General Medical Council

Regulating doctors
Ensuring good medical practice

Publishing fitness to practise data by secondary care location in the UK: a guide to the data

Our role

As the regulator for the medical profession, we receive complaints about doctors and use this to determine whether we need to investigate their fitness to practise. We only deal with the most serious concerns. The vast majority of doctors in the UK provide high standards of patient care. In most cases, the complaint does not meet our threshold for action and often the concern does not relate to an individual doctor's fitness to practise. Where appropriate, we refer concerns to other bodies such as the Care Quality Commission or other health regulators.

About the data

When we receive a complaint, where possible we record where the incident that led to the complaint took place. A complaint is assigned to a particular trust or board if the incident occurred there or the doctor was employed there when the incident took place (for example, a criminal conviction). This will not always be the organisation that currently employs the doctor or that the doctor is connected to for revalidation.

The data are published without analysis and caution is needed when interpreting the data.

The information has been provided in alphabetical order by countries of the UK according to the name of the trust or board and is not ranked by volume of complaints. Ranking by volume can be very misleading for the following reasons.

- The data do not in any way take account of the size of the healthcare provider, the number of doctors working there, or the different services they provide. This means that a provider might have a particularly high or low number of complaints simply because of its size or the type of cases they receive.
- Higher numbers of complaints could be due to a range of factors unrelated to the standards of medical practice in a location. These include: the effectiveness of the local clinical governance systems; better systems for handling complaints; or a culture where reporting concerns is encouraged.
- The data show both the number of complaints and the number of doctors complained about. One doctor may have received more than one complaint.

Reviewing the data

The data cover the complaints received and assessed between 1 January and 31 December of each year, 2007–12.

The data do not track a single cohort of complaints because cases opened in any given year will not necessarily reach an outcome in the same year. This has the following implications.

- The number of complaints recorded as investigated on the left hand side of the table will not equal the number of outcomes from an investigation in the middle of the table. A complaint can often take many months to investigate because of the complex issues it raises, so the complaint might be considered in one year but the conclusion of that investigation will not be known until the next.

- The number of complaints recorded as 'referred to panel' in the middle of the table will not equal the number of outcomes from a panel on the right hand side of the table. Our decision makers at the end of the investigation (case examiners) might refer the case to a panel in one year, but it takes a number of months for a hearing to start and for the panel to make a decision.

This means that the rows of data will not sum and are not linked. Therefore, the three sections of the table – complaints about a doctor, investigation outcome and panel outcome – should be reviewed independently from each other.

How accurate are the data?

Some complaints do not have an incident location for one of the following reasons:

- the complaint made to us is not detailed enough to identify the location

- the complaint is about a criminal, conduct or probity offence committed by a doctor who was not in work at the time

- the incident occurred outside the UK

- the complaint is about a doctor who writes reports in a private capacity.

We collect and check location data at various points in the complaint process. We have a quality assurance process in place, but there is an element of judgement to be made when allocating a complaint to a location. We don't always have as much information as we would like to make that judgement.

Scope of the data

We are publishing fitness to practise data for secondary care. This includes NHS and HSC trusts in England and Northern Ireland, including hospital, mental health and ambulance trusts. NHS area boards in Scotland and local health boards in Wales are also included – these boards are responsible for delivering both primary and secondary care.

Private organisations are not included. There is significant complexity and variety in in the way private healthcare is organised across the UK, which makes it difficult to include in this data release.

Why are we publishing these data?

We are committed to making our data more widely available. In recent years, we have improved the data that we hold at a local level and we are now in a position to publish this information. In future, we will be publishing these data annually.

Find out more

Our website has a wealth of information on how we deal with concerns about doctors. Our reports on the state of medical education and practice in the UK look at the data we hold and that of others to learn more about medical practice. Our last report, published in September 2013, focuses on the complaints we receive.

For definitions of the terms used in the data and in this document please see annex A.

Annex A – fitness to practise terms

Complaints about a doctor

Enquiry: information received by the General Medical Council (GMC) that needs to be assessed to consider whether it raises a question about a doctor's fitness to practise. This assessment is called triage.

Complaints: a complaint is an enquiry that raises a concern about a doctor's fitness to practise. Some of the complaints are not serious enough for the GMC as a national regulator to deal with and they are closed. In a small number of cases, we are unable to identify a specific doctor as there is not enough information included with the complaints. These unidentified doctors are not included in the 'unique doctor total'.

Investigated complaints (stream 1): a complaint is investigated if it raises a serious concern about a doctor's fitness to practise. The Medical Practitioners Tribunal Service (MPTS) interim orders panel can temporarily restrict a doctor's registration, either through a suspension or conditions, while the complaint against the doctor is investigated – these temporary restrictions are not included in the data.

Complaints referred to employers (stream 2): alone, these complaints do not meet the threshold for a full (stream 1) investigation, but could do if they were part of a wider pattern of behaviour or practice. In these cases, we ask the doctor's employers or contractors to find out if they have any wider concerns about the doctor's practice. Once we have this information, we do a second assessment to decide whether we need to carry out a full stream 1 investigation.

Outcome of an investigation

Two GMC case examiners (one medical and one non-medical) review each case at the end of our investigation into the allegations against a doctor. They can decide on one of the following outcomes.

Close a case with no further action: the case is closed because it did not raise serious allegations about the doctor's fitness to practise or we had insufficient evidence to take the case forward (eg because the complainant did not want to cooperate with the investigation).

Issue advice: the case is closed with advice given to a doctor about his or her conduct by a case examiner.

Issue a warning: the doctor receives a warning if their behaviour or performance shows a significant departure from the principles set out in our guidance for doctors – *Good medical practice* – but a restriction on the doctor's registration is not necessary. In a very small number of cases, a doctor may appeal against a warning and have it overturned by the Investigation Committee, but the warning will still appear in the data.

Agree undertakings: the doctor and the GMC agree to certain undertakings about the doctor's future practice, such as agreeing to undergo retraining or practising under the supervision of another doctor.

Refer to panel: the case examiners decide that the case is serious enough to be referred to an MPTS fitness to practise panel. Some cases can be referred to a panel by an assistant registrar, without a case examiner's decision. These referrals are not shown in the data on investigation outcomes.

Some cases promoted to investigation may end before a case examiner's decision and will not be shown in the data. For example, if the doctor is subject to voluntary erasure or administrative erasure, or the doctor dies before the investigation is completed.

Outcome of a panel hearing

An MPTS panel hears the case against a doctor and decides whether the facts are proven and, if so, whether the doctor's fitness to practise is impaired. If it is, the panel decides what, if any, sanctions are appropriate. Some cases recorded as having been referred to a panel may not result in a hearing if, for example, the hearing is cancelled after new information comes to light, the doctor is subject to voluntary erasure or administrative erasure, or the doctor dies.

The panel can do one of the following.

Find no impairment: the panel decides that the doctor's fitness to practise is not impaired.

Find impairment but take no further action: in a small number of cases, a panel may find a doctor was impaired, but feel that no further action is necessary to protect the public.

Issue a warning: if the panel concludes that the doctor's fitness to practise is not impaired, it may still issue a warning to the doctor.

Agree undertakings: the panel can in some cases accept undertakings offered by the doctor, provided the panel is satisfied that such undertakings protect patients.

Set conditions: conditions on the doctor's registration will in some way place requirements on their practice.

Suspend the doctor: a doctor is suspended from the medical register.

Erase the doctor: a doctor is removed from the medical register.

Some common questions

Why are we publishing only data on complaints by secondary care location?

Overwhelmingly we are asked to share data about complaints by secondary care location, so we have prioritised this work. We are committed to sharing more of our data and we are examining how we can publish data about other locations that doctors work in. In both Scotland and Wales, single organisations are responsible for both primary and secondary care. In these countries, we have removed any complaints or cases that were connected to GP surgeries, but we are not able to remove all primary care cases from these locations.

Why are we publishing the data without analysis?

We recognise that on its own these data do not tell us very much about medical practice. Our annual report on the state of medical education and practice in the UK explores in much more depth the data we hold. But we know there is a public interest in these data and we are committed to being open and transparent about the data we hold. Both the GMC and other bodies can use these data as part of our work to help build a better picture of patient care across the UK.

Are the doctors who are being complained about still employed by the trust or board that the complaint is recorded against?

A complaint is assigned to a particular trust or board if the incident occurred there or the doctor was employed there when the incident took place. This might not necessarily be the organisation that currently employs the doctor. Some doctors will no longer be registered to practice in the UK and, in some cases, we will have removed them from the medical register because an MPTS panel has decided they should not be working as doctors any more.

Why are we not publishing data at the level of the site?

At site level – for example, a particular hospital – the number of complaints is likely to be very small and care is needed when publishing small numbers.

Why are we publishing only data from 2007?

We only began recording an incident location in 2011. However, we retrospectively completed this for all enquiries received from 1 January 2007. Because of the time it takes to see a case through to an outcome, data on case outcomes and panel outcomes will not appear until the cases opened at the start of 2007 have gone through our process. No outcomes are recorded for cases that opened before 2007.

How have we handled mergers, closures and the establishment of new trusts and boards?

Mergers: where two or more bodies have merged, we have listed complaints received for the legacy bodies up to the point of merger. From the point of merger, all complaints made (including new complaints about doctors employed in legacy bodies) are assigned to the new body.

Closures: we will continue to record, by the closed organisation, complaints made about doctors after that organisation closed. With the passage of time, these complaints will decrease.

New bodies: we start listing new bodies from the point of establishment. Case outcomes will be recorded once they happen, which may take some time. Therefore, the number of outcomes recorded soon after the organisation starts its work may be low.

Published Apri 2014

Code: GMC/FTPDSC/0414