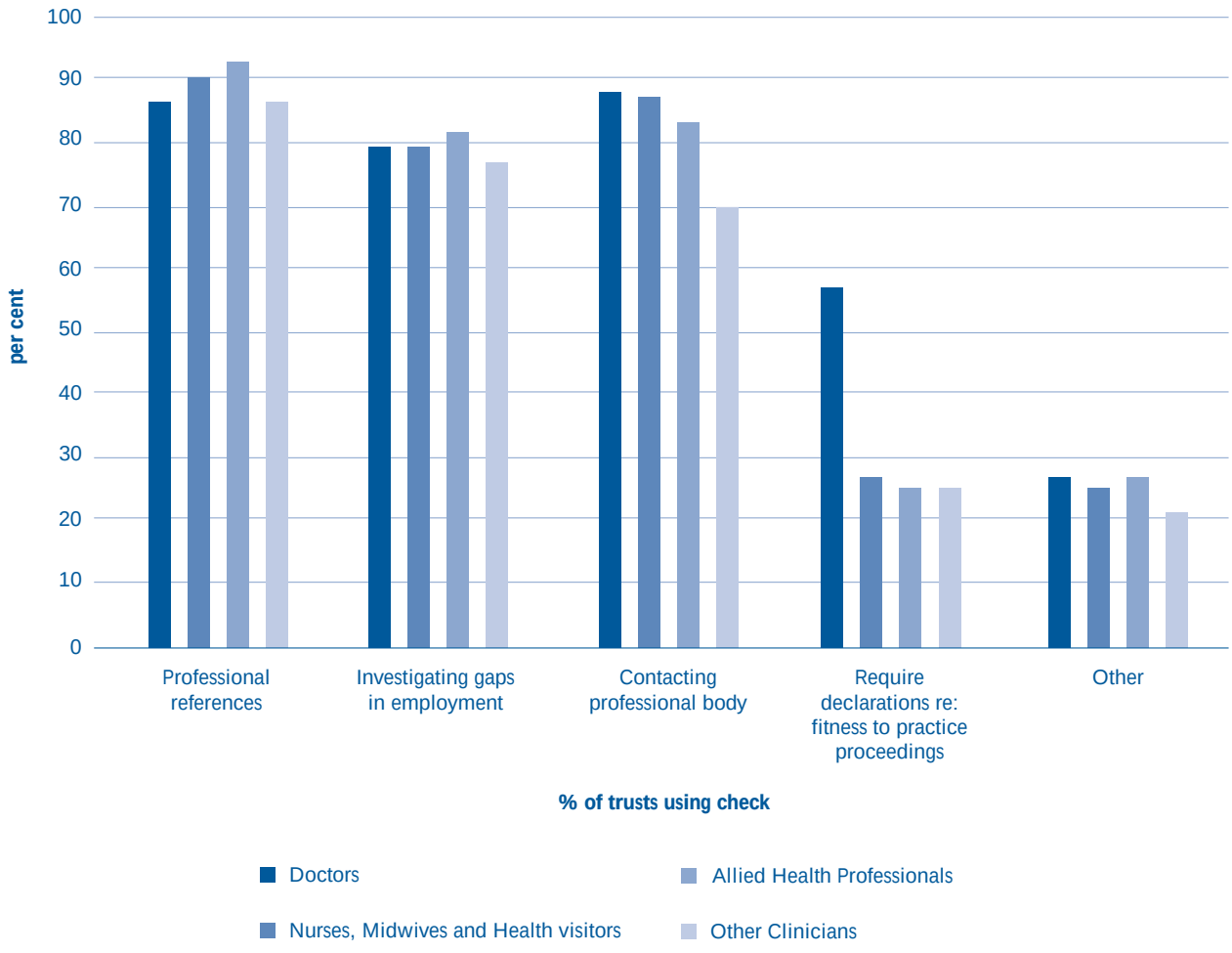
3.7 Clinicians, mostly doctors, who spoke to us were sceptical of the robustness of the system and considered that trusts could exploit their monopsony powers, as the major employer of most clinical staff. There were also concerns that trusts were slow to review their alert letters, which could remain on file even after a clinician may have been exonerated.

Other employment checks undertaken by trusts

3.8 Since June 2000 all NHS employers are required to include in their application forms for doctor posts a declaration stating whether or not the applicant has been or is the subject of fitness to practise proceedings by a UK or an overseas licensing or regulatory body; and further stating whether they have been or are currently the subject of any police investigation or conviction in this or any other country. Since May 2002 these checks have been made mandatory for all new NHS staff. However, this message has not got through as only 57 per cent of trusts reported that they required a declaration that a doctor has not been subject to fitness to practice proceedings, and only one quarter of trusts require such a declaration of other clinical staff **(Figure 19)**.

19 Employment checks undertaken by trusts

There are some gaps in trusts' employment checks, particularly declarations of fitness to practice.



Source: National Audit Office survey

3.9 Our survey found that most trusts contact professional bodies to confirm registration, investigate gaps in employment and obtain professional references. All trusts were either very confident or quite confident that their checks would identify clinicians who have been recently excluded. Despite this, mistakes can be made and between 10 per cent and 20 per cent of trusts do not follow best practice in this area (Figure 19).

3.10 Just over half (55 per cent) of trusts require an excluded clinician to seek their permission to work in another trust. But this means that a large number of excluded clinicians could seek work elsewhere without seeking permission.

3.11 There are increased difficulties with non-UK qualified clinicians **(Figure 20)**. A third of trusts use additional procedures in these cases, mainly Criminal Record Bureau checks, passport or identity checks, and checking registration with professional bodies. However, 38 per cent of trusts were not confident of identifying non-UK clinicians that have been recently excluded. The main reason was the lack of an alert letter system for non-UK clinicians.

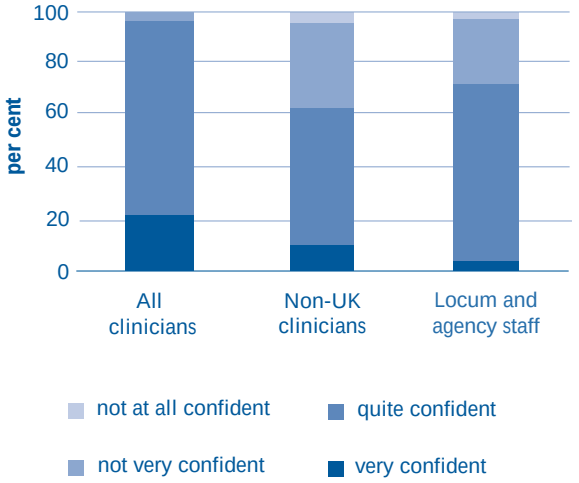
3.12 There is also a risk relating to agency and locum staff and a quarter of trusts were not confident with their checks on agency and locum staff. Trusts that check references for temporary staff were more confident in this area. These findings chime with the work of other bodies. The Audit Commission's 1999 report[16] on locum doctors concluded that many important pre-employment checks were not undertaken - the Commission found that two thirds of trusts check registration with the General Medical Council and two fifths of trusts checked references. The Commission for Health Improvement has also reported that trusts do not always undertake registration and criminal bureau checks and insufficient checks are made of agency and locum staff.[17]

Protecting patients when a clinician resigns or retires during investigation

3.13 Four fifths of trusts reported that they would complete their investigations if a clinician were to resign **(Figure 21 overleaf)**. They would consider issuing an alert letter or advising the appropriate regulatory bodies. But up to one fifth of trusts said they would not complete the investigation. Failure to complete investigations may represent a risk to patients and it is important that matters are properly resolved. Trusts also have an obligation to review alert letters expeditiously and cancel those where there are no longer risks to patients.

20 Trust confidence in identifying clinicians who have been recently excluded by another trust

Trusts are confident about clinical staff in general, but are less confident about non-UK and temporary staff.



Source: National Audit Office survey

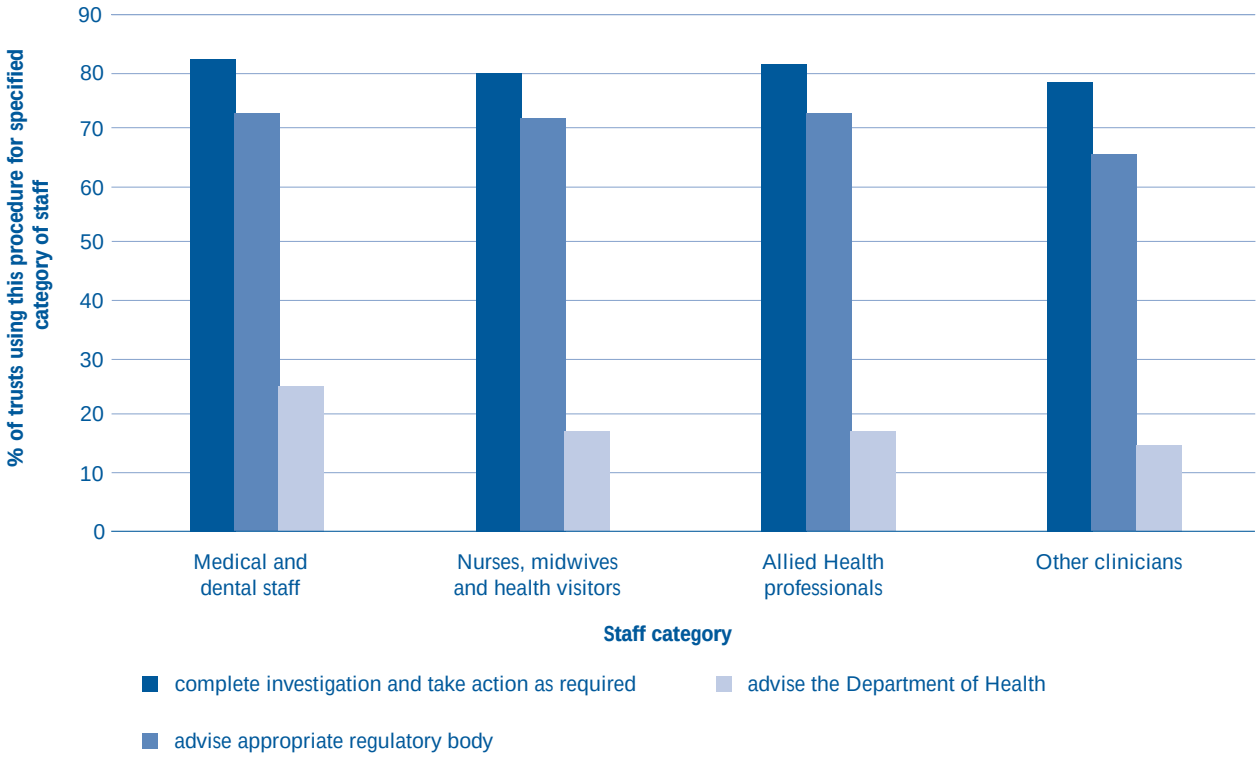
Supporting Doctors, Protecting Patients

3.14 When poor outcomes or mistreatment of patients occur arising from problems with the competence or conduct of individual doctors, they can cause a great deal of public concern. A number of cases that have arisen over the past decade shared certain features. In the light of these events, and recognition that the arrangements for dealing with poor performance were unsatisfactory, in November 1999, the Chief Medical Officer published the consultation document, *Supporting Doctors, Protecting Patients*. That paper envisaged greater use of support mechanisms for poorly performing doctors, and a reduction in the use of suspensions and disciplinary procedures, although it recognised that there would always be specific instances where suspension would be required.

3.15 In January 2001, the Department of Health published *Assuring the Quality of Medical Practice - Implementing Supporting Doctors, Protecting Patients*. This set out the Department's proposals for a simplified process for tackling poor performance by doctors. The key element of these was the establishment in 2001 of a new special health authority, the National Clinical Assessment Authority to provide impartial support to the doctor and advice to trusts on what action needs to be taken (Appendix 3). This process is designed to complement the General Medical Council's Performance Procedures, introduced in 1997 to deal with doctors whose performance is so seriously deficient that their continuing medical registration is called into question.

21 Trust procedures used when a clinician retires, resigns or moves post before an investigation is concluded

One fifth of trusts reported that they would not complete the investigation when a clinician retires, resigns or moves post before an investigation is concluded.



Source: National Audit Office survey

3.16 At present the National Clinical Assessment Authority approach applies only to doctors and dentists in the hospital and community setting and to doctors in primary care. These are the areas where the Department considers the impact of poor performance is usually highest. It proposes to monitor the outcome and consider the applicability and cost-effectiveness of the approach for other health professions.

3.17 In its first two years, the National Clinical Assessment Authority operated in a prototype phase whereby it did not provide a full service but developed systems and procedures. The full service came into operation in April 2003.

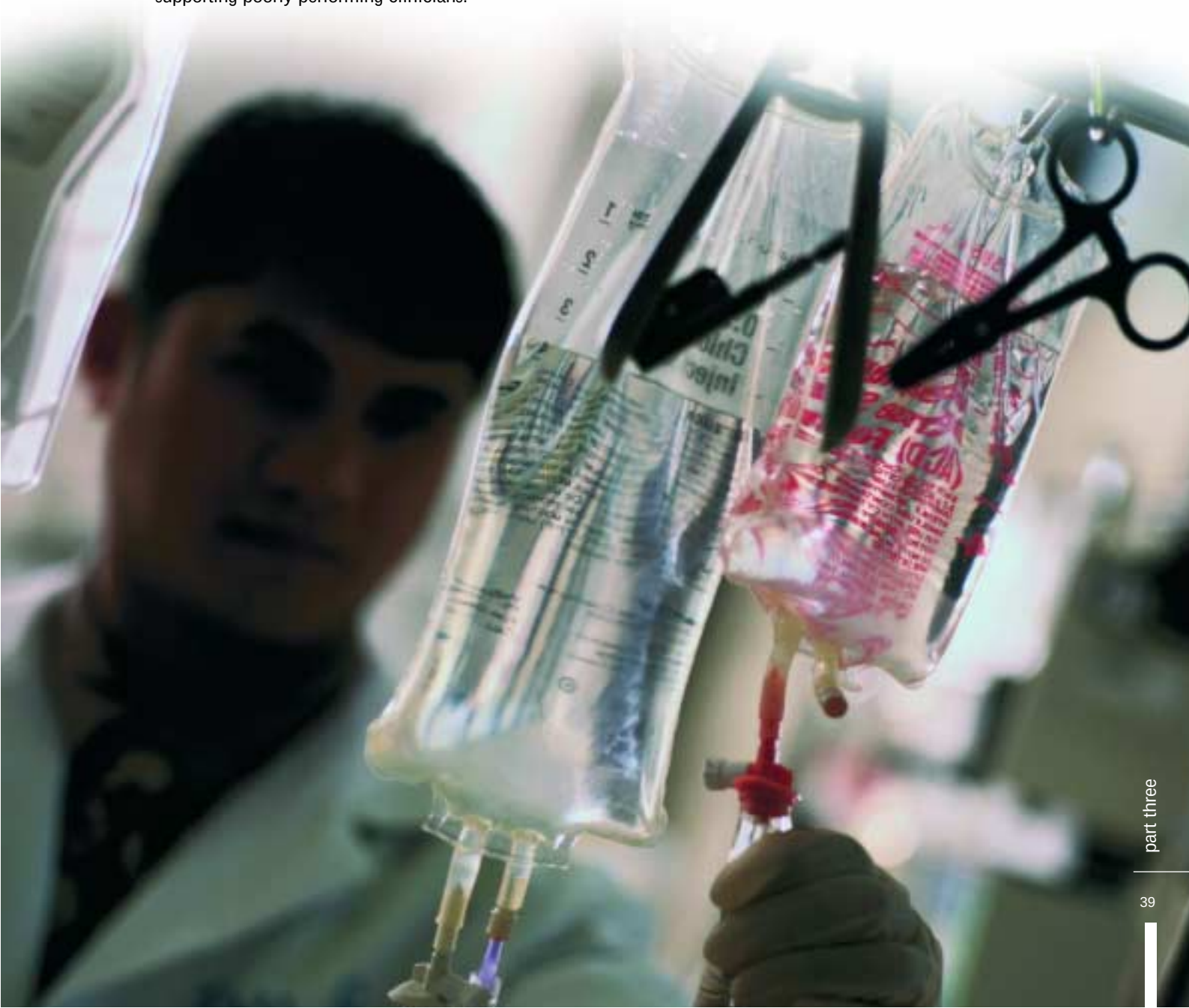
- The Authority has advised a number of trusts on exclusion cases and its intervention is likely to have prevented a number of exclusions. For example in 36 cases where the Authority was asked for early advice and where trusts were considering suspension, the Authority was able to identify alternatives to suspension in 30 cases.
- The Authority has handled over 500 calls for advice in its first two years. Many of these cases are dealt with through advice and continuing support and do not require the Authority undertaking detailed assessment of the doctor. The Authority has set challenging turn around times for dealing with calls for advice, including an emergency 24 hour response and all calls dealt with in five working days.
- In 10 per cent of cases the Authority does undertake a full clinical performance assessment of a doctor and in its first two years it completed 18 full assessments. It aims to complete assessments within three months. Performance has been mixed and we were told of a number of cases where milestones were not achieved, in part because the Authority is reliant on cooperation from external bodies - trusts, the Royal Colleges, the General Medical Council and the doctor. In 2003-04 the Authority is to assess the factors which contribute to assessments taking longer than three months and address those factors which are within its control.

- The Authority identifies recommendations at the end of the assessment process, but the trust is under no obligation to implement them. Where the Authority has concerns over progress, it can raise these concerns with the referring body's strategic health authority or the Department.
- In July 2003 the Authority published an evaluation of its prototype phase. Its survey of referring bodies demonstrated positive support: 60 per cent scored advisors' understanding of the case as 'very well' and 30 per cent as 'quite well'. It is also developing a web based toolkit to facilitate the sharing of good practice in managing performance concerns.

3.18 Trusts told us that they were confident that their procedures are effective in identifying and supporting poorly performing clinicians. The main methods used are appraisal and performance reviews and patient safety incident reporting. Training and personal development schemes are the most common way of supporting poorly performing clinicians.

3.19 Trusts recognised that there are many barriers to identifying and supporting poorly performing clinicians, mainly individuals not wanting to admit to having problems, the reluctance of other staff to come forward, and immature appraisal and performance systems. Trusts commented on the difficulties in defining poor performance and the absence of comparative data. Ongoing clinical audit would help identify under-performing doctors but clinical audit is relatively under-developed (paragraph 2.19). Finally some trusts considered that managers tended to shy away from tackling poor performance.

3.20 One option, short of exclusion from all clinical practice, is to restrict some of the clinician's activities, although such restrictions were used in 2 per cent of all exclusion cases (paragraph 1.14, Figure 8). Where trusts place restrictions on clinical activities, either at the outset of an investigation or following recommendations from an investigation, they told us that they are confident that their procedures are effective and the restrictions are enforced.



Appendix 1 Methodology

1 The key method for collecting data was a survey of all NHS Hospital and Ambulance Trusts in England and we established an expert panel to review our methods and emerging findings. In addition we interviewed stakeholders from the Department, trusts, professional and regulatory bodies, and medical defence organisations. We also spoke to a number of excluded clinicians and their representatives who approached us in response to our web page which publicised the study. We also invited Members of Parliament who have expressed interest in the exclusion of clinicians to contact us. The following paragraphs provide further details of our methodology.

Census of trusts

2 The objective of the survey was to examine the exclusion procedures in place for clinical staff in NHS Hospital and Ambulance Trusts, and whether these procedures are operated in a timely and cost effective manner, whilst at the same time protecting patients and other staff. As there are no central records on exclusions other than the reports to the Chief Medical Officer on doctors who have been suspended for more than six months, the survey was needed to collect primary data from NHS Hospital and Ambulance Trusts.

3 In the survey, we asked about local guidelines and policies for managing exclusions, the number of exclusions and also the ways in which trusts protect patients and staff. In addition, we asked Chief Executives for their views on the management of exclusions, and to endorse the completed questionnaire as the accountable officer. The survey collected data on all staff who were suspended or excluded from work for a period of more than one month as at the end of April 2001 and any further staff who were excluded over the period April 2001 to July 2002. For all cases of exclusion identified by trusts we asked for detailed information, including the clinician's grade and discipline; why the clinician was excluded and under what guise (formal suspension, gardening leave, etc.); whether the exclusion was ongoing or had been resolved, and the length to date; the management processes the trust undertook; and costs that were incurred in dealing with the exclusion.

4 Invitations to complete the questionnaire were mailed to the Chief Executive of all NHS Hospital and Ambulance Trusts in England. Respondents were given the option of completing a paper or online questionnaire. The questionnaires were distributed in late August, 2002, As of March 2003, seven trusts had not responded, giving an overall response rate of 96 per cent (269 out of 276 trusts responded). We undertook further surveys of long term doctor exclusions to collect data on gender and ethnicity and to determine progress on ongoing cases.

Validation

5 We visited a number of trusts to discuss their questionnaire responses in more detail and to validate the data provided. During these visits we spoke to Chief Executives and directors involved in managing the exclusion process. We also took the opportunity to identify examples of good practice in the management of exclusions.

Case Studies

6. We placed details of our study on a web page and invited clinicians who had been excluded to contact us. Some fifty clinicians chose to contact us and we discussed their experiences of the exclusion process. We have included some case material in our report and also drawn on the cases to make general points. We are very grateful to all who contacted us during the course of the study.

Expert Panel

7 We established an expert panel to advise on our methodology and emerging findings. We are very grateful to the following experts who provided comments and advice:

a) Mr Joe Brayford, Director of Human Resources Doncaster and Bassetlaw Hospitals NHS Trust

b) Miss Helen Davis, Senior Lecturer in Orthoptics, Royal Hallamshire Hospital - representing the Health Professions Council

c) Ms Jo Dent, Allied Health Professional Advisor, Commission for Health Improvement

d) Elizabeth Fradd, Director of Nursing, Commission for Health Improvement

e) Professor David A Haslam, Chairman, the Royal College of General Practitioners

f) Professor David Hatch, Chairman of the Committee on Professional Performances, General Medical Council

g) Dr Paul Lawler, Medical Director, South Tees NHS Hospital Trust

h) Professor John Lilleyman, President of the Royal College of Pathologists and Vice-Chairman of the Academy of Medical Royal Colleges

i) Ms Liz McAnulty, Director of Professional Conduct, Nursing and Midwifery Council

j) Ms Sandra Meadows, Organisational Development Advisor, the National Patient Safety Agency

k) Dr Linda Patterson, Medical Director, Commission for Health Improvement

l) Dr Alan Russell, Clinical Director, Bury Healthcare NHS Trust - representing the British Medical Association

m) Dr Alastair Scotland, Chief Officer and Medical Director of the National Clinical Assessment Authority

n) Mr Ian Stone, Advisor to the Chief Medical Officer, Long-term Suspensions, National Clinical Assessment Authority

o) In addition, Mr David O'Carroll, from the Department of Health, agreed to act as observer

Appendix 2 The Suspension of Dr O'Connell - PAC Recommendations and NHS response

Committee of Public Accounts conclusions	NHS Executive response	Paragraph Reference
(i) We consider it a matter for serious criticism that North East Thames Regional Health Authority failed over many years to confront the problem of how to resolve the suspension of Dr O' Connell. We note that it was only the legal proceedings brought by Dr O'Connell which brought matters to a head... we are disturbed that those responsible for dealing with the case seemed to find it easier to continue paying out public funds rather than take firm action to resolve the suspension earlier.	The NHS Executive notes the Committee's concerns and acknowledges that there has been a failure of management in this case. The Regional Health Authority have conducted an internal review and reported the outcome to the NHS Executive. The Executive has introduced guidance to all NHS employers so that these matters will be dealt with more speedily in future. The guidance contains indicative timetables for reviewing suspensions of medical and dental staff with a view to ensuring that suspensions are for the minimum necessary period of time. There is also provision for cases to be reported to the Executive if a practitioner has been suspended for six months.	2.2 2.5
(ii) We note that... trust medical directors would normally be responsible for the day to day handling of suspensions, but that overall responsibility rested with trust Chief Executives, and ultimately with trust Chairmen. We note that these arrangements do not differ significantly from those which prevailed in North East Thames for the greater part of Dr O'Connell's suspension.	The NHS Executive notes the Committee's conclusions. Decisions concerning the employment of individual NHS staff, including responsibility in handling suspensions, rest with the employing authority or trust. Whilst these arrangements have not changed significantly from those in place at the time of Dr O'Connell's suspension, individual trust employers are now much closer to the medical staff they are managing. They also have a stronger financial incentive to deal with matters promptly.	2.28
(iii) Given the Executive's view that the responsibilities of those involved in dealing with this case were clear at all times, we are concerned that, despite the clear failures of management neither the . . . Regional Health Authority nor the NHS Executive ensured that appropriate disciplinary action was considered at the time for the managers concerned.	The NHS Executive notes the Committee's concerns. This was a complex case dealt with by a number of different Regional Health Authority employees as part of their duties. The Executive accepts that failure to act is shared by successive managers at North Thames Regional Health Authority and that disciplinary action against individuals should have been considered. There is no legal basis for taking formal disciplinary action against individuals all of whom have left the employment of North Thames Regional Health Authority.	Executive Summary 6 1.7 2.28
(iv) We note that an investigation of those responsible is now under way. We look to the Executive to carry this out rigorously and expeditiously, and to inform us of the outcome.	The NHS Executive has now informed the Committee of the outcome of the review carried out by the Regional Health Authority. The investigation concluded that responsibility for failure to act is shared by successive managers at North East Thames Regional Health Authority and that under normal circumstances it would seem appropriate to move into formal disciplinary process against individuals. None of the individuals involved in the handling of the suspension of Dr O'Connell are still in the employment of North Thames Regional Health Authority. Legal advice confirmed that former employees can not be subjected to disciplinary action by their previous employer; neither is it open to a subsequent employer to initiate formal disciplinary proceedings in respect of an employee's alleged breaches of his/her contract of employment with a previous employer. Therefore it is not now possible to take any disciplinary action in individual cases.	

Committee of Public Accounts conclusions	NHS Executive response	Paragraph Reference
(v) We are unclear as to the basis on which individuals will be held accountable for their actions in handling such cases. We should therefore welcome a statement from the accounting officer on how in practice the respective responsibilities of trust Chairmen, Chief Executives and Medical Directors secure clear lines of accountability for dealing expeditiously with disciplinary proceedings concerning medical staff.	The NHS Executive notes the Committee's comments. The code of accountability issued in April 1994 said "NHS boards must comply with legislation and guidance from the NHS Executive on behalf of the Secretary of State, respect agreements entered into by themselves or on their behalf and establish terms and conditions of service that are fair to staff and represent good value for taxpayers money". NHS trusts have developed their own internal reporting arrangements which can legitimately vary. However, the trust Chief Executive as the designated accountable officer, is accountable to Parliament via the Chief Executive of the NHS for the proper stewardship of all the trust's resources.	Executive Summary 8 1.7 2.28
(vi) We are concerned that despite Ministerial instructions to have the case settled quickly it was allowed to drag on for a further six years after 1988. In our view, the Department of Health and the NHS Executive should have intervened more effectively much earlier and ... must share some responsibility for the unacceptable delays in bringing the case to a conclusion.	The NHS Executive notes the Committee's comments. The Executive, in considering how far it could intervene in this case, had to bear in mind that the Secretary of State had a potential appellate function in the event of Dr O'Connell being dismissed. It was not therefore open to officials to direct a solution which would have compromised the Secretary of State's position. In addition from the time the Executive was made aware of this matter in 1988 there were protracted legal discussions between the parties and little could have been done until that process was completed. The Executive's current guidance, and its monitoring of individual cases, will ensure that every effort is made to resolve future cases before they reach a similar position.	2.6
(vii) We are very disturbed that the cost of the case, excluding the legal costs of the Regional Health Authority, was nearly £600,000. This could otherwise have been spent on patient care. We are also disturbed by the Executive's estimate that to have contested the case and failed might have cost almost as much again. In our view, this is a measure of the intolerable situation into which the case had been allowed to drift.	The NHS Executive recognises that the money spent on this case could have been spent elsewhere. However, the NHS aims to deliver an effective service to patients. The suspension originated because of serious concerns that this was not being achieved in the paediatric service in Redbridge where Dr O'Connell was employed. It will be necessary at times to suspend a medical or dental practitioner. This should be seen as a neutral act and is intended to protect the interests of patients, other staff, or the practitioner and/or to assist the investigative process. As for this case, by the time the NHS Executive had intervened, the Regional Health Authority's ability to sustain any disciplinary action against Dr O'Connell had been fatally undermined. Given the estimate of the cost of pursuing this further a pragmatic solution had to be found. The NHS Executive has taken action to prevent a recurrence of the unacceptable delay which occurred in this case.	2.4

Committee of Public Accounts conclusions	NHS Executive response	Paragraph Reference
(viii) What we find quite unacceptable is that the settlement authorised by the NHS Executive includes a clause to keep confidential the sums of money involved. Such a condition is likely to impede accountability for a serious waste of public money and it is no defence to this criticism that such confidentiality was in the event unlikely to be maintained. We consider that this aspect of the settlement was quite inconsistent with the proper conduct of public business. We look to the Executive to ensure that confidentiality clauses play no part in severance settlements for NHS staff.	The NHS Executive agrees that as a matter of general principle confidentiality clauses should play no part in severance arrangements. The Department has issued guidance to this effect: Health Service Guideline (94)18 says "... an employment contract should not be framed in such a way as to suggest that a settlement on termination would escape proper public scrutiny".	1.23
(ix) We note that the Executive introduced new guidelines on suspensions of medical staff in October 1994 ... and that they expect ... arrangements to ensure that action is taken to resolve suspension quickly.	The NHS Executive welcomes the Committee's comments and is confident that the new guidance will prompt employers to resolve these suspensions quickly.	1.15
(x) We note ... that the Executive cannot compel trusts to adopt these guidelines, that they do not monitor compliance, that they cannot guarantee that all cases over six months are reported to them. We are not satisfied with the situation ... we therefore expect the Executive to consider monitoring compliance and to report in 12 months time on the extent to which guidance had been followed by individual trusts.	The NHS Executive notes the Committee's comments. Whilst the Executive does not accept it is necessary to monitor compliance with guidelines at individual trust level it will provide a report for the Committee in 12 months' time on the incidence of suspensions of medical and dental staff over six months.	1.8
(xi) We note the Executive's view that disciplinary procedures for senior doctors remain a difficult area and that they intend to refine their guidance further.... We expect the Executive to review... how the guidelines are operating in practice with a view to identifying further improvements....	The NHS Executive accepts the Committee's recommendation. It proposes to review the guidelines on suspensions in two years and will consider if any improvements are necessary.	Executive Summary 8
(xii) We note the Executive's view that there are now stronger incentives for NHS trusts to deal quickly with suspensions than was the case when consultants were employed by regions. We also note that disciplinary proceedings against medical staff may involve complex clinical and legal issues.... Individual trusts may lack the necessary expertise to deal with such complex cases.	The NHS Executive welcomes the Committee's recognition that the employment of consultants by trusts has introduced a stronger incentive for suspensions to be resolved quickly. It will continue to encourage trusts to develop the appropriate expertise themselves or to call on the expertise of other trusts.	2.11 2.17
(xiii) We expect the Executive to develop and encourage trusts to seek the appropriate expertise to deal effectively with suspensions of medical staff.		

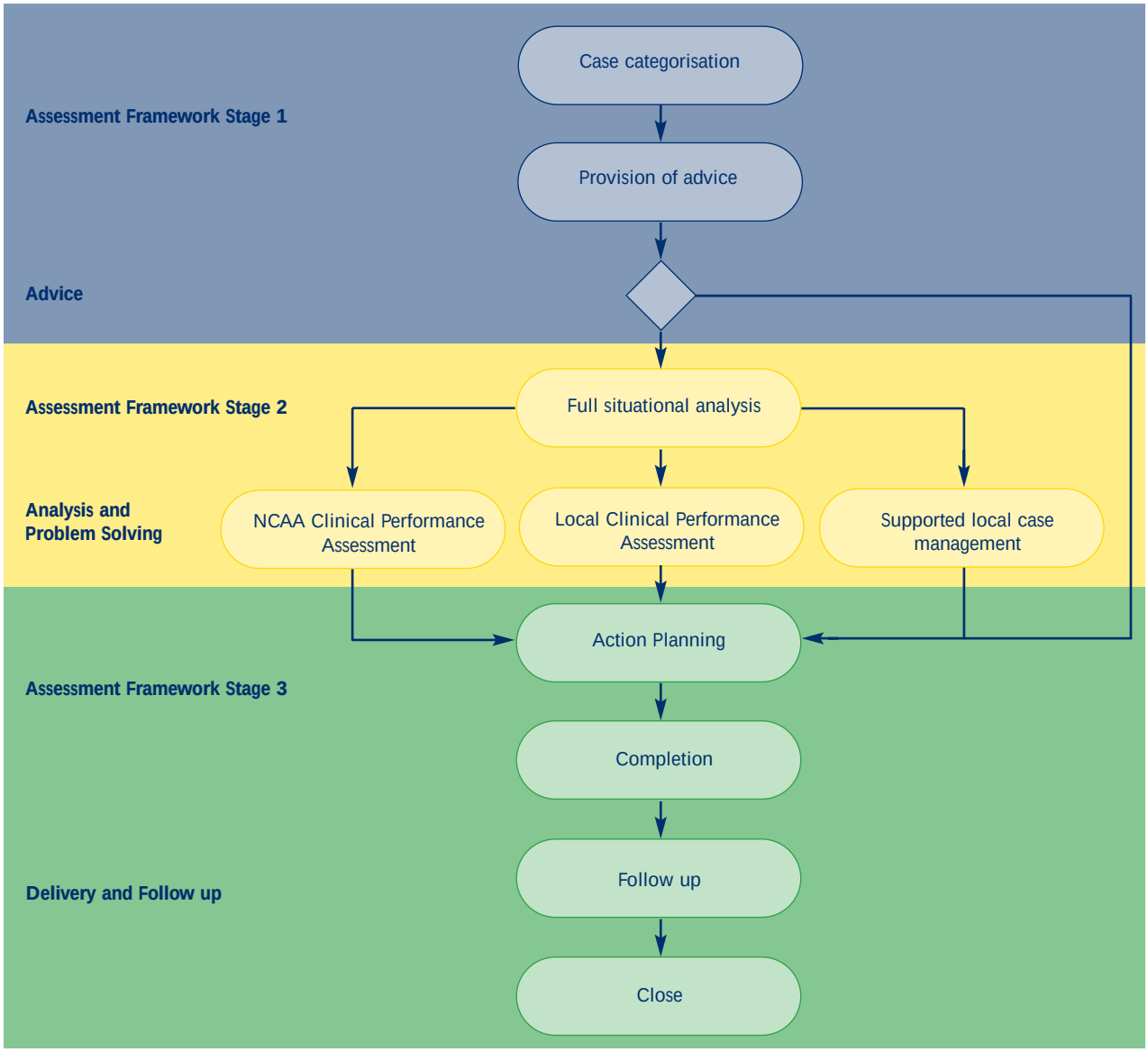
Appendix 3 The National Clinical Assessment Authority

1 The National Clinical Assessment Authority is a special health authority established on 1 April 2001 following recommendations made in the Chief Medical Officer's report *'Supporting Doctors, Protecting Patients'* (November 1999) and *'Assuring the Quality of Medical Practice: Implementing Supporting Doctors, Protecting Patients'* (January 2001). Its role is to help the NHS deal with concerns about the performance of an individual doctor or dentist. NHS organisations can contact the Authority for help, and individual doctors or dentists can self-refer if they wish. The flow diagram illustrates the range of services which the Authority can offer in any given referral.

2 There are four 'routes' which any referral can take:

Advice - in many instances, the referring body needs advice on how to move the problem on. This advice will often be on a sustained basis, perhaps taking the form of a series of telephone conversations between the referring body and an Adviser over a period of weeks. This is an expert and tailor-made advice service, but stops short of formal structured assessment activity.

If a referral requires more intensive support, it will enter a full situational analysis or 'mapping' stage where the Authority will work with the referring body, and



sometimes with the doctor or dentist and other local parties, to identify the issues and map out the next steps. The referral will then take one of the remaining three routes.

Advice leading to supported local case management - In these referrals, the Authority's role is to provide ongoing support while local bodies work to resolve the situation. It may be that the referring body needs to offer training to the doctor, or to facilitate a discussion between colleagues whose relationship has deteriorated. The Authority will provide advice on the phone and in person, and may attend meetings and case conferences to help the local parties work towards a resolution.

Advice leading to local clinical performance assessment - Sometimes it will become clear that a clinical performance assessment of the doctor is required, and that the local referring body has its own assessment procedure in place and wishes to use this. However, because individual bodies may have comparatively little experience of implementing such procedures, the Authority can be called upon to help advise on the most effective way of using these systems. The Authority therefore remains substantially engaged in the process.

Advice leading to National Clinical Assessment Authority clinical performance assessment - In some cases the Authority, the referring body and the doctor or dentist agree that a full Authority clinical performance assessment is necessary. This is the most intensive intervention, and is therefore reserved for those cases for which this expert integrated form of assessment is appropriate and where other approaches are not appropriate. These tend to be cases where specialist assessment tools are required, which are available to the Authority, but not at present locally. The Authority's assessment is a structured process which looks at clinical capability, health, job context and behaviour, and which leads to a full report. Both the doctor and the referring body have the opportunity to make comments.

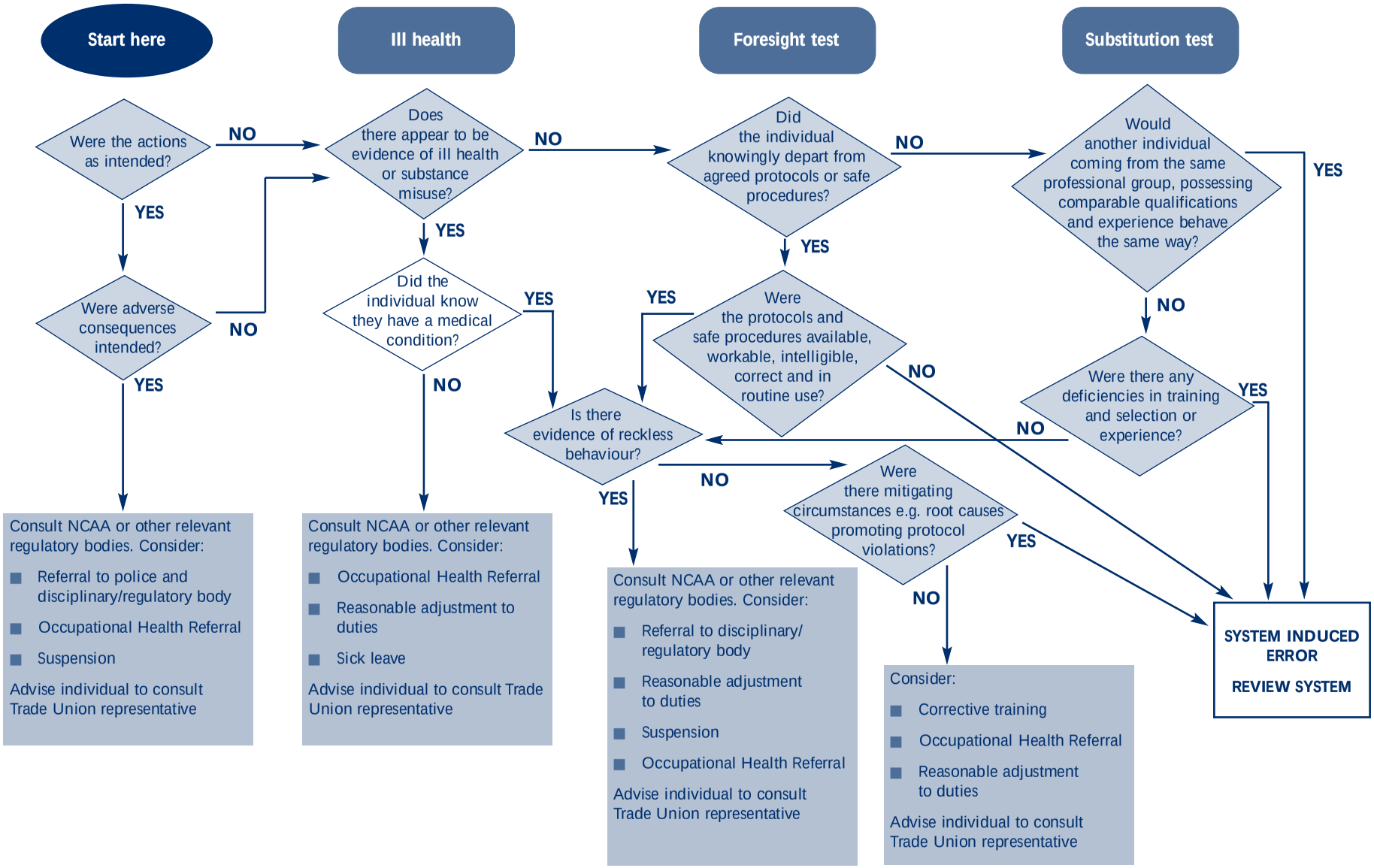
3 Whichever of the four routes is taken, the process leads to the development of an action plan. Appropriate follow up also takes place, before agreeing with the referring organisation that the case is closed.

Appendix 4 The National Patient Safety Agency's Decision Tool

1 The National Patient Safety Agency was established in July 2001 to co-ordinate the effort to record and learn from errors and near misses in healthcare and to promote an open and fair culture. Working with a number of other organisations, it is developing a decision tool to support managers considering their actions following patient safety incidents. Errors in healthcare have often been perceived as evidence of personal failure and there has been a tendency for trusts to exclude staff, often in haste. The draft decision tool (overleaf) provides a structure for managers to assess incidents and identify if there are systemic shortcomings. Use of the tool may result in greater openness in the reporting and analysis of patient safety incidents and reduced recourse to suspension. The draft decision tool is currently being tested in a number of trusts.

Incident Decision Tree - Based on James Reason's culpability model

National Patient Safety Agency



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