Suspension failure in the NHS

Report for Brian Jenkins MP, member of the Public Accounts Committee.

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SUMMARY

This report aims to highlight the lack of accountability, common procedures and effective management in situations of staff suspensions. It calls for action because of the cost to the NHS, to the individual and their family. This includes implementation of the Directions currently in place for doctors and dentists, for all NHS disciplines.

SOURCES OF INFORMATION

- These questions and this report are based on information received from nurses and midwives who believe they were unjustly and unnecessarily suspended from work or who went off sick when their working environment became so hostile, they were no longer able to practice safely. They have made contact through the web site www.suspension-nhs.org
- This web site was set up to provide support and information for people undergoing these traumas. In addition, I have personal experience of suspension.
- 62 people have emailed me to speak of their own experiences, of whom 58 worked in the NHS and of whom 52 were nurses and midwives.
- What they have been recounting, is corroborated by the findings of the National Audit Office (NAO) report 6.11.03, (www.nao.gov.uk) 'The Management of Suspensions of Clinical Staff in NHS Hospital and Ambulance Trusts in England', and Rachel Murray's unpublished PhD study, Researching the Lived Experience of Nurses Suspended from the Workplace: The University of Manchester, 2004 and used with thanks.
- Recommendations include observations made by the National Patient Safety Agency (NPSA) and their work on the Incident Decision Tree, and the new Directions for the Management of Exclusions of Doctors and Dentists, produced by the Department of Health, December '03.

THE PRESENT SITUATION

Suspension, a neutral act in employment law, is appropriate for the protection of the public, for the safety of patients and for the prevention of tampering with evidence, in cases of suspected gross misconduct, where there is well founded evidence. There is no statutory requirement to notify the Department of Health or any other body when suspension has occurred. Human resources departments are only required to keep a record of all staff excluded from work after 28 days. There is no record of shorter periods of suspensions.

The situation is changing for some NHS staff, that is, doctors and dentists. There has long been acceptance by the Department of Health that suspension is very wasteful, especially since the enquiry into the 11 year suspension of Dr O'Connell in 1995 (Appendix 2, NAO report). For the first time however, the NAO report provided a measure of the seriousness and extent of the problem. Moreover, the National Clinical

Assessment Agency (NCAA) has demonstrated that their participation in the process of dealing with allegations made against staff can make a significant difference to the number of staff actually suspended. Since April 2001 the NCAA has handled approximately 600 referrals and in 85% of cases suspension was avoided (Directions '03).

However the situation for other practitioners is different. Royal College of Nursing (RCN) data for 2002, revealed over 200 nurses had contacted the RCN for help following suspension. It is thought the numbers involved may be much higher (Murray 2004). In a 15 month period from April 2001 to July 2002, 567 nurses and midwives were excluded from work for longer than 28 days (NAO report). In 2002 – 2003, 154 nurses were removed from the Nursing and Midwifery Council register and 66 were given a caution. In other words, suspension had been necessary. This leaves several hundred who were not found guilty of gross misconduct, that is, suspension had been inappropriate.

Each trust or organisation has its own guidelines about who has the power to suspend and how it will be dealt with (NAO report). Suspensions are often the result of jealousy, arguments between managers and colleagues or to prevent a colleague blowing the whistle on them by getting in their own allegations first. They are not very often as a result of patients' complaints (NAO report). Bullying may be a component in the situation and bullying and suspension seem to bear many similarities.

The costs are high. As well as the loss of skills and expertise of a staff member, there is the cost of cover for the suspended nurse, if any is provided, the cost of managers' time for dealing with the suspension, plus the cost in lowered morale of colleagues, and damage to health for all involved. The suspended person may well become clinically depressed and require treatment. The NAO report put the cost at £29 million per annum. (They noted that there was serious underreporting of costs by organisations.)

The current system is disciplinary and adversarial, an inappropriate and damaging approach to problems which discourages incident reporting and examination of systems (NAO report).

Managers are often very busy and some appear to lack the skills required to deal with these situations (website contacts). In many cases NHS trust management do not acknowledge or work within current employment legislation (NAO report). Specialist solicitors are very expensive to hire and industrial tribunals are extremely stressful events for all involved. MPs may sometimes be able to demand an enquiry. The effects of suspension are often that experienced and competent practitioners leave the NHS (27% of all clinicians other than doctors and dentists in the study of resolved cases in the NAO report, resigned or retired) and the morale of remaining staff is damaged.

Suspension leaves the person in a state of shock. People have contacted me, expressing their devastation, disbelief, hurt, isolation, anger, mental ill-health, even suicidal thoughts, to name some of the emotions felt. My own experience of suspension has made me painfully aware of the cost to the individual and their families. Suspension is described by human resources as a protective mechanism. To protect is to shield from

danger or injury (Chambers Dictionary 1998). Clearly suspension fails to do this for the suspended person.

Suspension is such a serious step for managers to take that people assume that there must always be grounds for it. Many people with their families and friends now know that this is not correct.

THE ENVIRONMENT IN WHICH SUSPENSIONS MAY OCCUR

Often there are difficulties in the environment, for example staff shortages and excessive workloads (Murray R 2004). There may also be team clashes of personality, vision and direction (NAO report 2003). Powerful staff members with suspect practice have managers who protect them (see the Andrea Adams Trust web site). Bullying and harassment have been features of some people's experiences (website contacts). There is professional jealousy of innovative staff, who are often award winners (website contacts). Some of these people are outspoken but this is what is needed in the NHS cf Faugier J 'We need mavericks to save the NHS' (Nursing Times 1 April '03). Managers have little experience or knowledge of how to deal with complaints or of the criteria for suspending staff (NPSA).

REASONS FOR SUSPENSION

Allegations are not often from patients (NAO report). Where an allegation is made and staff protest their innocence, the patient may be believed even though there is no evidence to support the allegations. This is a particular problem for staff working in mental health settings (web site contacts). Staff are being suspended because of false allegations by other staff members (web site contacts and NAO report). This is happening to managers and clinicians alike.

'Whistleblowers' can have the whistle blown on them. A colleague refuses to respond in anyway to suggestions for improving her work performance and then uses false allegations to protect herself. Public Concern at Work, a research charity that supports whistleblowers, found that more than £10 million a year is paid out in compensation to employees who were victimised or sacked after reporting poor practice.

Poor judgment or an error by a clinician is dealt with harshly; it underlines the culture of blame endemic in the NHS. There is no attempt to look for systems failures implicated in most critical incidents (NPSA).

Some people go off sick anticipating that things are going badly wrong, often involving bullying and harassment, and they fear suspension. They are placed on half pay after six months sick leave and then when the situation has still not been resolved after a year, are paid statutory sickness benefit, which causes serious financial hardship.

PROCESS OF SUSPENSION

The following points are drawn from all the sources of information previously listed.

- Suspension with immediate effect denies people the opportunity to explain their actions or provide or safeguard evidence supporting their actions before suspension is implemented.
- The staff member is often told to leave the premises or escorted off in a state of shock and is in no fit state to travel home.
- The system means they are presumed guilty until innocence can be proved.
- Their defence with supporting evidence is often ignored.
- The whole process is adversarial and stressful for all. This is particularly true of disciplinary hearings.
- There is a serious conflict of interest for the investigator who is also a member of management. They will find it very difficult to be impartial when management colleagues have made the decision to suspend and now need evidence to support their action. The investigator may therefore feel under pressure to search for evidence to prove guilt not establish facts. It may even be that the investigator's own future in the organisation may be at stake.
- The person conducting the investigation may have been involved in the suspension and may also be the person making the allegation.
- Disciplinary policies and procedures are frequently not followed, for example, no written allegations are given.
- In the majority of cases the allegations do not justify suspension, that is, they do not constitute gross misconduct and neither is there any danger to patients, nor possibility of contaminating evidence.
- The 'accused' is often not kept informed of what is happening, for example, when the next decisions will be taken.
- Often no timescales are given. There may be no urgency to deal with the situation. It may continue for months. Industry, that is, large organisations, deal with suspensions as an emergency. They usually last no longer than one week. (Sources: human resources manager for a multi-national company; managing director of a European environmental research company; former Marks and Spencer's manager; former managing director of a steel business.) They treat it as an emergency, not only because of the cost to the company, but also because of the cost to the health of the individual and their family!
- People are regularly denied access to reports pertaining to their suspensions.
- New and unsubstantiated allegations may be introduced with no opportunity for the suspended staff member to address them.
- If no disciplinary action is to be taken, the staff member cannot appeal against the investigation report findings and recommendations even though they may contain new and unsubstantiated allegations.
- It is hard for human resources staff to remain neutral. They feel that they have to support the management. They rarely support the suspended member of staff.

COMMON OUTCOMES OF SUSPENSION

The people in the reports and who have made contact through the web site, very often experience totally unsatisfactory conclusions to investigations and hearings. This is illustrated by the following:-

- Many people are told there is no case to answer and have to return to work without any explanation or public apology.
- A person who has made malicious allegations goes unchecked.
- Return to work is very difficult. The person's confidence has been badly undermined and reputation damaged or destroyed.
- There is an understandable common misconception that if a person has been suspended, there is something dubious about their practice. They may be viewed with suspicion by some colleagues, who may also refuse to work with them.
- An unjust written warning or a unjust final written warning means the clinician works under constant duress even though innocent of any wrongdoing, as there is no procedure for refuting false allegations.
- Because of the serious nature of suspension, managers may justify their actions by putting some form of supervision or assessment in place. These are very difficult circumstances under which the clinician is being assessed. The clinician may well be suffering poor mental health as a result of the whole experience.
- The assessors themselves are in a difficult position as the managers expect some malpractice to be uncovered to justify their actions.
- Many people have given up the struggle and resign. Extensive expertise and experience is lost.
- Some of the people who have resigned go for constructive dismissal as the only way to establish their innocence, a stressful undertaking for all and costly to the NHS.
- They may also sue for damages. The NAO report did not have the possible range of costs involved in staff suspensions, only an average. As some staff experience serious mental ill health, damages awards are likely to be high.
- All this perpetuates the culture of blame; there is no learning from systems failures.

UNION REPRESENTATION OF SUSPENDED STAFF MEMBERS

First level union representatives are often volunteers who may have no agreement with their employers for cover. They rely on the goodwill of colleagues to provide cover for their own work and they vary in the amount of time and support they are able to give. The level of training they have received may also be variable and sometimes there is a lack of knowledge of procedures.

Cases may be complex and if they involve clinical issues, the second level representative may have no expertise to deal with them, if they come from non nursing backgrounds. There is also an issue here for clinicians and managers, that they need some protective mechanism to demonstrate that their practice is safe and based on current research etc.

Union representatives and staff members are approaching the situation from two opposing directions, that is, the union representative is looking at the situation dispassionately and in the light of organisational procedures, in line with employment practices. The staff member often lacks knowledge of these, is in a state of shock, and is devastated by the apparent attack on their integrity and practice. The staff member has to trust their union representative at a time when their usual ability to trust has been seriously damaged. Clear explanations, with written information to support what is being said, might help to prevent some of the disappointment and sense of disaffection some union members feel.

The union representative may also have to deal with managers who lack experience or training to deal with employment situations. When sound advice and recommendations from union representatives are given, trust senior managers may ignore them and this results in a confrontational situation that limits the possibility of a satisfactory resolution.

People's experiences were that some of the representatives had been excellent (Murray 2004 and web site contacts). Others found that they lacked knowledge and effectiveness. Some were described as 'useless'. Other comments included,
"The fulltime officer was too close to the managers, appeared to be in their pockets and on their side."
"The union representative did not return calls or reply to emails."

Some union members felt that the representatives thought they were mentally unbalanced. The union representative did not understand how stressful the whole experience was and thought the members were over-reacting. Some representatives appeared to believe the union members were guilty and they recommended compromising with the management and taking a reduced 'sentence' as a victory.

Difficulties were described arranging meetings quickly when the regional officer was involved due to his/her full diary and the full diaries of the managers. (Again, this rarely happens in industry, that is, large organisations, because they treat it as an emergency situation and expect to deal with it within a week. They cannot afford the cost to their business and its effect on their competitiveness.)

There is very little possibility of just resolution if the representative is unhelpful. The suspended person is completely alone, unless they have a helpful family member or friend with the necessary expertise or sheer determination and time to spend. Most people cannot afford a solicitor and in their distressed state, it is almost impossible for them to think coherently.

ATTEMPTED SOLUTIONS BY THE DEPARTMENT OF HEALTH

Unjust and unnecessary suspensions contravene the Government's attempts to change the culture within the NHS from a culture of blame to a culture of responsibility (cf Donaldson 2000 An Organisation with a Memory) recognising that 'culture matters in the delivery of successful healthcare.' (Bevington et al 'Culture vultures: change management' Health Service Journal 8 April '04).

The Department of Health has taken several measures to try and accelerate this change:-

- The establishment of the National Clinical Assessment Authority (NCAA) to deal with complaints and concerns made against doctors and dentists.
- The establishment of the National Patient Safety Agency (NPSA) and its subsequent publication of the Incident Decision Tree to give guidance to managers faced with allegations such as unsafe practice.
- The creation of a non-punitive and anonymous reporting and learning system by the National Patient Safety Agency for patient-related adverse events, near misses and medical errors, thus potentially providing safety to 'whistleblowers'.
- Directions published by the Department of Health for doctors and dentists in December '03, whose principles reflect ACAS best practice and can therefore be applied to other groups (see Frequently Asked Questions section of the Directions).
- Two meetings between the Chief Nurse's Office and the NCAA to look for ways of improving organisations' performance. The outcome of these meetings is not available to staff.
- To look at the possibility of systems failure (NPSA). How did the situation get to serious concerns? Why wasn't it already seen that this person constituted a threat to patient safety if there truly was poor work performance?

RECOMMENDATIONS

Sufficient resources need to be made available to ensure that the following changes are implemented. These resources would be available from the money saved by the avoidance of the use of inappropriate and over long suspensions.

1. All suspensions must be reported to the Department of Health regardless of the length of the suspension. A pro-forma should be used to ensure reasons for the suspension and staff member's job title etc are recorded, to estimate costs and aid research.
2. The Directions for doctors and dentists should be followed for all staff and also their use tightly monitored. (See Appendix 1 for a list of the Directions' processes and benefits.) This would include the involvement of the NCAA.
3. The NPSA Incident Decision Tree which looks for the possibility of systems failure prior to the use of suspension to establish if there is a need to suspend the staff member, should be followed and its use tightly monitored.
4. The checklist questions in Appendix 2 can be used as a tool to enable an independent organisation to monitor the suspension process.
5. More research is needed to establish the scale of suspensions, whether some staff are more vulnerable to suspension than others, if some organisations have developed a culture of suspension and if so, why. This research needs to be linked to the studies of workplace bullying which appears to share many similarities such as false allegations, isolation and devastation. Systems failure analysis should be used to try and identify what is going wrong and to find solutions.
6. Action needs to be taken against the staff members who make malicious and unfounded allegations to prevent them taking such action again, and to act as a deterrent.
7. Where a mistake has been made by management or where unfounded allegations have been made, and there is no case to answer, staff must have a written public apology.
8. The person making the assessment must be independent of the organisation's managers. They must also have the necessary skills, knowledge and experience to undertake it. They must be impartial and mediate a solution wherever possible. There must be an appeal mechanism built in to the process.
9. Examples of good practice for dealing with allegations of poor performance need to be made available nationally and used.

CONCLUSIONS

This report shows that:-

- organisations are not accountable.
- the full extent of the problem is hard to assess.
- there is a need for effective action because of the cost to the NHS, to individuals and their families.
- the Directions for doctors and dentists, would address many of the failings of the current systems if they were applied to all staff members.
- it would be a cost-effective solution in the long term to extend them to all staff.
- examples of good practice for dealing with allegations, need to be made available nationally.
- there is a need for independent, impartial investigators to conduct investigations and mediate a solution.
- there is a need for research to investigate suspensions within the NHS including the high numbers of reported cases of bullying, with the use of systems failure analysis, to try and identify what is going wrong and find solutions.

The cost of the suffering of the people who have made contact through the web site, is unquantifiable. The despair they detail, sometimes suicidal thoughts, and the distress of their families, needs to be heard and responded to. It is too late for most of them but people may be able to make some sense of their suffering if and when systems are put in place to protect others.

APPENDIX 1: THE NEW DIRECTIONS PUBLISHED BY THE DEPARTMENT OF HEALTH, DECEMBER '03 AND THEIR POTENTIAL FOR FAIRNESS

The Directions recognise:-

- that suspension may now only be used for the most exceptional circumstances
- that exclusion is not a solution
- that other approaches should first be exhausted
- the need for a speedy resolution and if the exclusion is not actively reviewed after four weeks, the practitioner is entitled to return to work.
- the need for the chief executive's involvement so that poor management decisions may be prevented
- the appointment of a non-executive board member so that some impartiality may be possible – a major failing of the current system. The board member can request reports and keep the process moving. The defendant may make representations to the board member at any time after the letter with allegations is received ie there is also the possibility of a mediator/advocate.
- the need for the involvement of the NCAA as an impartial outsider to recognise work systems failures rather than focusing only on the individual
- the need for and provision of a definition of what constitutes serious or repetitive performance difficulties
- the need for much greater fairness for the 'defendant', for example, to see all correspondence, to know who will be interviewed.
- that the purpose of the investigation is to ascertain the facts in an unbiased manner and not to secure evidence against the practitioner .
- the need to involve an outside practitioner if the case is complex.
- the need to stop the exclusion from premises except under exceptional circumstances, so that the member of staff can retain contact with colleagues, take part in clinical audit, keep up to date with developments, and undertake training and research.
- the need to monitor exclusions by the Department of Health via the strategic health authority from data provided by the trust board. The trust board also has to ensure these procedures are followed and that the case is being progressed.
- that many of the principles in the framework reflect ACAS best practice and can therefore be applied to other NHS groups. Under the Employment Act 2002, disciplinary action has to be consistent
- most failures in standards of care are caused by systems weaknesses

They therefore have the potential to help to change the blame culture that currently exists and to protect all staff.

APPENDIX 2 CHECKLIST QUESTIONS

Monitoring of the suspension process in an organisation

1. How many clinicians and managers are currently suspended from work in this trust?

2. If the suspension was imposed after May '04, was the Incident Decision Tree of the National Patient Safety Agency used to inform the decision? If not, why is this?

3. Was the possibility of systems' failures and how they may have impacted in the situation, considered?

4. What are the job titles and grades of the people currently suspended?

5. For how long have they been suspended?

6. On what grounds have they been suspended?

7. How many other staff are on sick leave for fear of impending suspension due to allegations being made against them?

8. What process is being used to investigate allegations made against staff, to resolve the situation?

9. Who in the organisation is overseeing the process?

10. Is this person independent or do they have a conflict of interest?

11. Are they operating by ACAS best principles as outlined in the new Directions? If not, which principles are they operating by? Why is this?

12. To what timescales are they operating? What and who is determining these timescales?

13. Do the people, charged with conducting the investigation and subsequent processes, have the necessary knowledge, skills and experience to undertake this work?

14. Will they have specialist advice and support through the process? If so, who will provide it?

15. Have time and resources been ring fenced for them, to accomplish the work thoroughly and speedily?

16. How is the suspended person being kept in touch with their clinical base and skills as advocated in the new Directions?

17. If there is no case to answer, how will the staff member's name be cleared and who will give them a written apology?

18. If it is found that allegations made were malicious, what action will be taken against the perpetrator(s)? What investigation will be undertaken to find the system's failure that allowed this to occur and what strategies will be put in place to prevent its reoccurrence?