

NCAS CASEWORK

The first eight years

September 2009

Acknowledgements

NCAS is grateful to the many managers and practitioners in the NHS who provided the information which made this publication possible. The NHS Information Centre's help is also gratefully acknowledged. The Centre provided detailed breakdowns of published workforce data which allowed deeper analysis and comparison with NCAS data than in previous work. Specifically, we were given permission to publish table 2.2 about the ethnicity and place of qualification of specialty groups outside general practice.

Within NCAS, thanks go to the advisers and caseworkers who collected the data, to Greg Phillpotts, consultant statistician, and to the project's Editorial Board – Peter Old (Chair), Diane Berrow, Janine Brooks, Rosemary Field, Christine Hopton, Claire McLaughlan, Umesh Prabhu, Diana Scarrott and Ian Stone.

Introduction

The National Clinical Assessment Service (NCAS) was set up in 2001 to help the NHS deal better with concerns about the performance of doctors. Services were extended to dentists in 2003. This report presents statistics about NCAS' work, cases and case concerns in ways that we hope will help the NHS to ask new questions about performance concerns and find new ways to reduce their incidence. Where concerns are reported more commonly, why might this be happening and what could be done to help the practitioners concerned stay out of difficulty? If reported concerns are uncommon in a particular group what might be the reason and could other groups learn from it? These are statistics with a practical purpose.

This report addresses one of our Directions, sharing learning from NCAS referrals and casework over the eight years 2001/02 to 2008/09. It follows up an earlier publication describing the first four years' referralsⁱ. Since then, the accumulated total of referrals has close to trebled, allowing more detailed analysis without risk to the confidentiality of case information. This report is intended as a reference resource for now and into the future and presents information in accordance with NCAS' external release policy². The report sits alongside operational information³ and NCAS' evaluation and research reports⁴. Services for pharmacists did not start until April 2009 so they are outside the scope of the report.

Some of the patterns identified here, for example the apparently lower incidence of concerns amongst women, were signposted in NCAS' earlier report. We have now firmed up some of our earlier findings and revised others. There is some important new work on the interaction between ethnicity and place of qualification in the reporting of concerns about practitioners. In his 2007 Annual Reportⁱⁱ, the Chief Medical Officer for England said that while much progress has been made towards achieving racial equality in medicine, there are still areas for concern. NCAS is in a strong position to observe whether there are differences in referral patterns and in the use of suspension or exclusion procedures.

Sharing such a large volume of information is not straightforward. The data presented here constitute 'official statistics'ⁱⁱⁱ and need to be published by NCAS itself. Our first aim has been to make wide-ranging data available as a research resource, with limited commentary. Presenting the data in a single report allows us to make linkages between different areas of work; for example, the relatively low rate of assessment for psychiatrists and their relatively high experience of exclusion. We have applied as much rigour to this publication as to our others, taking external advice on statistical methods and the presentation of conclusions but analysing the data ourselves in order to protect its confidentiality.

There is still scope for more detailed research reports in due course. We hope that our report will stimulate debate and we particularly invite discussion on the conclusions and emerging questions summarised in chapter 7. Above all, we hope that discussion and feedback will help NCAS to improve its services and its effectiveness in safeguarding patient safety and ensuring public protection.

We take this opportunity to acknowledge and thank in particular Diana Scarrott who steered our information collection and analysis over most of these eight years and prepared it for this report; and Greg Phillpotts who provided statistical advice and support.



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ⁱ NCAS *Analysis of the First Four Years Referral Data*¹ referred to as *First Four Years* in this publication.

ⁱⁱ The Annual Report of the Chief Medical Officer is available at:

www.dh.gov.uk/en/Publicationsandstatistics/Publications/AnnualReports/DH_086176. Ref: Department of Health. Chapter 7: On Equal Terms: Achieving racial equality in medicine. On the State of the Public Health: *Annual Report of the Chief Medical Officer*. London: DH, 2007.

ⁱⁱⁱ As defined by the Statistics and Registration Act 2007, available at www.opsi.gov.uk/acts/acts2007/ukpga_20070018_en_1. In January 2009 the UK Statistics Authority published a *Code of Practice for Official Statistics* and NCAS is considering the implications of the Code for statistical reporting in publications such as this.

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How to use this report

This report presents descriptive charts and tables supported by statistical modelling to examine differences between practitioner groups. Methods are briefly explained in the main text but fuller descriptions and source data can be found in the annex. Chapter 7 pulls together themes and conclusions from the earlier chapters. The chapter order is deliberate and the report is intended to be read in sequence.

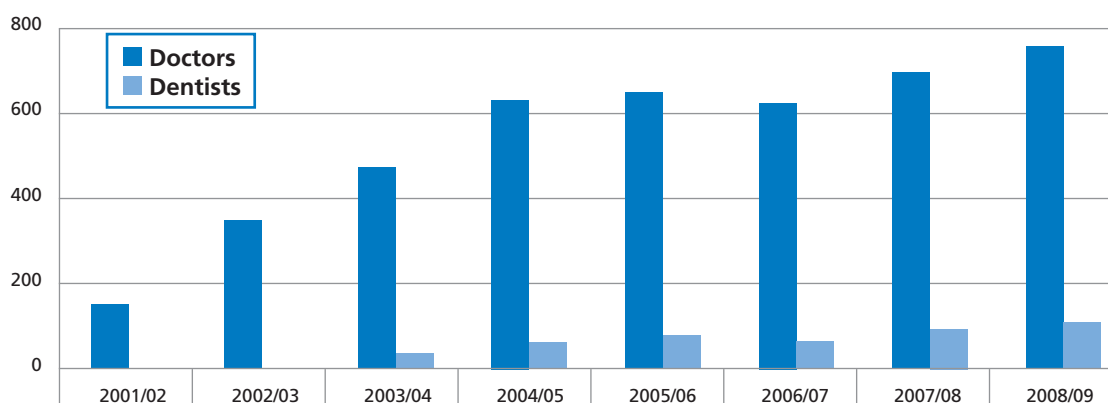
Chapter 1 – Overview

NCAS opened its advice line in April 2001. Eight years later NCAS advisers are working in all four countries of the UK, with offices in Belfast, Cardiff, Edinburgh and London. NCAS work normally starts with a phone call to one of the offices from an NHS manager. The referrer provides brief information and an adviserⁱ then follows up with phone support, meetings, case conferences or other interventions, as necessary. This chapter gives an overview of NCAS casework, using ‘referrals’ – requests for help – as a proxy measure for concern incidenceⁱⁱ. It looks at the geographical distribution of referrals, assessments and suspensions/exclusions to suggest that reported concerns are occurring in broad proportion to workforce size.

What is the likelihood of a practitioner being referred to NCAS?

NCAS services were launched in England first, with Wales, Northern Ireland and Scotland services added in 2003, 2005 and 2008 respectively. Services for dentists were launched in 2003. Referrals grew through the first three years, but slowed down in 2004/05 before starting to expand again – chart 1.1. More referrals were made in 2008/09 than ever before.

Chart 1.1 Referrals to NCAS, 2001/02 to 2008/09



*First Four Years*¹ estimated that in England each year one doctor in 190 was being referred to NCAS. With referrals now running at around 800 a year for doctors and 100 a year for dentists, and with around 150,000 doctors and 30,000 dentists working in the UK, the estimated risk of referral has not changed. Each year the performance of about one doctor in 190 causes enough concern to result in an NCAS referral. For dentists the one year referral rate is about one in 290 – table 1.1.

ⁱ The adviser is drawn from a team of senior practitioners and managers based across the country who all have considerable experience in the handling of performance concerns.

ⁱⁱ NCAS processes have been consistent through the period so case counts can be taken as measuring the volume of reported concerns and can be added up over the years for analysis purposes.

Table 1.1 Estimated one year referral rates

Profession Sector	Doctors			Dentists		
	General practice	Hospital & community	All doctors	General practice	Hospital & community	All dentists
UK workforce, 2007	41,100	111,100	152,200	25,300	5,100	30,400
Estimated referrals, 2009	270	525	795	90	15	105
One year risk	1 in 150	1 in 210	1 in 190	1 in 280	1 in 340	1 in 290

Do referral rates vary geographically?

When NCAS was first set up, there appeared to be geographical variation in the use of its services. As time has passed, however, these variations were seen as probably no more than might be expected for an uncommon event like NCAS referral. Chart 1.2 plots referrals in 12 areas of the UKⁱⁱⁱ and shows a close association with the size of an area's dental/medical workforce. Northern Ireland, with the smallest workforce, has the smallest number of referrals, while London has most referrals and the largest workforce. Scotland is not shown because a full NCAS service was not launched there until 2008.

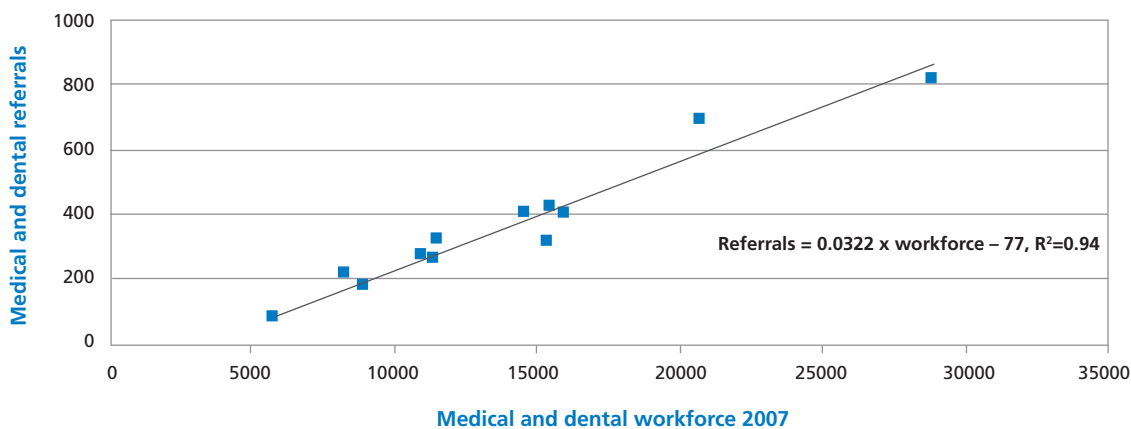
Chart 1.2 Total eight year referrals in England, Northern Ireland and Wales

Chart 1.2 includes both doctors and dentists and practitioners in both general practice (GP) and hospital and community (H&C) sectors. Charts 1.3a and 1.3b separate the sectors to show that referrals are more closely related to workforce size in the H&C sector than amongst GPs. But even amongst GP referrals the association is reasonably close^{iv}.

ⁱⁱⁱIn England, charts use strategic health authority areas as a geographical grouping for comparison purposes.

Usually, SHAs do not play a part in the referral process. Nor do national health departments in devolved administrations.

^{iv}R², shown in this chapter's scatter diagrams, is a measure of how far changes in one variable are associated with changes in another, with a maximum value of +1 meaning a very strong association.

Chart 1.3a Total eight year referrals and workforce – H&C sector

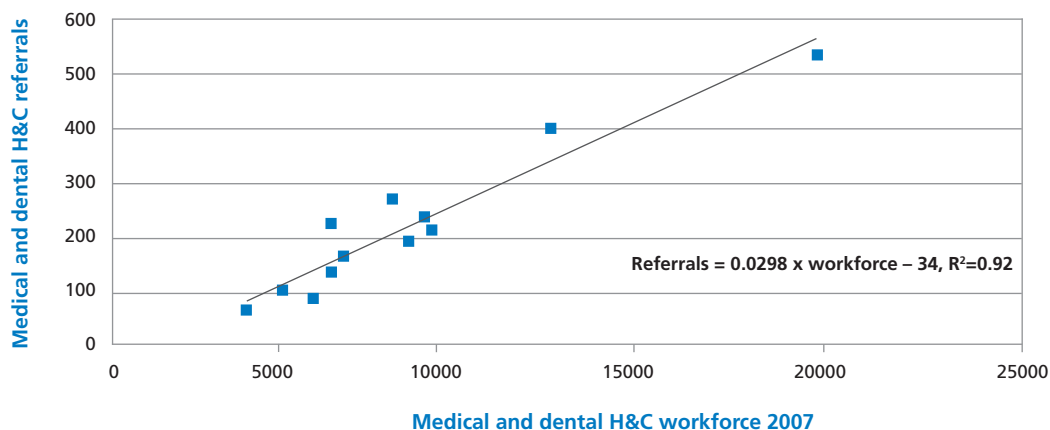
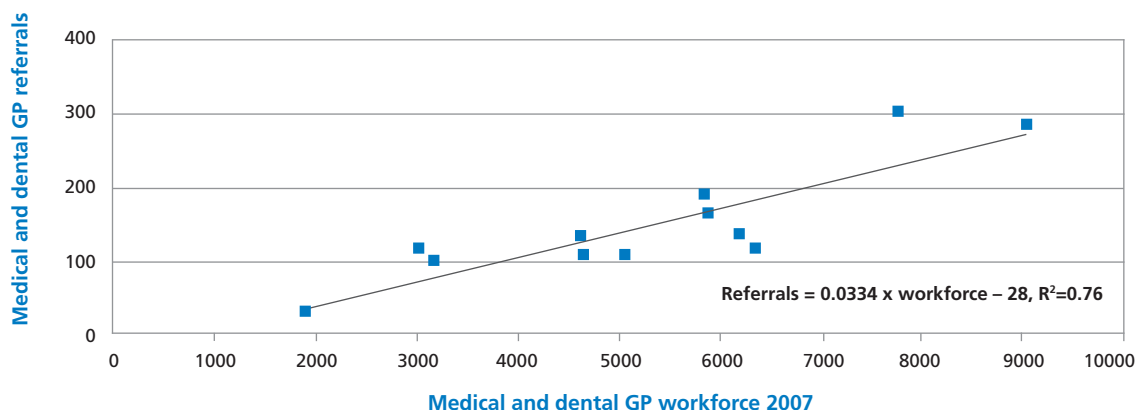


Chart 1.3b Total eight year referrals and workforce – GP sector



At single organisation level and from year to year, referrals are less predictable. NCAS does not release information about referrals from individual employing or contracting bodies, partly because of this unpredictability but, more importantly, to prevent identification of the practitioners concerned. Virtually all potential referrers have used NCAS services at least once since 2001. In 2008/09, 77 per cent of organisations made at least one referral to NCAS and 56 per cent of organisations had at least one open NCAS case at year end – table 1.2. In England, foundation and non-foundation trusts are using NCAS in similar ways and to similar extents.

Table 1.2 Use of NCAS by NHS service provider organisations, UK, 2008/09

Country	Type	Potential users	Number and per cent			
			Referrers in 2008/09		Referrers with active cases at year end	
			Number	Per cent	Number	Per cent
England	Foundation trusts	115	87	76	62	54
	PCTs and other non-foundation trusts	264	209	79	156	59
Northern Ireland		10	6	60	5	50
Scotland		16	13	81	10	63
Wales		31	19	61	12	39
All		436	334	77	245	56

Note: Foundation trust status is as at 31 March 2009

Referrals from organisations have accounted for the great majority of NCAS cases – 95 per cent of 863 referrals in 2008/09 and 97 per cent of all eight years' referrals. Alongside referrals from organisations, NCAS also received 115 self-referrals over eight years, 34 referrals from GPs unsure how to take forward a concern about a colleague's performance and 14 whistleblower referrals. In all these cases NCAS advised, provided support and, where necessary, ensured that action was taken.

Chapter 2 examines some of the demographic characteristics of referred practitioners and chapter 3 looks at the concerns being brought to NCAS' attention.

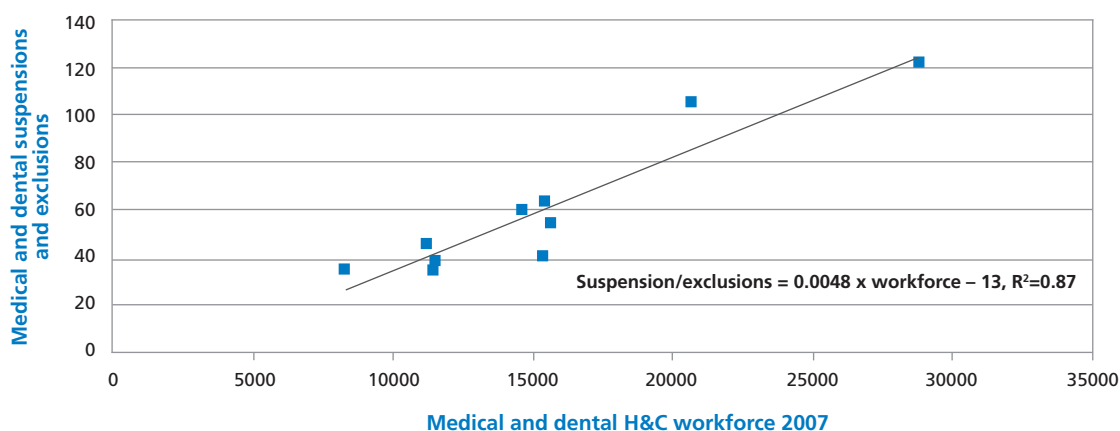
How many practitioners does the NHS exclude or suspend from work?

About a third of active NCAS cases involve practitioners who have been suspended or excluded from work. A specialist human resources team in NCAS advises on these cases which are described in more detail in chapter 4.

NCAS now has an archive of over 800 suspension and exclusion episodes. Although now UK-wide, the archive is most complete for England, so comparisons with the NHS workforce in this report cover England only. The term 'suspension' refers in this report to a GP process carried out under Performers List Regulations and 'exclusion' means the H&C process described in *Maintaining High Professional Standards*^v. GP suspension and H&C exclusions differ in character but they both, in the end, mean that practitioners are barred from duty, with ongoing costs for the NHS.

Chart 1.4 shows the number of suspensions and exclusions associated with workforce size, just as chart 1.2 showed an association between referrals and workforce size. Chart 1.4 is based on 601 England episodes started (but not necessarily concluded) by the end of 2007/08^{vi}. This total cannot be related precisely to specific start years because the NCAS archive was built up gradually and was initially incomplete. The earliest cases in the archive started in 2000.

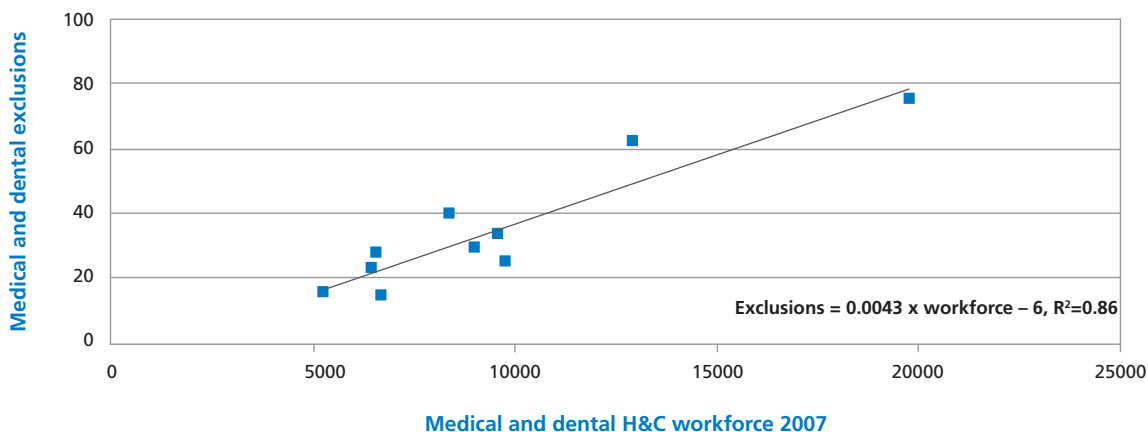
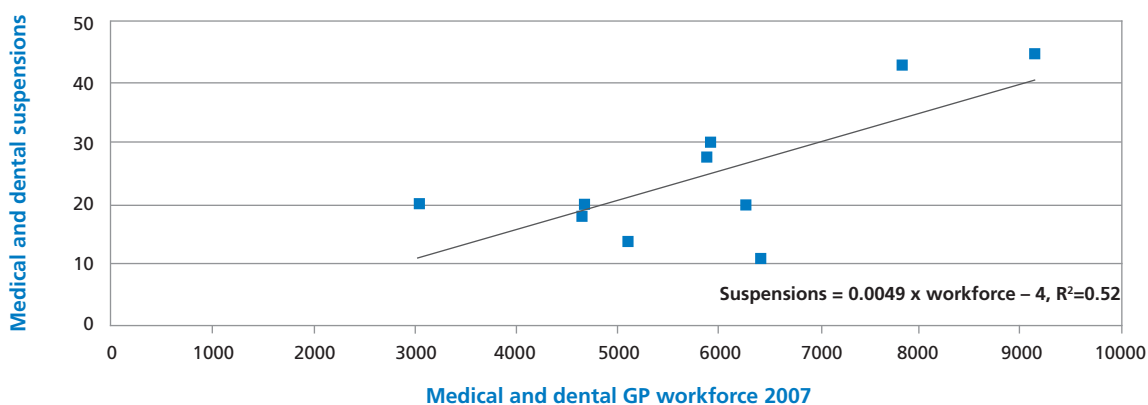
Chart 1.4 Suspensions/exclusions and workforce, England



Like referrals, however, there is a sector difference, with the workforce association again stronger in the H&C sector (chart 1.5a) than in general practice (chart 1.5b). This could suggest greater variation in management practices in the GP sector, but greater variation in the distribution of concerns in the GP sector is also possible. Given that there are fewer GP episodes for analysis (249) than H&C episodes (352), the wider scatter in chart 1.5b is not surprising. NCAS will continue to examine these variations, alongside its work with local managers, to ensure that suspension and exclusion are used appropriately. The suspension or exclusion of a practitioner is a significant step and should be used only where necessary to protect patient safety or the public interest.

^vTerminology varies across the UK. 'Exclusion' describes a process for H&C staff in England which is called 'suspension' in other parts of the UK. For simplicity, all H&C episodes are referred to in this report as 'exclusions' with 'suspension' used for GP episodes.

^{vi}A definitive dataset for episode starts by the end of 2008/09 was not available at the time of writing.

Chart 1.5a – H&C exclusions and workforce, England**Chart 1.5b – GP suspensions and workforce, England**

How many cases go to NCAS assessment?

Assessment cases are described in detail in chapter 5. NCAS carried out its first assessments in 2002/03. Assessment methods and reporting formats are under continuing development as the assessment model is applied in more clinical contexts. The most recent development work has been in pharmacy. More information about the NCAS assessment process is available in the NCAS Handbook⁵.

By the end of 2008/09, 269 assessments had been started^{vii} with 236 completed. The analyses in this report examine the 269 assessment starts, regardless of completion status, in order to maximise the dataset for analysis^{viii}. With 4,692 referrals of individual practitioners made in the eight years to 2008/09, about one referral in 17 has led to formal assessment.

^{vii} This includes a small number of assessments which did not progress to completion and some which were still under way at the end of 2008/09.

^{viii} Also, the questions of interest in chapter 5 are about the identification of cases appropriate for assessment rather than about the completion process so it is legitimate to analyse starts rather than completions.

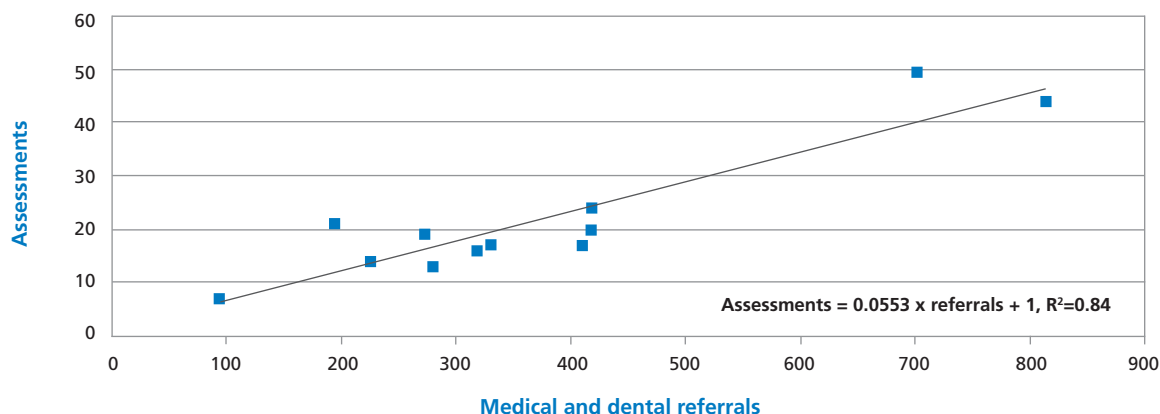
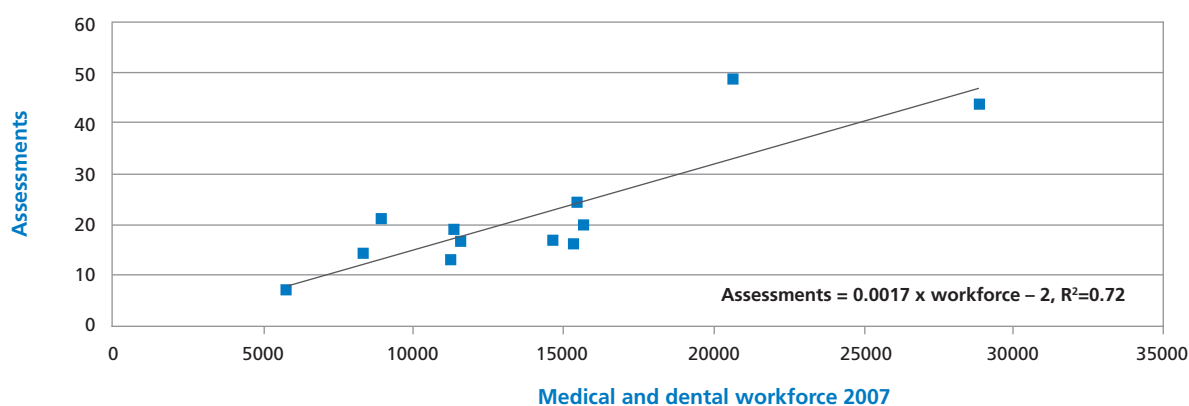
Chart 1.6 – Assessments and referrals over eight years

Chart 1.2 showed referrals associated with workforce size. Chart 1.6 shows assessment numbers associated with referral totals for each of the 12 geographical areas. The association of assessments with workforce size is weaker but still visible – chart 1.7. The message of these charts together is that NCAS referrals occur across the country at rates which do not vary dramatically between geographical areas; and once referrals have been made the likelihood of assessment does not vary dramatically between areas. NCAS has put considerable effort into defining and operating a common threshold for taking cases to assessment. Chart 1.6 suggests that this has been successful. The characteristics of assessment cases are discussed in chapter 5.

Chart 1.7 – Assessments over eight years and workforce

Summary

- Referrals are coming to NCAS from all parts of the UK, approximately in proportion to the size of the dental and medical workforce.
- Three NHS organisations in four make at least one new referral each year and over half have active cases with NCAS at any one time (56 per cent at the end of 2008/09).
- Suspension/exclusion cases form a large part of NCAS support work. These cases are also found right across the country in numbers approximately in proportion to workforce size.
- Assessments occur across the country too, though with a stronger association with an area's referral numbers than its workforce size. Once referred, a practitioner's chance of assessment is much the same whatever part of the country the practitioner works in.
- The association with workforce size shown by referrals and suspension/exclusion cases is stronger for the H&C sector than for the GP sector, for reasons which are presently uncertain and which need further investigation.

Chapter 2 – Referral rates

When NCAS reported on its first four years' work, certain patterns were already emerging. Practitioners in older age groups were more likely to be referred to NCAS, as were men and practitioners in certain specialties. This work also started to examine whether referral was associated with ethnicity or place of qualification or both. After eight years, the number of cases for examination has close to trebled. We also have more complete data although missing data in certain fields still hinders interpretation. This chapter updates *First Four Years* analyses, looking at cases as a single batch to maximise the size of subgroups.

What counts as a 'referral'?

A referral is logged when NCAS help is sought. Employing/contracting organisations and educational bodies will sometimes notify NCAS that action has been taken in relation to a named practitioner but without reporting a concern or asking for NCAS advice. The information is kept but these notifications are not treated as NCAS referrals.

A small number of referrals are concerned with the performance of teams so no information is held about the individual practitioners within the team. These count as 'cases' but are excluded from the analyses described in this report.

Self-referrals are included, as are whistleblower cases and the referrals made by practices about practice colleagues. Given that one of the purposes of these analyses is to understand better how the NHS handles performance concerns, there might seem to be a case for excluding self-referrals. However, another purpose is to understand performance concerns generally, so these cases are still of interest. As has already been noted, self-referrals, whistleblower and practice referrals account for only three per cent of the cases described, so their inclusion has little impact on the patterns identified.

What information does NCAS collect about referred practitioners?

NCAS asks referring managers to provide three types of information about all practitioners referred:

- Identifiers (name and registration number), so that referral of the same practitioner by more than one referrer can be tracked.
- Personal information, because of legal duties in relation to race, disability, age and gender equality.
- Information which may help the understanding of a case, such as grade, specialty, place of qualification and (for GPs) practice size.

This report investigates associations between performance concerns of various kinds and six independent variables – age group at referral, gender, specialty group, grade group, place of qualification and ethnicity. Where possible, definitions match those used by the NHS. An exception is 'grade group' for GPs, where NCAS distinguishes practitioners working with a high degree of autonomy (consultants or equivalent in the H&C sector, contractor performers amongst GPs) from practitioners whose work is more closely managed ('other career grades' in H&C, non-contractor performers amongst GPs) and from training grades. Classifications are discussed in more detail in the annex.

Which practitioner groups is NCAS able to report on?

NCAS normally reports on the characteristics of practitioner groups only where there are at least 50 cases to examine. This is partly to reduce the risk of conclusions which are merely chance sampling events and partly to prevent deductive disclosure of practitioner or referrer identities. In eight years' data, there are at least 50 cases in all specialty groups except clinical oncology and 'other'. But table 2.1 shows that many cells contain fewer than 50 practitioners when specialty is looked at alongside another variable with missing data. This report therefore gives a high level description of NCAS work, with a focus on the larger differences between the larger practitioner groups.

Table 2.1 – Number of cases for analysis, 2001/02 to 2008/09

											Number
	Gender		Age		Qualification		Ethnicity		Grade		All cases
	M	F	<40	40+	UK	Non-UK	White	Other	Consultant or contractor	Other grade	
Accident & emergency	95	27	48	58	44	59	46	55	27	94	124
Anaesthetics	157	34	44	120	78	75	86	74	122	66	197
Clinical oncology	...	...	...	...	...	...	...	...	...	...	16
Dental group	30	20	11	29	26	8	24	15	23	23	52
General medicine	290	67	89	217	167	136	143	160	218	132	360
Obstetrics & gynaecology	181	65	35	172	101	108	95	118	151	95	250
Paediatric group	117	60	40	111	62	87	69	85	104	70	180
Pathology group	67	22	6	69	33	41	36	36	69	16	89
PHM and CHS	51	34	16	58	46	26	44	24	18	62	85
Psychiatry group	389	136	107	322	217	233	223	219	341	187	541
Radiology group	73	16	8	63	33	46	44	36	87	3	94
Surgical group	560	51	103	394	259	236	239	256	433	181	628
Other	...	...	...	...	...	...	...	...	...	...	14
General medical practice	1245	244	148	1097	613	592	558	607	949	459	1549
General dental practice	252	64	79	163	163	98	164	74	170	111	329
All specialties	3635	873	764	2957	1900	1786	1829	1816	2793	1601	4508
Data missing	184		971		1006		1047		298		184

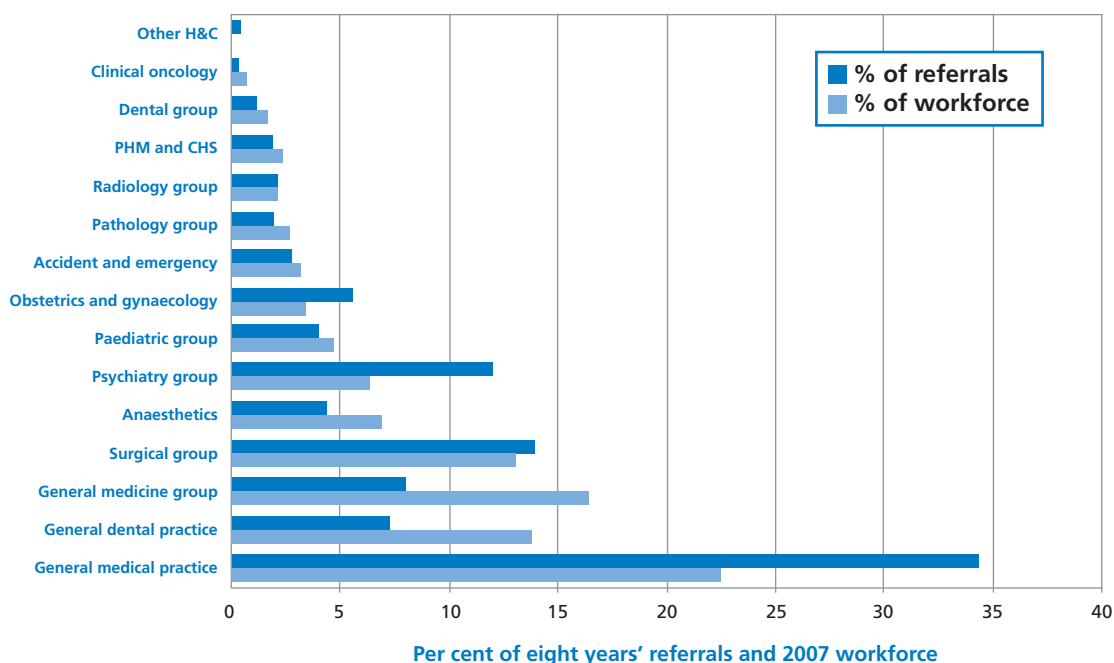
Note: The Public Health Medicine (PHM) and Community Health Services (CHS) group includes dentists as well as doctors. Section totals differ because of missing data.

Are some practitioner groups more likely to be referred?

Chart 2.1 compares specialty shares of referrals with share of the workforce, a comparison method also used for other variables. Specialty information is held about almost all cases.

Other things being equal and given the relationships described in chapter 1, the profile of the workforce might be expected to determine the profile of NCAS referrals. In fact, referrals often show a different pattern. Looking at the distributions together shows where the chance of referral is above or below average. Psychiatry, obstetrics and gynaecology (O&G), and general medical practice have noticeably more referrals than might be expected from their workforce size. General medicine has fewer. These are patterns which have been observed consistently since NCAS casework started.

Chart 2.1 – Specialty distribution of referrals and workforce



Data completeness is also very high for grade and gender. Chart 2.2 compares workforce and referral distributions in the same way as chart 2.1 to show fewer referrals of women than workforce size would predict, in both GP and H&C sectors. *First Four Years* also reported this.

Chart 2.2 – Gender distribution of referrals and workforce

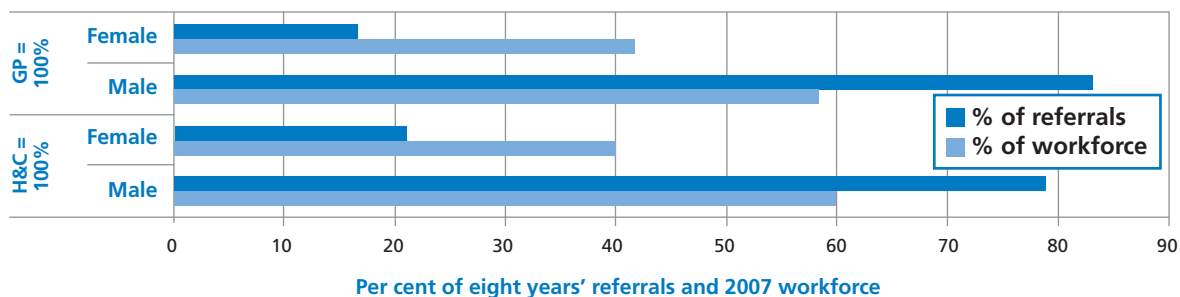


Chart 2.3 looks at referrals by grade group in the same way, but without workforce comparators for the GP sector. In the H&C sector, consultants are most likely to be referred, followed by non-consultant career grades, with a low rate of referral amongst training grades. The pattern is probably similar for GP referrals, although precisely-matching NHS workforce comparators are not available. Note that 17 per cent of H&C referrals over eight years came from training grades.

NCAS was set up primarily to help with performance difficulties amongst career grade practitioners, but has always accepted training grade referrals. Training grade referrals are usually made by or in conjunction with postgraduate deaneries.

Chart 2.3 – Grade distribution of referrals and workforce

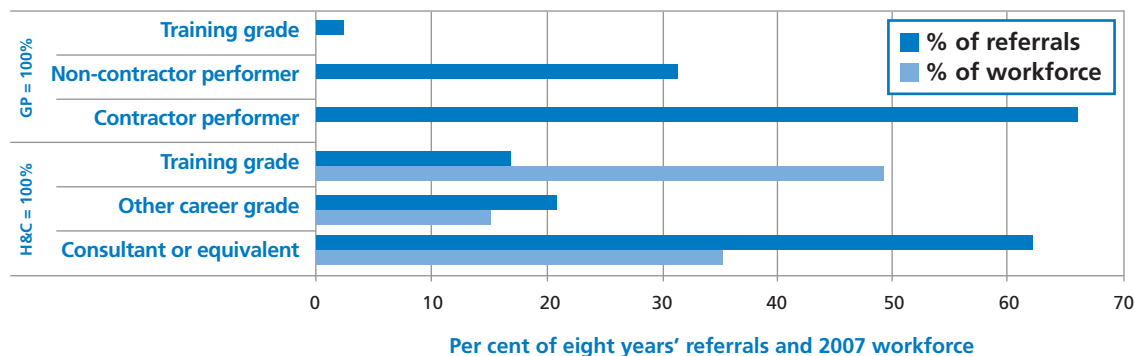
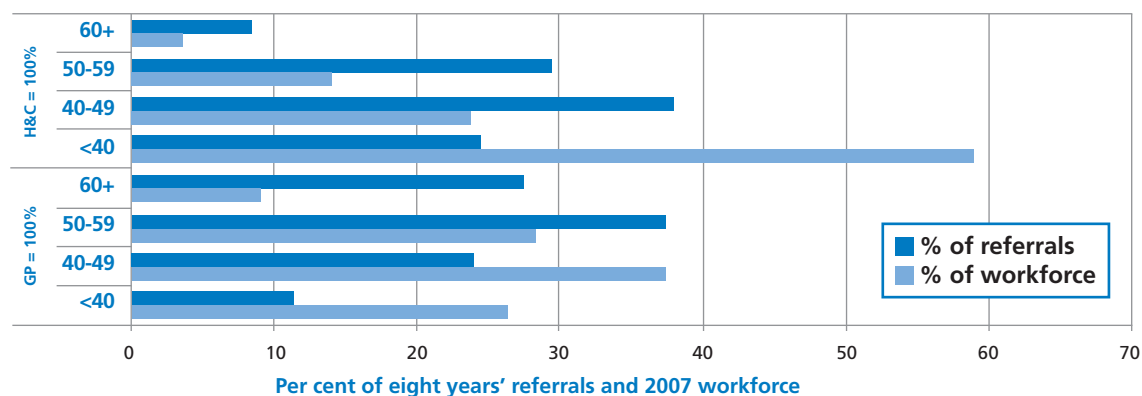


Chart 2.4 shows workforce and referral distributions by age for doctorsⁱ. Conclusions here are less firm because data completeness falls to 78 per cent for age. But if non-recording of age is assumed random, the chance of referral is lower in younger age-groups in both sectors.

Chart 2.4 – Age distribution of medical referrals and workforce



While this partly reflects the lower referral rate amongst training grades (seen in chart 2.3) there is also an age gradient within career grades. Relative eight-year rates can be estimated by dividing referrals by workforce and expressing the rate for each age-group as an index based on the all ages rate. The referral rate amongst practitioners aged over 50 is five times the rate below age 40 in the H&C sector, and for over 60s in the GP sector the referral rate is seven times the rate for under 40s:

Relative risk of referral, all ages risk = 100, doctors

	H&C	GP	All doctors
<40	40	40	40
40-49	160	70	120
50-59	210	130	180
60+	200	300	280
All ages	100	100	100

ⁱSee chapter 6 for the same information about dentists.

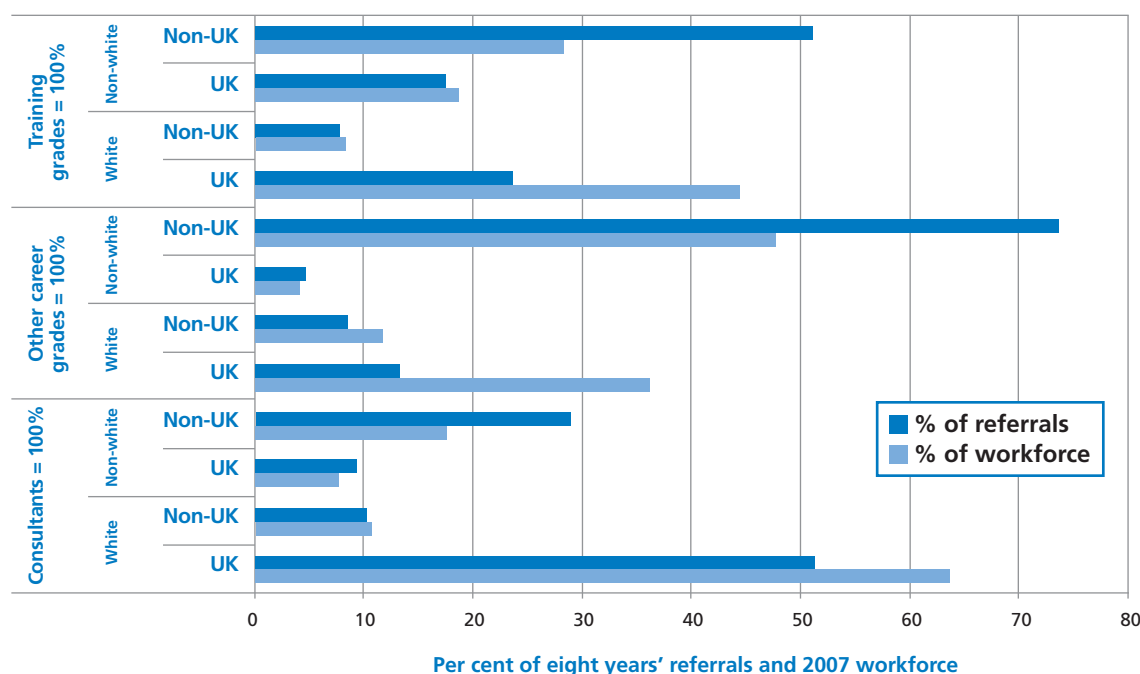
The remaining variables for examination in this way are ethnicity and place of qualification. These fields are 75 per cent and 79 per cent complete for GP referrals, and 80 per cent and 79 per cent complete for H&C cases. While non-recording bias might reasonably be assumed unlikely for age, gender, grade and specialty, it is less easy to rule out for ethnicity and place of qualification.

A further difficulty is that workforce comparator data is not available for GP referrals because primary care organisations do not have a national scheme for monitoring the ethnicity of NHS contractors. Without workforce comparators it is not possible to measure the relative chances of referral for white and non-white practitioners.

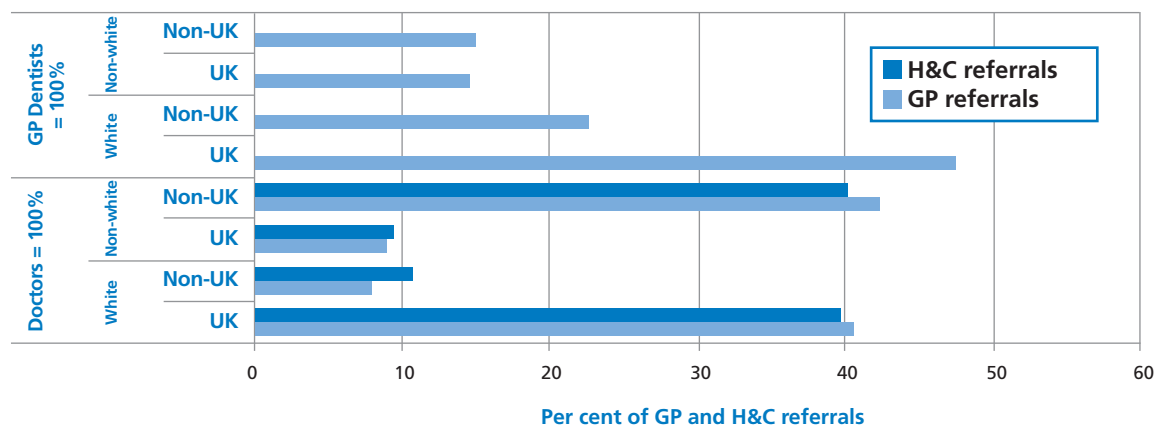
Chart 2.5 therefore shows only H&C practitioners, restricted to referrals from England because workforce monitoring data are not available for other parts of the UK and restricted to doctors because place of qualification information is not centrally collected for dentists. The three grade groups are shown separately because of their different referral rates. Within grade groups the percentages are calculated across the combinations of ethnicity and place of qualification.

In each grade group there are fewer UK-qualified white referrals than the workforce profile would suggest, and more non-UK-qualified non-white referrals. For UK-qualified non-white practitioners in each grade group, referrals are approximately in line with workforce share within the grade. The UK-qualified non-white groups are of particular interest. Their experience seems not to be the same as that of UK-qualified white practitioners where, grade by grade, share of referrals is smaller than share of workforce. But as charts 2.1–2.4 showed, other factors are operating and there might, for example, be a different gender or specialty mix between non-white and white UK graduates. Missing data could also account for the difference so chart 2.5 should not be interpreted as evidence of unequal treatment associated with ethnicity. The next section on statistical modelling discusses this more fully.

Chart 2.5 – Ethnicity and place of first qualification of medical H&C referrals and workforce



Finally, chart 2.6 compares the distribution of referrals in the GP and H&C sectors using the same four place of qualification/ethnicity groupings as chart 2.5. For doctor referrals the two distributions match closely, but we cannot deduce more from this in the absence of GP workforce comparators. We do know that 79 per cent of the medical GP workforce qualified in the UK so this group is under-represented amongst GP referrals, but whether this is associated with ethnicity as well is a matter for speculation. The sector comparison is not shown for dentists because too few H&C cases are available for analysis.

Chart 2.6 – Ethnicity and place of first qualification of referrals by sector

Can statistical modelling clarify referral patterns?

Modelling allows the effects of all the available variables to be investigated at the same time, in a way that is not possible with tables or charts with only two or three dimensions. There is a short general discussion of modelling in the annex. Models provide estimates of relative risk; for example, that specialty group A is significantly more likely to be referred than specialty group B with a relative risk of X. Referral models start with workforce numbers because of the strong relationships shown with workforce size in chapter 1. Explanatory variables were then added according to availability. Our first model included cases from both GP and H&C sectors and both doctors and dentists. This meant that it had to exclude ethnicity and grade (not available for GPs) and place of qualification (not available for dentists). The explanatory variables were therefore workforce, gender, specialty and age groupⁱⁱ. H&C specialties were grouped into four: general medicine, psychiatry, surgery with O&G, and 'other'. The grouping of surgery with O&G attempted to capture specialties at greater risk of complaint or litigation, which might then have more referrals as well. Psychiatry and general medicine were examples of specialties apparently showing high and low referral rates. Four age groups were used – under 40, 40–49, 50–59 and 60+.

The model showed referrals to be significantly higher amongst men than women, in surgery/O&G than in general dental practice or H&C general medicine, and also higher in general medical practice than in surgery/O&G. However, psychiatry did not have significantly more referrals than surgery/O&G. Age associations were unclear, probably because of the association between age and grade and possibly also because of the very high proportion of men amongst GP referrals in older age-groups.

A second model then added ethnicity, place of qualification and grade as explanatory variablesⁱⁱⁱ. This meant that the model had to be limited to the H&C sector where the necessary workforce comparators are available. Dentists were excluded because of lack of a place of qualification comparator. Ranking associations in descending order of relative risk^{iv}, referrals in this model were:

- significantly higher amongst consultants than training grades;
- significantly higher amongst men than women;
- significantly higher amongst other career grades than training grades;
- significantly higher in surgery/O&G than in general medicine;
- significantly higher amongst non-white than white doctors;
- significantly higher amongst doctors who qualified outside the UK than UK-qualified doctors.

ⁱⁱ 3,253 referrals out of 4,187 England referrals altogether (78 per cent) had the necessary data. They were matched against a workforce of 148,000 practitioners. Strictly, conclusions based on modelling only apply to England. NCAS will be investigating the scope for bringing the rest of the UK within this work.

ⁱⁱⁱ The second and third models, with grade, place of qualification and ethnicity added, use 1,631 H&C medical cases with the necessary data, 67 per cent of all H&C cases from England. These are compared with 84,000 H&C doctors with the necessary data. The higher level of data incompleteness means that conclusions should be treated with more caution.

^{iv} Relative risks are used to rank the findings but are not quoted because the estimates are tentative, in view of missing data. But to give an idea of orders of magnitude, relative risks ranged from around 1.5 to 5.

Ethnicity and place of qualification were therefore low-ranking associations even though statistically significant. However, when an interaction variable was included in the model, allowing the ethnicity association to operate differently between UK-qualified and non-UK-qualified doctors, referral was highest among non-white doctors who qualified outside the UK. Ranking by descending relative risk in this third model, referrals were:

- significantly higher amongst consultants than amongst training grades;
- significantly higher amongst men than women;
- significantly higher amongst other career grades than training grades;
- significantly higher in surgery/O&G than in general medicine;

and, at the lower end of the ranking:

- significantly lower amongst white doctors who qualified outside the UK than amongst white UK-qualified doctors;
- significantly lower amongst non-white doctors who qualified in the UK than amongst white UK-qualified doctors;
- significantly higher amongst non-white doctors who qualified outside the UK than amongst white UK-qualified doctors.

First Four Years said: 'Within grades, place of qualification appears to be a stronger influence on referral rate than ethnicity'. This conclusion needs to be modified because ethnicity appears to be impacting differently on UK-qualified and non-UK-qualified practitioners.

The suggestion that non-white UK-qualified and white non-UK qualified practitioners are at lower risk of referral than white UK-qualified doctors is surprising and needs to be investigated further. The more convincing conclusion, consistent with chart 2.5, is that non-white non-UK-qualified doctors are at significantly greater risk of referral. The lack of disproportionate referral risk amongst non-white UK-qualified doctors is an indicator of equity in referral. NCAS will continue to monitor the experiences of these practitioner groups as part of an ongoing equality and diversity programme.

Are psychiatrists really more likely to be referred?

Modelling may also throw light on the apparently high rate of referral seen amongst psychiatrists. Since psychiatry was not associated with high referrals relative to surgery/O&G, the H&C workforce data were re-examined (table 2.2). The specialties are ranked in order of proportions non-white and qualifying outside the UK (column 2). O&G and psychiatry rank highest (36 per cent and 33 per cent compared with 25 per cent for medical specialties together). They also have the lowest proportions white and UK-qualified (37 per cent and 40 per cent in column 5). Their share of UK-qualified non-white practitioners is below average (column 3) and white non-UK qualified practitioners have an above average share (column 4). Chart 2.1 may therefore be showing, for psychiatrists, the effect of ethnicity and place of qualification alongside specialty. *First Four Years* commented that since a higher proportion of practitioners in psychiatry are women, with generally low referral rates, there seemed to be a strong specialty association with referrals. It now appears that the interactions are more complex.

Such discussion is to some extent academic, however, because NCAS is not trying to produce a determinist explanation of referral patterns. The aim is rather to gain insights which might guide further educative and service development work. Based on chart 2.1 alone, NCAS and organisational partners in psychiatry might have been drawn towards discussion of, for example, management practices peculiar to work in psychiatry which might be encouraging referral. The modelling work described here suggests that this may not be the most useful question to ask.

Table 2.2 – Qualifications and ethnicity of medical H&C specialties, England, 2007

Ethnicity Place of qualification	Per cent						Headcount Base Number
	Non-white		White		Ethnicity not known		
	Non-UK Per cent	UK Per cent	Non-UK Per cent	UK Per cent	Non-UK Per cent	UK Per cent	
Obstetrics & gynaecology	36	10	10	37	4	3	5,000
Psychiatry group	33	7	13	40	5	3	9,600
Paediatric group	32	10	9	42	3	4	7,000
Surgical group	26	14	9	43	3	5	19,400
Accident & emergency	26	13	7	47	3	4	4,800
Anaesthetics	24	8	10	52	2	4	10,300
Pathology group	23	8	12	50	3	3	4,000
General medicine group	20	15	7	51	2	5	24,400
Radiology group	18	13	8	55	2	4	3,200
PHM & CHS group	18	7	9	59	3	5	2,000
Clinical oncology	17	11	8	59	1	4	1,100
All medical specialties	25	12	9	47	3	4	90,700

Note: The NHS does not collect place of qualification data centrally for dental group specialties so this table shows only medical specialties.

Summary

- Although referral totals are generally in proportion to workforce size (chapter 1) subsets of referrals are not. Some practitioner groups are more likely to be referred than others.
- Women are less likely to be referred than men.
- Referral rates are higher in career grades and in older age-groups.
- In the H&C sector, and amongst groups defined by ethnicity and place of qualification, referrals are highest amongst non-white doctors who qualified outside the UK.
- Non-white H&C doctors who qualified in the UK are not being referred disproportionately.
- The ethnicity/place of qualification profile of referred medical GPs closely matches the profile of H&C referrals. This may indicate that similar influences are operating to those at work in the H&C sector, but it is not possible to say more without GP workforce comparators.
- Above average rates of referral amongst psychiatrists may be explained partly by this group's distinct ethnic and place of qualification profile.
- Statistical modelling coupled with comprehensive collection of monitoring data on referrals provides a tool for testing for equity in NCAS referral. Monitoring referrals amongst non-white UK-qualified practitioners is particularly important.

Chapter 3 – Performance concerns

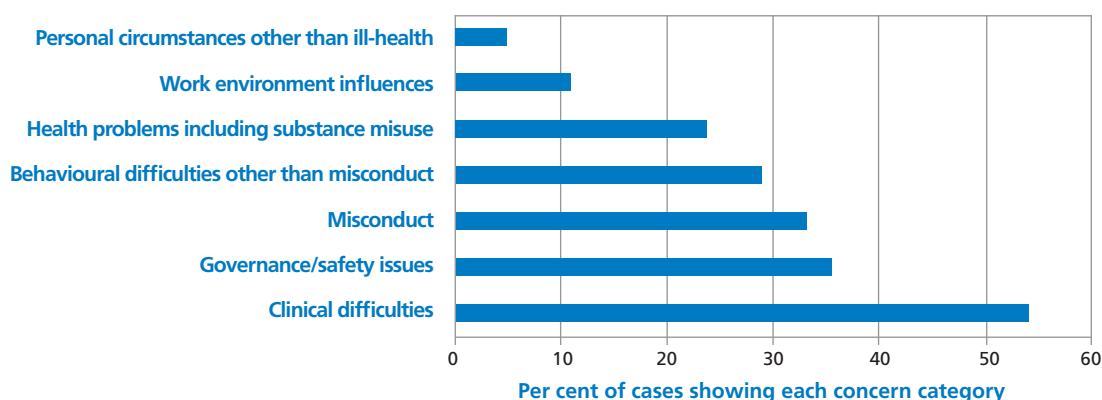
At the end of 2007, NCAS introduced a new classification system for logging case concerns encountered during advice work. This chapter describes what the new system showed in its first 15 months of use with 1,472 cases. The strength of this recording system is its ability to capture case information when advisers are most likely to recall it, using terms and categories which advisers have helped to define. Some differences in interpretation of categories may remain, and there is also a possibility that not all relevant case information is passed on to advisers by referring managers. Generally, however, the findings reported here are in line with data from retrospective case reviews carried out by the NCAS evaluation team and NCAS believes that the picture is reliable. There were few differences between practitioner groups in the types of concern causing referral.

Which types of concern are most common?

NCAS casework processes have included simple categorisation of performance concerns since 2002/03. Initially, concerns were logged as involving clinical capability (C), behaviour (B) or health (H) or any combination of these concerns. The possible influence of work environment was not logged because recording took place at the time of the first phone call to NCAS and it was unlikely that the information volunteered by referring managers would cover this. Recording using 'HBC' was described in *First Four Years*. The annex compares new and old classification systems in more detail.

Since December 2007 concerns have been classified in seven groups which between them cover 91 sub-categories. There is no free text entry. Advisers record what is 'confirmed or suspected' based on the information provided by the referrer, using volunteered information and information obtained through questioning. As many concerns as are relevant are logged. Chart 3.1 shows concern groups amongst 1,472 cases referred by the end of 2008/09 and handled by NCAS between December 2007 and March 2009¹.

Chart 3.1 – Prevalence of broad concerns amongst 1,472 cases



¹The batch of 1,472 cases described in tables 3.1 and 3.2 is 23 per cent open/77 per cent closed so these analyses are not showing a final picture of concerns. The batch is reasonably representative of casework generally, with 61 per cent of the closed batch being 'advice-only' cases.

The classification of concerns was informed by earlier classifications made by the NCAS evaluation team. An unpublished thematic analysis of performance concerns in 250 NCAS advice and support cases showed clinical concerns in 52 per cent of cases, conduct concerns in 44 per cent, behavioural concerns other than conduct in 36 per cent, health concerns in 23 per cent and organisational issues in 11 per cent. This analysis was based on a smaller number of cases, and used categories which do not precisely match the new database categories, but the pictures given by the two sources are still broadly similar and lead NCAS to believe that the new data collection system is reliable. Table A10 (see annex) compares concerns logged under the new database classification with the logging system operating until the end of 2007.

Performance concerns profiles are updated if case themes change over time. The new recording system has not been running long enough to research whether and how performance concerns change through the life of a case but that is NCAS' intention once enough concluded cases are available for analysis.

What is known about more specific concerns?

Table 3.1 shows selected sub-concerns within the seven broad concern groups. The first percentage column shows the proportion of cases with each sub-concern amongst the 1,472 cases examined. The second percentage column shows the proportion of cases within the concern group having each sub-concern. For example, 39 per cent of the 54 per cent of cases involving clinical difficulties involved a critical incident. This is the most common distinct clinical concern.

In most groups, sub-concerns are ranked in order of frequency but this is not possible for misconduct where some concerns define themselves by their position in the list. 'Theft, fraud, financial' misconduct is the most commonly recorded type.

Table 3.1 – Detailed concerns amongst 1,472 cases

Concerns group	Sub-concern	Per cent	
		Per cent of all 1,472 cases	Of cases within group, per cent with each sub-concern
Clinical difficulties 54% of cases	Critical incident	21	39
	Diagnosis skills	20	37
	Record keeping	18	33
	Consultation skills	18	32
	Prescribing	14	27
	Technical skills	13	23
	Observance of protocols	12	21
	Referral/onward referral	7	13
	Out of hours care	5	8
	Consent	2	4
Governance/ safety issues 36% of cases	Risk management	16	44
	Quality assurance	10	28
	Dealing with complaints	5	13
	Infection control	4	11
Misconduct 33% of cases	Theft, fraud, financial	7	20
	Driving under the influence of drugs or alcohol	...	1
	Other misuse of drugs or alcohol	2	5
	Breach of confidentiality	1	4
	Inappropriate sexual relationship with patient	1	3
	Other sexual misconduct	3	10
	Assault/threatening behaviour	2	7
	Bullying/harassment/discrimination	4	12
	Other personal misconduct towards patient or staff	5	16
	Use of illegal pornography	1	2
	Use of legal pornography at work	1	2
	Other misuse of resources/equipment	3	9

Table 3.1 continued

Concerns group	Sub-concern		Per cent of all 1,472 cases	Of cases within group, per cent with each sub-concern	
Behavioural difficulties other than misconduct 29% of cases	Communication with colleagues		20	69	
	Teamworking		15	51	
	Communication with management		12	40	
	Communication with patients, carers, relatives		12	40	
	Aggressive behaviour		8	27	
	Behaviour under pressure		7	24	
	Conflict management style		5	17	
	Leadership style		5	16	
	Decision-making style		4	15	
	Erratic/unpredictable behaviour		4	13	
	Withdrawn/isolated behaviour		2	6	
Health problems including substance abuse 24% of cases	Performance difficulties arising from physical or mental illness or disability	Changes in mood	7	29	
		Concentration	4	17	
		Energy/fatigue	4	15	
	Possible indicators of cognitive impairment	Mobility	1	6	
		Manual dexterity	2	6	
		Lifting and carrying	1	3	
		Sight	1	3	
		Memory	1	5	
		Problem solving	1	4	
		Planning	1	3	
		Specific health issues influencing performance ⁱⁱ	Anxiety/stress/burnout	6	27
			Depression/hypomania	6	25
			Alcohol misuse	5	22
			Drugs misuse	3	14
Work environment influences 11% of cases	Teamworking	Team communication	5	49	
		Communication with management	4	34	
		Workload management/distribution	3	30	
		Conflict management style	2	18	
		Feedback/isolated working	2	18	
		Leadership style	2	17	
		Role definition within team	2	14	
		Decision-making style	1	11	
		Systems, support	Support for teamworking	2	17
			Personal development support	1	13
	Information systems/info sharing		1	7	
	Other resource issues	Objective setting/best care decisions	1	6	
		Induction for international graduates	1	5	
		Workload/list size	3	25	
		Accommodation	1	6	
		IT equipment	1	6	
		Other facilities/equipment	1	6	
Personal circumstances other than ill-health 5% of cases	Relationships		2	41	
	Family illness/bereavement		1	22	
	Money worries		1	12	

ⁱⁱ A small number of specific ill-health descriptions are logged but advisers do not diagnose. Generally, they are logging performance impact rather than cause.

Health concerns are grouped to distinguish performance difficulties from possible indicators of cognitive impairment. Overall, possible cognitive impairment was identified in five per cent of the 1,472 cases examined.

Work environment influences are grouped to distinguish team-working difficulties from other system and support issues. Very few cases are logged as being influenced by personal circumstances other than ill-health but, amongst those that are, relationship difficulties are seen most commonly.

What are the common concern combinations?

Forty-three per cent of cases have involved only one of the seven broad areas of concern. On average, 1.9 concern areas are being logged per case. Only seven per cent of cases have more than three concern groups logged. Amongst 633 cases where concerns were focused in only one area:

- 36 per cent involved misconduct alone;
- 30 per cent involved clinical difficulties alone;
- 14 per cent involved health problems alone;
- 11 per cent involved behavioural concerns other than misconduct alone;
- eight per cent involved governance/safety.

Amongst single and multiple concern cases together, the following groups account for just over half the cases examined:

- misconduct alone – 16 per cent;
- clinical difficulties alone – 13 per cent;
- clinical difficulties and governance/safety issues – nine per cent;
- health concerns alone – six per cent;
- behavioural concerns with clinical concerns and governance/safety issues – four per cent;
- behavioural concerns and clinical concerns – four per cent.

Unsurprisingly, there is an association between the number of concern groups noted on the database as linked with a case and the processes that NCAS uses to manage the case. 'Advice-only' cases generally have fewer concerns noted than cases going on to support or assessment work:

- 1.7 concerns per case on average in advice cases;
- 2.0 concerns per case on average in support cases;
- 2.8 concerns per case on average in assessment cases.

Do concerns differ between practitioner groups?

Table 3.2 shows the percentage of cases in each practitioner group with each broad concern. Certain differences are noticeable, but most are not statistically significant. Those shown in bold type are significant at a five per cent levelⁱⁱⁱ:

- clinical and governance concerns are reported slightly more in the GP sector;
- more misconduct is reported in H&C;
- more health concerns are recorded amongst white practitioners;
- clinical concerns are reported more amongst practitioners qualifying outside UK.

This is an operationally useful finding for organisations endeavouring to deal equitably with cases across all practitioner groups. Concerns are similar between groups so consistent processes are appropriate.

ⁱⁱⁱ Significance was tested using χ^2 for each concern/variable contingency table and allowing for multiple comparisons across types of concern and variables of interest.

Table 3.2 – Concerns by practitioner group

	Per cent							Per cent
	Clinical difficulties	Governance /safety issues	Misconduct	Behaviour other than misconduct	Health inc alcohol or drug misuse	Work environment	Personal circumstances not ill-health	Base number of cases
	Per cent	Per cent	Per cent	Per cent	Per cent	Per cent	Per cent	Number
All cases	54	35	33	29	24	11	5	1,472
Profession								
Dentist	55	38	29	18	23	14	5	156
Doctor	54	35	33	30	24	8	5	1,316
Sector								
GP	57	41	27	26	23	14	5	615
H&C	51	32	37	31	24	8	5	857
Gender								
Female	54	35	25	34	33	14	7	279
Male	54	36	35	28	22	10	5	1,166
Age-group								
<40	50	29	40	26	25	11	5	217
40-49	51	30	35	35	27	11	7	399
50-59	55	43	28	30	23	11	4	401
60+	74	47	28	20	22	12	4	193
Medical speciality								
GMP	58	40	27	27	24	13	4	496
Psychiatry	50	24	37	33	31	13	7	204
Surgery/O&G	53	36	33	31	18	8	4	284
Other	50	32	39	31	25	7	5	344
H&C grade								
Consultant	51	31	34	36	22	10	5	538
Other career grade	56	37	35	27	28	8	6	196
Training grade	46	25	46	16	25	1	4	118
GP grade								
Contractor	61	44	23	27	23	16	4	387
Non-contractor	49	36	33	23	25	11	6	214
Ethnicity								
Non-white	60	35	35	29	18	12	5	615
White	51	37	30	30	30	10	6	580
Place of qualification								
Non-UK	63	37	33	28	17	12	4	659
UK	47	35	34	30	31	9	6	640

How long do referrers wait before contacting NCAS?

First Four Years commented that most NCAS referrals are not made in a crisis but relate to concerns which have been observed for some time. This was especially the case when NCAS was first set up and there were long-standing concerns for NCAS to deal with. As time has passed, a higher proportion of concerns are being brought to NCAS early.

Table 3.3 shows the interval between a concern first being noticed and NCAS referral, comparing 2002/03 (the first year this information was collected) and 2008/09. In 2008/09, two thirds of referrals were about concerns arising in the past six months, compared with one per cent in 2002/03. Referrers have become used to contacting NCAS and are acting quickly when concerns arise.

Table 3.3 – Time between a concern first being noticed and NCAS referral

	2002/03 Per cent	2008/09 Per cent
In the past week	1	20
More than a week but < 1 month		23
1-6 months		28
6-12 months	0	12
1-2 years	50	10
3-4 years	41	5
5-9 years	3	2
10+ years	5	1

Note: The short lead-in times shown in 2008/09 were initially grouped so comparable 2002/03 data are not available.

NCAS also logs the urgency of a referrer's need for telephone advice. NCAS processes are designed to ensure prompt response, including 24-hour cover using a duty adviser rota. In 2008/09, 58 per cent of cases were classified as needing a callback on the same day or next day.

To what extent are other agencies involved with NCAS cases?

Recording the involvement of other agencies tells us something about the nature of the cases being referred to NCAS. It also helps NCAS avoid inappropriate duplication of work though, in some cases, multiple involvements may be necessary.

NCAS reported after four years that overlap with regulator and college activity, while initially significant, fell to a low level by the end of 2004/05. This was based on recording at the time of referral. The new database, in use since the end of 2007, improves capture of other agency involvements through the life of a case but weakens precise capture of the position at the start of a case. The main agency involvements at time of referral were as follows for cases starting in 2008/09 and based on involvements known about within a month of cases starting:

- seven per cent General Medical Council/General Dental Council;
- five per cent police;
- three per cent postgraduate deanery;
- two per cent Counter Fraud and Security Management Service;
- one per cent Care Quality Commission (CQC) or equivalent body.

There is therefore more involvement of other agencies than reported in *First Four Years*. This almost certainly reflects increased visibility due to database changes.

At the end of 2008/09, 231 out of 863 2008/09 referrals, about one in four, involved one or more of the agencies listed above. If educational bodies (deaneries and colleges) and the CQC (or equivalent) are excluded the number of cases with other bodies involved falls to 193, about one in five. This is a higher proportion than at referral because other agencies become involved as cases progress.

Summary

- About two thirds of cases are concerned with clinical difficulties or governance/safety issues.
- About one case in six, 16 per cent, involves misconduct alone – this is the largest distinct concern category.
- There are many similarities in the broad concerns reported in different practitioner groups.
- One referral in five comes to NCAS within a week of a concern being identified.
- The General Medical Council or General Dental Council are involved in only seven per cent of cases at the time of referral to NCAS.

Chapter 4 – Suspension and exclusion from work

NCAS normally has around 450 cases open at any one time. About a third relate to practitioners excluded or suspended from NHS work by their employing or contracting bodies. NCAS' role is to track how these measures are being used and to provide advice on their appropriate useⁱ. Having started in England, this work is now extending to the whole of the UK and a large case archive is available for analysis. The archive is used here to examine the reasons for use of suspension or exclusion, the duration of episodes, methods of resolution and the extent to which the risk of suspension/exclusion differs between practitioner groups. Statistical modelling is used and reaches conclusions similar to those in chapter 2 in relation to groups defined by gender, ethnicity and place of qualification. NHS exclusion and suspension are not to be confused with regulatory suspension from a professional register. Regulatory action may or may not be taking place alongside NHS action.

What information does NCAS hold about suspension/exclusion cases?

The information held about these episodes matches that held for referrals generally, but with cause, outcome and regulatory framework also classified. The information is collected by NCAS as part of the normal case record. A specialist HR team provides casework back-up as necessary.

Virtually all episodes of suspension and exclusion have been captured in NCAS records since 2006/07. At the end of 2008/09 the archive contained information on over 650 closed episodes, including both dental and medical cases. The earliest episodes began in 2000. At the start, there was probably some under-recognition locally and therefore under-recording centrally, first in the Department of Health and then in NCAS when monitoring responsibilities were transferred.

Analyses of cause and method of resolution used 506 episodes concluded by the end of 2007/08 from throughout the UK. The group included 27 dentists and 479 doctors. There were 193 GP episodes and 313 H&C episodes. A definitive 2008/09 dataset was not available in time for use in this reportⁱⁱ.

For analyses requiring comparison with workforce profiles, a restricted dataset of England cases was used, because NCAS recording of suspension/exclusion episodes has been most complete in England. At the time of writing, collection procedures were still being discussed with Health Departments in Scotland and Wales. General dental practitioners were excluded from this dataset because compatible workforce comparators were not available. H&C dentists were included but alongside H&C medical staff to match their grouping in NHS workforce data.

What gives rise to suspensions/exclusions and how are episodes resolved?

Table 4.1 shows episode starts and ends by sector and profession over four years to 2007/08. A low number of 'ends' is recorded in 2004/05 when NCAS monitoring first started and starts were not fully captured.

Over the period shown, 80–100 H&C doctors were excluded each year in the UK and 60–70 primary care doctors were suspended. The risk of suspension for a general medical practitioner is approximately twice the risk of a medical H&C exclusion, taking into account the different sizes of the GP and H&C workforces.

ⁱ NPSA Directions 2005 refer to developing and administering the national suspensions and exclusions monitoring and reporting project

ⁱⁱ Some 2008/09 analyses will be included in the 2008/09 Casework Activity Report, due on the NCAS website in October 2009.

Table 4.1 – Suspension/exclusion starts and ends, 2004/05 to 2007/08, UKⁱⁱⁱ

	Doctors				Dentists				Number
	H&C Exclusions		GP Suspensions		H&C Exclusions		GP Suspensions		
	Starts	Ends	Starts	Ends	Starts	Ends	Starts	Ends	
2004/05	56	34	49	8	3	1	5	1	
2005/06	96	82	55	40	4	5	1	3	
2006/07	80	84	57	64	1	4	3	3	
2007/08	100	100	66	67	1	3	14	7	

Chart 4.1 shows active episodes at year ends. At the end of 2007/08, 122 doctors and dentists were formally held away from work, 55 by H&C exclusion and 67 by GP suspension. The end-of-year totals fluctuate without a clear upward or downward trend.

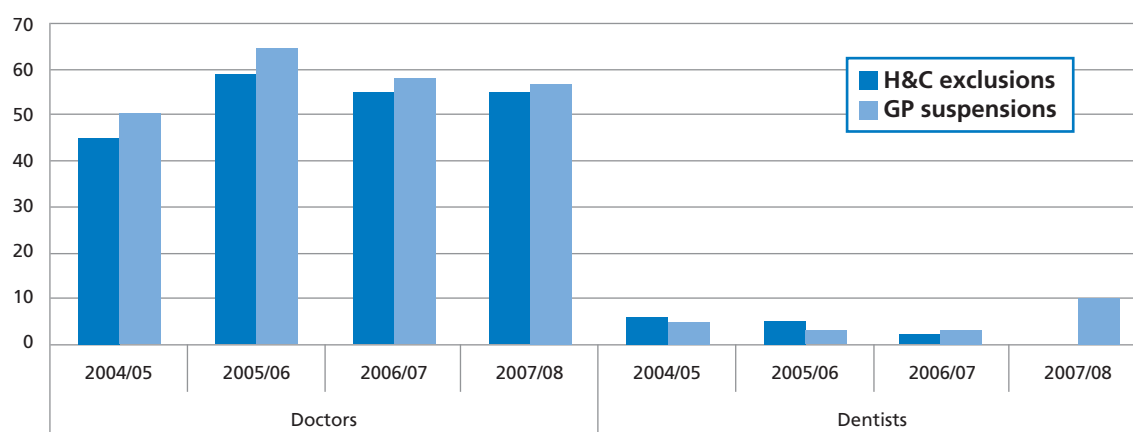
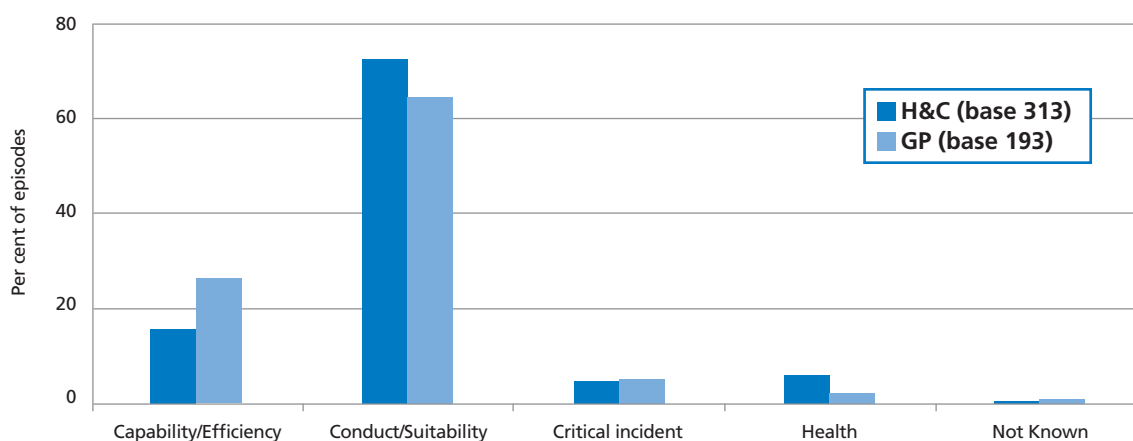
Chart 4.1 – Active exclusions and suspensions at year end, 2004/05 to 2007/08, UK

Chart 4.2 shows the causes of suspension or exclusion for cases brought to a close by the end of 2007/08. The chart uses terms which allow GP and H&C cases to be looked at together, the H&C terms 'capability' and 'conduct' being matched with 'efficiency' and 'suitability' in Performers List language^{iv}. 'Conduct/suitability' accounts for a large majority of cases.

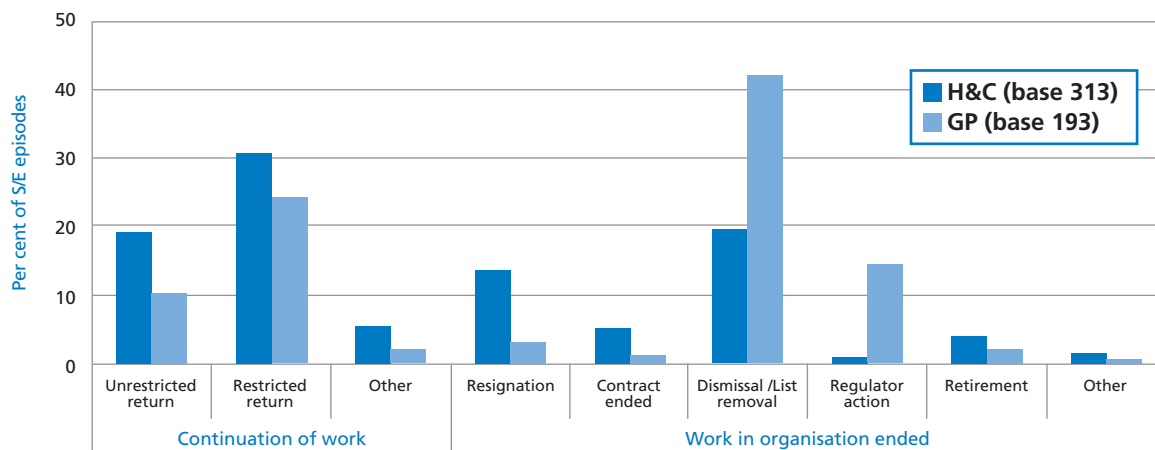
Chart 4.2 – Main causes of suspensions/exclusions ended by 2007/08, UK

ⁱⁱⁱ As the text explained, episodes are included from all parts of the UK but there is probably some incompleteness outside England in the first two years, in table 4.1 and charts 4.1 and 4.2.

^{iv} These categories are less detailed than the new concerns classification described in chapter 3. For recent suspension/exclusion cases chapter 3-type information is also held but we do not have this data for enough cases for separate analysis yet.

Chart 4.3 shows how the episodes were resolved, distinguishing episodes where work with the same organisation continued or came to an end. Amongst excluded H&C practitioners, 55 per cent returned to work while only 35 per cent of suspended GPs did so. The bulk of practitioners from both sectors returned to work under restrictions.

Chart 4.3 – Outcome of suspensions/exclusions ended by 2007/08, UK



While chart 4.2 showed considerable similarity between GPs and H&C practitioners in the reasons giving rise to suspension/exclusion, there is less similarity at the end of episodes in chart 4.3. Twenty per cent of H&C exclusions ended with dismissal but 42 per cent of GP suspensions ended with removal from the list. The processes of GP suspension and H&C exclusion are very different, however, with more options in the H&C sector for keeping a practitioner safely at work.

How long do suspension/exclusion episodes last?

While the number of new H&C exclusion episodes is not falling, it appears that episodes are being brought to a close more quickly. Table 4.2 shows more H&C episodes in 2007/08 at the low end of the duration distribution than in 2006/07. Table 4.3 shows a 20 per cent reduction in mean duration between the two years (a fall from 38 weeks to 30 weeks). Median duration fell 40 per cent (from 18 to 11 weeks). These falls are based on a fairly small number of cases so a downward trend cannot be said to be well-established yet. The indications are that managers in the H&C sector are using the exclusion procedure with greater confidence, knowing they can control the process and can bring it to an end once no longer needed.

For GP suspensions, table 4.3 shows mean duration rising between 2006/07 and 2007/08 (from 48 weeks to 55 weeks). Median duration was approximately static.

Table 4.2 – Duration of concluded suspension/exclusion episodes, 2006/07 to 2007/08, UK

		Number and per cent					
Doctors and dentists	Episode concluded in	<13 weeks	13<26 weeks	26<52 weeks	52<104 weeks	104 weeks or more	All episodes
Number of episodes closed							
H&C exclusions	2006/07	34	16	20	11	7	88
	2007/08	56	20	11	9	7	103
GP suspensions	2006/07	16	11	17	15	8	67
	2007/08	12	19	18	10	15	74
Per cent of episodes closed							
H&C exclusions	2006/07	39	18	23	13	8	100
	2007/08	54	19	11	9	7	100
GP suspensions	2006/07	24	16	25	22	12	100
	2007/08	16	26	24	14	20	100

Table 4.3 – Mean and median duration of episodes ended in 2006/07 to 2007/08, UK

Weeks				
	Duration in weeks	Episodes concluded in 2006/07	Episodes concluded in 2007/08	Change
GP suspensions	Mean	48	55	15% increase
	Median	34	33	
H&C exclusions	Mean	38	30	20% reduction
	Median	18	11	40% reduction

Are some practitioner groups at greater risk of suspension/exclusion?

This was examined using 567 England episodes started (but not necessarily concluded) by the end of 2007/08. Dentists were not included. H&C exclusions accounted for 340 of the episodes and 227 were GP suspensions. There are fewer missing data for suspension/exclusion cases than for referrals generally so comparisons with the workforce are strengthened. Completeness was 100 per cent for specialty and grade group, 99 per cent for gender, 93 per cent for place of qualification and age-group at referral, and 86 per cent for ethnicity group.

Observed exclusions and suspensions were compared with what might be expected if episodes arose in proportion to workforce share. Table 4.4 shows H&C exclusions and table 4.5 GP suspensions, but without an ethnicity comparison for GPs because there is no workforce comparator. Missing data are included in each 'actual' group to show the range of values possible'. 'Expected' figures also show ranges where there are missing data in workforce figures. The final column of each table shows whether actual exclusions and suspensions are within or outside the expected range.

There are close similarities between the two sectors, with more suspensions/exclusions amongst men, older practitioners and practitioners who qualified outside the UK than would be expected based on workforce profile. For the H&C sector there are also more non-white exclusions but this is not a comparison which can be made for GPs where there is no workforce comparator.

Table 4.4 – Characteristics of H&C doctor exclusions to end 2007/08, England

Number				
Group		Actual exclusions	Expected exclusions	Comparison
All		340	340	
Age	<40	102-131	196	Actual lower
	40-49	111-140	82	Actual higher
	50-59	76-105	48	Actual higher
	60+	22-51	14	Actual higher
Gender	Male	289-292	208	Actual higher
	Female	48-51	132	Actual lower
Grade	Consultant	180-183	123	Actual higher
	Other career grade	70-73	45	Actual higher
	Training grade	87-90	172	Actual lower
Specialty	Surgery - O&G	112	90	Actual higher
	General medicine group	59	90	Actual lower
	Psychiatry group	72	35	Actual higher
	Other H&C specialties	97	125	Actual lower
White	UK qualified	84-117	160-174	Actual lower
	Qualified outside UK	26-54	31-40	Ranges overlap
Non-white	UK qualified	27-68	40-54	Ranges overlap
	Qualified outside UK	153-189	86-95	Actual higher

^v For age, for example, the number of excluded practitioners aged under 40 amongst the 340 H&C cases examined was at least 102 but possibly as high as 131, given that age was not recorded for 29 cases. Fifty-eight per cent of the 2007 H&C workforce were aged <40 so 196 of the 340 might be expected to be in this age-group. This is well outside the observed range. Other 'expected' figures are generated similarly.

Table 4.5 – Characteristics of GP suspensions to end 2007/08, England

				Number
Group		Actual suspensions	Expected suspensions	Comparison
All		227	227	
Age	<40	23-36	59	Actual lower
	40-49	46-59	83	Actual lower
	50-59	88-101	64	Actual higher
	60+	57-70	21	Actual higher
Gender	Male	198-201	132	Actual higher
	Female	26-29	95	Actual lower
Grade	Contractor	152-157		
	Non-contractor	62-67		
	Training grade	8-13	Not available	Not available
Qual.	UK	93-104	177	Actual lower
	Outside UK	123-134	50	Actual higher
Ethnicity	White	79-121		
	Non-white	106-148	Not available	Not available

Tables 4.6 and 4.7 show in another way how ethnicity and place of qualification are associated with H&C exclusion. Given that white practitioners qualifying in the UK are apparently at lower risk of exclusion, the tables show the exclusions which would be expected if other groups experienced the white UK-qualified exclusion rate. Table 4.6 compares specialties and table 4.7 compares age-groups. The final column in each table shows where actual exclusions are outside the expected range. The largest differences between actual and expected exclusions are amongst non-white non-UK-qualified doctors. In general medicine, 'actual' exceeds 'expected' for non-white UK-qualified and white non-UK-qualified doctors as well, but with very small numbers involved.

Table 4.6 – Expected exclusions based on UK-qualified white doctor rates – specialty

						Number
Specialty	Place of qualification	Ethnicity	Actual exclusions	Expected exclusions	Comparison	
Psychiatry	UK	White	16-22			
		Non-white	5-12	3-6	Ranges overlap	
	Outside UK	White	4-10	5-10	Ranges overlap	
Surgery -O&G	UK	Non-white	39-46	12-21	Actual higher	
		White	33-48			
	Outside UK	Non-white	8-27	10-20	Ranges overlap	
		White	6-18	6-14	Ranges overlap	
General medicine	UK	Non-white	44-60	20-36	Actual higher	
		White	11-14			
	Outside UK	White	9-14	3-6	Actual higher	
Other specialties	UK	White	4-7	1-3	Actual higher	
		Non-white	29-34	4-6	Actual higher	
	Outside UK	White	24-33	4-9	Ranges overlap	
	Outside UK	White	5-15	4-8	Actual higher	
Non-white		11-21	11-18	Actual higher		

Table 4.7 – Expected exclusions based on UK-qualified white doctor rates – age

						Number
Age	Place of qualification	Ethnicity	Actual exclusions	Expected exclusions	Comparison	
Under 40	UK	White	18-42			
		Non-white	15-45	6-21	Ranges overlap	
	Outside UK	White	6-30	3-10	Ranges overlap	
		Non-white	50-83	9-26	Actual higher	
40 and over	UK	White	65-92			
		Non-white	12-43	6-15	Ranges overlap	
	Outside UK	White	18-43	13-25	Ranges overlap	
		Non-white	99-131	31-52	Actual higher	

As in chapter 2, statistical modelling was used to test these conclusions. The method was essentially the same so it is not described again. Including an ethnicity-place of qualification interaction variable and ranking associations in order of relative risk, exclusions were:

- significantly higher amongst men than women;
- significantly higher amongst non-white non-UK-qualified doctors than white UK-qualified doctors;
- significantly higher amongst consultants than training grades.

According to the modelling work, non-white UK-qualified doctors and white non-UK qualified doctors were not at greater risk of exclusion than white UK-qualified doctors. Nor were doctors in non-consultant career grades. They appeared to be in table 4.4 but when ethnicity and place of qualification are taken into account the greater risk is no longer apparent.

In addition, there was not a significant association with specialty, even though there appeared to be in table 4.4. Again, it appears that other factors are behind these differences. The chapter 2 discussion of referral risk amongst psychiatrists is probably relevant here too.

Have exclusion patterns changed since the National Audit Office survey of 2003?

In 2003, the National Audit Office (NAO) surveyed exclusions in order to measure their cost and see the scale of potential savings if exclusion use could be reduced. This was a one-off survey involving analysis of 206 doctor exclusions in the H&C sector^{vi}.

The NAO identified a high risk of exclusion amongst male doctors and doctors from ethnic minorities, looking at exclusion episodes lasting more than six months. There were 95 such cases in the dataset examined in this report, with ethnicity known for 78 of them and gender known for 94. The patterns are much the same now:

	NAO, 2003	NCAS, 2009	
	Per cent	Cases	Per cent
White	59-61	33-50	35-53
Non-white	39-41	45-62	47-65
Male	82	84-85	88-89
Female	18	10-11	11-12

^{vi} See National Audit Office. *The Management of Suspensions of Clinical Staff in NHS Hospital and Ambulance Trusts in England*. London: The Stationery Office, 2003. Available at: www.nao.org.uk/publications/0203/suspensions_of_clinical_staff.aspx

The number of NHS exclusions and suspensions is relatively small but the cost to the NHS is large^{vii}. In 2003, the NAO estimated that H&C doctor exclusions cost an average of £188,000, over an average period of 47 weeks. The NAO's H&C weekly cost estimate was therefore £4,000 at 2001-02 prices. The mean duration of the 313 concluded H&C exclusion episodes (shown in table 4.1) was 32 weeks, a substantial fall on the NAO study baseline of 47 weeks, so it is clear that savings have been made.

However, cost estimates should also include GP suspensions, where NCAS estimated the mean duration at 48 weeks. At current prices, the annual cost to the NHS of suspensions and exclusions together is probably in the region of £30 million. This figure is based on 100 new H&C exclusions and 70 new GP suspension episodes a year, assuming approximate cost equivalence between the sectors, and using current estimates of duration. There is therefore considerable scope for further savings.

NCAS will continue to support local management of suspension and exclusion episodes so that these measures are only used where necessary and are brought to conclusion as quickly as possible. In this way, costs can be minimised while ensuring that patients and public are protected. It should also be noted that doctors qualifying outside the UK account for about 60 per cent of NHS suspensions and exclusions^{viii}. The development of better induction and support systems for these doctors could therefore produce further savings.

Summary

- About two thirds of suspensions (GP) and exclusions (H&C) arise because of suitability or conduct issues.
- The number of new episodes each year is not falling but the duration of H&C exclusions appeared to shorten between 2006/07 and 2007/08.
- More than half of H&C practitioners return to work after exclusion but only a third of GPs do so. And while a fifth of exclusions end in dismissal, more than twice this proportion end in list removal amongst GPs.
- H&C exclusion from work is more likely amongst men, amongst consultants and amongst non-white practitioners who qualified outside the UK.
- We found no evidence that non-white H&C doctors who qualified in the UK were being excluded disproportionately.
- No significant specialty differences were found, apart from the higher risk of suspension for GPs relative to exclusion use amongst H&C doctors.
- Amongst GPs, the risk of suspension from work increases beyond age 50 and is higher for men, and non-UK-qualified practitioners. There seem to be strong similarities with H&C exclusion patterns but ethnicity effects cannot be investigated without a GP workforce comparator.

^{vii} The gross cost to the NHS comprises employment costs, costs of service cover, management time of various sorts and legal costs. There may also be retraining costs, or settlement costs if employment is terminated. If settlement and retraining costs are excluded, the cost of suspensions and exclusions will be approximately in proportion to duration.

^{viii} Based on 567 doctor exclusions and suspensions started by the end of 2007/08. Place of qualification is recorded for 93 per cent. The proportion qualifying outside the UK is in the range 55–62 per cent.

Chapter 5 – Support, assessment and action planning

All referrers receive NCAS telephone advice, usually on the same or next day if the concern is urgent and referrers are available. In about 60 per cent of all cases, telephone advice is sufficient to provide the help the referrers require and the case may only be open with NCAS for a week or two. In other cases NCAS gives the case more active support. The case remains with the same adviser, acting as an 'account manager' in effect. Specialist help is then brought in on a case-by-case basis, either from the support, specialist HR, assessment operations or action planning teams. This chapter describes some of the characteristics of these cases, discussing especially the 134 GP and 135 H&C cases which went to assessment during NCAS' first eight years.

How do cases progress after initial advice?

All cases involving formal suspension or exclusion receive ongoing advice and support until resolved. So do cases where an NCAS performance assessment may be appropriate. In addition, the following characteristics will keep a case open after initial advice:

- The problem is significant and/or repetitious but not serious enough to warrant immediate referral to the regulator.
- The referring organisation has taken reasonable steps to manage the problem but they have not been successful.
- It is appropriate for the adviser and case manager to visit the referring body or practitioner.
- The reasons above do not apply but the case is still complex and further support is needed to determine next steps.

NCAS provides 'support' in whatever form is agreed necessary in discussion with the referrer and often the practitioner. The work could involve preparation for assessment, advice on local investigations, the application of disciplinary processes, the handling of health concerns, or the tailoring of educational programmes. A typical support case will be with NCAS for about six months.

Prior to 2008/09, formal remediation programmes were proposed only following NCAS assessment. NCAS will now propose remediation plans without assessment, if there is agreement from the referring body and the practitioner and there are identifiable concerns to address. These could result from a local internal or external investigation or review, from an appraisal, or as part of a return to work programme following exclusion/suspension or an extended period away from practice. There were formal remediation plans in 30 non-assessment cases in 2008/09.

Assessment cases will normally be with NCAS for an extended period. The need for an assessment may be apparent immediately or it may emerge later in the case. The assessment process most commonly starts three to six months after referral. 'Start' is defined as the point when there is formal written agreement between the practitioner, referrer and NCAS to take the assessment forward. Assessments now typically take around 20 weeks to complete, measuring from formal start to delivery of a draft report to the referrer and practitioner.

NCAS will support the referrer and practitioner through the assessment preparation period, through the assessment itself and through the subsequent action planning process. The assessment process is described on the NCAS website⁶. It is the most resource-intensive part of NCAS work so considerable effort is made to ensure that assessments are carried out only in situations where they are likely to contribute to the employer's or contracting body's resolution of the case.

What are the characteristics of practitioners undergoing assessment?

The method here is the same as in chapters 2 and 4 – description of cases supported by statistical modelling. No demographic data are missing for assessment cases.

Table 5.1 compares the distribution of assessments and referrals, looking at eight-year totals for both. The assessment rate is higher amongst doctors than dentists, amongst career grade practitioners than training grades, and amongst GP career grades than H&C career grades. Since grade was not recorded for 298 of the 4,692 referrals examined, the table inflates referral total divisors so that rates in the final column are not overstated.

Table 5.1 – Assessments and referrals by grade, to 2008/09

Profession	Sector	Grade	Assessments	Number and per cent	
				Referrals (grossed up)	Assessments as per cent of referrals
Doctors	GP	Career	123	1500	8
		Training		47	
	H&C	Career	124	2247	6
		Training	3	470	1
Dentists	GP	Career	11	322	3
		Training		1	
	H&C	Career	8	100	8
		Training		5	
All	All	All	269	4692	6

Chart 5.1 shows the specialty distribution of assessments and referrals, again looking at eight-year totals. Psychiatry has fewer assessments than would be expected from referral numbers, and general medical practice has more – also seen in table 5.1. The low number of assessments of psychiatrists may reflect a distinctive referral threshold in this specialty.

Chart 5.1 – Specialty distribution of assessments compared with referrals

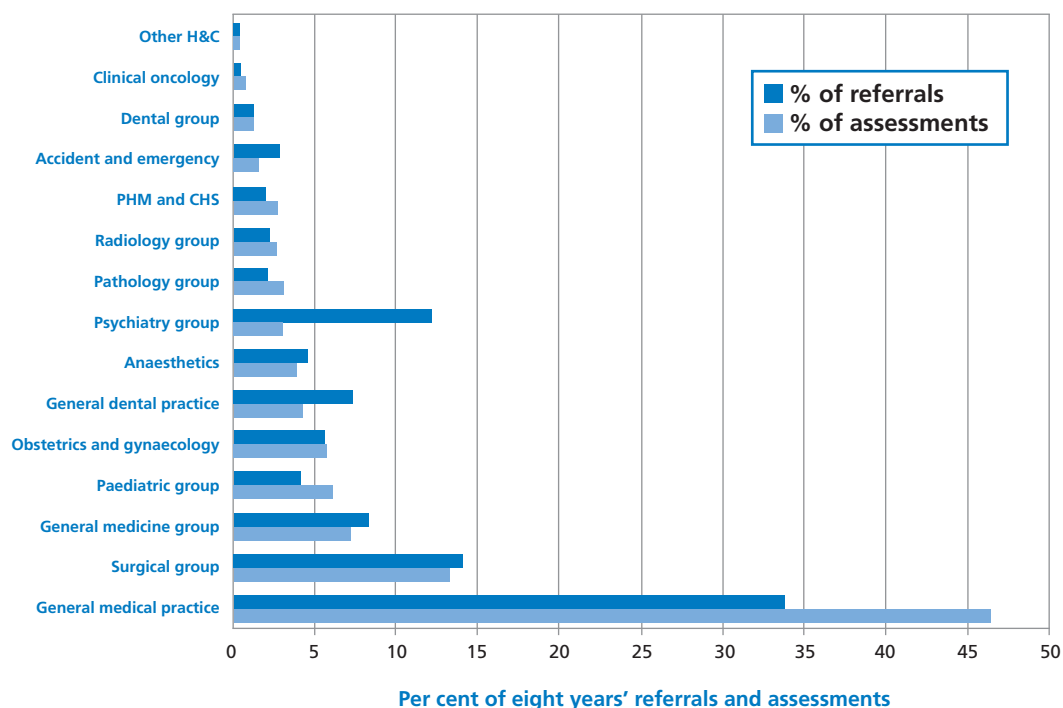


Chart 5.2 shows the age group of assessed practitioners, as recorded at the time of referral, and therefore possibly a year or so below age at assessment. Amongst general practitioners the 50–59 age group has appreciably more assessments than other age groups, while in the H&C sector the 40–49 and 50–59 age groups were close to equal. The chart includes both doctors and dentists.

Chart 5.2 – Age distribution of practitioners identified for assessment by sector

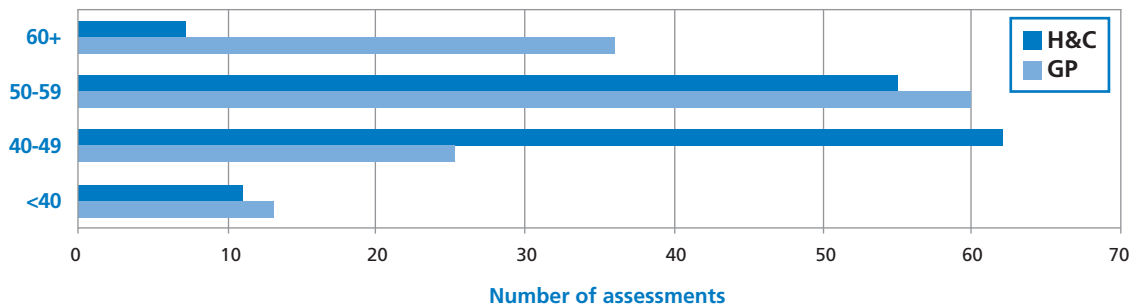


Chart 5.3 compares the age distribution of referrals and assessments. Chapter 2 showed that older age groups have more than their share of referrals. This chart shows the 50–59 age group having a disproportionate share of assessments relative to referrals. Only three assessments of training grade practitioners have been carried out so assessment is more commonly used to help resolve performance difficulties well into a practitioner's career. Training grade practitioners are of course subject to continuous assessment as part of their educational programmes.

Chart 5.3 – Age distribution of practitioners assessed and referred

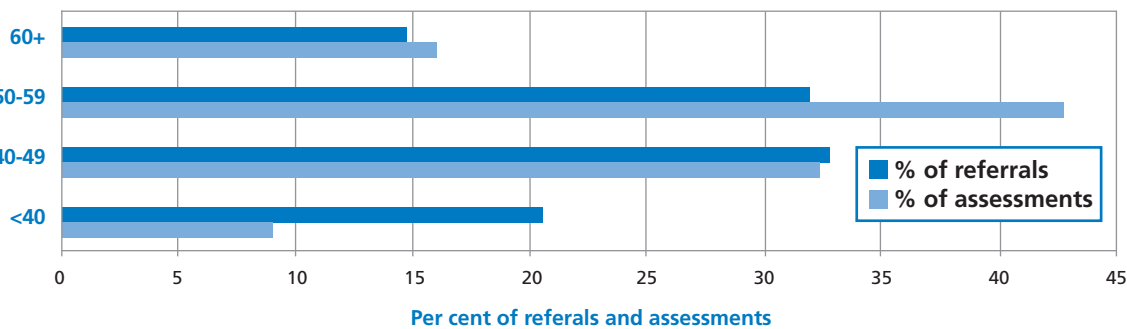
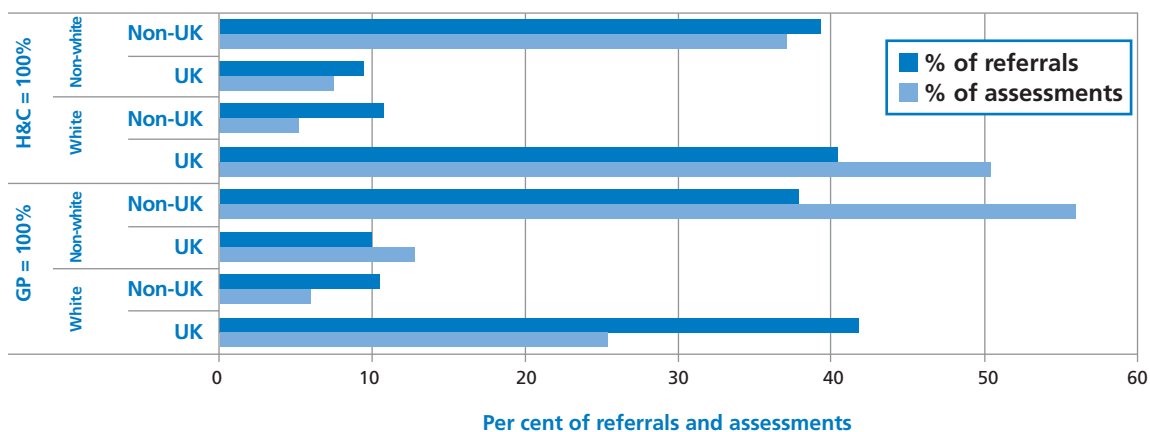


Chart 5.4 looks at ethnicity and place of qualification in the same way. There is a higher rate of assessment for GPs in the non-UK-qualified non-white group but not in the H&C group where the rate is higher amongst UK-qualified white practitioners.

Chart 5.4 – Ethnicity and place of qualification of practitioners assessed and referred



NCAS has a formal process for agreeing the suitability of a case for assessment. Those members of staff deciding which cases should progress to assessment are not aware of the practitioner's age, gender, ethnicity, place of qualification or disabilityⁱ. Referring to practitioners by number rather than name in case papers provides additional protection.

As in chapters 2 and 4, statistical modelling was used to look for associations between selection for assessment and the case characteristics described above – specialty, grade, age, gender, place of qualification and ethnicity. However, the comparison in this case was with referral numbers rather than workforce numbers because the purpose was to test whether assessments were occurring across all referrals or were associated with particular case characteristics. An ethnicity-place of qualification interaction variable was used again.

Ranking in order of relative risk from high to low, as usual, assessments were:

- significantly more likely amongst consultants and contractor performer GPs than amongst training grades;
- significantly more likely amongst other career grades and non-contractor performers than amongst training grades;
- significantly less likely in psychiatry than in surgery/O&G;
- significantly more likely in the 40–49 and 50–59 age groups than amongst practitioners under 40.

Modelling also suggested that assessment has been significantly more likely amongst non-white practitioners qualifying outside the UK, than amongst white UK-qualified practitioners. However, the association is much weaker than grade and age associations. Also, chart 5.4 suggested that it is only amongst GP cases that this is being seen, and that the opposite may be happening amongst H&C practitioners. Given that the processes for identifying cases appropriate for assessment are precisely the same across the two sectors, it seems reasonable to conclude that this weak association is the result of chance and is not indicating a discriminatory process. NCAS will nevertheless continue to scrutinise the operation of its assessment processes closely to ensure fairness.

How does NCAS support remediation programmes?

An NCAS performance assessment results in recommendations for the practitioner and the referring organisation. In the majority of cases a remediation programme is proposed. NCAS will support the parties through the remediation process but the referring body and practitioner are responsible for implementing the NCAS recommendations and the referring body remains, at all times, responsible for the practitioner's management.

NCAS recommends that the remediation process is underpinned by an action plan mapping out the programme's steps. Action planning as part of a remediation programme helps the practitioner and referring body address the assessment report's recommendations and provides robust evidence to support any further action required, including sign-off and a return to a defined and agreed work role if not necessarily to normal working.

NCAS recommends that action planning follows the principles set out in the *Back on Track* (2006) framework⁷. These can be applied to any situation where a practitioner has been out of practice for a significant period, has been working under restriction, or has been the subject of a performance assessment – not necessarily an NCAS assessment. The *Back on Track* framework was developed in collaboration with key stakeholders including deaneries, royal colleges, the General Medical Council and General Dental Council, the Department of Health, NHS Employers, NHS Professionals, the British Medical Association and British Dental Association, defence organisations and others.

To assist the parties through the action planning process NCAS offers to:

- Facilitate a structured meeting between the practitioner and the referring body to help the parties explore their options.
- Provide support (as needed) to the practitioner and referring body in drafting an action plan based on the recommendations within in the NCAS assessment report.
- Help the referring body to identify local deanery contacts and/or appropriate royal college representatives/services where necessary.

ⁱ There are very few occurrences of disability (as distinct from health concerns) amongst NCAS cases.

- Provide templates and guidance for use in drafting the practitioner and organisational action plans.
- Participate in further structured meetings to review progress against the agreed objectives, once the action plans are drafted and agreed by the referring body and the practitioner.
- Provide telephone support to review progress against the action plans and offer any additional advice required.

This form of NCAS support has been strengthened over the past two years and outcomes are now assessed and captured routinely and will be the subject of future published reports. For earlier outcome information we are dependent on retrospective analysis by the research and evaluation team—see the following section.

What are the longer term outcomes of NCAS assessment?

A recent NCAS review sought to establish remediation outcomes for 144 NCAS assessment cases where the final assessment report was received by the referrer and practitioner by the end of December 2006. Before this review, a similar project examined outcomes for the first 50 assessment cases⁸. Nearly all the 144 cases in the recent review were closed. Access to information about what happened after assessment depended on how long the case stayed open with NCAS. This varied substantially. In around half the cases, there was more than 18 months' follow-up information after assessment, and two thirds of cases had more than 12 months' information.

A remediation programme was taken forward in 101 of the 144 cases. In 41 cases a remediation programme was not pursued and in a majority of these cases the practitioner was referred to the regulator. In two cases the pathway was not known by NCAS.

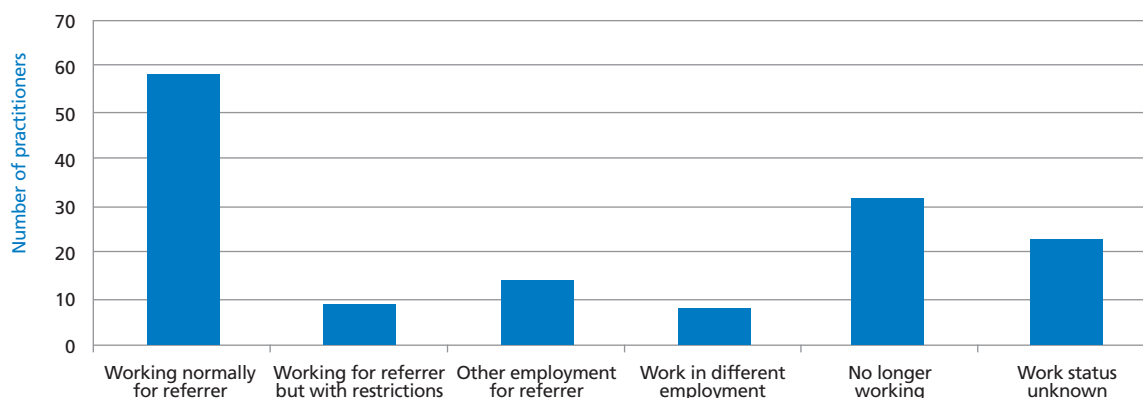
In 73 of the 101 cases where remediation was pursued, the remediation programmes had reached an endpoint while the case was open with NCAS, so NCAS could assess the extent to which performance concerns were resolved through the programme and examine working status on completion of remediation. In the remaining 28 cases the programme was ongoing at last contact on the case.

The extent to which NCAS considered there was resolution of concerns in the 73 cases at the time of case closure, or other last contact on the case, was as follows:

- In 48 per cent (35 cases) the concerns were considered by NCAS to be fully addressed.
- In 38 per cent (28 cases) they were partially or not at all addressed at case closure and the practitioner was working or potentially working. Five of the 28 cases were with the regulator at case closure, in two further cases the regulator had found the practitioner fit to practise, and in another the regulator did not progress the case. NCAS does not have any information about how any outstanding concerns were taken forward locally following case closure.
- In 10 per cent (seven cases) the practitioner was no longer working at case closure and this was likely to be permanent.
- In four per cent (three cases) NCAS did not have sufficient information to judge.

Chart 5.5 shows the last working status known to NCAS for the 144 practitioners followed up. In 56 per cent (81) cases the practitioner continued to be employed by the referring body. A large majority (58) were working normally, but a small number were working with restrictions. If employment for another organisation is included, about two thirds of practitioners were known to be working at case closure.

Chart 5.5 – Last known working status of 144 practitioners assessed by 2006



Summary

- About 60 per cent of cases are closed after initial advice. The rest remain open as support or assessment cases, for as long as is necessary.
- Assessments are carried out across the whole spectrum of grades and specialties but with assessment being more likely amongst practitioners in career grades.
- Selection for assessment uses internal processes designed to maintain a common threshold for assessment and fair treatment between practitioner groups. Statistical analysis suggests that this is successful.
- Assessments are being followed up with structured remediation programmes. Where appropriate, these programmes are now being used with practitioners who have not been through NCAS assessment.
- A recent review of 144 practitioners whose assessments were completed by the end of 2006 showed that two thirds were still in employment at case closure and after (in most cases) completion of an NCAS-recommended remediation programme.

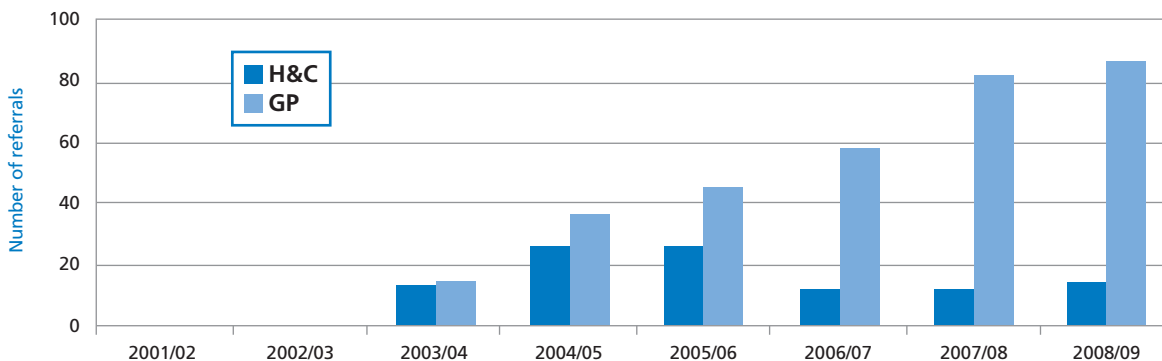
Chapter 6 – NCAS work with dentists

NCAS launched its dental services in April 2003 for employed dentists and in April 2005 for general dental practitioners, following wide consultation about how NCAS principles could best be applied to dental work. Dental services are now fully integrated into NCAS operations, with dental advisers dealing with medical as well as dental cases, working alongside advisers with medical or non-clinical backgrounds in both primary and secondary care. This integration provides a model for extension of NCAS services to pharmacy. By the end of 2008/09 NCAS had received 428 dental referrals. The same information is collected about referred dentists as referred doctors so there is unusual scope for comparing doctors and dentists and asking questions about why certain differences might be arising.

How many dentists have been referred to NCAS?

In 2008/09, 102 of the 863 referrals to NCAS (12 per cent) concerned dentists. In total, 87 referrals came from general practice and 15 were from the H&C sector. Chart 6.1 shows the build-up of dental casework in the two sectors. Note that 'sector' describes contractual arrangements rather than a clinical speciality.

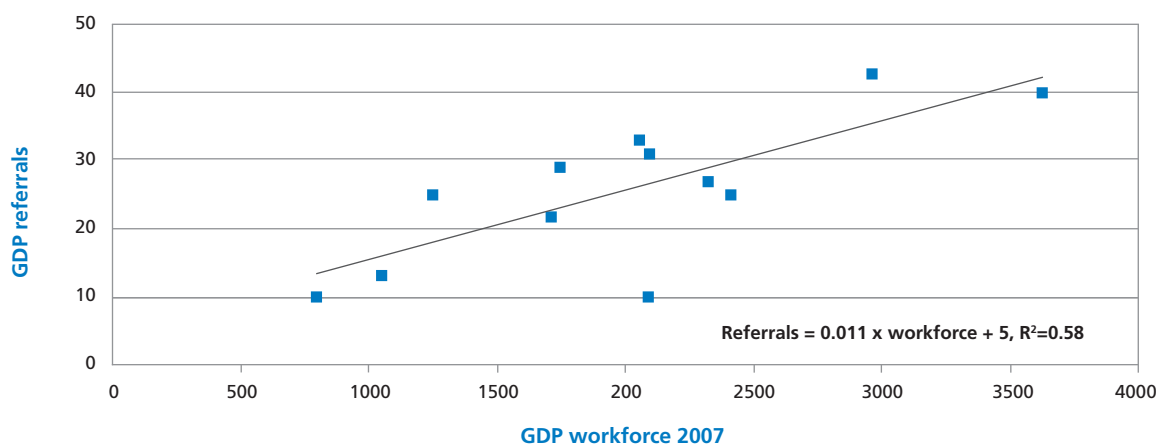
Chart 6.1 – Referrals of dentists to NCAS, 2001/02 to 2008/09



Most early dental referrals came from the H&C sector, probably because NCAS' first awareness-raising work was in this area. When NCAS dental services were first launched, primary care organisations had no role in performance-managing general dental practitioner services. Since introduction of the April 2006 dental contract they have been building this role, in some cases slowly. Sector referrals from dentistry are now approximately in proportion to sector shares of the workforce.

The chance of being referred to NCAS is still smaller for a dentist than a doctor, in both sectors. In chapter 1, table 1.1 estimated one year referral rates based on 900 referrals a year in the UK and the profession-sector profile seen in 2008/09. Overall, the one year rate of referral is about 1 in 290 for a dentist but 1 in 190 for a doctor.

Dentistry also differs from medicine in the way NCAS cases are spread across the country. In chart 1.2 we showed that over eight years, and taking medicine and dentistry and H&C and GP sectors together, the number of NCAS referrals is closely associated with workforce numbers. But if we look at general dental practitioner (GDP) referrals alone and plot against regional GDP workforce, there is a considerably weaker association – chart 6.2.

Chart 6.2 – Dental referrals over eight years from England, Northern Ireland and Wales

This could reflect geographical variation in the incidence of underperformance, variations in mechanisms for identifying and managing underperformance, or both. There is some indication from primary care organisation job titles that less senior managers are making dental referrals. For medical GPs, the first contact with NCAS in about two thirds of cases is from the chief executive or a referrer with a job title including 'director'. For dental referrals, only about a third are made at this level and a higher proportion are from referrers titled as 'managers', 'advisers' and 'officers'. If it is true that the local managers making dental referrals are more junior, and therefore possibly more mobile and less conversant and confident with local management mechanisms, then this might encourage use of NCAS, for reassurance. But equally, it might discourage referral because managers do not feel confident about going outside their organisations for help. Further discussion of dental referral routes is needed with primary care organisations.

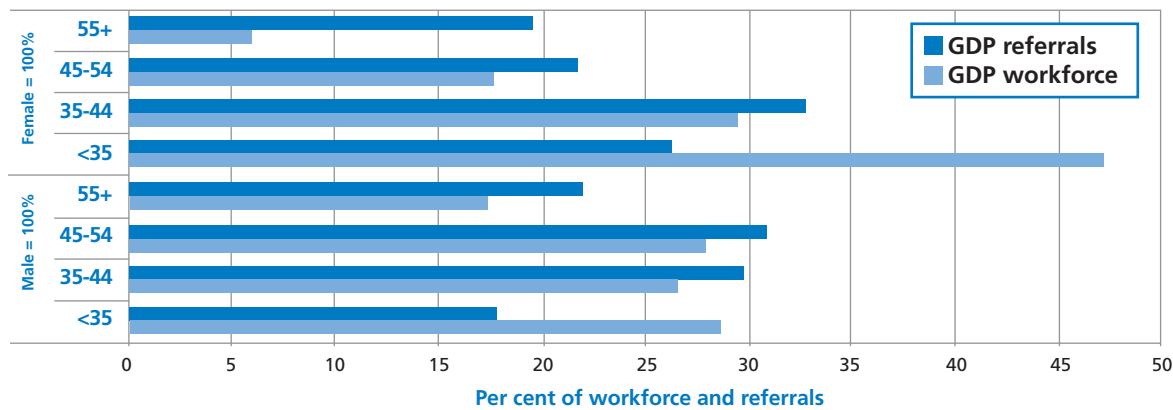
Another distinct feature of dental work is that dentistry makes more use of local 'self-help' systems for addressing underperformance of colleagues. Where a 'Practitioner Advice and Support Scheme' (PASS) is active, an NCAS adviser may work with the PASS team to clarify and resolve performance concerns. PASS mechanisms are a useful addition to local systems for bringing appropriate cases to NCAS attentionⁱ.

Are some groups of dentists more likely to be referred?

NCAS categorises dental cases in the same way as medical cases, and descriptions of data and data collection in the statistical annex apply here too. The new case database in use since 2007 also captures practice size, distinguishing single-handed dental and medical GPs from practitioners in practices of 2–3 or 4+. There is not yet enough data for an analysis of associations between performance difficulties and practice size but future work will cover this, for both doctors and dentists.

Because the number of dental cases is still relatively small these analyses are less detailed than in chapter 2 but the method is the same. Chart 6.3 compares the distribution of GDP referrals and GDP workforce by age group and gender. The pattern is very like that seen in medicine. Amongst both men and women, the referral rate is relatively low below age 35 and higher in the older age-groups.

ⁱ PASS schemes are normally set up under the auspices of the primary care organisation and the Local Dental Committee. Guidance is available from the General Dental Council and the British Dental Association on how to set up and run a PASS scheme. PASS schemes can assist with investigation and with local support and mentoring.

Chart 6.3 – Age and gender distribution of GDP referrals compared with workforce

Gender information about dental referrals is 96 per cent complete. Putting 95 per cent confidence intervals around the percentage of women amongst GDP referrals (20% +/- 5%) and the GDP workforce (40% +/- 1%), the gender difference between referrals and workforce is statistically significant. Similarly, the proportion of GDP referrals aged under 45 (49% +/- 6%) is significantly lower than the proportion under 45 in the workforce (64% +/- 1%) if referrals with age unknown are assumed to have the same age distribution as practitioners with known age.

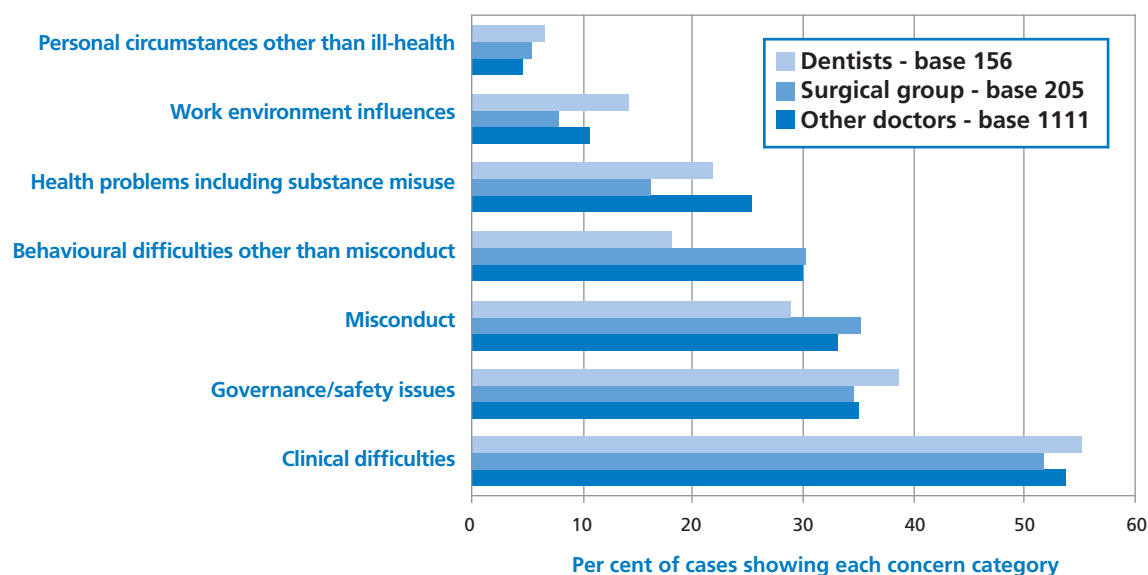
As for general medical practitioners, it is not possible to examine whether referrals are coming proportionately from all ethnic groups without ethnicity monitoring of contractors. A comparison of dental and medical referrals shows different profiles, as would be expected from the historically different approaches to recruitment and registration of doctors and dentists from outside the UK. The ranges in brackets show the potential effect of missing data:

Percentage qualifying in the UK	Dentists	65%	(51-73%)
	Doctors	50%	(39-61%)
Percentage white	Dentists	69%	(50-77%)
	Doctors	48%	(38-60%)
Percentage qualifying outside the UK and non-white	Dentists	16%	(11-32%)
	Doctors	41%	(29-51%)

What are the concerns in dental cases?

When NCAS started to take dental referrals in significant numbers it was recognised that new patterns of concern might be found, especially linked to the business pressures of general dental practice. So far, however, the pattern of concerns logged about dental cases has matched quite closely the pattern for medical cases, at broad concern category level. As the number of dental cases accumulates, more detailed analysis will be possible.

Chart 6.4 is based on the 1,472 cases described in chapter 3. Behavioural concerns may be less common amongst dentists, which matches an earlier reported finding (*First Four Years* table 13), but the difference is not statistically significant. One *First Four Years* hypothesis seems not to be supported: dentists and surgeons do not demonstrate a concerns profile distinct from other NCAS cases, looking at broad concern categories alone.

Chart 6.4 – Concerns observed in dental, surgical and other medical cases

What has NCAS learnt from its dental casework?

H&C dental cases have come predominantly from the community sector rather than from hospital practice. A few early H&C cases came to NCAS as long-standing concerns but once this backlog of demand was met H&C referrals settled into a pattern which is very like casework from other parts of the H&C sector.

Most of the general dental practitioners referred to NCAS so far have been working mainly for the NHS. Although their contracts allow them to provide private treatment alongside their NHS work, the dental mixed economy has not created particular difficulties. The purely private sector in dentistry is still relatively smallⁱⁱ. The business pressure on GDPs may mean an increasing risk of probity issues. But cases come to NCAS where NCAS interventions can be expected to be of some help. There are other mechanisms for dealing with possible fraud, for example, or inappropriate marketing of private treatment.

In primary care organisations, local managers dealing with dental performance may have tended to be less experienced than those managing general medical practitioners. But the gap is closing. Medical GP referrals are now well-documented, with prescribing analyses and Quality and Outcomes Framework reports included in referral information, for example. Dental cases are now arriving with Dental Reference Service reports and case reviews from dental practice advisers or consultants in dental public health. There may be a greater risk of a dental referral arising from a patient complaint to the primary care organisation, as a consequence of the greater mobility of dental patients, especially where dentists in general practice are reducing their NHS commitment. But generally, to NCAS, dental cases look much like medical cases.

By the end of 2008/09, 19 assessments of dentists had either been completed or were under way, 11 of them GDP casesⁱⁱⁱ. The number is too small to describe in detail without compromising practitioner and referrer confidentiality but it is possible to describe some general impressions from five years of dental assessment work:

- While concerns and referrals are generally more common in older age-groups, some dental assessments have been undertaken for dentists quite early in their careers.
- This may raise questions about the support available to dentists at critical career points such as the start of independent practice. But quick identification of concerns is important and this might equally be an indication of effective dental referral processes.

ⁱⁱ The British Dental Association estimate that about 1,000 dentists are currently working in private practice alone.

ⁱⁱⁱ This does not include assessments carried out by NCAS for the General Dental Council.

- Assessment will often uncover difficulties which go beyond the initial reasons for referral. This is in line with medical assessments. The 2005 review of 50 assessments, already referred to, showed that in many cases the process identified new broad or specific areas of concern which were not raised at referral⁸.
- Poor record-keeping is commonly identified as a problem and assessments are looking closely at how records clarify how dentists practise and, for example, what their normal approaches are to the taking of radiographs. Most assessed dentists have used electronic systems. In the long term, computer systems will improve practitioners' record-keeping, in dentistry as in medicine. In the short term, especially for older practitioners who find them difficult to adapt to, they may worsen record-keeping and referral letter-writing practice.
- Despite a growing literature about stress and burnout in general dental practice, health issues have not so far featured to a greater extent than in medical cases.
- A majority of dental referrals to NCAS have been UK-qualified and white. Most assessed dentists have approximately matched this profile. Amongst assessed dentists who qualified outside the UK, place of qualification was normally within the EEA. NCAS' dental work therefore differs from work in primary medical care. See chapter 5 for a fuller discussion of decisions to assess.

Summary

- Dentists are less likely to be referred to NCAS than doctors.
- Referrals of dentists come predominantly from the GP sector.
- There is greater geographical variation in referral rates for dentists than for doctors and further discussion of dental referral routes is needed with primary care organisations.
- As in medicine, women dentists are less likely to be referred to NCAS than men.
- As in medicine, older dentists are more likely to be referred than younger dentists.
- The concerns identified amongst referred dentists are generally much like those seen amongst doctors.

Chapter 7 – Key themes and emerging questions

Some of the themes running through this report are about differences and similarities between practitioner groups. Certain patterns tentatively identified in previous analyses are now seen more clearly. Other new patterns have emerged. They are summarised here.

Sector differences

Chapter 1 described how NCAS is now taking referrals from all parts of the UK in numbers that are broadly in proportion to workforce size. NCAS is a national organisation and many NHS bodies involve NCAS as part of their standard procedures for handling performance concerns. Even so, there is a significant sector difference, with more geographical variation in use of NCAS for GP cases than for H&C cases and more geographical variation in dental GP referrals (chapter 6) than for medical GP referrals. There are significant variations in the rate of GP referral and in use of the GP suspension process. Further research is needed to determine whether the distribution of concerns varies geographically or whether there is variation in the management of performance.

Gender

Chapter 2 looked at differences in referral rates between practitioner groups. Some of the differences are predictable, reflecting that NCAS was set up to work mainly amongst career grade doctors. Although some of our analyses are weakened by data incompleteness, we can say, based on descriptive statistics and regression modelling together, that referrals are substantially less likely amongst women practitioners. This is also seen in chapter 4 where women practitioners are significantly less likely to be suspended or excluded from work. After our *First Four Years* report it was suggested that the low numbers of referrals of women might be an artificial result explained by case differences. Statistical modelling makes us confident now that there is real gender difference in referral rates and therefore, presumably, in rates of performance concern.

When performance concerns do occur, men and women show very similar broad concern profiles (chapter 3). Further research is needed to identify precisely what it is that causes fewer performance concerns to be reported amongst women.

Ethnicity and place of qualification

Associations with ethnicity and place of qualification need careful interpretation. In the H&C sector, white practitioners qualifying in the UK are less likely to be referred (chapter 2) or excluded or suspended (chapter 4) than non-white practitioners qualifying outside the UK. There is no evidence that non-white UK-qualified practitioners are being referred or excluded disproportionately. The experiences of non-white UK-qualified practitioners are an important indicator of equity or lack of it and NCAS will continue to monitor their relative referral rates closely.

These findings suggest that the service should examine further how practitioners qualifying outside the UK should be supported. NCAS and the NHS must also improve the completeness of equality monitoring data to remove some of the uncertainty around current findings. Ethnicity monitoring of primary care contractors is also needed.

Psychiatrists

Our *First Four Years* report showed that the psychiatry group of specialties was accounting for a disproportionately large share of referrals. Descriptive statistics again show this specialty with more referrals (chapter 2) and exclusions (chapter 4). It is now apparent that the above average rates of referral amongst psychiatrists are partly explained by the group's distinct ethnic and place of qualification profile. Further research is needed.

Case concerns

Although there are differences in referral and assessment rates between doctors and dentists, performance concerns amongst dentists have much the same profile as concerns amongst doctors. Indeed, chapter 3 showed similar patterns of concerns amongst most practitioners groups. The launch of pharmacy services from April 2009 provides an opportunity to extend this comparison to a new practitioner group. More detailed analyses will be possible as the number of NCAS cases accumulates.

Outcomes

Chapter 4 showed that more than half of excluded H&C practitioners eventually returned to work in the same organisation, compared with only a third of suspended contractor GPs. Exclusion and suspension cases are amongst the most difficult coming to NCAS, with two thirds to three quarters of them involving serious conduct concerns.

Chapter 5 then showed that about two thirds of practitioners undergoing NCAS assessment were still in employment following NCAS assessment (and in many cases a remediation programme). Overall, therefore, and at the most difficult end of the performance spectrum, a majority of cases are ending with normal or near normal working.

NCAS does not yet have comprehensive outcome classifications for our other cases. A data collection system is under development for introduction later in 2009 and that will give us a clearer picture. But if more than half of the most difficult third of our cases lead to a continued work then it is reasonable to think that the proportion will be very considerably higher in the rest.

NCAS' Research and Evaluation Team will continue to examine how practitioners and managers view NCAS work so that service improvement and development can continue.

Statistical annex

Coverage

Most NCAS statistics are 'whole organisation' figures. Counts of referrals relate to the UK unless otherwise stated.

NHS workforce comparators

In 2007/08, the UK NHS workforce comprised over 180,000 dental and medical practitioners – table A1:

Table A1 – NHS workforce headcounts, 2007/08

	Number			
	Doctors		Dentists	
	Primary care	Secondary care	Primary care	Secondary care
England (mid year)	33,400	90,700	20,800	4,000
Northern Ireland (start of year)	1,100	3,600	800	200
Scotland (mid year)	4,700	11,000	2,500	700
Wales (end of year)	1,900	5,800	1,200	200
UK	41,100	111,100	25,300	5,100

Referral rate calculations and modelling use 2007 workforce figures rather than an eight-year midpoint. Changes in the workforce profile are taking place quite slowly (table A2 – England only) so taking a midpoint is unnecessary. At the time of writing, September 2007 workforce data were the most recent available. Headcounts are used rather than full-time equivalents because the chance of a performance concern being reported ought to be the same whether a practitioner is working part-time or full-time.

Table A2 – Changes in NHS workforce 2001-2007

	Per cent		
	2001 Per cent	2004 Per cent	2007 Per cent
H&C dental and medical staff, England (headcounts)			
Consultant posts	35	35	36
Female	36	37	39
In surgical group	19	19	19
In psychiatry group	11	12	12
Aged under 45	–	70	69
Place of qualification UK (medical staff only)	68	63	63
White (range reflects 'not stated')	65-68	60-61	57-61
Base	73,800	87,000	94,600
General medical practitioners, England (headcounts)			
Female	36	40	43
Place of qualification UK	82	81	79
Aged under 45	48	51	43
Base	30,700	34,100	35,900

Data collection

Data collection methods are as described in *First Four Years*. When a referral is made, basic case information is collected on the phone and entered into a database. This provides background for the NCAS adviser working with the referring manager. Since the end of 2007, advisers have viewed case information online, recording advice and recommendations directly into the case database as part of the advice and support process.

NCAS collects age group at referral rather than date of birth because this is usually all that referrers have readily to hand.

Place of first qualification is categorised as UK, 'other European Economic Area – EEA' or 'outside EEA' without going into more detail because NCAS is not trying to relate concerns back to educational establishments. For this report, place of qualification has been further simplified to UK or non-UK. The dataset includes 367 practitioners qualifying in other EEA countries.

NCAS uses the five ethnicity groupings adopted by the Department of Health (Asian or Asian British, Black or Black British, Chinese or other Ethnic Group, White or Mixed). Ethnicity information is usually provided by referring managers rather than practitioners themselves because NCAS is not in direct contact with many of the practitioners referred. If the manager does not have access to information on file then the referrer is asked to make a judgement, using the five groups listed. The indirect collection of ethnicity information from managers was agreed to be appropriate with the Commission for Racial Equality when NCAS monitoring systems were first set up.

NCAS does not record religion (except in Northern Ireland) or belief or sexual orientation because comparator information about the practitioner workforce as a whole is not available.

Data completeness

Most gaps in NCAS data are probably explained by pressure on referrer managers' time or their limited access to information. Data completeness levels have been maintained or improved since *First Four Years* but there is still some incompleteness and a risk of misinterpretation if data are not missing at random. Across both GP and H&C sectors, only 63 per cent of cases have data in all the fields shown in table A3.

Table A3 – Data completeness, NCAS cases

Field	Per cent		
	2001/02 to 2004/05 Per cent complete	2005/06 to 2008/09 Per cent complete	2001/02 to 2008/09 Per cent complete
Profession, sector	100	100	100
Gender	94	97	96
Specialty group	93	98	96
Grade group	89	96	94
Age group at referral	77	81	79
Place of qualification	69	84	79
Ethnicity	72	81	78

The main method used in this report is to compare NCAS data with workforce data to identify groups where referrals, suspensions/exclusions and assessments are more likely to be found. There are no centrally-collected data about place of qualification for the H&C dental workforce so certain comparisons with the workforce are necessarily restricted to doctors.

The report concentrates on the larger differences between practitioner groups partly because of data incompleteness and also because data are subject to sampling variation. With 197 referrals from the anaesthetics group over eight years and 180 from the paediatrics group in table A8, for example, the difference in referral share for these specialties is not statistically significant.

Missing data are a greater problem for referrals generally (chapter 2) than for suspensions (chapter 4) or assessments (chapter 5) where NCAS has more opportunity to collect case information:

- 1,829 H&C referrals out of 2,810 (65 per cent) have data for all six explanatory variables (age, gender, specialty group, grade group, ethnicity and place of qualification);
- 243 out of 298 H&C exclusions (82 per cent) have all six;
- all 269 assessment cases have all six.

Data gaps on ethnicity are a particular concern. Data could be missing in a way that is not related to the nature of the individual case. Cases with data should then reflect the underlying patterns in the full data. Alternatively, data could be missing in a way that depends directly on the characteristic of interest. For example, ethnicity might be more likely to be recorded as 'not known' when the practitioner concerned is of one specified ethnicity. This will introduce bias by raising the relative referral rate for the group with more ethnicity data recorded. Another possibility is that the chance of data being missing is associated with something else – for example, length of service with an employer, or place of qualification. The effects of missing data in such situations are then difficult to conjecture and assess.

For referrals, data are missing in combination to a greater extent than would be expected looking at one variable at a time. With completeness on age, ethnicity and place of qualification at around 80 per cent, we might expect only around 50 per cent to have all three, rather than the 65 per cent observed. Moreover, nearly all the cases missing gender data are missing age, ethnicity and place of qualification as well. NCAS is dependent on referring managers for information so this may indicate simply that some managers are more able or willing than others to provide the data asked for. Missing data on specialty and grade are less associated with other variables, and could therefore be more random.

Examination of the cases with and without age, ethnicity and country of qualification data showed no gross differences between the two sets of cases in terms of their specialty, gender and grade mix. However, this does not eliminate the possibility of age, ethnicity and place of qualification differences. It is reassuring that the key dependent variables of interest – referrals, assessments and exclusions/suspensions – cannot or are very unlikely to suffer from missing data. This reduces the risk of serious undetected bias.

In chapter 4, ranges are used to show some of the uncertainty which missing data are introducing.

Statistical modelling

Charts and tables can describe the main associations but show only two or three variables at a time and may identify associations which appear important but which actually show the influence of different untested variables.

Regression modelling allows examination of variables together. Poisson regression modelling is appropriate where data are counts of events which, in principle, depend on an overall count. This could be a count of practitioners at risk (in the case of referrals or suspension/exclusions) or referrals (in the case of assessment incidence). Regression has been used in this report to test whether associations are statistically significant rather than to predict referrals or exclusions or assessments deterministically. Cases are included in models only where all independent variables are known. Imputation of missing values may be considered for future work but has not been used in this report.

The regression models look at:

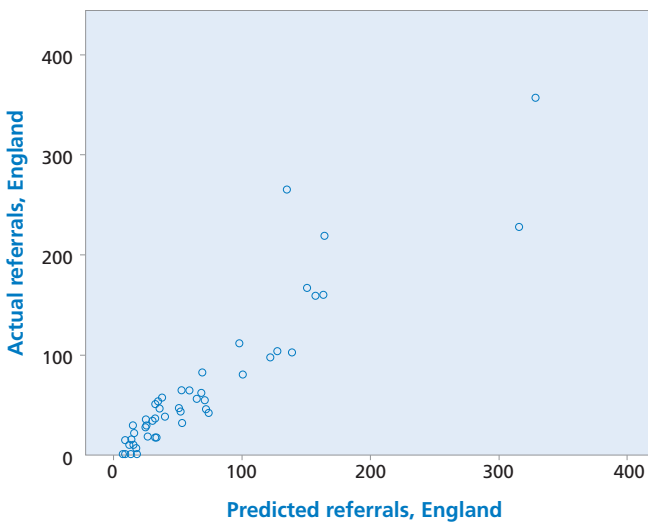
- The likelihood of referral, using workforce and referral groups defined by age, gender, specialty and, for H&C, grade, ethnicity and place of qualification (chapter 2).
- The likelihood of exclusion in the H&C sector, using exclusion and workforce groups defined in the same way (chapter 4).
- The likelihood of assessment given referral, using assessment and referral groups defined in the same way (chapter 5).

The first two are seeking to describe and explain the work that is coming to NCAS, so comparison with workforce numbers is appropriate. The third tests whether NCAS assessments reflect referrals.

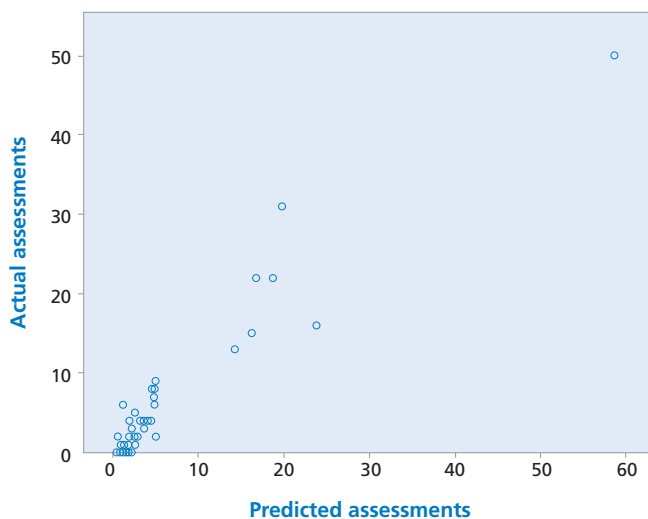
Because fuller workforce data are available for England than for other parts of the UK, the first two regressions used only case data for England, reducing the pool of available cases by 11 per cent. The referral-assessment regressions are NCAS-wide.

For modelling purposes, H&C specialties were grouped as general medicine, psychiatry, surgery/O&G (together) and 'other'. Four age groups were used: under 40, 40–49, 50–59 and 60+.

The first scatter diagram is an example of a model output. It compares eight years' referrals for 48 workforce groups in England with the modelled predictions based on workforce, age (four groups), gender (two groups) and specialty (six groups) in both H&C and GP sectors. The two outliers are male GMPs aged 40-49 (prediction too high) and male GMPs aged 60+ (prediction too low).



Similarly, assessments are quite well-predicted using an age-gender-specialty-referrals model in the same 48 groups. The point at the far right in the next scatter diagram represents male GMPs aged 50–59, the group with the largest share of assessments to date.



Statistical models show associations, not causes. The purpose of modelling is to identify common factors across practitioner groups and suggest starting points for further research, not to suggest that A necessarily causes B.

Data used in charts and text

Chapters 1 and 6

Table A4 – Annual referrals to NCAS, 2001/02 to 2008/09, UK

	Number		
	Doctors	Dentists	All referrals
2001/02	155	...	155
2002/03	350	...	350
2003/04	464	28	492
2004/05	631	62	693
2005/06	647	72	719
2006/07	621	70	691
2007/08	691	94	785
2008/09	761	102	863

Table A5 – Total eight year referrals and workforce by sector, UK except Scotland

	Number							
	Workforce 2007/08				Referrals 2001/02 to 2008/09			
	H&C	GMP	GDP	All	H&C	GMP	GDP	All
England - East Midlands	6,500	2,900	1,700	11,200	148	105	29	282
England - East of England	8,400	3,800	2,400	14,600	278	112	26	416
England - London	19,800	5,400	3,600	28,800	534	251	40	825
England - North East	5,200	2,000	1,000	8,300	110	105	13	228
England - North West	12,900	4,800	3,000	20,700	400	264	45	709
England - South Central	6,700	2,900	1,700	11,300	165	87	22	274
England - South East Coast	6,400	3,000	2,100	11,500	225	98	10	333
England - South West	9,000	4,000	2,300	15,300	203	92	28	323
England - West Midlands	9,600	3,800	2,100	15,400	253	137	31	421
England - Yorkshire and the Humber	9,800	3,800	2,100	15,600	232	156	33	421
Northern Ireland	3,800	1,100	800	5,700	64	20	10	94
Wales	6,000	1,900	1,200	9,100	93	77	26	196

Note: Region/country is not recorded for a small number of cases. Most are self-referrals.

Table A6 – Exclusions and suspensions started by end 2007/08, England

	Number		
	H&C exclusions	GP suspensions	All episodes
England - East Midlands	28	18	46
England - East of England	40	20	60
England - London	76	45	121
England - North East	16	20	36
England - North West	63	43	106
England - South Central	15	20	35
England - South East Coast	24	14	38
England - South West	30	11	41
England - West Midlands	34	30	64
England - Yorkshire and the Humber	26	28	54
	352	249	601

Table A7 – Dental and medical assessments started by end 2008/09, UK

	Number		
	GP/GDP	H&C	All
England - East Midlands	7	6	13
England - East of England	7	10	17
England - London	23	21	44
England - North East	8	6	14
England - North West	27	22	49
England - South Central	6	13	19
England - South East Coast	5	12	17
England - South West	6	10	16
England - West Midlands	17	7	24
England - Yorkshire and the Humber	11	9	20
Northern Ireland	3	4	7
Scotland	2	3	5
Wales	12	9	21
	134	132	266

Note: In addition to the 266 assessments shown here, three were carried out for practitioners in other territories served by NCAS.

Chapters 2 and 6

Table A8 – Referrals and workforce

	Number and per cent			
	Workforce ⁱ	Referrals ⁱⁱ	Per cent of workforce	Per cent of referrals
Doctors and dentists, UK				
General medical practice	41,100	1,549	23	34
General dental practice	25,300	329	14	7
General medicine group	30,000	360	16	8
Surgical group	23,900	628	13	14
Anaesthetics	12,700	197	7	4
Psychiatry group	11,600	541	6	12
Paediatric group	8,600	180	5	4
Obstetrics and gynaecology	6,100	250	3	6
Accident and emergency	5,800	124	3	3
Pathology group	4,900	89	3	2
Radiology group	3,900	94	2	2
PHM and CHS	4,300	85	2	2
Dental group	3,100	52	2	1
Clinical oncology	1,300	16	1	...
All	182,600	4,494	100	100

ⁱ There is some estimation in this column where the readily-available country statistics use different categories.

ⁱⁱ These are observed referrals excluding cases with missing data. The percentages in the last column assume that missing data are distributed between categories in the same way as known data.

Table A8 – Referrals and workforce - continued

			Number and per cent			
			Workforce	Referrals	Per cent of workforce	Per cent of referrals
Doctors and dentists, UK						
H&C	Male		69,700	2,143	60	79
			46,500	571	40	21
		All	116,200	2,714	100	100
GP	Male		38,700	1,492	58	83
			27,700	297	42	17
		All	66,400	1,789	100	100
H&C	Consultant or equivalent		41,200	1,674	35	62
			17,700	564	15	21
			57,300	455	49	17
		All	116,200	2,693	100	100
GP	Contractor performer			1,123		66
				533		31
				44		3
		All		1,700		100
Doctors, UK						
H&C	Male	<40	34,300	378	51	22
		40-49	17,900	651	27	38
		50-59	11,300	519	17	30
		60+	3,500	164	5	10
		All	67,000	1,712	100	100
	Female	<40	29,900	143	68	33
		40-49	8,800	164	20	38
		50-59	4,300	109	10	25
		60+	900	12	2	3
		All	43,900	428	100	100
	All	<40	64,200	521	58	24
		40-49	26,700	815	24	38
		50-59	15,700	628	14	29
60+		4,500	176	4	8	
All		111,100	2,140	100	100	
GP	Male	<40	4,500	102	19	10
		40-49	8,200	248	35	24
		50-59	7,900	391	34	38
		60+	3,000	300	13	29
		All	23,600	1,041	100	100
	Female	<40	6,300	37	36	20
		40-49	6,900	47	39	25
		50-59	3,600	66	21	35
		60+	700	39	4	21
		All	17,500	189	100	100
	All	<40	10,700	139	26	11
		40-49	15,100	295	37	24
		50-59	11,500	457	28	37
60+		3,700	339	9	28	
All		41,000	1,230	100	100	

Table A8 – Referrals and workforce - continued

			Number and per cent			
			Workforce	Referrals	Per cent of workforce	Per cent of referrals
GP dentists, UK						
	Male	<35	4,300	34	28	18
		35-44	4,000	57	26	30
		45-54	4,200	59	28	31
		55+	2,600	42	17	22
		All	15,100	192	100	100
	Female	<35	4,800	12	47	26
		35-44	3,000	15	29	33
		45-54	1,800	10	18	22
		55+	600	9	6	20
		All	10,200	46	100	100
H&C doctors, England						
Consultant	White	UK	19,800-21,000	573	64	51
		Non-UK	3,400-4,000	115	11	10
	Non-white	UK	2,400-3,600	104	8	9
		Non-UK	5,500-6,100	324	18	29
	All			1,116	100	100
Other career grade	White	UK	4,000-4,300	43	36	13
		Non-UK	1,300-1,800	28	12	9
	Non-white	UK	500-800	15	4	5
		Non-UK	5,300-5,800	240	48	74
	All			326	100	100
Training grade	White	UK	18,800-21,000	73	44	24
		Non-UK	3,500-5,000	24	8	8
	All	UK	7,900-10,100	54	19	17
		Non-UK	12,000-13,500	158	28	51
				309	100	100
GP referrals, UK						
Doctors	White	UK		420		41
		Non-UK		82		8
	Non-white	UK		93		9
		Non-UK		439		42
	All			1,034		100
Dentists	White	UK		101		48
		Non-UK		48		23
	Non-white	UK		31		15
		Non-UK		32		15
	All			212		100
H&C referrals, UK						
Doctors	White	UK		782		40
		Non-UK		211		11
	Non-white	UK		186		9
		Non-UK		792		40
	All			1971		100

Chapters 3 and 6

Table A9 – Concerns amongst cases handled from December 2007 to March 2009

	Number and per cent	
	Cases with concern	Per cent of cases
Clinical difficulties	791	54
Governance/safety issues	521	35
Misconduct	483	33
Behavioural difficulties other than misconduct	425	29
Health problems including substance misuse	349	24
Work environment influences	158	11
Personal circumstances other than ill-health	73	5
Base	1,472 cases	

Note: Percentages total to more than 100 per cent because a case can be logged as showing more than one type of concern

Table A10 – Comparison of case concerns classifications

Classification used until December 2007	Per cent of cases from 2002/03 to 2006/07	New database classification used since December 2007	Per cent
			Per cent of cases from December 2007 to end 2008/09
Health concerns	18	Health problems including substance abuse	24
Concerns about behaviour	65	Misconduct	33
		Behavioural difficulties other than misconduct	29
Concerns about clinical capability	60	Clinical difficulties	54
		Governance/safety issues	35
No comparable categories		Work environment influences	11
		Personal circumstances other than ill-health	5

Note: Percentages total to more than 100 per cent because a case can be logged as showing more than one type of concern

Table A11 – Concerns by profession/specialty, cases handled from December 2007 to March 2009

	Per cent		
	Dentists	Surgeons	Non-surgical doctors
Clinical difficulties	55	52	54
Governance/safety issues	38	35	35
Misconduct	29	35	33
Behavioural difficulties other than misconduct	18	30	30
Health problems including substance misuse	22	16	25
Work environment influences	14	8	11
Personal circumstances other than ill-health	6	5	5
Base number of cases	156	205	1,111

Chapter 4

Table A12 – One year risk of suspension/exclusion, doctors, UK, 2004/05 to 2007/08

	Estimated annual doctor exclusions/suspensions	Medical workforce, 2007	One year risk of suspension/exclusion
H&C	80-100	111,100	1 in 1100-1400
GP	60-70	41,100	1 in 600-700

Table A13 – Active suspensions/exclusions at year end, UK

At 31 March	Doctors		Dentists		All
	Exclusions	Suspensions	Exclusions	Suspensions	Number
2005	45	50	6	5	106
2006	59	65	5	3	132
2007	55	58	2	3	118
2008	55	57		10	122

Table A14 – Main concerns, suspensions/exclusion episodes ended by end of 2007/08, UK

	Capability - efficiency	Conduct - suitability	Critical incident	Health	Base number of cases
	Per cent				
H&C	16	73	5	6	313 (=100%)
GP	26	65	5	3	193 (=100%)

Note: Main concern was not recorded in three cases

Table A15 – Outcomes of 507 UK suspension/exclusion episodes concluded by 2007/08

Outcome	Number and per cent			
	Number of episodes		Per cent of episodes	
	GP Number	H&C Number	GP Per cent	H&C Per cent
Continuation of work with same organisation				
Unrestricted return	20	60	10	19
Restricted return	47	96	24	31
Other	4	17	2	5
Work with organisation ended				
Resignation	6	42	3	14
Contract ended	2	16	1	5
Dismissal/List removal	81	61	42	20
Regulator action	28	3	15	1
Retirement	4	12	2	4
Other	1	4	1	1
Outcome not known		2		
All episodes	193	313	100	100

Chapter 5

Table A16 – Specialty distribution of assessed and referred practitioners, UK, 2001/02 to 2008/09

	Number and per cent		
	Assessments started		Referrals
	Number	Per cent	Per cent
General medical practice	123	46	34
Surgical group	35	13	14
General medicine group	19	7	8
Paediatric group	16	6	4
Obstetrics and gynaecology	15	6	6
General dental practice	11	4	7
Anaesthetics	10	4	4
Psychiatry group	8	3	12
Pathology group	8	3	2
Radiology group	7	3	2
PHM and CHS	7	3	2
Accident and emergency	4	1	3
Dental group	3	1	1
Clinical oncology	2	1	...
Other H&C	1	...	...
	269	100	100

Table A17 – Age at referral of assessed and referred practitioners, UK, 2001/02 to 2008/09

	Number and per cent								
	Assessments started			Referrals					
	GP Number	H&C	All	GP Per cent	H&C	All	GP Per cent	H&C	All
<40	13	11	24	10	8	9	15	24	21
40-49	25	62	87	19	46	32	25	38	33
50-59	60	55	116	45	41	43	36	30	32
60+	36	5	41	27	5	16	25	8	15
	134	135	269	100	100	100	100	100	100

Table A18 – Ethnicity and place of qualification of assessed and referred practitioners, UK, 2001/02 to 2008/09

Ethnicity	Ethnicity	Qualification	Number and per cent			
			Assessments		Referrals	
			Number	Per cent	Number	Per cent
GP	White	UK	34	25	521	42
		Non-UK	8	6	130	10
	Non-white	UK	17	13	124	10
		Non-UK	75	56	471	38
				100		100
H&C	White	UK	68	50	827	40
		Non-UK	7	5	218	11
	Non-white	UK	10	7	194	9
		Non-UK	50	37	805	39
All			269	100	3290	100

Table A19 – Last known working status of 144 practitioners assessed before 2007, UK

	Number and per cent	
	Number	Per cent
Working normally for referring body	58	40
Working with restrictions in referring body	9	6
Other employment with referring body	14	10
Working in different employment	8	6
No longer working	32	22
Working status unknown	23	16

Chapter 6

Table A20 – Dental referrals by sector

All referrals	Number		
	H&C	GP	All
2001/02	...	...	...
2002/03	...	...	...
2003/04	13	15	28
2004/05	26	36	62
2005/06	26	46	72
2006/07	12	58	70
2007/08	12	82	94
2008/09	15	87	102

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The National Clinical Assessment Service (NCAS)

works with health organisations and individual practitioners where there is a concern about the performance of a dentist, doctor or pharmacist.

We help to clarify the concerns, understand what is leading to them and support their resolution. Services are tailored to the specific case and can include:

- Expert advice and signposting to other resources.
- Specialist interventions such as performance assessment and back to work support.

NCAS uses evaluation, data analysis and research to inform its work and runs a programme of national and local educational workshops.

Contact NCAS

In England or Northern Ireland call **020 7062 1655**

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In Wales call **029 2044 7540**

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