The publication of fitness to practise data by secondary care location in the UK: guide to the data

For terminology used in the data and in the memo please see Annex A.

**Our Role**

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

2. When we receive a complaint, where possible we record where the incident that led to the complaint took place. A complaint is assigned to a particular board or trust on the basis of an incident occurring there. This will not always be the organisation which currently employs the doctor or the doctor’s prescribed connection for the purposes of revalidation.

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

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

   - The data does not take account of the size of the healthcare provider, the number of doctors working there, or the different services they provide. This means that a provider might have a particularly high or low number of complaints simply reflecting its size or type of cases they receive.
- Higher numbers of complaints could be due to a range of factors unrelated to the standards of medical practice in a location. These include: the effectiveness of the local clinical governance systems; better systems for handling complaints; or a culture where reporting concerns is particularly encouraged.

- The data show both the number of complaints and the number of doctors complained about. One doctor may have more than one complaint made about him or her.

### Reviewing the data

5. The data covers complaints received and assessed by the GMC between 1 January and 31 December of each year, 2007-12.

6. It does not track a single cohort of complaints because cases opened in any given year will not necessarily reach an outcome in the same year. This has the following implications:

   - The number of complaints recorded as investigated on the left hand side of the table will not equal the number of outcomes from an investigation in the middle of the table. A complaint can often take many months to investigate because of the complex issues raised.

   - The number of complaints recorded as ‘referred to panel’ in the middle of the table will not equal the number of outcomes from a panel on the right hand side of the table. Case examiners might refer the case to a panel in one year but it takes a number of months for a panel to commence and make a determination.

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

### How accurate is the data

8. Not all complaints have an incident location either because:

   - the complaint made to us is not detailed enough to identify the location
   - the complaint is about a criminal/conduct/probity offence committed by a doctor who was not in work at the time
   - the incident occurred outside the UK
   - it concerns a doctor writing reports in a private capacity.

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

### Scope of the data

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

11. Private organisations are also included in the data although they might be delivering care in a variety of primary and secondary care settings.

Why are we publishing this data?

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

Learning more

13. Our website has a wealth of information on how we deal with concerns about doctors. Our publication series: the State of Medical Education and Practice looks at the data we hold to inform the debate about healthcare in the UK. Our last report published in September 2013 focuses on complaints to the GMC.
Annex A - fitness to practise terminology

Complaints about a doctor

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

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

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

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

Investigation outcome

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

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

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

Issue a warning: The doctor receives a warning if their behaviour or performance shows a significant departure from the principles set out in our guidance for doctors – Good medical practice – but a restriction on the doctor’s registration is not necessary.

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

Refer to panel: the case examiners determine that the case is serious enough to be referred to a fitness to practise panel of the MPTS.
Panel outcome

A Medical Practitioner Tribunal Service (MPTS) panel hears the cases against doctors and decides whether the facts are proven and, if so, whether the doctor’s fitness to practise is impaired, and decides what, if any, sanctions are appropriate.

The panel can do one of the following:

**Take no further action:** the panel decides that the doctor’s fitness to practise is not impaired.

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

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

**Set Conditions:** conditions are put on the doctor’s registration which in some way places requirements on their practice.

**Suspend the doctor:** a doctor is suspended from the register for a period of 3, 6 or 12 months.

**Erase the doctor:** a doctor is removed from the medical register.
Question and Answer

Why only data on complaints about secondary care locations?

Overwhelmingly we are asked to share data about complaints by secondary care location so we have prioritised this work. We are committed to sharing more of our data and we are examining how we can publish data about other locations doctors work in.

Why only publish the data without analysis?

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

Why not publish data at the level of the site?

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

Why only data from 2007?

We only began recording an incident location in 2011. However, we retrospectively completed this for all enquiries received from 1 January 2007.

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

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

Closures: We will continue to record, by the closed organisation, complaints made about doctors which are made after that organisation has closed. We will continue to record complaints made about doctors which are made after a trust or board is closed by closed body. With the passage of time, these complaints will decrease.

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

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

A complaint is assigned to a particular trust/board on the basis of an incident location. This might not necessarily be the organisation which currently employs the doctor but is simply the recorded location where the incident took place. Some doctors will no longer be registered to practice in the UK and in some cases the GMC will have removed them from the list of registered medical practitioners because an MPTS panel has decided they should not be working as doctors any more.