

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

executive summary

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.

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.

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.

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.

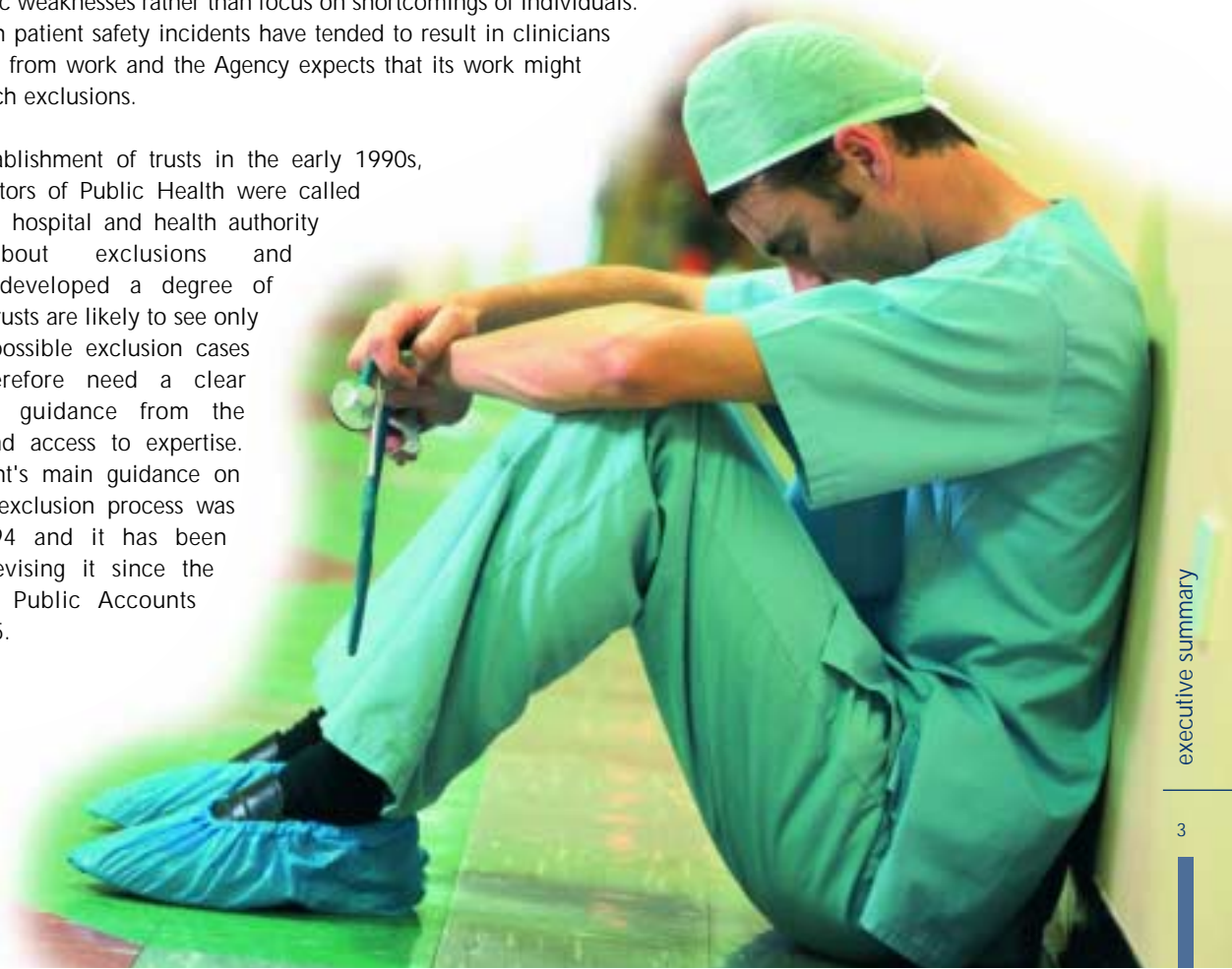
Professor Wendy Savage

"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 Bristol¹, 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.