



National training survey 2014

Key findings

General
Medical
Council

Regulating doctors
Ensuring good medical practice



Introduction

Every year, we ask around 54,000 doctors in postgraduate training what they think about the quality of their training. This year we had a record response rate of 98.2%.

The survey is an important part of how we make sure medical education and training is meeting the standards we set to support high quality medical care and patient safety across the UK. This report gives an overview of the main findings of the 2014 survey. * UK-wide scores[†] have risen slightly in each area we measure, and overall satisfaction remains high, particularly in general practice and anaesthetics training.

At a local level, although the standard of many areas of training has improved or remains high, some areas still remain a concern. We have reviewed the areas with three years of poor results in our trend reports, and we are working with the relevant deaneries, local education and training boards (LETBs) and local education providers (LEPs) to address problems and make sure action is taken. The report also includes several case studies to show how results from the survey have been used to make positive changes to education and training.

You can see the detailed results in our interactive tool at www.gmc-uk.org/nts.

How can the findings be used?

Deaneries, LETBs, LEPs and employers look at local data to find out which aspects of their training work well or can be improved. Medical royal colleges and faculties can also use the results of the specialty-specific questions to inform how they develop and deliver their curricula.

We also work closely with other regulators to ensure the survey findings are used effectively in their work to assure the quality and safety of healthcare.

This year, for the first time,[§] we have three years of results available, allowing data to be analysed for trends (see page 11).

The data generated from this survey are just one source of information about the quality of medical education and training and should be considered alongside other data. In some cases, local organisations will need to follow up survey results with a detailed investigation.

* The survey was open from 26 March to 8 May 2014. Doctors in training were asked about the post they were in on 26 March 2014.

† UK-wide scores are the overall score for each indicator, across all specialties and stages of training.

§ We introduced our online reporting tool in 2012, and so we now have three years of results to display side-by-side.

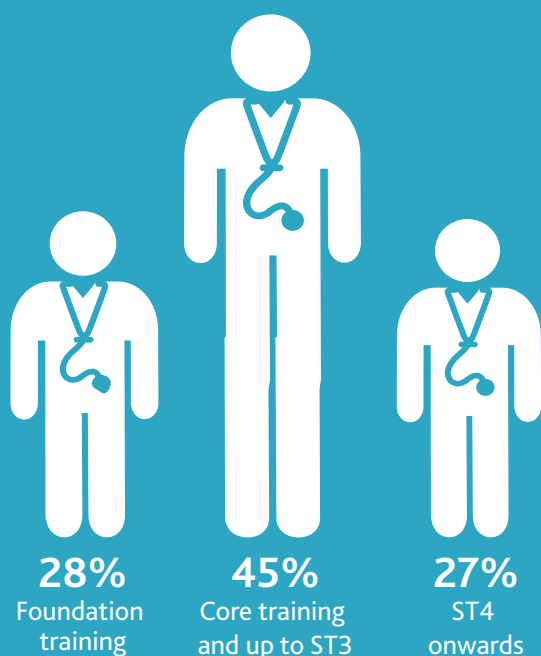
Who answered the survey?

This year, 53,077 doctors in training completed the survey out of 54,068 who were eligible, giving a response rate of 98.2%.* This compares with 97.7% in 2013.

The response rate by deanery or LETB ranged from 92.1% to 100%, with nine achieving over 99%.

Figure 1 shows the response from doctors at different stages of training.

Figure 1: Response from doctors at different stages of training (n=53,077)



ST3 = third year of specialty training
ST4 = fourth year of specialty training

55.6% of respondents were female and 44.4% were male (n=53,077).

11.3% said they were in less than full-time training (6,010 of n=53,077). Of these, 80.4% were female and 19.6% were male.

Health and disability

Doctors in training were asked if their day-to-day activities were limited because of a health problem or disability that has lasted, or is expected to last, at least 12 months. 2.3% said their day-to-day activities were limited a little or a lot (1,174 of n=51,959), compared with 2.4% in 2013.

Of those reporting a health problem or disability that limited their activities, 38.8% said that they need adjustments to be able to carry out their work, and 6.8% of those who need adjustments, said that the adjustments they need have not been made. In training locations where adjustments have not been made, we will discuss the issues with the relevant deaneries and LETBs.

* Not all doctors in training answered all questions, so we have given the total number of respondents with valid answers in brackets for each key finding. We excluded answers that were not applicable from the analysis. All percentages and scores have been rounded to one decimal place.

Overall satisfaction with training

Overall satisfaction by stage of training

To measure satisfaction, we asked doctors in training about various aspects of their post, such as how they rate the quality of teaching, experience and supervision, how useful the post will be for their future career, and whether they would recommend the post to a friend.

Figure 2: Overall satisfaction of doctors at different stages of training (n=52,588)



The overall satisfaction score is 81.2 out of 100, which is slightly up from the score of 80.8 in 2013. This follows the pattern of rising satisfaction levels from 2006 to 2013.

Figure 2 shows the overall satisfaction score for doctors at different stages of training (n=52,588). Following the trends from previous years, we can see that satisfaction rises as doctors progress through their training, with foundation doctors giving lower scores than those in core training and up to the third year of specialty training (ST3) and those in the fourth year of specialty training (ST4) onwards.

This is not an unexpected finding. Doctors who are in later stages of training will most likely have chosen to pursue a career in that specialty, and have acquired experience and competence, so it follows that overall satisfaction will be higher.

Overall satisfaction by post specialty

Figure 3 shows the overall satisfaction score split by post specialty.* Post speciality is determined by where the doctor in training was working at the time of the survey. For example, the score for the general practice posts includes foundation doctors in general practice posts.

This year, the survey shows doctors training in general practice posts are the most satisfied. However, doctors training to be general practitioners (GPs) give lower scores when training in other specialty posts. We discuss this further in our focus on key indicators on page 8.

Like most specialties, satisfaction of doctors training in surgery has been rising since 2006 (72.9 in 2006, rising to 77.1 in 2014). Nonetheless, it consistently has the lowest average score compared with other specialties when all doctors training in surgery posts are included. However, when surgery satisfaction scores are separated into the three main stages of training, we see big differences: 72.1 for foundation training, 77.2 for core training and up to ST3, and 85.5 for ST4 onwards in 2014. This represents the biggest difference in satisfaction scores between foundation training and ST4 onwards in any of the specialties.

Foundation doctors giving lower satisfaction scores for their surgery posts is a recognised trend and, in England in particular, work is being done to broaden the Foundation Programme and give extra support to foundation doctors in surgery posts.†

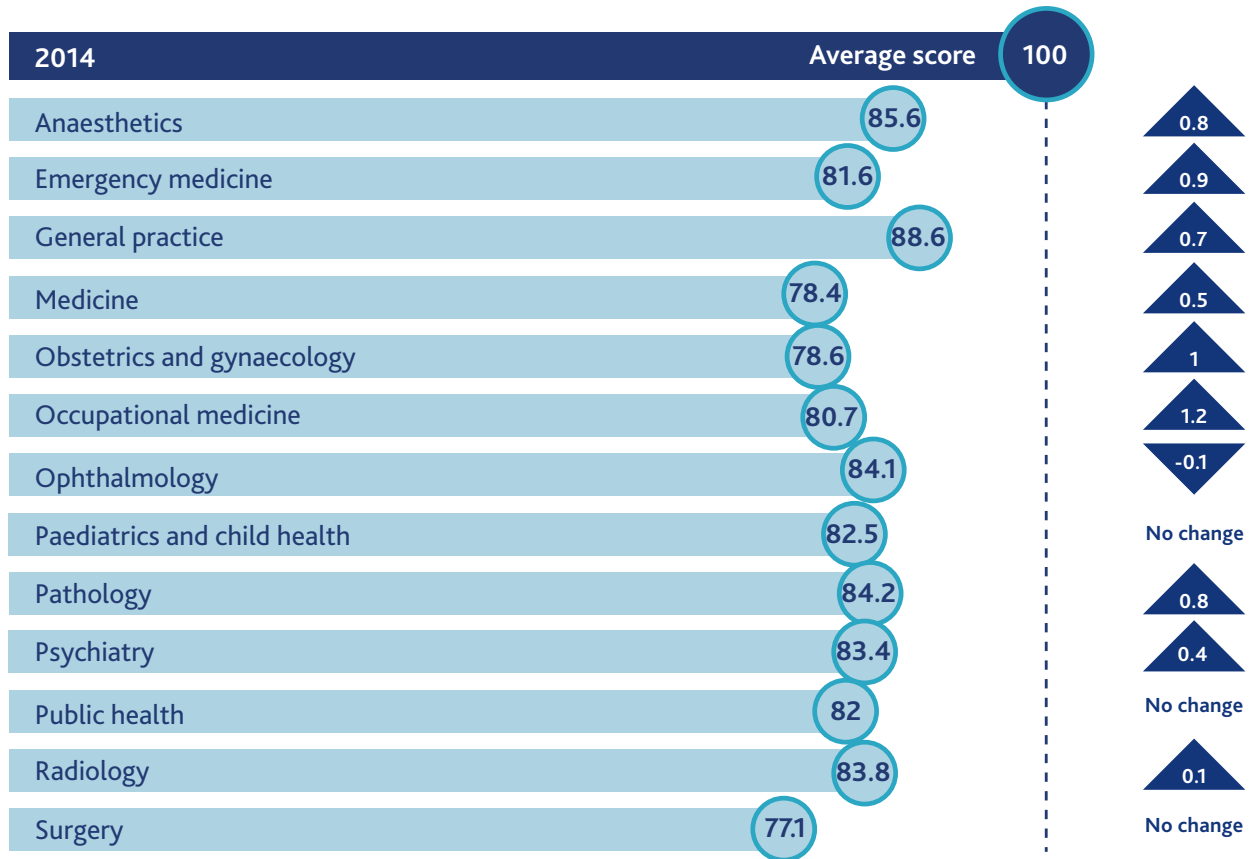
The biggest rises in overall satisfaction this year came in occupational medicine posts (up 1.2 since 2013) and obstetrics and gynaecology posts (up 1.0), whereas satisfaction in ophthalmology posts has fallen slightly (from 84.2 to 84.1).

Perhaps because of the well documented pressures in emergency services, recruitment into the specialty remains a challenge. Despite this, satisfaction of doctors training in emergency medicine posts remains above the UK-wide average (81.6, compared with 81.2).

* We use the terms 'post specialty' and 'programme specialty' to differentiate between the specialty a doctor is currently working in (post specialty) and the programme of training the doctor is undertaking (programme specialty). For example, a doctor in training can have a programme specialty of 'foundation', 'core medical training' or 'general practice', but be working in a cardiology post. Therefore, post specialty scores for 'surgery' are for all doctors currently working in surgery posts, including foundation, core and general practice, as well as those in higher surgical specialties.

† For more information, see the report *Broadening the Foundation Programme: recommendations and implementation guidance* at http://hee.nhs.uk/wp-content/uploads/sites/321/2014/02/Broadening_the_Foundation_V16-Final.pdf.

Figure 3: Overall satisfaction score by post specialty and change in the score since 2013*



* We have included the pharmaceutical medicine score in the score for medicine. This is different from previous years when it was recorded separately because doctors training in pharmaceutical medicine were surveyed in a separate IT system.

Focus on key indicators

We asked doctors in training a number of questions about the quality of different aspects of their medical education and training.

This year we have focused on five key indicators:

- clinical supervision
- educational supervision
- induction
- handover
- adequate experience.

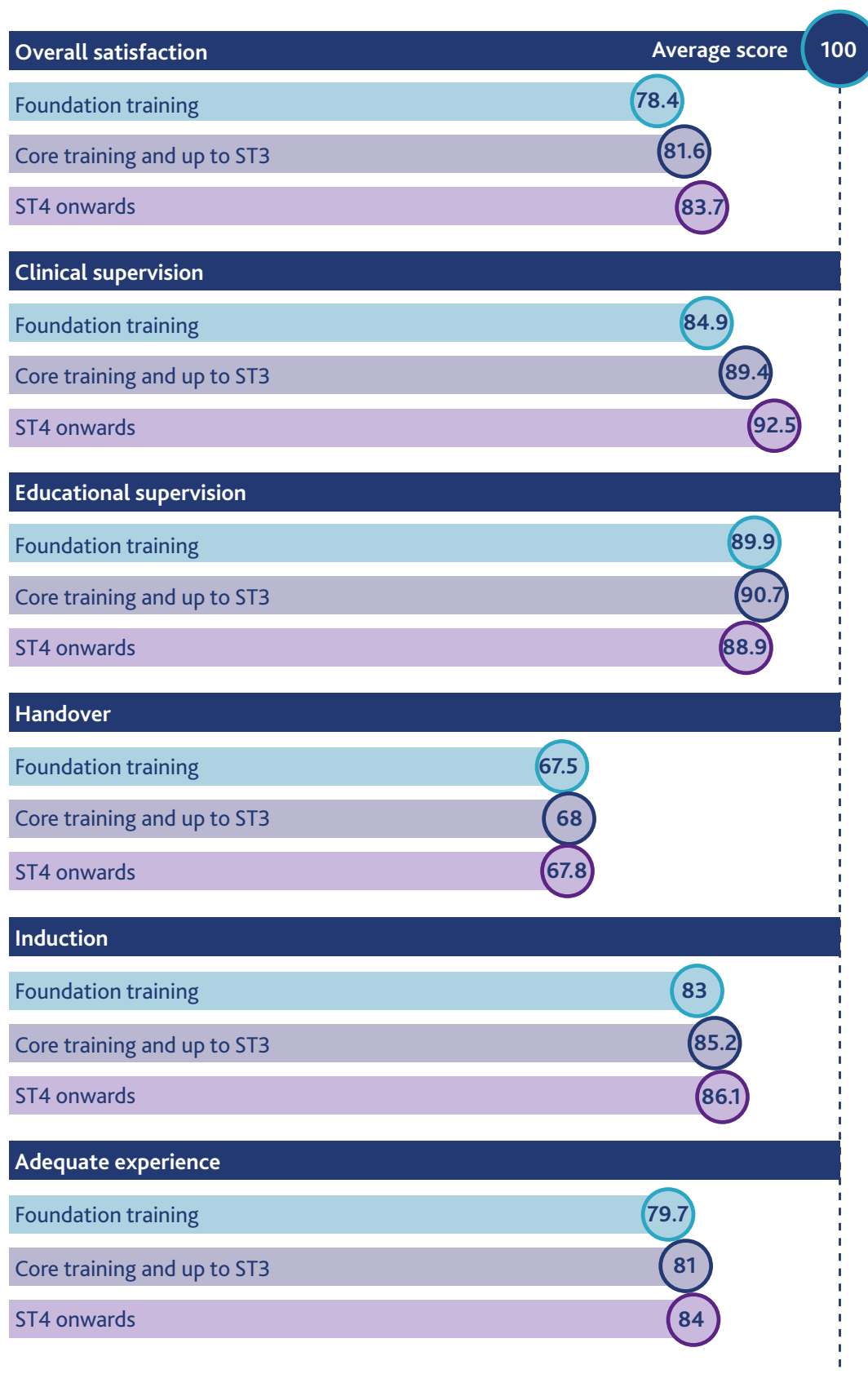
The average indicator score (on a scale of 0–100) is shown in figure 4. The figure separates responses from doctors in foundation training, in core training and up to ST3, and in ST4 onwards.*

Figure 4 shows that the further doctors progress through training, the more satisfied they are with most aspects of that training, with the exception of educational supervision and handover. This could reflect a general sense of assurance among doctors that increases with experience and greater competence.

We have looked in more detail at each of these key indicators and included some case studies illustrating how the survey has been used to make changes in local systems and training environments.

* Foundation includes years one and two of the Foundation Programme (F1 and F2). Core training includes years one, two and three of the core training programme (CT1, CT2 and CT3).

Figure 4: Average indicator score for five key indicators by stage of training



Clinical supervision

The day-to-day clinical supervision of doctors in training is fundamental in making sure patients receive safe, high quality care.

The quality of clinical supervision is measured by asking doctors in training a number of questions including the following.

- Did you always know who was providing your clinical supervision?
- Did you feel forced to cope with clinical problems beyond your competence?
- If yes to either of the questions above, how frequently?

In ST4 onwards, clinical supervision is the highest ranked of all the key indicator scores, with scores of 92.5 out of a possible 100.

Looking at respondents' programme specialty,* doctors who are training to be GPs have one of the lowest scores for clinical supervision (89.0, compared with anaesthetics at 92.7). However, when looking at respondents' post specialty instead, general practice posts attain one of the highest scores (92.1). Doctors training to be GPs rotate through a number of other specialties during their training (including emergency medicine and obstetrics and gynaecology, among others).

The difference between the programme specialty and post specialty scores could be explained by doctors in GP training being more satisfied with the supervision they receive in GP practices than with their supervision in other settings.

* For this analysis, programme specialties have been grouped together by the royal college, faculty or joint board that manages the curriculum for those programmes. For example, all eight surgical specialty programmes are grouped together under 'surgery'.

Case study: doctors in training work with clinical supervisors to resolve problems with out-of-hours work

After services had been reconfigured across two local hospitals in the same trust/board, the results of the national training survey showed that doctors in training were feeling unsupported and under pressure when working out of hours. Recognising this was not only a risk to the quality of education and training, but a risk to the quality and safety of care provided out of hours, the deanery/LETB immediately called a meeting with trainers and local doctors in training to deal with the problem.

As a result, the trust/board provided funding for an extra doctor over the weekend. This doctor now works across both sites, depending on where they are most needed. Workload is now much more manageable and feedback has been extremely positive, both from doctors in training and consultants.

Educational supervision

Educational supervision provides an important source of support for a doctor in training, both for their professional development and pastoral care. We assessed the quality of educational supervision by asking doctors in training about the support they received from their educational supervisor.

Educational supervision has high indicator scores across all stages of training: 89.9 for foundation training and 90.7 for core training and up to ST3, but falling slightly to 88.9 for ST4 onwards. This pattern is consistent with last year's results, but the 2014 scores are slightly higher in each group.

This year, most doctors said they had a designated educational supervisor (the person responsible for appraising their educational progress; n=52,446):

- 99.6% of foundation doctors, compared with 99.3% in 2013
- 99.1% of doctors in core training and up to ST3, which is the same as in 2013
- 99.4% of doctors in ST4 onwards, which is the same as in 2013.

Of all respondents, 88.1% said they were told who to talk to in confidence if they had personal or educational concerns (n=49,390), compared with 85.4% in 2013.

Induction

A structured induction to the workplace is key to ensuring of doctors in training practise safely when starting in a new role, providing them with the necessary local knowledge of policies and procedures.

Again, the overall score for this indicator has improved. The scores are higher in later stages of training than in earlier stages, and have increased since 2013:

- 83.0 for foundation training, compared with 82.2 in 2013
- 85.2 for core training and up to ST3, compared with 84.1 in 2013
- 86.1 for ST4 onwards, compared with 85.3 in 2013.

By post specialty, surgical specialties have the worst score for induction (score of 80.9, against a national mean of 84.8).

Case study: doctors in training use the survey results to improve their department's induction

The survey highlighted that doctors training in the anaesthetic department were unhappy with the induction they received when starting their posts.

As a result, doctors in training took the initiative to gather further feedback on induction from all doctors training in the department. This feedback highlighted several problems with induction. For example, doctors in training attended a long lecture in a small, non-air conditioned room in the middle of a very hot summer, making it difficult to concentrate and retain key messages. Also, the induction contained a lot of information but did not cover key practical tasks, such as receiving passes to access key areas of the hospital.

Doctors in training took their feedback to departmental consultants as evidence that induction needed to be improved. They worked together to come up with improvements to induction in the department. One improvement was to make sure that practical matters, such as security badges, lockers in theatre and theatre shoes, were sorted out at the start of the induction process. Learning was then split into a series of shorter talks, rather than one big lecture.

Senior doctors in training have captured feedback on the new process, which shows that results have moved from being very poor to good. More changes are being implemented to increase feedback to excellent and improvements will be monitored using the survey results.

Handover

A well managed, thorough and organised handover is crucial for ensuring the quality and safety of patient care. It is particularly important for high risk specialties, such as obstetrics and gynaecology. Poor handover can contribute to a fragmented experience for doctors in training. The national score for handover has risen slightly in 2014 (from 66.0 to 67.8) with big rises in emergency medicine (from 52.2 to 58.0) and ophthalmology (from 39.0 to 43.3) posts. For specialties that use handover, scores for handover have not dropped in any post specialty. Scores for handover have increased across all stages of training.

According to respondents in obstetrics and gynaecology posts, handover is far better than in other specialties (86.5, compared with a national mean of 67.8). We plan to examine why obstetrics and gynaecology scores so highly to understand how other specialties could improve their results.

Case study: using survey results to identify handover issues and improve processes by sharing good practice

Results from the 2013 national training survey showed that, in one hospital, handover was considered to be excellent in the gynaecology department but poor in the medicine department. The gynaecology department's lead was invited to speak to the medicine department and share their experience. They suggested several measures the department could take to improve handover.

Several of these measures are now being used and have led to a much improved handover process. For example, the day and night teams now meet in person twice a day. There is now also a Friday afternoon meeting where the full medicine team provides handover to the weekend team, informing team members of patients to be reviewed and those who could potentially be discharged.

Adequate experience

It is essential that doctors in training are given opportunities to acquire the the experience they need. We ask doctors in training to rate their practical experience and ask how confident they are that their post will help them acquire the competences they need at this stage of their training.

As with other key indicators, scores for adequate experience are higher for doctors later in training:

- 79.7 for foundation training, compared with 79.2 in 2013
- 81.0 for core training and up to ST3, compared with 80.5 in 2013
- 84.0 for ST4 onwards, compared with 83.4 in 2013.

By post specialty, doctors in medical posts gave the lowest scores (78.3, compared with 88.0 for general practice posts). But this is still a rise from 2013, when medical posts scored 77.9 and general practice posts scored 87.1. Low scores in adequate experience could point to training posts where training is neglected in favour of service delivery.

Trend analysis

In the autumn of 2013, we added several new features to the reporting tool, including trend analysis. June 2014 will be the first time that three years of results have been displayed side-by-side.

Trend analysis is a powerful way of displaying improvements or deterioration in results over three

years. It allows training providers to instantly see where, according to the perceptions of doctors in training, things have improved or need attention.

In figure 5 below, you can see the patterns for paediatrics in a particular trust.

Figure 5: Example from the reporting tool, showing trend analysis for post specialty by trust or board

Post Specialty	Trust / Board	Indicator	Outcome			Mean		
			2012	2013	2014	2012	2013	2014
Paediatrics	Name of trust or board	Overall satisfaction	Below outlier	Below outlier	Within the middle quartile (Q2/IQR)	60	66.67	91.2
		Clinical supervision	Below outlier	Within the lower quartile (Q1), but not a below outlier	Within the middle quartile (Q2/IQR)	70.42	75.14	92.6
		Handover	Within the middle quartile (Q2/IQR)	Within the middle quartile (Q2/IQR)	Above outlier	76.39	79.17	90
		Induction	Below outlier	Within the middle quartile (Q2/IQR)	Below outlier	48.89	78.89	74
		Adequate experience	Below outlier	Within the middle quartile (Q2/IQR)	Above outlier	64.44	75.56	92
		Workload	Below outlier	Within the middle quartile (Q2/IQR)	Within the upper quartile (Q3), but not an above outlier	30.56	48.61	58.75
		Educational supervision	Within the middle quartile (Q2/IQR)	Within the middle quartile (Q2/IQR)	Within the middle quartile (Q2/IQR)	88.89	77.78	95
		Access to educational resources	Below outlier	Within the lower quartile (Q1), but not a below outlier	Within the middle quartile (Q2/IQR)	49.99	53.82	72.32
		Feedback	Within the lower quartile (Q1), but not a below outlier	Within the middle quartile (Q2/IQR)	Above outlier	60.42	76.56	88.33
		Local teaching	Below outlier	Within the middle quartile (Q2/IQR)	Within the middle quartile (Q2/IQR)	46.78	51	66.2
		Regional teaching	n<3, result not published	Within the middle quartile (Q2/IQR)	Within the middle quartile (Q2/IQR)		65.14	70.94
		Study leave	Within the middle quartile (Q2/IQR)	Within the middle quartile (Q2/IQR)	Within the middle quartile (Q2/IQR)	48.33	67	69.17

KEY:

■ Below outlier	■ Within the lower quartile (Q1), but not a below outlier	■ Above outlier
■ Within the middle quartile (Q2/IQR)	■ Within the upper quartile (Q3), but not an above outlier	■ n<3, result not published

n is the number of doctors in training whose responses contribute to the outcome. Q1, Q2, Q3 (quartiles) are how the benchmark group is divided. For an explanation of how outcomes are calculated (what makes a result green or red), please visit www.gmc-uk.org/education/national_summary_reports.asp.

Figure 5 shows that the trust had problems in paediatrics in seven out of 12 indicators in 2012. There were improvements in 2013, but overall satisfaction remained poor. If there were three years of red here, we would expect to see a response in the dean's report.

There have clearly been vast improvements across the board in 2014, with greens appearing in handover, adequate experience and feedback. Looking at the scores, we can also see that overall satisfaction has shot up from 66.67 in 2013 to 91.20 in 2014.

Induction remains a problem area and will need to be examined further, but overall the signs for this department are encouraging.

What our stakeholders say about trend analysis

Dr Eleanor Wood, Director of Medical Education, Consultant Physician & Gastroenterologist, and Dr Emma Breese, Head of Medical Education at Homerton University Hospital, say:

'Trending is a powerful way of viewing the survey results. Educational supervision in endocrinology and diabetes suddenly changed from white (2012) to red (2013) which was unexpected. We were then able to investigate further and identified accessibility as an issue. We provided support and allocated a new supervisor.'

'Changes across time identified by trending is a very useful way to assess the impact of previous/ ongoing interventions. Within the gastroenterology department several new consultants underwent faculty development training which contributed to improved feedback to trainees (2011 white, 2012 and 2013 green). Formalised induction was also implemented with a change from white (2011, 2012) to green (2013).'

'Trending supports our integration of training with service. A major review of the elderly care/geriatric service resulted in the opening of a 56-bed elderly care unit. This has contributed to the change in adequate experience from pink (2012) to white (2013) in geriatrics.'

The following case study shows a real example of how trend reporting can be used to make crucial interventions and quick improvements to ensure good quality training.

Case study: using trend reports to identify serious issues at a local education provider

By looking at trends in survey results over two years, a deanery/LETB noticed concerns in a department of an LEP. In 2012 this department had no particularly negative results, but in 2013 they had several. The results therefore pointed to a new and potentially serious problem with training. It is possible that the problem related to an increased number of doctors in training leaving their posts to complete academic training, which in turn increased the pressure on those left behind.

The deanery/LETB reported this case to us and we worked with them to monitor progress and to set the LEP requirements that they must fulfil. The deanery/LETB has carried out visits to the LEP, which has confirmed that half of the requirements have now been met. Problems were also reported with supervision including, for example, foundation doctors being left unsupervised on the on-call rota.

As a result, we joined the deanery/LETB on a follow-up visit in May 2014 that focused only on this issue. The visit showed this was not an immediate concern and foundation doctors were not being left unsupervised. The trust and deanery/LETB will work together to strengthen the formal supervision arrangements.

The concern about doctors in specialty training on out-of-programme experience is still being addressed and the LETB/deanery is monitoring this.

What happens next?

Doctors in training play a key role in ensuring patient safety by raising concerns if they feel that patients are at risk. The survey includes an opportunity for doctors in training to raise concerns about patient safety, as well as any concerns they have about bullying and undermining. We will investigate all these concerns and publish our findings in the autumn.

From 23 June, deaneries, LETBs, LEPs, and royal colleges and faculties will examine their results and investigate any areas of concern. Deaneries and LETBs will report to us on these results in their October deans' reports and will explain actions they are taking to resolve the problems identified. Should the problem require more regular updates, they will report to us through our enhanced monitoring process. Royal colleges and faculties will report on any problems identified in their results in the annual specialty returns next year. We publish all these reports on our website.

Annex A: key findings in the four countries of the UK

Table 1: Mean score and number of respondents for all 12 indicators across all stages of training

		England	Northern Ireland	Scotland	Wales	UK total
Overall satisfaction	Mean	81.1	82.5	81.5	81.9	81.2
	n	43,661	1,626	4,971	2,330	52,588
Clinical supervision	Mean	88.9	90.3	88.9	88.3	88.9
	n	43,416	1,624	4,962	2,324	52,326
Educational supervision	Mean	90.0	91.4	89.7	89.5	90.0
	n	43,627	1,626	4,968	2,327	52,548
Induction	Mean	84.7	86.6	85.3	84.6	84.8
	n	43,520	1,617	4,927	2,313	52,377
Handover	Mean	68.0	66.4	67.8	65.2	67.8
	n	28,873	1,180	3,371	1,601	35,025
Adequate experience	Mean	81.4	81.6	81.8	81.8	81.5
	n	43,661	1,626	4,971	2,330	52,588
Feedback	Mean	76.5	76.6	76.5	76.2	76.5
	n	38,004	1,397	4,344	1,958	45,703
Regional teaching	Mean	71.5	69.7	70.6	69.8	71.3
	n	23,845	794	2,359	1,262	28,260
Workload	Mean	45.8	45.6	47.1	48.1	46.0
	n	43,534	1,626	4,971	2,330	52,461
Local teaching	Mean	63.9	62.6	64.1	65.4	63.9
	n	31,303	1,120	3,396	1,659	37,478
Study leave	Mean	68.4	72.7	72.7	66.9	68.8
	n	33,741	1,224	3,669	1,837	40,471
Access to educational resources	Mean	68.6	67.9	68.5	71.2	68.7
	n	42,431	1,576	4,728	2,289	51,024

Table 2: Mean score and number of respondents for the six indicators reviewed in this report across the three stages of training

		England			Northern Ireland			Scotland		
		Foundation training	Core training and up to ST3	ST4 onwards	Foundation training	Core training and up to ST3	ST4 onwards	Foundation training	Core training and up to ST3	ST4 onwards
Overall satisfaction	Mean	78.2	81.5	83.5	80.4	82.6	84.9	78.4	82.0	84.6
	n	12,231	19,616	11,814	506	720	400	1,575	2,235	1,161
Clinical supervision	Mean	85.0	89.3	92.4	86.7	90.7	94.0	84.7	89.6	93.1
	n	12,215	19,490	11,711	504	720	400	1,575	2,231	1,156
Educational supervision	Mean	89.9	90.6	88.9	90.5	92.3	90.8	90.2	90.1	88.0
	n	12,225	19,600	11,802	506	720	400	1,575	2,232	1,161
Induction	Mean	83.1	85.0	85.9	80.9	88.9	89.9	82.8	85.9	87.7
	n	12,227	19,566	11,727	506	719	392	1,574	2,225	1,128
Handover	Mean	67.7	68.3	67.9	66.3	66.9	65.7	70.0	67.1	67.7
	n	4,517	13,928	10,428	225	585	370	681	1,680	1,010
Adequate experience	Mean	79.7	80.9	83.9	80.2	81.0	84.6	79.7	81.7	84.8
	n	12,231	19,616	11,814	506	720	400	1,575	2,235	1,161

		Wales			Total			Total
		Foundation training	Core training and up to ST3	ST4 onwards	Foundation training	Core training and up to ST3	ST4 onwards	
Overall satisfaction	Mean	79.3	82.5	83.7	78.4	81.6	83.7	81.2
	n	671	1,092	567	14,983	23,663	13,942	52,588
Clinical supervision	Mean	82.1	89.8	92.9	84.9	89.4	92.5	88.9
	n	670	1,089	565	14,964	23,530	13,832	52,326
Educational supervision	Mean	87.9	90.9	88.6	89.9	90.7	88.9	90.0
	n	671	1,091	565	14,977	23,643	13,928	52,548
Induction	Mean	83.1	85.3	85.2	83.0	85.2	86.1	84.8
	n	671	1,081	561	14,978	23,591	13,808	52,377
Handover	Mean	59.9	66.0	66.5	67.5	68.0	67.8	67.8
	n	256	835	510	5,679	17,028	12,318	35,025
Adequate experience	Mean	80.7	81.8	83.2	79.7	81.0	84.0	81.5
	n	671	1,092	567	14,983	23,663	13,942	52,588

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