

The state of medical education and practice in the UK

2013

General
Medical
Council

Regulating doctors
Ensuring good medical practice

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Regent's Place

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Telephone: 0161 923 6602

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Introduction

The medical profession and medicine itself continue to undergo substantial change and doctors are now working in ever more complex and exacting environments.

Despite these new and emerging challenges, this year's edition of *The state of medical education and practice in the UK* highlights that there is much to be positive about the standard of medicine. Although the data we have analysed in this year's report highlight that complaints about doctors continue to rise and that there are still unacceptable variations in standards of practice, these patterns are not representative of the vast majority of doctors, who provide excellent care to their patients.

But in order to better understand the challenges facing doctors and the environments in which they work, we have focused more heavily in this edition on understanding and analysing complaints about doctors and the sources of those complaints. This is intended to help us and others identify how and where to provide support to doctors – if we are to be more than a firefighter, dealing with problems of patient safety after they have occurred, it is vital that we identify any patterns or trends and try to understand what they mean.

Overall, the standards of medical care are good and the level of respect and trust bestowed on doctors by the public remains exceptionally high. Our graduates are also sought after by other countries, and medical education here has pioneered and continues to shape training in many parts of the world. Without in any way wishing to foster complacency, there is still a strong case for celebrating what doctors and medicine achieve across the UK and this report should be read in this context.

A challenging year for frontline staff

This has been a difficult year for those working in healthcare in the UK. Financial pressures since 2009 have started to make their mark on services for patients. Emergency departments – the front door of acute care – are under considerable pressure and, at times, struggling to cope. The longstanding strain between hospital and community services, particularly for older people with comorbidities, is proving hard to manage in some parts of the country.

Into this challenging environment, the final report of the Mid Staffordshire inquiry landed in England.¹ It revealed an environment where care, compassion and leadership were lacking. It highlighted that frontline clinicians were disengaged and accepting poor standards. It contained few revelations, instead serving as a damning indictment of what happens when organisations, and the regulatory mechanisms that surround them, fail to operate effectively.

The report has in turn spawned others,^{2,3} each one highlighting the flaws and pressures of a system that is having to manage relentless increases in demand, the opportunities created by technological innovation, and different and rising expectations from staff and patients. Although specific to the English system, the lessons learnt can be applied across the whole UK.

Some doctors blame politicians and managers for what they see as a loss of medical autonomy and a misplaced focus on targets and money.⁴ To an extent, the Mid Staffordshire inquiry supports this view. Others believe professional unwillingness to embrace organisational goals is at least partly to blame and, again, that is evident in the findings of the inquiry.⁵ One thing is clear – where such antagonisms prevail on either side, and where doctors and other clinical staff are disengaged, for whatever reason, the quality of care is likely to suffer.⁶

The Keogh review, which looked at 14 National Health Service (NHS) trusts in England with high mortality rates, showed that doctors had limited understanding of how important and simple it is to listen to patients and staff.³ It pointed to the strong correlation between higher staff engagement and lower mortality rates.

Beyond those interested in policy and regulation, this debate may seem remote and irrelevant. In the Mid Staffordshire inquiry, the criticism focused more on what doctors didn't do than on what they did. While the inquiry did point to serious shortcomings in some medical care, the central charge against doctors was that they did not appear to accept overall responsibility for patient care – medicine had been reduced to one technical aspect in the treatment process. What is more, for various reasons, doctors and other healthcare professionals felt unable or unwilling to raise concerns when patient safety was clearly being compromised.

The question that now needs to be answered is: will this be a tipping point? Have we reached a seminal moment in which this disengagement is tackled and where quality and patient safety become the organising principles for healthcare systems?

Central to achieving this – as again is recognised in these reports – will be engaging clinical leadership. Such leadership, together with the principles of transparency and accountability that are so fundamental to safe and effective care, can determine the culture of a healthcare organisation.

The Mid Staffordshire inquiry called for named clinicians to be responsible for every patient. The Secretary of State for Health in England has now embraced this by calling for the name of the lead doctor and nurse to be at the end of every hospital bed. In this age of multidisciplinary care, defining who is responsible may be complex, but the case for clearer responsibility and accountability is a strong one. At the General Medical Council (GMC), we have begun to explore whether there is more we can do within our own guidance to define and highlight the additional responsibilities of doctors who should have overall charge of a patient's care.⁷

Systems under pressure

In the past year, the overall pressures on the system have increased. The NHS in England has gone through major structural change and the service has been attempting to make £20 billion worth of efficiency savings by 2015. NHS England has also warned that there could be a £30 billion funding gap by 2021 unless hospital and GP care is further reorganised.⁸ Some parts of the service have been particularly stretched and we have seen direct evidence of this in our monitoring of medical education.

Many concerns we receive about educational quality are about the level of supervision and support of less experienced doctors in training. The pressure on emergency care was evident in our review of education and training in seven emergency departments, which found that most were struggling with increased demand and staff shortages.

The House of Commons Health Select Committee has reported that, without immediate action, emergency departments in England will become unsustainable in the coming year.⁹ While much of the focus has been about the NHS in England, doctors elsewhere in the UK face similar issues.

In Wales, rising demand and limited resources have prompted health leaders to call for an urgent change in how the NHS delivers care.¹⁰ This has resulted in several consultations on the reconfiguration of health services across the country.

Although the Scottish Government has committed to increasing the NHS budget by £249 million by 2012–13, the service is still facing similar challenges. The forthcoming report of the Vale of Leven Hospital inquiry¹¹ is also likely to have lessons and implications for services across the UK.

In Northern Ireland, the focus on reforming the delivery of services to take account of future health needs continues against the backdrop of tight budget constraints. The introduction of 17 Integrated Care Partnerships is a core part of the Transforming Your Care programme that aims to deliver health services in a more coordinated way in the community. As with other parts of the UK, emergency departments continue to be under pressure and providers are consulting on increasing capacity and alleviating waiting times.

Within this context, and the media coverage it engenders, there is understandable public concern – according to the British Social Attitudes survey 2013, public satisfaction with the NHS fell sharply between 2010 and 2013 (from 70% to 61%).¹²

The environment in which doctors work is creating new challenges

These challenges must also be considered alongside the wider environment in which doctors work.

The UK population continues to increase and live longer.¹³ There are now 1.7 million more people over 65 years old than there were 25 years ago, and the number of people aged 85 years and over has doubled in the same period. By 2034, 23% of the population is expected to be over 65 years old.¹⁴

As life expectancy increases, so does the likelihood of more years spent in ill health – on average, women have 11 years and men have 6.7 years of poor health.¹⁴ The health service is now largely for older people, with very elderly patients occupying most hospital beds: the average length of stay is fewer than four days for patients under 60 years old, and more than ten days for those over 75 years old.¹⁵ The proportion of frail elderly people has risen to 30% of all admissions in the past year.¹⁶ It is now generally accepted that the ageing population is the major challenge in healthcare and those who work in it.^{16, 17, 18}

Medical science continues to advance. The full ramifications of mapping the human genome lie ahead, but the nature of practice is already changing in response to what doctors can do to improve quality of life and to prolong it.

The digital revolution is likewise transforming the way services are organised and the relationship between professionals and patients. As the 2010 Royal College of Physicians' report on the future physician highlighted, health information and communication technologies are changing relationships and power balances, and they have the potential to transform them completely in the next 20 years.¹⁹

Access to data also means that individual, team and organisational performance is under greater scrutiny and will inevitably become more transparent in the next few years. The pioneering work undertaken by cardiothoracic surgeons to define and publish performance data is now being taken forward by other surgical specialties, and NHS England now requires every surgeon to publish his or her outcome data on the NHS Choices website.²⁰

There is still strong evidence of high-quality care and improving standards

Alongside the many difficulties, every day in homes, surgeries, clinics and hospitals around the UK doctors and other clinical staff provide outstanding treatment and care for hundreds of thousands of patients, supported by managers and other healthcare staff. Feedback from patients receiving care is overwhelmingly positive – in England, 80% of inpatients said they were always treated with dignity.²¹

In Scotland, 85% of patients rated their care and treatment as excellent or good in 2012, the same as in 2011.²² In Northern Ireland, 95% were very or fairly satisfied with the care given by their general practice surgery in the latest survey, slightly higher than the year before.²³

In medical education, there is evidence of growing pressures from the service, and difficulties with working hours and implementing the Working Time Regulations.^{24, 25} But there's also evidence of progress and positive experiences. This year, our national survey of doctors in training found that the average score for overall satisfaction with training was 81 on a 100-point scale.²⁶

In the past year, we have also helped to introduce revalidation. This is a system of regular checks on doctors' performance, which aims to provide greater assurance that each doctor is competent, up to date and able to deliver safe and effective care. These are very early days, and the system will need to be refined and developed. But it is the first in the world – the most comprehensive system to try to ensure that every doctor is a good doctor.

Already, revalidation has resulted in major improvements to clinical governance across the UK. For example, a key component of revalidation is regular appraisals and, by 2012, appraisal rates had risen to 73% across the NHS in England, with 90% for general practitioners (GPs).²⁷ There is clearly more to be done but, by September 2013, more than 17,000 doctors had been revalidated. The full effect will not be known for some years, but already this reform – the biggest change in medical regulation for more than 150 years – does appear to be having a positive impact.

Two years ago, the GMC increased the level of language requirements for international medical graduates seeking to work in the UK. If necessary, we will increase this level further and remain committed to making sure that every doctor who comes to work here can practise safely and effectively.

For some time, the GMC, the British Medical Association and many others have been concerned that the UK's regulatory system is not able to check the language skills of doctors coming from other parts of Europe to work in the UK. But, in March 2013, the UK Government announced plans to amend the *Medical Act 1983* to give the GMC new powers to do so, when we are concerned about a doctor's ability to speak English. This will be an important improvement.

At the same time, the European Union has made very good progress towards passing new legislation that would allow the GMC and similar authorities throughout Europe to check routinely that all doctors benefiting from free movement between member states can speak the language well enough to practise safely.

Even in the area of candour and transparency, where there is so much more to do, we should acknowledge how much has already been achieved. Doctors and other staff are more willing to raise concerns, which is evident in the substantial increase in cases referred to the GMC from both individual doctors and medical managers. For the first time last year, we included a question about patient safety in our survey of doctors in training, resulting in more than 2,000 matters being raised.²⁸ We see this too in our confidential helpline for raising concerns, which received more than 500 calls in its first six months. Clearly more needs to be done to encourage routine discussion of such matters at local level, but this also shows that doctors are prepared to speak out about their concerns if they are given the opportunity to do so.

The key to improving patient safety is for organisations to work together

It is not only individual clinicians who have come under scrutiny in the recent debate over the NHS – regulatory systems have been found wanting. In particular, the systems did not identify deep-seated problems early enough, did not share the right information at the right time and, in some instances, appeared to be more concerned with targets and money than the reality of what was happening to patients.²

NHS England has pointed out that no one organisation can have a full picture of quality in a healthcare provider.²⁹ Organisations need to share information and intelligence about the quality and risks across the NHS. This is an essential principle for all countries in the UK to work towards.

For professional regulators such as the GMC, the reports have demonstrated that we must see ourselves as a part of, not apart from, the systems in which doctors work. For example, that means taking part in quality surveillance groups and risk summits that oversee quality and safety at regional level in England. It also means better coordination and closer working with other regulators and, above all, it means much more effective sharing of information. As an important first step, we have developed a new practical protocol with the Care Quality Commission (CQC) in England to help staff at all levels in the CQC and GMC to link up with their counterparts.

We are already working with other regulators across the UK to establish similar levels of cooperation and shared information.

How does this year's report contribute to our understanding of the challenges and risks facing doctors and healthcare?

The recent reviews about healthcare services have underlined the importance of using our data, and those held by others, to identify areas where there are risks to patient safety and any interventions that could help mitigate such risks. The Keogh review in England, for example, found that hospital boards and leadership teams did not use data to drive quality improvement.³

This report is a contribution to that process. It charts a medical profession that has changed substantially in composition and attitude over recent years, and that continues to provide the UK with high standards of care. It should also begin to help us identify where there may be areas of additional risk to patient safety related to the doctor's age, gender or place of primary medical qualification.

A constant challenge for both patients and doctors is the lack of resources, particularly frontline clinicians, in some parts of the healthcare service. In this year's report, we have looked at the changing shape of the medical register over six years and analysed where doctors are working across the UK to highlight several implications for workforce planning. We have also analysed the data we hold about doctors training in emergency medicine to understand some of the challenges that emergency departments are facing.

Our analysis of the sources of complaints and trends since 2007 is intended to help us and other organisations to identify issues that might put patient safety at risk, and to contribute to a wider debate about the importance of raising concerns when poor care is identified.

Building on our analyses from previous years about the characteristics of doctors receiving a complaint, we have identified where there may be greater risks of poor performance within certain groups. Although the vast majority of doctors provide excellent care to their patients, this analysis is our contribution to understanding where some doctors are facing challenges and how we and others can support them better in the workplace.

There has been much debate about the need for regulators to share information about patient safety risks, but we and others have had a limited understanding of what our data tell us about the systems in which doctors work. In this year's report, we have explored whether any of our data correlates with indicators of variation in the healthcare system in England, such as mortality rates and patients' perceptions of the care they receive. We hope this will help us and others begin to understand how our data can be used to understand and identify risks in healthcare systems.

This report is part of our contribution to the need for greater transparency and openness about our data. We will use the findings to help us improve our work and to stimulate discussion about the challenges doctors are facing. At the same time, we need to recognise the limits of what regulation can achieve and what we can do on our own – there is a need for organisations across the healthcare sector to work together to address these issues. As ever, we will welcome feedback on this report and ways we can develop these insights in the future.



Niall Dickson
Chief Executive and Registrar, GMC

Executive summary

This is our third report on the state of medical education and practice. It uses GMC and other data to provide a picture of the medical profession in the UK and to identify some of the challenges it faces.

We hope this report will encourage discussion and debate about some of the practical steps we and others could take in better supporting doctors and improving patient care.

This year we have focused on complaints to the GMC to see if we can understand more about them and whether they can help us identify areas of risk within medical practice.

But this report needs to be seen in the wider context – the overall standard of medical practice in the UK is good, and we need to learn from best practice as well as have a better understanding of what happens when things go wrong.

This executive summary provides an overview of this report's main findings and conclusions.

The changing shape of the profession and medical education (chapter 1)

Shape of the profession since 2007

The number of doctors on the register has increased substantially from 244,540 doctors in 2007 to 252,553 in 2012.

Overall, the most substantial change in this period has been the growth in the number of female doctors. But now this seems to be slowing: 55% of medical students were female in 2012, compared with 61% in 2003 and 57% in 2007.

27% of doctors on the register were international medical graduates in 2012, but the supply of these doctors is reducing and the group is ageing. The number of international medical graduates under 30 years old decreased by 61% between 2007 and 2012. Graduates from the UK and European Economic Area (EEA) are now filling this gap as fewer international medical graduates are able to start postgraduate training in the UK.

Where doctors are working

London and Scotland have the highest numbers of doctors per 100,000 people, and the East Midlands and the east and southeast of England have the lowest.

Some parts of the UK are more reliant on certain groups of doctors.

- Wales has the highest proportion of international medical graduates out of the four countries of the UK: 28% compared with 26% in England, 12% in Scotland and 7% in Northern Ireland. In England, a number of regions also had high proportions of international medical graduates, particularly the east of England and the West Midlands (37% and 32% respectively; figure 5 on page 30).
- Across parts of the UK, Scotland and Northern Ireland have the highest proportion of female doctors (over 48%), compared with the east of England and West Midlands (40% and 41% respectively).

Medical education and training

Some areas of the UK retain more medical graduates in the local postgraduate training deanery after they leave university: Queen's University Belfast, University of Glasgow and University of Birmingham had the highest retention rates, whereas University of Dundee, University of Oxford and Bristol University had the lowest. 21% of all medical students graduating from Bristol, Oxford and Cambridge between 2009 and 2012 went on to train at the London Deanery.

Several specialties continue to face challenges in recruiting and retaining doctors, particularly in general practice, psychiatry and emergency medicine.

Complaints and complainants (chapter 2)

Complaints about doctors in 2012

In 2012, we received 8,109 complaints – a 24% increase since 2011 and a 104% increase since 2007.* But the rise in complaints in recent years does not necessarily indicate increasing concerns about doctors' practice and, relative to the number of interactions between doctors and patients, the number of complaints is still very small.

A third of all complaints received met the threshold for a full GMC investigation. Only 20% of complaints from the public met this threshold, compared with 84% from employers and 48% from individual doctors (figure 10 on page 47).

54% of complaints were about clinical care or about both clinical care and communication with patients.† These were the most common complaints made by members of the public, employers and the GMC. By contrast, the most common complaints from individual doctors and the police were about probity (38% and 70% respectively), such as a criminal conviction or a conflict of interest.

Complaints about probity or the health of a doctor are more likely to meet the threshold for a GMC investigation than complaints about clinical care because of differences in the type of concerns they raise.

Who complains and raises concerns about doctors?

The largest source of complaints is the public. Certain groups of the public are more likely to make a complaint to the GMC.‡

- Those aged 46–60 years are the most likely to complain, making 237 complaints per million people, compared with just 108 complaints per million people in the youngest group (18–30 years) and 182 per million people in the oldest group (over 60 years).
- In the age group that makes the most complaints (those aged 46–60 years), women are more likely to make a complaint to us than men: 260 versus 215 complaints per million people.
- Household income, adjusted for size, did not have a substantial bearing on an individual's likelihood to complain, but the lowest-income households (less than £15,000) are more likely to make a complaint than those earning more.

The vast majority of complaints from the public do not meet the threshold to trigger a full investigation. But, in 2012, we still investigated 989 complaints from the public – more than the number for doctors and employers combined. Many complaints from the public might be better investigated and responded to locally.

* This year, we have separated out complaints from enquiries so that we can analyse data that raise a specific concern about a doctor's fitness to practise. We received an additional 2,196 enquiries that did not raise issues that could be dealt with by the GMC or did not raise a concern about an identified doctor.

† We only assign an allegation for complaints that are not closed immediately – ie those that are closed after checking for wider concerns with the doctor's employer and those that are fully investigated.

‡ There are a number of limitations with the demographic profile of complainants. Please see the note on data for further information (pages 60–61).

The number of complaints from employers and doctors that we investigate is also increasing. We encourage increased reporting of concerns, but there is more to be done to create a culture in which errors and complaints are viewed as opportunities for learning, and where poor practice is identified and tackled before escalation to the GMC.

The GMC itself is also a key source of concerns about doctors through our scanning of press coverage and other sources. But only 31% of the concerns we raised through these sources met the threshold for full investigation. This suggests that we need to reflect on how to use our resources in this area most effectively.

Variations in the standards of UK medical practice (chapter 3)

Complaints might be an indicator of future problems

Previous complaints may be an indicator of future problems: doctors who received no complaints between 2007 and 2011 had only a 1% risk of a full investigation by the GMC in 2012. This increased to 3% if a doctor was complained about once and 8% if the doctor was complained about twice or more, over the same period.

What is associated with a doctor's risk of being complained about?

A doctor's risk of being complained about varies across their career and is affected by their gender, where they gained their primary medical qualification and the role they work in.

Doctors under 30 years old have a different pattern of risk than doctors aged 30 years and over: 4% versus 10% received a complaint between 2007 and 2012. But it is more likely for complaints about doctors under 30 years old to be investigated and to lead to a sanction or warning. This is because younger doctors receive fewer complaints about clinical care, and so receive a higher proportion of complaints about probity or their health, both of which raise issues that are more likely to be fully investigated.

A higher proportion of GPs are complained about than other doctors, but doctors who are on neither the GP nor the Specialist Register are more likely to have complaints against them investigated (figure 19 on page 68).

The risk of doctors aged 30 years and over being complained about is affected by their personal characteristics.

- Male doctors were around twice as likely as female doctors to be complained about, irrespective of the register they were on. For example, 22% of male GPs received a complaint compared with just 11% of female GPs between 2007 and 2012.
- The proportion of doctors over 50 years old who received a complaint was higher than for doctors aged 30–50 years. This was particularly true for GPs.
- International medical graduates received a higher proportion of complaints than UK or EEA graduates. This was particularly true for GPs: 25% of international medical graduates received a complaint compared with only 15% of UK graduates and 17% of EEA graduates.

Groups of doctors with high risks of receiving a sanction or warning

During 2007–12, only 1% of doctors had an incident reported to us that merited a sanction or warning. But there were some groups of international medical graduates and EEA graduates that stood out as having had more than double the risk of receiving a sanction or warning in this period:

- male doctors over 50 years old who were EEA graduates
- male doctors over 50 years old who were international medical graduates
- male GPs aged 30–50 years who were EEA graduates
- male GPs aged 30–50 years who were international medical graduates.

How our data might contribute to understanding system risks (chapter 4)

The variation in complaints across the UK

There continued to be a variation in the number of complaints that were received and investigated across the four countries of the UK in 2012 (figure 26 on page 79).

What do our data tell us and others about the quality of care at NHS trusts in England?

We did an exploratory analysis to understand whether our complaints data or national training survey results are related to external data about NHS trusts in England. This work can help us and others begin to understand how our data may contribute to understanding and potentially identifying risks in the future.

We found a number of statistically significant correlations between our data and other data about NHS trusts.

Addressing the challenges facing medical practice (chapter 5)

We are committed to changing the way we work with doctors to better support them and enable them to provide the best possible care.

Below we set out four areas that we have identified in this report as needing further debate and action to address some of the challenges doctors face.

The changing shape of the medical workforce

Successful workforce design requires both national and local solutions. At the national level, greater flexibility in training and career paths is urgently required.

At the local level, the challenge of attracting and retaining sufficient numbers of doctors with the right mix of skills needs to be addressed. This is particularly relevant where the healthcare service is relying on certain types of doctors, such as international medical graduates who may be declining as a proportion of the workforce.

As part of the information required for revalidation, we are committed to gaining a better understanding of where doctors are working and in which settings. This will provide new insights about the shape of the workforce across the country.

Supporting complainants

Helping patients and their carers, relatives and friends to navigate the complaints maze remains a substantial challenge – this is indicated by the large number of complaints to us that do not meet our thresholds for investigation.

We need to work with patients so that they know what to expect from their doctor and where different types of complaints are best directed.

Employers and doctors need to be encouraged to continue raising concerns.

Variation in the risk of being complained about or receiving a sanction or warning from the GMC

There are several individual and organisational factors that increase the risk of poor practice. This year's analysis has identified particular characteristics associated with higher risk. We and others need to understand why certain groups of doctors face higher risks of falling below our standards.

This will help us to identify where we may need to change the relationship we have with doctors so that we are better at supporting them in the workplace.

The interactions between professional and system risks

The correlations identified between our data and data about NHS trusts confirm the importance of organisations working together to share data and intelligence about the quality of care.

We need to understand more about the organisational factors that affect the quality of medical practice and training, and the implications that these might have on a doctor's ability to meet our standards.

Chapter 1: The changing shape of the profession and medical education

This chapter gives a picture of the medical profession, drawing primarily on our data from January to December 2012. Where the data are available, we have also looked at how the profile of doctors has changed between 2007 and 2012. For the first time this year, we have analysed the distribution of doctors across the four countries of the UK. We have been able to do this because we now gather data on where doctors with a licence to practise are employed.

Who are the doctors on the medical register?

The medical register in 2012

14,024 doctors joined the medical register in 2012, bringing the total to 252,553 doctors. Of these, 16,315 did not hold a licence to practise, meaning they could not work as doctors in the UK.

The 252,553 doctors fall into five categories:

- 73,481 on the Specialist Register*
- 61,062 on the GP Register†
- 1,382 on both the GP and Specialist Registers
- 59,535 in approved postgraduate training programmes‡
- 57,093 other doctors who were not in approved postgraduate training programmes or on the GP or Specialist Register.

In 2012, 11,378 doctors left the medical register or gave up their licence to practise. 7,288 told us why they were leaving:

- 49% said they were planning to go overseas
- 40% were retiring
- 3% indicated that they did not want to take part in revalidation.§

Notable changes since 2011

During 2012, the medical register grew slightly by about 3%.

This change does not include the 843 doctors from more than 140 countries who were temporarily registered to support their athletes during the 2012 Olympic and Paralympic Games.

* Doctors on the Specialist Register have been awarded a Certificate of Completion of Training (CCT) or joined the Specialist Register through the Certificate of Eligibility for Specialist Registration (CESR) equivalence process. Specialist doctors can work as consultants in the NHS.

† Doctors on the GP Register have been awarded a CCT or joined the GP Register through the Certificate of Eligibility for GP Registration (CEGPR) equivalence process. GPs can be added to an NHS performers list and work as GPs in the NHS.

‡ Doctors are either in the two-year Foundation Programme or in an approved GP or specialist training programme. The number excludes 505 doctors who were on the GP or Specialist Register but might be completing postgraduate training in a second specialty or sub-specialty.

§ Revalidation is the process by which all licensed doctors have to regularly demonstrate to us that they are keeping their skills and knowledge up to date and are fit to practise medicine. 8% gave us other reasons for leaving.

The medical register in more detail

We have analysed the profile of doctors in three age groups: under 30 years, 30–50 years and over 50 years. Table 1 sets out the gender, place of primary medical qualification and ethnicity of doctors on the medical register in these age groups.

The demographic characteristics of doctors on the GP and Specialist Registers, and other doctors who were not in training or on either the GP or Specialist Register, can be found in tables 1–3 in appendix 1 of this report.

TABLE 1: Demographic characteristics of doctors on the medical register in 2012

	<30 years (n=36,584)	30–50 years (n=148,318)	>50 years (n=67,651)	Total (n=252,553)
GENDER				
Male	14,298 (39%)	80,520 (54%)	48,661 (72%)	143,479 (57%)
Female	22,286 (61%)	67,798 (46%)	18,990 (28%)	109,074 (43%)
PLACE OF PRIMARY MEDICAL QUALIFICATION				
UK graduate	32,989 (90%)	84,903 (57%)	42,006 (62%)	159,898 (63%)
EEA graduate*	1,788 (5%)	17,764 (12%)	5,978 (9%)	25,503 (10%)
International medical graduate†	1,807 (5%)	45,651 (31%)	19,667 (29%)	67,125 (27%)
ETHNICITY				
White‡	17,853 (49%)	68,396 (46%)	36,914 (55%)	123,163 (49%)
BME§	9,463 (26%)	45,395 (31%)	14,227 (21%)	69,085 (27%)
Unknown	9,268 (25%)	34,527 (23%)	16,510 (24%)	60,305 (24%)

The majority of doctors under 30 years old were female, but this pattern reversed for doctors aged 30–50 years and over 50 years old.

90% of doctors under 30 years old were UK graduates, but this percentage was much smaller in older doctors. For example, 29% of doctors over 50 years old were international medical graduates.

We did not know the ethnicity of 24% of the register.

* European Economic Area (EEA) graduates are doctors who gained their primary medical qualification in the EEA, but outside the UK, and who are EEA nationals or have European Community rights to be treated as EEA nationals.

† International medical graduates are doctors who gained their primary medical qualification outside the UK, EEA and Switzerland, and who do not have European Community rights to work in the UK.

‡ White includes white British, white Irish and other white.

§ Black and minority ethnic (BME) includes Asian or Asian British, black or black British, other ethnic groups or mixed ethnic groups.

Doctors on the GP and Specialist Registers

69% of doctors on the Specialist Register, but only 53% of those on the GP Register, were male.

On the Specialist Register, 61% of doctors were UK graduates, 24% were international medical graduates and 15% were EEA graduates. By contrast, 77% of doctors on the GP Register were UK graduates, 17% were international medical graduates and 6% were EEA graduates.

Other doctors on the register

There are a further 57,093 doctors on the medical register who were not in approved postgraduate training programmes or on either the GP or the Specialist Register. 37,138 of these doctors had a licence to practise and were registered at a UK address, suggesting that they were working as doctors in the UK.

The medical register does not include information about what positions these doctors held. We do know that they did not form a homogeneous group – they may have been working as specialty doctors* or locum doctors, in private practice or academic research, or under one of several other titles designated by employers.

41% of this group were female but, in the youngest cohort (<30 years), this rose to 58%, which is in line with the overall population of doctors on the medical register in this age group.

52% of these doctors were international medical graduates. However, in the youngest cohort (<30 years), only 17% were international medical graduates and 65% were UK graduates.

* Previously known as staff grade doctors or as staff and associate specialist (SAS) grade doctors.

Where are doctors working?

The data we collect give a picture of where doctors are employed in the UK (box 1).

Figure 1 shows that there is substantial variation across the UK in the number of doctors per 100,000 people.

The number is highest in London and Scotland and is lowest in the East Midlands and in the east and southeast of England.

A more detailed breakdown of the distribution of doctors across the UK is set out in the next section.

BOX 1: Analysing data on where doctors are employed across the UK

With the introduction of revalidation in December 2012, we are now able to show where doctors with a licence to practise are employed across the UK.

Under revalidation, every doctor has to be connected to an organisation, such as the NHS trust or board where they work.

This information tells us where doctors are likely to be working. There are limitations with these data. For example, a locum GP may be connected to an area of the country but carry out most of their work elsewhere. A doctor might also be working predominantly in the private sector but be connected to an NHS organisation. There are also some national organisations that may have connections with doctors who work around the UK.

We have attempted to address these limitations by removing around 7% of the 662 designated bodies that are national organisations – such as medical

royal colleges, UK-wide locum agencies and the Departments of Health in each of the four countries – but there will still be some imprecision.

At this stage, there are also 42,106 doctors who do not yet have a connection to an organisation.*

As a result, the number of doctors we have recorded per 100,000 people may be substantially lower than from other data sources. We are working to collect this information for all doctors working in the UK.

We believe this information will prove valuable, both for us and for other organisations. It should lead to a better understanding of where doctors are working, and in which settings.

In this chapter, we have linked characteristics – such as gender and place of primary medical qualification – with these connection data to identify where different groups of doctors are based.

* This number was accurate as of 12 August 2013. Only 20% of doctors in this group have not yet engaged with us. Most doctors without a prescribed connection either are new to the register or do not have a connection in their current position.

FIGURE 2: Changes in the UK medical register between 2007 and 2012

Changes are shown by gender and place of primary medical qualification for three age groups.

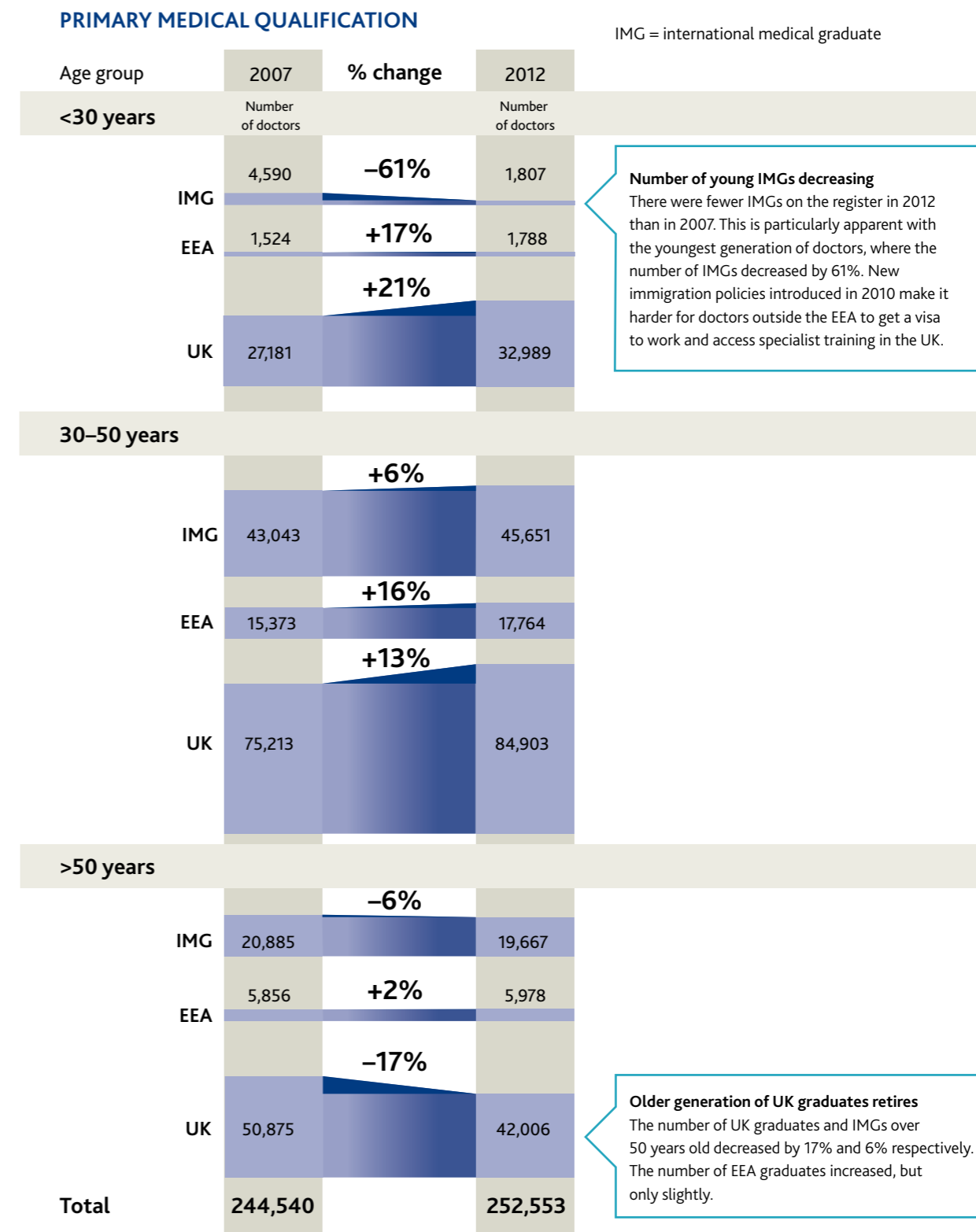
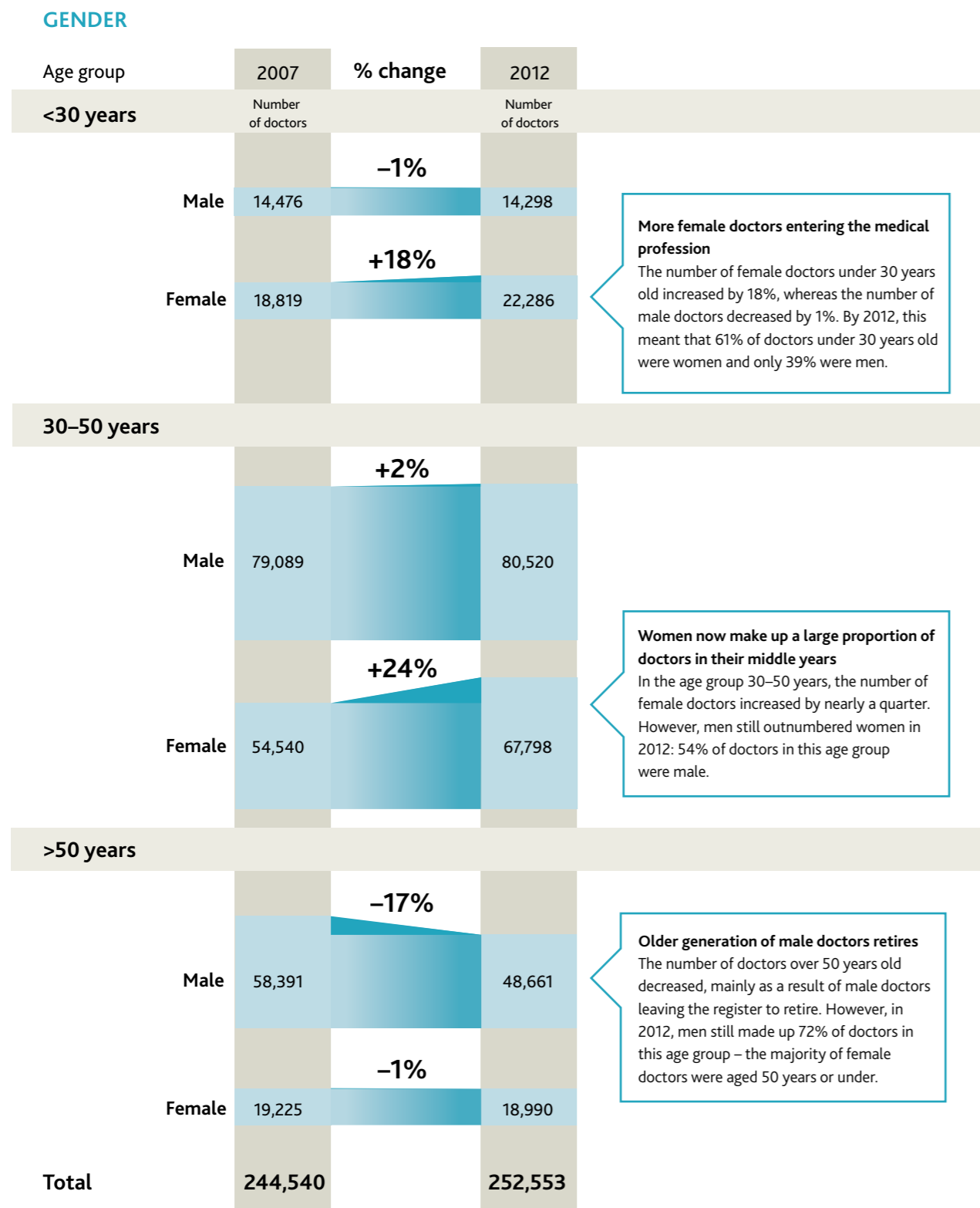
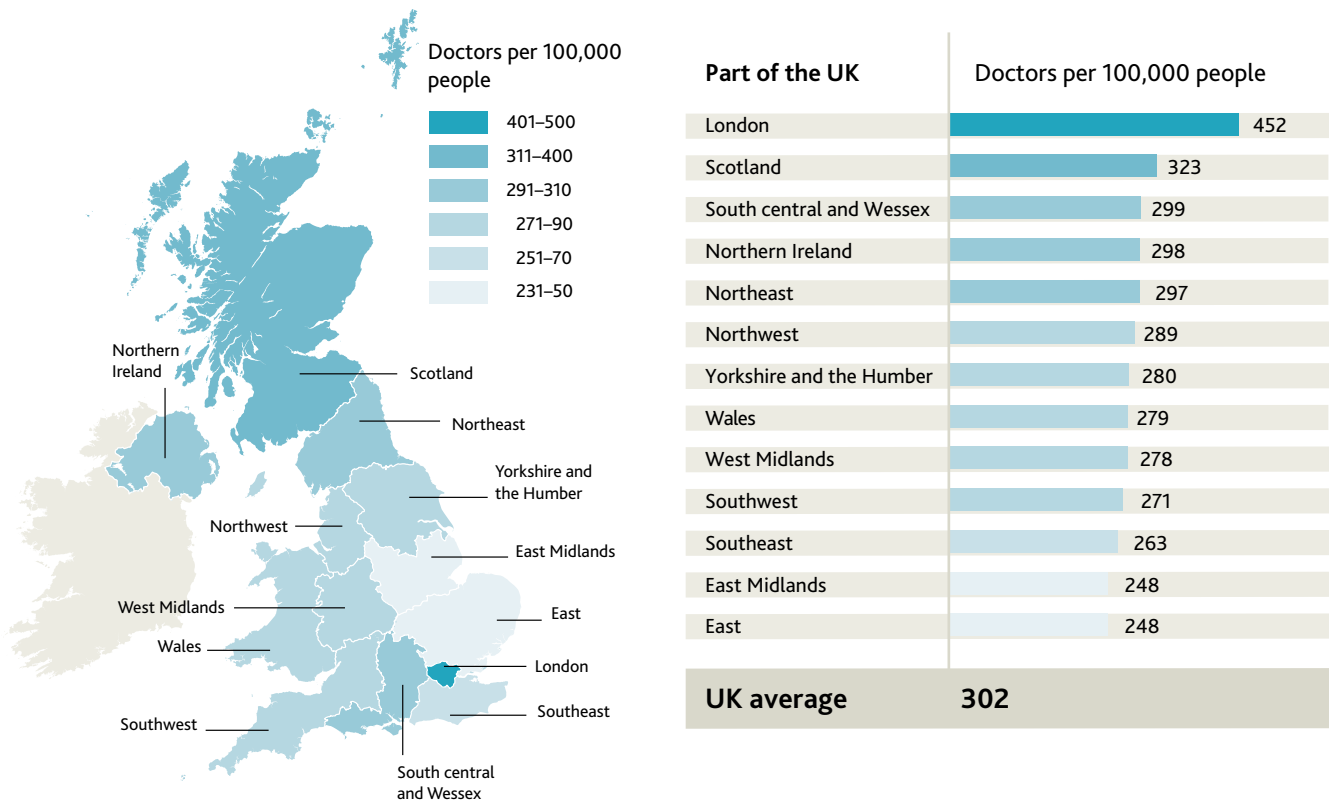


FIGURE 1: Where doctors are employed across the UK

Changes in the medical register over five years

In this year's report, we have sought to show how the shape of the profession changed between 2007 and 2012. Figure 2 shows the demographic characteristics of doctors in the three age groups.*

Some of the changes can be explained by external developments and changes to our policy (figure 3).

Gender

Overall the most significant change in this period has been the growth in the number and proportion of female doctors. From a profession once dominated by men, the past six years have seen a further step towards medicine being increasingly female.

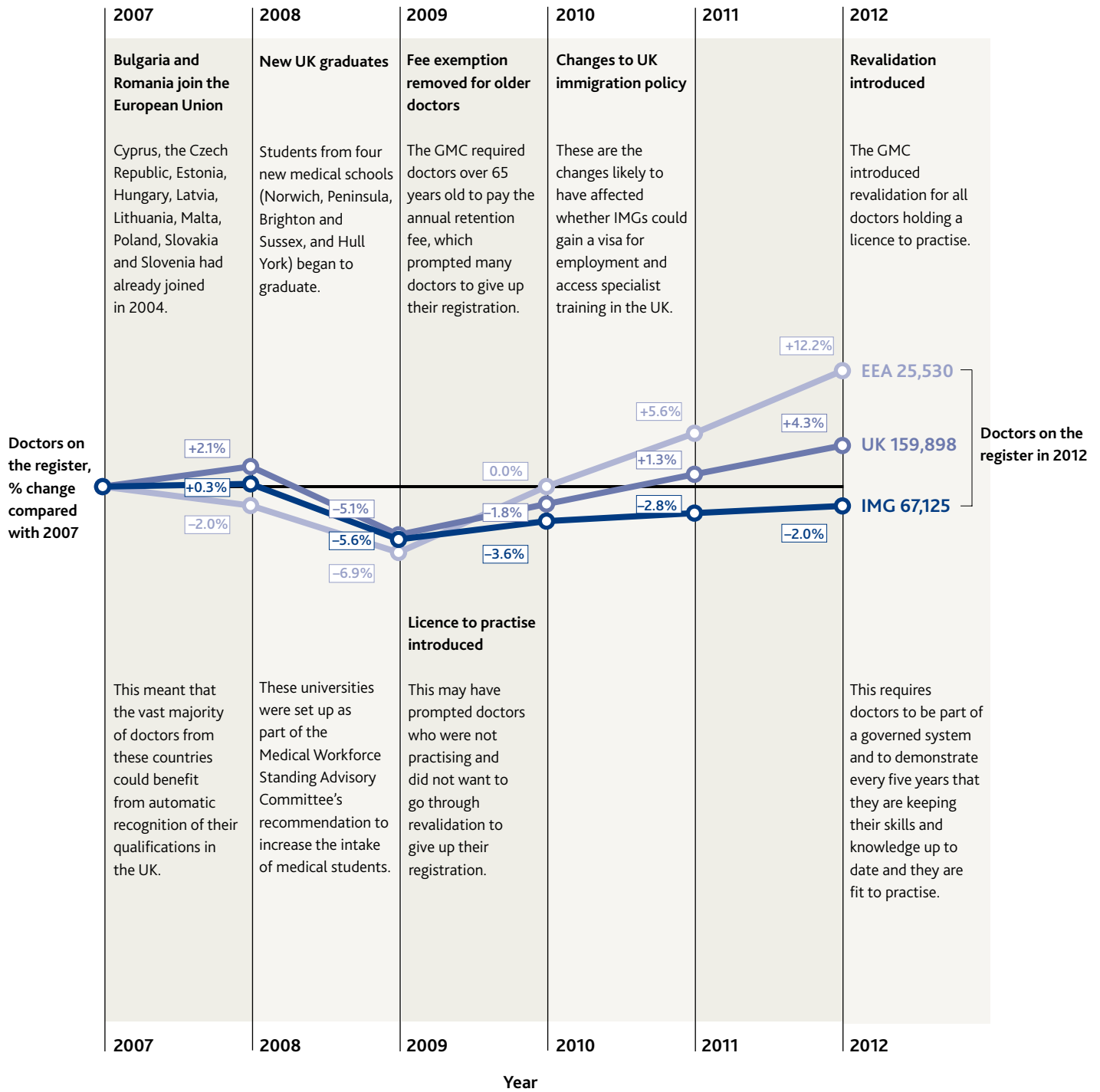
Primary medical qualification

The number of international medical graduates on the medical register declined by 2% between 2007 and 2012. This is mainly due to fewer international medical graduates joining the medical register early in their careers.

* We have not been able to analyse ethnicity because these data were not available for a large proportion of the medical register during this six-year period. We are working to improve the quality of the data we hold about doctors' ethnicities. In 2012, we did not have these data for 24% of the medical register – an improvement from 31% in 2007 – which is because doctors do not have to tell us their ethnicity when they apply for registration.

FIGURE 3: Major changes affecting the make-up of the medical register during 2007–12

IMG = international medical graduate



Notable breaks in trend during 2007–12

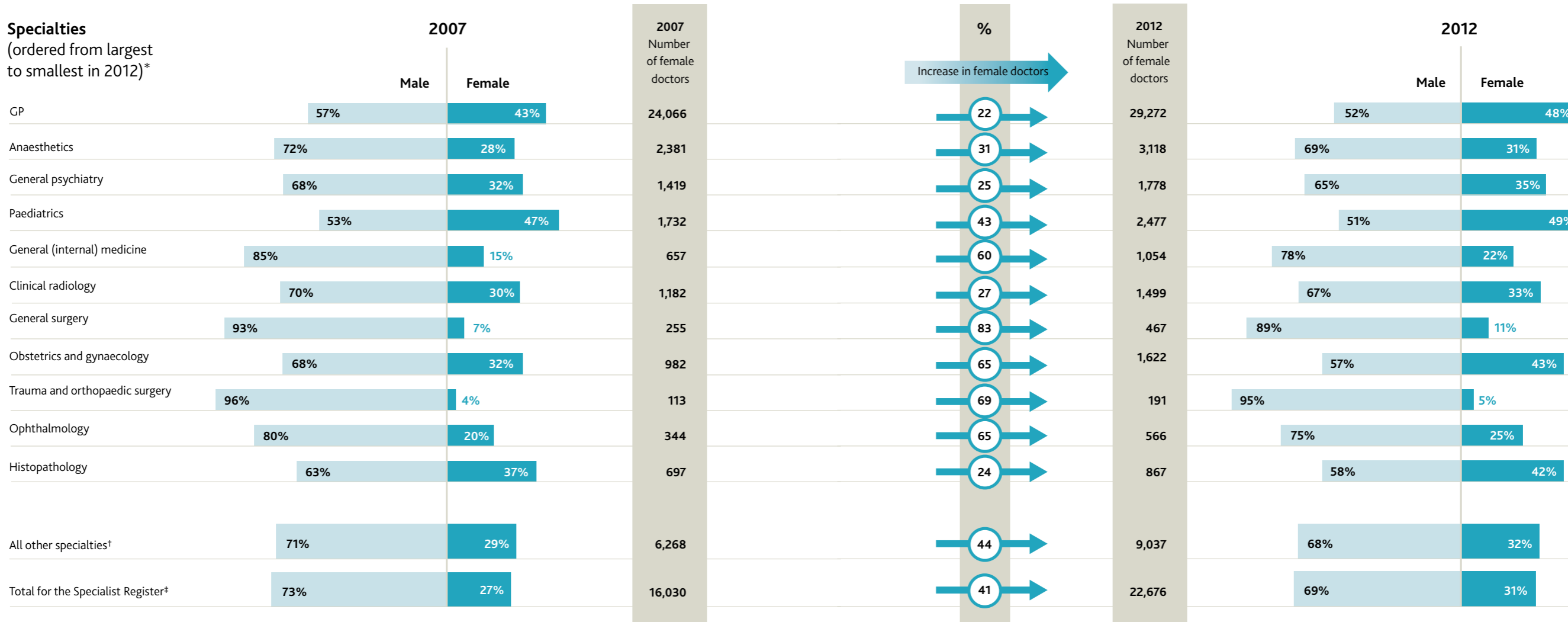
Most of the trends have been continuing year on year, but there was a notable fall in the number of UK graduates, EEA graduates and international medical graduates on the medical register in 2009, reflecting two key policy changes set out in figure 3.

Since then, new registrations from UK and EEA graduates have been steadily increasing, but the number of international medical graduates has remained constant and the group is ageing. Again, as noted in figure 3, this may be the result of changes in UK immigration policy.

Specialists and GPs

- On the Specialist Register, the number of female doctors increased by 41% and male doctors by 16% (although the increase in the actual number of male doctors was greater than that of female doctors).
- EEA graduates and international medical graduates made up a substantial and growing proportion of the Specialist Register, accounting for 61% of the increase.
- The number of doctors in different specialties has changed.
 - Paediatrics grew by 35%, becoming the fourth largest specialty.
 - The proportion of female doctors in all specialties grew, some more than others (figure 4). Female doctors were still underrepresented in several specialties, including general surgery, and trauma and orthopaedics.
 - General practice, anaesthetics and general psychiatry remained the largest specialties.
- There was a 10% rise in the number of GPs – with female doctors accounting for most of the increase. The number of female GPs under 30 years old did fall by 23%, but in absolute numbers this decrease was very small.

FIGURE 4: The changing profile of male and female doctors in the largest specialties between 2007 and 2012



* For GPs we used data from the GP Register and for all other specialists we used data from the Specialist Register (according to the doctor's primary specialty). We excluded doctors who were on both the GP and the Specialist Registers.
 † All specialties on the Specialist Register excluding all those listed above.
 ‡ Excludes data for the GP Register.

What do these trends mean for the make-up of the profession?

The supply of international medical graduates is decreasing

In 2012, only one in 20 doctors under 30 years old was an international medical graduate, whereas they made up a third of all other doctors.

This has not always been the case. In 2007, international medical graduates made up one in seven doctors under 30 years old. Although the proportion of international medical graduates aged 30–50 years has increased over six years, the decrease in the number under 30 years old means that there were fewer international medical graduates on the medical register in 2012 than in 2007.

UK and EEA graduates may now be filling part of this gap. In particular, in 2012, nine out of ten doctors under 30 years old graduated from the UK. As the European Union has enlarged, an increasing number of European doctors have joined the medical register, benefiting from automatic recognition of their qualifications.

What might have caused this change in the balance of younger doctors?

First, the national expansion of medical schools in England³⁰ has led to an increase in home-grown doctors. In 2000, the intake of medical students was just over 5,600 across the UK but, by 2012, it had risen to around 8,000, with most expected to do their postgraduate training in the UK. Although it has been suggested that there has been an exodus of doctors out of the UK after graduating here, only one in 20 doctors under 30 years old went overseas to work between 1999 and 2005.^{31, 32} This indicates that most doctors who graduated in the UK during that period did stay here to work.

Second, new immigration rules were introduced in 2010, making it harder for doctors outside the EEA to get a visa to work and to access specialist training in the UK. Employers can now recruit international medical graduates into posts only where there are shortages. For all other posts, they must be able to prove that no EEA or UK graduate is qualified to fill them.

It is possible that international medical graduates may be coming to work in the UK later in their careers, once they have completed GP or specialist training. However, since 2007, the increase in the proportion of doctors aged 30–50 years has actually been lower for international medical graduates than for UK and EEA graduates, and we've seen a decline in the number of international medical graduates over 50 years old.

International medical graduates are concentrated in a few specialties

International medical graduates are less likely to be on the Specialist Register than UK doctors, but their number still grew by 45% between 2007 and 2012, and most notably in the 30–50-year age group. This is likely to be because those who came to the UK in earlier years had completed their specialist training here. In the second largest specialty after general practice – anaesthetics – the percentage increase for international medical graduates was three times more than for UK graduates.

In some specialties, the UK has been reliant on doctors trained abroad. International medical graduates are now overrepresented (compared with their number on the register) in obstetrics and gynaecology, general psychiatry, paediatrics and histopathology. EEA graduates are overrepresented in general surgery and ophthalmology. In fact, half the growth in ophthalmology was from EEA graduates alone (234 doctors out of 466), although the specialty is relatively small.

International medical graduates appear to choose different specialties from UK graduates. For example, in histopathology, the number of UK graduates decreased by 1% between 2007 and 2012, whereas the number of international medical graduates increased by 33%. The pattern is the same in the larger specialty of obstetrics and gynaecology (1% decrease in UK graduates, 70% increase in international medical graduates).

Other areas of the health service might rely heavily on international medical graduates

52% of the other doctors on the medical register – those who were not in postgraduate training programmes and were not on either the GP or the Specialist Register – were international medical graduates.

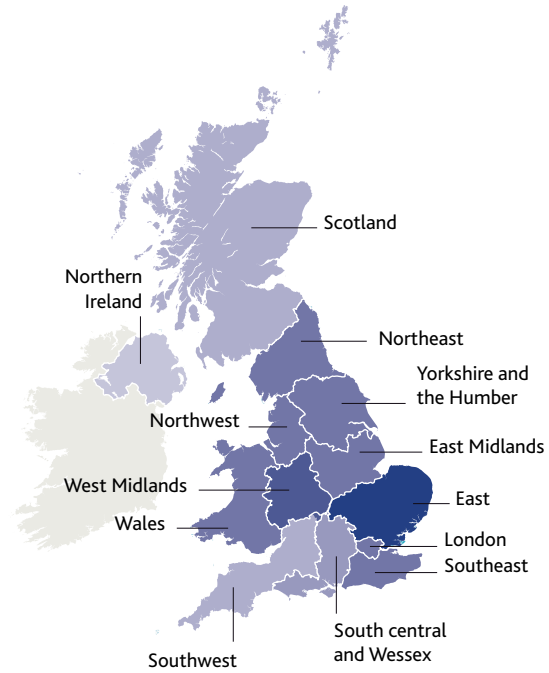
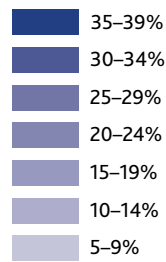
Again the age profile shows how patterns in the profession are changing – international medical graduates represented only 17% of these doctors under 30 years old in 2012. However, the UK graduates who represented 65% of this group under 30 years old in 2012 may only be working in these positions for a short period before doing further postgraduate training.³³

Although not a homogeneous group, it is clear that the majority of these doctors substantially contribute to providing NHS services. Their time commitment to teaching and management is generally less than that of consultants, meaning that almost all of their contracted time is devoted to direct clinical care. Some will be included in the rotas with doctors in postgraduate training to provide out-of-hours cover.

FIGURE 5: Where international medical graduates are employed across the UK

IMG = international medical graduate

Percentage of doctors who are IMGs, by region



UK, by country	IMGs	EEA graduates	UK graduates
England	26%	8%	66%
Scotland	12%	5%	83%
Wales	28%	6%	66%
Northern Ireland	7%	10%	83%
England, by region*			
East	37%	10%	53%
West Midlands	32%	7%	61%
East Midlands	28%	5%	67%
Northwest	28%	6%	66%
Yorkshire and the Humber	28%	6%	66%
London	25%	10%	65%
Northeast	25%	6%	69%
Southeast	25%	8%	67%
South central and Wessex	17%	7%	76%
Southwest	12%	6%	82%

* Regions are based on NHS England area team boundaries.

Some parts of the UK have a high proportion of international medical graduates

The east of England and the West Midlands have the highest proportion of international medical graduates (over 32%) compared with the UK national average of 25% (figure 5).^{*} Northern Ireland, Scotland and the southwest of England have the lowest.

We've been able to separate out primary and secondary care for each of the NHS regions in our analysis for England.[†] In primary care, the proportion of international medical graduates is close to the national average of one in five GPs in most regions.

But, in London and the West Midlands, one in four GPs is an international medical graduate, compared with only one in 21 in the southwest. In secondary care, there are proportionally more international medical graduate specialists in the east of England and the West Midlands. By contrast, in the southwest, only a fifth of specialists are international medical graduates.

These patterns broadly reflect the demographic make-up of these local populations, as reported by the Office of National Statistics.³⁴

It is clear that parts of the UK have relied, and continue to rely, on international medical graduates, and research suggests that they have often ended up working in less popular areas in the UK.³⁵ Ageing of these doctors raises concerns about who will work in these areas when they retire.

There are a number of recruitment campaigns to attract new doctors to parts of the UK where there are shortages. For example, the Work for Wales campaign (www.medicalcareerswales.com) aims to attract doctors from elsewhere by highlighting the opportunities available, particularly in the rural and coastal regions of Wales.

Several other countries have sought to tackle workforce shortages by requiring international medical graduates to work in certain areas. For example, in Australia, some international medical graduates are encouraged to work in rural or remote areas as a condition of their registration.³⁶

* 27% of doctors on the medical register were international medical graduates in 2012. This national average is lower because, as explained in box 1, not all doctors have a connection to a designated body.

† These regions are based on NHS England area team boundaries. In this analysis we have not separated out primary and secondary care when analysing data from Scotland, Wales and Northern Ireland.

The rapid rise in the proportion of female doctors now seems to be slowing

Our data show that women are still entering the medical profession in high numbers. Female doctors represented 61% of doctors under 30 years old and 46% of those aged 30–50 years in 2012. But the increase has not yet affected the oldest age group – in 2012, well under a third of doctors over 50 years old were female. This will rise in future years as the population of female doctors grows older.

The increase in the proportion of female doctors does appear to be slowing: 55% of medical students were female in 2012, compared with 61% in 2003 and 57% in 2007. There are also some indications that female doctors are beginning to choose different roles, although there are still distinct patterns differentiating male and female career paths.

More female doctors in primary care

Primary care has traditionally been a popular career choice for female doctors. The 10% growth in the overall size of the GP Register between 2007 and 2012 was almost entirely due to female doctors and, in 2012, the split between male and female GPs was nearly equal (figure 4). Since 2007, the number of female GPs aged 30 years and over increased by 23%.

This supports the Centre for Workforce Intelligence's estimate that female doctors will represent most GPs in England by 2030, although they are forecasting an undersupply of GPs overall.³⁷

These trends reflect patterns across other parts of the UK – Wales, Northern Ireland and Scotland have all reported increases in the number of female doctors in recent years,^{38, 39, 40} but there are still challenges in recruiting sufficient numbers of GPs in some parts of the country.

The UK Government is now looking to recruit more doctors into GP training in the short term and has set up a task force to consider how to improve planning for the GP workforce in the long term.

The proportion of female specialists is increasing

Although female doctors were still underrepresented on the Specialist Register in 2012 (69% male versus 31% female doctors), the number of female specialists increased by 18% between 2007 and 2012, compared with a 6% decrease for male doctors.

There were notable changes in some specialties (figure 4).

The Royal College of Physicians reported in its 2011 census that 48% of female specialists work part time, compared with 6% of male specialists.⁴¹ This trend has prompted discussions about female doctors being underrepresented in certain specialties, possibly because some specialties are less conducive to part-time working.⁴²

The difference between male and female working patterns also raises issues about the total number of doctors that will be required in the future if the proportion of those working part time continues to grow.

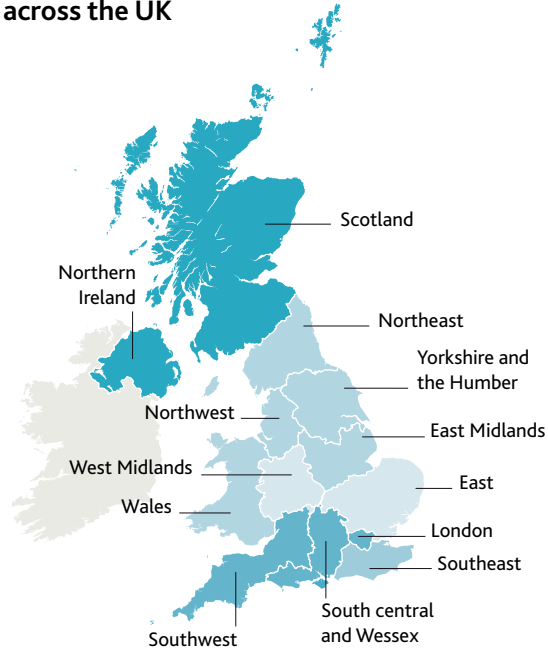
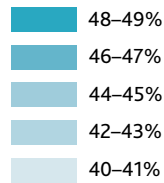
Some areas of the UK have a high proportion of female doctors

Overall, Northern Ireland and Scotland have the highest proportion of female doctors (48% or higher), compared with the UK average of 44% (figure 6). The east of England and the West Midlands have the lowest (41% or less).

In secondary care, the proportion of women is highest in London and is lowest in the West Midlands. This pattern is similar for primary care, with the lowest proportion of women in the West Midlands, but in this case the highest proportion of women is in south central and Wessex.

FIGURE 6: Where female doctors are employed across the UK

Percentage of doctors who are female, by region



UK, by country	Female doctors	Male doctors
England	44%	56%
Northern Ireland	48%	52%
Scotland	49%	51%
Wales	42%	58%
England, by region*		
South central and Wessex	47%	53%
Southwest	47%	53%
London	46%	54%
Southeast	45%	55%
East Midlands	43%	57%
Northeast	43%	57%
Northwest	43%	57%
Yorkshire and the Humber	43%	57%
West Midlands	41%	59%
East	40%	60%

* Regions are based on NHS England area team boundaries

Medical education and training

The profile of medical students

In the academic year 2012–13, there were 41,422 medical students studying at 32 medical schools in the UK:

- 33,127 in England
- 5,156 in Scotland
- 1,786 in Wales
- 1,353 in Northern Ireland.

More than half of all medical students in the UK were female, with the percentage ranging from 46% at the University of Edinburgh to 62% at Cardiff University.

Some parts of the UK retain more doctors after graduation

In 1997, the Medical Workforce Standing Advisory Committee recommended increasing the intake of medical students.⁴³ Four new medical schools were set up – Norwich Medical School at the University of East Anglia, Peninsula College of Medicine and Dentistry, Brighton and Sussex Medical School and Hull York Medical School – to address shortages of doctors in these regions.³¹ Graduates were expected to complete their foundation and specialty training at the local deanery, thereby contributing to delivering health services in these regions.

Our data suggest that some areas of the UK retain more doctors after graduation (figure 7). Between 2009 and 2012, Queen’s University Belfast had by far the highest retention rates, followed by the University of Glasgow and the University of Birmingham. The new medical schools set up after the 1997 expansion fall somewhere in the middle.

Following a long-established pattern, a large number of medical students want to continue their training in London after graduation – the London Deanery is the most oversubscribed in the country and places are very competitive.⁴⁴ * During 2009–12, 21% of medical students from Bristol, Oxford and Cambridge subsequently did their postgraduate training in the London Deanery.

So why do some areas retain more newly qualified doctors? First, young doctors are likely to want to work in large cities, which may explain the high retention rates in London, Birmingham, Newcastle and Leeds.

Some doctors might want to train in specialties not offered across all parts of the UK or to experience a more varied caseload, which is more likely to be achieved in large urban settings.

* This report refers to deaneries because these were the organisations responsible for postgraduate medical education and training at the start of the academic year 2012–13. In England, this responsibility has now moved to the local education and training boards.

FIGURE 7: Which deaneries retain the most medical graduates?

PMQ = primary medical qualification

Two medical schools are not included in this figure: students at the University of St Andrews School of Medicine are included with the numbers for the University of Manchester because the students transfer for their final year and are awarded their degree by the University of Manchester; and, until July 2011, students at Swansea University School of Medicine were transferred to Cardiff University School of Medicine for their final year so they are included with the numbers for Cardiff University.

Medical school PMQ awarding body	Proportion of graduates going on to train within local deanery % of total, average for 2009–12 except where noted
Queen's University Belfast	85.4%
University of Glasgow	68.6%
University of Birmingham	64.6%
Newcastle University	60.6%
University of Leeds	59.9%
Cardiff University*	58.3%
University of Liverpool	56.7%
University of Sheffield	55.1%
Keele University†	53.6%
King's College London‡	53.2%
University of East Anglia	52.8%
University College London‡	52.6%
Hull York Medical School	51.2%
University of Manchester	49.3%
St George's Hospital†	48.6%
Imperial College London	48.0%
University of Nottingham	47.5%
University of Leicester	47.3%
University of Southampton	46.5%
Universities of Exeter and Plymouth	42.3%
University of Warwick	42.2%
Brighton and Sussex Medical School	39.1%
University of London§	37.5%
University of Edinburgh	36.2%
University of Aberdeen	34.9%
University of Cambridge	33.3%
Bristol University	31.2%
University of Oxford	26.9%
University of Dundee	20.6%

* Includes degrees awarded by the University of Wales.

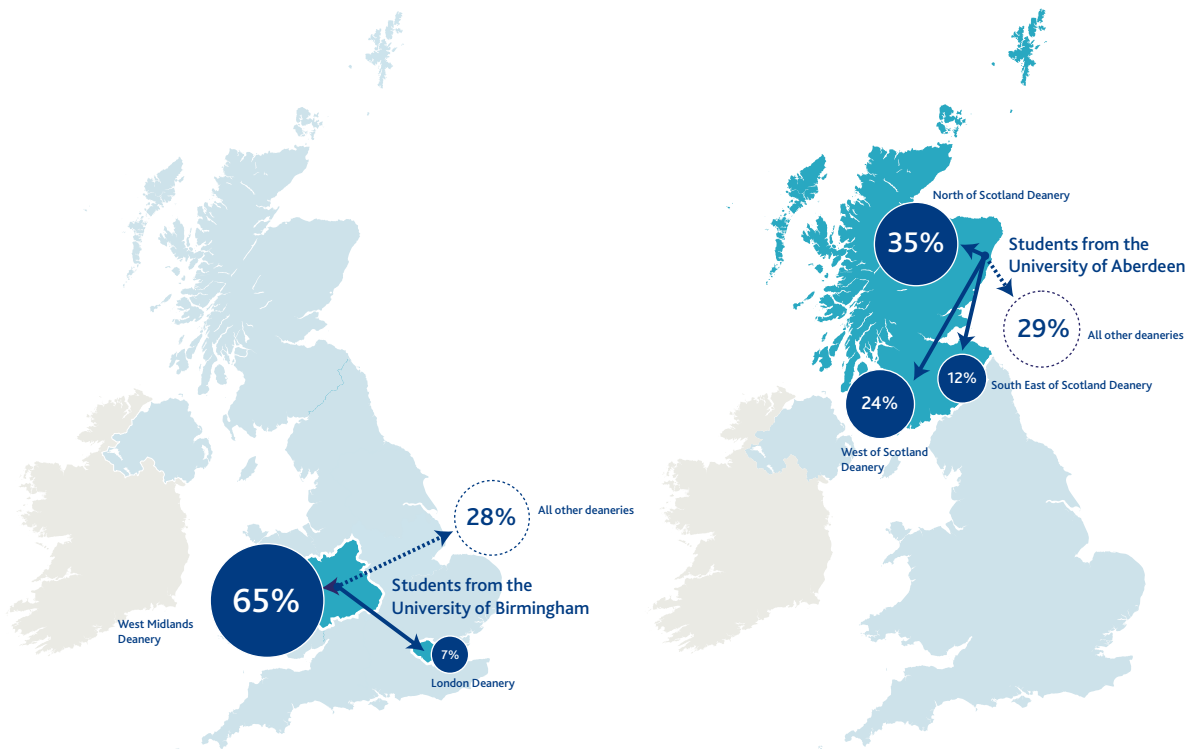
† Data are for 2012 only.

‡ Data are for 2010–12 only.

§ Degrees awarded by the University of London, rather than its constituent institutions (St George's Hospital, University College London and King's College London).

Training destinations

There is a strong tendency for medical students to progress on to postgraduate training within either their local deanery or a neighbouring one.



Second, some medical schools attract local students who are happy to continue their postgraduate training in the same area.

Third, there may be factors inherent to the medical schools themselves. In the GMC annual national training survey, we ask postgraduate doctors in the first year of the Foundation Programme how well their medical school prepared them for practice.

Our data show a very weak association between universities where students felt that their medical school had prepared them well for practice and retention to the local deanery.

The profile of doctors in training

There were 59,820 doctors in postgraduate training programmes in the year 2012–13:*

- 50,043 in England
- 5,540 in Scotland
- 2,451 in Wales
- 1,786 in Northern Ireland.

These doctors were concentrated in certain areas of the UK, relative to the general population (figure 8). For example, London had the largest deanery with 11,632 doctors in training, which equates to 146 doctors per 100,000 people.†

Over half of doctors in postgraduate training were female – the proportion varied slightly across the UK, from just over 53% in the East Midlands Healthcare Deanery and NHS West Midlands Workforce Deanery and up to 63% in the Severn Deanery.

There are clear demands for flexible working patterns during training – just over one in ten doctors are training part time in the Severn Deanery, compared with one in 20 in the Kent, Surrey and Sussex Deanery.

There are also differences across specialties: 17% of doctors training in paediatrics and general practice work part time, compared with only 3% in surgical posts. There are inevitable challenges emerging in some areas and specialties in reconciling individuals' preferences to work flexibly with the need to maintain sustainable services for patients. Training programmes and employers will need to explore these implications.

Doctors are satisfied with their training but are working beyond agreed hours

Although the average overall satisfaction with training is high, scoring 80.8 on a 100 point scale in the GMC's latest national training survey, almost 60% reported that they worked beyond their agreed hours on a daily or weekly basis. High workloads can lead to doctors in training and their supervisors focusing on providing services, potentially at the expense of learning opportunities. Although the health service is currently facing considerable financial pressure, employers and supervisors need to ensure that doctors in training are given protected time to train.

* The training year began in August 2012. These data are taken from the national training survey census date of 26 March 2013. We have excluded doctors training in pharmaceutical medicine (123 doctors) and those from the Defence Postgraduate Medical Deanery (118 doctors).

† Not all doctors training with the London Deanery are placed in London. Some will do part of their training in neighbouring deaneries.

FIGURE 8: Where doctors in training are working in the UK*

Deanery	Percentage of all doctors in training	Number of doctors in training	Doctors in training per 100,000 people [§]
London	19.4%	11,632	146
Yorkshire and the Humber	8.8%	5,290	101
West Midlands	8.1%	4,873	89
North Western	6.7%	3,989	82
East of England	6.0%	3,579	62
East Midlands	5.8%	3,484	78
Kent, Surrey and Sussex	5.8%	3,464	79
Northern	4.9%	2,914	113
West of Scotland	4.6%	2,750	104
Mersey	4.3%	2,576	123
Wales	4.1%	2,451	80
Wessex	3.8%	2,280	88
Severn	3.8%	2,258	79
Oxford	3.5%	2,108	94
Northern Ireland	3.0%	1,786	99
South West Peninsula	2.7%	1,596	95
South East of Scotland	2.4%	1,427	105
North of Scotland	1.3%	799	92
East of Scotland	0.9%	564	138
Total		59,820[†]	

* Data were correct on 26 March 2013.

† Data exclude doctors training in pharmaceutical medicine (123 doctors) and those from the Defence Postgraduate Medical Deanery (118 doctors) because their training can take place throughout the UK. Including these doctors, the total number of doctors in training was 60,061.

§ Deanery boundaries are not precisely fixed, so the area on which the population is based may vary slightly from that used in other analyses.

Training in emergency medicine is facing challenges

Whereas some specialties are struggling to attract sufficient numbers of doctors after the Foundation Programme – such as GP and psychiatry training – emergency medicine is struggling to retain doctors in specialty training.

Our data suggest that while many doctors are keen to experience emergency medicine during the two-year Foundation Programme, many do not go on to apply for the next stage: three years' core training in acute care common stem (ACCS). Even those who do decide to pursue ACCS often do not continue for the three years' higher specialty training needed to become an emergency medicine specialist – instead they attempt to change to one of the other component specialties: acute medicine, anaesthesia or intensive care medicine.

1,400 doctors in foundation training were holding a post in emergency medicine in our 2013 national training survey, but only 500 of those were recorded in core training. Furthermore, 65% of doctors who applied for an emergency medicine ACCS training position in England and Wales were offered one, but only 35% accepted – the second lowest acceptance rate across all specialties.

Overall, emergency medicine lost 12% of its doctors in training between 2012 and 2013 (from 665 doctors to 587).^{*} When compared with other training specialties, emergency medicine proportionally lost the most doctors in training between 2012 and 2013.

The annual review of competence progression (ARCP) provides an overall assessment of the progress a doctor in postgraduate training is making. The process is intended to scrutinise the doctors' suitability to progress to the next stage of, or to complete, a training programme. Our data indicate that doctors in emergency medicine are struggling to progress – the proportion who received an unsatisfactory outcome in the ARCP more than doubled between 2010 and 2012. Low recruitment and retention rates may explain some of these changes, but more research is needed to understand the causes and the impact it may have on frontline services.

The GMC's work in assuring the quality of medical education and training has also identified issues with emergency medicine. In our national training survey in 2012, we found an increasing number of concerns about recently qualified doctors working unsupervised at night.⁴⁵ In 2012, we undertook an audit of emergency department rotas across 20 sites, which showed that there was often insufficient supervision from a senior doctor.⁴⁵

^{*} This analysis does not take into account the fact that some doctors in training would have left because they had been awarded their CCT.

The GMC's national survey also found that concerns about patient safety in emergency medicine tended to be raised by doctors at a higher grade. This was notably different from all other specialties where doctors in foundation training raise proportionally more concerns. We will be publishing an analysis of patient safety concerns raised in the 2013 survey later this year.

The struggle to recruit and retain doctors training in emergency medicine also appears to be contributing to the strain under which emergency departments are working. According to the College of Emergency Medicine, doctors and other staff are having to cope with a rising number of patients, with more severe and complex conditions, without adequate resources to assess and admit them.⁴⁶ Emergency departments saw 17.6 million patients in 2011–12, up from 14 million in 2003–04.^{47, 48}

An interim report from the Emergency Medicine Taskforce, which was set up last year to tackle the growing mismatch between supply and demand in the specialty, suggested that moving the emergency medicine component of ACCS from year three to year one would help curb the attrition rates.⁴⁹ The report noted that this could encourage commitment to the specialty and boost the pass rate for the College of Emergency Medicine's membership exams.

Emergency medicine is not the only specialty struggling to recruit sufficient doctors – competition for training places varies significantly across specialties.⁵⁰

In 2012, the range of applicants per vacant post was:

- 0.5 applications in higher specialty emergency medicine training
- 1.4 applications in core psychiatry training
- 1.8 applications in GP training.

By comparison, more popular specialties such as neurosurgery had 15.9 applications per post, and obstetrics and gynaecology had 2.9 applications per post.

There is a need to understand how to attract more doctors to train as GPs or in specialties such as emergency medicine and psychiatry. Our data suggest that doctors' experience of GP and psychiatry posts during the Foundation Programme is weakly associated with the subsequent uptake of training in these areas. This suggests that if a doctor has a more positive experience of GP and psychiatry posts during the Foundation Programme, they may be more likely to pursue training in these areas. It is also important that medical students understand the range of opportunities that will be available to them when they graduate and that most of them may be needed in generalist roles.

The Shape of Training review will help to consider these questions in more detail

This independent review of postgraduate training – set up by the four parts of the UK together with the GMC, the Academy of Medical Royal Colleges, Health Education England and the Medical Schools Council – will also report this year. It is aiming to ensure that doctors receive high-quality training that supports patients' needs. A key theme is to examine how current training structures could be made more flexible – for example, enabling doctors in training to move between specialties more easily once they have entered postgraduate training. This could prove crucial in addressing some of the challenges facing emergency medicine and other specialties.

Conclusion

The composition of the medical profession in the UK continues to change. We are seeing fewer young doctors coming to the UK from outside the EEA, a profession that will soon become predominately female (although the growth in the number of women now entering medicine has begun to slow down) and changing expectations among doctors themselves. The effect will be felt in the years ahead, not least in the numbers of doctors that will be required. The profile of doctors on the GP and Specialist Registers is also changing, as is the composition of different specialties.

These changes also have consequences for undergraduate and postgraduate medical education and training. As a result of fewer overseas graduates, the NHS is becoming increasingly reliant on doctors who have graduated from UK medical schools.

Our data show that there are still significant challenges. The decline in the number of international medical graduates will have a substantial impact on areas of the UK that have been particularly reliant on them, especially as they try to meet the growing demand for healthcare. Furthermore, some areas of the UK continue to find it difficult to retain new doctors out of medical school. Some specialties are also having difficulty recruiting and retaining doctors in training.

These issues are bound to have a direct impact on the quality of services and patient care and we and others need to do more to address them. The Shape of Training review will consider many of these issues but there are still important questions to be resolved about how to ensure doctors in training are going into specialties where patients' needs are greatest.

Chapter 1: A note on data

Data in this chapter were primarily drawn from the information we collect when registering doctors and assuring the quality of medical education and training.

Registration and revalidation data

Data for the analysis of the profession in 2012 refer to the List of Registered Medical Practitioners, the Specialist Register and the GP Register on 31 December 2012. Data for the analysis of the change between 2007 and 2012 refer to the registers on 31 December 2007 and 31 December 2012.

Some doctors have multiple specialties recorded on the Specialist Register. For the analysis used in this chapter, we have used their primary specialty although a small number of doctors will have trained in multiple specialties. General practice is included in our analysis of specialties but the data were extracted from the GP Register.

There is a small group of doctors on the register with no date of birth recorded (4% in 2007 and 2.5% in 2012). In these cases, age was approximated by taking their time since qualification plus 23 years.

For the analyses in this chapter, we grouped doctors on the register into three distinct groups:

- under 30 years old
- 30–50 years old (inclusive)
- over 50 years old.

The analysis of joiners and leavers was based on our records of doctors who joined or left the medical register between 1 January 2012 and 31 December 2012 inclusive.

We used revalidation data to analyse where doctors have a prescribed connection to a designated body. Data were drawn from the GMC's database on 14 August 2013. For analysis of the geographical distribution of doctors, we excluded 7% of designated bodies that are national organisations.

The number of doctors per 100,000 people was derived using a denominator based on mid-2012 population estimates from the Office for National Statistics in England and Wales, the General Register Office for Scotland and the Statistics and Research Agency in Northern Ireland.

Education data

Data about medical students in the academic year 2012–13 came from the medical schools' annual return from 2012.

The number of doctors in postgraduate training programmes was estimated using data that deaneries provided in the 2013 national training survey and was accurate on 26 March 2013. It included doctors who were not in a training post on 26 March 2013 and therefore included those taking a career break or maternity leave.

The number of doctors in training per 100,000 people by deanery was derived from the mid-2010 population estimates from the Office for National Statistics in England and Wales, the General Register Office for Scotland and the Statistics and Research Agency in Northern Ireland.

Chapter 2: Complaints and complainants

As the regulator of the medical profession, we must decide from the complaints we receive about doctors whether we need to investigate their fitness to practise.

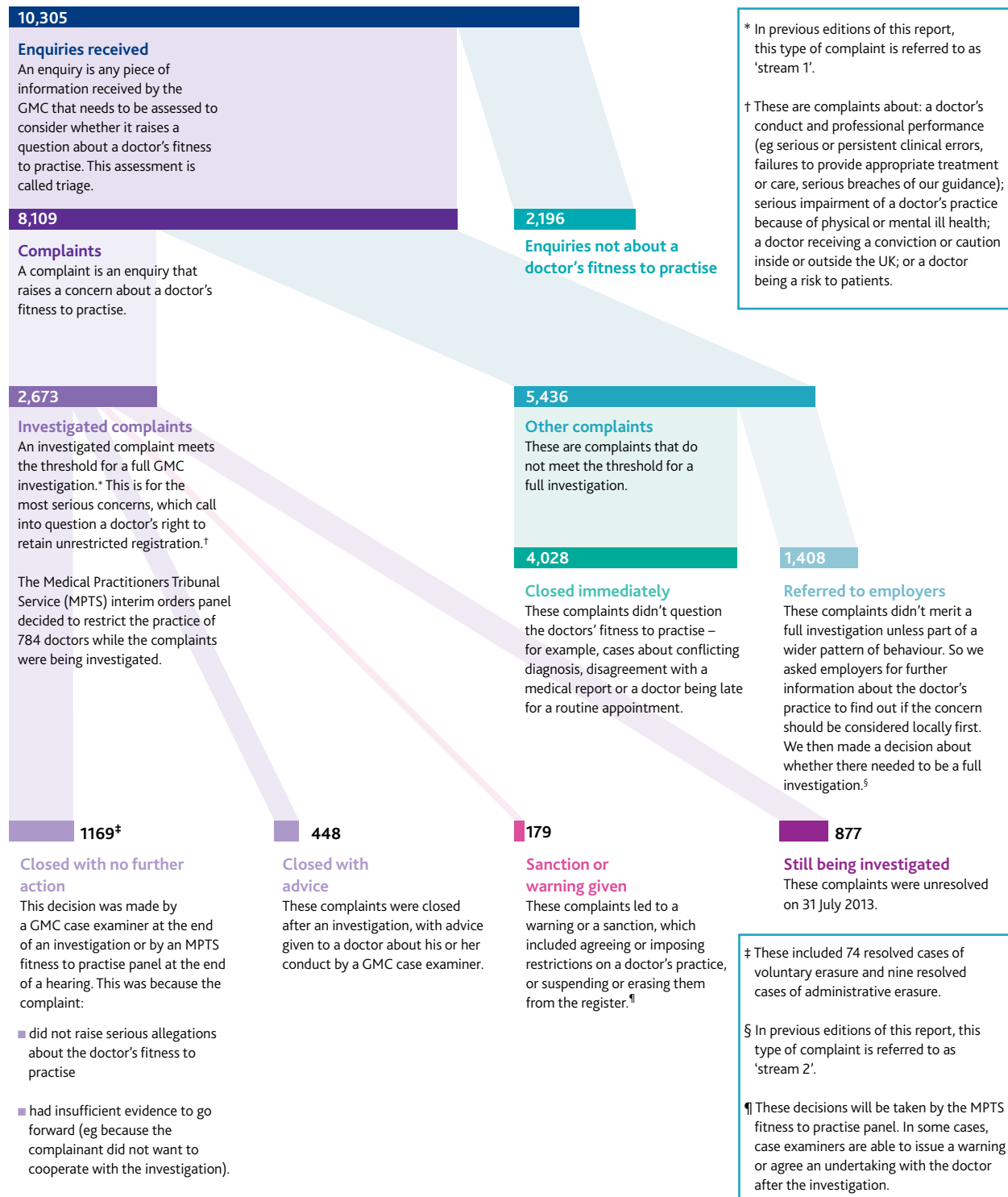
The overall number of complaints received by the GMC is small relative to the number of interactions between doctors and patients. However, the number of complaints, which has been growing substantially since 2007, has continued to grow in 2012.

This trend is not confined to doctors or to the UK – several other organisations have reported increases in the number of complaints they are handling, including other regulators of healthcare professionals and ombudsmen across the UK.^{51, 52, 53, 54}

We have analysed complaints to the GMC in detail, both for 2012 and over a six-year period (2007–12), to explore whether the profile of complaints and complainants may have changed.*

* In previous reports, we have based our analysis on all enquiries but, this year, we have separated out complaints from enquiries so that we can analyse data that raise a specific concern about a doctor's fitness to practise. In this chapter, we are also looking at the outcomes of complaints originating in 2011 – many complaints originating in any given year are not resolved within that same year because of the complexity of the issues raised. Therefore the most recent data available for this analysis are outcomes of complaints originating in 2011.

FIGURE 9: How the GMC handled the enquiries we received about doctors in 2012



What types of complaint do we receive?

Complaints in 2012

Figure 9 and table 2 show how we processed the 10,305 enquiries we received in 2012. Of these, 2,196 did not raise an issue that could be dealt with by the GMC or did not raise a concern about an identified doctor. This left a total of 8,109 complaints about a doctor's fitness to practise.

Complaints to the GMC come from five main sources: the public, employers, doctors, the GMC and the police. We also receive complaints from other organisations, such as other healthcare professionals, patient groups and professional organisations, but we do not analyse these sources in detail because each organisation accounts for a small proportion of complaints.

TABLE 2: Source of enquiries we received in 2012 and how we dealt with them

	Enquiries not about a doctor's fitness to practise (n=2,196)	Complaints (n=8,109)			Total (n=10,305)
		Closed immediately (n=4,028)	Complaints referred to the doctor's employer (n=1,408)	Fully investigated (n=2,673)	
Public	988	2,755	1,270	989	6,002
Employer	500*	75	16	493	1,084
Individual doctor	171	371	61	403	1,006
GMC	41	636	24	293	994
Police	22	47	4	114	187
Other bodies	474	144	33	381	1,032

* A large proportion of enquiries from employers related to general correspondence or updates to performers' lists.

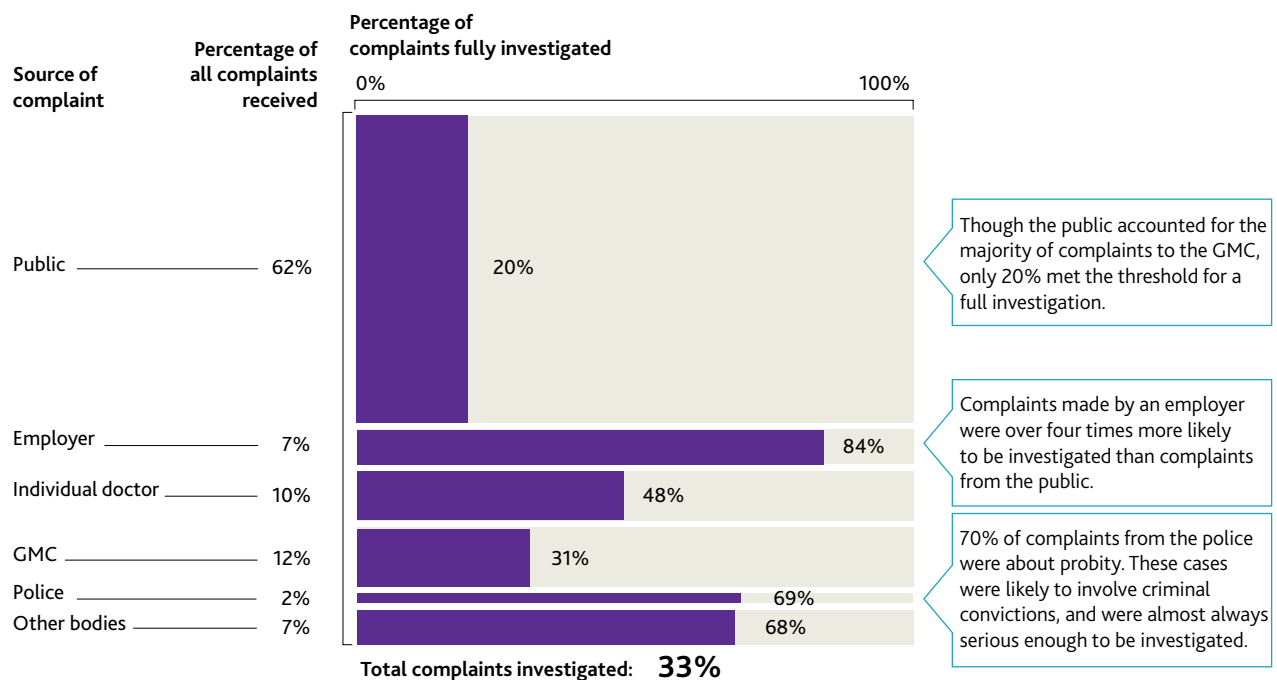
A third of the 8,109 complaints in 2012 were fully investigated (figure 10): only 20% of complaints from the public met the threshold for a full investigation, compared with 84% from employers and 48% from individual doctors.

Given that the public were the GMC's largest source of complaints about doctors, they made up 37% of all complaints fully investigated, compared with 18% from employers and 15% from individual doctors.

5,436 complaints did not reach the threshold for a full investigation. Of these, 4,028 were closed immediately and the remainder were referred to the employer to check for wider concerns about the doctor's work. 74% of complaints that were not fully investigated came from the public.

FIGURE 10: Proportion of complaints that we investigated in 2012, by source

Data are for the 8,109 complaints about a doctor's fitness to practise.



The number of complaints received in 2012 has increased by 24% since 2011 and by 104% since 2007. Several other regulators of healthcare professionals have also seen a rise in the number of complaints since 2011, with the Health and Care Professions Council reporting an increase of 68%,* the General Dental Council an increase of 44% and the Nursing and Midwifery Council an increase of 5% since last year.† The ombudsmen in the four countries of the UK have also reported an increase since 2011 in the number of complaints they received.^{51, 52, 53, 54}

We have commissioned research to try to understand why the number of complaints is rising. Employers and other bodies believe it is largely the result of

changing attitudes among healthcare professionals, including doctors, a greater willingness within organisations to refer complaints to the GMC, and improved local governance and management systems that are more likely to identify problems with a doctor's practice.⁵⁵ We have undertaken research to understand the increase in public complaints and will be publishing the findings.⁵⁶

These patterns should be seen in the context of increasing patient expectations and demand for healthcare – one calculation suggests that there has been a 28% increase since 2001.⁵⁷

* This increase relates in part to the fact that in 2012 the Health and Care Professions Council started to regulate social workers in England.

† Data for the Health and Care Professions Council, General Dental Council and Nursing and Midwifery Council come from a questionnaire we sent to the Chief Executives' Steering Group, which is made up of the chief executives of nine of the healthcare professional regulators in the UK.

What were the complaints about?

In 2012, 54% of complaints* were about clinical care or about clinical care combined with issues around communication with patients. However, these made up only 44% of complaints that the GMC investigated fully, whereas complaints concerning probity or the health of a doctor almost always reached the threshold for investigation.

Figure 11 shows who the complainant was for each type of allegation.

Most complaints made by the public, employers, and the GMC were about clinical care. Whereas the most common complaints from individual doctors and the police were about probity, such as a criminal conviction or a conflict of interest.

A large proportion of complaints about clinical care came from members of the public, but just over half (53%) did not meet the threshold for a full investigation. By contrast, 100% of complaints about clinical care from employers and 69% from doctors were fully investigated. These differences reflect the nature of the clinical issues raised by different groups – employers, for example, are much less likely to make a one-off complaint than a patient or relative.

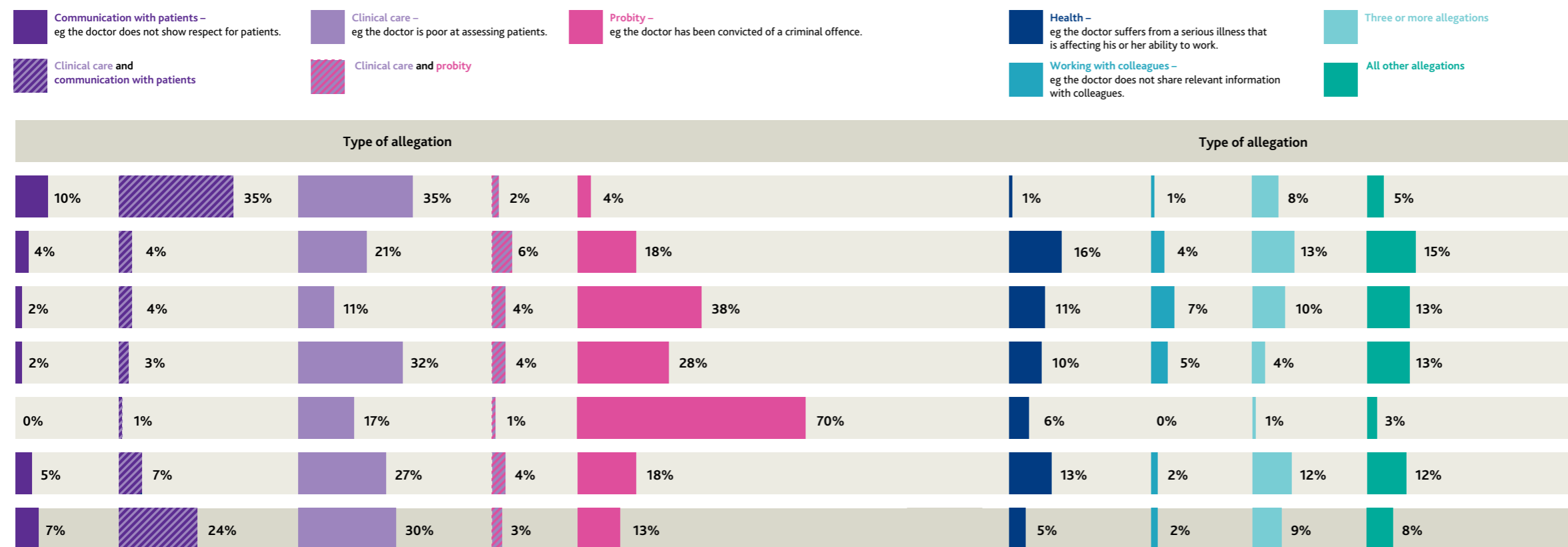
A substantial proportion of complaints from doctors and employers were about probity (38% and 18% respectively) or clinical care (11% and 21% respectively). This partly explains why the GMC investigates a higher percentage of complaints from employers and doctors.

4% of complaints from the public were about probity and 1% were about the health of a doctor. Whereas, 70% of complaints from the police were about probity. This is unsurprising because these cases usually involve criminal convictions, which the police have to report to us under notifiable occupations schemes.

52% of complaints about the health of a doctor were made by an individual doctor or employer. Doctors have a duty under *Good medical practice* to report concerns about their own health that could affect their practice.

FIGURE 11: Types of allegation assigned to the complaints we received in 2012, by source

For example, 16% of complaints made by employers were about health.



Percentages are rounded so may not add up to 100%.

* We only record allegations for complaints that are fully investigated or for those that are referred to the doctor's employer to check for wider concerns.

* There are two notifiable occupations schemes in the UK: one covering England, Northern Ireland and Wales, and one covering Scotland.

Outcome of investigations

Inevitably not all complaints are resolved within the year they are made. Some are complex and take some time to investigate. Therefore, we have analysed complaints originating in 2011, the majority of which have already been resolved.

Figure 12 shows that, for investigations that have concluded, the GMC gave the doctor either advice, or a sanction or warning in over half of all cases.

In 17% of cases the doctor was given a warning, which stays on his or her public record for five years, or a temporary restriction on their practice (in the form of an undertaking or conditions).

In 4% of cases (73), the doctor was suspended or erased from the medical register although this number is likely to be higher when all the complaints from 2011 have been resolved.*

In any given year we erase or suspend more doctors than this from the register because complaints made in previous years are still being investigated. For example, in 2012, 119 doctors were suspended or erased from the medical register, but the majority of these cases did not originate from complaints made in 2012.

43% of the complaints we investigated were closed without any action taken against the doctor because the complaint turned out to be unfounded or unsubstantiated.

FIGURE 12: Outcomes of investigations for complaints received in 2011

Source of complaint	Outcome		
	Sanction or warning given [†] (including suspension/erasure)	Closed with advice [†]	Closed with no further action [†]
Public	5% 37	40% 284	55% 393
Employer	32% 103	32% 101	36% 114
Individual doctor	36% 140	33% 128	31% 122
GMC	12% 28	40% 93	48% 110
Police	41% 40	28% 27	31% 30
Other public bodies	25% 64	40% 102	36% 92
Total	21% 412	37% 735	43% 861

Percentages are rounded so may not add up to 100%. The numbers in this figure exclude the 292 cases that originated in 2011 but were still unresolved on 31 July 2013.

* 13% of fully investigated complaints did not yet have an outcome when we extracted the data on 31 July 2013.

† Includes a few cases that did not initially meet our threshold for full investigation.

Complaints from the public

The public is an important source of complaints

Most complaints about doctors come from patients and from relatives and friends of those patients. Between 2007 and 2012, the overall number of complaints from the public rose by 87% to 5,014.

At the same time, the proportion that were fully investigated also increased from 11% to 20%, so that in 2012, 989 complaints from the public were fully investigated. This is more than the total from doctors and employers combined.

The public are therefore a very important source of complaints that merit an investigation. But, in 2012, 80% of their complaints – 4,025 – were closed without a full investigation.

Also, only 45% of investigations originating from public complaints in 2011 led to a doctor receiving a sanction, warning or advice, compared with 67% of complaints from employers and doctors.

There is a great deal of evidence that patients find it difficult to navigate the sometimes bewildering array of organisations to which they might complain. It is therefore not surprising that the vast majority of complaints are not ones suitable for the regulator to take action on.

These complaints may well be founded, but the GMC is not able to manage all patient complaints or to provide redress. There is also no reason why the public should have an intimate knowledge of the legal framework that sets the GMC's thresholds for investigation.

Improving the complaints system

For the GMC, complaints from patients and relatives about doctors are an invaluable source of information. We are determined to understand them better, to use them to inform our work and to feedback what we learn to employers and the medical profession. However, the threshold for investigation means we do not take forward many of these complaints. We recognise this can lead to further frustration for those who may already feel exasperated with the system.

By not pursuing an investigation, we are not suggesting that the complaints are invalid – indeed the very fact that a patient has raised a complaint must be taken seriously – but, in many instances, the complaints are better resolved locally. However, when their complaints are not dealt with appropriately at a local level, patients are likely to turn to national organisations. Last year, complaints to the Parliamentary and Health Service Ombudsman in England about inadequate responses to patients' complaints in the NHS rose by 13% from 2012.⁵⁸

The challenge for the GMC and wider healthcare system is to create a complaints system that is easy to access and that enables individuals to reach the right person or organisation as quickly and easily as possible.

The Mid Staffordshire inquiry highlighted how a poor complaints system negatively affects patients. It explained that patients are entitled to readily accessible and easily understood methods of making a complaint.¹

More needs to be done to increase patients' understanding of the complaints system

There is a need for better signposting so that patients and their relatives know which organisation they should first raise their concerns with. There is also a need for better coordination and support for patients navigating their way through the system.

Our online interactive guide, *Patients' help*, gives patients information on which organisation to complain to if they have a concern about a doctor. But we know this is just a small step.

In the wake of the Mid Staffordshire inquiry, the UK Government launched the Clwyd/Hart Review of best practice in the handling of complaints in England, which is considering what common standards could be applied across the NHS.⁵⁹

It also promised that NHS England would develop an easy-to-use, one-stop shop for clinicians, managers, patients and the public to report patient safety incidents and receive advice.⁵⁹

This is certainly not the first attempt at reform, but it is in everyone's interest to make the complaints system work throughout the UK and to ensure that patients and their relatives are listened to and their concerns acted on. As a national regulator, the GMC is not, nor should it be, designed to provide redress for patients and their families who have been harmed by doctors. But it is our responsibility to protect future patients and to protect the reputation of the medical profession. Complaints from the public are vital in helping us to deliver that responsibility.

As well as creating a clearer more accessible system at local level, more can be done to increase patients' awareness of what they can expect from their doctors and we will play our part in this. We have now established employer and regional liaison services to engage with employers, patients and doctors. This year, our new regional liaison service in England is engaging with each local Healthwatch, which is a new service created to gather and represent the views of those who use the NHS. Similar work is being undertaken at the GMC's offices in Northern Ireland, Scotland and Wales.

We also need to do more to support and explain our work to potential and actual complainants, as well as ensuring we understand their concerns. As a first step, we are currently trialling a new system to improve how complaints about doctors are investigated, part of which involves meeting with patients and relatives who have raised concerns about doctors.

We now have a better understanding of who is complaining about doctors

We have analysed the demographic profile of our complainants (box 2) and several interesting patterns emerge.

Age

We found that age is the strongest single determinant of an individual's likelihood to complain to the GMC. Figure 13 shows those aged 46–60 years were most likely to complain, making 237 complaints per million people, compared with just 108 complaints per million people in the youngest group (18–30 years) and 182 per million people in the oldest group (over 60 years).

Although older people use more NHS services – those over 75 years old stay substantially longer in hospital¹⁶ – middle-aged friends or family might be complaining on their behalf. The low proportion of complaints by young people might relate to them having less contact with health services and so less reason to raise a concern about a doctor.

The Parliamentary and Health Service Ombudsman in England reported that only 5% of its complaints are made by people aged 18–34 years.⁶⁰

From 2007 to 2012, we saw an 87% increase in the number of complaints from the public and a 156% increase in the number of these complaints being investigated. We also saw several interesting changes in the age profile of complainants. The biggest increase was in young people aged 18–30 years. There was a 117% increase in complaints from this group and a 267% increase in the number that were fully investigated. We also saw an increase in the number of complaints by people aged 46–60 years but not to the same extent (82% increase, with a 173% increase in complaints being investigated). So the increase in the number of complaints from the public has been driven in part by young people.

FIGURE 13: Complaints received from the public, by age group

Pooled data for 2010–12, per million people in the UK in 2012.

Age (years)	Fully investigated complaints	Other complaints	Total
18–30	22	86	108
31–45	43	157	200
46–60	55	183	237
>61	39	144	182
All ages	40	145	185

Numbers are rounded so may not sum exactly.

BOX 2: Understanding who our complainants are

For this year's analysis, we used Experian UK Public Sector services to help us understand the demographic profile of our complainants. This tool is used by many public sector bodies to find out more about the way they relate to the public and about those who use their services. There are a number of limitations with this analysis outlined in the note on data (pages 60–61).

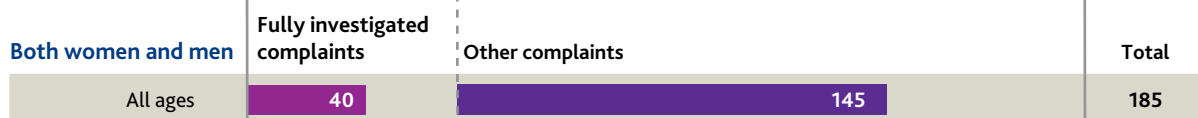
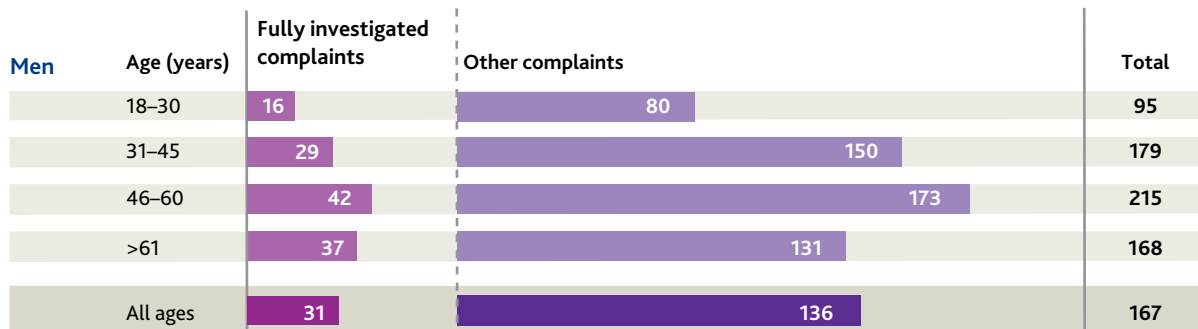
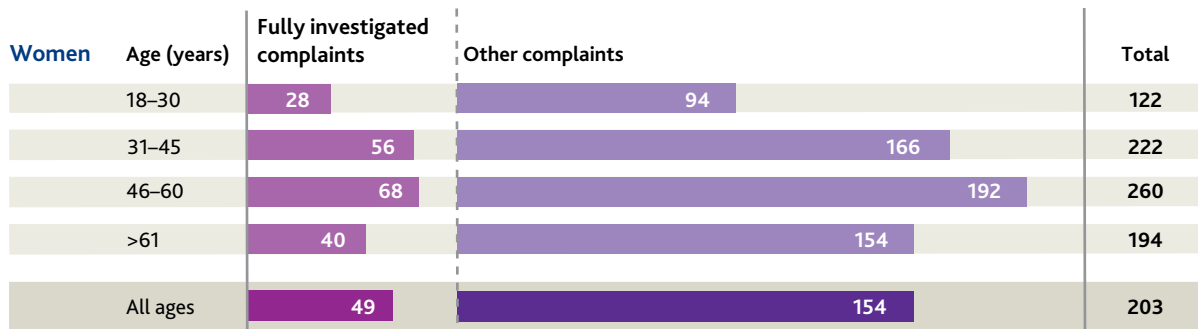
Gender

Gender is a strong determinant of an individual's likelihood to complain to the GMC in all age groups.

Figure 14 shows that women made more complaints to us than men did, and a higher proportion of these were investigated, in all age groups. Between 2007 and 2012, complaints from women increased by 92% and those from men by 75%.

FIGURE 14: Complaints received from the public, by gender

Pooled data for 2010–12, per million people in the UK in 2012.



Numbers are rounded so may not sum exactly.

Household income

Figure 15 shows that household income, adjusted for household size, did not have a substantial bearing on an individual's likelihood to complain. Those in the lowest-income households (less than £15,000) were more likely to complain than those earning more.

Complaints from the lowest-income households were less likely to meet the threshold for an investigation than those from the highest-income households (over £35,000), but the differences were fairly small. For example, in the 46–60-year age group, 58 complaints per million people in the lowest-income households were investigated, compared with 67 complaints per million people from the highest-income households.

FIGURE 15: Complaints received from the public, by household income*

Pooled data for 2010–12, per million people in the UK in 2012.

<£15,000		Fully investigated complaints	Other complaints	Total
Age (years)				
18–30		21	113	134
31–45		46	196	243
46–60		58	211	269
>61		37	125	162
All ages		40	161	201
£15,000–£35,000		Fully investigated complaints	Other complaints	Total
Age (years)				
18–30		20	73	93
31–45		43	148	191
46–60		47	177	223
>61		39	146	185
All ages		38	140	178
>£35,000		Fully investigated complaints	Other complaints	Total
Age (years)				
18–30		27	83	110
31–45		39	144	183
46–60		67	172	239
>61		39	161	200
All ages		44	141	186
All income bands		Fully investigated complaints	Other complaints	Total
All ages		40	145	185

* Data are equivalised – this involves adjusting household income to account for different demands on resources, by considering the household size and composition.
Numbers are rounded so may not sum exactly.

Complaints from doctors and employers

Employers and doctors are also an important source of complaints about doctors sent to the GMC. In 2012, they submitted fewer complaints than the public did but a higher proportion reached the threshold for investigation. Apart from the fact that they are likely to have a better understanding of an individual doctor's practice and the context in which that takes place, it also reflects that more of their complaints related to probity or to health issues, both of which are more likely to prompt an investigation.

Complaints from individual doctors and employers accounted for a similar proportion of all complaints (10% and 7% respectively) and we received an increasing number of complaints from both.

Employers are now making two-thirds more complaints that lead to an investigation in 2012 than in 2007. This is very unlikely to reflect any changes in the standards of medical practice, but may well be the result of better clinical governance and could reflect changes to the system in the preparation for introducing revalidation. The GMC also introduced the employer liaison service in 2012, which has helped to create closer working relationships between the GMC and employers.

In 2012, 835 doctors (10% of all complaints) came straight to us to report concerns about their colleagues rather than first going through their employer (or, in the case of GPs, their contractor).

In 2012, 84% of complaints from employers led to a full investigation, compared with 48% of complaints made by individual doctors.

For complaints made in 2011, a similar proportion from employers and doctors (32% and 36% respectively) led to a doctor receiving a sanction or warning.

Doctors must be empowered to raise concerns

The fact that raising concerns is much more common now than in the past is an indication of how far forward the medical profession has moved on this issue. There was a time when doctors were aware of their colleagues' failings but did not act. Now they are more likely to do so.

However, that does not mean all the barriers have been removed. There are still too many instances in which inadequate practice is tolerated or when doctors feel, for whatever reason, that they cannot raise concerns. One of the great challenges facing our healthcare system is to change the culture so that staff at every level routinely raise concerns and are encouraged to do so.

The UK Government has said it will create a new duty of candour for every organisation in, or working for, the NHS and this has been widely welcomed. It has also expressed some caution about the proposal in the Mid Staffordshire inquiry report that an individual healthcare professional could face criminal liability if they fail to report concerns about treatment or care provided. The Government is right to be cautious about any measure that may have the unintended consequence of creating fear and a lack of openness.

Nevertheless, it is incumbent on employers, commissioners and regulators, together with professional bodies, to do all they can to help create an open culture in which errors and complaints are viewed as opportunities for learning and where poor practice is identified and tackled immediately.

At the GMC, we have taken a number of steps but know there is more to do. Raising concerns is often not easy. In December 2012, we set up a confidential helpline for doctors to raise concerns about patient safety. By June 2013, we had received more than 500 calls, 40 of which led to a full investigation.

We have continued to encourage doctors to raise concerns and have enshrined this in new guidance, *Raising and acting on concerns about patient safety*,⁶¹ which was issued to every doctor in the UK last year.

For the first time last year we created a formal opportunity for every doctor in postgraduate training to raise a concern about patient safety in the place they were working. In the 2012 national training survey, we asked all respondents: 'Do you have any concerns about patient safety at your trust?'

Given the very high participation rate in this study (95% of doctors in training took part in 2012), the results revealed substantial levels of concern. 4.7% of doctors in training (more than 2,400) reported a current concern. Each of these was followed up locally – while 76% of those who reported concerns had also reported the issue locally, the rest were not and needed to be investigated.

We have repeated this exercise in the 2013 survey and although the results are still being analysed, the level and pattern of concerns appear to be similar to last year. This exercise is important, not just in helping to identify risks to patient safety, but also in encouraging younger doctors to raise concerns and to send a clear signal that this is part of what it means to be a professional.

These initiatives, however, do underline the fact that there are still substantial barriers that inhibit professionals from raising concerns or referring complaints to their employers or contractors.

This is supported by widespread evidence of staff not feeling able or empowered to raise concerns.^{62, 63, 64} There have been a number of well-publicised examples over the past few years where staff have not been allowed, or felt able, to raise concerns. One of the greatest lessons to emerge from the Mid Staffordshire inquiry was the catastrophic implications of healthcare professionals not speaking up.

A report published by Public Concern at Work highlighted that healthcare is an area where staff feel unable to raise concerns and where those who do can find themselves isolated.⁶⁵ In a study of 1,000 staff who raised concerns, 15% were dismissed and senior staff were more likely to lose their jobs.⁶⁵

It is also essential that the NHS has appropriate complaint handling systems at local level so that doctors and other healthcare professionals are empowered to speak up, if this is in the interests of patient safety. They are first-hand witnesses when things go wrong and it is vital that they are able and willing to speak up to prevent failings in care.

As Dame Janet Smith pointed out in the Shipman inquiry, the importance of raising concerns in the healthcare services should not be underestimated – it provides a vital source of information about clinical performance and has an important role to play in clinical governance.⁶⁶ More recently The King's Fund argued that the first line of defence in the battle against serious quality failures in healthcare is frontline professionals.⁶⁷ In the light of the evidence from the Mid Staffordshire inquiry, perhaps that should be amended to say that professionals should be the first line of defence, but that sometimes patients and their relatives are also smoke alarms for the system and must be listened to at all times.

Complaints raised by the GMC

For many years, the GMC has scanned media coverage and other sources for items that may indicate there is a concern about a doctor's practice.* More recently, we have sought to do this more systematically and extensively, so the number of this type of complaint rose to 953 in 2012, from 516 in 2011 and only 237 in 2010.

Most of these complaints did not reach the threshold for a full investigation. In 2012, 31% were investigated fully. And of the complaints from 2011 that were fully investigated, 12% led to a doctor receiving a sanction or warning.

The low proportion of concerns raised in the press that led to an investigation or a sanction or warning suggests there are limitations in the intelligence that can be garnered from these sources. We need to reflect on how to use our resources in this area most effectively.

* We do not use our employer liaison advisers as a source of concerns about doctors. Their role is to support responsible officers and medical directors to raise concerns about doctors, not to raise concerns themselves.

Conclusion

One of the key lessons for the healthcare system over the past 18 months has been the importance of listening to patients and their relatives. That is a lesson that the GMC and other regulators are taking on board. At the same time, we have to accept that while complaints we receive from patients and relatives must always be carefully assessed and handled sensitively, many do not reach the legal threshold for us to investigate. They can and should be investigated and responded to at local level. It is clear from our data, and not surprising, that complaints from employers and doctors are both more likely to be investigated and more likely to lead to a doctor receiving a sanction or warning.

The challenge of helping patients and their carers, relatives and friends to navigate the complaints maze remains substantial. We are keen to do what we can to support individuals including redirecting them to someone who can help when we cannot. We need to work with others to encourage people to raise concerns and complaints that we can deal with, while making sure that complainants can access other organisations that can often deal more effectively with their concerns.

Certain groups in the public are more likely to make a complaint to the GMC about their doctor. Age is the strongest determinant of an individual's likelihood to complain, with those aged 46–60 years making proportionally more complaints. Gender also makes a difference, with women making more complaints overall, a higher proportion of which are investigated.

We investigate a higher proportion of complaints from employers than from individual doctors. However, individual doctors do make a substantial number of complaints to us. We encourage this, but it does raise questions about whether there are appropriate local systems in place to enable doctors to raise concerns.

Our data also highlight some of the challenges we have in our own approach to identifying potential risks to patient safety. We need to reflect on how to use our sources of information most efficiently and effectively.

There is much more to do in this area – part of being an effective regulator must involve understanding the nature and extent of the concerns that are raised with us. We have made a start with this, but we accept that there is frustration among some patients and relatives who understandably see us as the means of redress for what has happened to them. That is not our role, but we need to be better at explaining what we can and cannot do.

At the same time, there will always be individuals who feel hurt as a result of their contact with the healthcare service and who will never be fully satisfied. But we believe there is more we can do in the way we handle cases, and more that can be done locally to answer the legitimate grievances and concerns brought by patients and their families.

Chapter 2: A note on data

Data in this chapter were drawn from the information we collect when assessing doctors' fitness to practise. The data were drawn from the GMC's database for this analysis on 31 July 2013.

In this chapter, we used fitness to practise data for 2007–12 enquiries received between 1 January 2007 and 31 December 2012. For data referring to specific years, we have used enquiries received between 1 January and 31 December of that year.

For the analysis on the outcome of investigations, 2011 data were used because a substantial proportion of complaints originating in 2012 that were fully investigated did not yet have an outcome when the data were drawn from the GMC database: 877 complaints (33% of all investigated complaints).

The types of complaint the GMC processes

For the analysis of allegation types, allegation data were grouped into mutually exclusive categories:

- communication with patients
- clinical care and communication with patients
- clinical care
- clinical care and probity
- probity
- health*
- working with colleagues
- three or more allegations
- all other allegations.

Around 23% of complaints did not have an allegation recorded against them because they had not yet been assigned allegations at the time the data were extracted, or because the complaint was closed immediately. We only record allegations for complaints that are fully investigated or for those that are referred to the doctor's employer to check for wider concerns.

* This includes complaints concerning health and about health combined with any other allegation.

Understanding our public complainants

These data were analysed by Experian UK Public Sector services. Anonymised fitness to practise data were used from complaints made by the public where we had the necessary information. This was linked to datasets held by Experian to estimate the demographic profile of our complainants.

Our data used for this analysis were drawn from the GMC database on 2 May 2013.

There are a number of limitations with the analysis on the demographic profile of our complainants.

Complainants' gender was derived from Experian's consumer database, which contains approximately 12,000 forenames. If the forename was inconclusive in establishing definite male or female gender because some names are ambiguous, then the person's gender was flagged as unknown and they were excluded from the analysis. This method has been tested against a random sample of Experian's Lifestyle surveys and 98.5% of all estimates for gender were correct.

Complainants' age was derived from a variety of data sources including Experian's Lifestyle surveys and their consumer database. It used a number of variables to predict a person's age, such as the length of residency at the same address and household composition.

Complainants' equivalised household income

identifies the adjusted net household income at an address taking into account income tax, national insurance, council tax and the household size and composition. This means that the variable is able to indicate how much money people have to spend on goods and services, but at the same time taking into account household composition so that different types of households can be more readily compared. For example, an adult couple with children needs a higher income than a single person to reach the same standard of living. For the analysis in this chapter we used three bands for household income: less than £15,000, £15,000–£35,000 and more than £35,000.

The external data Experian used is only updated annually so if an indicator, such as household income, were to change dramatically within a year, this would not show in the data.

Chapter 3: Variations in the standards of UK medical practice

Although the vast majority of doctors provide very good medical care, there are inevitable variations in the standards of medical practice. Some variations are clearly unacceptable, especially when patients receive care that falls far short of what they should expect. Those who provide and those who regulate healthcare need to understand these variations and use data to identify where standards have not been met and where there is a risk of future failure.

We are moving into an era when data on the quality and safety of healthcare will become both easier to analyse and more accessible to patients, health providers, regulators and doctors themselves.

This chapter looks at whether complaints to the GMC about a doctor are an indicator of future performance problems, and which groups of doctors are more at risk of falling below acceptable standards. We have taken this a step further this year by pooling data for 2007–12 – this has enabled us to examine which combinations of characteristics are associated with the probability of being complained about, or receiving a sanction or warning from the GMC.

However, a remaining limitation, even when pooling data, is that we have not currently been able to consider how ethnicity is associated with the risks discussed in this chapter – we do not hold ethnicity information for a large number of doctors and it is also very difficult to separate out the effects of ethnicity and where a doctor originally trained.*

* Despite these limitations, we are currently carrying out a further examination of what our data can tell us about the risks associated with ethnicity and will be publishing our findings separately.

Sharing data can help us develop a risk-based approach to regulation

The conclusions we draw from our fitness to practise data are limited and we must view these data in context. Only a small proportion of doctors are complained about, and an even smaller proportion go on to receive a sanction or warning from the GMC – fewer than 1% of all doctors on the medical register over the six years from 2007 to 2012.

In isolation, individual pieces of data can tell us little about the performance of healthcare services and professionals. But inquiries and reviews, particularly the Mid Staffordshire inquiry, have suggested that combining quantitative and qualitative data from several sources could help to identify existing failures or indicators of future failures more effectively.

For that reason, in chapter 4 we consider whether GMC-generated data is in any way indicative of other measures of quality in the healthcare system, such as differences in mortality rates. If we are able to identify associations of this kind, it may help us and others identify problems earlier and, over time, to develop a risk-based model of regulation.

Increasingly, we are also gathering qualitative data from our employer and regional liaison services in England, and from our offices in Northern Ireland, Scotland and Wales. This, together with the information that we will gain through revalidation and our relationships with responsible officers,* should broaden the contribution we can make in the future.

* Responsible officers are licensed medical practitioners, and in most cases will be the medical director within a healthcare organisation. They have a key role in revalidation. They are responsible for making a recommendation to the GMC, usually every five years, about whether each doctor in their organisation should be revalidated. Responsible officers also ensure that systems of clinical governance and appraisal in their organisation are working and are appropriate for revalidation.

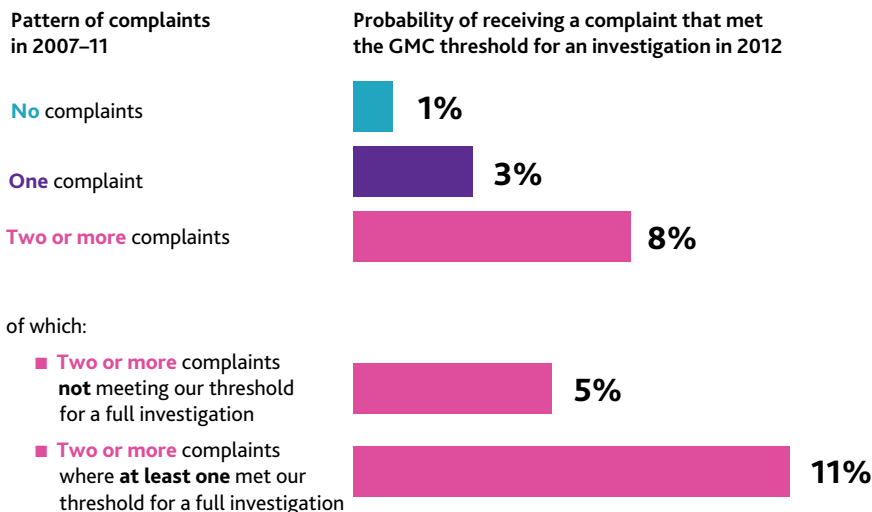
Complaints as a leading indicator of future problems

How we handle the complaints we receive about doctors is outlined in figure 9 (page 45). We have a specific threshold for deciding whether a complaint is fully investigated.

Several studies have shown that recurrent complaints can be an important early warning signal of future complaints that are investigated.^{68, 69} Our data appear to reinforce this finding (figure 16). Doctors who received no complaints between 2007 and 2011 had only a 1% risk of a full investigation in 2012. If a doctor was complained about once between 2007 and 2011, this risk increased to 3%, and, if a doctor was complained about more than twice, this rose to 8%.

Identifying doctors who are the subject of recurrent complaints and assessing whether they might need additional support may therefore help reduce the risk of an investigation into their practice in the future. In doing this, it is important to consider complaints that do not meet our thresholds for investigation as well as complaints that do. A doctor who had two or more complaints between 2007 and 2011 was five times more likely to have an investigation in 2012 compared with doctors receiving no complaints in that period, even if none of these complaints met our threshold for investigation (5% versus 1%).

FIGURE 16: The pattern of complaints during 2007–11 affecting the probability of a doctor being investigated in 2012



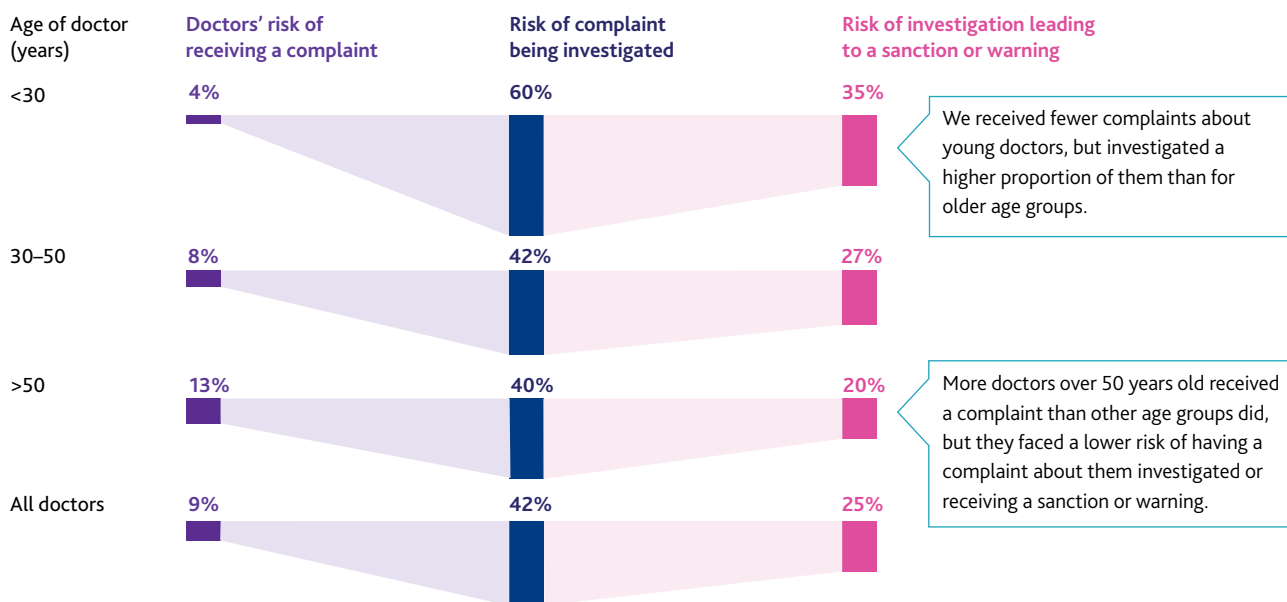
Complaints and investigations for doctors under 30 years old

The pattern of complaints differs substantially for young doctors. We have therefore analysed doctors under 30 years old separately because they are predominately in postgraduate training or at an early stage of their career and have not yet joined the GP or Specialist Register.

We receive fewer complaints about young doctors

Most doctors in this age group are still in training – only 3% were specialists or GPs in 2012* – and as such they are likely to be more closely supervised than older doctors. It is reasonable to assume that concerns about their performance and behaviour are more likely to be picked up before they need to be escalated to the GMC. Unsurprisingly then, only 4% of doctors under 30 years old received a complaint between 2007 and 2012, compared with 8% of those aged 30–50 years and 13% of those over 50 years old (figure 17).

FIGURE 17: Risk of doctors in different age groups receiving a complaint, of those complaints being investigated and of those investigations leading to a sanction or warning during 2007–12



* Data correct on 31 December 2012.

We investigate a higher proportion of complaints about young doctors

Although we receive fewer complaints about this group, a higher proportion of them reach our threshold for a full investigation and more lead to a sanction or warning. Of all the complaints we received between 2007 and 2012, we fully investigated 60% about doctors under 30 years old, compared with 41% about doctors aged 30 years and over. 35% of investigated complaints resulted in a sanction or warning for doctors under 30 years old, compared with 27% for doctors aged 30–50 years and 20% for doctors over 50 years old (figure 17).

This is partly because doctors under 30 years old are more likely to be working in supervised settings and much less likely to have clinical care allegations than doctors aged 30 years and over. The proportion of allegations linked to health and probity is therefore much higher (53% compared with 23%). As noted in chapter 2, these types of allegation are more likely to reach the GMC threshold for investigation and lead to a sanction or warning.*

The fact that younger doctors are as likely to have allegations of probity as older doctors underlines the importance of medical schools making sure that students understand their professional obligations and what will be expected from them as a doctor, including a good understanding of the GMC's ethical guidance. This also needs to be reinforced during postgraduate training.

There is a key role for the GMC in supporting medical schools and engaging with students about professionalism, our role and the purpose of our standards. All first-year students receive our booklet *Welcome to medicine*, which sets out what is expected of them as future doctors, and we send out a bimonthly e-bulletin to around 11,000 students.

We are, however, committed to doing more with medical schools. Our new regional liaison service in England has begun a major engagement programme, meeting with more than 3,000 medical students in the first half of 2013. Similar work is being undertaken at the GMC's offices in Northern Ireland, Scotland and Wales.

* This is based on those complaints for which we record allegation types (see chapter 2: a note on data, pages 60–61).

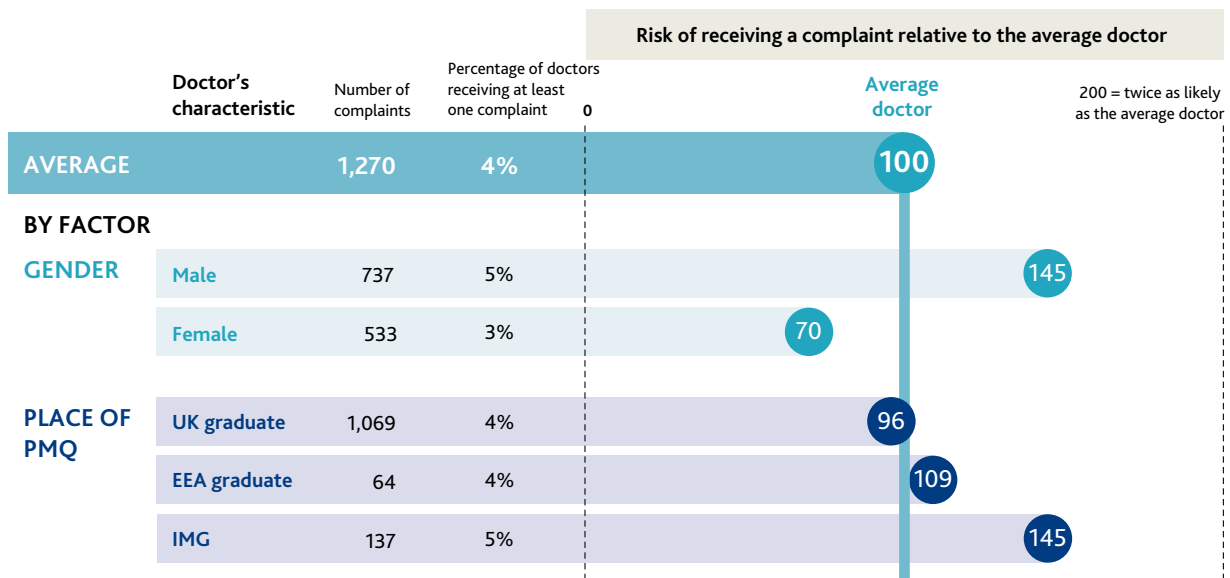
Some personal characteristics are associated with more complaints against doctors under 30 years old

Although the overall number of complaints against doctors under 30 years old is low, two characteristics have a significant bearing on their likelihood to be complained about (figure 18).

- Male doctors under 30 years old were twice as likely as female doctors to be complained about.
- International medical graduates under 30 years old were more likely to be complained about than UK or EEA graduates.

FIGURE 18: Personal characteristics affecting the likelihood of doctors under 30 years old receiving at least one complaint during 2007–12

PMQ = primary medical qualification | IMG = international medical graduate



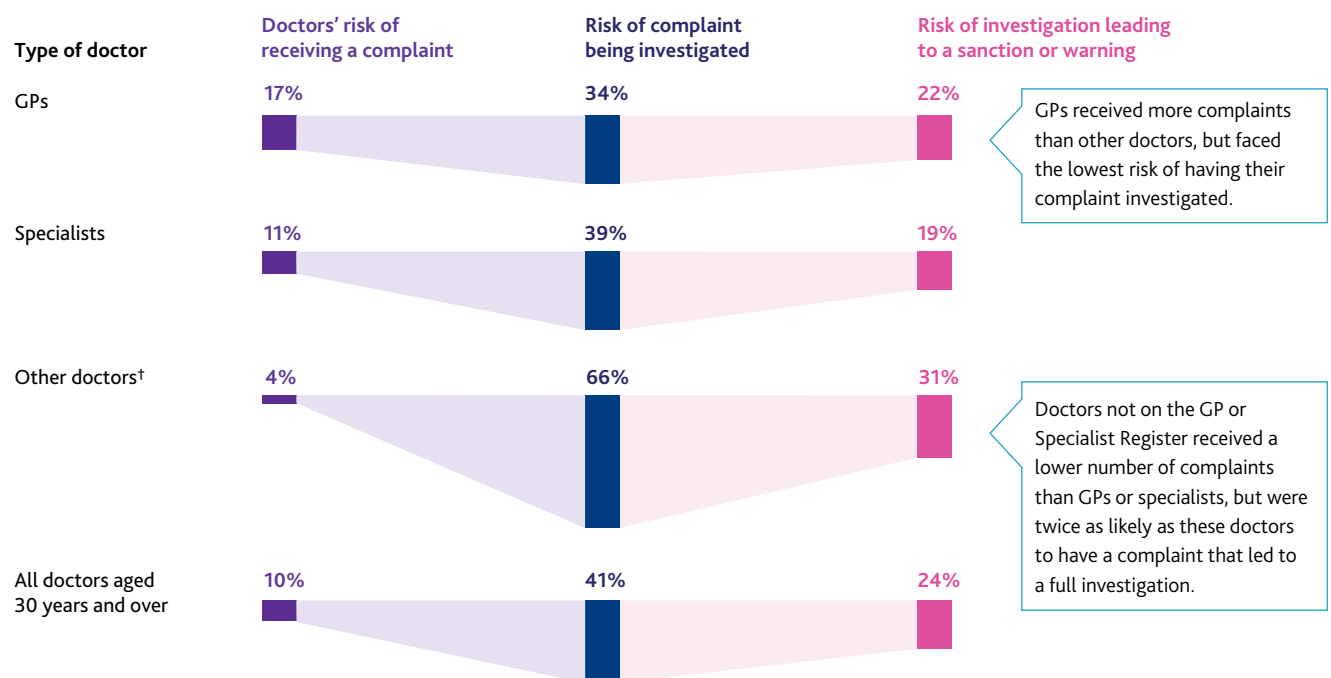
The percentages above are rounded but the index for the risk of receiving a complaint relative to the average doctor is calculated using exact numbers.

Complaints and investigations for GPs, specialists and those on neither register aged 30 years and over

By looking at the patterns of complaints and investigations for doctors in this age group, we can get a picture of how the risk of poor practice varies between different types of doctors after they have completed their postgraduate training. The vast majority of GPs and specialists are aged 30 years and over – on average only 1.8% of GPs and a handful of specialists were under 30 years old between 2007 and 2012.*

This first section looks at how the pattern of complaints and investigations differs between GPs, specialists and other doctors.† We then look at how a doctor’s characteristics – age, gender, and primary medical qualification – were associated with these patterns.

FIGURE 19: Risk of different types of doctors aged 30 years and over receiving a complaint, of those complaints being investigated and of those investigations leading to a sanction or warning during 2007–12



* We do not have the precise figures for doctors in postgraduate training for pooled 2007–12 data. However, in 2012 among doctors aged 30 years and over, 86% were not in training.

† Doctors not on the GP or Specialist Register.

GPs attract most complaints

GPs received more complaints during 2007–12 than specialists or other doctors (figure 19), accounting for 46% of all complaints. This is not surprising, given the large number of interactions between GPs and their patients – there were 303.9 million GP consultations in England between 2008 and 2009.⁷⁰

The finding is also consistent with the pattern of complaints about GPs to other organisations during 2011–12.

- NHS in England: 29,897 complaints about doctors working in family health (GP) services, compared with 49,264 about all other doctors working in hospitals and community services.⁷¹
- NHS in Scotland: 2,944 complaints about doctors in family health services, compared with 1,363 about doctors in hospital and community health services.^{72, 73}
- NHS in Northern Ireland and Wales: both countries have reported increases in complaints about GP services.^{74, 54, *}

The fact that the GMC receives relatively more complaints about GPs than about specialist or other doctors may also reflect weaknesses in the local handling of complaints. In its review of how the NHS manages complaints, the Parliamentary and Health Service Ombudsman for England reported that some GPs were failing to deal with even basic complaints correctly.⁷⁵

The same report highlighted that some GPs were failing to manage relationships with patients properly. Of the complaints we receive about GPs that have an assigned allegation, 29% were linked to their communication with patients. GPs may therefore need more support, guidance or resources to ensure that their engagement with patients is appropriate.

Doctors aged 30 years and over not on the GP or Specialist Register are more likely to have their complaints investigated

Doctors aged 30 years and over not on the GP or Specialist Register were less likely to be complained about than GPs or specialists. However, they were around twice as likely as GPs or specialists to receive a complaint that led to a full investigation during 2007–12 (figure 19). They were also more likely to receive a complaint that led to a sanction or warning.[†] These proportions are very similar to those for doctors under 30 years old, suggesting that the pattern of complaints remains constant for doctors who have not joined the GP or Specialist Register.

Although GPs accounted for nearly half (46%) of all complaints, they accounted for only 35% of all sanctions or warnings issued. By contrast, doctors not on the GP or the Specialist Register accounted for only 18% of all complaints, but for 38% of sanctions or warnings issued.

* We are not able to give numbers for Northern Ireland and Wales because the data are not currently collected in the same way as in England and Scotland.

† This is not greatly affected by the fact that some doctors on neither the GP nor the Specialist Register were still in postgraduate training. The patterns reported in this chapter were also similar for those on neither register under 40 years old, where the majority were still undertaking their postgraduate training.

The number of doctors aged 30 years and over on neither the GP or the Specialist Register has declined by 15% between 2007 and 2012 (in contrast to an increase of 17% of GPs and specialists aged 30 years and over in the same period). In 2012, international medical graduates made up nearly half of this group (47%). This is a group that has not traditionally been well supported, but who that has been expected to take on substantial elements of frontline care.

The introduction of revalidation should ensure over time that these doctors are given greater support, offered more opportunities for professional development and made part of a governed system that monitors the quality of their work.

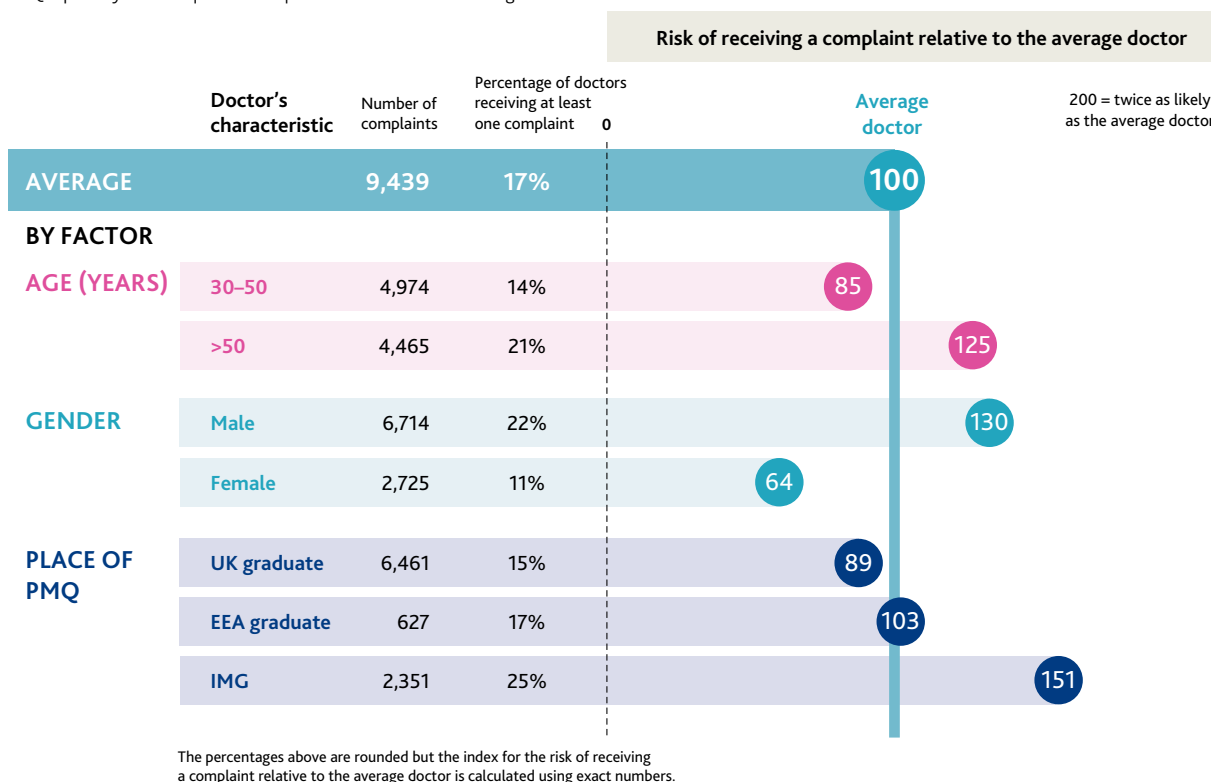
Some personal characteristics are associated with more complaints

Some characteristics are associated with a doctor’s likelihood of being complained about and of that complaint being investigated by the GMC – many of these patterns are similar to those highlighted for doctors aged under 30 years old.

By combining the data for 2007–12 for doctors aged 30 years and over, we have been able to look in more detail at how these factors affect the risk of different types of doctors receiving a complaint or facing an investigation.

FIGURE 20: Personal characteristics affecting the likelihood of GPs aged 30 years and over receiving at least one complaint during 2007–12

PMQ = primary medical qualification | IMG = international medical graduate



Doctors over 50 years old

More doctors over 50 years old received a complaint than doctors aged 30–50 years (figure 20).

This was particularly true of GPs (21% versus 14%; figure 20) but less so of specialists (13% versus 10%; figure 21) and other doctors (5% versus 4%; figure 22).

Male doctors

Male doctors were around twice as likely as female doctors to be complained about, irrespective of whether they were on the Specialist or the GP Register.

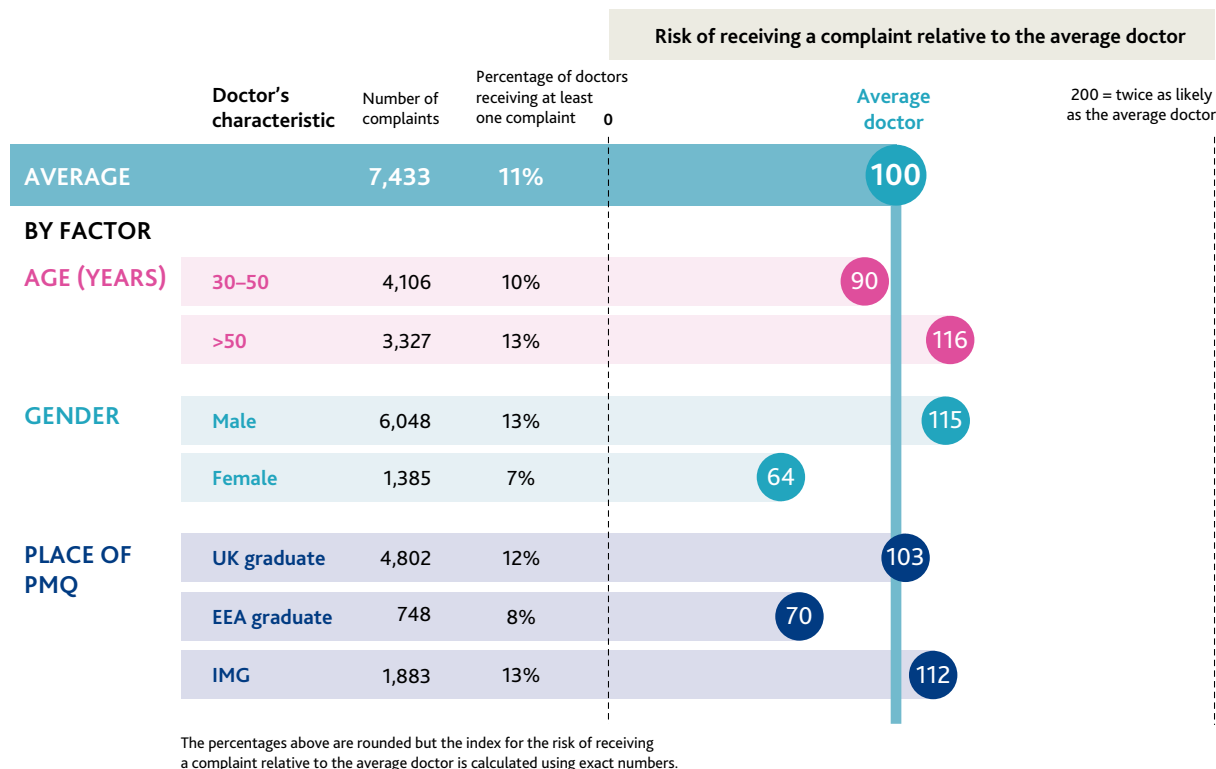
22% of male GPs received a complaint, compared with 11% of female GPs (figure 20). 13% of male specialists received a complaint, compared with 7% of female specialists (figure 21).

Male doctors were also more likely than female doctors to have their complaints lead to a full investigation (43% versus 36%).

These findings are similar to the pattern of complaints about professionals in other sectors. A study by the Solicitors Regulation Authority cites evidence that male police officers in the USA, male healthcare professionals in the UK, and male solicitors in New South Wales (Australia) and in the UK were more likely to be complained about than their female counterparts.⁷⁶

FIGURE 21: Personal characteristics affecting the likelihood of specialists aged 30 years and over receiving at least one complaint during 2007–12

PMQ = primary medical qualification | IMG = international medical graduate



Doctors who graduated outside the UK

GPs' place of primary medical qualification was associated with the probability of receiving a complaint (figure 20). Of those on the GP Register, 25% of international medical graduates received a complaint compared with only 15% of UK graduates and 17% of EEA graduates.

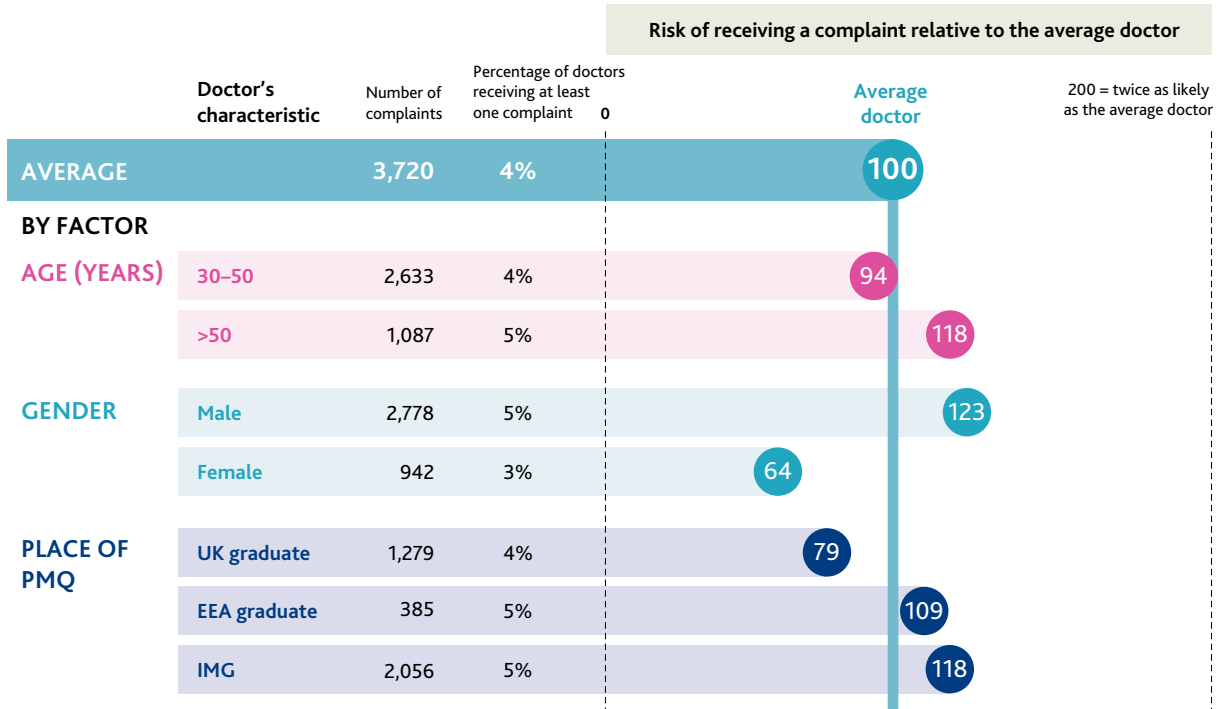
Among specialists, the GMC received complaints about a similar proportion of UK graduates and international medical graduates (12% and 13% respectively), but fewer about EEA graduates (8%; figure 21).

However, international medical graduates and EEA graduates were more likely to have a complaint that led to a full investigation (51% and 53% respectively) than UK graduates (35%), irrespective of which register they were on.

Other medical regulators have reported that a doctor's place of primary medical qualification affects the likelihood of receiving a complaint. For example, in Australia, international medical graduates had a 24% higher chance of attracting complaints than doctors who graduated in Australia.⁷⁷

FIGURE 22: Personal characteristics affecting the likelihood of doctors not on the GP or Specialist Register aged 30 years and over receiving at least one complaint during 2007–12

PMQ = primary medical qualification | IMG = international medical graduate



The percentages above are rounded but the index for the risk of receiving a complaint relative to the average doctor is calculated using exact numbers.

Sanctions and warnings for doctors aged 30 years and over

The number of doctors receiving a complaint that merited a sanction or warning is small, but it is important for us to understand which groups of doctors are at higher risk and to consider whether and how they could be further supported. Practice that is poor enough to merit a sanction or warning falls seriously short of the standards that patients should expect, particularly practice that leads to suspension or erasure from the medical register.

In this section, we have looked at which characteristics, when combined, led to high risks of a sanction or warning. All the differences discussed below are statistically significant.*

We used whether the doctor was a GP, specialist or on neither register, and their place of primary medical qualification, as a starting point. We used these factors rather than the doctors' personal characteristics, because they are probably more useful when considering possible practical support.

However, personal characteristics are still important in understanding the risks that doctors face as highlighted in this analysis, and previous analyses of our fitness to practise data.^{78, 79} For example, figure 23 shows the differences between gender and age in the proportions receiving a sanction or warning. Male doctors and older doctors are more likely to have received these. On the next page, we identify some specific male and older groups with a particularly high risk of this.

FIGURE 23: Doctors receiving a sanction or warning between 2007 and 2012

BY GENDER + AGE	Doctors who were suspended or erased	Doctors who received a sanction or warning other than suspension or erasure	Total
Male + 30–50 years (n=79,252)	265	788	1,053
Female + 30–50 years (n=60,684)	50	222	272
Male + over 50 years (n=50,205)	215	416	631
Female + over 50 years (n=17,877)	12	57	69

* We used a standard chi-squared test at the 99% confidence level.

Four groups of male doctors are at increased risk

Between 2007 and 2012, male doctors were more than three times as likely to receive a sanction or warning than female doctors – 1.3% compared with 0.4%. This is broadly similar irrespective of the type of doctor, age or place of primary medical qualification.

Male doctors over 50 years old who were EEA graduates and international medical graduates were more than twice as likely than UK graduates over 50 years old to receive a sanction or warning (2.1% and 1.9% versus 0.8%). And this increased risk applies to all types of doctors: GPs, specialists and doctors who were not on the GP or Specialist Register.

The pattern is also similar for male GPs aged 30–50 years, with a high risk for EEA graduates and international medical graduates.

These increased risks mean that there were four groups of doctors who stood out as having at least twice the average risk of receiving a sanction or warning during 2007–12. Two of these were male doctors over 50 years old (figure 24):*

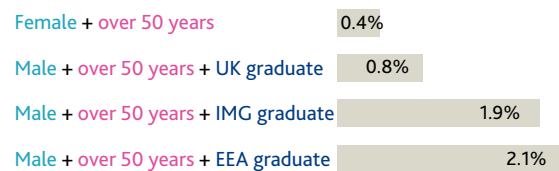
- male doctors over 50 years old who were EEA graduates
- male doctors over 50 years old who were international medical graduates.

These two groups accounted for 60% of the total sanctions and warnings given to male doctors over 50 years old (377 of 631), although they accounted for only 38% of these doctors on the register.†

FIGURE 24: Percentage of all doctors receiving a sanction or warning in 2007–12

PMQ = primary medical qualification | IMG = international medical graduate

BY GENDER + AGE + PLACE OF PMQ



The other two groups were GPs aged 30–50 years (figure 25):

- male GPs aged 30–50 years who were EEA graduates
- male GPs aged 30–50 years who were international medical graduates.

These two groups accounted for 37% of the total sanctions and warnings given to male GPs aged 30–50 years (110 of 296), although they accounted for only 24% of these doctors on the GP Register.

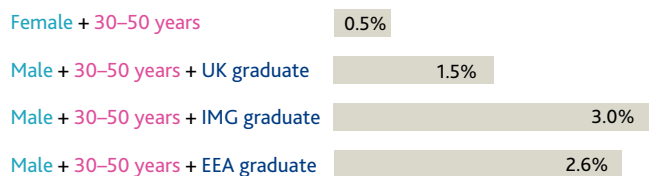
* The proportion of these groups receiving the most serious sanctions – a suspension or erasure – is also higher than for other groups of male doctors. The higher risk is therefore not because of a higher risk of warnings relative to the more serious sanctions.

† Male doctors aged 30–50 years on neither the GP nor the Specialist Register also had a higher risk of a sanction or warning if they were EEA graduates or international medical graduates (1.6% and 1.5%) compared with UK graduates (1.1%). The increased risk for these groups is not as high as for the other GP groups identified here and is only just statistically significant at the 99% level. But it should be noted this group of international medical graduates is a very large group (10% of the total register) and therefore accounted for 292 sanctions and warnings between 2007 and 2012.

FIGURE 25: Percentage of GPs receiving a warning or sanction in 2007–12

PMQ = primary medical qualification | IMG = international medical graduate

BY GENDER + AGE + PLACE OF PMQ



These differences are not accounted for by any variation in the type of allegations against these groups or by any variation in the source of complaint.

What might be the reasons for these findings?

We do not fully understand the reasons behind these patterns. For example, if the higher risk faced by doctors over 50 years old is a one-off generational risk, the effect may disappear over time. Conversely, if it is associated with age or time since primary medical qualification, our findings could have longer-term implications for continuing professional development.

The vast majority of EEA graduates on the medical register have benefited from automatic recognition of their qualifications. This allows them to join our medical register with few checks on their ability to practise medicine in the UK by the regulator. In 2012, 32% of EEA graduates over 50 years old on the medical register had joined in the past ten years and therefore will almost certainly have spent most of their career outside the UK. Cultural factors could therefore have contributed to the increased risk faced by these doctors.

On the other hand, only 9% of international medical graduates over 50 years old had been on the medical register for less than ten years, so the vast majority had already spent considerable time in the UK. This suggests that the relationship between a doctor's original training, the cultural aspects of working in a different country and the time spent working abroad is complex and needs further consideration.

The risk is higher for surgical specialists who graduated from the EEA

We looked at whether a doctor's specialty also affects the risk these doctors face. This was not significant, other than for EEA surgeons – a higher proportion of EEA male surgeons over 50 years old received a sanction or warning: 2.5%, compared with 1.1% of those who were UK graduates.

Also, a higher proportion of male EEA graduates over 50 years old worked in surgery compared with UK graduates (32% versus 22%).

As a result, surgeons accounted for 44% of all the sanctions and warnings issued to EEA male specialists over 50 years old but only 32% of sanctions and warnings issued to UK graduates in the same group.

Conclusion

It is important for us and others to understand the factors that affect a doctor's risk of being complained about, being investigated, and in some cases receiving a sanction or warning.

Our data show that previous complaints, even those that did not meet the GMC threshold for investigation, have been a leading indicator of future complaints. This finding reinforces the importance of supporting doctors in the workplace, before significant concerns arise about their practice.

It is well known that the pattern of complaints differs across the stages of a doctor's career. Our findings confirm that doctors under 30 years old were less likely to have received a complaint in 2007–12 than older doctors, but their complaints were more likely to be investigated. We also found clear patterns between different types of doctors aged 30 years and over.

- GPs were more likely to have a complaint made against them than other doctors, but a fairly low proportion led to a sanction or warning. This is probably because GPs have far more interactions with patients than doctors in hospital settings do, but they might need more support from the GMC, their royal college and their employer to make sure they are meeting their patients' expectations.

- Although not a homogeneous group, doctors not on the GP or Specialist Register might need additional support in the workplace – they had fewer complaints made against them, but a relatively high proportion of these complaints led to a sanction or warning.
- Some groups of male doctors had a higher risk of receiving a sanction or warning during 2007–12 – particularly those over 50 years old and GPs aged 30–50 years who had graduated outside the UK.

These findings should be interpreted with caution. We are not suggesting that the relationship between a doctor's characteristics and the risks they face is causal. We know that the factors contributing to poor performance are complex. Our own data cannot alone explain these differences.

We need to work with others to consider whether there are any other individual and organisational factors common to the groups who were at high risk of a sanction or warning. This may help identify whether there are better ways to support these doctors in the future.

Chapter 3: A note on data

This chapter draws on data collected as part of the GMC's fitness to practise processes and our work in registering doctors. The data were drawn from the GMC's database for this analysis on 31 July 2013.

Fitness to practise data (enquiries received between 1 January 2007 and 31 December 2012) and registration data were used throughout this chapter. To improve sample sizes six years of pooled data were used.

It should be noted that the numbers of investigations and sanctions could have been slightly underrepresented in this data since some cases opened in 2011 and 2012 were still unresolved, accounting for 4% of the total number of cases in the pooled fitness to practise data.

To determine the underlying population of doctors during the six-year period, the average number of doctors on the register was calculated by summing the number of doctors on the register (by cohort) at the end of each year (2007–12) and dividing by the number of years (six). This was used as a proxy for the average size of each cohort.

As with other analyses throughout the document, complaints about doctors exclude enquiries to the GMC that were not about a doctor's fitness to practise.

Analyses throughout this chapter exclude the very small cohort of doctors who appeared on both the GP and Specialist Registers (0.5% of registered doctors), since the cohort was so small that it was not possible to draw any meaningful conclusions from the data.

For doctors' characteristics the following three points should be noted.

- Doctors' exact age was derived from their date of birth, where this is known.
- For around 3% of the medical register, date of birth is not recorded – these are mostly doctors who have been registered for a long time. The age for these doctors is approximated by taking their time since qualification and adding 23.
- For the analyses in this chapter, we grouped doctors on the register into three distinct groups:
 - under 30 years old
 - 30–50 years old (inclusive)
 - over 50 years old.*

* When we refer to doctors aged 30 years and over in this chapter, we refer to doctors in two of these age groups: 30–50 years and over 50 years.

Chapter 4: How our data might contribute to understanding system risks

The Mid Staffordshire inquiry called for healthcare regulators to cooperate more effectively and share information.¹ Regulators need to understand not only the performance of healthcare professionals, but also how this relates to the systems in which those professionals work if they are to promote good practice and take appropriate action where standards are unacceptable.

This chapter examines the extent to which variations in GMC data are associated with differences in indicators of care at the local level. From this we can start to understand whether GMC data match indicators of variation, such as mortality rates, in different healthcare settings. As a preliminary study, we have looked at NHS trusts in England.

We are already working closely with system regulators and routinely share information about patient safety risks. A better understanding of the interactions between GMC and external data will help us to work more effectively with other organisations.

What do our data tell us about variations in practice across the UK?

Complaints have at least doubled in most parts of the UK since 2007

The GMC received 8,109 complaints* in 2012. Relative to the population in each country, England had the highest rate of complaints received and investigated (figure 26). Other parts of the UK had lower rates of complaints and Northern Ireland in particular had a lower rate of complaints that were investigated.

The distribution of licensed doctors in each country closely matched the distribution of the population, so the rates of complaints received and investigated are comparable.

Most regions in England were close to the English national average of 129 complaints per million people, apart from London with 248 per million. This explains in part why England had proportionally more complaints than other parts of the UK. Of the other English regions, the northeast and south central had the lowest rate with 86 and 97 per million respectively.†

FIGURE 26: Complaints in the UK in 2012, by country

Country	Number of all complaints per million people in 2012			Percentage of complaints coming from the public
	Fully investigated complaints	Other complaints	Total	
England	44	85	129	62%
Scotland	30	63	93	60%
Wales	35	60	95	64%
Northern Ireland	24	70	94	57%
UK average	42	82	123	62%

Numbers are rounded so may not sum exactly.

* Our definition of complaints in this chapter is the same as in the rest of this report – ie we have excluded enquiries that are not about a doctor's fitness to practise. The figures reported here are for all sources of complaints (the public, employers, doctors, the GMC, the police and other bodies).

† We have less data available at the English regional level for reasons explained in the note on data (pages 91–93). Therefore, we have factored up these numbers in order to make a meaningful comparison with country level data. The raw numbers for the English region average, London, northeast and south central were 102, 176, 61 and 69 per million people respectively.

The number of complaints originating from all parts of the UK roughly doubled between 2007 and 2012, except in Scotland, where the number trebled.*

Some variation in the number of complaints between the parts of the UK is due to differences in the source, with Wales receiving a higher percentage from the public than elsewhere (figure 26).

Several factors could contribute to these variations

Clearly caution is needed when comparing data. For example, higher numbers of complaints could be due to more effective clinical governance systems, better systems for handling complaints or a culture where reporting concerns is encouraged. They could also be due to the way services operate in certain parts of the UK. For example, healthcare in London is complex with high volumes and turnover of patients as well as high levels of staff turnover. More complaints may be the result of higher numbers of patients and a high concentration of acute services. Thus higher volumes of complaints do not necessarily mean poorer standards of practice, and vice versa.

The variations may also be influenced by the populations' health or profile – for example, by patients being older, more economically disadvantaged, or better informed. As highlighted in chapter 3, doctors' characteristics can have a bearing on their propensity to be complained about. Some variation might, therefore, indicate a different make-up of the doctor population in certain areas.

Does the performance of healthcare systems have a bearing on the variation in complaints?

Variations in the level of complaint do not necessarily reflect differences in the quality of care. For example, the UK's National Audit Office used admissions to emergency departments as a proxy to understand the quality of primary care. This is based on the idea that good primary care should reduce emergency admissions. Using 2009–10 data, it found that Wales had the highest proportion of admissions, with 11,471 per 100,000 people, compared with 9,994 in England, 9,917 in Scotland, and 8,274 in Northern Ireland.⁸⁰

The Nuffield Trust published a report on differences in expenditure in the four healthcare systems, with Scotland spending the most money on health per person and England the least.⁸¹ It noted that higher health spending does not necessarily correspond with better health outcomes – although the findings of the report are contentious.

The complexity of factors, both inherent to the healthcare system and separate from it, suggests that we need to do more to understand the variation in complaints and whether this is related to the quality of care being delivered.

* These figures refer to the total enquiries received by the GMC between 2007 and 2012. See page 45 for our definition of enquiries and complaints in this report.

What do our data tell us and others about the quality of care at NHS trusts in England?

For the first time, we have started to explore whether there are relationships between GMC data and external data on the quality of care at NHS trusts in England, such as mortality rates, or patients' perceptions of the care they receive.* This should help us and others begin to understand how our data can contribute to understanding and identifying risks in the UK healthcare system.

We used two sets of data in this analysis:

- the location of the hospital or clinic in which doctors were working when we received a complaint about them† – this gives us a better understanding of the variation among individual trusts and care settings
- responses from doctors in training to our annual national training survey – these give us insights into the environments in which doctors are undertaking their postgraduate training.

This is a first step and we have limited it to acute NHS trusts in England. We excluded trusts with fewer than 20,000 admissions a year, because of the small numbers of complaints and sanctions recorded. Mid Staffordshire NHS Foundation Trust was also omitted as it was an outlier in the external data, partly because of its prominence in the national debate about the quality of healthcare.

We found correlations between GMC data and system data, which are statistically significant, plausible and meaningful. In many cases GMC data explained‡ 5–20% of the variation in data about the healthcare system, suggesting that we should explore these relationships further.

Tables 3 and 4 summarise the key findings reported in this chapter. The full correlation results can be found in tables 1–4 (appendix 2 to this report).

* We have focused on secondary care in this analysis as the data are not as readily available for primary care, but we would like to examine this further in the future.

† A complaint is assigned to an NHS trust on the basis of whether the incident took place there. The doctor involved will not necessarily be employed by the same organisation.

‡ When we say 'explain' in this section we are not suggesting causality. We use it in the statistical sense that the variation in our data may account for a particular percentage of the variation in other data about the quality of care at an NHS trust.

BOX 3: Interpreting the findings

The findings in this chapter are derived using statistical inference. The key principles of this can be summarised as follows.

When analysing the relationship between two datasets, there are three questions to consider.

- Could the relationship simply be explained as being due to chance? A p-value, ranging from 0–1, expresses the chance that such strong results would be observed, even if the variables were unrelated. Smaller p-values are better and indicate a lower likelihood of such a strong relationship occurring, if the same test were applied to two datasets containing randomly generated numbers. The usual test for any association between variables is to require a p-value of 0.05 or less. In this chapter, a stricter test is used to test the association between variables, requiring a p-value of 0.01 or less.
- How strongly associated are the two datasets in question? An R-squared value, ranging from 0% (no fit at all) to 100% (the datasets follow identical patterns), expresses the strength of the association, ie how much of the variance in one dataset can be explained by the other dataset. Larger R-squared values are better and indicate a stronger relationship. The R-squared values in the analysis reported in this chapter are low to moderate, partly because the analysis is reliant on survey data and on the relatively small volumes of complaints at each trust.
- Does this imply causation? Correlation does not, on its own, prove causality. A correlation indicates that a causal relationship might be present, but in itself does not provide definitive conclusions regarding causality. Deeper analysis is needed to draw any further conclusions on causality.

TABLE 3: Selected correlations between GMC fitness to practise data and wider health sector datasets

External dataset	Percentage of variance explained by GMC fitness to practise data (pooled 2007–12)		
	Complaints	Investigated complaints	Sanctions or warnings
Summary Hospital-level Mortality Indicator (SHMI)	*	7%	12%
NHS Staff Survey: Family friends average	15%	17%	7%
NHS Staff Survey: Appraisal well structured	*	*	5%
NHS Staff Survey: Staff engagement	6%	9%	5%
CQC Patient Survey: Positive patient experience	15%	9%	*

* Correlation not statistically significant. For details please see box 3.

These numbers suggest that our data may have explanatory power in understanding the variation in other data about NHS trusts. However, these are simple correlations and the level of explanatory power reported in this table may be different in a fuller model of risk.

TABLE 4: Selected correlations between national training survey 2012 results and wider health sector datasets

External dataset	Percentage of variance explained by national training survey indicator (2012)			
	Clinical supervision	Overall satisfaction	Working beyond competence or experience	Quality of care
Summary Hospital-level Mortality Indicator (SHMI)	5%	*	*	7%
NHS Staff Survey: Family friends average	25%	20%	11%	54%
CQC Patient Survey: Positive patient experience	26%	22%	12%	43%

* Correlation not statistically significant. For details please see box 3.

These numbers suggest that our data may have explanatory power in understanding the variation in other data about NHS trusts. However, these are simple correlations and the level of explanatory power reported in this table may be different in a fuller model of risk.

Mortality rates vary widely

The annual *Dr Foster Hospital Guide* has published mortality statistics for NHS trusts in England since 2002. The most recent edition found wide variations – 12 trusts did poorly on two of four measures of mortality.¹⁶ * Scotland has published quarterly mortality rates since 2009, as part of the Scottish Patient Safety Programme drive to reduce hospital mortality by 20% by December 2015. Wales published its mortality rates for the first time in 2013 – 11 of 17 district general hospitals had higher mortality rates than expected.^{82, †}

In the wake of the Mid Staffordshire inquiry, NHS trusts in England with high mortality rates have been subject to increased scrutiny. Earlier this year, Sir Bruce Keogh, NHS Medical Director for England, published his review of 14 NHS trusts in England that had shown higher-than-expected mortality rates for two successive years.⁸³ The review highlighted that most of the trusts performed worse than would have

been expected in emergency care, with admissions at the weekend and at night particularly problematic.³ As a result, 11 of these trusts were put under special measures.⁸³

The Royal College of Physicians looked at NHS trusts with the 12 highest and lowest mortality rates in England, to investigate factors that might contribute to high mortality rates. It found a relationship between the number of consultants and mortality rates, and suggested that the higher staffing levels in London were the appropriate ones.⁴¹

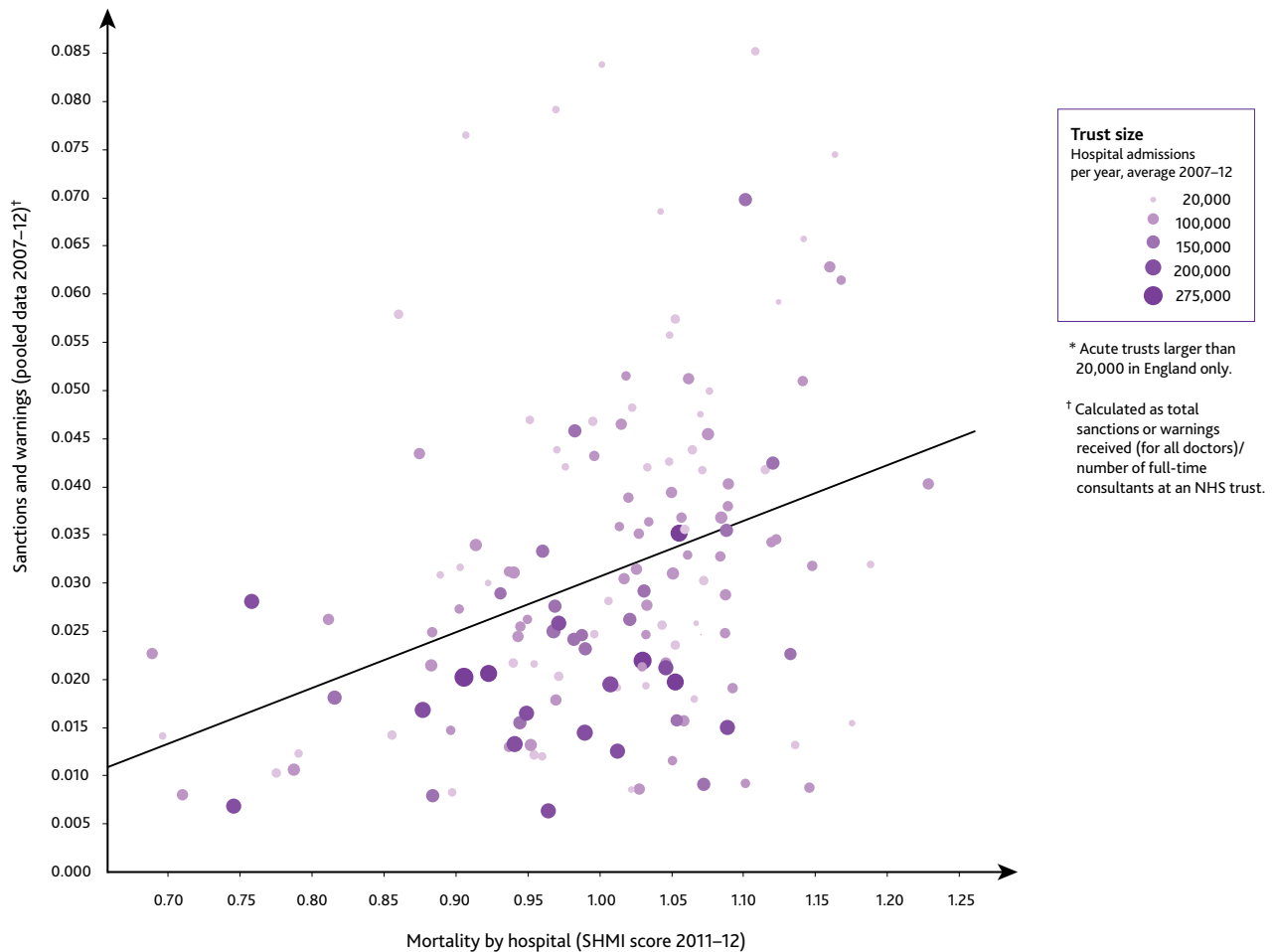
While that may be true, it is unlikely that senior staffing levels alone can explain variation in mortality between NHS trusts. It is also worth noting that in its 2012 *State of Care* report, the CQC noted that inspectors saw poor care on well-staffed wards and good care on understaffed ones.⁸⁴

* Hospital-standardised mortality ratio, summary hospital-level mortality indicator, deaths after surgery, and deaths in low-risk conditions.

† Wales uses risk-adjusted mortality rates and Scotland uses hospital-standardised mortality ratio.

FIGURE 27: The correlation between sanctions and warnings and hospital mortality

Trusts* with higher hospital mortality rates tend to receive more GMC sanctions or warnings.



Mortality rates* are associated with the number of doctors who received a sanction or warning

Turning to the GMC’s data, the overall number of complaints received or investigated by the GMC was not associated with standardised mortality rates in NHS trusts in England.†

However, figure 27 shows that higher mortality rates are associated with higher proportions of doctors who received a sanction or warning.

The proportion of doctors who received a sanction or warning in relation to one or more incidents at a given NHS trust explained 12% of the variance in mortality across trusts. Although this correlation does not prove causality and many factors drive and contribute to variations in mortality rates and the volume of complaints, this association does merit further investigation and we will be working with other organisations to explore this.

* Summary hospital-level mortality indicator (SHMI) is used as the measure of mortality in this analysis.

† When referring to complaints or sanctions and warnings in this chapter, this has been converted to a ratio to allow comparison between NHS trusts: the number of complaints per consultant working full time. Please see the note on data (pages 91–93) for more information.

The GMC's fitness to practise procedures mean that there is inevitably a gap between the incident or incidents prompting a complaint and the resolution of that complaint. Cases that are fully investigated or go to a public hearing inevitably take longer. This means it is unlikely that sanctions and warnings issued by the GMC could be used as an early warning of mortality issues in acute hospitals, as the death rates will be known before the complaints are resolved.

Nevertheless, the association between mortality rates and professional practice meriting a sanction or warning is worth recognising. For example, high mortality rates at a trust may signal professional practice issues, highlighting that doctors working there might need further support. This may be useful for the GMC's employer liaison service and for responsible officers in the trusts concerned.

Mortality rates are also associated with trainees' perceptions about the care they provide to patients

There is a weak association between higher mortality rates and lower scores for clinical supervision and for quality of care from the GMC's national training survey. However these indicators explained 5% and 7% respectively, of the variance in mortality rates between NHS trusts. This does not demonstrate a causal relationship between the quality of postgraduate training and mortality rates but it does highlight an association that we need to explore further.

Staff perceptions of the quality of healthcare

NHS employees across parts of the UK are invited to take part in the NHS Staff Survey, which is carried out annually in England and less frequently in the other parts of the UK. This year, Wales published the results of its staff survey for the first time in six years⁸⁵ and Northern Ireland⁸⁶ for the first time in three years, and Scotland is, at the time of writing, carrying out its first survey since 2010.⁸⁷

There is now widely an accepted link between staff perception and the quality of care, and that good management of employees leads to higher quality of care, more satisfied patients and lower mortality.⁸⁸ Therefore the data collected through staff surveys are essential in understanding where there might be concerns about healthcare.

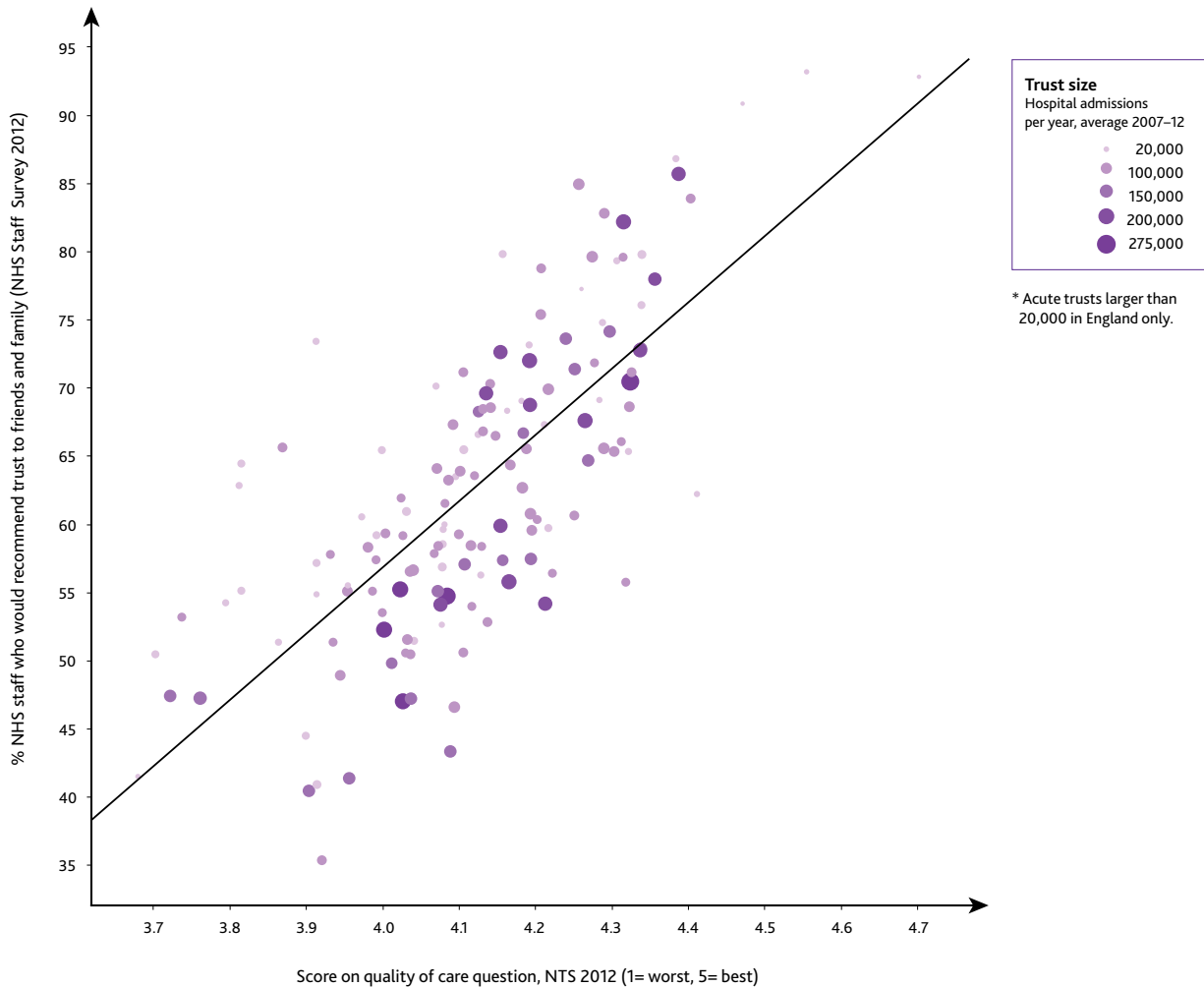
Numbers of complaints about doctors are associated with whether staff would recommend their trust to their family and friends

In the NHS Staff Survey in England, employees are asked: 'Would you recommend this trust to your friends and family?'. Although it has been challenged, the UK Government regards this as a critical question – so much so that all NHS trusts in England now also have to ask this in acute inpatient services and emergency departments.⁸⁹

The 2012 NHS Staff Survey showed that, on average, 63% of staff in England would recommend their hospital to their family and friends.

FIGURE 28: The correlation between doctors’ perception of their training and recommendations to friends and family

Where a trust* scores higher on the national training survey quality of care question, NHS staff are more likely to recommend it to friends and family.



Our analysis found significant correlations between GMC data and the outcome of the friends and family question.

- The lower the number of complaints about doctors, both received and fully investigated, in a given NHS trust, the more positive staff were about recommending the trust. This association was strongest when analysing complaints that met our threshold for a full investigation – this

explained 17% of the variance in scores between trusts on the friends and family question.

- Higher scores for quality of care (figure 28), clinical supervision and overall satisfaction in the GMC’s national training survey were associated with more staff responding positively about recommending their trust. These indicators explained 54%, 25% and 20% respectively, of the variance in scores between trusts on the family and friends question.

Patient experience is associated with complaints and doctors' perceptions of their training

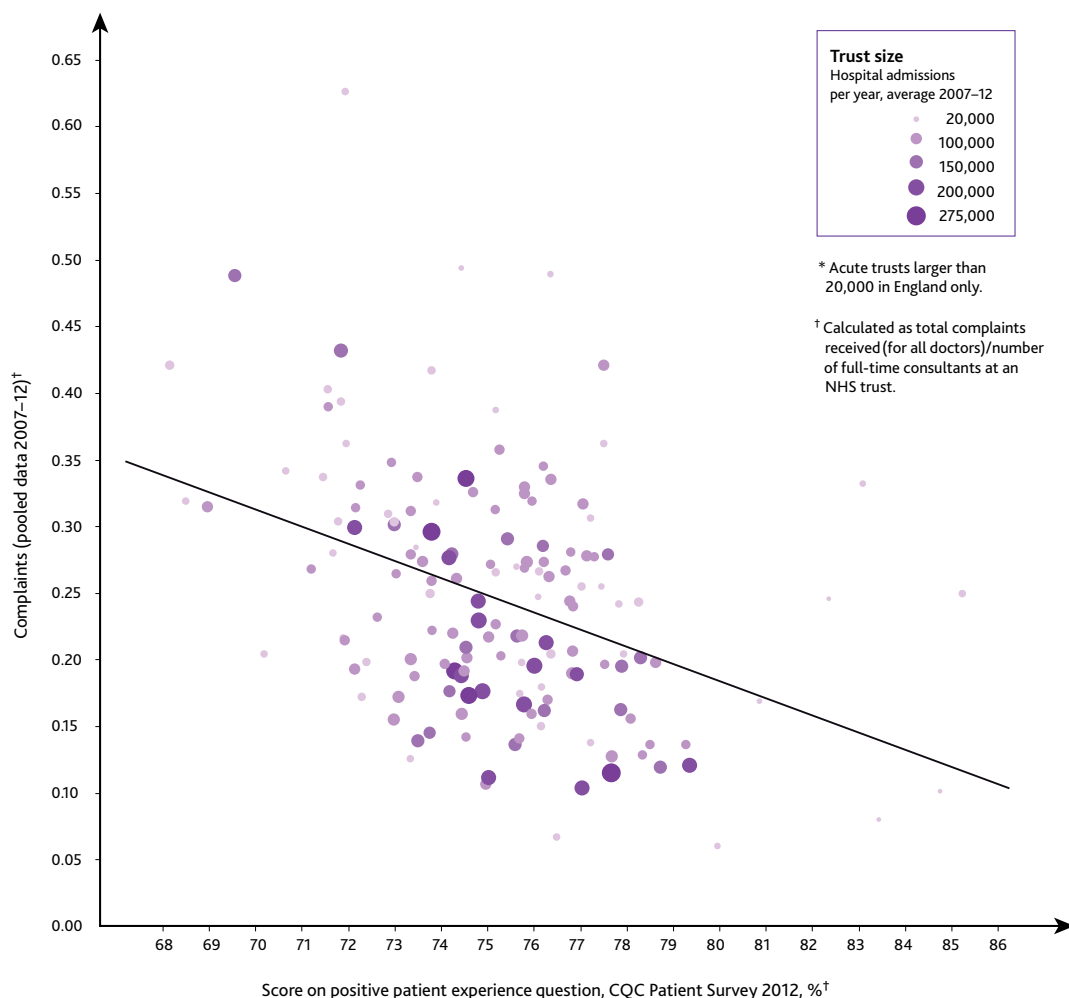
In England, the CQC carries out a survey of patients' experience every year. In 2012, this looked at the experiences of more than 64,500 patients who were admitted to an NHS hospital.²¹

Our analysis using the CQC's inpatient survey had three key findings.

- Lower numbers of complaints were associated with higher patient survey scores in NHS trusts (figure 29). This explained 15% of the variance in patient survey scores between trusts.

FIGURE 29: The correlation between complaints and patient experience

Trusts* scoring higher for patient experience in the CQC Patient Survey tend to receive fewer complaints.



- Trusts with fewer doctors in postgraduate training working beyond their competence had higher scores in the patient survey. This explained 12% of the variance in patient survey scores between trusts.
- Trusts with trainees scoring higher for clinical supervision and quality of care were associated with higher scores in the patient survey. These indicators explained 26% and 43% of the variance respectively.

This analysis has a number of implications.

The correlation between mortality rates and GMC data was for complaints that had resulted in a sanction or warning, whereas the correlation for patient survey scores was for complaints that we had received. Further analysis might be able to explore whether GMC data could play some role in explaining patient and staff survey scores or vice versa.

The relationship with data from the national training survey reaffirms the importance of collecting information on the real-world experiences and perceptions of doctors in training. The Mid Staffordshire inquiry noted that surveys of doctors in training are particularly valuable because they notice things that senior doctors may not.¹

The analysis here suggests that the results could also help other organisations identify concerns in the wider system.

Staff engagement is associated with the number of complaints we investigate

Previous studies have shown that several individual and organisational factors contribute to levels of staff engagement.⁹⁰ High staff engagement is achieved by promoting a healthy and safe working environment, and providing supportive management and leadership. When staff members feel motivated, engaged and able to contribute to improvements at work, the NHS trust has better financial management, patient satisfaction and mortality rates.⁹¹ As a result, measures of staff engagement can help indicate the health of an organisation's culture.⁹⁰

The NHS Staff Survey in England measures levels of staff engagement by asking staff members whether they feel motivated and able to contribute to improvements at work, and whether they would recommend their NHS trust as a place to work or receive treatment.

There is a modest association between lower staff engagement and a higher number of complaints that we fully investigated. This indicator explained 9% of the variance in staff engagement between NHS trusts.

Staff perceptions of the appraisal process are weakly associated with NHS trusts in which high numbers of doctors received a sanction or warning

Regular and well-structured appraisals contribute to higher staff engagement, and are associated with better clinical performance, and lower mortality rates, staff absenteeism and staff turnover.^{88, 90, 91} An effective annual appraisal process is a key component of revalidation.

Appraisals can be a powerful means of ensuring that staff members have clear objectives, are developing their skills, and feel valued, respected and supported by their managers at work.⁹¹ It is, therefore, not surprising that this has positive effects on patient care.

The NHS Staff Survey in England measures the quality and frequency of appraisals by asking staff whether the process was useful in helping them to understand how to do their job, whether clear objectives were set during their appraisal and whether they felt the process was valued by their employer.* According to the survey, there continues to be an improvement in the proportion of staff receiving appraisals, up from 80% in the 2011 survey to 83% in 2012. However, only 36% of staff said these appraisals were well structured.

There is a modest negative association between the number of staff reporting they had a structured appraisal and the number of doctors receiving a sanction or warning. This correlation explained 5% of the variance between NHS trusts. As part of our evaluation of revalidation, we need to understand further the interaction between our fitness to practise and revalidation data.

Lower satisfaction with postgraduate training is associated with more complaints

We have previously shown that in NHS trusts where doctors in training reported below-average satisfaction with the quality of training and their clinical supervision, we received a higher-than-average number of complaints about doctors.⁷⁹

This year, we have confirmed and extended this analysis. As highlighted in appendix 2 to this report, there are several significant associations between the volume of fitness to practise complaints at a particular NHS trust in England and trainees' perceptions about the clinical supervision they receive and their overall satisfaction with the training delivered at that organisation.

* The NHS Staff Survey is not limited to doctors, so the results reported here are for all healthcare professionals in the NHS in England.

Conclusion

Recent inquiries and reports have highlighted the importance of organisations sharing data and intelligence about the quality of care and risks to patient safety.^{1,2,3} The GMC is committed to playing a part in this.

Our exploratory findings demonstrate an association between GMC data and other indicators of the well-being of NHS trusts in England. They make a compelling case for us to do further analysis in this area and to work more closely with system regulators to identify risks to patient safety. We have already committed to working closely with the system regulators and to building on our information-sharing agreements to ensure that we contribute routinely to their work.

This analysis has highlighted that there is still a great deal we do not know about how variations in standards across NHS trusts affect the quality of medical practice and training. Our data were associated with mortality rates as well as staff and patient perceptions, but they were not related to other risks in the system, including readmission rates, staff sickness rates, meticillin-resistant *Staphylococcus aureus* (MRSA) rates, serious untoward incidents, and never events. (A full list of the variables tested and the results of the analysis are in tables 1–4 of appendix 2 to this report.) In short, the relationship between GMC data and other data about quality is complex and needs further investigation, in conjunction with other organisations.

Chapter 4: A note on data

This chapter draws on data collected as part of the GMC's fitness to practise processes and our work in quality assuring medical education and training.

The variation in practice across the UK

We hold three pieces of information connecting a complaint with a location in the UK. These are:

- the incident location
- the complainant's address
- the doctor's registered address.

We do not always hold all three pieces of information for each complaint, depending on how far a complaint progressed; how it was reported; and what type of incident was reported.

To gain a complete picture for four-country data, we used all three pieces of information above to determine the country the complaint was associated with.

For the analysis of English regions, which were based on the former Strategic Health Authority boundaries, we had information only from the incident location field but not the complainant's address or doctor's registered address. This meant that we had less complete information. Therefore, in order to provide a meaningful analysis between the country and regional level, the figures shown in this chapter were factored up to account for the missing data.

Correlation analysis of GMC data with external data on acute trusts in England

The results presented in this chapter are based on exploratory analysis conducted by PA Consulting Group to identify relationships between key GMC datasets and other system-wide datasets.

The analysis was conducted using an ordinary least squares regression model on various subsets of GMC and NHS data to identify any correlations and measure their statistical significance (the p-value) and the strength (the R-squared value).

The analysis was conducted at trust level and was restricted to acute trusts in England. Due to the different structures of healthcare provision in the three devolved countries, we could not conduct one analysis that included all countries.

A small number of trusts with either a very low or a very high number of complaints were excluded from this analysis.

- Trusts with fewer than 20,000 admissions per year (due to the small numbers of complaints and sanctions recorded at these trusts).
- The Mid Staffordshire NHS Foundation Trust (due to the large number of complaints recorded at this trust, in part because of its prominence in the national debate about the quality of healthcare).

The following datasets were used in the analysis.

GMC fitness to practise complaints by NHS acute trust: we pooled six years of data (2007–12) and analysed these at a number of levels, specifically:

- overall number of complaints received
- complaints that met our threshold for a full investigation
- complaints that led to a sanction or warning.

The analysis was based on the total number of complaints recorded at an NHS trust rather than only complaints about individual doctors – if one doctor received two complaints this was recorded as two complaints at a given NHS trust.

GMC national training survey 2012: we used scores from acute trusts on three individual questions and two indicators (which are made up of a number of questions) covering five areas.

- Clinical supervision indicator.
- Overall satisfaction indicator.
- Patient safety concerns: do you have any concerns about patient safety at your trust?

- Working beyond your competence or experience: in this post how often did you feel forced to cope with clinical problems beyond your competence or experience?
 - Possible responses: never, rarely, monthly, weekly or daily, converted to 1–5.
 - Approximate stated number of occasions encountered per annum: 0 for 'never', 1 for 'rarely', 10 for 'monthly', 40 for 'weekly', 100 for 'daily'.
- Quality of patient care: overall, how would you rate the quality of care provided to patients in this post?
 - Possible responses: very good, good, neither good nor poor, poor or very poor, converted to 1–5.
 - Nonlinear scale to reflect the likely level of risk to patient safety: 0 for 'very good', 1 for 'good', 10 for 'neither good nor poor', 40 for 'poor', 100 for 'very poor'.

Wider health sector data

- Summary Hospital-level Mortality Indicator, 2011–12, England.
- Serious untoward incidents, 2008–12, England (Severity code of: 'Death', 'Severe' or 'Moderate').
- 'Never' events – serious, largely preventable patient safety incidents that should not occur, 2010–12, England.
- MRSA case volumes, 2007–12, England.
- Readmission rates, 2007–11, England.
- NHS Staff Survey scores (2011–12) regarding whether the respondent would recommend their workplace to friends and family needing treatment. Two such datasets were sourced and used.
 - The proportion of staff who said they 'agree' or 'strongly agree' with the statement that they would recommend their workplace, 2012 data.
 - The average score for staff responses, converted to a scale from 1 ('strongly disagree') to 5 ('strongly agree').
- A wider set of NHS Staff Survey scores, across a range of topics, covering quality of care, engagement, quality of appraisal process, support from management, training, and others, 2012, England.
- NHS staff sickness days, from the sickness absence report for NHS England, 2010–12.
- Patient satisfaction indicator – NHS England's chosen summary, derived from CQC data, 2010–12, which is sourced from surveying inpatients.
- Hospital Episode Statistics (HES) Inpatient Admission volumes – average admissions across calendar years 2008, 2009 and 2010, England.
- Numbers of full-time equivalent (FTE), from monthly Employment Statistics Report (ESR) data, by provider, used to give volume-corrected versions of other indicators to facilitate the analysis of trusts of different sizes (staffing levels are based on the average ESR reported staff numbers for the calendar years 2011 and 2012).

In order to give a fair and meaningful analysis of variation in the volumes of fitness to practise complaints across NHS trusts of different sizes, these volumes were converted into a ratio: the number of complaints per consultant FTE. This ratio is relatively insensitive to the size of the trust, allowing for valid comparisons of complaint volumes across a range of medium and large trusts (ie with case volumes ranging from 20,000 to over 200,000 admissions per year).

Chapter 5: Addressing the challenges facing medical practice

The medical profession continues to deliver high-quality care across the UK. This is evident in the thousands of positive testimonies from patients and their families, the great strides in innovation and research, where we continue to be a global leader, and the high respect for the UK's medical education and practice around the world.

At the same time, as this report shows, medicine is undergoing substantial change and faces many challenges. In all specialties, doctors are experiencing more demands, the nature of their practice is becoming more complex, and most are working in organisations under greater strain.

Understanding what is happening to the medical profession and the environment in which it has to operate is vital if we are all to identify the

opportunities and risks facing medical practice.

This report provides a perspective on this, although inevitably it is a partial one. It does, however, raise questions for the GMC, as we seek to develop a new model of regulation for doctors, leaders of the medical profession, educators and employers.

How does regulation need to change?

Three overarching themes are discernible. First, this is the age of data and intelligence, which will profoundly change the transparency of the healthcare system, the nature of transactions (above all with patients) and the capacity to understand and rank individual, team and institutional performance.

Second, the standards set for medical practice should be seen as contributing to part of a wider movement that puts safety and quality at the heart of the UK's healthcare system, not as something distinct or separate.

Third, a national debate is developing about how the medical profession is to provide clarity about what is expected of doctors in this changing world. In particular, recent inquiries have highlighted the question of accountability – the fact that too often no one was taking responsibility for the overall care of highly vulnerable patients. The practice of medicine is not merely a technical skill or the prescription of a limited intervention. Doctors must ensure that they are responsible for their patient's complete care and treatment and for the effective functioning of the healthcare organisation in which they are practising.

In the past year, there have been initiatives aimed at tackling accountability – the Mid Staffordshire inquiry called for a single clinician to take responsibility for each patient's hospital care.¹ In Wales, the NHS has also introduced a key worker to coordinate the clinical and non-clinical care of those diagnosed with cancer, in part to ensure that the care provided is holistic and patient centred.⁹² But more still needs to be done to clarify the responsibilities of doctors in this new environment.

What can we and others do to address the challenges raised in this report?

Among the issues in this report, four are worth highlighting for action by the GMC and others.

- The shape of the workforce has changed substantially over the past six years. We and others need to consider how this affects our ability to meet future healthcare demands.
- There is a rising tide of complaints about doctors and other healthcare professionals – the evidence suggests this is a reflection of a changing and more challenging world, not a reduction in standards. But the GMC and others need to understand more about the nature and source of complaints and the contexts in which these complaints arise.
- The risks of being complained about, being investigated by the GMC, or receiving a sanction or warning vary substantially between different groups of doctors. We need to better understand these patterns because they suggest that some doctors may need more support.
- Some of the data held by the GMC can provide insight into wider safety and quality issues. The fact that our data are associated with indicators of variation in the healthcare system, such as mortality rates, underlines how important it is for us to work with other organisations, sharing data and intelligence, to identify risks to patient safety.

The changing shape of the medical workforce

As discussed in chapter 1, the shape of the medical profession continues to change and grow, but not necessarily at the pace required to meet the changing demands for healthcare.

There are clear variations in the size and shape of the medical profession across the UK. Some parts of the UK have traditionally relied more heavily on international medical graduates, and now face the growing demand for healthcare with fewer of these doctors. So far, this decreasing supply has been matched by creating more places in UK medical schools – but the need for an adequate supply of medical graduates remains and we also need to make sure that UK graduates are attracted to the roles that need filling and in locations where there are vacancies.

The number of female doctors is continuing to increase and, in just a few years, there will be more female than male doctors. Although the rapid rise in the proportion of female doctors does now seem to be slowing, based on the profile of students entering medical school, the shape and character of the profession have now changed permanently.

While the work patterns of doctors are difficult to predict, and may well change, it is reasonable to assume that more doctors – both male and female – will choose to work part time in the decades to come. Some caution therefore is needed when predicting an oversupply of doctors. Historically, UK workforce planning has underestimated demand for doctors, training too few – not too many.

The Centre for Workforce Intelligence in England is forecasting an undersupply of GPs and an oversupply of other specialists.^{37,93} But this does not mean that the workforce is keeping up with the pattern of demand in hospitals – far from it. Certain specialties are continuing to struggle with recruiting doctors, including general practice, emergency medicine and psychiatric medicine.

Action

Greater flexibility in training and career paths is urgently required to design a workforce capable of meeting future healthcare needs. But this complex problem cannot be addressed by one organisation alone. Our analysis on the changing shape of the profession offers further insight for us, governments, workforce planners, and educators, who all have a part to play.

The independent Shape of Training review, which is due to publish its findings later this year, is considering these issues in the context of postgraduate training. But, as The King's Fund highlights, most professionals who will be working in the NHS in ten years' time are already working in the NHS.⁹⁴ In this context, we must also focus on retraining and support for current professionals, as well as making sure that tomorrow's doctors have the appropriate skills.

As part of the information required for revalidation, we will acquire a much better understanding of where doctors are working and in which settings. This should provide further insight into the nature and shape of the medical workforce across the UK.

Supporting complainants

As discussed in chapter 2, the rising number of complaints we receive about doctors is part of a wider picture of rising complaints about all healthcare professionals to the NHS, to other regulators and to ombudsmen. Never before has it been so important to understand these complaints and to do everything possible to make sure they are handled effectively and sympathetically. It is vital too to explore the pattern of complaints – we need to understand if there are common themes in who complains, what they complain about and what drives their complaints.

For the complaints received by the GMC, it would clearly be inappropriate for us to fully investigate every one – most could never result in us taking action on a doctor’s registration and are better dealt with locally. Nevertheless, as discussed in chapter 3, we have found that even past complaints that do not meet our threshold for investigation indicate an increased risk of investigation into a doctor’s medical practice in the future. The risk is still small but we need to reflect on this and discuss the implications.

We continue to see increases in complaints from members of the public, including patients and their relatives. We now have a better understanding of what type of complaints they are making and we are undertaking further research into what drives their complaints. The research is looking at a number of factors that might be driving this trend, such as the heightened profile of the GMC and other regulators, better access to information through the internet and social media, and easier ways to complain.

The fact that we are unable to take forward the vast majority of their concerns highlights the challenge that patients still face in navigating through the maze that is the complaints system in healthcare. It would be much simpler if most complainants felt they could have their complaint dealt with locally, and only need to take the matter to the GMC if they were dissatisfied with the outcome of that process.

Along with rising complaints from patients, we have seen a large increase in complaints from employers and doctors. We believe this is due to better clinical governance and to doctors and other healthcare professionals being more willing to raise concerns. As such, where the concerns reflect serious shortcomings in a doctor’s practice, it is something to be welcomed and encouraged. That said, we cannot be complacent and the evidence from the Mid Staffordshire inquiry and from our own confidential helpline suggests that more needs to be done to make sure doctors feel confident about raising concerns.

Action

One of the key lessons for the healthcare system over the past 18 months has been to recognise the importance of listening to patients and their relatives. The complaints system is complex and difficult to navigate and we and others need to do more locally and nationally to make sure that patients have appropriate channels through which to voice their concerns and have them addressed.

We are committed to playing our part in this. We will work with other organisations and the UK Government to simplify the process and direct complainants to where they can receive appropriate help. This year, for the first time, the GMC produced a guide for patients on what to expect from their doctor and this has proved popular among patient groups. We will build on this, working closely with patient and advocacy groups through our regional liaison service in England, and our offices in Northern Ireland, Scotland and Wales.

We also need to manage the increasing number of concerns from employers and doctors. Our employer liaison service has been extremely well received and we will evaluate its impact over the coming year. At the same time, we will continue to raise awareness that every doctor has a professional obligation to raise and act on concerns about patients' safety and welfare, and that organisations need to change their culture to allow doctors to do so.

Variation in the risks of being complained about or receiving a sanction or warning from the GMC

There are clear associations between a doctor's characteristics and area of practice and the chance that they will be complained about, investigated, or receive a sanction or warning from the GMC.

We recognise that the contribution our data can make to understanding risks of poor practice may be limited by the small proportion of doctors who are complained about and by the even smaller proportion who receive a sanction or warning. Furthermore, the circumstances leading to poor practice are complex and likely to involve several different individual and organisational factors.

But the fact remains that some groups of doctors are at greater risk than others and may need more support from us, their employer or their college or faculty. There will always be variations in practice, but we need to identify and, where possible, reduce the future risk of care falling short of what patients expect and deserve.

In chapter 3, we have identified that a doctor's age, gender, and place of primary medical qualification all have a bearing on the likelihood of being complained about, investigated, or receiving a sanction or warning from the GMC. By analysing these characteristics together using data from several years, we can see that there are particular groups that face a significantly higher risk of falling below the standards expected.

Action

Recent and past inquiries into failings in healthcare show that many of the problems are systemic – the result of organisational and process design rather than individuals' failings. The risk of a doctor performing poorly is influenced by the context in which they work – for example, how much pressure they are under, the organisation's expectations, and the amount of support they get from others in the team. But this is only part of the picture.

We and others need to understand better which doctors are at greatest risk of poor performance and in need of additional support, and in which environments they are likely to struggle to deliver high standards of care. This, together with addressing the systemic factors, must form part of the move towards safer healthcare.

Again, this is not just a matter for the GMC. It needs to be part of a wider professional debate and it is important that employers, governments, and other regulators, as well as those who contract with doctors, understand the nature of the risks and take steps to monitor and support practice where risks are higher.

The interaction between professional and system risks

Professional regulation does not exist in a vacuum – a doctor’s ability to provide good medical practice is affected by the working practices and culture of the organisations they work in. However, what we have been less certain about, until this year, is how the data we hold about doctors relate to data about the environments in which they work.

Our findings in chapter 4 are only exploratory, but they do show that our fitness to practise and education data are associated with indicators of the well-being of acute NHS trusts in England. This relationship needs further exploration to see if it can contribute to models of risk in the healthcare sector.

It is clear from this report that there is still much we do not know about how the healthcare system affects the quality of medical practice and training. Our data were associated with a number of indicators of quality at a NHS trust but not with some other risks in the system.

The challenge for the GMC is to move from a focus on investigating complaints, when things have gone wrong, towards making sure that there are systems to support doctors and help them overcome challenges, before such issues become a risk to patient safety.

Action

The Mid Staffordshire inquiry highlighted the importance of organisations working together and sharing data and intelligence about the quality of care. The findings in this year’s report indicate that sharing our data as part of working more closely with others could help identify risks to patient safety.

At the same time, at the GMC we need to understand better the data that we hold and consider the contribution that we can make to identifying and tackling the risks to healthcare services. As we continue to analyse fitness to practise data and the responses to our national training survey, alongside other external data sources, we should be able to identify trends at regional and at trust or board level.

References

- 1 Mid Staffordshire Foundation Trust Public Inquiry (2013) *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry* available at: www.midstaffpublicinquiry.com/report (accessed 28 August 2013)
- 2 Department of Health (2013) *A promise to learn – a commitment to act* available at: www.gov.uk/government/uploads/system/uploads/attachment_data/file/226703/Berwick_Report.pdf (accessed 28 August 2013)
- 3 NHS England (2013) *Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report* available at: www.nhs.uk/NHSEngland/bruce-keogh-review/Documents/outcomes/keogh-review-final-report.pdf (accessed 28 August 2013)
- 4 Davis J, Tallis R (2013) *NHS SOS: How the NHS was betrayed and how we can save it* London, Oneworld Publications
- 5 Maynard A, Bloor K (2010) Will financial incentives and penalties improve hospital care? *BMJ* 340: c88
- 6 The King's Fund (2012) *Medical engagement: Too important to be left to chance* available at: www.kingsfund.org.uk/sites/files/kf/medical-engagement-nhs-john-clark-leadership-review2012-paper.pdf (accessed 28 August 2013)
- 7 General Medical Council (2013) *GMC statement: Mid Staffordshire Public Inquiry* available at: www.gmc-uk.org/news/14380.asp (accessed 28 August 2013)
- 8 BBC News (11 July 2013) NHS 'heading for £30bn funding gap' *BBC News* available at: www.bbc.co.uk/news/health-23258962 (accessed 28 August 2013)
- 9 Health Select Committee (2013) *Urgent and emergency services* London, The Stationery Office
- 10 The NHS Confederation (2013) *Changing care, improving quality* available at: www.nhsconfed.org/NationalAndInternational/Wales/news/Documents/Changing-care-improving-quality.pdf (accessed 28 August 2013)
- 11 *The Vale of Leven Hospital Inquiry* (2013) available at: www.valeoflevenhospitalinquiry.org (accessed 28 August 2013)
- 12 NatCen Social Research (2013) *British Social Attitudes 30 (2012)* London, NatCen Social Research
- 13 Office of National Statistics (2012) *2011 Census, Population and Household Estimates for the United Kingdom* available at: www.ons.gov.uk/ons/rel/census/2011-census/population-and-household-estimates-for-the-united-kingdom/index.html (accessed 28 August 2013)
- 14 Parliamentary and Health Service Ombudsman (2011) *Care and Compassion? Report of the Health Service Ombudsman on ten investigations into NHS care of older people 2011* available at: www.ombudsman.org.uk/care-and-compassion/introduction (accessed 28 August 2013)
- 15 Hospital Episode Statistics (2012) *HESonline. Summary report, 2011–12* available at: www.hscic.gov.uk/hes (accessed 28 August 2013)
- 16 Dr Foster Health (2012) *Dr Foster hospital guide 2012. Is your hospital fit for the future?* available at: drfosterintelligence.co.uk/wp-content/uploads/2013/02/Hospital_Guide_2012.pdf (accessed 28 August 2013)
- 17 King's Fund (2012) *The care of frail older people with complex needs: time for a revolution* available at: www.kingsfund.org.uk/publications/care-frail-older-people-complex-needs-time-revolution (accessed 28 August 2013)

- 18 Centre for Workforce Intelligence (2011) *Integrated care for older people: Examining workforce and implementation challenges* available at: www.cfwi.org.uk/publications/integrated-care-for-older-people (accessed 28 August 2013)
- 19 Royal College of Physicians (2010) *Future physician: changing doctors in changing times* RCP, London
- 20 NHS Choices (2013) *Your choices: consultant choice* available at: www.nhs.uk/choiceintheNHS/Yourchoices/consultant-choice/Pages/consultant-data.aspx (accessed 28 August 2013)
- 21 Care Quality Commission (2012) *Inpatient survey 2012* available at: www.cqc.org.uk/public/reports-surveys-and-reviews/surveys/inpatient-survey-2012 (accessed 28 August 2013)
- 22 The Scottish Government (2012) *Scottish Inpatient Patient Experience Survey 2012* available at: www.scotland.gov.uk/Publications/2012/08/8317 (accessed 28 August 2013)
- 23 The Department of Health, Social Services and Public Safety (2011) *The GP Patient Survey in Northern Ireland 2010/11 Summary Report* available at: www.dhsspsni.gov.uk/2010-11_gpps_in_northern_ireland_national_summary_report.pdf (accessed 28 August 2013)
- 24 Royal College of Physicians (2013) *Hospital workforce: fit for the future?* London, RCP
- 25 General Medical Council, Ipsos Mori (2011) *The impact of the implementation of the European Working Time Directive (EWTD)* available at: www.gmc-uk.org/The_impact_of_the_implementation_of_the_European_Working_Time_Directive_EWTD_42536543.pdf (accessed 28 August 2013)
- 26 General Medical Council (2013) *GMC national training survey 2013: key findings* available at: www.gmc-uk.org/National_training_survey_key_findings_report_2013.pdf_52299037.pdf (accessed 28 August 2013)
- 27 NHS Revalidation Support Team (2012) *Organisational Readiness Self-Assessment (ORSA) Report: A report on implementation indicators for revalidation in England as at 31 March 2012* London, Department of Health
- 28 General Medical Council (2012) *National training survey 2012: key findings* available at: www.gmc-uk.org/National_training_survey_2012_key_findings_report.pdf_49280407.pdf (accessed 28 August 2013)
- 29 NHS England (2012) *The NHS Commissioning Board's role in maintaining quality* available at: www.england.nhs.uk/wp-content/uploads/2012/11/board-7-main-qual.pdf (accessed 28 August 2013)
- 30 Department of Health (2004) *Medical Schools: delivering the doctors of the future* available at: www.nhshistory.net/tomorrowsdocs.pdf (accessed 19 August 2013)
- 31 Goldacre M, Davidson J, Lambert T (2010) *The junior doctor exodus* available at: careers.bmj.com/careers/advice/view-article.html?id=20001543 (accessed 19 August 2013)
- 32 Goldacre M, Davidson J, Lambert T (2009) Retention in the British National Health Service of medical graduates trained in Britain *BMJ* 338 b1977
- 33 NHS Medical Careers (2013) *SAS doctors: specialty doctors* available at: www.medicalcareers.nhs.uk/postgraduate_doctors/specialty_doctors.aspx (accessed 19 August 2013)
- 34 Office for National Statistics (2012) *Population by Country of Birth and Nationality Report* available at: www.ons.gov.uk/ons/dcp171776_277619.pdf (accessed 19 August 2013)

- 35 Snow S, Jones E (2011) *Immigration and the National Health Service: putting history to the forefront* available at: www.historyandpolicy.org/papers/policy-paper-118.html (accessed 24 July 2013)
- 36 Medical Board of Australia (2013) *Limited registration: area of need* available at: www.medicalboard.gov.au/Registration/Types/Limited-Registration/Area-of-Need.aspx (accessed 19 August 2013)
- 37 Centre for Workforce Intelligence (2013) *GP in-depth review: Preliminary findings* London, CfWI
- 38 Statistics for Wales (2013) *General Medical Practitioners in Wales 2002–2012* available at: www.wales.gov.uk/docs/statistics/2013/130321-general-medical-practitioners-2002-2012-en.pdf (accessed 19 August 2013)
- 39 HSC Business Services Organisation GPs by Gender (From 1985) available at: [www.hscbusiness.hscni.net/pdf/MEDICAL-GPs_by_Gender\(From_1985\).xls](http://www.hscbusiness.hscni.net/pdf/MEDICAL-GPs_by_Gender(From_1985).xls) (accessed 19 August 2013)
- 40 ISD Scotland Number (headcount of GPs in post, by gender and age group 2004–2012) available at: www.isdscotland.org/Health-Topics/General-Practice/GPs-and-Other-Practice-Workforce/A1_ALLGPS_DES_SEX_OCT04_SEP12.xls (accessed 19 August 2013)
- 41 Royal College of Physicians (2012) *Hospitals on the edge? The time for action* London, RCP
- 42 Taylor K, Lambert T, Goldacre M (2009) Career progression and destinations, comparing men and women in the NHS *BMJ* 338: b1735
- 43 Medical Workforce Standing Advisory Committee (1997) *Planning the medical workforce: third report of the Medical Workforce Standing Advisory Committee* available at: www.nhshistory.net/mwfsac3.pdf (accessed 19 August 2013)
- 44 UK Foundation Programme (2013) *FP/AFP 2014 Applicant's Handbook* available at: www.foundationprogramme.nhs.uk/download.asp?file=FPAFP_2014_Applicants_Handbook_FINAL.pdf (accessed 19 August 2013)
- 45 General Medical Council (2013) *Medical education's front line: A review of training in seven emergency medicine departments* London, GMC
- 46 College of Emergency Medicine (2012) *Response to Royal College of Physicians report – hospitals on the edge* available at: <http://secure.collemergencymed.ac.uk/Public/Latest%20News/CEM%20Statements/default.asp> (accessed 19 August 2013)
- 47 White C (2012) *Emergency in emergency medicine* available at: www.careers.bmj.com/careers/advice/view-article.html?id=20010042 (accessed 19 August 2013)
- 48 NHS Information Centre (2012) *Accident and Emergency Attendances in England (experimental statistics) 2011/12* Leeds, NHS Information Centre for Health and Social Care
- 49 College of Emergency Medicine (2012) *Emergency Medicine Taskforce Interim Report* available at <http://secure.collemergencymed.ac.uk/code/document.asp?ID=6723> (accessed 19 August 2013)
- 50 Modernising Medical Careers (2013) *NHS Specialty Training Competition ratios in 2012* available at: www.mmc.nhs.uk/specialty_training_landing_pag/specialty_training_in_sem.aspx (accessed 9 August 2013)
- 51 Parliamentary and Health Service Ombudsman (2013) *The Ombudsman's Annual Report and Accounts 2012–13: Aiming for impact* available at: www.ombudsman.org.uk/__data/assets/pdf_file/0011/21611/FINAL_PHSO_Annual_Report_2012-13-28low-res29.pdf (accessed 21 August 2013)
- 52 Northern Ireland Ombudsman (2013) *Annual Report of the Assembly Ombudsman for Northern Ireland and the Northern Ireland Commissioner for Complaints 2012–2013* Belfast, Northern Ireland Ombudsman

- 53 Scottish Public Services Ombudsman (2013) *Annual report 2012–2013* available at: www.spsso.org.uk/files/webfm/Media%20Centre/SPSO_Annual_Report_2012-13.pdf (accessed 21 August 2013)
- 54 Public Services Ombudsman for Wales (2013) *Annual report 2012–2013* available at: www.ombudsman-wales.org.uk/~media/Files/AnnualReports_en/Annual%20Report%202012-13-%20Final%20for%20laying%20and%20website%20-%20English.ashx (accessed 21 August 2013)
- 55 Archer J, Regan de Bere S, Bryce M, et. al. (forthcoming) *Understanding the rise in fitness to practise complaints from members of the public*
- 56 GfK NOP Social Research (2011) *Research into Fitness to Practise referrals* available at: www.gmc-uk.org/Research_into_Fitness_to_Practise_referrals___2011.pdf_44498587.pdf (accessed 21 August 2013)
- 57 Health Select Committee (2011) *Sixth report: complaints and litigation* available at: www.publications.parliament.uk/pa/cm201012/cmselect/cmhealth/786/78602.htm (accessed 21 August 2013)
- 58 Parliamentary and Health Service Ombudsman (2013) *The NHS hospital complaints system: a case for urgent treatment?* London, Parliamentary and Health Service Ombudsman
- 59 Department of Health (2013) *Patients First and Foremost: The initial government response to the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*, London, Department of Health
- 60 Parliamentary and Health Service Ombudsman (2012) *Customer Satisfaction Research: Summary of results June 2012–October 2012* available at: www.ombudsman.org.uk/__data/assets/pdf_file/0010/19585/Customer-Satisfaction-Report-June-Oct-2012.pdf (accessed 21 August 2013)
- 61 General Medical Council (2013) *Raising and acting on concerns about patient safety* London, GMC
- 62 Eadie A (2012) Medical error reporting should it be mandatory in Scotland? *J Forensic Leg Med* 19(7):437–41
- 63 The Lancet (2011) Blowing the whistle on intimidation of NHS whistleblowers *Lancet* 378(9790):458
- 64 Kendall K, Wiles R (2010) Resisting blame and managing emotion in general practice: The case of patient suicide *Soc Sci Med* 70(11): 1714–20
- 65 Public Concern at Work and the University of Greenwich (2013) *Whistleblowing: the inside story. A study of the experiences of 1,000 whistleblowers* available at: www.pcaw.org.uk/files/Whistleblowing%20-%20the%20inside%20story%20FINAL.pdf (accessed 21 August 2013)
- 66 The Shipman Inquiry (2004) Fifth report *Safeguarding Patients: Lessons from the Past – Proposals for the Future* available at: www.archive2.official-documents.co.uk/document/cm63/6394/pdf/s5cov.pdf (accessed 21 August 2013)
- 67 The King's Fund (2012) *Preparing for the Francis report: how to assure quality in the NHS* available at: www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/preparing-for-the-francis-report-jul2012.pdf (accessed 21 August 2013)
- 68 Bismark M, Spittal M, Gurrin L, Ward M, Studdert D (2013) Identification of doctors at risk of recurrent complaints: a national study of healthcare complaints in Australia *BMJ Quality and Safety* 22: 532–40
- 69 Papadakis M, Arnold G, Blank L, Holmboe E, Lipner R (2008) Performance during internal medicine residency training and subsequent disciplinary action by state licensing boards *Ann Intern Med* 148: 869–76

- 70 The NHS Information Centre (2009) *Trends in Consultation Rates in General Practice 1995/1996 to 2008/2009: Analysis of the QResearch database* available at: <https://catalogue.ic.nhs.uk/publications/primary-care/general-practice/tren-cons-rate-gene-prac-95-09/tren-cons-rate-gene-prac-95-09-95-08-rep.pdf> (accessed 3 September 2013)
- 71 NHS Information Centre for Health and Social Care (2012) *Data on Written Complaints in the NHS 2011–2012* available at: <https://catalogue.ic.nhs.uk/publications/patient/complaints/data-writ-comp-nhs-2011-2012/data-writ-comp-nhs-2011-2012-rep.pdf> (accessed 3 September 2013)
- 72 ISD Scotland (2012) *NHS Complaints Statistics* available at: www.isdscotland.org/Health-Topics/Quality-Indicators/Publications/2012-09-25/2012-09-25-Complaints-Report.pdf (accessed 3 September 2013)
- 73 ISD Scotland (2012) *NHS Complaints Statistics: Hospital and Community Health Services Complaints* available at: www.isdscotland.org/Health-Topics/Quality-Improvement/Publications/2012-09-25/Issues-by-staff-Scotland-2011-12-FINAL.xls (accessed 3 September 2013)
- 74 Northern Ireland Statistics and Research Agency and Department of Health, Social Services and Public Safety (2013) *Complaints received by HSC Trusts, NSC Board and Family Practitioner Services in Northern Ireland 2012–2013* available at: www.dhsspsni.gov.uk/complaints__2012-13_v2.pdf (accessed 22 August 2013)
- 75 Parliamentary and Health Service Ombudsman (2012) *Listening and Learning: The Ombudsman's review of complaint handling by the NHS in England 2011–2012* London, Parliamentary and Health Service Ombudsman
- 76 Solicitors Regulation Authority (2009) *Research into Issues of Disproportionality – Initial Interim Report* London, Pearn Kandola
- 77 Elkin K, Spittal M, Studdert D (2012) Risks of complaints and adverse disciplinary findings against international medical graduates in Victoria and Western Australia *Med J Aust* 197:448–52
- 78 Humphrey C, Hickman S, Guildford MC (2011) Place of medical qualification and outcomes of UK General Medical Council “fitness to practise” process: cohort study *BMJ* 342:1817
- 79 General Medical Council (2012) *State of Medical Education and Practice 2012* London, GMC
- 80 National Audit Office (2012) *Healthcare across the UK: A comparison of the NHS in England, Scotland, Wales and Northern Ireland* London, NAO
- 81 The Nuffield Trust (2010) *Funding and performance of healthcare systems in the four countries of the UK before and after devolution* London, Nuffield Trust
- 82 The Welsh Government (2013) *Hospital mortality data* available at: www.wales.gov.uk/topics/health/publications/health/reports/mortality/?jsessionid=F9894CCFD7F0F9EA43CA3A4AD75A0F64?lang=en (accessed 22 August 2013)
- 83 Oral Statement to Parliament (2013) *Oral Statement – Sir Bruce Keogh review* available at: www.gov.uk/government/speeches/oral-statement-sir-bruce-keogh-review (accessed 22 August 2013)
- 84 Care Quality Commission (2012) *State of Care report 2011/2012* London, CQC
- 85 BMG Research (2013) *NHS Wales Staff Survey 2013 – national overview* available at: www.wales.nhs.uk/nhswalesstaffsurveyresultspublished (accessed 22 August 2013)

- 86 Department of Health, Social Services and Public Safety (2012) *Health and Social Care Staff Survey September – October 2012* available at: [www2.hscni.net/HSC_Staff_Survey_2012/HSC%20Staff%20Survey%20Report%202012%20%20%20PDF%20Version%20of%20Final%20Overall%20Report%20\(Amended\)%20and%20Shortened%20Version.PDF](http://www2.hscni.net/HSC_Staff_Survey_2012/HSC%20Staff%20Survey%20Report%202012%20%20%20PDF%20Version%20of%20Final%20Overall%20Report%20(Amended)%20and%20Shortened%20Version.PDF) (accessed 22 August 2013)
- 87 NHS Scotland (2010) *NHS Scotland Staff Survey* available at: www.staffgovernance.scot.nhs.uk/monitoringemployee-experience/staff-survey/ (accessed 22 August 2013)
- 88 West M, Dawson J, Admasachew L, Topakas A (2011) *NHS Staff Management and Health Service Quality: Results from the NHS Staff Survey and related data* available at: www.gov.uk/government/uploads/system/uploads/attachment_data/file/215455/dh_129656.pdf (accessed 21 August 2013)
- 89 Department of Health (2012) *'Friends and family' test aims to improve patient care and identify best performing hospitals* available at: www.gov.uk/government/news/friends-and-family-test-aims-to-improve-patient-care-and-identify-best-performing-hospitals (accessed 22 August 2013)
- 90 West M, Dawson J (2012) *Employee engagement and NHS performance* available at: www.kingsfund.org.uk/sites/files/kf/employee-engagement-nhs-performance-west-dawson-leadership-review2012-paper.pdf (accessed 21 August 2013)
- 91 The King's Fund (2012) *Leadership and engagement for improvement in the NHS* London, The King's Fund
- 92 The Welsh Government (2012) *Together for Health – Cancer Delivery Plan* available at: www.wales.gov.uk/docs/dhss/publications/120613cancerplanen.pdf (accessed 28 August 2013)
- 93 Centre for Workforce Intelligence (2011) *Shape of the medical workforce: Informing medical training numbers* London, CfWI
- 94 The King's Fund (2013) *NHS and social care workforce: meeting our needs now and in the future?* London, The King's Fund

Appendix 1: Chapter 1

TABLE 1: Demographic characteristics of doctors on the Specialist Register in 2012*

	<30 years (n=8)	30–50 years (n=45,304)	>50 years (n=28,169)	Total (n=73,481)
GENDER				
Male	4 (50%)	28,984 (64%)	21,817 (77%)	50,805 (69%)
Female	4 (50%)	16,320 (36%)	6,352 (23%)	22,676 (31%)
PRIMARY MEDICAL QUALIFICATION				
UK graduate	2 (25%)	26,543 (59%)	18,035 (64%)	44,580 (61%)
EEA graduate	6 (75%)	8,034 (18%)	3,206 (11%)	11,246 (15%)
International medical graduate	0 (0%)	10,727 (24%)	6,928 (25%)	17,655 (24%)
ETHNICITY				
White	8 (100%)	25,667 (57%)	17,504 (62%)	43,179 (59%)
BME	0 (0%)	12,631 (28%)	5,549 (20%)	18,180 (25%)
Unknown	0 (0%)	7,006 (15%)	5,116 (18%)	12,122 (16%)

* 1,382 doctors who were on both the GP and Specialist Registers are excluded from the count.

TABLE 2: Demographic characteristics of doctors on the GP Register in 2012*

	<30 years (n=955)	30–50 years (n=36,692)	>50 years (n=23,415)	Total (n=61,062)
GENDER				
Male	326 (34%)	15,739 (43%)	15,725 (67%)	31,790 (52%)
Female	629 (66%)	20,953 (57%)	7,690 (33%)	29,272 (48%)
PRIMARY MEDICAL QUALIFICATION				
UK graduate	950 (99%)	28,858 (79%)	17,448 (75%)	47,256 (77%)
EEA graduate	4 (0%)	2,296 (6%)	1,355 (6%)	3,655 (6%)
International medical graduate	1 (0%)	5,538 (15%)	4,612 (20%)	10,151 (17%)
ETHNICITY				
White	434 (45%)	19,203 (52%)	13,983 (60%)	33,620 (55%)
BME	144 (15%)	8,036 (22%)	4,128 (18%)	12,308 (20%)
Unknown	377 (39%)	9,453 (26%)	5,304 (23%)	15,134 (25%)

* 1,382 doctors who were on both the GP and Specialist Registers are excluded from the count.

TABLE 3: Demographic characteristics of other doctors on the register in 2012*

	<30 years (n=7,050)	30–50 years (n=34,911)	>50 years (n=15,132)	Total (n=57,093)
GENDER				
Male	2,989 (42%)	20,430 (59%)	10,494 (69%)	33,913 (59%)
Female	4,061 (58%)	14,481 (41%)	4,638 (31%)	23,180 (41%)
PRIMARY MEDICAL QUALIFICATION				
UK graduate	4,581 (65%)	8,745 (25%)	5,866 (39%)	19,192 (34%)
EEA graduate	1,262 (18%)	5,679 (16%)	1,285 (8%)	8,226 (14%)
International medical graduate	1,207 (17%)	20,487 (59%)	7,981 (53%)	29,675 (52%)
ETHNICITY				
White	2,869 (41%)	10,014 (29%)	4,843 (32%)	17,726 (31%)
BME	2,042 (29%)	13,878 (40%)	4,412 (29%)	20,332 (36%)
Unknown	2,139 (30%)	11,019 (32%)	5,877 (39%)	19,035 (33%)

* Other doctors who were not in approved postgraduate training programmes or on the GP or Specialist Register.

Appendix 2: Chapter 4

TABLE 1: Correlations between fitness to practise data and wider health sector datasets

adm = admissions
FTE = Full-time equivalent
Eng = England

Non-GMC variable	Measure	GMC fitness to practise data		
		All complaints	Investigated complaints	Sanctions or warnings
Summary hospital level mortality indicator	R-squared	0.02	0.07	0.12
	p-value	0.083	0.00105	<0.0001
Serious and untoward incidents per 1,000 adm	R-squared	0.00	0.00	0.03
	p-value	0.463	0.768	0.031
'Never' events per 1,000 adm	R-squared	0.00	0.00	0.00
	p-value	0.565	0.422	0.650
MRSA cases per 1,000 adm	R-squared	0.01	0.00	0.01
	p-value	0.205	0.605	0.174
Staff sickness days per staff FTE	R-squared	0.00	0.04	0.03
	p-value	0.548	0.018	0.036
NHS Staff Survey (Eng): family/friends % positive	R-squared	0.12	0.14	0.05
	p-value	0.0001	<0.0001	0.008
NHS Staff Survey (Eng): family/friends average	R-squared	0.15	0.17	0.07
	p-value	<0.0001	<0.0001	0.00145
CQC Patient Survey: positive patient experience	R-squared	0.15	0.09	0.00
	p-value	<0.0001	0.00013	0.790

TABLE 2: Correlations between fitness to practise data and NHS Staff Survey 2012 key findings (KF)

NHS Staff Survey 2012	Measure	All complaints	Investigated complaints	Sanctions or warnings
% feeling satisfied with the quality of care they can provide (KF #1)	R-squared	0.00	0.02	0.03
	p-value	0.504	0.099	0.033
% agreeing that their role makes a difference to patients (KF #2)	R-squared	0.01	0.04	0.07
	p-value	0.199	0.015	0.00122
Work pressure felt by staff (KF #3)	R-squared	0.04	0.06	0.02
	p-value	0.011	0.002	0.064
Effective team working (KF #4)	R-squared	0.03	0.02	0.00
	p-value	0.032	0.065	0.726
% working extra hours (KF #5)	R-squared	0.00	0.01	0.00
	p-value	0.981	0.318	0.968
% of staff receiving job-relevant training, learning or development (KF #6)	R-squared	0.02	0.01	0.00
	p-value	0.071	0.182	0.609
% appraised in last 12 months (KF #7)	R-squared	0.00	0.00	0.00
	p-value	0.787	0.649	0.609
% having well-structured appraisal (KF #8)	R-squared	0.01	0.04	0.05
	p-value	0.281	0.024	0.008
Support from immediate managers (KF #9)	R-squared	0.01	0.02	0.01
	p-value	0.168	0.133	0.226
Engagement (blend of KF #23, #24 and #25)	R-squared	0.06	0.09	0.05
	p-value	0.003	0.0003	0.0096

TABLE 3: Correlations between national training survey scores and wider health sector datasets

Non-GMC variable	Measure	GMC national training survey 2012				
		Clinical supervision	Overall satisfaction	Patient safety concerns	Beyond competence or experience	Quality of care
Summary hospital level mortality indicator	R-squared	0.05	0.03	0.01	0.04	0.09
	p-value	0.009	0.043	0.483	0.016	0.00124
Serious and untoward incidents per 1,000 adm	R-squared	0.00	0.00	0.04	0.00	0.00
	p-value	0.834	0.651	0.174	0.796	0.670
'Never' events per 1,000 adm	R-squared	0.02	0.06	0.00	0.02	0.03
	p-value	0.114	0.005	0.899	0.087	0.040
MRSA cases per 1,000 adm	R-squared	0.01	0.02	0.00	0.00	0.04
	p-value	0.326	0.114	0.957	0.864	0.020
Staff sickness days per staff FTE	R-squared	0.01	0.00	0.07	0.00	0.07
	p-value	0.207	0.479	0.069	0.664	0.001
NHS Staff Survey (Eng): family/friends % positive	R-squared	0.19	0.14	0.00	0.09	0.44
	p-value	< 0.0001	< 0.0001	0.730	0.00017	< 0.0001
NHS Staff Survey (Eng): family/friends average	R-squared	0.25	0.20	0.00	0.11	0.54
	p-value	< 0.0001	< 0.0001	0.944	< 0.0001	< 0.0001
CQC Patient Survey: positive patient experience	R-squared	0.26	0.22	0.01	0.12	0.43
	p-value	< 0.0001	< 0.0001	0.458	< 0.0001	< 0.0001

TABLE 4: Correlations between fitness to practise data and national training survey data

National training survey data 2012 (with question code)	Measure	GMC fitness to practise data		
		All complaints	Investigated complaints	Sanctions or warnings
Clinical supervision indicator	R-squared	0.12	0.14	0.09
	p-value	<0.0001	<0.0001	0.00039
Overall satisfaction indicator	R-squared	0.09	0.08	0.04
	p-value	0.00023	0.00043	0.026
Patient safety concerns question (CLSGQ53)	R-squared	0.10	0.04	0.01
	p-value	0.040	0.1444	0.570
Working beyond competence or experience question (GENHQ39)	R-squared	0.04	0.05	0.03
	p-value	0.012	0.008	0.029
Working beyond competence or experience (with change of units)*	R-squared	0.11	0.13	0.08
	p-value	<0.0001	<0.0001	0.00057
Quality of care question (GENHQ24)	R-squared	0.16	0.17	0.05
	p-value	<0.0001	<0.0001	0.009
Quality of care question (with change of units)*	R-squared	0.13	0.13	0.03
	p-value	<0.0001	<0.0001	0.040

* Please see note on data (pages 92–93) for explanation of how the units were changed.

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Miriam Quick
Jacqui Thornton
Sarah Seager

Email: gmc@gmc-uk.org
Website: www.gmc-uk.org
Telephone: **0161 923 6602**

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