NHS
National Patient Safety Agency
National Clinical Assessment Service

Use of NHS exclusion and suspension from work amongst doctors and dentists

2010/11 mid-year report

NCAS is a national service bringing expertise to the resolution of concerns about professional practice. This is the third half-yearly report from NCAS on the use of NHS exclusion and suspension from work amongst doctors and dentists. It covers the period April-September 2010 and makes comparisons back to 2005, the period during which NCAS has been actively monitoring use of suspensions and exclusions. It includes new analyses of episodes where the General Medical Council or General Dental Council (GMC/GDC) are involved concurrently.

In the NHS, primary care organisations 'suspend' general practitioner doctors and dentists (GPs) while employed hospital and community (H&C) practitioners are 'excluded'. Both measures mean that practitioners are separated from their work. The practitioner will usually (but not necessarily) remain on full pay. These measures entail cost to the NHS in locum arrangements as well as legal and management costs. At the same time, suspension or exclusion may be necessary to protect patient safety so cost must be balanced against safety benefit.

NHS suspension should be distinguished from suspension for regulatory purposes by the GMC/GDC.

Key findings

<u>Incidence and prevalence (page 3)</u>

- Taking doctor and dentist suspensions and exclusions together, the number of new episodes starting in the first half of 2010/11 was stable (table 1) and there was a small fall in the number of episodes active at 30 September 2010 compared with six months earlier (table 2). There was also a fall in the active total in the preceding period.
- GP doctors are about twice as likely to be suspended from work as H&C doctors are to be excluded. The incidence risk of suspension/exclusion was increasing in both GP and H&C sectors up to 2009 but has since stabilised (table 3).

<u>Duration (page 5)</u>

- On average, GP doctor suspension episodes last about twice as long as H&C exclusion episodes – 39 weeks compared with 21 weeks in the year to September 2010. Average duration is falling in both sectors but the sector difference persists (table 4 and chart C).
- The distribution of duration remains highly skewed. Half of H&C exclusion episodes last less than 13 weeks but only about a fifth of GP suspension episodes (table 5).

<u>Concerns and outcomes (page 6)</u>

- The latest half year figures show little change in the reasons for using suspension or exclusion. Conduct-suitability issues predominate in both sectors but with a larger

proportion of episodes concerned with capability-efficiency in the GP sector (32%) than amongst H&C practitioners (17%) (table 6).
- The latest half year figures also show the same pattern of episode outcome as earlier data. Overall, about one episode in two ends with the practitioner resuming work with the same organisation, with restrictions applying in approaching two thirds of these cases (table 7).

Involvement of General Medical Council/General Dental Council (page 7)

- The GMC/GDC are involved concurrently in about two thirds of GP suspensions but only a quarter of H&C exclusions. Episodes with GMC/GDC involvement take longer to resolve (table 8) and the distribution of duration differs between regulator episodes and other episodes (table 9).
- The distribution of episodes by main concern is similar between regulator and other cases in the H&C sector but GP episodes with regulator involvement are more likely to be concerned with conduct/suitability (table 10).

Cost to the NHS (page 9)

- In the year to September 2010 in England, an estimated 6500 practitioner working weeks were lost through exclusion or suspension (table 11) at a cost to the NHS probably in excess of £20million. However, there was a fall in estimated weeks lost in the most recent reporting period (chart G)
- If costs per week are assumed equal between sectors and practitioner groups, episodes with concurrent regulator involvement could be accounting for more than half the total NHS cost of suspensions and exclusions (paragraph 23).

Scope and method

1. Regulations governing suspension and exclusion differ across the UK. This report relates only to England. While statistics for the UK are less robust, NCAS plans to include UK summaries in a 2010/11 end year report.

2. The report describes episodes involving the professions within NCAS' remit - doctors and dentists but not pharmacists where the dataset is too small for analysis.

3. Information about use of suspension and exclusion is given to NCAS as part of the normal casework process. Case managers and advisers note the start and end date of each episode and use picklists to record the reason for using suspension or exclusion and the way in which each episode is resolved. No changes have been made to data collection for this report. The report looks at 1017 episode starts since 2005 and 1003 concluded episodes.

4. Data completeness is believed to be good for England where regulations governing suspension and exclusion are clear and where the Department of Health has asked local NHS managers to discuss all use of suspension or exclusion with NCAS. The dataset is 'live' so on-going casework produces data corrections and reclassifications. As usual in these reports, the entire dataset has been reanalysed and minor adjustments have been made to earlier releases. Adjustments are not identified because they are small and do not indicate any change of interpretation.

5. This is a half year report and tables tracking scale of use show half year totals back to 2005. In some tables, annual figures are shown to simplify presentation. These are for years to September to allow comparison of the most recent year with earlier years. Where tables are looking at patterns across the whole dataset, we have shown the most recent half year alongside the previous five years to establish whether there has been a change of pattern.

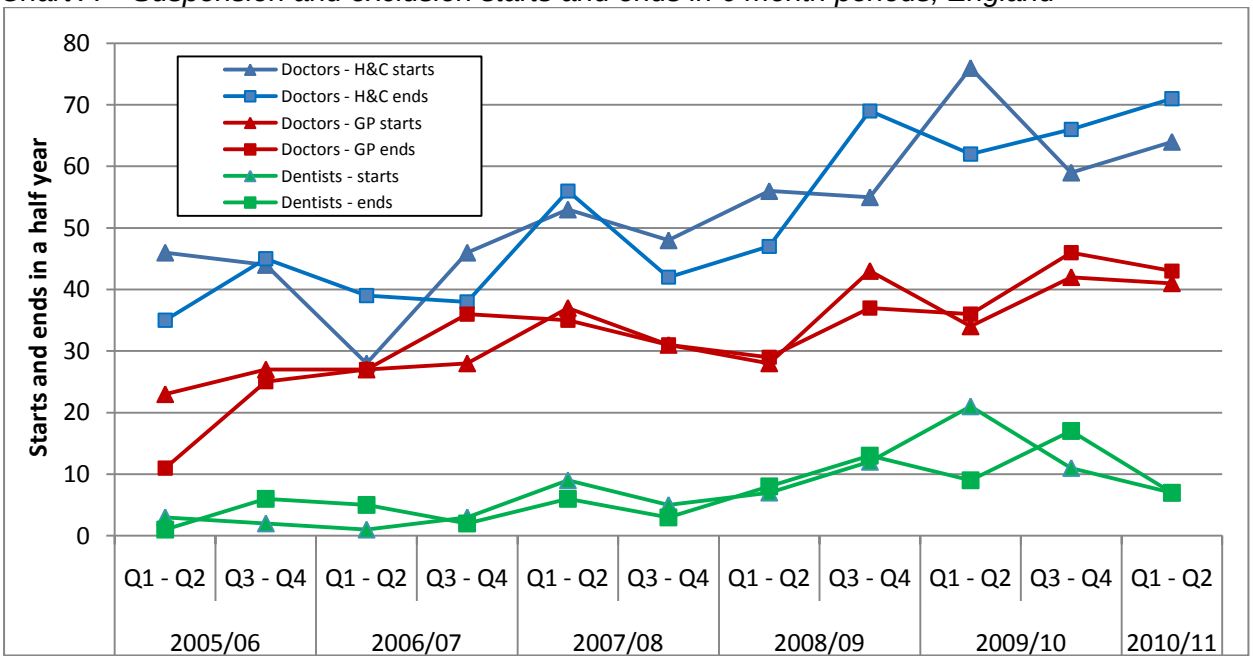
Incidence and prevalence

6. Previous reports identified an upward trend in use of both H&C exclusion and GP suspension. Table 1 and chart A show that the trend is probably continuing for doctors though not for dentists where there has been a fall in 2010/11 from a peak in 2009/10. Provisionally, in the six months to 30 September 2010, 65 new doctor and dentist exclusion episodes started and 47 GP doctor and dentist suspensions. The number of starts in the previous reporting period was the same, 112.

Table 1 – Suspension and exclusion starts and ends, England numbers

	Doctors				Dentists				All starts
	H&C exclusions		GP suspensions		H&C exclusions		GP suspensions		
	Starts	Ends	Starts	Ends	Starts	Ends	Starts	Ends	
				Half years					
2005/06 A-S	46	35	23	11	2	0	1	1	72
2005/06 O-M	44	45	27	25	2	4	0	2	73
2006/07 A-S	28	39	27	27	1	3	0	2	56
2006/07 O-M	46	38	28	36	0	1	3	1	77
2007/08 A-S	53	56	37	35	1	2	8	4	99
2007/08 O-M	48	42	31	31	0	1	5	2	84
2008/09 A-S	56	47	28	29	2	1	5	7	91
2008/09 O-M	55	69	43	37	3	3	9	10	110
2009/10 A-S	76	62	34	36	6	3	15	6	131
2009/10 O-M	59	66	42	46	1	2	10	15	112
2010/11 A-S prov	64	71	41	43	1	1	6	6	112
				Years to end September					
2005/06 O-S	72	84	54	52	3	7	0	4	129
2006/07 O-S	99	94	65	71	1	3	11	5	176
2007/08 O-S	104	89	59	60	2	2	10	9	175
2008/09 O-S	131	131	77	73	9	6	24	16	241
2009/10 O-S prov	123	136	83	89	2	3	16	21	224

Chart A – Suspension and exclusion starts and ends in 6 month periods, England

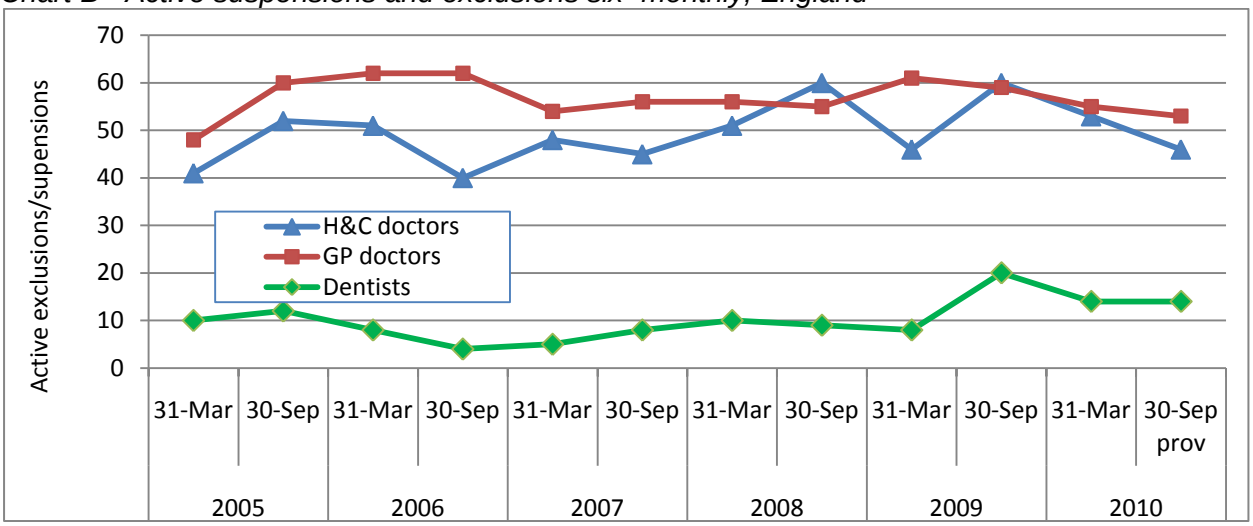


7. Although new episodes have been rising, so have episode closures. The number of practitioners suspended or excluded at any moment has therefore been static, with a fall in the first half of 2010/11 for the second half year running – table 2 and chart B.

Table 2 – Active suspensions and exclusions at period ends, England

Active at end	Doctors		Dentists		All active episodes
	Exclusions	Suspensions	Exclusions	Suspensions	
2005 Mar	41	48	5	5	99
2005 Sept	52	60	7	5	124
2006 Mar	51	62	5	3	121
2006 Sept	40	62	3	1	106
2007 Mar	48	54	2	3	107
2007 Sept	45	56	1	7	109
2008 Marh	51	56	0	10	117
2008 Sept	60	55	1	8	124
2009 Mar	46	61	1	7	115
2009 Sept	60	59	4	16	139
2010 Marh	53	55	3	11	122
2010 Sept prov.	46	53	3	11	113

Chart B - Active suspensions and exclusions six- monthly, England



8. Some of the rise in use of exclusion and suspension (Chart A) reflects growth in the medical and dental workforce: if there are more practitioners then more concerns about practice are to be expected, other things being equal. Table 3 therefore shows new episodes (from table 1) and active totals (from table 2) alongside workforce to estimate incidence and prevalence risks.

Table 3 – One year percentage risk of suspension or exclusion, England

	GP doctors			H&C doctors and dentists			GP dentists		
	Suspension-exclusion incidence								
Year to 30 Sept	Estimated workforce 31 March	Starts	*Risk %*	Estimated workforce 31 March	Starts	*Risk %*	Work-force	Starts	*Risk %*
2006	36,000	54	*0.15*	88,600	75	*0.08*	20,000	0	
2007	36,200	65	*0.18*	91,000	100	*0.08*	20,200	11	*0.05*
2008	37,100	59	*0.16*	93,900	106	*0.11*	20,800	10	*0.05*
2009	39,000	77	*0.20*	98,300	140	*0.14*	21,300	24	*0.11*
2010	40,700	83	*0.20*	102,600	125	*0.12*	22,000	16	*0.07*
	Suspension-exclusion prevalence								
End Sept	Workforce 30 Sept	Actives	*Risk %*	Workforce 30 Sept	Actives	*Risk %*	Work-force	Actives	*Risk %*
2005	35,900	60	*0.17*	87,000	59	*0.07*	20,000	5	*0.03*
2006	36,000	62	*0.17*	90,200	43	*0.05*	20,200	1	..
2007	36,400	56	*0.15*	91,800	46	*0.05*	20,800	7	*0.03*
2008	37,700	55	*0.15*	95,900	61	*0.06*	21,300	8	*0.04*
2009	40,300	59	*0.15*	100,600	64	*0.06*	22,000	16	*0.08*
2010	41,100	53	*0.13*	101,600	49	*0.05*	22,500	11	*0.05*

9. For incidence comparisons (upper section of table 3), years to 30 September are shown alongside estimated workforce at 31 March as the midpoint. For prevalence comparisons (lower section) active totals at 30 September are shown alongside 30 September workforce figures. The incidence risk for GP doctors was rising but may now have stabilised and the GP prevalence risk has been falling. For H&C doctors and dentists, the incidence risk is lower than for GP doctors, though showing a rise over the five year period. The H&C prevalence risk has been approximately static. For GP dentists, incidence and prevalence risks are both much lower than for doctors despite increased episodes from 2007/08.

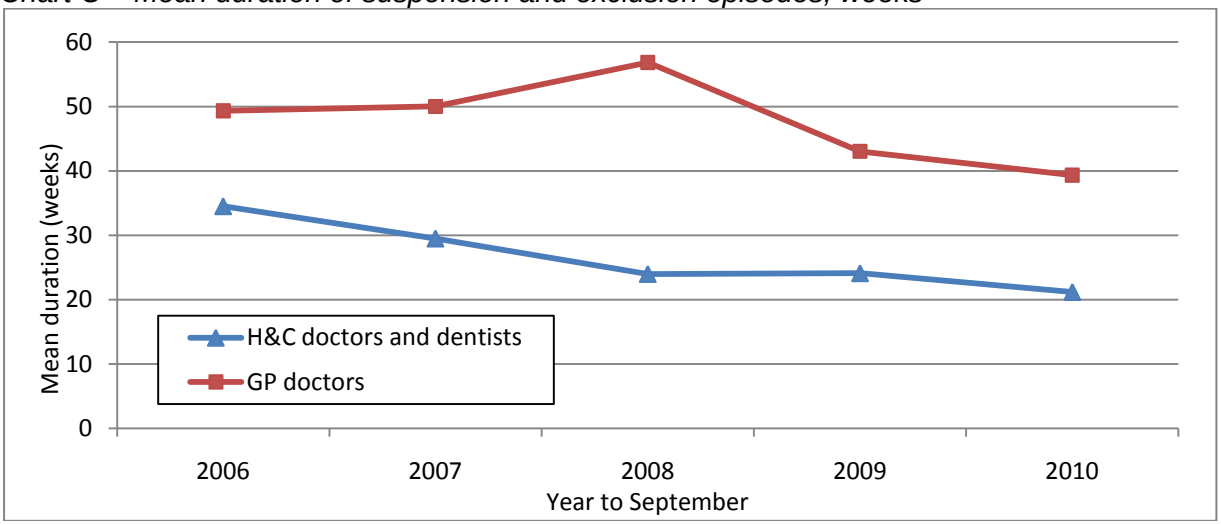
Duration

10. The number of active episodes has been stable despite rising incidence because episodes have been getting shorter. Table 4 shows the mean duration of concluded episodes by the year in which the episode ended. For GP dentists, base numbers are small so the picture is uneven. For GP doctors and for H&C doctors and dentists, however, there is a reasonably clear downward trend – see Chart C. The downward trend in duration of H&C exclusions could be a response to the clearer framework for exclusion use introduced in 2003 in *Maintaining High Professional Standards*. The different picture for GP suspensions (longer duration amongst episodes concluded up to 2008) may reflect the 2006 reorganisation of primary care in England and possibly interrupted management of episodes arising around that time.

Table 4 – Duration of concluded episodes, England, 2005/06-2009/10 Numbers

Year to Sept	GP doctors		H&C doctors and dentists		GP dentists	
	Mean (wks)	Base	Mean (wks)	Base	Mean (wks)	Base
2006	49	52	34	91		4
2007	50	71	29	97		5
2008	57	60	24	91	32	9
2009	43	73	24	137	33	16
2010 prov	39	89	21	140	26	21

Chart C – Mean duration of suspension and exclusion episodes, weeks

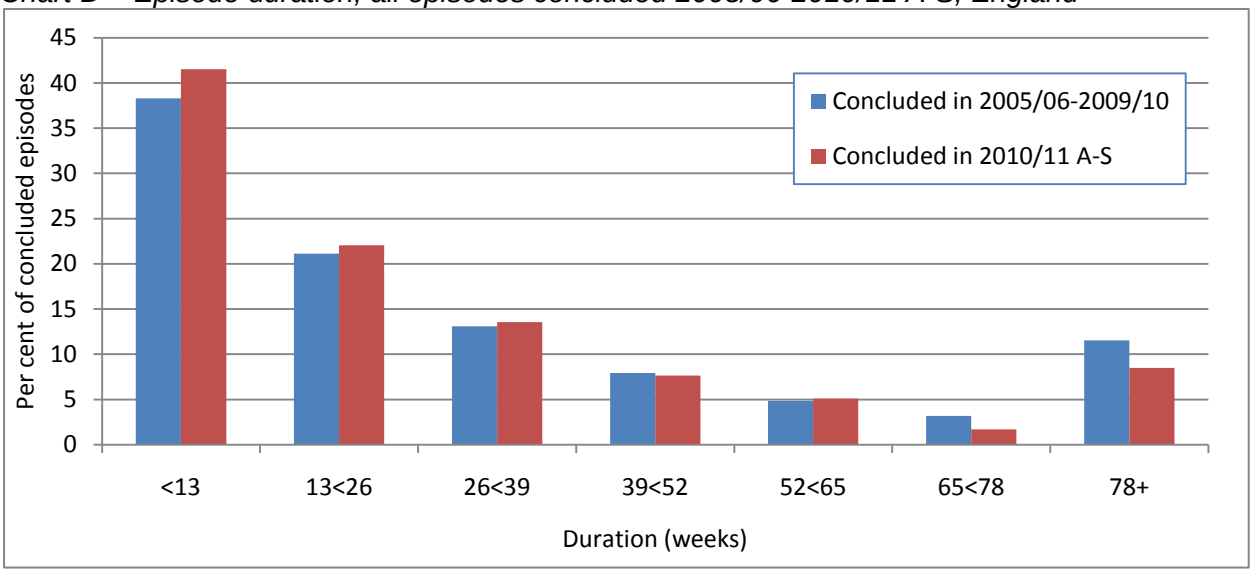


11. Mean durations are a convenient summary but conceal that the distribution of durations is very skewed towards shorter episodes. Table 5 shows the distribution of duration for episodes concluded in the most recent half year and in the previous five years. Over half the H&C episodes lasted less than 13 weeks, well below the mean duration (24 weeks over the five years covered, for H&C exclusions). Also, the distribution of duration may have become more skewed towards shorter episodes (chart D) though the base for the most recent period is small (121 episodes).

Table 5 – Duration distribution, episodes ended 2005/06-2010/11, England Numbers

Episode concluded	Episodes by duration (weeks)								Base
	<13	13<26	26<39	39<52	52<65	65<78	78+		
	Per cent of GP doctor and dentist episodes								
2005/06-2009/10	*20*	*24*	*18*	*10*	*8*	*3*	*17*	*100*	364
2010/11 A-S Prov	*23*	*25*	*21*	*10*	*4*	*0*	*17*	*100*	48
	Per cent of H&C doctor and dentist episodes								
2005/06-2009/10	*51*	*19*	*10*	*6*	*3*	*3*	*7*	*100*	521
2010/11 A-S Prov	*54*	*20*	*9*	*6*	*6*	*3*	*3*	*100*	70
	Per cent of all concluded episodes								
2005/06-2009/10	*38*	*21*	*13*	*8*	*5*	*3*	*12*	*100*	885
2010/11 A-S Prov	*42*	*22*	*14*	*8*	*5*	*2*	*8*	*100*	118

Chart D – Episode duration, all episodes concluded 2005/06-2010/11 A-S, England



Concerns and outcomes

12. NCAS classifies episodes as involving capability/efficiency, conduct/suitability, a critical incident or health issues, using these categories for both GP and H&C sectors. Only one concern is attributed to each episode. Table 6 shows first that the distribution of concerns in the most recent reporting period was approximately in line with the preceding five years. The table then uses the whole dataset to compare concerns by sector. A higher proportion of GP episodes are concerned with capability/efficiency. When mean duration is examined (final section of table) there is little sector difference where concerns are with capability/efficiency.

Table 6 – Episodes by cause, concluded 2005/06-2010/11A-S, England *Per cent*

	Capability-efficiency	Conduct-suitability	Critical incident	Health	All causes	Base (inc cause not known)
	Per cent of all episodes concluded					
2005/06-2009/10	*23*	*64*	*6*	*7*	*100*	882(8)
2010/11 A-S Prov	*25*	*59*	*7*	*9*	*100*	121(3)
All	*23*	*64*	*6*	*7*	*100*	1003(11)
	Per cent of concluded episodes by sector					
GP	*32*	*55*	*5*	*8*	*100*	412(4)
H&C	*17*	*70*	*7*	*7*	*100*	591(7)
All	*23*	*64*	*6*	*7*	*100*	1003(11)
	Mean duration of episodes concluded 2005/06-2010/11A-S by sector					
GP	37	48	64	41	44	
H&C	36	24	27	22	26	
All	37	32	40	30	34	
Base	227	633	61	71	992	

13. Table 7 then shows the outcome of episodes concluded in the first half of 2010/11 and in preceding years. Outcomes in the most recent half year have a distribution similar to that in the preceding five years. Unrestricted return to work after suspension/exclusion is more likely in the H&C sector and a higher proportion of episodes end with dismissal or list removal in primary care. Overall, about half of all episodes end with the practitioner resuming work with the same organisation, with restrictions on work applying in approaching two thirds of those cases.

Table 7 – Outcome of concluded episodes, 2005/06-2010/11 A-S, England

	Outcome	Concluded episodes				*Per cent of concluded episodes*			
		GP		H&C		*GP*		*H&C*	
		2005/06-2009/10	A-S 2010/11	2005/06-2009/10	A-S 2010/11	*2005/06-2009/10*	*A-S 2010/11*	*2005/06-2009/10*	*A-S 2010/11*
Continued work with organisation	Unrestricted return	52	5	102	16	*15*	*11*	*21*	*23*
	Return with restrictions	101	15	155	23	*29*	*32*	*32*	*33*
Work with organisation ended	Resignation	8	1	55	4	*2*	*2*	*11*	*6*
	Contract ended	2		36	6	*1*		*7*	*9*
	Termination/list removal	138	20	93	13	*40*	*43*	*19*	*19*
	Regulator action	27	1	5		*8*	*2*	*1*	
	Retirement	4	1	16	3	*1*	*2*	*3*	*4*
Other		14	4	27	5	*4*	*9*	*6*	*7*
Base (inc outcome not knowns)		363(17)	49(2)	519(30)	72(2)	*100*	*100*	*100*	*100*

Involvement of General Medical Council/General Dental Council

14. For casework purposes, NCAS records any other agencies also considering concerns about the practitioner. We have reported before that long suspension/exclusion episodes are likely to be associated with concurrent action by the GMC/GDC. We have now examined this in more detail. NCAS recording does not specify the precise regulator process and recording was not consistent until the start of 2009/10. These new analyses are therefore based on 357 episodes concluded from April 2009 to September 2010, analysed as a single batch.

15. Table 8 shows the proportion of episodes with GMC/GDC involvement by profession and sector (upper section) and the mean duration of episodes (lower section). For doctors, GMC involvement is more likely in GP cases (62%) than in H&C cases (26%). This may account for the sector difference in duration seen in chart C. Mean duration differs little between sectors in episodes without regulator involvement and the difference between professions also seems to be small (though the base number of dental cases is only 33 so this conclusion has to be tentative). Overall, across both sectors and professions and over the 18 month period specified, mean duration was 43 weeks where there was also GMC/GDC involvement compared with 19 weeks in other cases.

Table 8 – Duration by regulator involvement, episodes concluded April 2009-September 2010

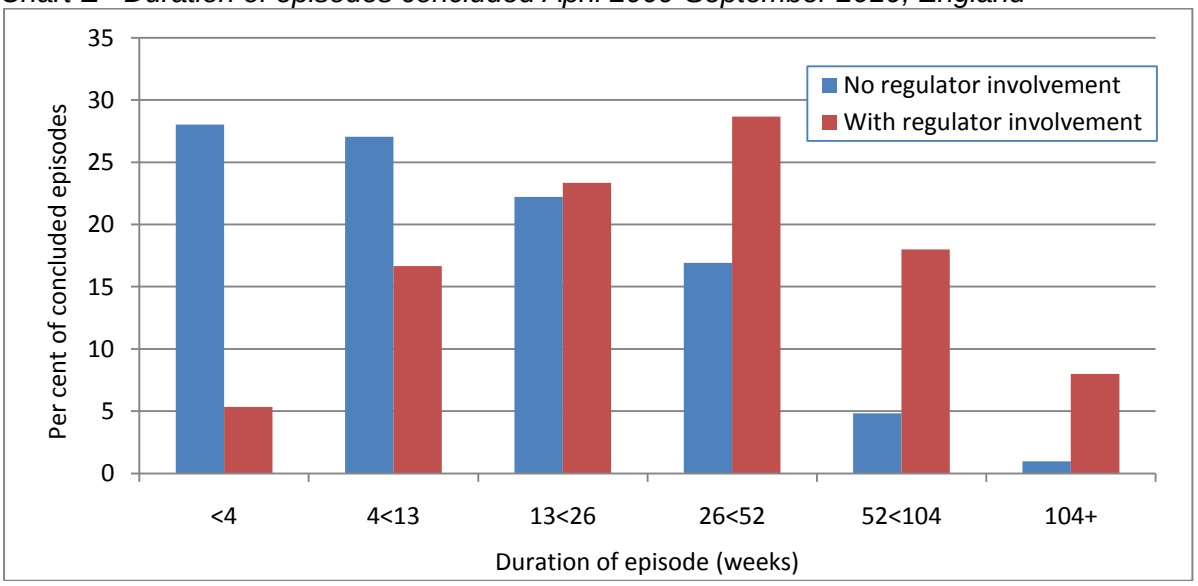
GMC/GDC involvement	Doctors		Dentists	
	H&C exclusions	GP suspensions	H&C exclusions	GP suspensions
	Number of concluded episodes, April 2009-September 2010			
No	147	48	6	6
Yes	52	77		21
All	199	125	6	27
% Yes	*26*	*62*	*0*	*78*
	Mean duration of concluded episodes, April 2009-September 2010, weeks			
No	18	23	16	19
Yes	33	54		25
All	22	42	16	24

16. Table 9 and chart E then look at the distribution of duration according to whether or not there was concurrent GMC/GDC involvement. Overall, across both sectors and professions, more than half of all episodes without GMC/GDC involvement lasted less than 13 weeks, compared with less than a quarter of episodes with regulator involvement.

Table 9 – Duration of episodes and GMC/GDC involvement, England

GMC/GDC involvement	Episodes by duration (weeks) <4	4<13	13<26	26<52	52<104	104+	All episodes
Number of episodes concluded April 2009-September 2010, doctors and dentists, both sectors							
No	58	56	46	35	10	2	207
Yes	8	25	35	43	27	12	150
All	66	81	81	78	37	14	357
Per cent of episodes							
No	*28*	*27*	*22*	*17*	*5*	*1*	*100*
Yes	*5*	*17*	*23*	*29*	*18*	*8*	*100*
All	*18*	*23*	*23*	*22*	*10*	*4*	*100*

Chart E –Duration of episodes concluded April 2009-September 2010, England



17. These cases can also be examined by cause – table 10. For H&C cases, episodes with and without GMC/GDC involvement have a similar concerns distribution, but amongst GP cases there are more conduct-suitability concerns where there is regulator involvement. One interpretation could be that referrals to a regulator are independent of the type of concern in the H&C sector but more influenced by concern in primary care.

Table 10 – Cause by regulator involvement, episodes concluded April 2009-September 2010

GMC/GDC involvement	Capability-efficiency	Conduct-suitability	Critical incident	Health	All episodes	Base (inc cause not known)
Per cent of GP episodes						
No	*50*	*30*	*9*	*7*	*100*	*54(2)*
Yes	*32*	*50*	*4*	*14*	*100*	*98*
Per cent of H&C episodes						
No	*18*	*65*	*8*	*6*	*100*	*153(5)*
Yes	*13*	*69*	*2*	*13*	*100*	*52(1)*
Mean duration, weeks, GP episodes						
No	*24*	*17*	*33*	*24*	*22*	
Yes	*33*	*57*	*109*	*31*	*48*	
Mean duration, weeks, H&C episodes						
No	*29*	*16*	*9*	*17*	*18*	
Yes	*51*	*33*	*52*	*16*	*33*	

Cost to the NHS

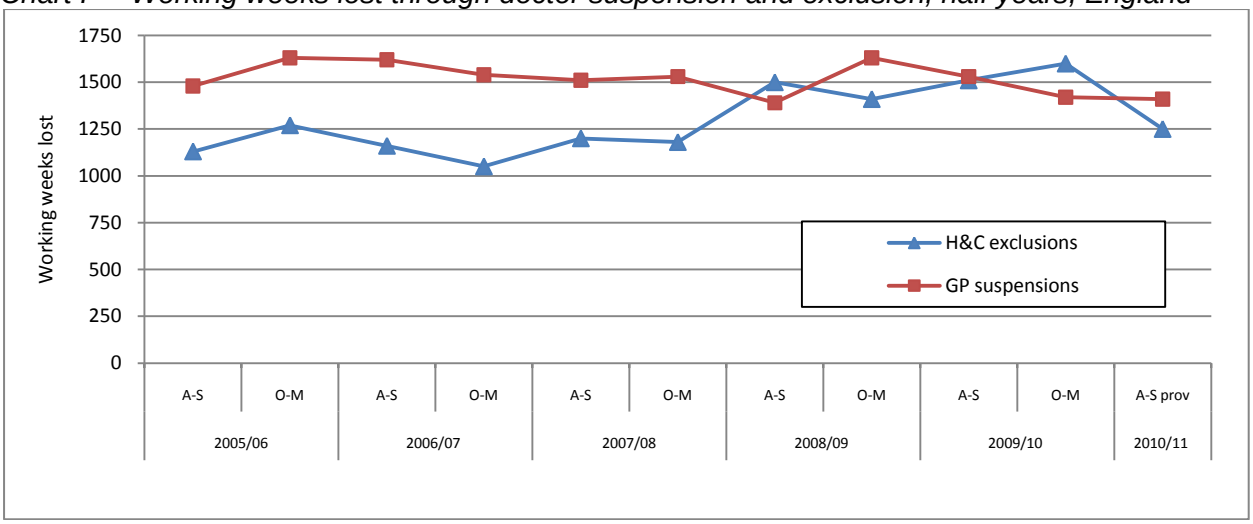
18. The tables above describe the experience of practitioners but they are less good as an indicator of current cost and current practice for the NHS as a whole. Episodes being concluded now can reflect decisions taken several years ago. And if measures exclude currently open episodes, there could be a concealed upward trend in duration which the measures above miss. Our recent reports have therefore used measures of weeks lost in successive periods as a better indicator of cost impact on the NHS. This measure is based on all episodes current within each period including those just starting and those being brought to an end. We also track the number of episodes managed within each period to indicate management load[i].

19. Using these measure, and taking both sectors and professions together, an estimated 6500 working weeks were lost through suspension or exclusion in the year to September 2010 – table 11. This is equivalent to about 130 whole time practitioners. The cost to the NHS is probably in excess of £20 million in locum, legal and management costs but excluding the continuing cost of the excluded or suspended practitioners. In the most recent reporting period, however, there is a marked drop in weeks lost in the H&C sector – see chart F.

Table 11 – Estimated working weeks lost through suspensions and exclusions, England

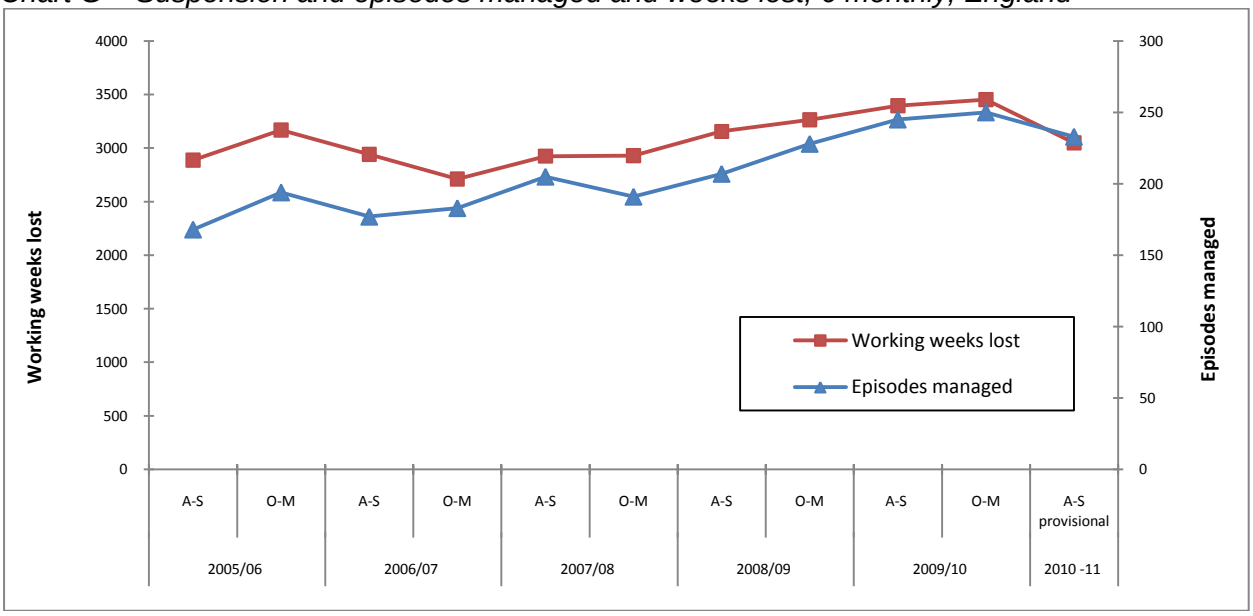
	Doctors		Dentists		All groups	Episodes managed
	Exclusions	Suspensions	Exclusions	Suspensions		
2005/06 A-S	1130	1480	150	130	2890	170
2005/06 O-M	1270	1630	160	110	3170	195
2006/07 A-S	1160	1620	110	40	2940	175
2006/07 O-M	1050	1540	60	60	2710	185
2007/08 A-S	1200	1510	60	150	2920	205
2007/08 O-M	1180	1530	20	200	2930	190
2008/09 A-S	1500	1390	10	250	3160	205
2008/09 O-M	1410	1630	30	200	3260	230
2009/10 A-S	1510	1530	80	280	3400	245
2009-10 O-M	1600	1420	80	350	3450	250
2010/11 A-S provisional	1250	1410	70	320	3050	235
			Years to September			
2006	2430	3260	270	150	6200	370
2007	2250	3040	120	220	5640	390
2008	2680	2930	30	450	6090	400
2009	2910	3160	110	480	6660	470
2010	2850	2830	150	670	6500	480

Chart F – Working weeks lost through doctor suspension and exclusion, half years, England



20. Chart G uses table 11 data again, looking at suspensions and exclusions together for both doctors and dentists. Weeks lost and episodes managed move in step, with weeks lost rising less than episodes managed because average episode duration has been falling. Both measures then show a marked downturn in the most recent period.

Chart G – Suspension and episodes managed and weeks lost, 6 monthly, England



21. Finally, the progression seen in chart G can be put alongside workforce to see whether use of suspension/exclusion is outstripping or falling behind workforce growth. Table 12 looks at doctors only, measuring weeks lost per thousand in the workforce for years ending September. The exclusion rate in the H&C sector was rising until the most recent downturn but the GP suspension rate shows a fall which has continued into the most recent year.

Table 12 – Doctor weeks lost through exclusion/suspension related to workforce, England

Year to September	Estimated workforce at midpoint, 31 March	Working weeks lost through exclusion or suspension	Weeks lost per 1000 in workforce
		H&C doctors	
2006	84,700	2430	29
2007	87,100	2250	26
2008	89,800	2680	30
2009	94,000	2910	31
2010 provisional	98,200	2850	29
		GP doctors	
2006	36,000	3260	91
2007	36,200	3040	84
2008	37,100	2930	79
2009	39,000	3160	81
2010 provisional	40,700	2830	70

22. Sector comparisons are therefore complex but the main conclusion remains, that relatively more time is lost in the GP sector through suspensions than is lost through exclusions in the H&C sector, by a factor of more than two (70 weeks per year per 1000 in GP workforce most recently, compared with 29 weeks in the H&C sector). Also, if estimated weeks lost over the five years to September 2010 are totalled, GP weeks total about 15,000 compared with 13,000 in the H&C sector. If legal, locum and management costs per case are assumed equal, then GP suspensions have been costing the NHS more than H&C exclusions. H&C exclusion costs have been subject to public scrutiny for many years but there has been less examination of primary care suspension costs.

23. The analysis of regulator involvement in paragraphs 14-18 above can also be applied to these broad cost estimates. If durations are totalled for episodes concluded over the period April 2009-September 2010, the distribution of time lost is as follows:

GP suspensions without GMC/GDC involvement	12% of time lost
GP suspensions with GMC involvement	45%
H&C exclusions without regulator involvement	27%
H&C exclusions with regulator involvement	17%

Episodes with regulator involvement could be accounting for more than half the total cost of suspensions/exclusions to the NHS.

[i] Within any reporting period episodes fall into four groups: those started in the previous period and carrying through to the next period (so the duration is 26 weeks by definition, if half year periods are being used), those starting and ending within the period, those starting before the period but ending within it, and those starting in the period and continuing into the next period. Each episode active during a reporting period contributes to an estimate of total working weeks lost to the NHS through suspension or exclusion. The working weeks estimate assumes that all practitioners are working full time for the NHS, so there is an approximation here. NCAS does not record working hours of excluded or suspended practitioners because it is not relevant to the casework process.