Serious Incident
Investigation of Croydoc Out of Hours Service

FINAL REPORT

NHS Croydon

25.3.11

SUI Reference	2009/11588
Commissioners:	NHS Croydon
SUI team	Dr Ben Essex (Assistant Medical Director) Bachchu Kaini (Quality and Governance Manager)

Acknowledgements

We would like to express our gratitude to all Croydoc non medical staff past and present, for their continuous cooperation at all times throughout this long investigation. They met with the lead investigator several times to clarify facts, help to analyse data, and understand how rotas, and Croydoc functioned. We are also grateful to all the doctors who cooperated with this investigation.

As part of this investigation, audits were undertaken to review activity and pay claims, significant events and complaints, and probity concerns related to different doctors. These audits could not have been done without the hard work and help of the finance officer, IT analyst, IT manager, and the service, and complaint manager. We are also grateful to the interim Chief Executive for his cooperation with this investigation.

We would like to thank all the doctors, patients, practice and PCT staff for their cooperation with this investigation.

Glossary

PCT	Primary Care Trust (NHS Croydon is referred to as Croydon PCT in this report)
OOH	Out of hours
PEC	PCT professional executive committee
Triage	Phone call to patient by out of hours doctor.
Unresulted call	Doctor does not record clinical details of phone conversation or patient consultation.
Governance	The process used to monitor the quality and safety of the out of hours service.
Croydoc	Croydoc is now called Patient Care 24. Throughout this report it is referred to as Croydoc.
Balanced score card	Used to show if calls were answered within target times.
New commissioning organisation:	South West London cluster of PCTs.
Opted in practices	Practices who have contracted individually with Croydoc to provide out of hour services.
Opted out practices	Practices who opted out of responsibility for providing out of hour cover, and whose patients were provided with out of hours care via a PCT commissioned contract with Croydoc.
CE	Croydoc chief executive

People interviewed

Croydoc non medical staff	**Croydoc doctors**	**Dr A's practice**	**PCT contract managers**
Chief Executive (CE) until Nov 2009 Interim Chief Executive until June 2010 Finance Officer Service Manager Service leader Operations manager Rota manager IT manager Information analyst Operations coordinator Administrative coordinator Personal Assistant to CE1 Call handler 1 Call handler 2 Driver	Dr C Dr D Dr E Dr F Dr G Dr P <u>Other doctors</u> Dr Q Dr R	Dr H Dr I Practice manager Patient 1 Patient 2	Contract manager 1 2005 - 2009 Contract manager 2 2009 onwards

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Executive Summary

1. Background

From July 2008 until August 2009, Dr A made several withdrawals of funds for himself from Croydoc. In July 2009 the CE and finance officer decided to alert the Croydoc auditor to withdrawals of money by Dr A not authorised by the board. The auditor asked Dr A to confirm he had informed the Board and to provide plan for repayment of £44,000. In September 2009, Dr A informed the auditor that he had told the Board members who were happy with the repayment arrangements. However in October the auditor wrote for the second time to every Board member informing them of funds advanced to Dr A as it was now clear that Dr A had not discussed these withdrawals with the board or provided a repayment plan to the auditor. An internal investigation by Croydoc highlighted serious financial and other concerns about Dr A's behaviour and conduct. In November the Board notified the PCTs of these concerns and the PCT declared this a serious untoward incident (SUI). In December the chief executive and Dr A were suspended from Croydoc. A suspension hearing was held by the PCT in December 2009 following which, Dr A was suspended from the performers list. In January the GMC suspended Dr A for 18 months. This PCT investigation was then started

2. Terms of reference

The terms of reference of this investigation are outlined below.

1. Compare patterns of work done by Dr A and Dr B with that done by other doctors.
2. Review if Dr A had cancelled shifts at short notice or failed to turn up. If so, to assess outcomes and implications for patients and call handlers.
3. Investigate concerns about Dr A's behaviour in relation to:
    - 3.1 allegations of bullying and intimidation.
    - 3.2 organisation of his remote triage work.
    - 3.3 communication with staff when on overnight rota, and any impact this might have on patient safety.
    - 3.4 appropriateness of his triage decisions e.g. base or home visits, A&E referral or 999 ambulance.
    - 3.5 his way of recording information about triage calls and its impact on other staff.
    - 3.6 the way in which he organised the rota work.
    - 3.7 To identify the extent and nature of Dr A's financial arrangements with staff and patients.
4. Investigation of any other areas identified as relevant.

Other areas

6. Review Croydoc policies and procedures for dealing with allegations of bullying and intimidation and their implementation in practice.
7. Review level of Croydoc OOH cover 05 – 09 and its impact on quality and safety of services.
8. Review Croydoc procedures for assessing significant events, designating a serious untoward incident (SUI), and the appropriateness of its responses.
9. Review Croydoc clinical governance policies and procedures followed to ensure Board accountability.
10. Review methods used by PCT commissioners to performance manage Croydoc OOH service.
11. Investigation of any other areas identified as relevant.

3. Fundamental causes

The fundamental causes that relate to the way Croydoc was managed are outlined below.

3.1 Croydoc

- Individual board members lacked an understanding of their corporate responsibility for the safety of the service. They delegated overall management responsibility to Dr A without recognising that they were responsible for holding him to account.
- The organisation had a board composed only of GPs. The presence of non-executive directors might have provided a more robust system for challenging decisions and taking appropriate actions.
- Potential conflicts of interest were not recognised or dealt with adequately.
- A number of the board members appeared to lack the knowledge needed to effectively run a multimillion pound out of hours business. Furthermore, they were not fully aware of the governance arrangements needed to run such an enterprise.
- Croydoc lacked essential policies and procedures needed to ensure the service was safe and appropriate governance arrangements were in place. The failure to implement many existing policies and procedures had an adverse impact on the safety and efficiency of the service.
- Dr A's behaviour was a cause of much stress and distress to staff and patients, and had a serious impact on the safety and efficiency of the service.

3.2 PCT commissioners

The fundamental causes related to PCT commissioners are:

- They did not monitor the safety of rotas or review the adequacy of overnight cover.

- It did not ensure the governance arrangements stipulated in the contract were implemented by Croydoc.

3.3 Patients

The fundamental reason why patients entered into financial arrangements with Dr A was that they believed that as their doctor, they trusted him implicitly to act in their best interests. However Dr A was responsible for ensuring a clear separation existed between his roles as doctor and financial advisor.

4. Recommendations

4.1 Patient care 24 (previously Croydoc)

- All board members to have job descriptions and training to ensure they understand their own roles and responsibilities, and those of all other staff and clinicians working in the organisation, and can demonstrate competencies needed in their role on the board.
- Patient Care 24 (previously called Croydoc) to demonstrate the implementation of up to date, comprehensive policies and procedures related to: governance, conflict of interest, appraisal, bullying, unresulted calls, target failures, whistleblowing, late shift cancellations, contingency planning for high demand or emergencies, financial management, rates of pay, directors requesting advances, management of performance concerns, patient participation, equality and diversity.
- Patient Care 24 to fund an external review of its service to ensure safe policies and procedures are implemented and the service is now safe, efficient and acceptable to patients. This report could help to identify its terms of reference, see appendix.
- South West London Cluster to ratify the Terms of Reference, approve who will do this review, agree its procedures and receive the full report.
- Patient Care 24 undertakes an indepth review of all claims where verification concerns exist e.g. all extra hour claims by Dr D April 07 – March 08, claims made by Dr A and E for Tuesday and Thursday overnight rotas, and Dr B's Morden Rd work prior to 2008.
- Patient Care 24 and its auditors to review procedures followed when alerted to concerns about validity of payment claims by finance officer.
- Patient Care 24 considers what actions may be needed to address issues raised in this report related to individual doctors.

4.2 New Commissioning Organisation

Commissioners to

- identify appropriate service level specifications needed to commission, monitor and evaluate an out of hours service
- seek evidence that recommendations in this report have been implemented.

- to consider what actions are needed to address the issues related to individuals or to contracts.

5. Conclusions

It is unusual to find an organisation providing NHS out of hours care which is so controlled by one doctor who took on the roles of chair, operations director, finance director and medical director. Dr A was able to control many aspects of the service without being effectively held to account.

All the Croydoc call handlers, many of whom have worked there for years, have shown enormous commitment to patients and loyalty to the organisation. They have tried at all times to ensure patients received appropriate responses from doctors and worked under extremely stressful conditions. Many staff made recommendations to the board about changes needed to make the service safer for patients. The CE and finance officer were concerned that doctors appeared to have been paid when there was no evidence of activity. They introduced a payment system to try and ensure pay correlated with evidence of work done. They highlighted concerns about the validity of some claims to the auditors on three separate occasions in 2008 and 2009. They also challenged inappropriate and unvalidated claims and informed the auditors about unauthorised withdrawals of money from Croydoc.

Although the chief executive (CE) denied she had instructed staff to alter data, a number of staff said she asked them to do this. The CE did not inform the board of the unauthorised withdrawals of money by Dr A. However, she had worked very hard for Croydoc from 1995 – 2009 under very stressful circumstances. She felt intimidated and bullied by Dr A and unsupported by the board. There is ample evidence that she had tried for many years to challenge Dr A about his behaviour and to indicate what effect this had on patients and staff. This is noteworthy as this investigation could not find any examples of board members ever challenging Dr A.

Final accountability for ensuring the safety of this service rested with the board. Most board members were aware of the effect Dr A's behaviour had on patients, staff and the effectiveness of the service, but did not challenge Dr A or seek external advice. Conflict of interests were not recognised by the board. However in most respects the members of the board were untrained for this role. They expected Dr A to take full responsibility for Croydoc as an organisation. They did not accept that they were also accountable for the safety and effectiveness of a multimillion pound organisation providing out of hours care for a population of 950,000.

It is hoped that Patient Care 24 can demonstrate that it is providing a safe, acceptable and efficient service for the population it serves.

The investigating team would like to share the learning from this investigation with new commissioning bodies. With the expected abolition of strategic health authorities and PCTs, a new system for shared learning from serious incidents will need to be established.

Contents

1. Background

1.1 Croydoc organisation

This brief outline is intended to give the reader some background information about this out of hours service.

PCT role

The PCT is responsible for commissioning out of hours services on behalf of local practices. Each PCT i.e. Croydon, Sutton and Merton and Kingston has a separate contract with Croydoc to provide services for their populations.

Population covered

Croydoc provides an out of hours service for a population of 950,000 who live in Croydon, Sutton and Merton, and Kingston. Before 2006 Croydoc provided a service for Croydon PCT and Sutton and Merton PCT. After 2006, it also won the Kingston PCT contract for out of hours care.

Practices

In 2009 there were 68 `opted in' practices in the three PCTs who had separate practice contracts with Croydoc. There were also 76 `opted out' practices for whom the PCT contracted services with Croydoc.

Services

The service operates weeknights 6.30pm until 8am the following day, weekends Friday 6.30 until Monday 8am, and covers bank holidays. Since 1995 it has also provided minor illness clinics 1pm – 4pm, and 4pm until 7pm for patients who attend A&E with minor conditions. It is then open from 19.00 to 08.00 the next morning.

Staff

There are call handlers, drivers, and staff who manage the calls and visits. Specific mangers deal with data handling, finance, operational issues and complaints. GPs from all three PCTs provided medical cover on a sessional basis.

Organisation

- An operations group deals with operational aspects of the service.
- Clinical governance group is responsible for quality and safety.
- Chief Executive (CE), responsible for overall management.
- The board members consisted of 6 GP directors and a chair Dr A.
- On basis of interviews, Dr A held the roles of Chair of the board, financial director, operations director and medical director.

Meetings

- Bimonthly meetings of clinical governance group where GPs and PCT staff meet to review complaints and significant events.
- Quarterly contract meetings for PCT and Croydoc staff to review targets.

Audits

Croydoc undertakes regular clinical audits of consultation records of each out of hours GP four times a year. This assesses the quality of the consultation and action is taken if specific criteria are not met.

Bases

Croydoc operated from bases in Croydon and Kingston, and ran clinics in Morden Rd (Sutton and Merton), and the Powell unit in St Helier

Hospital. The central Croydoc base is in the Mayday Hospital. The base in Morden where patients could be seen until 11pm was subsequently closed.

Place of work

Working from base

Most on call doctors work from the base when on call. They would then be available to answer call handlers' queries, phone patients back to assess the problem, see patients at the base, or do visits if required.

Overnight calls

Some doctors doing overnight shifts would deal with the calls by working from home and not from the base.

Calls

- Call handler takes the calls and enters the following information on computer, time of call, and patient details and symptoms.
- If an emergency, the call should be immediately transferred to a doctor.
- Other calls would be designated as `urgent' or `routine' and passed to duty doctor to phone patient and assess problem. This is called triaging the call.

Triage

- Dr on call would be given the call details on the computer and would then `triage the call' by phoning the patient back.
- Dr records details of conversation with patient on computer (`Triage / advice notes) and indicates what was advised e.g. base visit, home visit, collect prescription, contact GP in morning, go to A&E, or 999 admission.
- All triage calls by doctor to patients are required to be recorded.
- Call handler would indicate urgency, i.e. clinical assessment within 20 minutes for urgent calls, routine calls phone back within 60 minutes.
- If patient needs to see a doctor in base or have a home visit, the doctor who sees the patient would record findings, management and advice on the computer.
- Call information is normally sent to the patient's GP by 8am the next working day. For this to happen, the clinical details have to be entered by the doctor who spoke to or saw the patient. When this happens the call data is complete and the call is removed from the system.

Overnight Rotas

Before 2006

Two areas, and two doctors each working 00.00 until 08.00, one in Croydon and one in Sutton and Merton.

After 2006

Croydoc now covered three areas, Croydon, Sutton and Merton, and Kingston. The overnight rota showed three doctors working 7 or 8 hour shifts. In reality, the overnight rota was now divided into three 2.6hr shifts with one doctor doing approximately 2.6 hours but covering all three areas. There would only be one doctor on the rota at any one time covering a population of 950,000.

1.2 Dr A

Before the present concerns, Dr A was in practice with two other partners and was one of the founder members of Croydoc. Until late 2009, he was its chair, director of finance, operations director, and medical director. The chronology outlines the sequence of events that led to his suspension and to this investigation.

2. Chronology

1995	Croydoc Out of Hours Service Co-operative was founded initially providing out of hours cover for many Croydon practices.
2005	PCTs commissioned a review of Croydoc by Healthskills organisation. Recommendations included overhaul of night services to provide cover and visible management and need to restructure the organisation. (Doc 45)
2005	Sutton and Merton PCT contracted out of hours services from Croydoc.
2006	Kingston PCT commissioned its out of hours service from Croydoc.
2006	Croydon PCT commissioned Croydoc as an out of hours provider for 17 practices. Currently 32 practices are `opt out status' and come under the PCT contract with Croydoc. Another 29 practices contract their out of hours service directly with Croydoc.
2006 – 10	Board of Directors consisted of Dr A (Chair), Dr C, Dr D, Dr E, Dr F, Dr G, and Dr P.
July 2008	From July 2008 until August 2009, Dr A made several withdrawals of funds for himself from Croydoc.
Aug 2008	Barclays Bank wrote to Croydoc CE asking Croydoc to remove its account from the bank. The board was not informed of reason for changing Banks.
March 2009	CE and finance officer ensured repayment made before the accounts were audited.
April 2009	From April until July Dr A obtained 3 further withdrawals which took the total to £100,000.
July 2009	CE asked finance officer to show auditors evidence of withdrawals of monies by Dr A.

July 2009	Auditor became aware of withdrawal of money by Dr A. There was no evidence that anyone other than Dr A and the CE had authorised this.
Aug 2009	Auditor delayed issuing report because Dr A requested time to inform the Board. Auditor asked Dr A to confirm he had informed the Board and to provide plan for repayment of £44,000.
Sept 2009	11 Sept auditor phoned Dr A to say he had informed the Board and would prepare a repayment schedule. The auditor stated that Dr A had said the Board were happy with the arrangements.
Sept 2009	24 Sept the auditor wrote to every Board member informing them of funds advanced to Dr A as it was clear that Dr A had not discussed these withdrawals with the board or provided a repayment plan to the auditor.
Sept 2009	Dr A and Croydoc finance officer agreed a repayment plan of £15,000 per month to be completed by December 2009. This would have entailed excessive working hours and as he often cancelled his sessions, this plan was not accepted by the Board.
Oct 2009	2nd October auditor wrote to Board members about this situation and expressed surprise that Dr A had not informed them.
Oct 2009	Internal investigation by Croydoc highlighted serious financial and other concerns about Dr A's behaviour and conduct.
Nov 2009	Board sought approval to treat withdrawals as a `director's loan' in return for Dr A agreeing to repay the loan by March 2010. Auditors advised that this would avoid a significant tax charge.
Nov 2009	Board Director Dr C notified Croydon, Kingston, and Sutton and Merton PCTs that Dr A had been withdrawing funds for himself without informing the Board.
Nov 2009	Board informed PCT of situation with regards Dr A.
Nov 2009	PCT declared this as a Serious Untoward Incident.
Nov 2009	PCT informed that Dr A had financial arrangements with patients who were also staff in the practice.

Dec 2009	Croydoc Chief Executive officer suspended pending further investigation. Dr A was suspended as a Croydoc director. PCT was informed that Dr A had financial arrangements with patients.
Dec 2009	14 December GMC referral
Dec 2009	17 December, PCT suspended Dr A from its performers list.
Jan 2010	11 January GMC suspended Dr A for 18 months.
Jan 2010	SUI investigation and counter fraud investigations started.

3. Terms of reference

The terms of reference of this investigation are outlined below.

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2. Review if Dr A had cancelled shifts at short notice or failed to turn up. If so, to assess outcomes and implications for patients and call handlers.
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7. Review level of Croydoc OOH cover 05 – 09 and its impact on quality and safety of services.
8. Review Croydoc procedures for assessing significant events, designating a serious untoward incident (SUI), and the appropriateness of its responses.
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11. Investigation of any other areas identified as relevant.

4. Methodology

Investigation Team

This consisted of lead investigator Dr Ben Essex (Assistant Medical Director) and Mr Bachchu Kaini (Quality& Governance Manager for Primary Care Commissioning)

SUI panel

The two panel members originally responsible for overseeing this investigation were the Director of Primary Care Commissioning and the PCT financial director. A new panel had to be convened to sign off this report because of the organisational restructuring that occurred in 2011.

Procedure

The team undertook the following steps:

- Terms of reference agreed with counter fraud officer to ensure they did not overlap or conflict.
- A chronology of events was produced.
- A meeting with Croydoc staff (clinical and non-clinical) was held to explain the aims of the investigation, its terms of reference and to answer staff questions.
- The lead investigator spent time in Croydoc with call handlers, drivers and other staff to understand how the service operated.
- Croydoc staff provided all the documentation that was requested and provided audit data requested by the investigating team.
- SUI interviews were scheduled to ensure they did not interfere with those conducted by the counter fraud officer.
- Questions for board members were submitted to counter fraud to ensure they did not cover areas being dealt with by the other investigation.
- Interviews were conducted with 15 non clinical Croydoc staff, 6 GP board directors, two PCT contract managers, Dr A's two GP partners, his practice manager, and two patients with whom he had financial arrangements. Dr A declined to be interviewed.
- Interview transcripts sent to interviewees to correct factual errors.
- All relevant documents were obtained, and examined.
- Specific audits were undertaken.
- A root cause analysis was done to identify the contributory causes and ensure these were evidence based. This is outlined in more detail below.

Root cause analysis (RCA)

RCA is a technique used in SUI investigations to identify the fundamental causes related to the incident. The first step is to identify concerns from evidence obtained in interviews, and reviews of relevant documents and audits. The next step is to identify the contributory causes of the incidents. These are grouped as follows.

- **Individual**
  These include an individual's knowledge, skills, competence, insight, attitude, perceptions, behaviour and conduct.

- **Tasks**
  These relate to the implementation of existing appropriate policies and procedures.
- **Team**
  These include roles, responsibilities, supervision, and delegation.
- **Communication**
- **Education**
  This relates to an individual's competence, supervision, and appropriateness of actions.
- **Work, environment**
  These include workload, skill mix, administration, time, health and safety.
- **Organisation**
  These relate to the absence of policies, standards and procedures.
- **Patient safety**

These factors are reviewed and grouped in a way that enables the few fundamental causes to be identified.

Recommendations

The final step is to produce a report which makes recommendations for relevant organisations and individuals, the implementation of which, might prevent a recurrence and lead to a safer, more effective service.

5. Rota concerns

It is important for the reader to understand how the rota system operated in Croydoc prior to 2010. The following is a brief outline of the system in operation until Dr A left Croydoc in November 2009. (Information from interviews with Croydoc staff including call handlers, receptionists, administrators, managers for service, operations, IT, rota, complaints, the Chief Executive (CE). and also a service leader, and a driver).

Who determined the allocation of shifts?

Although staff were allowed to fill the day rotas, it was clear from staff interviews that Dr A had overall control over the allocation of all shifts to GPs. He was the final arbiter and decided who should do any shift work for Croydoc. It appears that Dr A allocated most overnight and Bank holiday shifts to the same small group of doctors. These usually included himself, Dr B, Dr D, Dr E, Dr O and Dr L. Other doctors were rarely allocated overnight shifts.

How were overnight rotas organised?

Before 2006

Until November 2005, two areas, two doctors two drivers, each working 00.00 until 08.00 (week days and until 7am weekends), one in Croydon and one in Sutton and Merton.

After 2006

Croydoc got the contract for Kingston PCT. As it now covered three areas, Croydon, Sutton and Merton, and Kingston, it might be

appropriate to have three doctors each working for the whole eight hour overnight shift. However, what now happened was that Dr A changed the rota system but this was not ratified by the Board or communicated to the PCT. The overnight rota 00.00 – 08.00 was divided into three 2.6hr shifts. One doctor would work for 2.6 hours covering all three areas. The service now provided only one doctor working at any one time overnight, who would be covering a population of 950,000. This re-organisation of the overnight work was established by Dr A.

Where were the overnight doctors?
The doctor doing the first third overnight shift 00.00 – 02.30 would work from the base. Dr D who often did overnight rotas would triage from home but also come to base or do a visit if necessary. The last third overnight period 05.30 – 08.00 when done by Dr A would normally be from his home either in Croydon or in Norfolk. From 2008 onwards, Dr A usually did his overnight Friday shift (i.e. Saturday 05.30 – 07.00) from Norfolk. Most shift work done by Dr A and Dr B on Saturdays and Sundays were also done by them whilst in Norfolk.

Why no overnight visiting doctor 05.30 – 08.00
When Dr A did the last shift of overnight from 05.30 – 08-00, if he decided that a patient needed a home visit and was in Norfolk, he would not be able to do this. If this occurred on Friday overnight shift, he would usually be in Norfolk. There was, in effect, no visiting doctor between 05.30 – 07.00.

What happened on Friday evening?
Dr A and B would put their names down for Friday 18.30 – 23.30 shifts but regularly failed to attend or came very late. They may do triage from home but would not be working in the base. Therefore they could not see any patients. Managers had to put in extra doctors to do these shifts.

What happened on Saturday mornings?
Dr A and B would often be on the rota for Saturday mornings from 7am. Staff alleged they would not log on until very late and log off before the end of the shift. They would work for an hour then log off for periods of time. Calls went out of time and other doctors had to work harder.

Where were the doctors on call at weekends?
Most doctors on the rota during the weekends would be expected to work at the base where they could triage the calls, see patients, and do visits if necessary. However from 2008, Dr A and B did most of their weekend work from home in Norfolk. They could not therefore see patients who came to base or do visits. This meant there were less doctors left in the base to see patients. Dr A was allowed to do this even though many board members were aware of staff concerns about this pattern of working.

What happened on Tuesday and Thursday overnight shifts?
Doctors A and E were both on overnight rotas on Tuesdays and Thursday nights. However, staff confirmed that they had an internal arrangement where Dr A would cover Dr E's overnight shift on Tuesdays, and Dr E would cover Dr A's overnight shift on Thursdays. The rota showed that both Dr A and Dr E did two overnight sessions. In reality each worked for five hours on one night only. Staff were not allowed to change the rota to reflect this unofficial arrangement. Doctors were paid according to shifts shown on the rota.

What happened on Wednesday and Friday evenings?
Dr A usually put himself down to do Wednesday and Friday 18.30 – 23.00 base sessions. If he did not turn up for these sessions, staff would then have to find extra doctors. Staff asked Dr A not to undertake base shifts because he failed to attend most of the time. However, he would not allow his name to be removed from these rota shifts.

What happened when Dr on rota was on holiday?
When a doctor was on holiday, staff were not allowed to remove his name from the overnight rota. The overnight doctors themselves organised who would cover when one of them was on holiday. This was a dangerous system as highlighted in the significant event outlined on p40.

What happened in Sutton & Merton Morden Rd clinic?
Dr B was often down on the rota for Morden Rd clinic sessions 8pm until 11pm on Mondays, Wednesdays, and Fridays, and also on Saturday and Sunday evenings. She was expected to see patients and undertake triage. Often she failed to turn up for these sessions. (interviews with service leader, information analyst, call handler 1 and service manager). As a result this clinic was actually closed a total of 83 times between 1.1.07 and 31.10.07 (Doc 1). When Dr B did not attend these clinic rota sessions the service was one doctor down. This resulted in a reduced capacity to treat patients and undertake triage.

Minor illness clinic rotas (MIC)
These clinics were held from 13.00 – 16.00 and from 16.00 – 19.00. Prior to 2009, the doctors on the rota for these clinics worked efficiently. In 2009 Dr A removed these doctors and put his and Dr B's names down for most of these shifts. They would either arrive late or not at all. Staff would try to get patients an appointment with their own GP or ask the patient to return at 18.30 when another doctor would come on duty.

Why did staff prefer doctors to work from base?
If an on call doctor worked from the base, that doctor could answer emergency calls immediately, triage calls, see patients at the base, or do a home visit. The staff felt that doctors were being paid to work

from the base and be able to do a range of tasks. When this happened, the call handler had someone available to respond immediately to any queries. Dr A usually did all his overnight work from home and could therefore only triage calls. This greatly limited the service that the duty doctor could provide and had a `knock on effect' on patients, other doctors and call handlers.

What happened if duty doctor unavailable or extra demand?
On 10.12.08 service leader sent email to doctors `on last two evenings the overnight duty doctor has come on duty to over 20 patients waiting to be triaged, with patients in the base, and home visits outstanding'. To cope with this situation receptionist was asked to phone second overnight shift doctor at midnight for help with backlog if necessary. However, this did not resolve the management of extra overnight demand. There was no written contingency plan for call handlers to follow when dealing with extra demands or failure to contact duty doctor.

Shift cancellations
Many of the doctors would often cancel shifts one or two hours before they were due to start. Often these shifts could not be filled with another doctor and this would cause serious delays in dealing with calls and visits. This had an adverse effect on all targets. Staff kept records of late cancellations from 2007 until April 2008 when they stopped recording this data. From April 2007 – April 2008, Dr A cancelled a total of 51 shifts. For most cancellations, no reasons were given or it would record `busy'. (Doc 2). Several other doctors also cancelled many shifts at short notice and for no apparent reason.

Bank holiday rota cover
Examples of concerns about bank holiday rotas are outlined below.
<u>Xmas 2007</u>
11 day period, December 22nd until January 1st, total rota period of 214 hours. Dr D on rota every day and on rota for 138.5 hours (65%) of total rota period of 214 hours. Rota showed Dr D down to work continuous for periods of 12, 13, 17, 23 hours.
<u>Easter 2008</u>
Four day bank holiday, the rota covered a total of 107 hours. Dr D on rota for 74.5 hours (70% of total time). Rota showed Dr D down to work continuous for periods of 16, 21, and 24 hours.
<u>Xmas 2008</u>
Five day bank holiday, the rota covered a total of 105 hours.
Dr D on rota for 66 hours (63% of total). Rota showed Dr D down to work continuously for 12 hours and two periods both of 19 hours.
Dr D said that he was on so many rotas over these bank holidays because staff could not find other doctors to work over bank holidays. Staff disagreed with this explanation. They said they did not organise these rotas as Dr A always stipulated which doctors would be working over bank holidays. Doctors were paid time and a half for working over bank holidays and double pay on Xmas day. (Docs 3, 4, 5)

Practice visits passed to Croydoc
Dr A was the duty doctor normally on call in his own practice on Wednesday mornings. His partner and practice manager stated that Dr A would pass visits that came in during that morning to Croydoc. (Interviews with Dr H and manager)

6. Workload distribution

Workload audit

A review of the distribution of rota shifts to individual GPs was done for the year 1.10.08 to 30.9.09. There were 8091 shifts available during the year.

Total rotas per GP

Dr A	605	(7.5%)
Dr T	408	(5%)
Dr B	292	(3.6%)
Dr D	340	(4.2%)
Dr O	296	(3.7%)
Dr E	291	(3.6%)

Summary
33.6% of all rotas were done by a total of 9 GPs. Although Dr B was on the rota for 292 shifts, all of her overnight rotas were done by Dr A. Dr A and Dr B were on the rotas for a total of 11% of all shifts. Overnight shifts were always done by the same group of GPs (Drs A, D, E, O, L).

Home visits
Dr A put himself down for more shifts than any other doctor. However, out of 13,208 home visits done that year, only 19 were done by Dr A. This was because:

- Dr A did a substantial proportion of all work from home.
- When overnight triage was done in Norfolk, home visits could not be done by Dr A.
- Dr A and B were on the rotas during the daytime on Saturdays and Sundays but from 2008, for many of these weekends they were in Norfolk. Had they worked from the base as other doctors did at weekends, they would have been available to do visits.
- If Dr A thought an overnight visit was needed, staff said that Dr A often asked them to pass it back to the surgery after 8am.

7. Communication

(Evidence from interviews with call handler 2, service manager, service leader, information analyst, complaint manager, call handler 1, operations co-ordinator).

7.1 Communication overnight with Dr A

Type of work
Dr A did overnight triage from home.

Failure to use home computer
The computer system was set up at Dr A's homes in Croydon and in Norfolk to enable call handlers to transfer details of calls. He knew how to use it and it worked. If he was on the rota to triage calls during the day from home, he would log on to the computer. However, he would normally not have it switched on when on call overnight.

Shift session
When Dr A did overnight sessions, he normally did the last third of the overnight shift from 5.30 until 8am on weekdays or until 7am at weekends.

Phone calls
Dr A instructed the overnight call handlers to phone him on his mobile to give the details of patients who he needed to phone.

Communication difficulties
Many call handlers have recorded concerns about failure to be able to contact Dr A by phone when he was on duty. Evidence on the phone systems showed his mobile number went to 02 voice mail messaging when a call handler phoned. (IT analyst interview) The home phones were also switched to voicemail. Examples of difficulty contacting Dr A are outlined below.

- 15.7.08 recording of phone call 15.7.08 call handler to service leader unable to contact duty Dr A.
- Call handler recorded 46 calls before Dr A would answer the phone. (call handler 2 interview)
- Call handler reported making up to 40 calls to Dr A before he would answer the phone. (call handler 1 interview)
- Call handler logged 43 calls trying to contact Dr A via mobile and house phone before he finally answered his phone (operation co-ordinator interview).
- On 18.7.08 a call handler recorded a log of 114 calls she made to try to contact Dr A overnight. (Doc 6). She informed the Chief Executive (CE) and service leader about this.
- On that day CE email to Dr A expressed her frustration and asked Dr A what excuse could she give? (Doc 7).
- On 27.6.08 there is an email from CE to Dr A expressing her concern about failure of staff to contact him and having to send patients to A&E (Doc 8).
- Many call handlers reported having to send patients to A&E because of concerns and inability to contact Dr A (call handler 2 interview)
- Email CE to Dr A 6.2.09 re overnight staff concerns (Doc 9)

Outcomes
<u>`Warm' calls</u>
A warm call is an emergency. The handler should pass these calls over to a doctor when the caller is still on the phone. The caller could not do this if the duty Dr was Dr A and he was at home and was not on

the network of telephones. Call handlers would have to try to communicate with Dr A by phone. However it would often be switched over to voicemail or would not be answered. There were significant delays in dealing with warm calls, and some had to wait an hour and a half. (information analyst, operations co-ordinator interviews). For some warm calls there was no evidence that Dr A had phoned the patients. (Doc 10 and section 10 audit of responses)

`Urgent' calls

A doctor was expected to respond to `urgent' calls within 20 minutes. The call handler reported that Dr A sometimes took 3 hours to answer calls that needed a 20 minute response.

Delayed home visits

When doing his overnight triage from 05.30 onwards in Norfolk on Saturday morning Dr A may decide that a patient needed a visit. As he was in Norfolk, staff said Dr A would ask them to wait and pass visit to day staff at 7am. The visit would have to be done by the doctor who came on call at 7am. Even visits assessed as urgent would have to wait until after 07.00.

Calls returned to GP

Because call handlers could not contact Dr A, they would often return overnight calls to the patients' GPs. (Complaint manager, administrative co-ordinator interviews)

Triage call outcomes

Call handlers would pass calls over to Dr A but because he did not log onto the computer, they would not know if he had phoned patients back i.e. if he had triaged the call. Patients sometimes phoned back some hours later to say Dr had not contacted them. Call handlers would then have to try to contact Dr A again to ask him to triage the call. (service manager and operations co-ordinator interviews)

Lying to patients

Staff would have to lie to patients and carers about why overnight doctor did not phone them back. (interviews with CE, call handlers and service managers)

Past history

By not logging onto his laptop, Dr A would not have access to other recent out of hour calls or consultations made by the patient who he now needed to phone. This information is needed to enable the duty doctor to make safe assessments and management decisions.

Phone lines blocked

Repeated calls to try to contact Dr A would block a phone line for incoming calls from patients. This would have an effect on the targets for time of answering calls.

Dealing with the problem

CE made many attempts to get Dr A to answer his phone calls without success. On 6.2.09 she informed the staff that Dr A had given an assurance that he would answer his calls. However his behaviour remained unchanged and the overnight communication difficulties persisted (Doc 11).

Patient safety implications
The impact these communication problems had on patients is outlined in Section 14 p40.

7.2 Chief Executive (CE)

Communication with Board

- CE said Dr A's unauthorised withdrawals were not shown in these monthly profit and loss accounts. However, the finance officer said she gave the CE a monthly spreadsheet showing Dr A's withdrawals and the balance of his debt. These were not shown to the board.
- CE did not feel the board members would support her if she said she found Dr A's behaviour intimidating and unacceptable.
- She felt unable to inform the board of her concerns about Dr A because of fears of retribution and job loss.

Changing Banks
In September 2008, Barclays bank wrote to CE asking Croydoc to remove its account from the bank. The bank letter stated that this was because Dr A was a Croydoc director. CE email 27.8.08 to Dr A outlined her concerns about this situation. She stated that `Barclays have terminated our accounts due to the fact that you are a director of this organisation.' CE did not inform the board that the reason given for closure of the account was the Bank's concerns about Dr A (Doc 12). Had Board been alerted to the Bank's concerns about Dr A appropriate advice might have been sought and action taken earlier.

With Chairman Dr A
The CE felt there was a complete breakdown of communication between herself and Dr A.

With PCTs
CE did not inform PCT about `unresulted calls'.

7.3 Instant messaging (Doc 13)

The instant messaging system enables doctors and call handlers to communicate with each other when on duty. It is used to obtain or provide information, or to ask for action to be taken for specific patients. These messages can be read by doctors and Croydoc staff. The investigators reviewed the instant messages written by Dr A to call handlers when he was duty doctor. There were hundreds of instant messages typed by Dr A which were overtly racist, ageist, sexist, threatening, intimidating and abusive. These caused great distress to staff because:

- Everyone who has read this material (Dr C, F, and G, and Croydoc staff) said they were shocked, upset and distressed by the racist language recorded by Dr A.
- Dr A makes many disparaging remarks about the performance and conduct of his medical colleagues and board members.

- Dr A subjects staff to unacceptable verbal abuse and insults.
- Dr A makes many derogatory personal comments about people.
- Dr A records critical adverse comments about work done by staff.
- Staff felt intimidated when Dr A recorded his intention to get rid of certain members of staff.

These comments would be abhorrent regardless of who has written them. However they are especially shocking coming from a doctor working within a multi-ethnic organisation.

7.4 Board and staff

Several board members were unaware of the problems staff had trying to communicate with Dr A overnight.

7.5 Between board members

Some members knew of the concerns staff had about Dr A but did not share this information with other members.

8. Dr A's behaviour

Dr A's behaviour had significant effects on a wide range of people.

8.1 Patients

The impact on patients of failure to respond to emergency, urgent and routine calls within acceptable time periods are outlined in sections on patient safety (section 14), complaints (section 12), and significant events (section 13).

8.2 Croydoc staff

(Interviews with call handlers, service manager, CE, IT manger, complaint manager, Dr F, Dr R, rota manager, instant messages)
Dr A's behaviour had a profound effect on the CE, call handlers, service managers and other doctors. The main contributory causes of staff stress are outlined below.

Working conditions / communication

- Inability to contact Dr A to ensure urgent calls or emergencies were dealt with promptly caused much stress to all staff.
- Staff were upset at having to lie to patients.
- Late cancellations by Dr A at short notice caused great stress as replacements could not always be found at such short notice. Staff would then have to try to run the service without the appropriate number of doctors. This was an additional source of anxiety.
- Staff described Dr A's behaviour as rude, aggressive, autocratic arrogant, abusive, intimidating and undermining. They also alleged that he made disparaging remarks to them and would scream and shout at them.
- Saturday morning staff would panic when Dr A was on the rota from 7am because he would be anything from 1 to 3 hours late in logging

on to the computer. This caused much stress because of the number of calls waiting to be triaged.
- Staff were stressed when they phoned Dr A to confirm if he would be doing his shifts that day. He would often say he would phone later. Staff felt they were `made to suffer' when he did not call back to confirm shifts.
- Staff were upset when they had to deal with patients who were distressed and angry because Dr A was so late starting work.
- Some staff felt it was inappropriate for Dr A to dictate his overnight triage calls after 8am when he should have recorded this on the laptop. This meant a delay answering calls and a phone line would be blocked.

Intimidation
- Staff felt intimidated when Dr A would say he was going to sack them or asked them to find another job. They did not think this was said as a joke.
- Staff felt intimidated when Dr A recorded instant messages indicating his intention to get rid of certain members of staff.
- The service manager was upset when told by Dr A to get rid of a receptionist who expressed concerns about his failure to answer the phone.
- One dispatcher alleged that she was bullied by Dr A who ejected her from the premises. Dr B subsequently phoned to apologise on his behalf.
- Staff concerned that if Dr A wanted somebody off a shift, they went regardless of personal circumstances or contractual obligations.
- Staff commented that they were afraid to complain about Dr A or challenge him because they believed this would result in reduced shifts or losing their jobs.
- Many staff felt there was a culture of bullying.

Loss of staff
- Resignations of 9 overnight staff due to stress of working with Dr A.

Patient safety concerns
- Staff felt the way the overnight service operated compromised patient safety.
- They thought failure to provide appropriate information to GPs the next morning, could adversely affect patients.
- They worried because they could not transfer overnight `warm' emergency calls immediately to Dr A. There would be a delay in contacting him, and would not know if he had phoned the patient.
- Staff felt that Dr A prevented them from running a safe service.
- Staff were upset at having to advise patients to attend A&E because they could not contact Dr A overnight.

Racist language
- All staff who had read Dr A's instant messages were very distressed as they considered the language racist and intimidating.

Home triage

- When Dr A was on the rota staff would have no base doctor available to answer queries, respond to emergencies, and see patients. This made them feel unsupported and vulnerable.

Dictating overnight clinical notes

- Dr A was the only doctor who did not use the computer to record his overnight clinical notes. He dictated some of these notes over the phone for staff to enter on the system. He spoke fast and his speech was unclear. This delayed answering calls and blocked a phone line which meant calls were not answered within target times. Staff had concerns about logging in as Dr A and then saying he had written the clinical records. They felt this was additional stress which could have been avoided had he used his home laptop. They were subsequently advised to record `as dictated by Dr A'.

Chief Executive stress

She felt under considerable stress for the following reasons.

- There was a communication breakdown between herself and Dr A.
- She felt intimidated, bullied, belittled and undermined by Dr A.
- Serious communication difficulties meant meetings were difficult to arrange and emails and phone messages were ignored.
- Dr A would make important decisions without informing her.
- CE had to move staff off shifts because many found it too stressful to work with Dr A.
- On 6.2.09, the CE alerted Dr A to the stress on staff from having to lie to patients and carers about why overnight doctor could not be contacted. She did not get a response. (Doc 9)

GMC Good Medical Practice

46. You must treat your colleagues fairly and with respect. You must not bully or harass them or unfairly discriminate against them by allowing your personal views to affect adversely your professional relationship with them. You should challenge colleagues if their behaviour does not comply with this guidance.

8.3 Croydoc doctors

- Staff said that if doctors knew Dr A was on the rota for an evening (18.30 – 23.30) base shift they would be reluctant to take the other base session, as they knew he would not attend and there would therefore be one doctor short. This would add to the pressures on the doctor who did work at the base on those evenings.
- Other GPs felt that the way in which shifts were allocated by Dr A was unfair but could do nothing about this (Interview Dr R).
- They were also concerned that Croydon GPs were paid more than GPs from the other two PCTs who worked for Croydoc.

9. Staff concerns (Doc 14)

In 2007 an operations group was set up to deal with organisational issues. Board minutes April 2008 show Directors A, D, and E were members of this group. It would meet bimonthly and report to the board. The operations group raised the following concerns.

27.3.08 Meeting

A meeting on 27.3.08 recorded that the CE had to ask overnight Drs working away from base to take calls immediately and not say they will phone staff back. This related to Dr A.

23.7.08 Meeting overnight receptionist

July 2008

The service leader recorded the following concerns of overnight staff:

- Not being able to contact an overnight doctor either on mobile or house phone when several messages had been left.
- What to inform patients and callers when they telephone back, because the target time has lapsed and no call has been received (Doc 15).
- The legality of entering doctor case notes under that doctor's codes.
- A significant amount of calls in the morning not answered within target because overnight receptionist is recording dictated case outcomes from duty Dr A, or trying to contact duty doctor. (Doc 16)
- What excuse should receptionist give to surgery when the patient has not been contacted by duty doctor after phoning Croydoc?
- What should staff tell relatives or spouse when a death was reported at 06.30 but no visit done and call passed back to surgery? (GP not able to visit until end of surgery).
- Difficult to fill overnight receptionist shift because of these issues.
- Staff requested out of hours duty doctor to clear his own overnight calls and do all home visits particularly a death that comes in prior to 07.00.

All of these concerns related to Dr A.

CE to Dr A 6.2.09

In an email to Dr A (Doc 9) the CE states the main staff concerns.

`They are tired of having to lie to carers, patients etc regarding the availability of the overnight doctor. They feel that if other doctors can go out and visit and confirm deaths then why don't you. I have tried to smooth things out but it is now at the stage of most of the staff trying to give up the overnights when you are working. Can we please rectify this situation by (a) you going out when necessary to see patients (b) answering your phone when you are on duty (c) resulting off your calls'. She goes on to say:

`I have received a complaint from the daughter of XX. She rang in at 06.50 and she was then told to ring her own surgery. She says this isn't the way out of hours works. She should know as she works for Thamesdoc. Call handler was very concerned about this patient as you didn't ring back until 7.40 and then you couldn't get through. She did try to pass to Dr D but he told her to contact you, he wasn't dealing with it. I am sorry but this is an enormous risk for the organisation, can we please sort it out before something happens.'

Meeting 3.3.09 (Dr C in attendance)

- Staff requested that all doctors work from base and not from home.
- Concerns were expressed about cancelling shifts on Sat and Sun at last minute which meant problems for workforce being short, patients waiting long times for call backs and face to face.

Meeting 17.3.09

At this meeting the minutes record that:
`The 07.00 home visiting Drs (on Saturdays) are going out 90% of time on home visits from the overnight.' This would be due to the fact that Dr A would be doing the triage from home in Norfolk and would not be able to do any visits.

Feedback to Board

There appears to have been no formal procedure for staff concerns to be communicated to the board. However, many board members would have been well aware of these staff concerns.

10. Overnight clinical records

(Interviews with service manager, IT manager, and CE)

`Unresulted' calls

When all relevant data has been entered on the computer, the call is said to be `completed'. A completed call must contain all the clinical information obtained from both the doctor who phoned the patient, and any Croydoc GP who subsequently saw the patient for this illness episode. An `unresulted' call is one where the doctor has not recorded any clinical information. The call handler would record `enter case details'.

Dr A's unresulted calls

- The IT manager alerted Board members and CE to the large numbers of Dr A's unresulted calls.
- 15.7.08 email from CE to Dr A outlined financial implications for Croydoc (Doc 17). 5.1.09 email CE expressed her concerns about the large numbers (250) of his unresulted calls (Doc 18).
- 13.1.09 IT manager memo to CE and Dr A outlining the financial and clinical impact of unresulted calls (Doc 19).
- 11.2.09 email service manager to Dr A about unresulted calls (Doc 19).
- 2.6.09 email IT manager to board members listing 167 unresulted calls causing a loss of £4000 to Croydoc (Doc 19).
- 23.10.09 IT manager memo to CE and board about 287 of Dr A's unresulted calls and his concerns about impact on patient safety and Croydoc's finances (Doc 20).
- 5.7.10 IT analyst stating that unresulted calls breach all National Quality Requirements (standard 2 on balanced score card) (Doc 21).

- From January until November 2009 there were a total of 339 calls were closed without any clinical information being written or dictated by Dr A. There was no policy for the management of failure to record clinical information, or respond to requests to entering this clinical information later. (Doc 22)

Audit of responses

The outcome of calls passed to doctor A to be triaged remains unknown because no clinical data was recorded. However the types of call designated by call handlers would be recorded. An audit of a sample of Dr A's unresulted calls from 28.6.09 until 20.11.09 (Doc 10) showed that out of 78 unresulted calls, 5 (6%) were urgent and needed a doctor to call back within 20 minutes. This was not often possible because of the difficulty contacted Dr A overnight. 9 calls (11.5%) were emergency (warm) calls where the call should not have been disconnected but passed immediately to the duty doctor. The reason for this appears to be that Dr A was at home. The call handler would have to try to contact Dr A by phone to pass over these `warm' calls and they would be worried when he would not answer his phone.

Outcome

When calls are `unresulted' several things happen.

- Important clinical information is not sent to patient's GP the next day.
- Patients who need urgent follow up will not be reviewed.
- If patient deteriorates, the GP has to make treatment decisions without knowing what medication was given by out of hours doctor.
- Calls cannot be removed from the system until the clinical information is entered.
- Croydoc cannot claim payment for unresulted calls from opted in practices.
- There is no information on the time the doctor called the patient. This is needed to show if triage response is within target times.

GMC Good Medical Practice

2. Good clinical care must include:
   (a) adequately assessing the patients conditions
3. In providing care you must:
   (f) keep clear accurate and legible records.
   (g) make records at the same time as the events you are recording or as soon as possible afterwards.
52. If you provide treatment or advice for a patient, but are not the patient's general practitioner, you should tell the general practitioner the results of the investigations, the treatment provided and any other information necessary for the continuing care of the patient, unless the patient objects.

11. Payment system

11.1 Overnight

Before November 2005

One GP covered Croydon all night 00.00 until 08.00, and one GP covered Sutton and Merton all night. Each was paid for a full nights work at a rate of £63 per hour. There were two doctors visiting overnight.

After November 2005

Instead of having a doctor in each area, it was decided that one doctor would cover both areas at night. Cover went from having two doctors both working all night, to one overnight doctor who was now paid twice as much per hour i.e. £126, although the total hours of work remained the same.

From 2006

In 2006, Croydoc took over Kingston population and the pay system changed again. The night shift of 00.00 till 07.00 or 08.00 weekdays, was now divided into 3 subshifts of 2.6 hours. These 2.6hr subshifts were divided amongst the same group of doctors selected by Dr A. The equivalent rate of pay now increased from £126 per hour to £189 per hour. Instead of having three doctors working a 7 hour night shift for three different districts (total population 950,000) there was now only one doctor at any one time, covering all three districts, but earning £189 per hour. This was equivalent to an income of £1323 for one doctor on call for the whole 7 hour overnight shift. The rota served as the claim procedure i.e. doctors were paid for the session shown on the rota. Doc 23)

Double pay overnight

If a doctor did two 2.6hour overnight shifts i.e. two thirds of the 8 hour overnight shift, they would be paid for two overnight payments.

Payment Decisions

This payment system was devised by Dr A. There is no evidence that this was ever ratified by the board.

11.2 Bank holidays

Doctors were paid time and a half for bank holidays, and double time for Xmas day.

11.3 Overnight double claims

The doctors instituted a system of payment which enabled them to be paid twice for the same overnight rota shift. The finance officer paid what was shown on the rota. This showed two different shifts, one for Croydon and one for Sutton and Merton. Both were done by one GP at the same time. The rota should have shown that one doctor was on duty for that shift regardless of the areas covered. If it had reflected the true situation, the doctor would have been paid for one session only. Most out of hours organisations pay a set rate for a specific period of time regardless of the number of PCTs covered by the service. (see section 11.8). Dr L thought he was paid two fees for

doing two jobs concurrently i.e. working for Croydon as well as for Sutton and Merton (Doc 24).

11.4 Director's fees

Dr A and C received £30,000 as an annual Directors fee. Other Board members received £12,000 a year for their work as directors.

11.5 Financial controls

Before April 2008

Before April 2008 doctors were paid for the sessions of work shown on the rota. There were spot checks on 5 doctors a month where an audit on 50% of shifts would show if activity matched pay claims.

After April 2008

After meeting Dr B in homebase when she was on the rota for Croydoc, the CE and finance officer decided to check the monthly activity of doctors A, B, and D every month. She also did spot checks as outlined above, but on 10 doctors not five. Pay was withheld if there was no evidence of activity. This could not be done for Dr A's overnight work as he did not log on to the computer.

April 08 home triage concerns Dr A, Dr B

In April 2008 CE and finance officer had concerns about home triage by these doctors so she did an audit every 10 days of log on and off times and reduced pay accordingly.

Financial accountability

Financial officer thought CE and Dr A were accountable for the financial probity of the organisation, and not the board as they would not have known what was going on.

Monthly accounts

Financial officer prepared monthly spreadsheets of accounts for CE. CE said these did not show Dr A's withdrawals. CE said she regularly asked Dr A to inform board of withdrawals but he would not allow her to do so herself and said he would inform the board.

Extra hours claims

If a doctor worked extra hours the call handler or receptionist would have to sign the claim at the time, to verify the extra hours had been done on that day.

Signing cheques

Cheques could be authorised if signed by the CE and only one director. The CE said she had tried to get agreement for an additional signature for previous five years but Dr A would not agree to this change.

11.6 Challenging claims

CE instructed the finance officer to check doctors' time sheets. Financial officer felt unable to challenge overnight payments as these related to Directors and she feared she would lose her job. However, she did challenge claims where there was no evidence of work and sent these to the auditors. She also refused to pay claims by doctors shown on the rota to be working at the same time at different sites.

11.7 Morden Rd clinic

Dr B was often on the rota for Morden Rd clinic sessions 8pm until 11pm on Mondays, Wednesdays, and Fridays, and also on Saturday and Sunday evenings. She was expected to see patients and undertake triage but she often failed to turn up for work when on these rotas. Before 2008, checks of pay against activity were not regularly undertaken. She would have been paid for clinic sessions she did not attend unless receptionist informed finance officer that she had not attended. This did not always happen (finance officer interview).

11.8 Xmas overnight 2008

Dr A was on the rota for 00.01 – 07.00 and was paid for this session. There was no evidence of any work done by Dr A during this shift. (Doc 25 and information from finance officer)

11.9 Dr D's overtime claims 2007 - 2008

Claims for extra work unsupported by evidence

There were concerns about the validity of a substantial number of overtime claims submitted by Dr D in monthly batches. They were countersigned by Dr A and amounted to thousands of pounds between April 2007 and March 2008. CE asked finance officer to review some of these claims. This audit showed that for many of these claims, there was no evidence of overtime activity (Doc 26).

- This included a new shift which was not on the normal rotas.
- Total days and claim forms 52
- Each claim form had several different extra hour claims.
- Total overtime hours claimed: hundreds of hours
- Several claims showed no evidence of any clinical activity.
- Finance officer sent these claims to the auditor.
- Dr A suggested that this work was `Director's work'. However Dr D was paid extra for his work as a director, and times of extra work done often included 22.00 to 02.30.
- The finance officer alleged that Dr A told her she had to pay these claims. In the absence of instructions to the contrary from the auditor, she did so.

Normal procedure

The normal procedure for claiming overtime was that the doctor would submit an extra hours claim form which would be signed immediately by the service manager or receptionist, verifying that the work had been done. Everyone did this including other directors. Dr D alleged he was unaware of the normal procedure for validating overtime claims. He therefore submitted all these extra claim forms at the end of each month. The finance officer remained very concerned about the validity of some unverified claims and the failure to follow normal procedures to ensure such claims could be verified at the time.

Audit of Dr D's extra claims 2007 - 2008

In an email to Dr A (Doc 27) the finance officer expressed concerns about extra hour claims by Dr D for a new shift (22.00 – 02.30) which staff knew nothing about. She was concerned about paying doctors for time when they are off site and unavailable. She also noted that for some of these claims, there was no record of triage or consulting or that Dr D had logged on to the computer. The lead investigator undertook an audit of a sample of claims related to this new 22.00 – 02.30 shift.

Method

An audit was done of a sample of claims for extra hours of work done by Dr D between May 2007 and April 2008. During this period, there were claims for base shifts 13.00 – 16.00, 14.00 – 19.00, 22.00 – 02.30. However this audit reviewed evidence of activity related only to claims for the 22.00 – 02.30 shifts. As he was not in the base, his periods of work are between the time he logged on to the computer and the time he logged off it.

Findings

Dates of these claims	4.6.07 – 27.4.08
Type of shift	22.00 – 02.30
Number in sample	43 shifts (22.00 – 02.30)
Shifts with no evidence of activity or that Dr D logged in or out.	25 (58%)
Evidence of activity but log in and log out times do not cover 4.5 hours claimed by Dr D.	18 (41.8%)

Log in log out times

Less than 30 minutes	1
Less than 1 hr	7
1 – 1.5 hrs	5
1.5 – 2 hrs	2
2 – 3 hrs	2
> 3 hrs	1

In the 18 shifts showing evidence of work done by Dr D, he claimed for doing 4.5 hours of work per shift. The evidence shows that for 15 of the 18 shifts where work was done (83%), Dr D logged in for less than 2 hours.

Financial audit

The SUI investigators asked the finance officer to do an audit of the amount of money Dr D was paid when there was no evidence of activity for these Friday to Saturday shifts from 2007 – 08. This showed from April 2007 to March 2008 there was a payment of £10,287 when there was no evidence of activity. From April – October 2008 there was payment of £6301 when there was no evidence of activity. (Doc 28)

Dr A's letter 24.11.08

These claims related to work done by Dr D between April 2007 – March 2008. At no time was there a written agreement from Dr A to

CE or finance officer to clarify the basis of Dr D's extra hours claims. The first explanation from Dr A is provided in his letter to the board and auditor in 24.11.08 (Doc 46). This stated that Dr A agreed with Dr D that payment of 4 hours would be made for being available from 18.30 – 02.00. However, many of extra hour claims made by Dr D included times outside this period e.g. 13.00 – 16.00 and 14.00 – 19.00. The CE and finance officer were not informed of this arrangement and were unaware of a `new shift' 22.00 – 02.30. Dr D was not paid a standby rate and claimed for specific time periods of work when there was no evidence of activity.

Summary
This audit shows that Dr D was paid for many 22.00 – 02.30 shifts where there was no evidence of work done. For shifts where there is evidence of activity, the hours worked were significantly less that the extra hours claimed.

11.10 Croydoc GP incomes

Table 1. Annual Croydoc incomes Dr A, Dr B, Dr D, and Dr E

Doctor	**2006 - 2007**	**2007 - 2008**	**2008 - 2009**	**2009 – 2010**
Dr A	£154,016	£190,598	£207,054	£155,447 April – Nov 09
Dr E	£152,499	£138,141	£108,004	£108,813
Dr D	£110,657	£164,111	£157,602	£152,360
Dr O	£42,977	£107,880	£129,209	£113,621
Dr B	£95,337	£77,275	£64,045	£72,482 April – Nov 09

Most of these doctors were in full time practice and it is surprising that they were able to earn so much money from an out of hours service. Perhaps part of the explanation is that Drs A, D, E, and O all did overnight shifts and obtained a full nights pay for working one third of the shift period. They were also paid double for some overnight shifts. These rates of overnight pay greatly exceeded that paid by other out of hours providers. In July 09 alone, Dr A earned £23,500. At the rate Dr A was being paid in 2009, had he completed the year, his Croydoc income may have exceeded £230,000.

12. Complaints about delays

From January to December 2009, there were 95 complaints, 11% of which related to Dr A as the primary named doctor. These included complaints about delays. This may reflect the fact that Dr A did more triage calls than other doctors. However, there are many complaints from patients about delays in contacting a doctor or obtaining a home

visit. The examples outlined below illustrate system failures that existed and would have affected many patients (Doc 29)

Case 1
A 12 hour delay in visiting a patient who called at 22.57 on 27.12.08 but was not visited until 11.30 on 28.12.08. The patient was treated at home but deteriorated, was admitted to hospital and died that afternoon. The complaint related to the 12 hour delay in visiting this patient. The Croydoc written response to this complainant stated that the service was unable to cope with heavy demands for visits.

Case 2
Call 466 on 27.12.08 received at 22.22, designated urgent. Dr A triaged the call at 23.46 recording that the patient had continuous vomiting, fever, photophobia, pain neck but no stiffness, cannot get up. Dr A advised a home visit for this urgent call but this visit was not completed until 09.56 when an urgent 999 ambulance was called for suspected meningitis. Although this was a significant event it is not known if the cause of the delay was ever investigated.

Case 3
This complaint related to a call to Croydoc on 15.9.09 at 05.42 by a patient known to have cardiac failure. This was passed to duty doctor (Dr A) at 05.57 who phoned patient back within 98 minutes. At 07.41 Dr A instructed the call handler to pass this call back to patient's GP and this was done at 08.47. The Croydoc response to this complaint stated that:

> `I have identified flaws in our systems which include delays in receipt of messages from NHS Direct, and failure of some of our doctors to use the IT systems in place to record accurate details of telephone conversations and timings. I am also concerned that the urgency of your call was not communicated effectively to your surgery. I can assure you that these issues will be discussed at our next clinical governance meeting and that steps will be taken to avoid a recurrence of these problems in the future'.

Case 4
In a complaint received on 14 December 2009 (code SM.09.15 E) the overnight call handler can be heard calling Dr A at 5.58am, 6.34am, and 6.45am asking Dr A to contact the service.

Case 5
Another complaint related to excessive delays in dealing with an urgent call on 27 and 28 December 2009. Diabetic on insulin difficulty breathing and swallowing. Call at 11.12 on 27th Dec, call handler informed patient there would be a delay of 2 hours before doctor could call back. Call handler suggested patient should go to A&E if worse or call again. 15.30 called back and advised to go to A&E by call handler. At A&E she was advised to go to the Powell out of hours Croydoc base, where a doctor finally saw her at 18.20. On 28 December patient called back at 16.27 as she could not swallow fluids. This was clearly an emergency. Patient called again at 20.38 as no doctor had phoned

back. Doctor phoned at 21.16 when she was advised to reattend the Croydoc Powell base. She was seen at 22.32 and admitted immediately to hospital with severe obstruction of the throat (acute epiglottis) In the Croydoc response to this complainant, reasons given for the delays included failure to find doctors to fill shifts and doctors cancelling shifts at short notice.

Case 6
Another complaint related to a delay of 15 hours for a visit from a doctor for a cancer patient who was vomiting continuously. Called Croydoc 14.12 on 24 December 2009. Advised it would take 2 hours for doctor to call back. Patient called again 17.26 as no response from doctor. Told there was a five hour delay in returning calls by doctors. 18.03 doctor phoned patient and suggested home visit but warned to expect a delay of up to 6 hours. Patient called again 23.03 but call handler unable to say when doctor would visit. Visit finally done at 04.53. The response to this complainant also mentioned the failure to be able to fill shifts and cancellations at short notice.

System failures
These complaints illustrate a breakdown of the service and its inability to provide an acceptable safe service at times. The system failures that existed would have affected many patients during this bank holiday period. In the response to the complainant related to Case 5, it is recorded that some complaints would have been prevented had shifts not been cancelled at the last minute.
(Doc 29, case 5)

Failure to respond to complaints
A major concern for staff was that Dr A did not provide a prompt response to enable Croydoc to respond to complaints. From Jan – April 2009 there was no response to 20 requests for Dr A to give statements about the outstanding complaints (Doc 30). The complaint manager put this information in red and sent it to the board. This was included in the CE's report to the board in May 2009. This included failure of Dr A to respond to many requests from January to September 09 to respond to a complaint about failure to visit a patient who had died . The board failed to respond to complaint manager's request for help to deal with Dr A's failure to respond.

13. Significant events

Croydoc had a clear significant event policy and procedure. However the concerns were that many serious incidents were not designated as significant events. There are many examples of incidents which filled the criteria for designation as a significant event but which were not investigated as such. The following are just two examples of serious incidents not designated as significant events. This failure meant that no investigation was done to identify system failures and changes needed to reduce the risk of recurrence.

13.1 2009 Significant event

On 19.2.09 Dr E and Dr A were on the overnight rota. Dr E was thought to be doing the first third of the overnight from 00.00 – 02.30. Dr A was on the rota from 02.30 - -08.00. At 23.09, the call handler phoned Dr E to ask if he was coming in. Dr E can be heard to say he did not think he was on call, that he had drunk too much alcohol and was incapable of doing visits but offered to do triage. This offer was declined. From 23.09 until 23.57 the call handler made 10 phone calls to other doctors including Dr A and other Directors, to find someone to do the 00.00 – 02.30 overnight shift. No doctor was able to help and the call handler can be heard saying the situation was desperate. There were 20 calls waiting for advice, some for over 2 hours. There were also seven patients in the base waiting to be seen (19.2.09 10 voice recordings call handler to various doctors 23.09 - 23.57).

No incident review

Some board members, the CE, service leaders and call handlers were aware of this incident. Yet no-one designated this as a significant event and investigated why this happened. The doctors on the rota for that shift were not questioned about this incident. There was no learning and no evidence of any actions taken to prevent a recurrence.

13.2 Unresulted calls

CE asked IT manager to inform the board about Dr A's unresulted calls. (Doc 19). CE alleged that many times she tried to report this as a significant event, but was prevented from doing so by Dr A. At interview, many board members considered the very large number of unresulted calls relating to Dr A to be a significant event. However no board member reported this as a significant event even though it was recognised to be a serious risk to patient safety.

13.3 Contributory causes

Contributory causes may include the conviction that staff could not investigate incidents involving Dr A or other board members for fear of loosing their jobs or having shifts cut. Even when board members recognised issues related to Dr A were significant untoward incidents they did not report them as such.

14. Patient safety

The way in which the service was organised, and the doctors worked, had serious implications for patient safety which are outlined below.

Availability when on duty

The communication problems staff had in contacting Dr A when on duty were outlined in section 7. These posed serious risks to patients who needed emergency or urgent assessment by the duty doctor.

GMC Good Medical Practice	
3.	In providing care you must:
	(h) be readily accessible when you are on duty.

Home triage
When Dr A triaged calls from home without using his computer he would not have information about any previous recent contact made by the patient with Croydoc. This lack of relevant recent information could have a serious impact on decisions made by an overnight doctor working from home. A report dated 13.4.10, of an investigation into a significant incident (SM.09.03 M) that occurred on 1.1.09, highlights concern that Dr A triaged the call from home without using his computer to access important information about a previous recent contact with Croydoc. Had he had this information his management decisions may have been different (Doc 31).

Continuous hours on call
Over bank holiday Xmas 2007, Easter 2008 and Xmas 2008 Dr D was on the rota for periods of continuous on call work which ranged from 12 to 24 hours. Although he would not have done a full overnight work this still amounted to excessive periods of continuous on call. Croydoc had no set limit to the time one doctor could continue to work. Being on the rota continuously for such long periods would be a cause of concern and have implications for patient safety. (Docs 3, 4, 5).

Overnight cover
Having only one doctor on call at any given time, from 00.00 until 08.00 for 950,000 people cannot be considered safe, and certainly not without any backup or additional cover. Doctors who did these shifts (Dr D, and Dr E) alleged that there was always a first, second and third doctor on call. Second on call would normally mean a named doctor could be called to work if demand was heavy or the doctor on rota did not attend. This is not what Dr D and E meant when they talked about a first, second and third on call for overnight work. They meant that the first doctor on call was the one who did the first third of the overnight shift i.e. 00.00 – 02.30. The second on call doctor did next third, and the third on call did the last shift from 05.30 until 08.00. There was no named doctor staff could ask to help if the duty doctor was delayed, unavailable or overwhelmed.

Response to emergencies
When a doctor did an overnight shift from the base, emergency calls could be passed over immediately to the doctor on call. When Dr A worked from home this could not happen. Serious delays occurred in dealing with emergency (`warm') calls as these could not be passed to the duty doctor without terminating the call. Staff would have to try to phone Dr A which would entail further delay. For some `warm' calls, there was no evidence to show Dr A had actually phoned the patient back (see audit of responses section 10).

No visiting doctor
No doctor was available for overnight visits from 5.30 onwards when Dr A was doing the last third of the overnight shift from home in Norfolk. This resulted in serious delays for patients who needed a home visit.

Late starts
Late starts to shifts always had a knock on effect on the service as there would be a serious delay in responding to calls some of which would have been designated as urgent or emergency calls. The delay in triage caused an inevitable delay in doing any home visits.

Visits passed to Croydoc in surgery opening hours
Dr A was the duty doctor on call in his own practice on Wednesday mornings. His partner Dr H stated that Dr A would pass visits that came in during that morning, to Croydoc. An example given was a visit that came to the surgery at 9.30am but was not visited until 8pm by Croydoc. (Doc interviews with Dr H and practice manager)

Cancellations
Dr A would often cancel one or two hours before his shift was due to start. Failure to find another doctor to do this shift at such short notice was a patient safety concern. Often these shifts could not be filled, with resulting delays in dealing with calls and visits. This had a knock on effect on all targets.

Shifts unfilled
There has been difficulty in filling shifts in Croydoc for many years. This inevitably had an impact on patient safety. It meant that one doctor would have to do the work of two or more, and that serious delays would occur.

No contingency plan
There was no contingency plan if shifts could not be filled or call handlers could not contact the duty overnight doctor.

Referral to A&E
Call handlers had to advise patients to go to A&E. This would affect patient safety as it would inevitably delay assessment by a doctor.

Overnight visit delays
The complaints reviewed on p37 showed the significant impact in terms of prolonged pain and distress caused to patients by system failures that resulted in unacceptable delays.

Passing calls back
Overnight calls often had to be returned to the practices because Dr A could not be contacted.

Staff concerns
Staff concerned that the way the overnight service operated compromised patient safety.

Unresulted calls: risks to patients
The serious risks to patients when no clinical data is recorded are outlined in detail in section 10 p31.

Failure to use laptop
Dr A had a laptop at home which he used when doing triage on Saturday and Sunday during the daytime. However it appears he would not use this when triaging from home at night. His failure to use the computer had a serious impact on patient safety. He never explained to staff why he refused to use his home laptop overnight when he used it during the day on Saturdays and Sundays. He was well aware of the problems this created for patients and call handlers.

Rudeness and patient safety
The instant messages written by Dr A confirm staff allegations about rudeness and intimidation. There is evidence that this does have an impact on patient safety. Many studies have shown that being the victim of rudeness can impair cognitive skills. This was recognised by the Joint Commission (which accredits healthcare organisations in the United States), which issued an alert in 2008 warning that rude language and hostile behaviour among healthcare professionals posed a serious threat to patient safety and the quality of care. (Doc 32).

15. Financial arrangements with patients

Background
On 10.12.09 Dr H and Dr I (Dr A's partners) informed the PCT that two patients who also worked in the practice and someone who had been a temporary patient had financial arrangements with Dr A (Doc 33). At the hearing to consider suspension in December 2009, Dr A declined to answer the question about how many patients he had financial arrangements with. In 2010, the partners were given the list of Dr A's creditors. They were asked to contact any patients on this list and request consent for their names to be given to the lead SUI investigator. In September 2010 the doctors wrote to say that two other patients had been identified but were not willing to be interviewed (Doc 34).

Patient 1 (Interview and statement Doc 35)
This lady had been working in the practice for eight years and had been Dr A's patient for the previous four years. She asked Dr A if he would share the purchase of a house as she did not have enough capital to purchase a house by herself.

- She gave Dr A £110,000 as her share of the house purchase.
- Dr A bought a buy to rent house in his own name.
- Patient 1 thought her name would be added to the deeds but this was never done.
- Dr A pays the mortgage and she pays him £200 per month towards the cost of the mortgage.
- There was no written documentation to indicate shared ownership.
- She did not seek legal advice at the time.
- She was only aware of financial concerns about Dr A when he was suspended by the PCT.

- Dr A asked her to provide written evidence that he owed her £110,000 which she did.

Patient 1 trusted Dr A and believed he did his best to help her and acted in her best interests. She felt he was very charismatic and that she could trust a doctor.

Patient 2 (Interview)
This member of staff had been Dr A's patient for 20 years and worked in his practice for the past eight years. The sequence of events related to her house purchase are outlined below.

- She had a lump sum from sale of a house and wanted to buy a mobile home without a mortgage. Dr A suggested bricks and mortar would be a better option. Because she could not get a mortgage he offered to purchase a property with her. They would each own 50%.
- She wanted a small house with a little garden and told him to go ahead.
- She gave Dr A £49,000 in 2003, and £41,000 in 2005.
- Dr I advised her to seek solicitor's advice at the time.
- A suitable property was purchased by Dr A in 2003.
- Dr A gave her a receipt for the money, but there was nothing in writing about a house purchase.
- She assumed she owned half the property.
- In 2008 she did a bankruptcy search which showed a petition for bankruptcy was filed on 24.11.08. She assumed this related to Dr A's other business interests and took no further action at that time.
- In 2009, after hearing about Dr A's debts, she did an internet search which showed her house was in Dr B's name only (Dr A's wife). There was nothing on the land registry to indicate she owned half the property.
- It showed a charge had been put on the house by the Bank of Ireland for debts incurred by Dr A.
- At end of 2009, she asked Dr A to ensure her name was on the land registry. She said that Dr A said it would be better for him to give her trust document. She did not seek legal advice before signing it.
- She was very worried and asked Dr A to ensure her name was put on the land registry. He told her that a trust document would be better.
- Dr A gave her a `trust' document at end of 2009 which she assumed was alright and signed it without obtaining legal advice.
- She subsequently showed this to a solicitor who said she should have sought advice before signing it. This document said that before she could sell the house, the mortgage and the solicitors had to be paid. In the end there would be no equity left.
- The solicitor advised that a further charge should be put on the property in her name.

- Before Dr A was suspended she expressed her concerns and asked him if she should be worried. He said he would tell her when to worry and reassured her that it will be alright.
- She feels devastated as she may now lose her house.

Patient 2 regarded Dr A as her employer and also looked upon him as a friend. She said as a doctor she trusted him implicitly. The practice manager told Dr A she thought financial involvement with staff was ill advised.

Patient 3

Patient 3 had some money to invest. Patient 2 suggested that he talk to Dr A. She says he gave Dr A £60,000 who agreed to invest this for him. Patient 3 was unwilling to be interviewed but has accepted the loss of his capital. He had been a temporary patient in the practice.

Summary

Patients 1 and 2 had good reasons to trust Dr A. They knew he had business interests outside the practice. He was their employer, and above all, he was their doctor. Legal advice was not sought at the time although this had been suggested, because they believed he would act in their best interests. They trusted him implicitly.

GMC Good Medical Practice

1. Good doctors ….. are honest and trustworthy and act with integrity.
56. Probity means being honest and trustworthy, and acting with integrity: this is at the heart of medical professionalism.
57. You must make sure that your conduct at all times justifies your patients' trust in you and the public's trust in the profession.
65. You must do your best to make sure that any documents you write or sign are not false or misleading.

GMC Good Medical Practice

73. You must be honest in financial and commercial dealings with employers, insurers and other organisations and individuals.
    (b) if you manage finances you must make sure the funds are used for the purpose for which they were intended and are kept in a separate account from your personal finances.

16. Possible concerns about probity

(Interviews CE, finance officer, call handler 2, service leader, information analyst, IT manager, call handlers, administrative co-ordinator, service manager, Dr H, Dr I, audits done by lead investigator)
This investigation has identified probity concerns related to Dr A, Dr B, and Dr D.

16.1 Financial arrangements with patients

Probity concerns related to Dr A's financial arrangements with patients are outlined above (section 15).

16.2 Dr D's overtime claims

There are probity concerns relating to the validity of payments for many of Dr D's extra hours claims for Friday shift 22.00 – 02.30 April 2007 – March 2008 (see section 11.9 p35).

16.3 Overnight triage of unresulted calls by Dr A

From January until November 2009 Dr A was passed 11,423 cases by call handlers. 339 calls were closed without any clinical information recorded or dictated, and Dr A did not record his phone calls to patients. Therefore, there is no evidence he ever phoned these patients back (Doc 22)

16.4 Dr A's unauthorised withdrawals

These unauthorised withdrawals are outlined in the chronology and (docs 36, 37). These raise probity concerns.

16.5 Dr B Morden Rd payments

Before 2008, checks of pay against activity were not regularly undertaken. Dr B was not paid if the clinic was closed. However, she would however have been paid for clinic sessions unless receptionist informed finance officer that she had not attended. Call handlers did not always inform the finance officer when Dr B did not attend, but a review of pay against activity would show how often this happened.

16.6 Dr J activity

The board commissioned an audit of her Croydoc work and a log of activity was done (Doc 38). This showed serious discrepancies between the log on and log off times recorded by Dr J and those recorded by the driver. There were also concerns about her doing personal business when on call (see above). However, these do not appear to have been followed up by the board. Dr J continues to work for Croydoc.

16.7 Personal business when on call

(Interviews with Croydoc staff)

- Evidence from satellite navigation system showed Dr J in the supermarket car park when on duty in the Croydoc car.

- April 2008 finance officer met Dr B in Homebase when she should have been triaging calls.
- Dr A going to see solicitor when on duty, and using driver to take and collect children from school and from martial arts classes in 2008 and 2009.
- When this happened on Saturday mornings staff would have to delay home visits to allow for this personal work. This was not considered appropriate.
- Dr B seeing carpet salesman and interior designer during Croydoc base sessions.
- Dr B doing shopping during her Saturday morning shift.
- Dr B brought her youngest daughter with her on three occasions and expected receptionist to look after her.

16.8 Log in for doctors

CE said she informed the board that staff logged in for Dr A before he started to work but board took no action. This was also a concern in relation to Dr J.

16.9 Alteration of data

Alteration of balanced score card

Information is routinely collected to indicate if calls categorised as routine (Dr call back within 1 hour) , urgent (Dr call back within 20 minutes) or emergency (call immediately passed to Dr) were handled within these specified time periods.

A member of staff alleged that in April and May 2008, the CE asked him to alter the statistics related to the balanced score card targets. The number of calls answered within a minute was in the red, and CE asked him to put them in amber for two months. This request was witnessed by a member of staff (staff statement). The member of staff expressed his concerns about doing this to the service leader and also in a statement written at the time (Doc 39). CE denied ever asking staff to alter the balanced score card data.

The member of staff stated that the CE asked him to change the data more than once which he did `because she was the boss'. This would be data for all PCTs not just Croydon.

Unresulted calls removed

These were calls where no clinical information was recorded by the doctor. Croydoc could not obtain payment from practices for the very high number of unresulted calls until they were removed from the system. Staff believed that the only way this could be done was to entered fictitious times for when triage calls started and ended. Nearly all these unresulted calls related to Dr A but there was no evidence that he ever called these patients (triaged these calls). Staff alleged that CE instructed them to enter fictitious triage times that were within the targets. The CE denies this claim. In this way, over 300 unresulted

calls were removed from the system in 2009 (Docs 40). This averted a financial loss of several thousand pounds. The evidence that these times were invalid is shown by audit trails showing staff had entered these triage dates months after the calls were sent to Dr A by the call handler.

Unresulted calls: failure to inform PCT

At the bimonthly clinical governance and the quarterly contract meetings, the balanced score card targets were reviewed by PCT and Croydoc clinical and management staff. However Croydoc staff never informed the PCT about the problem of unresulted calls. Had they done so, the PCT could have helped to monitor and resolve this issue much earlier.

Data submitted to PCT

The huge number of Dr A's unresulted calls, if included in the statistics, would have a negative effect on the quality (balanced score card) targets. IT manager alleged that CE instructed IT analyst to omit breaches of overnight call targets from statistics. (Doc 21).

16.10 Lying to patients

Many staff expressed concerns about having to lie to patients when Dr A was unavailable. This would have to be done when these doctors were late starting shifts, failed to attend, or cancelled on the day. Email CE to Dr A 6.2.09 re having to lie to patients about availability of overnight doctor and failure to answer call handler's phone calls (Doc 9) One call handler commented `You feel awful lying but obviously you can't turn round and say I think the doctor is in bed asleep and I can't wake him up.' When Dr A would not attend the MIC rota shifts, staff would have to lie to patients saying the doctor had to confirm a death.

16.11 Mitigating circumstances

The IT analyst expressed his concerns about altering target data to other Croydoc staff at the time and wrote a statement about his reservations. It is also noted that staff believed the only way to remove the unresulted calls was to enter fictitious times of triage. They did not see any other way in which these calls could be removed from the system and submitted for payment. Staff felt that if they did not agree to falsifying the data, they would lose their jobs.

16.12 Summary

There are probity concerns that relate to Drs A, B, D. In addition, other concerns exist about the behaviour of the CE. The probity concerns are summarised below.

- Dr A's financial arrangements with patients.
- Dr A's unauthorised withdrawal of money from Croydoc.
- Auditor email to Dr G 24.9.09 about Dr A failing to inform the Board about unauthorised loans when he said he had done so, and they

were happy with the arrangements. However he had not done this (Doc 41).
- Doctors doing a 2.6 hour overnight shift paid for full overnight work.
- Doctors paid without evidence of activity.
- Doctors earning excessively high incomes from Croydoc.
- Doctors doing personal business when on call (Dr A, Dr B, Dr J)
- Alteration of target data on balanced score cards.
- Entering fictitious times of triage on unresulted calls.
- Failure to inform PCT about unresulted calls (CE).
- Having to lie to patients when duty doctor could not be contacted.
- There is no evidence that Dr A ever triaged the `unresulted' calls.

These issues were not followed up by the board.

17. Board issues

(Interviews with all board members except Dr A, CE, Croydoc staff and board minutes (Doc 42).

Board members

The following GPs were board members: Drs A, C, D, E, F, G, P.
Dr A was also the chair of the Board, director of operations, director of finance, and medical director. He left the Board in November 2009 but prior to this, most of these GPs had been on the board for some years. The way in which the board functioned was affected by many factors.

Individual

- Board members did not think there was a risk to the organisation when one person has so many roles and so much control.
- Board members focused on their own individual interests e.g. audit, education. They did not consider the effectiveness and safety of the service as a whole.
- They all had different perceptions of accountability and some board members thought they were accountable to Dr A as the chair.
- Individuals did not consider potential conflicts of interest between the organisation and individual board members.
- Board members had implicit trust in Dr A.
- Board members assumed the organisation ran smoothly and did not have concerns.

Organisation

- The board never ratified any job descriptions for its members who were unclear about their roles and responsibilities.
- There was no conflict of interest policy.

Education

- Only those board members who did overnight shifts understood how these rotas worked (Dr A, Dr D, Dr E). This information was not shared with the rest of the board members (Dr C, Dr G, Dr F).

- All board members interviewed said they had not read the PCT / Croydoc contract (Doc 43) so did not know what the clinical governance requirements were.

Tasks

- Dr A invited a GP to join the board (Dr E) without following an appropriate election procedure.

Roles and responsibilities

- They did not accept a corporate responsibility because `Dr A ran the show'.
- Prior to November 09, they did not know where the responsibilities of board members were recorded.
- Dr A was the chairman and also the financial and operational director. He took the lead in all major decisions. Board members had no concerns about one person having so many different roles and responsibilities and did not consider this was a risk to the organisation.
- Members thought the clinical governance group and not the board, was responsible for monitoring targets.
- Board members did not support staff when they tried to implement actions agreed by the board.
- Staff felt it was very difficult to get the board to make any decisions.
- The board failed to take sufficient responsibility for dealing with many of the above concerns.

Board Communication

Communication with CE (chief executive)

- The communication between the chief executive and board members was poor.
- CE did not feel the board would support her if she said Dr A's behaviour was intimidating and unacceptable.
- The perceived lack of support meant, for example, that the CE felt unable to share the information showing Dr A had made withdrawals.
- CE felt unable to inform board of her concerns about Dr A because of fear of retribution and job loss.
- CE did not inform board that bank's concerns about Dr A being a director was given as a reason for closure of the Croydoc account.

With croydoc staff

Several board members said they were unaware of the problems staff had trying to communicate with Dr A.

With each other

Some members knew of staff concerns about Dr A but did not share this information with other members.

With operations group

There was poor communication between board members and this group. The doctors on this group rarely attended so were unaware of

staff problems and did not contribute to ways of improving the efficiency and safety of the service.

Patient safety

- In Jan 09, board members were alerted to concerns about large number of unresulted calls and that this represented a risk to patient safety. They had little awareness of this problem or the risk it posed to patients and did not follow-up outcomes.
- Although a November 2009 report to the board recorded that patients were at risk when doctor on rota fails to turn up or cancels at short notice, most thought the overnight rota did not pose a risk to patients.

Governance

The board was responsible for ensuring the service was safe and effective. Concerns related to its governance roles are outlined below.

18. Governance

18.1 Governance procedures

Governance is about ensuring the service is safe, accessible and effective. Croydoc had many ways to monitor the quality and safety of the service it provided to patients.

Croydoc clinical governance group

This group was responsible for identifying and dealing with clinical care and patient safety issues. Many board members and Croydoc senior staff were on this group and it was accountable to the board.

Bimonthly clinical governance meetings

Meetings were held every two months at which PCT managers from all three PCTs were invited, as well as Croydoc directors and GPs. At these meetings anonymised complaints and significant events brought to their attention by Croydoc, would be reviewed to facilitate shared learning.

PCT contract (Doc 43)

The contract that Croydon PCT had with Croydoc clearly stipulated what information Croydoc was expected to provide to assure the PCT about the safety and effectiveness of this service. The contracts Sutton and Merton PCT and Kingston PCT had with Croydoc were not reviewed as part of this investigation.

Balanced score cards

Information is routinely collected to identify if calls categorised as routine (Dr call back within 1 hour) , urgent (Dr call back within 20 minutes) or emergency (call immediately passed to Dr) were handled within these target times. This information is entered onto the

`balanced score card'. This enabled Croydoc and the PCTs to know whether or not these target response times were met.

Quarterly contract meetings
These were meetings held by the PCT contract manager and Croydoc staff. The aims were to monitor the service as outlined in the contract. The balanced score card provided information about call response times. These targets were reviewed and the PCT expected to be informed of any issues that affected the safety of the service.

GP audits
Croydoc has a well established and effective system for monitoring the quality of all GPs written clinic records of triage phone calls and patient consultations. It did not monitor complaints, significant events, unresulted calls or communication problems related to individual doctors.

Staff concerns
All out of hours organisations depend upon staff alerting relevant individuals to anything that puts patients at risk and may affect the safety of the service.

Complaint procedures
There was a complaint procedure which outlined how complaints were reviewed, and a specific time time period for providing a response.

Significant events
A significant event is any incident which resulted in a serious outcome for a patient or a `near miss' where serious harm could have occurred. A significant event procedure was in place and staff and doctors knew how to use it. All significant events would require an internal investigation and a report should be produced for review by the board.

Board accountability
Croydoc board members were accountable for the safety and quality of this service.

18.2 Safe governance

To monitor the safety and effectiveness of the service several things need to be in place. These include:

- Having clear policies.
- Having written procedures which are effectively implemented.
- Ensuring data is comprehensive, relevant and accurate.
- Analysing and presenting information in ways that facilitate understanding.
- Taking appropriate action to deal with organisational issues that impair efficiency and safety or represent a risk to patients.
- Ensuring no conflict of interest exists when board members make policy decisions.

18.3 Board accountability

Board members were accountable for the safety of the service. The clinical governance group were accountable to the board. Concerns about how the board discharged its governance responsibilities are outlined below.

- Board members had not read the service contract and knew nothing about what governance arrangements were stipulated.
- There was no conflict of interest policy. However a conflict of interest may exist when decisions about changes needed to make the service safer were being made by doctors whose income might be adversely affected. Staff experienced great resistance to bringing in the Rotamaster system used by other OOH services. This would have allowed remote rota booking by doctors but would have removed Dr A's control over the lucrative overnight rotas.
- The board was responsible for reviewing the outcome of audits it requested staff to undertake to investigate its specific concerns. However, it did not review the results at subsequent board meetings. Examples of audits commissioned by the Board to deal with specific issues included audits of
    - calls handed back to GPs after overnight shift.
    - complaints and significant events by type and individual doctor.
    - doctors' shift patterns and working hours
    - Dr J's working patterns.
    - ongoing routine reviews of complaints performance statistics and clinical incidents for all doctors

  There is evidence that a number of these audits were not done, and those that were done were not reviewed again by the board. Therefore relevant actions needed to address concerns were not identified.
- Board members were unaware of complaints about delays or failures to contact a doctor within an acceptable time and impact this had on patients.
- Some board members did not feel responsible for using the balanced score card system for monitoring targets.
- The board failed to adequately deal with organisational failures related to patient safety e.g. failure to respond to warm calls within the target times, failure to deal with unresulted calls, difficulty contacting the overnight doctor, unfilled rotas, late cancellations and failure to respond to complaints.
- Board members said they were unaware of serious staff concerns about doctors arriving late or not at all for shifts, passing calls to surgery at end of shifts, using cars for personal use, staff concerns about rudeness and intimidation by doctors.
- Dr F knew staff could not contact Dr A in transit from London to Norfolk when on duty, and he was unavailable for periods during his shifts. He recognised this would affect patient safety but did not report it as a significant event or discussed these issues with Dr A.

- Board were concerned about Dr J doing personal business when on call (Sept 09 board minutes). Dr A said he would deal with this but did not do so.
- Board did not respond to complaint manager's plea for help to try to get Dr A to respond to patient complaints about his care.
- Board members who did not do overnight work did not know there was only one doctor on call at any one time for the whole population.
- Clinical governance group did not inform board members of concerns about the safety of the service. It did not provide the board with an annual audit of complaints and significant events by type and by doctor.

Summary
The board failed in its governance responsibilities. It knew about serious concerns about the safety of the service but failed to take appropriate or adequate action. The reasons for this will be reviewed under fundamental causes.

18.4 PCT monitoring

Healthskills review of Croydoc 2005
In 2005, Croydon PCT together with Sutton and Merton PCT commissioned an external review of Croydoc by Healthskills organisation. Its recommendations included an overhaul of night services to provide cover and visible management, as well as a restructuring of the organisation. (Doc 45). There is no evidence to show that the PCTs reviewed these recommendations.

Procedure
The contract was monitored through bimonthly meetings to review complaints and significant events, and quarterly contract monitoring meetings to review balanced score card targets.

Contract specifications
The contract stipulates that

- Croydoc should have an annual audit plan agreed with the PCT. No audit plan was ever agreed or produced.
- PCT should audit record keeping to review quality of records.
- Croydoc should produce an annual return to include activity levels, quality standards, summary of complaints, and annual accounts.
- 100% of urgent calls should be clinically assessed immediately on same phone call.
- All outcomes should be stored electronically.
- GPs were to be informed by 8am about patients who contacted the service overnight.
- PCT to monitor ability of service to respond to fluctuations in demand.

Monitoring

- Balanced score card data showed response times to three categories of calls and was reviewed monthly by the PCT.
- The PCT did not review any audit of record keeping, or request an annual return, or assess the effectiveness of overnight communication with practices.
- The ability of the service to respond to fluctuations in demand was not formally monitored.
- There was no monitoring of the safety of the rotas.
- The PCT were unaware that Dr A did not record any of his overnight triage calls to patients.
- PCT did not monitor the transfer of data about overnight calls to GPs by 8am. If this had been done, it may have found out about the problem of unresulted calls.

Summary

The PCT contract managers did not know:

- that Dr A had sole responsibility for organising overnight rotas.
- about the failure to fill so many shifts.
- that there were significant gaps in service provision.
- that overnight, there was only one doctor on duty at any one time for a population of 950,000.

Croydon PCT could have had more robust systems in place for monitoring the contractual arrangements with Croydoc.
Croydon PCT has monitored the rotas since July 2010. It is important that following reorganisation and restructuring, the responsible commissioning body continues to monitor the contract effectively to ensure Croydoc, now Patient Care 24, is providing a safe service.

19. Contributory causes

The root cause analysis was done to identify the contributory causes related to the way Croydoc was managed prior to 2010.

19.1 Croydoc

Individual

- In his roles as chair, operations director, medical director, and finance director Dr A had a central role in running Croydoc.
- Dr A had control of how rotas operated, who was allocated specific shifts, rates of pay and level of overnight cover.
- Dr A was perceived by staff to have an intimidating manner which prevented any constructive challenge to his management decisions.

Roles and responsibility

- Board members were not clear to whom they were accountable.
- Some board members and staff felt they were accountable to Dr A.
- Dr A did not appear to be accountable to anyone.

- Board members did not understand their roles and responsibilities and had no job description or training and were content to let Dr A assume responsibility for the service.
- Croydoc was organised to meet the demands of the doctors rather than the needs of patients.
- Management team were not sufficiently empowered to manage the service.
- All members of the board were GPs, with no non-executive directors to challenge them or to whom staff could appeal. The chief executive reported to the board but was not a member of it.
- Corporate risk in that only one person appeared to understood finance of the organisation and could pay invoices and people.
- There is ample evidence that staff made many suggestions over the years about changes needed to improve the safety and efficiency of the service. These were never effectively implemented by the board.

Tasks
There were examples of policies and procedures in place which were either inadequate or not followed.

Patient safety
There is evidence that the way the service operated overnight increased risks to patients.

Organisation
There was a lack of many basic policies and procedures, some of which are outlined below.

- No policy for bullying or harassment or whistleblowing.
- No policy on how long a doctor should work continuously on rotas.
- No policy for dealing with late shift cancellations (mainly by Dr A).
- No annual audit plan submitted to the PCT as stipulated in contract.
- No systematic staff appraisal policy or procedure in place.
- No procedure to ensure all calls are triaged by doctor before being handed back to own GP.
- No conflict of interest policy until after November 2009.
- CE provided draft job descriptions but only one doctor commented and these were never ratified by the board.
- No policy for board members to declare business interests with each other.
- Unsafe financial arrangements for signing checks, only one Director and CE signatures needed.
- No policy on how to deal with Director requests for advances.
- No contingency plans to meet high demand, failure to contact duty doctor, or deal with late cancellations or if driver unable to work.
- No procedure for dealing with doctors who often cancelled shifts.

Working conditions
Intimidating behaviour had a serious adverse effect on working conditions for staff and caused considerable increase in levels of stress.

Croydoc Governance
Unacceptably weak governance procedures existed. Board members did not act or seek external advice when appropriate.

19.2 PCT monitoring

The PCT commissioned review of Croydoc in 2005 (Doc 45) made many wide ranging recommendations about all aspects of the service. These included overhaul of night services to provide cover and visible management. The PCT does not appear to have taken any follow-up actions in relation to the recommendations in this report.

The PCT monitored times of responses to calls, and reviewed complaints and significant events. It did not monitor the safety of the rotas until after this incident had occurred. Soon after this investigation started, the investigators identified serious concerns staff had about unfilled rotas. From July 2010 the PCT monitored the adequacy of the rotas. However the PCT has not undertaken a review of the safety of this service following its reorganisation and restructuring 2009 - 2011.

19.3 Croydoc auditors

In 2008, the CE and finance officer alerted the Croydoc Auditors to concerns she had about the validity of extra hour claims submitted by Dr D. In a letter to Dr A 4.12.08 (Doc 44) the auditor stated there was a duty to report any variation in procedures to the Board who were responsible for taking appropriate action. The auditor stated that `testing may highlight areas which are not consistent with our expectations of accounts'. In August the auditor wrote to the directors about the need for further information. However, there was no formal response from the board. The finance officer was not informed of the outcome of the auditor's correspondence and Dr A demanded that these payments were made. In late 2009 when action was taken about Dr A's unauthorised withdrawals, the finance officer asked the auditors if she should revisit Dr D's unsubstantiated claims for 2007 – 2008. She said the auditor told her to let things lie. It is not known why a further review of Dr D's claims was not recommended at that time.

19.4 Financial arrangements with patients

Patients entered into financial arrangements with Dr A because they had implicit trust in him, as their doctor as well as employer. Therefore they believed he would act in their best interests rather than his own.

20. Fundamental causes

The fundamental causes that relate to the way in which Croydoc was managed are outlined below.

20.1 Croydoc

- Individual board members lacked an understanding of their corporate responsibility for the safety of the service. They delegated overall management responsibility to Dr A without recognising that they were responsible for holding him to account.
- The organisation had a board composed only of GPs. The presence of non-executive directors might have provided a more robust system for challenging decisions and taking appropriate actions.
- Potential conflicts of interest were not recognised or dealt with adequately.
- A number of the board members appeared to lack the knowledge needed to effectively run a multimillion pound out of hours business. Furthermore, they were not fully aware of the governance arrangements needed to run such an enterprise.
- Croydoc lacked essential policies and procedures needed to ensure the service was safe and appropriate governance arrangements were in place. The failure to implement many existing policies and procedures had an adverse impact on the safety and efficiency of the service.
- Dr A's behaviour was a cause of much stress and distress to staff and patients, and had a serious impact on the safety and efficiency of the service.

20.2 Croydon PCT

The fundamental causes related to Croydon PCT are:

- It failed to monitor the safety of rotas or review the adequacy of overnight cover.
- It did not ensure the governance arrangements stipulated in the contract were implemented by Croydoc.

20.3 Patients

The fundamental reason why patients entered into financial arrangements with Dr A was that they believed that as their doctor, they trusted him implicitly to act in their best interests. However Dr A was responsible for ensuring a clear separation existed between his roles as doctor and financial advisor.

21. Learning

All people interviewed were asked what they had learnt from this incident. They made the following comments.

- Absolute power enables systems to be breached.
- Need for checks and balances in the system.
- Not to be reliant upon one individual.
- More accountability to include appointment of non-executive directors.
- Better management and clinical governance.
- Priority to meet needs of patients rather than those of GPs.
- More equitable GP payments.
- Changing skill mix.
- Need for new policies and procedures.
- Better feedback to board.
- Need to engage with patients and commissioners.
- Better clinical and financial management.
- Better communication system.
- Clearer strategy for financial dealings to be agreed by board.
- Cheques to be signed by more than one director.
- Better understanding of responsibilities of being a board member.
- When Board members asked about a problem, avoid cover-up.
- Stop one doctor having absolute control over shift allocation.
- To much potential for conflict of interest.
- Don't keep quiet, don't let things lie.
- If uncomfortable at the beginning stop it then.
- Have stronger line management.
- Have a financial director who cannot be coerced by other directors.
- Change structure of the company.
- Board needs to be strong enough to make decisions, challenge doctors and support staff.
- Needs non-executive directors.
- Staff need to be praised when something is done well.
- Clearer channels of communication.
- Board needs to be more involved.
- GPs did not have the skills needed to run a multimillion pound business.

Summary

It is clear that long before this report has been produced, the staff and doctors had learnt many things and made many suggestions to strengthen the management and organisation of Croydoc.

22. Organisational changes

Croydoc's organisational structure, policies and procedures have changed since November 2009. Dr A and Dr B have been removed from the organisation and a new Social Enterprise company Patient Care 24 has been created. It has independent non-executive directors, and patient and community involvement. It has a new organisational structure, and new policies, procedures, and governance arrangements. Detailed changes are listed below:

- Interim management in place.
- May 2010 Interim Chief Executive appointed.
- Financial reorganisation and new procedures.
- Board more strategic rather than operational.
- No Croydoc board members are on the Patient Care 24 board.
- More GPs on rota, two doctors on call overnight
- Interim chief executive allowed to manage and have accountability.
- Staff more content.
- Rotamaster electronic system introduced.
- Moved to social enterprise.
- More business-like organisation.
- Governance procedures have been reviewed and strengthened.
- Now compliant with all quality requirements.
- Doctors were challenged over organisational issues.
- Conflict of interest and whistle blowing policies are now in place.
- Lay non-executive directors have been appointed.
- Management team empowered to make decisions.
- Job description has been produced for CE.
- Management structure changed.
- Business plan produced.
- Shifts now allocated to match capacity to demand.
- System of payment changed to ensure doctors in Kingston and Sutton and Merton now earn the same as doctors in Croydon.
- Same rate of pay regardless of the type of work done.
- Overnight double pay stopped.
- Standby doctors available to cover cancellations and extra demand.
- Saving £200K on clinical cover and ensuring shifts are filled.
- By end of June 2010 Croydoc had achieved all its quality targets.
- From July 2010 until November 2010 interim Board appointed.
- Oct 2010 Another interim Chief Executive appointed
- From November 2010 until present time, new Board. Croydoc is now a Community Benefit Society renamed as Patient Care 24.

23. Recommendations

23.1 Croydoc

Fundamental causes

- Individual board members lacked an understanding of their corporate responsibility for the safety of the service. They delegated overall management responsibility to Dr A without recognising that they were responsible for holding him to account.
- The organisation had a board composed only of GPs. The presence of non-executive directors might have provided a more robust system for challenging decisions and taking appropriate actions.
- Potential conflicts of interest were not recognised or dealt with adequately.
- A number of the board members appeared to lack the knowledge needed to effectively run a multimillion pound out of hours business. Furthermore, they were not fully aware of the governance arrangements needed to run such an enterprise.
- Croydoc lacked essential policies and procedures needed to ensure the service was safe and appropriate governance arrangements were in place. The failure to implement many existing policies and procedures had an adverse impact on the safety and efficiency of the service.
- Dr A's behaviour was a cause of much stress and distress to staff and patients, and had a serious impact on the safety and efficiency of the service.

Recommendations	Priority	Outcome	Date of completion
All board members have job descriptions and have had training to understand their own roles and responsibilities, and those of all other staff and clinicians working in the organisation, and can demonstrate competencies needed in their role on the board.	High	Board members can demonstrate an understanding of everyone's roles and responsibilities, and have acquired the relevant competencies needed by board members. Targeted at management team & board	May 2011
• Patient Care 24 (previously called Croydoc) to demonstrate the implementation of up to date, comprehensive policies and procedures related to: governance, conflict of interest, appraisal, bullying, unresulted calls, target failures, whistleblowing, late shift cancellations, contingency planning for high demand or emergencies, financial management, rates of pay, directors requesting advances, management of performance concerns, patient participation, equality and diversity. • Patient Care 24 considers what actions may be needed to address issues raised in this report related to individual doctors.	High	All policies and procedures are available, up to date, comprehensive, and staff trained to use them. Targeted at management team	April 2011

Recommendations	Priority	Outcome	Date of completion
• Patient Care 24 to fund an external review of its service to ensure safe policies and procedures are implemented and the service is now safe, efficient and acceptable to patients. This report could help to identify its terms of reference, see appendix. • South West London Cluster to ratify the Terms of Reference, approve who will do this review, agree its procedures and receive the full report.	Urgent	Outcome will provide evidence that this new organisation is fit for purpose. Targeted at Chief Executive	May 2011
Patient Care 24 undertakes an indepth review of all claims where verification concerns exist e.g. all extra hour claims by Dr D April 07 – March 08, claims made by Dr A and E for Tuesday and Thursday overnight rotas, and Dr B's Morden Rd work prior to 2008.	Medium	Outcome could be recovery of payments for invalid claims. Finance officer Best person to do this but would need time and support.	Aug 2011
Patient Care 24 and its auditors to review procedures followed when alerted to concerns about validity of payment claims by finance officer.	Medium	Outcome: a written procedure for board to follow to deal with concerns about verification of claims. Targeted at chief executive, finance officer and auditor	June 2011

23.2 New Commissioning Organisation

Recommendations	Priority	Outcome
Commissioners to identify: • appropriate service level specifications needed to commission, monitor and evaluate an out of hours service. • Evidence needed to ensure recommendations in report are implemented. • to consider what actions are needed to address the issues related to individuals or to contracts. The appendix outlines an approach which may be useful.	High	A document that can be used by new commissioning organisations to tender for and evaluate out of hour services.

23.3 Dr A

Dr A declined offers to be interviewed and the team felt it could not make any recommendations for him. He is still suspended by the GMC and the GMC has asked for this report. It will be up to the regulator to decide if further actions or recommendations are needed in relation to any of the issues raised in this report.

24. Conclusions

It is unusual to find an out of hours organisation, which was so controlled by one doctor who took the roles of chair, operations director, finance director and medical director. Dr A was able to control many aspects of the service without being effectively held to account.

It is worth noting that although a number of concerns have been raised relating to the way Croydoc was run, over 60 GPs worked for Croydoc and most worked hard to provide a good service for patients.

All the Croydoc call handlers, many of whom have worked there for years, have shown enormous commitment to patients and loyalty to the organisation. They have tried at all times to ensure patients received appropriate responses from doctors and worked under extremely stressful conditions which many found intolerable. These front line staff, past and present, deserve praise and respect for their unwavering dedication to patients.

Many of the staff have made recommendations to the CE, board members about changes needed to address what they identified as serious failures that they felt put patients at risk. These people include the service, operation, IT, complaint, rota and coordinator managers, and the IT data analyst and drivers.

The CE and finance officer worked in a very difficult environment. There were concerns that doctors appeared to have been paid when there was no evidence of activity, and a payment system was introduced that tried to ensure pay correlated with evidence of work done. The auditors were alerted to concerns about the validity of some claims on three separate occasions in 2008 and 2009. Inappropriate and unvalidated claims were challenged and auditors informed about unauthorised withdrawals of money from Croydoc.

Although the chief executive (CE) denied she had instructed staff to alter data, a number of staff said she asked them to do this. The CE did not inform the board of the unauthorised withdrawals of money by Dr A. However, it has to be remembered that she worked very hard for Croydoc from 1995 – 2009 under very stressful circumstances. She felt intimidated and bullied by Dr A and unsupported by the board. There are many examples in this report, of her attempts at damage limitation in dealing with Dr A's conduct. She also worked with the finance officer to try to reduce the withdrawal of money by Dr A. There

is ample evidence that she tried very hard over many years to challenge Dr A about his behaviour and to indicate what effect this had on patients and staff. This is noteworthy as this investigation could not find any examples of board members ever challenging Dr A.

Final accountability for ensuring the safety of this service rested with the board. Board members were aware of the effect Dr A's behaviour had on patients, staff and the effectiveness of the service, but did not challenge Dr A or seek external advice. Conflict of interests were not recognised by the board. However in most respects the members of the board were untrained for this role. They expected Dr A to take full responsibility for Croydoc as an organisation. They did not accept that they were also accountable for the safety and effectiveness of a multimillion pound organisation providing out of hours care for a population of 950,000.

It is hoped that Patient Care 24 can demonstrate that it is providing a safe, acceptable and efficient service for the population it serves. The investigating team would like to share the learning from this investigation with the many new commissioning bodies. With the expected abolition of strategic health authorities and PCTs, it is not clear how shared learning from such significant incidents can be achieved. A new system for shared learning from such incidents will need to be developed.

APPENDIX

Commissioning / evaluating an out of hours service

We hope to share learning from this investigation with new commissioning organisations. To enable commissioners to identify appropriate service level specifications, or to evaluate an out of hours service, they need to know what questions to ask. Some relevant ones are shown in the box below.

- Does its structure include non executive directors and patient participation?
- Does it have appropriate policies, procedures? (check list)
- How does it provide assurance that its rota cover is safe at all times?
- Can it demonstrate effective implementation?
- How are staff trained and how is competence assessed?
- Are appraisals done on all staff regularly?
- What training exists to update staff and help them acquire new skills?
- What audits are done regularly to assess the competence of doctors and nurses?
- What employment procedures are followed for employing doctors and staff?
- How is GMC registration reviewed?
- What arrangements exist to share information about performance concerns of a doctor?
- What procedures exist for informing others when a doctor is suspended?
- Are effective governance arrangements in place to monitor quality and effectiveness?
- What are the financial governance arrangements?
- How does the organisation assess the quality of its service?
- Are there clear lines of accountability?
- How can staff express concerns?
- How are significant incidents identified and managed?
- What contingency plans exist for emergencies and extra demands?
- What information is needed to demonstrate quality and effectiveness and how will this be presented and with whom will it be shared?
- If financial cuts have to be made, will patients share `rationing' decisions?
- What arrangements exist for shared learning for all staff and doctors?
- Is there a commissioner presence at board meetings and for sharing minutes?