



House of Commons
Committee of Public Accounts

The management of suspensions of clinical staff in NHS hospitals and ambulance trusts in England

**Forty–seventh Report of
Session 2003–04**

*Report, together with formal minutes,
oral and written evidence*

*Ordered by The House of Commons
to be printed 13 October 2004*

HC 296
Published on 16 November 2004
by authority of the House of Commons
London: The Stationery Office Limited
£11.00

The Committee of Public Accounts

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Summary

Introduction

Patients expect the highest standards of safety when being treated in the NHS. Where there are concerns about patient safety, such as the children's heart surgery cases in Bristol, it is important that these are investigated promptly. NHS trusts may therefore decide to suspend staff formally from work, restrict them from undertaking specific activities, or send staff on informal 'gardening leave'. Clinical staff are sometimes excluded for other reasons, such as personal conduct where patient safety is not a factor. Whatever the reason for excluding staff, the process must be fair, open and transparent.

Between April 2001 and July 2002 over a thousand clinical staff at NHS hospital and ambulance trusts in England were excluded from work for more than a month. Excluding staff is costly, both financially and in human terms. The annual total cost to the NHS is £40 million. For the clinician, exclusion can result in reduced self esteem and depression and the clinician's family can be adversely affected. The clinician may also lose important clinical skills and require substantial retraining before returning to work. The Department had no national picture of the extent of clinical exclusions prior to the Comptroller and Auditor General's Report.¹

In 1995 our predecessors examined the case of Dr Bridget O'Connell,² who was suspended for 11 years. They severely criticised the management of the case, and called on the Department of Health to review how new guidelines were operating, which the Department agreed to undertake by 1997. Since then there have regularly been a number of high profile exclusions, with some cases continuing for long periods, costing large sums of public money and harming the careers of excluded clinicians. Even where clinicians have been exonerated, careers can be damaged as there may well be a need for retraining following lengthy exclusion from clinical practice, and some clinicians have chosen to leave the NHS.

On the basis of the Comptroller and Auditor General's Report, we examined the Department on the scale and cost of exclusions, case material illustrating difficulties in managing exclusions, and the scope for improving the management of exclusions.

1 C&AG's Report, *The Management of Suspensions of Clinical Staff in NHS Hospital and Ambulance Trusts in England* (HC 1143, Session 2002–03)

2 40th Report from the Committee of Public Accounts, *The Suspension of Dr O'Connell* (HC 322, Session 1994–95)

Conclusions and recommendations

- 1. Prior to the Comptroller and Auditor General's Report, the Department had no appreciation of the full scale and costs of exclusions of clinical staff as its monitoring was limited to formal suspensions of doctors lasting more than six months and was itself largely inaccurate up to 2000.** There is a pressing need for accurate and timely reporting of exclusions to NHS trust and Foundation Hospital boards, and Strategic Health Authorities to enable them to see that cases are properly managed. The Department needs a better grip on the management of all exclusions of clinical staff and should repeat the National Audit Office's survey of all NHS trusts to determine the extent and costs of exclusions and report its results.
- 2. The Department's new guidance finally issued in December 2003 is welcome, incorporating many of the recommendations in the Comptroller and Auditor General's report, but it has taken ten years to produce and is incomplete.** The Department should complete its negotiations with the British Medical Association and issue further guidance on disciplinary processes. The guidance only applies to doctors and, with several hundred other clinical staff excluded each year, it is unacceptable that similar arrangements have not been made for them. The Department should now issue extended guidance covering all clinical staff.
- 3. The Department's guidance sets a six month limit on exclusions, and it receives regular data on cases exceeding this limit. Where cases are pending for more than six months, the Department should identify what actions it might take to promote an early resolution.**
- 4. A number of exclusions have dragged on for years, wasting large sums of money. If exclusions did not exceed six months, £14 million annual savings would be realised.** Some cases have taken more than two years, including cases where patient risk is not a factor. One long-running case is unlikely to be resolved until March 2005, resulting in an additional delay greater than the Department's target of six months for dealing with new cases. Such personal conduct cases need to be dealt with much more expeditiously using the employing NHS trust's disciplinary process, with its range of sanctions. Suspension should be reserved for cases of gross misconduct which could result in dismissal.
- 5. Despite our predecessors' concerns, payments to clinical staff who resign have sometimes been inappropriately covered by confidentiality clauses to the detriment of local accountability.** The Department's latest guidance on confidentiality clauses following our report on inappropriate adjustments to waiting lists is limited to chief executives and board directors. The Department should make clear that confidentiality clauses should not be used to prevent disclosure of settlements for any NHS staff.
- 6. The National Clinical Assessment Authority has helped improve the management of exclusions in a number of cases but has had mixed success in resolving legacy cases.** Fully operational from April 2003, the Authority should now be expected to achieve its target turnaround times for advising trusts and completing assessments. Trusts and Foundation Hospitals should seek advice from the Authority

and trust boards and Strategic Health Authorities should hold trust managers to account where Authority advice is not taken. The Authority only covers doctors, and the Department should consider extending its remit to other clinical staff.

7. **Trusts are failing to undertake the specified employment checks when recruiting staff and are therefore putting patient safety at risk.** In addition, there are weaknesses in communicating concerns to other potential employers where staff are excluded and many trusts fail to complete their inquiries if excluded clinicians leave. Trusts should undertake employment checks for all new staff. They should ensure that they advise potential employees and regulatory bodies where they have concerns about clinical competence, and complete disciplinary action once begun.
8. **It is a cause of concern that a significantly higher proportion of ethnic minority consultants are excluded.** The National Clinical Assessment Authority should monitor the ethnicity of doctors referred to it and make the relevant statistics known. As part of their diversity policy, trusts should monitor the ethnicity of excluded staff and if a disproportionate number of ethnic minority staff are excluded, should investigate the reasons.

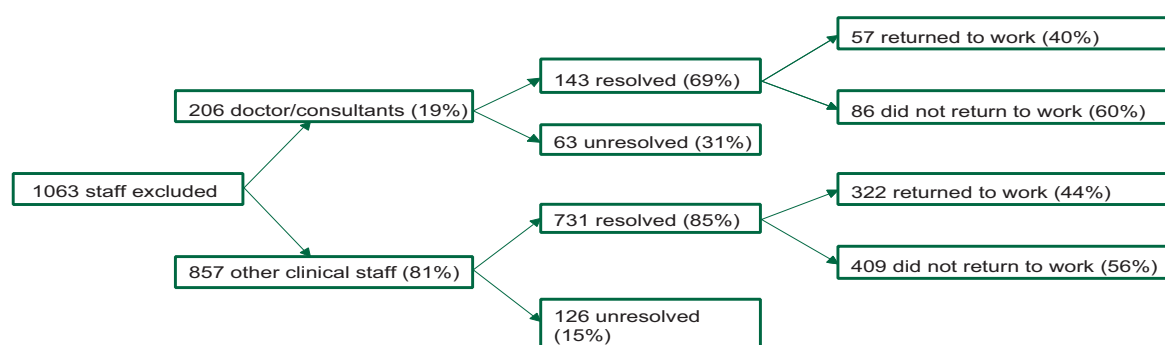
1 The scale and cost of clinical exclusions

1. Patient safety is vital and where there are concerns about professional performance, clinicians may be excluded from work in order to protect patients. The NHS is in effect a monopoly employer, so the burden of proof required to terminate a clinician's contract on grounds of professional competence is high. Clinicians are sometimes excluded where there are concerns about personal conduct, which can result in NHS trusts instigating disciplinary processes.³ Whatever the reason for exclusion, cases require careful management as costs, both human and financial, can be significant.

2. Until the Comptroller and Auditor General's Report, the Department had little appreciation of the extent and costs of exclusions. Following the Dr Bridget O'Connell case on which our predecessors reported, the Department began collecting data from trusts on suspensions of doctors that lasted more than six months. The Department's own monitoring figures are only accurate from 2000 onwards. The Department has not monitored suspensions lasting less than six months, informal exclusions often referred to as 'gardening leave', save for a special exercise undertaken in 2002, or any exclusions of other clinical staff.⁴

3. The Comptroller and Auditor General's Report showed that over 1,000 clinical staff were excluded from work for at least one month in the period from April 2001 to July 2002. Doctor exclusions averaged 47 weeks and exclusions for other clinical staff averaged 19 weeks. There were 30 cases of clinical staff being excluded for more than two years. Where cases were resolved, just under half of all staff returned to work (**Figure 1**).

Figure 1: Details of exclusions reported to the National Audit Office for the period April 2001 to July 2002



Over 80% of the 1,063 staff excluded were clinical staff other than doctors. Where cases were resolved, 40% of doctors and 44% of other clinical staff returned to their jobs.

Source: C&AG's Report, para 1.16

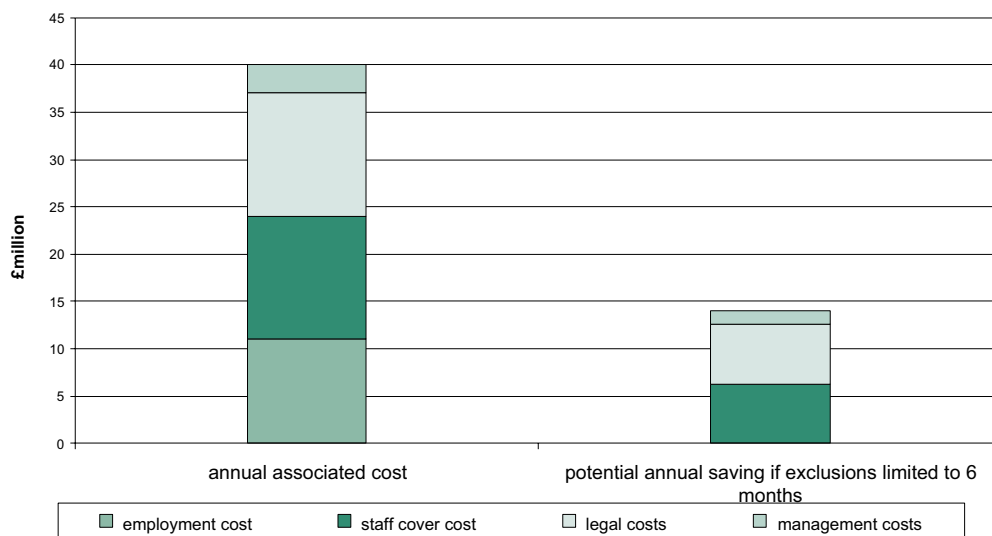
4. The National Audit Office estimated the annual gross cost of exclusions as £40 million, and that if exclusions were limited to six months, there would be annual savings of £14

3 Q 13

4 C&AG's Report, para 1.8

million.⁵ **Figure 2** provides a breakdown of the gross cost and potential savings. With doctor exclusions averaging £188,000, the costs of exclusion can be significant for individual trusts.⁶ Trusts continue to pay the excluded clinician's salary and may well have to provide staff cover. The costs of managing exclusions can also be significant in terms of management time and negotiated settlements where clinicians agree to resign. In addition to the financial costs, the human cost to excluded clinicians and their families is high, with many excluded clinicians experiencing reduced self esteem and depression.⁷ Careers can be damaged with clinicians losing expertise and requiring retraining if they have been excluded from clinical practice for lengthy periods.⁸

Figure 2: Annual cost of exclusions and potential savings



£14 million savings could be made each year if exclusions were limited to six months

Source: C&AG's Report, para 1.25 and Figure 14

5. In explaining how it expected to realise the savings identified in the Comptroller and Auditor General's Report, the Department pointed to three developments. In December 2003 it issued new guidance which called for a maximum length of exclusion of six months,⁹ as well as a number of other measures recommended by the Comptroller and Auditor General (**Figure 3**). Secondly, the National Clinical Assessment Authority, established in 2001 and fully operational from 2003, has helped to prevent a number of possible exclusions and is regarded as a centre of expertise. Thirdly, the Chief Medical Officer appointed a Human Resources Director who has been able to resolve a number of long running cases.¹⁰

5 C&AG's Report, para 1.25

6 Q 34

7 C&AG's Report, Executive Summary, para 2

8 *ibid*, para 2.25

9 *Doctors and dentists: Discipline and Suspension*, Department of Health December 2003

10 Q 6

Figure 3: Key features of the new Department of Health guidance

✓ denotes a recommendation made in the Comptroller and Auditor General's Report

- Emphasis on a consideration of alternatives to exclusion. ✓
- Consultation with the National Clinical Assessment Authority at an early stage when suspension is being contemplated. ✓
- In the first instance limiting exclusion from work to no more than 2 weeks. ✓
- Immediate written notification of the reasons for exclusion. ✓
- Any further exclusion limited to four-week periods which must be subject to active review.
- Appointment of one named case investigator, and other measures to improve the quality and efficiency of case management. ✓
- Appointment of a board member to oversee exclusion and subsequent action. ✓
- A six month limit on exclusion, except for those cases involving criminal investigations of the practitioner concerned. ✓
- Abolition of informal 'gardening leave' exclusions.

Source: Maintaining high professional standards in the modern NHS, Department of Health, December 2003

2 Case material illustrating how exclusions are managed

6. A number of the case studies described in the Comptroller and Auditor General's Report were disturbing, illustrating some of the worst aspects of the exclusion process: apparent victimisation of whistleblowers; a breakdown of team working; exclusions unrelated to clinical competence; and cases being allowed to drag on thus increasing cost.¹¹

7. In a number of cases clinicians considered that they had been excluded following their criticisms of trust procedures. Half of the fifty clinicians contacting the National Audit Office claimed that their 'whistle blowing' was a factor in their exclusion, illustrated by cases at Coventry and Plymouth.¹²

8. The NHS is dependent on effective team working and in some cases there have clearly been problems in maintaining team cohesion. At Coventry, for example, there was a serious breakdown in relations between senior management and some consultants. The Commission for Health Improvement's clinical governance review identified a deep concern that medical staff felt bullied and victimised and its follow up report concluded that relationships had broken down between some consultants and senior managers. The Commission for Health Improvement removed the Trust's star ratings and the management was franchised with senior members of the Trust's board resigning.¹³

9. In several cases there were no concerns about clinical competence and no apparent risk to patient safety. The Department considered that personal conduct cases should be treated seriously as a malfunctioning team can present a risk to patients.¹⁴ But it should be possible to deal expeditiously with such cases through standard disciplinary proceedings which apply to all staff, and in cases which would not lead to dismissal if allegations were proven, suspension is inappropriate.¹⁵

10. Cases included in the Comptroller and Auditor General's Report have dragged on for years, costing significant sums of taxpayer's money. Five cases have lasted for a total of 11 years, one of which is still continuing, and have cost more than £2.5 million.¹⁶ The Department recognised that a number of cases had not been well handled.¹⁷

11 Qq 8, 80–81

12 C&AG's Report, para 2.22 and Cases 5, 8

13 Q 59

14 Q 9

15 *Maintaining high professional standards in the modern NHS*, Department of Health, December 2003

16 C&AG's Report, Cases 3, 4, 8

17 Q 36

3 Scope for improvements in the management of exclusions

11. Following our predecessor's Report on the Dr O'Connell case in 1995, the Department promised to review its guidance by 1997. In fact new guidance was only issued in 2003.¹⁸ The new guidance takes on board many of the Comptroller and Auditor General's recommendations in his report, but it only covers initial investigations of doctor exclusions. The Department considered that whilst it could have brought out revised guidance earlier, it would not have been as good.¹⁹ We were not impressed by this argument as earlier dissemination of revised guidance might have helped reduce the current extent of the problem and helped resolve some cases.

12. The Department has focused almost exclusively on doctor exclusions, its rationale being that these cases tend to last longer, are more complex and cost more money. For example the National Clinical Assessment Authority is concerned exclusively with doctors and dentists. However, the National Audit Office showed that more than 800 other clinical staff were excluded for at least one month and a quarter of these exclusions lasted more than six months.²⁰ None of these exclusions is covered by the new guidance. Much of the Department's guidance is generic, highlighting sensible management practice, and could be readily extended to other clinical staff.²¹ Under the Employment Act 2002 disciplinary action has to be consistent across any employing organisation.²²

13. We questioned the Department on the extent of its powers to enforce compliance with guidance. The Department told us that it is not possible to micro-manage trusts but that ultimately powers exist to compel trusts to comply.²³ The Chief Medical Officer suggested that if a Trust were to reject the advice of the National Clinical Assessment Authority, the Strategic Health Authority and the Department would inevitably become involved.²⁴ The Commission for Healthcare Audit and Inspection could be called in to undertake an inspection which would look at wider management issues, as has happened at Wakefield in January 2004.²⁵ The Department's enforcement powers are further limited as it can not mandate Foundation Hospitals and it would be for the regulator to ensure that high standards were achieved.²⁶ In mitigation the Department considered that Foundation Hospitals would wish to follow the best practices included in the Department's guidance and that the regulator might insist on employment checks and adoption of smart cards containing key information on clinical staff.²⁷

18 *Maintaining high professional standards in the modern NHS*, Department of Health, December 2003

19 Q 11

20 C&AG's Report, para 1.11

21 Qq 46–48

22 *Maintaining high professional standards in the modern NHS*, Department of Health, December 2003, para 9

23 Qq 21–26

24 Qq 37, 41

25 Ev 18

26 Q 26

27 Q 28

14. Trusts have tended to rush to exclude clinicians with insufficient initial investigations.²⁸ Often other measures, such as restrictions on the clinician's duties, would allow more expedient resolution of the problems. In analysing thirty six cases referred to it, the National Clinical Assessment Authority was able to identify thirty cases where there were alternatives to suspension.²⁹

15. Where clinicians are excluded, cases should be resolved more quickly. Problems to date have been largely attributable to bad management, but the legalistic nature of the current guidance on the disciplinary process has also been a factor. The new guidance issued in December 2003 should enforce better case management, and the Department expects to issue further guidance on the disciplinary process following completion of negotiations with the British Medical Association.³⁰ Much would be gained by the Department undertaking a survey of trusts along the lines of the National Audit Office's survey. At local level trust boards and Strategic Health Authorities will need to ensure that they have accurate information on exclusions.

16. When staff resign during an investigation one fifth of trusts said they do not conclude the investigation, so that it is not possible to alert prospective employers to any concerns about the clinician.³¹ Similarly, only 57% of trusts said that they comply with the requirement to request a declaration from applicants for doctor posts saying that they have not been the subject of fitness to practice proceedings.³² Just under half (45%) of trusts stated that they do not require an excluded clinician to seek their permission to work in another trust.³³

17. Our predecessors highlighted the misuse of confidentiality clauses in the Dr O'Connell case and we criticised the widespread use of such clauses in our report on inappropriate adjustments to waiting lists.³⁴ The Department has recently issued a new direction on these clauses but the direction is limited to chief executives and board directors.³⁵ There continues to be inappropriate use of confidentiality clauses, which prevent proper disclosure of settlements and limit accountability.³⁶

18. The Comptroller and Auditor's Report showed that a significantly higher proportion of ethnic minority consultants were likely to be excluded. Ethnic minority consultants comprised one fifth of all consultants, but accounted for over one third of all consultants excluded for more than six months.³⁷ Whilst the Department has not historically collected information on the ethnicity of long term suspended doctors, it recognises that this is a

28 C&AG's Report, para 2.12

29 *ibid*, para 3.17; Q 38

30 Q 15

31 C&AG's Report, para 3.13; Q13

32 C&AG's Report, para 3.8; Q21

33 C&AG's Report, para 3.10

34 40th Report from the Committee of Public Accounts, *The suspension of Dr O'Connell* (HC 322, Session 1994–95); 46th Report from the Committee of Public Accounts, *Inappropriate adjustments to NHS waiting lists* (HC 517, Session 2001–02)

35 *Use of confidentiality and clawback clauses in connection with termination of a contract of employment*, Health Service Circular, February 2004

36 Qq 7, 69–70

37 C&AG's Report, para 1.17 and Figure 10

cause for concern and has begun to collect this information as part of its quarterly monitoring.³⁸

Formal minutes

Wednesday 13 October 2004

Members present:

Mr Edward Leigh, in the Chair

Mr Richard Allan	Jim Sheridan
Mr Richard Bacon	Mr Gerry Steinberg
Mrs Angela Browning	Jon Trickett
Mr David Curry	Mr Alan Williams
Mr Ian Davidson	

The Committee deliberated.

Draft Report (The management of suspensions of clinical staff in NHS hospitals and ambulance trusts in England), proposed by the Chairman, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 18 read and agreed to.

Conclusions and recommendations read and agreed to.

Summary read and agreed to.

Resolved, That the Report be the Forty-seventh Report of the Committee to the House.

Ordered, That the Chairman do make the Report to the House.

Ordered, That the provisions of Standing Order No. 134 (Select Committees (Reports)) be applied to the Report.

[Adjourned until Monday 25 October at 4.30pm]

Witnesses

Wednesday 28 January 2004

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Sir Nigel Crisp KCB, Professor Sir Liam Donaldson KCB, and Mr Andrew Foster, Department of Health

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Third Report	The Sheep Annual Premium Scheme	HC 64 (<i>Cm 6136</i>)
Fourth Report	Improving service delivery: the Forensic Science Service	HC 137 (<i>Cm 6155</i>)
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Sixth Report	Department of Trade and Industry: Regional Grants in England	HC 207 (<i>Cm 6155</i>)
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Tenth Report	Purchasing and managing software licences	HC 306 (<i>Cm 6175</i>)
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Twelfth Report	Getting it right, putting it right: Improving decision-making and appeals in social security benefits	HC 406 (<i>Cm 6191</i>)
Thirteenth Report	Excess Votes 2002–03	HC 407 (<i>N/A</i>)
Fourteenth Report	Inland Revenue: Tax Credits	HC 89 (<i>Cm 6244</i>)
Fifteenth Report	Procurement of vaccines by the Department of Health	HC 429 (<i>Cm 6244</i>)
Sixteenth Report	Progress in improving the medical assessment of incapacity and disability benefits	HC 120 (<i>Cm 6191</i>)
Seventeenth Report	Hip replacements: an update	HC 40 (<i>Cm 6271</i>)
Eighteenth Report	PFI: The new headquarters for the Home Office	HC 501 (<i>Cm 6244</i>)
Nineteenth Report	Making a difference: Performance of maintained secondary schools in England	HC 104 (<i>Cm 6244</i>)
Twentieth Report	Improving service delivery: the Veterans Agency	HC 551 (<i>Cm 6271</i>)
Twenty-first Report	Housing the homeless	HC 559 (<i>Cm 6283</i>)
Twenty-second Report	Excess Votes (Northern Ireland) 2002–03	HC 560 (<i>N/A</i>)
Twenty-third Report	Government Communications Headquarters (GCHQ): New Accommodation Programme	HC 65 (<i>Cm 6302</i>)
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Twenty-ninth Report	Improving public services for older people	HC 626 (<i>Cm 6303</i>)

Thirtieth Report	Out of sight—not out of mind: Ofwat and the public sewer network in England and Wales	HC 463 (<i>Cm 6303</i>)
Thirty-first Report	Cambridge-MIT Institute	HC 502 (<i>Cm 6302</i>)
Thirty-second Report	HM Customs and Excise Standard Report	HC 284 (<i>Cm 6304</i>)
Thirty-third Report	Income generated by the museums and galleries	HC 430 (<i>Cm 6304</i>)
Thirty-fourth Report	Strategic Rail Authority: improving passenger rail services through new trains	HC 408 (<i>Cm 6304</i>)
Thirty-fifth Report	Early years: progress in developing high quality childcare and early education accessible to all	HC 444
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The reference number of the Treasury Minute to each Report is printed in brackets after the HC printing number

Oral evidence

Taken before the Committee of Public Accounts on Wednesday 28 January 2004

Members present:

Mr Edward Leigh, in the Chair

Mr Richard Bacon
Mr Brian Jenkins

Jon Trickett

Sir John Bourn KCB, Comptroller and Auditor General, and **Ms Karen Taylor**, Director, Health VFM, National Audit Office, further examined.

Mr Rob Molan, Second Treasury Officer of Accounts, HM Treasury, further examined.

REPORT BY THE COMPTROLLER AND AUDITOR GENERAL:

The management of suspensions of clinical staff in NHS Hospital and Ambulance Trusts in England (HC 1143)

Witnesses: **Sir Nigel Crisp KCB**, Permanent Secretary/NHS Chief Executive, **Professor Sir Liam Donaldson**, Chief Medical Officer, and **Mr Andrew Foster**, Director of Human Resources, Department of Health, examined.

Q1 Chairman: Good afternoon, welcome to the Committee of Public Accounts where this afternoon we are considering the Comptroller and Auditor General's Report on The Management of Suspensions of Clinical Staff in NHS Hospital and Ambulance Trusts in England. We welcome back Sir Nigel Crisp, who is Permanent Secretary at the Department of Health. We also welcome Professor Sir Liam Donaldson, who is Chief Medical Officer. We are also joined by Mr Andrew Foster, who is Director of Human Resources at the Department. You are all very welcome and thank you for agreeing to come and speak to us this afternoon on what is a very important subject. May I start Sir Nigel by asking you a few questions and ask you please to look at paragraph 1.10, figure 9 of the Comptroller's Report. You will see in paragraph 1.10 it says that the Department only has data on long term doctor suspensions, so it is true to say, is it, that you did not know before the National Audit Office did their work that 1,000 clinical staff were excluded for at least a month, some for much longer; you did not know that?

Sir Nigel Crisp: No.

Q2 Chairman: I must then ask you why this important subject appears to receive such scant attention from your Department?

Sir Nigel Crisp: I think we have spent an awful lot of attention over the last few years since the last hearing here on creating a completely new quality framework, which is preventative in terms of trying to make sure that we have got proper clinical quality arrangements in place, led very largely by the Chief Medical Officer. Also over this period we have concentrated very much on medical suspensions. What we have not done and what we are now starting to do is to concentrate on looking at the

suspensions of other staff. The effort has gone into prevention rather than into making counts of particular numbers of people suspended.

Q3 Chairman: But you of course accept that the suspension of clinical staff is still very important. We are talking about midwives, and there is national shortage of midwives, so having a particular midwife out of work for many months is not good for the NHS.

Sir Nigel Crisp: I think the most important point is to try and make sure that we never get to the point of suspension and that is where the work has been done. The fact that one in 700 clinical staff have been suspended in the period looked at in the NAO Report is bad and each individual case needs attention and we need to try and make sure that they do not happen but the most important thing is to get the environment right.

Q4 Chairman: I agree. At the moment we are trying to get an exactly accurate picture of how many are suspended. To help us in that, if you look at figure 5 on page 14 you will see it says there at the top that the Department considers that data are only reliable from 2000. Are you absolutely sure that your data is reliable after 2000?

Sir Nigel Crisp: We are absolutely sure of the order of magnitude. As you may be aware, during the course of the last few weeks we have identified one other person who should have been on this list during this time, so we think it is very nearly accurate, as accurate as we can get it.

Q5 Chairman: Why was it not accurate up to 2000?

Sir Nigel Crisp: There is another point which is just worth bearing out. Because of the new more systematic accent on quality there are quite a lot of reasons why suspensions may have increased a bit in

 Department of Health

recent years because we are being more systematic in looking at quality issues. Why it was not accurate before was simply that the collection methods were not good enough. There are also some definitional issues here which again this Report brings out about when people are suspended as opposed to when there may be some other arrangement like gardening leave. There are some issues like that. It is from 2000 that we are confident at that stage, through your instigation, that these figures are the right order of magnitude.

Q6 Chairman: Thank you. Having established the extent of these exclusions, can we look at the costs and to help us with that if we look at paragraph 1.25 on page 21 you will see it says there: “If all cases were resolved within six months, the staff cover and other resources would be available to provide additional services worth some £14 million a year.” So what are you doing, Sir Nigel, to try and ensure that these savings, which are quite considerable, are realised?

Sir Nigel Crisp: I think there are three main things. The first one is that we have introduced the National Clinical Assessment Authority to help with these cases and to avoid exclusions where we can work through the often complex issues. That was speeded up. Secondly, we have since 2002 appointed a Human Resources Director who is available and working with any of the cases where they become long, and he has helped resolve a number of cases by simply being able to go in with experience from outside. Thirdly, we have now issued additional guidance which picks up a number of things which are again speeded up.

Q7 Chairman: You know this Committee takes a dim view of confidentiality clauses. Can you give an assurance that trusts are no longer using confidentiality clauses?

Sir Nigel Crisp: We have guidance waiting to go out, but I am waiting to the end of this Committee to see whether or not I ought to change it at all, which indicates how and under what circumstances people are entitled to have confidentiality clauses. We cannot outlaw them completely because there are issues of patient confidentiality involved. So there are legitimate reasons for confidentiality clauses but, as I say, I have a circular literally waiting to go out pending anything that may come up in this meeting.¹

Q8 Chairman: Let us look at the way the exclusions are managed. If we look at page 5, paragraph 14 of the Report it is quite a damning indictment there. It says: “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”—which is when we last dealt with this in this Committee—“were still prevalent: a failure to follow guidelines, continued use of confidentiality clauses

in settlements, and poor cost information.” As I say, that is a pretty damning indictment. What are you doing to put this right?

Sir Nigel Crisp: I think it is the three things in a sense I have already said. We have introduced this new assessment authority, which will help us with that. We have introduced a senior, experienced HR Director to help and the new guidance provides a new method of monitoring and overseeing what is happening because you are quite right this Report shows a number of instances where trusts have not done what we would want them to do, and in future they are going to have to report on a regular basis to strategic health authorities so that there is an oversight of this happening on a regular basis and not just periodically, which is what happens at the moment.

Q9 Chairman: What the public would want to know is that somebody will be excluded as a result of the doctor or clinician or surgeon being no good at their job and having made a mistake, but they might be alarmed to read in paragraph 13 of this Report that “a number of exclusions occur as a result of a breakdown in team working . . .” There does not appear to be any risk to patient safety here so why do so many exclusions result from a breakdown in team working? Is this something you should be addressing in your review of what is going on?

Sir Nigel Crisp: I will ask Sir Liam to say a bit more about that but I think the point is that these are actually quite complex issues and team working does affect the ability of a service to run effectively.

Professor Sir Liam Donaldson: Thank you, Chairman. I think it is true that we have tended to concentrate in the past on the harder end of poor clinical performance, the technical incompetence which occurs in a very small number of cases. Let us remember that the vast majority of doctors practise to a very high standard indeed and we are dealing here with the minority. The NHS and a lot of other public services have not had experience in dealing with behavioural and team dynamic factors and had not even appreciated that they are important as far as quality of care is concerned. If you look at other industries where there is high risk such as the airline industry you see that a dysfunctional team is a source of danger to air passengers and, likewise, a dysfunctional clinical team would be a source of danger to patients. It is only in the last few years that this has been recognised worldwide and a lot more emphasis is placed upon the team and the organisational environment in which they are working rather than simply concentrating on the individual alone and trying to improve their skill levels. It is something that we are working on but it is not something to be regarded as at the minor end of the spectrum. It is as serious in its own way as technical incompetence.

Q10 Chairman: Alright, thank you for that. You published new guidance on doctor exclusion in December, did you not?

¹ Ev 15–16

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Sir Nigel Crisp: That is right.

Q11 Chairman: If you remember, we last reported and did a fairly scathing report in this Committee on the Dr O'Connell case 10 years ago. Why has it taken so long to produce this new guidance? Will we have to wait another 10 years for guidance on other clinicians from you?

Sir Nigel Crisp: No, what actually happened was that work started immediately on providing that guidance. I think the commitment was to review it and the review was underway by 1997, I think was the date on this, and it is perfectly true that we could have published guidance at that point. One thing I would say is the guidance had we published it then would not have been as good as the guidance which we have published now because the work of the Department was taken over from that date by two things. Firstly, again very much under the leadership of the Chief Medical Officer, he was looking at a whole series of work entitled *Supporting Doctors, Protecting Patients* which was putting in place this quality framework for actually looking at how we made sure that these things did not happen, which is, may I say, a world beater because this is the strongest quality system in any country. The second thing that happened is that at the end of 1999 we then entered into contract negotiations with the consultants which picked up these issues as well and that has just been resolved. The net result of that is that while we could have published guidance, and you may well be critical of us for not doing so in 1997, the guidance we have now finally produced has benefited from those two things and is a much stronger and more effective method of dealing with it. But that is the story.

Q12 Chairman: Sir Liam, could I just ask you a couple of questions. Could you look at page 4, paragraph 9. You will see that it says: "The Authority has developed targets for dealing with enquiries, ranging from a 24-hour emergency service to completing detailed assessments in three months." Why are you still at the target stage? Why have you not achieved this?

Professor Sir Liam Donaldson: It is an entirely new Authority doing work that is unprecedented worldwide. In other countries regulatory bodies like the General Medical Council deal with such matters as far as doctors are concerned and use a variety of approaches, but there is no health care system in the world that is attempting to do this for its health service. In most other countries if there are concerns about a doctor's performance and a hospital is seriously concerned about it they will simply withdraw their consulting rights and they will drift away and potentially practise somewhere else, causing harm to patients. We have tried to put in place a procedure that will operate across the NHS as a whole. So the new Authority had to be set up and it had to work out from scratch methods of assessment, it had to set up a network of advisers, train them, skill them, and we had to notify the NHS of the availability of the Authority and the circumstances in which referrals could be made. I am

quite pleased so far that the Authority has dealt with about 600 referrals and seems to be dealing with them very effectively, at the same time as developing its methodology. The final building block in this, which has been very frustrating that it has been so long delayed, is the removal of the old disciplinary procedures which have such a legalistic element to them. The Authority has not been able to have its full impact because until that element of the consultant contract negotiations is finished then it will not be permitted to do everything that potentially it will be able to do.

Q13 Chairman: Sir Liam, may I also ask you, what the public are concerned with is they want to be sure that if somebody has been suspended for any reason that people know about that. If you look at page 7, paragraph 18, that last bullet point there you will see that: "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." Is that not rather alarming?

Professor Sir Liam Donaldson: I think it is a weakness and, as I set out in my last answer, the idea is that we should look at the NHS as a whole system so that we should not have situations where there are concerns about doctors' standards of care move somewhere else without their new employer being aware of the problem. There are clearly at least two categories here and they are very different. One would be a situation where there is some dispute between a doctor and his or her employer where there may be concerns about their attitude and their behaviour but their standard of clinical practice is good, and in those circumstances a termination of contract may be agreed within the regulations and the doctor then goes and works elsewhere. In such circumstances it is difficult to see what further investigation or what information could legitimately be passed to another employer. The other situation is one where there is a serious concern, it is being investigated, and the hospital agrees with the doctor or the doctor's lawyers that rather than running a disciplinary procedure with all the difficulties and time constraints that they will simply negotiate a settlement of the contract and the doctor will depart. In my view that is highly inappropriate because it does expose the public to the sort of situations that you, I think, were implying when you asked the question and so we have, we believe, made it clear to trusts that this should not happen, but clearly we will be monitoring the situation very carefully.

Q14 Chairman: Thank you for that.

Mr Foster: Can I add a point to the answer to the previous question. There is a framework which we have not published yet because we are in discussions with the BMA as a follow-on to our consultant contract negotiations, which is on capability and misconduct. In doing the draft that we currently have with the BMA our proposal is that it should be mandatory that where a disciplinary procedure has been started it must be brought to a conclusion. So that is our proposal.

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Q15 Chairman: You see in conclusion what somebody reading this Report might think is that this is somewhat of a scandal and it reinforces a general impression that the NHS often is mired in bureaucracy. Here you have some doctor whom you are putting on gardening leave not just for a month, sometimes for years, apparently at great cost to the NHS, and people might think that this would never be allowed to happen in the private sector, so why is it happening in the NHS? You would say you are dealing with safety of patients and the issues are more complex but it is an issue of some importance and it is important to resolve.

Professor Sir Liam Donaldson: Two points, Chairman. I think certainly in situations where doctors may have been suspended and the charges against them may eventually not be held to be valid, then clearly that is a situation where somebody's skills are being wasted and so on, but in a situation where there are serious concerns, the problem at the moment is that under the current disciplinary procedures which I have explained are still being negotiated with the BMA, the burden of proof required to terminate somebody's contract on grounds of incompetence is very high. It is high because the NHS has been regarded as virtually a monopoly employer so that depriving somebody of their employment rights in one local hospital in effect removes their right to employment or places such a stigma on them that they will not get a job elsewhere, so the reason that these things have dragged on so long in a way is because of bureaucracy but it is a bureaucracy that has been laid down as part of employment law backed up by very strong legal safeguards for the doctor.

Sir Nigel Crisp: May I just add an extra point, which is that in many other countries where it is operating through a private sector arrangement the private sector organisation may remove the right to consult in the hospital and that is it. We have the additional responsibility, which you are very properly asking us about, of how do we make sure these doctors do not reappear somewhere else in the system, and that is a different responsibility that we have from the responsibilities of the private sector.

Professor Sir Liam Donaldson: If I may add very briefly, in my old job in the regional health authority, many times a new chairman of a trust coming in from industry seeing such a situation would say, "Why won't you just let us sack them, this is just using up too much management time and too much money. Never mind about disciplinary procedures, let's just sack them." Of course, one can understand the frustration but that would not be a fair way to proceed in the employment law situation that we are in.

Chairman: Thank you very much. Jon Trickett?

Q16 Jon Trickett: But is it not a fact that there are many occasions where management have gone almost to subterfuge to find excuses to sack or remove clinicians because the burden of proof was so high that it was impossible to stick the main

charge? It is like getting Al Capone for tax evasion rather than running the murderous operation that he was doing. Is that not a fact?

Professor Sir Liam Donaldson: I hope that has not happened. There have been situations in the past where somebody's practice has been quite dubious but it has been impossible to find enough evidence to substantiate what is a very, very strongly held clinical concern by other colleagues. We have seen in some of the cases in the past where doctors have in the end come to some disastrous situation where patients have been seriously harmed and it has come out that it has been known about for some years, it is just there has not been the burden of proof to call them to account.

Q17 Jon Trickett: From time to time, consultants have been caught on, say, expense fiddling type stings in order to deal with them because the authorities were unable to demonstrate clinical failure. Is that not a fact that has been happening?

Professor Sir Liam Donaldson: I am not aware of specific instances where a tactical approach has been used for that purpose and I think that is an inappropriate way to proceed.

Q18 Jon Trickett: Sir Nigel, are you aware of any such situations?

Sir Nigel Crisp: I am aware of one reported some years ago but I am not aware that that is something that happens significantly.

Q19 Jon Trickett: Let me ask you on governance issues really. In Wakefield, which is my home authority, it is the Mid Yorkshire Trust, there is a mysterious civil war going on between clinicians and the bureaucracy or the executive or the managers which has eventually brought in CHI for some sort of investigation. Is it not a fact that if the clinicians form an *esprit de corps*, as you might call it or somebody else might call it a *Mafioso* approach, where they can defend themselves because of the nature of the contract and the nature of the lack of medical skills that the managers have, that turf wars break out and frequently it is the managers who are removed? In the case of my own trust I notice the chief executive has now retired early having tried to deal with a problem in gastroenterology. Is it not a fact that that is happening?

Sir Nigel Crisp: I think it is more complicated than that. I think in any big organisation—and I am aware in the periphery of what you are talking about but I do not know the details—it is not quite as simple as one group versus another group. There are often a whole lot of different undercurrents going on and that is why we need a proper investigation. What is perfectly true, and I have been a chief executive of two trusts, is that as a chief executive of a trust you work alongside your clinical colleagues who are the people doing the business, and you have got to get that relationship right. There is one account which I think is in this Report of the trust in Solihull which describes how the climate changed over a period in terms of how a new and better working relationship

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was established, so it is very important that you get that right. I think what you were saying was an over-generalisation.

Professor Sir Liam Donaldson: If I could add, Chairman, most chief executives would have the qualities of leadership to deal with not just the consultants that were co-operating with management but also with some of the difficult ones and get them onside and work with them, just as a good football manager would be able to deal with players who were more wayward than the others, but from time to time—and it is rare—there will be a situations where the consultants gang up unfairly on the management and try and pass a vote of no confidence. In such situations there is a level of management above the local level—the strategic health authority—and we would expect if management was trying to do the right things for improving patient care and was being obstructed by the clinical staff, and I cannot believe that is anything other than rare, we would expect the strategic health authority chief executive to step in and sort things out.

Q20 Jon Trickett: Where a chief executive wants to move a particular consultant from one hospital to another within a trust, is it not a fact that the clinicians, if they are robust enough, are able to resist such a move, as has happened in my experience?

Professor Sir Liam Donaldson: It depends on the reasons for wanting to make the move. If there is a good reasoned case whereby standards of care will be improved or safety of care will be improved or cross-cover arrangements will be improved and the clinical staff are resisting, as I have said, in many situations I would expect the manager, by engaging the medical director and other managerial clinical staff, would be able to persuade people of the strength of their case. There may be situations where there is unreasonable resistance and it is in those situations I would expect the senior management level of the strategic health authority to come in and help to sort the problem out.

Q21 Jon Trickett: I would like a note for the Committee, if the Chairman gives permission, on the situation in Wakefield and the Mid Yorkshire Trust because some of the questions I am asking are informed by a perception of what is happening there.² More generally, I want to refer you to paragraph 3.8 where in June 2000 it describes an application form for doctor posts to require a declaration by applicants that they have not been subject to certain actions, and in the next sentence it talks about from May 2002 those checks were made mandatory for new NHS staff. Yet only 57% of the trusts are actually complying with this mandatory requirement. Do you have the power to mandate trusts to change their practice? If you do, what steps are you able to take to reprimand or to take further action against those trusts who fail?

Sir Nigel Crisp: The answer is yes we can require people to do this and at the end of the day we can send out a direction from the Secretary of State insisting that they do it. What we then do is because we do not micro manage everything that every trust does but we do have a human resources management arrangement whereby we look at the standards of human resources in trusts, which is run through Mr Foster. That means that we would pick up periodically when things are going wrong rather than checking on a very regular basis that they are doing that, but that is a disturbing finding.

Q22 Jon Trickett: Why did you not know that 43% of all trusts were failing to co-operate with the mandatory instruction from the Department and why had you not taken any action against then and what action have you now taken against them?

Sir Nigel Crisp: Taking those in order, firstly, we do not know on a day-to-day basis everything that is going on with everything that every trust is meant to be doing. We can only check it out periodically.

Q23 Jon Trickett: This is a mandatory instruction.

Sir Nigel Crisp: There are quite a lot of them.

Q24 Jon Trickett: Mandatory instructions?

Sir Nigel Crisp: There are quite a lot of requirements around human resources and we do not consistently check up on them. Having found this piece of information, we will be picking up from this Report and going back to trusts and drawing attention to quite a lot of weaknesses that are here about how people are actually handling staff within their organisations because there are quite a number of areas here. We will be going back on that and I do not know whether Mr Foster wants to add anything.

Mr Foster: I would say two things. First of all, I would say it is disappointing that the compliance figure is only 57%. That will certainly be one of the outcomes of this Report and this Committee hearing on which we will be issuing a strong reminder. In the longer term what we are trying to do with all doctors is to have an occupational health smart card, effectively an electronic record which will automatically have this information on it and therefore this will be carried out without the bureaucracy.

Q25 Jon Trickett: What sanctions do you have? It seems to me the background to all this in my mind and probably the public's mind is Shipman. I know that Shipman had not got to the stage where he would have had to declare some things, but the background to all of this in the public mind is that experience. This does not seem to me to be just one of 100 other edicts which are issued from Leeds from time to time. This is quite an important issue because we are dealing with potential malpractice of a serious nature. You did not even know that they were not complying and you have said that you are going to issue a stern reminder but what sanction do you have against the trusts which are failing to respond to this mandatory instruction?

² Ev 18, Ev 19–21

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Mr Foster: As Sir Nigel has said, we are installing an HR performance framework. You are quite right in saying this is very important but it is also very important that criminal records checks take place, and checks to see if there is any record of involvement in problems with children. There is a variety of other things the HR function does that have to be properly carried out. Our proposal is to develop a performance management framework for HR which is then the subject of the CHAI inspection so the sanction, if you like, would come through criticism by CHAI and they have various powers themselves to take action against trusts which are not conforming to directions.

Q26 Jon Trickett: So you have no sanctions at all then, since I have asked you twice and you have not answered. I want to ask you about foundation hospitals because my time has probably already expired. I want you to give me an assurance if you can that movement to foundation hospital status with a different corporate structure will not mean that those HR directors and chief executives and boards have even more impunity ready to give you a two-fingered salute, as we say in Yorkshire, when you issue these mandatory instructions. Are you able to give me that assurance?

Sir Nigel Crisp: They will be subject to the CHAI inspections and the standards that Mr Foster has talked about will apply to the NHS and in due course to the private sector as well. They have the sanctions that Mr Foster has referred to. Things like star ratings and performance ratings are really quite important, and increasingly so, and CHAI can also intervene, make recommendations and make sure that action is taken. The new Regulator of Foundation Trusts, who has only been in post for a very, very short time, is very alive to this issue of making sure that we do maintain the standard, which can I say is higher than other countries. It may also be worth noting, since you mentioned Dr Shipman, that you cannot actually get to be a GP on a PCT list until those checks are completed and there is a step down the line.

Q27 Jon Trickett: I do not want to follow that particularly, except that mandatory instructions, which you have not answered about for foundation trusts, only apply to new staff. As far as I can see it does not apply to anybody already in post. I think it is a very, very serious problem with the instructions you have given, notwithstanding the fact that the instruction seems to be ignored with some impunity as it only applies to new employees. Anybody who is already in place is not required to go through any of those tests. I want to ask one last time, are you able to give mandatory instructions to foundation hospitals?

Sir Nigel Crisp: Not to foundation hospitals but they will be subject to the same arrangements in terms of being inspected and the inspector having powers to intervene.

Q28 Jon Trickett: If you do not mind I do want to pursue this because there are two issues really. One is foundation hospitals are not subject to mandatory instructions, as I assumed, in terms of the kind check-ups by inspectors, they may invent their own, but somebody leaving a foundation hospital and moving across into the NHS into a non foundation hospital. Is there not the possibility of a loophole there because there are different issues of governance, as I understand, between foundation hospitals and the NHS (if you like to call them that) hospitals?

Sir Nigel Crisp: The hospitals which are directly accountable to me and the Secretary of State will have the requirements which are here and they will have to do pre-employment checks. That will be helped by the smart cards which Mr Foster talked about. I would find it very surprising if foundation trusts did not use these because they will be subject to legal proceedings and everything else and this is an effective method of making sure that you are employing staff who do not have a problematic record for whatever reason. So I would be very surprised if foundation hospitals did not require that. I suspect that the inspector, through CHAI, may even say that that is a requirement or a standard. Be clear, NHS foundation trusts are fully part of the NHS and need to be exchanging information with all other parts of it.

Q29 Jon Trickett: Yes or no—because I really must finish now—am I right in assuming that these checks do not apply to people who are not moving from one employer to another, in other words who are already in place?

Sir Nigel Crisp: They apply to people moving from one employer to another.

Q30 Jon Trickett: Anybody who is already in place who had been the subject of some sort of clinical governance proceedings of some kind would not have to inform their employer if they were already in place?

Sir Nigel Crisp: If they were already in place and had been for a number of years, but moved 10 years ago.

Q31 Jon Trickett: Just as Shipman was.

Sir Nigel Crisp: I think that is true.

Q32 Mr Jenkins: Sir Nigel, what do you think of the Report—good, bad or just “another problem another day”?

Sir Nigel Crisp: I think it is an important Report because, as so often happens, this Committee has picked up an issue that needs to be drawn attention to.

Q33 Mr Jenkins: Where is it in the priority list with regard to your commitment?

Sir Nigel Crisp: I think I said to the Chairman at the beginning that the most important priority in this area for us is improving the whole quality framework. This is an element of it. It is the element when all else has failed and we have ended up suspending some clinicians sometimes for the wrong

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reasons and sometimes for the right reasons. We ought to remember that some of these people have been suspended for the wrong reasons as well. It is at that end of the spectrum. The most important thing is that we get the really good clinical audit and clinical governance arrangements in across the NHS as a whole and I would rate that higher than this, but this is important, as are many other areas.

Q34 Mr Jenkins: The Report gives us some figures of some savings that could be achieved if we improve the system. I think they quote £14 million but £14 million is like petty cash really in the NHS.

Sir Nigel Crisp: It is not to the individual organisations and remember that the problem on a day-to-day basis since we have been an employing authority is with the individual—and again this Report quite rightly reveals some of the human pain behind the statistics, it actually shows how painful it has been for individuals and for their families and often for the employers and colleagues. That is why that is important but it is a much more significant issue for an individual trust if they have one or more consultant (because we are tending to talk about doctors) suspended.

Q35 Mr Jenkins: Let us look at Case 8 then on page 32, the individual trust if you like. This refers to Coventry and Warwickshire NHS Trust. You may or may not be aware that we have had two adjournment debates in this House with regard to this particular Trust. It has been an on-going problem for a while. You see the background here where two very qualified surgeons have both been suspended for an issue that in no way reflects on their competence but issues within the team itself. The figure given here is different to the figure I have got. I have been given a figure of £1.4 million and rising.

Sir Nigel Crisp: On what, sorry?

Q36 Mr Jenkins: On these suspensions, the total cost to the Trust itself. If this is an on-going case what power have you got to ensure that this is resolved rapidly?

Sir Nigel Crisp: Again, I might bring in the Chief Medical Officer here because he has been dealing with these issues and making sure that we provide strong human resources support to help people work things through because these are complicated cases.

Professor Sir Liam Donaldson: I think the thing that has not changed over the years is the nature of the problems that occur in this small proportion of the medical profession and they are very, very difficult for people at local level, who might come across one in every few years, to unravel, and really that is why we have set up this national source of expertise in the Clinical Assessment Authority. The Authority has been involved in at least one of these cases and that is why I appointed a Human Resources Director nationally as a trouble-shooter to go into those situations. In the long term we should not have to rely on those. We should have sufficient expertise at the local level to be able to deal with these problems. There has been a lot of work undertaken by the British Association of Medical Managers and others

to train medical directors and clinical directors in dealing with and assessing these problems. They have not been well handed, I agree with you, but I hope in the future we will not have situations like this occurring.

Q37 Mr Jenkins: This is a real case going on today and it is ratcheting up costs that should be spent on medical care for patients. I said what can you do about this case right now, and the answer of course is nothing, is it not?

Sir Nigel Crisp: Not entirely.

Professor Sir Liam Donaldson: The Briony Ackroyd case, as I understand it (and I do not know all the details) was resolved when the National Clinical Assessment Authority came in to support local management to resolve it. The other case which I think you are referring to at the moment, I understand, is the subject of a local procedure and it probably would not be right to comment on the detail of it at the moment, but I agree with you that we have been trying to put as much pressure and as much expertise from a national level as is necessary to bring to an end and resolve satisfactorily these long suspensions. The new suspensions guidance which was put out in December deliberately introduces a four-week suspension exclusion period which has to be actively renewed and case conferences are triggered if there has to be a renewal. The strategic health authority and the Clinical Assessment Authority are both brought in after two four-week renewals. That was my idea when we were discussing this and it was to put the sort of pressure for resolution into the system, and I think once that starts to bite there will be a big difference to the way these things are handled.

Q38 Mr Jenkins: I see on page 4, paragraph 9 that 36 referrals to the Assessment Authority resulted in 30 non-suspensions. So they managed to resolve this problem, which I think is tremendous. Why do we not force them? Now we are going to force them to consult you and get you involved with assessment and stop some of these problems from rolling on.

Professor Sir Liam Donaldson: That is a requirement in the new suspensions guidance but the only missing building block, as I mentioned and touched on in an earlier answer, is that we have not yet negotiated with the BMA the replacement of the old disciplinary procedure which has caused so many problems with the new one. Those negotiations are on-going and I think Mr Foster will be able to give you our expected deadline for completion, but it is very soon.

Q39 Mr Jenkins: Mr Foster, when you have situations in hospitals, like situations in any workplace, and you maybe get a problem with people not getting on with one another and people abusing their authority and getting accused of bullying *et cetera*, this is gross misconduct. Why not deal with the gross misconduct challenge through internal disciplinary machinery rather than the much, much more serious clinical side where somebody is being challenged for clinical

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incompetence which I appreciate because of the safety of patients, *et cetera*, will result in a suspension and could result in a long inquiry. Surely for different things we should be using different channels?

Mr Foster: That would have been an alternative way of doing it, but I think for the reason that the Chief Medical Officer said earlier on whatever the cause of major misconduct, whether of capability or of behaviour, if the consequences can lead to a serious action which may lead to an individual losing their career then I think you do have to have a slightly different framework available. That is why doctors are treated differently in this respect to other members of staff because of the serious consequences an adverse finding in hearing could have.

Q40 Mr Jenkins: Sir Nigel, in the past trusts have taken expert advice from outside and ignored it and you have no power to make sure that they actually take that advice.

Sir Nigel Crisp: Expert advice from lawyers?

Q41 Mr Jenkins: Lawyers, *et cetera*, yes, and my concern is that you still do not appear to have the power to order trusts to act in a certain manner, and that is causing some concern especially with the trust that might have a cultural problem with regard to suspending people too quickly. How can we incentivise them to come on board? Have we any plans for either stopping the salaries of managers and putting them on performance-related pay to ensure that we do get the best value for money?

Professor Sir Liam Donaldson: If I could briefly outline how the future will be different from the present and the past. The National Clinical Assessment Authority, having assessed a doctor with difficulties and having made recommendations for a course of action, whether it is retraining, rehabilitation or whatever it is, if the trust should choose to ignore that, we would know about it. It would be an exceptional thing and I think we would intervene unless there were good grounds for it. If in the course of the investigation of the individual doctor the National Clinical Assessment Authority discovered that the organisation was dysfunctional, there were rifts between doctors and managers and there was a culture which was adverse in the way that you describe, then it has got a memorandum of understanding with the Commission for Health Improvement at the moment and its successor body, in the Commission for Healthcare Audit and Inspection, and they would notify them and they would then have the power to go in and investigate the whole organisation and its practices. So those would be the two mechanisms. We would be sitting on top of that system and in the (we hope) exceptional cases that would come to us that could not be resolved by those mechanisms, we would be available to intervene directly, and that might mean taking action against the chief executive if he or she was managing badly.

Q42 Mr Jenkins: We need a culture in all our hospitals and throughout the NHS of openness, accountability, transparency and particularly one which safeguards whistle-blowers because it is whistle-blowers that get suspended now, I suppose. What do you do to engender that type of culture today?

Professor Sir Liam Donaldson: Our whole approach to clinical governance has been based on trying to introduce a culture in the NHS where quality is central, where on the whole blame and retribution are not the preferred methods of dealing with the problem; learning and improving are the approaches. That is the sort of culture that we are trying to generate and in such a culture a whistle-blower would never need to blow the whistle because they would quite openly with everybody's knowledge be able to draw attention to the problem and instead of being blamed for drawing attention to it, management and the clinicians would say, "Here is an opportunity for us to learn and improve services for patients." That is what we are trying to get to. It is very difficult, as cultural change always is, but that is definitely the direction.

Q43 Mr Jenkins: Do you need some incentives to move along a bit faster?

Professor Sir Liam Donaldson: My own view is that financial incentives are not a particularly good way of improving behaviour and changing culture, but I think it is down to leadership and rewarding, if necessary, with salary and payments good leaders who produce the sort of cultures that we want to see.

Q44 Mr Jenkins: We have got this document in front of us, *Doctors and Dentists: Discipline and Suspension* and it has taken 10 years to produce this.

Sir Nigel Crisp: Is this the guidance?

Q45 Mr Jenkins: Yes. You then answered the Chairman by arguing you were going to extend this to all clinicians and nurses but you did not say what target date you have got in mind to extend this to all.

Sir Nigel Crisp: Mr Foster is dealing with this so perhaps it would be better if he replied.

Mr Foster: We do not plan to issue central national guidance for non-medical suspensions. What we want to do is use the learning from the operation of the National Clinical Assessment Authority and the work that that has done with doctors in reducing and preventing suspensions. We want to see how those lessons can be applied to non-medical staff and the Chief Nursing Officer has got a multi-professional project working on that at the moment.

Q46 Mr Jenkins: But medical staff, that includes nurses and midwives; are we not going to issue guidance for those?

Mr Foster: No, we are not proposing to issue national guidance on how suspension procedure should work but we are proposing to learn the lessons on how they can be reduced through NCAA intervention.

 Department of Health

Q47 Mr Jenkins: I must have misunderstood the Permanent Secretary.

Sir Nigel Crisp: What I actually said was there is more work to do on nurses, and that includes the working party which the Chief Nursing Officer is leading, because this covers a whole range of different professions, it is not just one profession that we are talking about, and learning the lessons and seeing what we then need to do. We have not got a fixed view as to what we have got to do. The other thing that we are also looking at is whether we should be doing a regular snapshot of suspensions across the NHS to make sure we have an understanding of what is going on. So there is quite a number of things we are looking at.

Q48 Mr Jenkins: I am surprised because most of the guidelines apply to a lot of staff and I should have thought it would not be a great difficulty to lay down some general guidance on having the emphasis on keeping staff in work rather than suspending them and allowing staff the opportunity to understand their rights within a system. At the present time staff can get suspended, and I have got a case where staff have got suspended, and they have never found out really why they were suspended because the goalposts keep moving and after six or eight months they are being taken back in to carry on with the job with a little bit of supervision. They never really find out what the problem is.

Mr Foster: Every trust will have its own disciplinary procedures and its own suspension procedures and its own grievance procedures and those will be agreements that have been sorted out locally with staff side organisations. If you are talking about individual cases where people do not know what their rights are, I would strongly recommend they speak to their HR department and make sure that they get hold of their local policies because there will be such policies.

Mr Jenkins: If they have not it is very, very difficult in this area, I can assure you. Thank you.

Chairman: Mr Richard Bacon?

Q49 Mr Bacon: Chairman, thank you very much. Sir Liam, may I start with you and the case of Briony Ackroyd. You became Chief Medical officer in 1998?

Professor Sir Liam Donaldson: I did.

Q50 Mr Bacon: So you were the Chief Medical Officer referred to in the Report on page 28?

Professor Sir Liam Donaldson: I think it refers to me coming to post in 1999 but I did not spot that.

Q51 Mr Bacon: My brief says 1998 and it says on page 28 Miss Ackroyd asked the Chief Medical Officer for help; that means you?

Professor Sir Liam Donaldson: Yes it does.

Q52 Mr Bacon: Thank you. I see, incidentally, the case settled three years after the original suspension and there was an agreement whereby she resigned

and she is now successfully retraining as a GP, at a total cost of £825,000. Is it possible that you could let the Committee have a breakdown of the costs?

Professor Sir Liam Donaldson: Yes I can, but I would have to do that by letter after the meeting.³

Q53 Mr Bacon: Yes of course, a note will be fine. Is it correct that settlement payments of less than £100,000 do not have to be reported in the accounts of a trust?

Professor Sir Liam Donaldson: I do not know the answer to that question.

Mr Foster: I do not think that is right but I would have to check.⁴

Q54 Mr Bacon: There is no threshold as far as you are aware?

Mr Foster: I am not aware of any.

Sir Nigel Crisp: We will check that.

Q55 Mr Bacon: I understand that Miss Ackroyd was paid £90,000, which I gather was reported in the press. That seems quite a small amount to give up a career as a consultant, which is effectively what happened. Can you confirm that in fact it was £90,000 per year for 15 years?

Sir Nigel Crisp: What was, the settlement?

Q56 Mr Bacon: She was paid £90,000 per year for 15 years.

Sir Nigel Crisp: I do not know but we can obviously find out for you.

Q57 Mr Bacon: If you could give us a note that would terrific.⁵

Sir Nigel Crisp: It does not sound right.

Q58 Mr Bacon: If you could let us know the amount that would be very kind. On page 32 I would like to return to the case that Mr Jenkins raised of Case 8. It refers to one consultant suspended for nearly three years before being reinstated following High Court and Court of Appeal rulings in support of the consultant. Was that the case where the judge had threatened to send the chief executive of the trust to jail unless he reinstated the consultant?

Sir Nigel Crisp: I do not know. I do not know if others do.

Q59 Mr Bacon: It says here that the Commission for Health Improvement investigated the situation there. Its clinical governance review, which came out in 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 'limited progress had been made by the Trust to

³ Ev 18

⁴ *ibid*

⁵ *ibid*, Ev 21

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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.” In other words, despite the fact there was a culture of fear and the CHI reported there was a culture of fear, nothing was done, was it?

Sir Nigel Crisp: That is part of what CHI is for and if you remember this case, I do not know if you do, the trust was actually removed from performing otherwise at two star level and it became zero star.

Q60 Mr Bacon: It says here it lost its star rating and was franchised.

Sir Nigel Crisp: It was franchised, in other words the management changed within the organisation so there was a very clear set of sanctions that came up. That is the point, if I may say so, of the CHI review, to get underneath the surface to look beyond the published figures and to understand what is going on. That seems to be a case where that is what happened and that is what worked.

Q61 Mr Bacon: I would like to come on to management. It says in the next paragraph that the Chairman, Chief Executive and Director of Personnel resigned and then later the Medical Director resigned. I would like to ask this question of the National Audit Office, is it correct, Karen Taylor, that the Chairman who is referred to in there as resigning actually resigned in the autumn of 2001 and when one of these consultants was suspended the new Chairman, Mr Brian Stoten, was already in place?

Ms Taylor: I will have to ask my manager. Yes.

Q62 Mr Bacon: So it is not simply the case there was a problem and the Chairman resigned. The Chairman who is there now was there when one of these consultants was suspended?

Ms Taylor: Yes.

Q63 Mr Bacon: I just wanted to be sure of that. Sir Nigel, could you say what the severance pay was for Mr David Loughton when he left?

Sir Nigel Crisp: I can find out for you.⁶

Q64 Mr Bacon: And did Mr Gary Reay when he resigned as Chairman get severance pay?

Sir Nigel Crisp: I will find that out for you as well.⁷

Q65 Mr Bacon: And the Personnel Director, Mr Roger Faulkner?

Sir Nigel Crisp: Okay.⁸

Q66 Mr Bacon: In the Annual Report of the Coventry and Warwickshire Trust for 2002 in the page called “salary and pension entitlements” on page 36 there is a line for Mr Faulkner, who is the person referred to on page 32 of the National Audit

Office Report, and there are asterisks against it and it says at the bottom “denotes consent to disclosure withheld”. You said earlier on in the question on confidentiality clauses that there were legitimate reasons for confidentiality clauses, for example where it involves patients, which I can understand, but why would there be a legitimate reason for withholding disclosure for a personnel director?

Sir Nigel Crisp: I think these are two different things. I genuinely do not know whether or not the Personnel Director got a package on resignation or not.

Q67 Mr Bacon: The appearance of these accounts suggests that he did.

Sir Nigel Crisp: There is an entirely separate point which is that senior managers are entitled under a particular Act not to have their salaries disclosed. These are two separate issues. We have gone back to people to say that whilst people do of course have an entitlement not to have their salary disclosed, for people working in the public sector this is highly inappropriate and we do not want to see people doing that. I think it may be a separate issue.

Q68 Mr Bacon: Firstly, if you could send us a note about his settlement and also whether the Medical Director got a settlement perhaps you could send the Committee a note about that as well.

Sir Nigel Crisp: I am sure we can find that out.⁹

Q69 Mr Bacon: I think the Medical Director was Dr Harrison referred to on page 32 when it says that the Medical Director resigned. If I could ask you to turn to page 44, here it talks about the previous statement of this Committee concerning confidentiality clauses and the NHS Executive’s own conclusion. You referred at the beginning in the Chairman’s question to the fact that you are about to issue some new guidance. There is clearly some guidance already, this is Health Service Guideline (94)18 in which it says: “An employment contract should not be framed in such a way as to suggest that the settlement on termination would escape proper public scrutiny.” That is correct, is it not?

Sir Nigel Crisp: I am sure it is if it says so here. The difference is that this is guidance and what I am issuing is a direction.

Q70 Mr Bacon: Good, so from now on—

Sir Nigel Crisp: From now on it will be very clear where confidentiality agreements are legitimate and where they are not appropriate.

Q71 Mr Bacon: Where are they legitimate?

Sir Nigel Crisp: Why do I not send you the circular.¹⁰ The sort of example I would give is things to do with information about individuals, particularly patients and so on.

⁶ Ev 18

⁷ *ibid*

⁸ *ibid*

⁹ Ev 18

¹⁰ Ev 15–16

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Q72 Mr Bacon: I can understand for patients. You would accept that in the public sector—and after all the salaries of all Members of Parliament are publicly available and for ministers and so on—for people working in the Health Service in senior positions often earning six-figure salaries those amounts ought to be publicly available?

Sir Nigel Crisp: What I said to the NHS—and I am sorry I cannot remember the particular regulation under which people can withhold information about their salary¹¹—I sent out a clear letter that my personal view was that if you work in public service then you should disclose your salary, however there is a law passed somewhere locally which says they do not have to.

Q73 Mr Bacon: As far as settlements are concerned, it is your view that severance pay settlements as distinct from salary should be disclosed?

Sir Nigel Crisp: That is my view certainly.

Q74 Mr Bacon: Are there any reasons why a financial settlement involving a doctor as opposed to confidentiality relating to a patient, should not be disclosed?

Mr Foster: The confidentiality agreements such as they are, are about what either party may say about each other. They do not remove the duty of the trust to report any severance payment in their annual accounts.

Q75 Mr Bacon: So how come Mr Faulkner does not?

Mr Foster: Because I think those asterisks refer to something else.

Q76 Mr Bacon: You do not think they refer to a settlement?

Sir Nigel Crisp: I think they refer to an annual salary.

Q77 Mr Bacon: Golden hello, compensation for loss of office. It is just an asterisk, it is not a salary, is it?

Sir Nigel Crisp: Other people's salaries are listed there.

Q78 Mr Bacon: But under “golden hello or compensation for loss of office” Mr Faulkner has got an asterisk. It has got his salary in one column and his age in another if you are interested, but the one I am interested in is compensation for loss of office.

Sir Nigel Crisp: I am sorry, I have not seen that. Can we send you a note when we have seen it?

Chairman: Send us a note.¹²

Q79 Mr Bacon: Is it correct that if a patient dies in the care of a trust, if it is one individual it is likely to be misadventure but if it is more than one patient death in a related incident then, and only then, the opportunity for a charge of corporate manslaughter is started; is that right?

Sir Nigel Crisp: I am not quite sure if that is right.

Mr Foster: I think that is a very particular way of putting the question. There will be all sorts of circumstances where there will be individual deaths of people who happen to die at a similar time so I do not think the way you phrase the question in relation to corporate manslaughter is correct.

Q80 Mr Bacon: I am particularly interested in the case that again Mr Jenkins referred to in the adjournment debate only a couple of weeks ago. It was acknowledged that one of the doctors involved, Dr Raj Mattu, was not suspended for incompetence. On the contrary he was an able cardiac specialist. I am quoting from Member for Coventry North West in his adjournment debate and he carries on and says that the investigation should have been carried out before the suspension was proceeded with but this suspension has been carrying on now for over two years involving a lot of taxpayers' money. Why is the system unable to deal with a problem like this more effectively when medical competence is not in question?

Professor Sir Liam Donaldson: In relation to this particular case, as Sir Nigel said earlier, the trust is undergoing internal procedures about that individual case more or less as we speak. I think it would be wrong for us to say anything about that individual case. In terms of the more general answer to your question these are the steps that have been reported by Sir Nigel by the creation of the NCAA, the appointment of somebody to investigate and sort out these procedures and now the recent publication of guidance as to how we should substantially improve and reduce suspensions.

Q81 Mr Bacon: I am interested in the individual case because often looking at things on a micro level can expose major themes. One of the things I would like when you send us the note, which you said you would do, with the settlement payments for the Chief Executive, the Personnel Director and the Medical Director from page 32, could you also state for those four individuals what they are doing now. Are they employed by an NHS body?

Sir Nigel Crisp: Certainly we can come back on that. I know the answer to some of those questions but why do I not send you a complete set.¹³

Mr Bacon: Thank you, Chairman.

Q82 Mr Jenkins: Following on what Mr Bacon said, I meant to ask you, Sir Nigel, on Case 8 could you send the Committee an update on exactly what the situation is with regard to this hospital and what you see the end being. How much longer is it going to go on? I would like to know.¹⁴

Sir Nigel Crisp: On that particular outstanding case.

Q83 Mr Jenkins: On Case 8 on the hospital there. Also I would like to know how many people are in suspension at the present time in that hospital?

¹¹ Note by witness: This refers to the Data Protection Act.

¹² Ev 17

¹³ Ev 18

¹⁴ *ibid*, Ev 21

 Department of Health

Sir Nigel Crisp: In that hospital?¹⁵

Q84 Mr Jenkins: This is a good example of looking at this sort of thing. The other one on page 37, 3.10 says that just over half of trusts require an excluded clinician to seek permission to work in another hospital. Does this mean that 45% of excluded clinicians can go down the road and work in another hospital with no information being given to that hospital?

Mr Foster: I saw this comment and it looks very odd to me. I would imagine that what this means is that perhaps 55% of trusts have done something in writing to formally notify somebody that they cannot work in another hospital but all the trusts should have taken steps to ensure that an excluded person does not work elsewhere. I would be very surprised if 45% is right. That does not sound right at all.

Mr Jenkins: Can I ask you to supply the Committee with a note on that when you find out.¹⁶

Q85 Chairman: Can I ask you finally, Sir Liam, to look at page 7, paragraph 17. It says: "When looking at consultants however, a significantly higher proportion of ethnic minority consultants are excluded." Why is that?

Professor Sir Liam Donaldson: I am sorry, which paragraph?

Q86 Chairman: If you look at page 7 of the Report and look at paragraph 17 it says at the top: "A number of doctors who contacted us raised concerns that ethnicity and gender might be factors in doctor exclusion cases." It says lower down: "When looking at consultants a significantly higher proportion of ethnic minority consultants are excluded." Why is that do you think?

Professor Sir Liam Donaldson: We do not know the answer to that. When we looked at National Clinical Assessment Authority data, which I included in my analysis in my 2002 Chief Medical Officer's Report, there was a slight difference showing that there was a higher than expected proportion of ethnic minority consultants but it was not a statistically significant difference and we have been monitoring this extremely carefully. I know the General Medical Council has been very concerned as well, so this is something that we will have to look into further but it has not been showing up in our own figures and we have been monitoring that very closely.

Q87 Chairman: You see there is some anecdotal evidence passed to the National Audit Office that I have been told about that there is no criticism of the consultants who are from ethnic minorities in terms of ability; is that correct?

Professor Sir Liam Donaldson: I do not think we can make any generalisation about any group.

Q88 Chairman: But there is anecdotal evidence that sometimes they are not prepared to mix socially after hours and therefore they might be put under pressure by their colleagues and there may therefore be unfair suspensions. Do you have any evidence of that or any worries on that score?

Professor Sir Liam Donaldson: We do not have any evidence and, again, I would be reluctant to generalise about any particular groups because they are made up of individuals and I think that is the best way of looking at it. If subsequent monitoring did show a clear excess of either women doctors or ethnic minority doctors or any other subgroups of the population of consultants then we would want to investigate further.

Q89 Chairman: So you take this seriously. It says that there is a significantly higher proportion of ethnic minority consultants who are excluded. That is something to be worried about, is it not?

Professor Sir Liam Donaldson: We do take it seriously and it will be something that we are looking at. As I said, it has not emerged so far from the National Clinical Assessment Authority case referrals but I know it is being looked at within the General Medical Council. It is being looked at across the board and it will be looked into further.

Q90 Chairman: If any evidence comes to you in the next few weeks while we are preparing our report you might send us a note on this.

Professor Sir Liam Donaldson: Yes.¹⁷

Q91 Chairman: Sir Nigel finally, why do you not feel it is right to give central guidance to ensure effective management of suspensions of clinical staff?

Sir Nigel Crisp: You mean beyond medical staff?

Q92 Chairman: Yes?

Sir Nigel Crisp: I think it has been that it is a different level issue very often, that the numbers involved in other clinical groups may be higher, as indeed is shown on these figures, but the length of suspension and the costs of suspension and so on are generally much shorter than that. So that is why we have not chosen to do that at this stage. As I say, we do have the Chief Nursing Officer meeting with the relevant people to think about what it is we should do in terms of the next steps there. It is a range of different professions we are talking about here so we have not absolutely ruled it out.

Q93 Chairman: Thank you, gentlemen, for appearing before us this afternoon and thank you for your answers in what has been an important session. I take note of what you say, Sir Nigel, these are very complex matters and of course it is different in a sense from the private sector because it is more difficult for somebody permanently excluded to get another job. But still you have heard the examples which Richard Bacon and others quoted to you of very large sums of money being paid out and very many years of suspension so we are delighted to hear

¹⁵ Ev 19

¹⁶ *ibid*

¹⁷ Ev 19

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that you are taking this matter seriously and you are going to try and improve your procedures. On a slightly lighter note Richard Bacon mentioned that some staff felt “bullied, intimidated, threatened and oppressed”. I hope that the panel of Accounting Officers and Permanent Secretary has never felt “bullied, intimidated, threatened or oppressed” by this Committee!

Sir Nigel Crisp: As a good civil servant I had better say “no comment”, but thank you.

 Memorandum submitted by the Medical Protection Society (MPS)

ABOUT MPS

MPS is the leading mutual protection organisation for doctors and dentists in the UK and the world. We pride ourselves on being a forward thinking and strive to create an environment where adverse incidents occur less frequently. MPS believes that when patients do suffer avoidable harm they should be properly and swiftly compensated.

MPS helps doctors and dentists with legal problems that arise from clinical and professional practice. Our members have access to a 24 hour medico legal helpline and professional advice from doctors with experience of working in the health service and possess specialist legal knowledge. Last year we received 25,000 requests for advice by phone alone. Talking through a problem may be enough to confirm a proposed course of action or prevent a doctor from doing something with potentially disastrous consequences.

We are a not for profit organisation and have over 211,000 members worldwide including over half of all doctors and dentists in the UK. Our total UK membership is 114,000.

MPS AND SUSPENDED DOCTORS

MPS supports and advises doctors suspended by their Trust for reasons relating to their professional conduct or competence. At any one time we provide support to around 40 suspended doctors.

MPS is likely to be involved in the process within hours of the doctor being informed that action is being taken, we will then be involved at every stage of the process. Our role includes providing advice on whether the decision to suspend is justified, checking the procedure followed is correct, insisting on clarity and fairness, helping to shape the doctor’s case and providing representation at hearings. In our experience it is not unusual for prolonged or badly managed suspensions to last in excess of two years.

A case study, illustrating the stages of a lengthy and messy suspension is attached as an Annex.

MPS COMMENTS ON THE NAO REPORT

The NAO’s assessment of the cost and impact of the suspension of hospital doctors and other healthcare professionals matches MPS’s own experience. We are pleased the Report acknowledges that suspension is not a neutral act. For many of our members suspension has had devastating effects on their personal and professional life.

Prior to the Report’s publication there was no accurate picture of the number and costs of suspensions on the NHS. We hope the figures prove to be a catalyst for change and would like to see accurate figures collated annually in order for improvements to be tracked.

The Report does not look at the primary care sector. Accurate information on the number of GPs suspended would provide a fuller picture of the impact of suspensions on the NHS.

KEY PROBLEMS REQUIRING ATTENTION

Across the NHS there is an inconsistency of approach to suspending a doctor which needs to be addressed. Lack of expertise at Trust level has caused problems with procedures not always fully understood or applied fairly. Greater pressure should be placed on Trusts to seek expertise externally and from the National Clinical Assessment Authority (NCAA).

Unfortunately MPS continues to encounter suspensions where the underlying cause of suspension can be attributed to personality problems rather than professional issues. There are occasions when either a Trust’s management or an individual manager will seek opportunities to remove a doctor with whom there are disagreements. Insistence on a more consistent approach would help eliminate these cases.

In MPS’s experience suspended doctors are immediately cut off from all support at the Trust. It is seen as a condemnation of the doctor’s practice and the longer the doctor is suspended the harder it is to get the doctor back to work. If the period of suspension goes beyond three months it becomes harder still as there is an inevitable loss of skills.

The NHS is in effect a monopoly employer, a doctor suspended from one Trust will find it extremely difficult to find employment elsewhere and an NHS suspension inevitably leads to a loss of private hospital admitting rights and associated income. In effect suspension can mean an end to a doctor's career as all opportunities are closed.

MPS has long argued that the way suspensions are managed should be reformed to minimise both the financial and human cost. We have called for seven measures to be adopted.

- Take the minimum action required to ensure patient safety.
- Look at alternative measures to suspension, such as agreed restrictions on practice.
- Establish national criteria for suspension and create a framework for good practice.
- Accurately record the number of doctors on suspension.
- Gather all the facts to resolve the suspension speedily as an absolute priority.
- Set up ways to monitor and move the process forward in individual cases.
- Ensure procedures are in place to help doctors back into the workplace.

INITIATIVES AIMED AT TACKLING THE PROBLEMS

Since its creation the NCAA has helped to tackle lengthy suspensions and we have seen a decline in the number of very long cases. MPS would like to see a greater onus placed on Trusts to involve the NCAA in decisions to suspend and a more consistent and fair approach adopted.

We welcome the publication of the Department of Health (DoH) framework on suspensions: Maintaining High Professional Standards in the Modern NHS which embraces many of the changes we have campaigned for as detailed above. If implemented consistently across all Trusts, the framework could have a very positive effect. Trusts must be actively encouraged to follow the framework closely. From MPS's perspective failure to do so will be a missed opportunity.

MPS's key concern about the new framework is that it removes the right for a doctor to have legal representation at a hearing or interview during the suspension process. Doctors are troubled by this change. Suspension for a worker in different circumstances might mean the end of a job and difficulties before a fresh start. For a doctor, because the NHS is a monopoly employer suspension can mean they will never work again in a professional capacity either in the NHS or privately.

Dr Gerard Panting
Director of Policy & Communications

14 January 2004

Annex

CASE STUDY: THE "SUSPENSION" OF MR X

7 November 2000	Clinical Director alerted Medical Director to concerns about Mr X's practice.
14 November 2000	Mr X agrees to go on special leave. Royal College requested to review his practice in relation to eight cases.
15 December 2000	Rapid Response Team set aside two days to meet people from the Trust to examine case notes and interview Mr X.
15 January 2001	Rapid Response Team report received. A number of recommendations are received but it essentially says he is fit to work but required additional training including communication training.
22 January 2001	Mr X met with Medical Director and Human Resources. Trust wish to pursue disciplinary action on the basis of the report.
26 January 2001	Trust confirmed disciplinary hearing to take place.
2 March 2001	Disciplinary hearing. Confined to one allegation of personal misconduct. Final written warning. Mr X signals his intention to return to work.
9 March 2001	Mr X receives a letter informing him that he is suspended because they feel he is unable to return to work as issues remain unresolved.
28 November–5 December 2001	Formal disciplinary Hearing with the Trust and Mr X legally represented. Panel chaired by a QC with two consultants from other Trusts as Assessors.

11 January 2002	Draft report from Hearing received by Mr X.
1 February 2002	Final report of Hearing received by Mr X.
1 May 2002	Departure of Mr X from Trust and payment to Mr X negotiated and agreed.

NB Mr X received full pay from his Trust throughout his suspension.

Department of Health Service Circular (HSC 2004/001)

USE OF CONFIDENTIALITY AND CLAWBACK CLAUSES IN CONNECTION WITH TERMINATION OF A CONTRACT OF EMPLOYMENT

SUMMARY

1. A National Audit Office Report on adjustments to waiting lists¹ highlighted the inappropriate use of confidentiality clauses in severance agreements involving NHS managers. The clauses risked inhibiting disclosure of the terms of the severance agreements in circumstances where it was in the public interest for disclosure to be made. The Report also criticised the absence of “clawback clauses” in severance agreements for managers. The absence of such clawback provisions means that managers can negotiate what may be a considerable termination payment from their NHS employer only to be employed at a senior level by another NHS employer shortly thereafter, without having to repay any part of the termination payment.

2. The National Audit Office recommended that the Department of Health should strengthen the existing guidance on the use of confidentiality clauses and clawback clauses.

3. This Circular reflects the commitment given by Sir Nigel Crisp, in his capacity as Accounting Officer to the Public Accounts Committee Hearing on 14 January 2002 to strengthen and clarify the existing guidance concerning these issues, and the commitment given by Government in the Treasury Minute dated 28 November 2002.

4. This Circular and Direction on clawback clauses and confidentiality clauses contained herein applies to Board Members including Chief Executives and Executive Directors, regardless of whether they have a permanent or fixed term contract.

CURRENT GUIDANCE ON CONFIDENTIALITY CLAUSES & CALCULATING TERMINATION PAYMENTS

5. Existing Guidance on the use of confidentiality clauses & calculating termination payments is contained in Health Service Circular 1999/138 for NHS Trusts: “*Conditions of service for general and senior managers: early termination of fixed term rolling contracts*”, issued on 17 June 1999, and in Health Service Circular 1999/140 “*Conditions of Service for General and Senior Managers employed by Health Authorities*” issued on 2 July 1999.

6. This Circular replaces the advice in HSC1999/138 and in HSC 1999/140 relating specifically to the use of confidentiality clauses in severance agreements between senior or general managers and their NHS employers.

7. Subject to the above, Health Service Circulars 1999/138 & 1999/140 remain current, and must be followed when calculating “termination payments”, for fixed term rolling contracts.

8. In the case of termination of employment on disciplinary grounds, payments are not appropriate. Employers should follow good practice in disciplinary procedures as set out in ACAS guidance on discipline, and the Code of Conduct for NHS managers.

THE PUBLIC INTEREST DISCLOSURE ACT 1998 AND CONFIDENTIALITY CLAUSES

9. Health Service Circular 1999/198—“*The Public Interest Disclosure Act 1998: Whistleblowing in the NHS*” was issued following the implementation of the Public Interest Disclosure Act 1998 on 2 July 1999, and must continue to be followed.

10. Any confidentiality clause in a contract between an employee or ex-employee and his/her employer or ex-employer which seeks to prevent the employee making a “protected” disclosure in accordance with the Public Interest Disclosure Act 1998 read with the Employment Rights Act 1996 (hereinafter referred to as the “Public Interest Disclosure Act 1998”) is void and ineffective.

¹ C&AG’s Report, *Inappropriate adjustments to NHS waiting lists* (HC 452, Session 2001–02).

CONFIDENTIALITY CLAUSES AND SEVERANCE AGREEMENTS

11. It is not contrary to Department of Health policy or the Public Interest Disclosure Act to use confidentiality clauses in contracts of employment *per se*. Indeed, employees are subject to various legal obligations dictating how they use, treat and disclose confidential information. Express terms are sometimes included in contracts of employment in order to emphasize a legal obligation relating to the protection of confidential information both during the employment and after the termination of that employment. An express confidentiality clause might be included in a contract where an employee has access to confidential patient information, or information considered to be a trade secret. These are not exhaustive examples of what constitutes confidential information. In the absence of an express term, the employee's contract of employment will be subject to implied terms relating to the protection of confidential information.

12. A severance agreement is any agreement made between an NHS employee or ex-employee and his/her employer or ex-employer in connection with the termination of the employee's employment with that NHS employer. It includes, but is not confined to, compromise agreements within section 203 Employment Rights Act 1996, as well as compromise contracts within section 75 Sex Discrimination Act 1975 and section 72 Race Relations Act 1976, and conciliation agreements made through ACAS. This Circular and Direction is concerned with severance agreements and confidentiality clauses in which the employee or ex-employee is, or was, a chief executive or executive director.

13. Subject to the above, it is not contrary to the Department of Health's policy for confidentiality clauses to be contained in severance agreements. However, employers must consider with their legal advisers whether a confidentiality clause is necessary in the particular circumstances of each case. Further, if it is decided that a clause is appropriate, then its terms should go no further than is necessary to protect the NHS Body's legitimate interests.

14. NHS Bodies are also responsible for ensuring that any terms in an agreement reached comply with their various statutory obligations regarding treatment of confidential information. NHS Bodies' attention is particularly drawn to the Data Protection Act 1998, the Official Secrets Act 1989 and the Public Interest Disclosure Act 1998.

ACTION:

Employers must consider with their legal advisers that where a severance agreement contains a confidentiality clause in regard to all or any of the terms of that agreement, the agreement complies with the provisions set out in the attached Schedule.

CLAWBACK CLAUSES AND TERMINATION PAYMENTS

15. The Guidance in HSC 1999/138 and HSC 1999/140 on calculating compensation for termination of fixed term rolling employment contract, also referred to as "termination payments" remains in force. This Circular and Direction supplements that guidance, and applies to any termination payments that an NHS Body agrees to pay or make in connection with the early termination of an employee's employment. The terms of this Circular and Direction are confined to chief executives and executive directors.

ACTION:

Employers must consider with their legal advisers whether any clawback clause complies with this Guidance and Schedule attached. In addition to the undertakings required by HSC 1999/138 and 1999/140, NHS Bodies must ensure that, subject to the terms of this Guidance, the additional undertakings set out in the attached Schedule are also provided before any termination payment is made. This is to ensure, so far as is possible, the enforceability of any clawback clause.

5 February 2004

Department of Health Direction to NHS Bodies

USE OF CONFIDENTIALITY AND CLAWBACK CLAUSES IN CONNECTION WITH
TERMINATION OF EXECUTIVE DIRECTORS' CONTRACTS OF EMPLOYMENT
NATIONAL HEALTH SERVICE ACT 1977
NATIONAL HEALTH SERVICE AND COMMUNITY CARE ACT 1990

The Secretary of State for Health, in exercise of the powers conferred on him by section 17, paragraph 10(1) of Schedule 5, and paragraph 8(3) of Schedule 5A to the National Health Service Act 1977², and paragraph 16(5) of Schedule 2 to the National Health Service and Community Care Act 1990³ hereby gives the following Directions:

APPLICATION, COMMENCEMENT AND INTERPRETATION

1.—(1) These Directions apply to all NHS bodies in England and shall come into force on 5 February 2004.

(2) In these Directions—

“NHS bodies” means Strategic Health Authorities, Special Health Authorities, NHS Trusts, and Primary Care Trusts;

“severance agreement” means an agreement made between an NHS body and an executive director in connection with the termination of that person’s employment with that NHS body;

“termination payment” means any payment that an NHS Body agrees to make in connection with the early termination of an executive director’s employment (other than in cases of genuine redundancy and/or in the case of payments made in accordance with section 45 of the General Whitley Council Handbook “Arrangements for Redundancy Payments” and which:

- (a) is made in connection with the fact that the executive director’s employment is terminating or has been terminated; and
- (b) in the case of a executive director employed on a fixed term contract, is to be paid, before the date on which that fixed term contract would have expired through passage of time; or
- (c) in the case of a permanent employee, is to be paid before the date on which the contractual notice period to which that employee was entitled would have expired; and
- (d) is calculated in whole or in part by reference to the unexpired portion of that fixed term contract or contractual notice period.

CONFIDENTIALITY CLAUSES IN SEVERANCE AGREEMENTS

2.—(1) NHS bodies must ensure that where a severance agreement contains a confidentiality clause in regard to all or any of the terms of that agreement, the agreement must contain provision under which:

- (a) the NHS body undertakes to disclose the terms of the severance agreement to any other NHS body which is proposing to employ the former executive director, and
- (b) the executive director consents to such disclosure and to the further disclosure of the terms of the severance agreement by the Department of Health or the National Audit Office, if either, or both requests that information for the Appointed Auditor, the Public Accounts Committee and Parliament.

RECOVERY OF TERMINATION PAYMENTS (CLAWBACK CLAUSES)

3.—(1) NHS bodies must ensure that any severance agreement which includes a termination payment in connection with the early termination of an executive director’s employment contains a provision (in these directions called a clawback clause) which:

- (a) requires the executive director to inform the NHS body of any employment which he obtains with another NHS body before the expiry date of the relevant fixed term contract or contractual notice period (“the expiry date”); and
- (b) empowers (but does not oblige) the NHS body to recover the whole or part of the termination payment where the executive director has received, or is to receive, payment from the new NHS employer which is referable to the period before the expiry date.

Signed on behalf of the Secretary of State

David Amos
Member of the Senior Civil Service

² 1977 c. 49.

³ 1990 c. 19.

Supplementary memorandum submitted by the Department of Health

Question 21 (Jon Trickett): What is the situation in Wakefield and the Mid Yorkshire Trust?

The Commission for Health Improvement (CHI) announced on 21 January an investigation into gastro-enterology and related surgical services provided by Mid Yorkshire Hospitals NHS Trust, particularly at Pinderfields General Hospital in Wakefield.

The investigation follows concerns raised about services at the trust. The concerns relate to alleged substandard clinical practice, disputes between clinicians and management behaviour. Both the trust and West Yorkshire Strategic Health Authority have strongly welcomed CHI's involvement.

The investigation will look at the systems and processes the trust has in place to ensure the quality and safety of the care it provides within its gastro-enterology and related surgical services. CHI will also look at the management of those services.

A consultant and the chief executive of the trust are currently on sick leave. As the chief executive is due to retire this July, a new chief executive has been appointed to take up post in April.

Questions 52, 53 and 57 (Mr Bacon): (With regard to the Ackroyd case) Can the Committee have a breakdown of the £825,000 costs; is it correct that settlement payments of less than £100,000 do not have to be reported in the accounts of the trust; and, was she paid £90,000 per year for 15 years?

Miss Ackroyd will not be paid £90,000 per year for 15 years, but she did receive a compensation payment of £90,000. This was equivalent to 15 months salary. The compensation payment was based on the GMC's recommendation that she be given a period of 12 months for retraining/assessment as a GP, with a further three months to find a job.

The total figure, for the case, is £833,640 and is broken down as follows:

Locum costs	£279,210—non NHS medical staff.
Legal costs	£218,230—legal fees and disbursements.
Salary	£246,400—Feb 00 to Feb 03 plus 27 days pay in lieu of untaken leave.
Compensation	£90,000—equivalent to 15 months salary.

The costs for Miss Ackroyd were recorded within the trust's accounts.

Since April 2002, for a trial period of three years, HM Treasury has relaxed the delegated limits system whereby trusts were required to seek Departmental approval for "Losses and Special payment" cases. Losses and Special payments, however, are recorded in a trust's annual summarised accounts and certified by external audit before submission to the Department.

Questions 63, 64, 65, 68 and 78 (Mr Bacon): Did the Chief Executive, Chairman, Personnel Director and Medical Director receive severance payments?

Of the four, only the Personnel Director received a severance payment. The payment was worth £102,590.77.

Question 81 (Mr Bacon): What are these four doing now, are they employed by an NHS body?

Enquiries indicate that:

- the former Chief Executive is now working as a Development Director for "In Health" a private company;
- the former Chairman has retired;
- the former Personnel Director works as an independent management consultant, sometimes contracting with NHS bodies;
- the former Medical Director continues to work at the trust as a consultant histopathologist.

Question 82 (Mr Jenkins): What is the situation with regard to this hospital and what do you see the end being? How much longer is it going to go on?

The trust is currently in discussion with Dr Mattu's lawyers regarding the membership of an independent inquiry panel, which will take evidence from all parties and reach an independent decision.

The trust is keen to resolve the case as quickly as possible, but at this stage it is impossible to indicate when a resolution may be reached.

Question 83 (Mr Jenkins): How many people are in suspension at the present time in that hospital?

The only person currently suspended, at the trust, is Dr Mattu.

Question 84 (Mr Jenkins): Does this mean that 45% of excluded clinicians can go down the road and work in another hospital with no information given to that hospital?

There was nothing in previous guidance about the need to inform other organisations or the private sector that a clinician had been suspended, however, the mandatory suspension framework HSC 2003/012 *Maintaining High Professional Standards in the Modern NHS*, issued on 29 December 2003, provides that:

- “Where there is concern that the practitioner may be a danger to patients, the employer has an obligation to inform such other organisations including the private sector, of any restriction on practice or exclusion;
- Failure to provide details of other employers by the practitioner may result in further disciplinary action or referral to the relevant regulatory;
- Where a NHS employer has placed restrictions on practice, the practitioner should agree not to undertake any work in that area of practice with any other employer (Part II, paragraph 27)
- As exclusion under the framework should usually be on full pay, the practitioner must remain available for work with their employer during their normal contracted hours.
- The practitioner must inform the case manager of any other organisation(s) with whom they undertake either voluntary or paid work and seek their case manager’s consent to continuing to undertake such work or to take annual leave or study leave.” (Part II, paragraph 25).

HSC 2003/012 is more robust than its predecessor HSG(94)49. It was issued under the “*Restriction of Practice and Exclusion from Work Directions 2003*” and is legally binding. Under HSG(94)49, although NHS employers were expected to ensure that they took account of the guidance when drawing up local procedures, they were not legally obliged to do this.

In addition, there was concern that employers were using periods of “gardening leave” or “special leave” as a way to avoid the “stigma” of suspension. HSC 2003/012 provides that no practitioner should be excluded from work other than through the new procedure, no NHS body may no longer use “gardening leave” as a means of resolving a problem covered by the framework.

Questions 86–90 (Chairman): Why, when looking at consultants, is a significantly higher proportion of ethnic minority consultants excluded?

The National Clinical Assessment Authority routinely monitors the ethnicity, gender and other characteristics of the doctors and dentists in NCAA cases. It has a programme of development work in place in relation to equality and diversity to ensure policies and procedures are not discriminatory. Referrals of doctors from ethnic minorities to the NCAA are largely consistent with the proportion of doctors of ethnic origin in the NHS but the figures are not broken down by grade.

The figures in the NAO Report which show a disproportionate number of suspended ethnic minority consultants is a cause for concern. The Department has not historically collected information on the ethnicity of long term suspended doctors. However, following the findings in the NAO Report, and an increasing number of queries from MP’s and members of the public, the Department has recently undertaken to collect this information as part of its routine quarterly data collection exercise.

24 March 2004

Further supplementary memorandum submitted by the Department of Health

When the Committee scrutinised the supplementary memorandum returned in March, they were concerned about the amount of information given in a couple of answers. We have, therefore, taken the opportunity to update two of the answers given (Question 21 and Question 82) with the latest position, as at the end of June. At the same time, we have confirmed the amount of compensation paid to Miss Briony Ackroyd as one of the Members had raised some doubt.

Update to Question 21 (Jon Trickett): What is the situation in Wakefield and Mid Yorkshire Hospitals NHS Trust?

THE TERMS OF REFERENCE FOR THE REVIEW

1. The Commission for Health Improvement (CHI) announced on 21 January that it would carry out an investigation into gastroenterology and related surgical services at the Mid Yorkshire Hospitals NHS Trust (and predecessor organisations). The investigation follows issues raised about these services at Pinderfields Hospital at the Mid Yorkshire Hospitals NHS Trust and subsequent public concern about the quality of care provided in the unit.

2. The concerns include allegations of substandard clinical practice, poor team working and communication amongst consultants, and management failure to respond to external reviews and resolve these issues, with a consequent impact on patient care.

3. The investigation will:

Examine the management, provision and quality of health care, incorporating clinical governance systems and processes in place in the Mid Yorkshire Hospitals NHS Trust (and predecessor organisations) to ensure the safety, effectiveness, quality and appropriateness of gastroenterology and related surgical services. This examination will include, but will not necessarily be restricted to:

- (a) An analysis of available outcome information relating to endoscopy and gastro-intestinal surgery, including mortality and complication rates.
- (b) The organisation of the service including the physical environment, facilities and equipment, philosophy of care, and arrangements for patient and public involvement.
- (c) Arrangements to ensure the provision of clinically effective services including the existence of and compliance with national and local guidelines, protocols and care pathways, and clinical audit systems to monitor these.
- (d) Staffing and staff management including working relations amongst staff working in gastroenterology and related services, staffing levels, use of bank, agency or locum staff, supervision, training, continuing professional development, whistle blowing and grievance and disciplinary procedures.
- (e) Risk management arrangements and learning including untoward incident reporting and complaints systems, medicines management, record keeping and systems in place to obtain consent.
- (f) Performance management and how information is used to enable this, taking into account evidence from previously conducted reviews and enquiries.
- (g) The overall strategic capacity, leadership, culture, communications and management effectiveness of the Trust(s), and of gastroenterology and related surgical services, including actions in response to previous reviews.

Examine historical/cultural and organisational factors in the local health community and in the wider NHS that impact on the management, provision and quality of these services at the trust, including, but not necessarily restricted to:

- (a) Accountability arrangements in the local health community, to include the commissioning, external performance management and quality monitoring of the trust (and predecessor organisations).
- (b) The nature of relationships between key stakeholders including the effectiveness of joint working where applicable
- (c) The impact of national policy.

Consider any other matters arising during the investigation which CHI considers to be relevant in reaching its conclusions.

4. As part of the investigation, CHI will seek the views of those using gastroenterology and related surgical services, including relatives, friends and organisations representing relevant users and any other individual or organisation who wishes to express their views to the Commission for Health Improvement about the quality of gastroenterology and related surgical services provided by Mid Yorkshire Hospitals NHS Trust (and predecessor organisations).

5. The investigation will be conducted by CHI under powers set out in Section 20(1)(c) of the Health Act 1999. This empowers CHI to investigate, and make reports on, the management, provision and quality of health care. CHI's purpose in investigating a trust or other NHS organisation is to help that organisation to improve the quality of the health care it provides, build or restore public confidence in the services provided and to help the organisation and the wider NHS to learn lessons about how best to ensure patient safety.

6. From April 2004 the Commission for Healthcare Audit and Inspection (CHAI) assumed CHI's functions.

7. CHAI will publish a report on the findings of the investigation and will make recommendations as appropriate to the trust and other relevant bodies.

Where recommendations are made, CHAI will provide advice and assistance to all relevant organisations towards the preparation of an agreed action plan for implementation. Overseeing the implementation of an action plan prepared by the trust will be the responsibility of the Strategic Health Authority. CHI/CHAI will ensure effective collaboration, as required, with other organisations.

8. The report is expected to be published in early autumn.

9. Mr Mike Tobin, a gastro-enterology consultant at the trust, was suspended for five weeks between October and November 2003. Following his suspension, he returned for two weeks but has been on long term sick leave since. The trust chief executive, Roger French, has announced his intention to retire in July. He is currently on secondment to the three Strategic Health Authorities in Yorkshire. A new chief executive, John Parkes, took up post at the trust in April.

Update to Question 57 (Mr Bacon): Will she (Miss Ackroyd) be paid £90,000 per year, for 15 years?

1. I have confirmed that the £90,000 payment to Miss Ackroyd was a one off payment. It was a compensation payment for loss of employment and the equivalent to 15 months basic salary. This calculation was based on the fact that the General Medical Council's recommendation was that she be given a period of 12 months for retraining/assessment—she had already been accepted to retrain as a GP at the time of her termination. West Midlands South Strategic Health Authority paid a further three months to give her time to get a new job on completion of the training.

Update to Question 82 (Mr Jenkins): What is the situation with regard to this hospital and what do you see the end being. How much longer is it going to go on (Dr Mattu case)?

1. Dr Mattu was suspended on full pay on 21 February 2002 following allegations of bullying. His supporters allege the suspension was, rather, linked to Dr Mattu's "whistleblowing" on the inappropriate practice of placing a fifth patient in a ward bay intended for four patients.

2. Progress of this case has been slowed by the lengthy and complex disputes between the trust and Dr Mattu and his representatives about the application of trust procedures and as a consequence of Dr Mattu's unavailability due to sickness for five months during the spring and summer of 2003. The disciplinary case is now progressing in accordance with the advice of the National Clinical Assessment Authority (NCAA).

LATEST POSITION/PROGRESS

3. Mr Andrew Stafford QC has been appointed as Chair of the panel in agreement with Dr Mattu. Furthermore the trust has received two nominations from the BMA Joint Consultative Committee (JCC) from which it has nominated Dr R Bain. The second nomination was known to the Chief Executive, Chief Operating Officer and Medical Director of the trust and was therefore rejected by the trust. A further name was requested—this name has now been provided and the trust is now awaiting comments from the Chair of the Senior Hospital Medical Staff Committee in line with trust policy. This has caused no delay to the process as both legal teams are still in the process of preparing cases for submission to the panel in due course.

4. The trust and its advisers also had a meeting with Dr Mattu on 23 March where options for early resolution were again discussed along with the progression of the formal case. A Directions Hearing was held on 15 June at which both legal teams met to discuss process. The trust has now been advised, by the Chair of the panel, that the inquiry will take place on 31 January 2005 and will last approximately five weeks.

MINISTERIAL INVOLVEMENT

5. Ministers see the matter of suspension as a neutral act, to allow proper processes to take place between the concerned parties.

While seeking to reassure themselves that the trust is acting appropriately and working to bring the matter to a conclusion as quickly as possible, Ministers have consistently declined to intervene or comment.

NATIONAL POLICY ON SUSPENSIONS

6. A new framework was published in December 2003 to deal with the suspension of doctors more efficiently and speed up investigations. The framework is supported by the BMA and is a positive development for doctors, as the emphasis is on early intervention to provide support rather than disciplinary action later.

20 July 2004