Practitioner Performance Advice Insights

Insights from 10 years of supporting the management of exclusions in England

Overview

NHS Resolution's Practitioner Performance Advice service has a unique perspective on exclusions of doctors and dentists within the NHS. NHS organisations are expected to seek advice from the Practitioner Performance Advice service when considering a formal exclusion and if an exclusion extends beyond 12 weeks. This publication looks at key themes and data from 1359 exclusion cases in England between 2009 and 2019 to highlight opportunities for improvement and to signpost to resources for use by employers. It represents our contribution to the commitment made by the Department of Health and Social Care, in response to the Paterson Inquiry, to provide guidance to inform decisions around exclusion.

What is the purpose of exclusion?

Maintaining High Professional Standards in the Modern NHS (MHPS) provides a framework for the handling of concerns about doctors and dentists. This framework is mandatory for non-foundation trusts and its use is encouraged in all organisations who deliver NHS care. In the independent sector, The Medical Practitioners Assurance Framework published by the Independent Healthcare Providers Network (IHPN), references MHPS and as far as possible mirrors the arrangements for handling concerns. MHPS acknowledges that there are circumstances where exclusion may be necessary to either:

- protect the interests of patients or other staff, and/or
- assist the investigative process where there is a clear risk that the practitioner's presence would impede the gathering of evidence.

Exclusions are a feature of responding to concerns about practitioners working in a secondary care setting. The Performers' List Regulations govern practitioners working in primary care where suspension from the list has a similar function. Whilst there are similarities, this guidance is intended to support the use of exclusion and not suspension.

Exclusions are intended to be a short-term temporary measure until the nature and cause of the concerns are understood and should be regularly reviewed.

Whilst the considerations of benefits of patient safety are paramount, the costs to the practitioner and the service are real. Although exclusion is not a formal disciplinary action it changes the status quo from work to no work, and it inevitably impacts on how the practitioners perceive themselves and are perceived by others. The absence of a colleague can have a profound effect on a service in terms of both performance and cost and impact wider than just the main employer if the doctor works across the health system.

Any decision to exclude is a challenging judgement which seeks to ensure patients and staff are protected from harm whilst the doctor or dentist is treated fairly. The complexity of getting this balance right is illustrated by two recent high profile cases.

In 2016 Amin Abdullah, a nurse who had been dismissed from his job, took his own life. This triggered the commissioning of an independent inquiry undertaken by Verita Consulting, the findings of which were reported to the board of the employing Trust and to NHS Improvement in August 2018. The report concluded that, in addition to serious procedural errors having been made, throughout the investigation and disciplinary process Amin was treated very poorly, to the extent that his mental health was severely impacted. This led to Dido Harding, then Chair of NHS England and NHS Improvement, writing to all trust chairs and chief executives in May 2019 with a request they review their investigative and disciplinary culture. This included their use of exclusion. The review aimed to ensure local investigations and disciplinary procedures demonstrate fairness, efficiency, compassion and that there are appropriate safeguards for the individual's dignity, health and wellbeing throughout the process.

In 2020, the independent inquiry into the issues raised by Ian Paterson heard from senior managers and healthcare professionals that opportunities were missed, in both the NHS and the independent sector, to exclude Paterson and protect patients. The report recommended that any perceived risk to patient safety should result in the suspension of that healthcare professional. This recommendation was not accepted, due to concerns that a blanket approach would not be fair or proportionate, but there was a commitment to provide clear guidance on decisions to suspend or exclude a healthcare professional.

Complex issues like these are never binary. Our advisers are skilled at supporting responsible officers, medical directors and colleagues reach judgements, which protect patients and are fair and supportive to the practitioner. This publication and the resources linked to it draw on our experience and good practice in the NHS and the independent sector. It has been supported by commissioned research to understand if there are any patterns in exclusions and if anything can be done to improve how exclusions are managed. We are very thankful to Dr Marie Bryce, Dr Nicola Brennan and Josephine Cockerill of the Faculty of Health, University of Plymouth for conducting the research.

Key findings from 10 years of exclusions

NHS Resolution

10 years of exclusions in England 2009-2019

136 Doctors and dentists excluded each year on average

97% of exclusions involved doctors

1.2 Exclusions per 1000 doctors

Some groups are significantly more likely to face exclusions:

Males* ♂

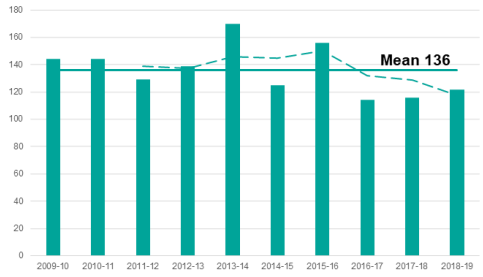
Aged on average** **55-64**

Ethnicity **Black, or Black British**

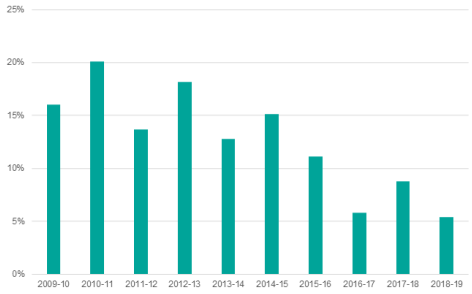
Working as **Consultants**

In specialties of
- **Emergency medicine**
- **Obstetrics & gynaecology**
- **Psychiatry**
- **Surgery**

Exclusions are decreasing



The proportion of exclusions ending in dismissal has fallen



57%

In 2018-19

of excluded practitioners return to work including unrestricted return, or return with temporary or permanent restrictions on their practice.

20% resign or retire, 5% are dismissed and 2% reach the end of their contract. For 16% of excluded practitioners the end reason is other or unknown.

**Male practitioners were significantly more likely to be subject to an exclusion with the odds being 3.41 times higher than for female practitioners.*

***The logistic regression analysis found that all other age bands were more likely to be excluded than those aged under 35, with the 55-64 age band having the highest odds of exclusion at 4.70 times higher than for those aged under 35 band.*

The groups described were found to be significantly more likely to be excluded using appropriate statistical tests. The employer of the practitioner reports information about the practitioner to Practitioner Performance Advice. The research highlighted that data was more incomplete for age and ethnicity compared to other characteristics, with this data missing in approximately 20% of cases. Ethnicity groups reflect those from the 2001 census.

Analysis conducted by Dr Marie Bryce, Dr Nicola Brennan and Josephine Cockerill, Faculty of Health, University of Plymouth.

Opportunities for improvement

Whilst the figures above indicate trends over the past 10 years, the analysis cannot answer the question about whether these exclusions were appropriate. To seek to understand this better, 43 cases were reviewed in more detail and opportunities for improvement in the following areas were identified:

- **Decision to exclude:** The legitimate reasons for exclusion are limited to those in the MHPS framework. It is important when considering an exclusion that these guide any decision and there is a full exploration of the possible alternatives to exclusion. To support this we have created an exclusions flowchart to ensure compliance with good practice.

- **Documenting decisions:** Maintaining a full and contemporaneous record of decisions is essential throughout the process of managing concerns about a practitioner and the decision to exclude or not is no different. To support this we have produced a recording template for formal exclusion of a practitioner for documenting any case where exclusion is considered to ensure the rationale for an exclusion is documented at the outset and at regular review points. It also provides prompts for other aspects of managing an exclusion case including: informing other parties, appointing a board member and reporting to the board.

- **Keeping exclusions under review:** It is vital that an exclusion is reviewed regularly or as soon as circumstances change to ensure it is not maintained any longer than is necessary or fair. The recording template for formal exclusion of a practitioner prompts the scheduling and recording of the date of every review.

- **Supporting the practitioner:** Whilst the safety of patients remains the paramount concern it should not be forgotten that exclusions are associated with emotional and psychological costs for the practitioner and the exclusions should be managed fairly, efficiently and compassionately.

  How the exclusion is managed can impact on the outcome of the exclusion and the likelihood of the practitioner returning safely to practice. Our *Just and Learning Culture Charter* for employers, included in our publication Being Fair offers a helpful framework for organisations.

  We have produced a template letter for exclusions for NHS employers to use when communicating with the practitioner to help ensure all the relevant information is included. The template provides a helpful structure for communications with practitioners in the independent sector but will need to be amended to reflect the organisational context.

How can Practitioner Performance Advice help?

- Our team of experienced advisers can offer objective support and advice to both employers and practitioners. This can provide assurance that exclusion is used appropriately, proportionately and fairly in both the NHS and the independent sector. Our advisers can also signpost to the sources of support for practitioners from other agencies Support for practitioners - NHS Resolution.

- Our educational programmes include case studies that allow participants to explore good practice when considering exclusions. Our learning resources include an exclusions case studies – learning pack.

- Compassionate Conversations is a new, half day, evidence-based learning programme which aims to develop confidence and capability to have a compassionate conversation that is honest and engages with challenging subjects, particularly in relation to practitioner performance. It recognises a recurrent theme, namely that there are ways of approaching performance conversations that make discussions more effective for everyone involved, including the practitioner. It is being piloted in 2022.

- We will be publishing annual reports on the use of exclusion, derived from our data, and share any learning from these reports with the health system.

- We have commissioned further research to better understand the lived experience of practitioners when their employers raise concerns about them.

Our *Insights* publications share analysis and research which draw on our in-depth experience of providing expert, impartial advice and interventions to healthcare organisations. By sharing these insights, we aim to support the healthcare system to better understand, manage and resolve concerns about doctors, dentists or pharmacists. You can find all past reports via our Insights page on our website.

If you are interested in hearing more about our research and insights programme, please get in touch with us at nhsr.adviceresearchandevaluation@nhs.net

If you would like to learn more about our work and the services we offer, please visit our Practitioner Performance Advice webpages. Our Education service offers training courses to provide healthcare organisations with the knowledge and skills to identify and manage performance concerns locally.

References:

1. Maintaining High Professional Standards in the Modern NHS
2. The Medical Practitioners Assurance Framework published by the Independent Healthcare Providers Network (IHPN)
3. Being Fair