1. **Title of Paper**

   Board Update – The State of Medical Education and Practice 2016

2. **Author(s) of Paper**

   Professor D Stewart Irvine, Medical Director & Deputy Chief Executive

3. **Purpose of Paper**

   To provide the Board with an update on the GMC report for 2016 – the state of medical education and practice, and to make the Board aware of the significant issues that the GMC has drawn attention to in publishing this report.

4. **Key Issues**

   The GMC published their 2016 SoMEP report on 27th October 2016, As with previous reports, this report covered a wide range of topics, and presented a detailed analysis of data held by the regulator.

   This year, however, the report raised concerns that a ‘state of unease’ exists within the medical profession as services throughout the UK come under increased pressure. The medical regulator warned that systems of healthcare and the health professionals working within them are struggling to cope with a range of issues – including the impact of health services under pressure and fragile social care services.

   The report makes clear that the GMC takes the view that it has a role to play in addressing the ‘state of unease’ – by making regulation as ‘light touch as possible’, reassuring trainees that they are valued doctors, and addressing the anger and frustration which has built up during the ongoing dispute in England between the BMA's Junior Doctors' Committee and the Government.

5. **Educational Implications**

   The GMC says it also wants to play more of a role supporting those engaged in **workforce planning** – to make sure doctors have the right knowledge, skills and standard of behaviour to serve patient needs in the years ahead, and has drawn attention to the need for action by employers, to the need of the system to value staff, and to value doctors in training in particular.

   The report finally indicated that the GMC has recently started **a review to explore how postgraduate training can be made more flexible** for doctors in the future, and that
work must continue to reform the way doctors’ education and training is organised. These reforms should be driven by a detailed action plan that must be developed following widespread engagement with doctors, employers, educators and others.

The paper also seeks to provide the Board with background information on the context in which this report sits, some of the consequences of the recent contractual dispute involving Doctors in training in England, and some of the work being taken forward in England following this, which may have implications across the UK.

6. **Recommendation(s) for Decision**

The Board is invited to note and comment upon the contents of the GMC Report.

NES
December 2016
DSI

Note: The executive summary of the GMC SoMEP Report is attached.

The full report can be found at:

Board Update – The State of Medical Education and Practice 2016

1. General Medical Council – State of Medical Education and Practice 2016

1.1 The GMC published their 2016 SOMEP report on 27th October 2016, As with previous reports, this report covered a wide range of topics, and presented a detailed analysis of data held by the regulator, covering:

- Doctors working in the UK
- Medical students and doctors in training in the UK
- Complaints about doctors
- Groups of doctors at higher risk of complaints and investigations
- Regional differences in the types of doctor
- The future of healthcare regulation in the UK

1.2 This year, however, the report raised concerns that a ‘state of unease’ exists within the medical profession as services throughout the UK come under increased pressure. The medical regulator warned that systems of healthcare and the health professionals working within them are struggling to cope with a range of issues – including the impact of health services under pressure and fragile social care services.

‘Patients should be assured that the standard of healthcare provided by doctors working in the UK remains among the best in the world ... The international standing of British medicine and medical education is among the best, with strong contributions made from both UK and overseas doctors in every part of our healthcare service.’

‘Yet, in spite of this positive conclusion, there is a state of unease within the medical profession across the UK that risks affecting patients as well as doctors. ... This should not be seen as a counsel of despair but as a message to governments, employers, regulators, and the profession itself. The GMC is concerned because of the impact this might have on the professional standards for which we are responsible.’

1.3 In particular, the report highlighted growing pressure on doctors, ‘dangerous levels of alienation’ felt by doctors in training, and the impact which struggling healthcare services are having on doctors’ education and training.

1.4 The report makes clear that the GMC takes the view that it has a role to play in addressing the ‘state of unease’ – by making regulation as ‘light touch as possible’, reassuring trainees that they are valued doctors, and addressing the anger and frustration which has built up during the ongoing dispute in England between the BMA’s Junior Doctors’ Committee and the Government:

‘There are a host of underlying non-contractual issues, some of them long standing, that have helped to create this dangerous level of alienation among the next generation of medical leaders. This should worry not just those of us close to the medical profession, but everyone concerned with the future of our healthcare system.’

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1.5 The GMC says it also wants to play more of a role supporting those engaged in workforce planning – to make sure doctors have the right knowledge, skills and standard of behaviour to serve patient needs in the years ahead.

1.6 Attention was drawn to the need for action by employers:

‘Some of this demands the attention of employers. A survey of a group of doctors in training ... reported a lack of receptivity from their organisations. Most responded that they did not feel valued by managers (83%), by the chief executive and the organisation (both 77%), and by the NHS (79%). But the profession itself has nothing to be complacent about – nearly 60% did not feel valued by their consultants.’

1.7 Attention was also drawn to the need of the system to value staff:

‘The link between staff and patient satisfaction is strong and has been long established – more recently work on the clinical engagement score has shown the vital importance of active involvement and shared objectives between institutions and professionals, not just for professional wellbeing but critically for the delivery of safe, compassionate care.’

1.8 And to value doctors in training in particular:

‘Yet a strong theme in many descriptions of modern medical practice, especially among doctors in training, is a feeling of being undervalued. The anger around the dispute certainly owes much to this – in some ways this is hardly surprising given the programmes that move doctors in training to different geographical locations about every six months, sometimes with limited effort to make them feel that they belong. This has now become an urgent issue that needs to be tackled.’

1.9 The report finally indicated that the GMC has recently started a review to explore how postgraduate training can be made more flexible for doctors in the future, and that work must continue to reform the way doctors’ education and training is organised. These reforms should be driven by a detailed action plan that must be developed following widespread engagement with doctors, employers, educators and others.

2. Context

2.1 The recent industrial dispute over contractual terms and conditions for doctors in training in England has led to several actions being taken, or being considered, with a view to improving the working lives of doctors in training in England.

2.2 Although the Devolved nations have chosen not to introduce a new contract for doctors in training now, there is a view that some of the provisions of the new contract, and some of the non-contractual proposals being considered out with the new contract may significantly improve the working lives of doctors in training in England.

2.3 Given the shortage of doctors in training in many specialties and locations, there is a need to consider the Scottish position in relation to these matters. This short paper aims to summarise the issues raised by the GMC report, and some of the actions being considered in England, with a view to opening discussion on a Scottish narrative.
3. **Junior Doctor’s Contract Dispute**

3.1 Following a prolonged dispute, and a period of industrial action, in July 2016, the Secretary of State for Health in the UK Government announced in Parliament his decision to introduce a new contract for doctors in training in England. In making this announcement he pointed to “the legitimate concerns of many junior doctors about their working conditions” and indicated a number of areas where he wished to see action taken to improve junior doctors working lives. These included:

a. ‘rota gaps and rostering practices ... expectation that all hospitals should invest in modern e-rostering systems by the end of next year’.

b. ‘particular concerns of foundation year doctors who often feel most disconnected in that period of their training before they have chosen a specialty ... progress in addressing these concerns under the leadership of Sheona Macleod at Health Education England’.

c. ‘a separate process to look at how we can improve the working lives of junior doctors more broadly, led by the Minister for Care Quality’.

3.2 Further details of the new contract were subsequently published, and summarised in a parliamentary briefing. Some of the key points of the new arrangements include:

a. An increase in basic pay of between 10% and 11% (down from 13.5% announced on 11 February 2016).

b. A weekend allowance of between 3% and 10% paid when any junior doctor is rostered to work more than 6 weekends per annum. The allowance, applied as a percentage of basic pay, will increase as the number of weekends worked increases (from 3% for working 1 weekend in 8 up to 10% for doctors working 1 weekend in 2).

c. A new system for overnight pay, with shifts that start at or after 8pm, last more than 8 hours and finish at or by 10am the following day paid at an enhanced rate of 37% (the Government’s previous position was to pay any hours between 9pm and 7am at an enhanced rate of 50%).

d. An on-call allowance is applied as 8% of basic pay over and above any weekend allowance payable.

e. A clarification of the role of Guardian of Safe Working, including a requirement to report on rota gaps at least once a quarter and to levy additional fines on trusts where breaks are missed on more than 25% of occasions across a 4 week period.

f. An increase to the flexible pay premia paid to those training in emergency medicine, psychiatry and oral and maxillofacial surgery, to £20,000 (£5,000 per annum over a standard four year training programme).

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3 [http://researchbriefings.parliament.uk/ResearchBriefing/Summary/CBP-7314#fullreport](http://researchbriefings.parliament.uk/ResearchBriefing/Summary/CBP-7314#fullreport)
g. Employers to appropriately **compensate individual doctors working beyond scheduled hours** to secure patient safety, where authorised by an appropriate person.

3.3 As noted above, the parties to the dispute also agreed to a number of issues outside of the contract, including:

a. To remove, as far as possible, **disadvantages faced by those who take time out of training** due to, for example, caring responsibilities.

b. Health Education England to review the process for training placement applications, to consider **joint applications by couples** and **defined travel times for those with caring responsibilities**.

c. While all NHS staff currently have protected rights to raise concerns about their employers under **whistleblowing** legislation, junior doctors will be given the right to raise concerns regarding the work of HEE without detriment, from either their employer or HEE.

3.4 It is also understood that during the dispute, the Secretary of State asked the General Medical Council to consider taking forward a review of ‘flexibility’ in the pathways through training, referred to in the 2016 SoMEP Report.

3.5 The GMC has been clear from the outset that any such review would require to be developed on a 4-Nation basis, and that it would be limited to those areas under the control of the regulator.

‘...the GMC stands ready to work with doctors in training and their organisations, such as the BMA, employers, education funders and providers, medical royal colleges and others with an interest in this area. There is a need for a UK-wide conversation, to understand fully the views of doctors in training as well as the perspective of employers, educators and others. From this should emerge a detailed action plan to reform the way education and training are organised so that they match the needs and expectations of the doctors and the healthcare systems they serve.’

4. Health Education England non-contractual support for doctors in training

4.1 Health Education England is taking forward a wide range of initiatives to tackle the non-contractual concerns that have been highlighted by junior doctors\(^5\). Those in the public domain include:

a. HEE has already announced the extension of **whistleblowing** protection for junior doctors, and will now place into its contracts with local employers a provision that protects junior doctors making patient safety disclosures.

b. looking at **rotations** so that, where possible in terms of delivering the curriculum and while ensuring that doctors are fairly distributed for patient care, trainees do not have to rotate more than necessary so that they can establish a relationship with a single organisation.

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c. reviewing the **application rules** for doctors with caring responsibilities and doctors who are in a relationship. HEE is working with stakeholders, particularly the British Medical Association’s Junior Doctors’ Committee (BMA JDC) to look at improving recruitment for those doctors with caring responsibilities.

d. reviewing **recruitment processes** for those in partnerships as is currently done in the Foundation Programme.

e. improving the communication between deans and local education providers to ensure that doctors beginning rotations know their **schedule** a month earlier than at present, so that there is no more ‘fixed leave’ in rotations.

f. work with the Academy of Royal Medical Colleges (AoMRC) to prepare doctors who have taken time out of programme on their **return to training** using mentoring, simulation training and ‘boot camp’.

g. establishing an HEE working group to improve the **experience** of junior doctors - work is continuing with key partners to:

- identify and remove barriers to flexible working
- make more equitable use of the study budget
- address rising costs for individual trainee.

h. improving standards through the introduction of HEE’s Quality Framework, including in the culture and educational leadership and in supporting and empowering both trainees and educators in order to ensure consistent and high quality learning environments.

**4.2** Further detail on some of these issues has been made available in several UK fora. These include:

a. **Rota notification and fixed leave - Updated Code of Practice.** The CoP sets what trainee should expect from HEE and employers in terms of provision of information pertaining to their rotations, and the timing of this. It also outlines the information that a trainee should provide to facilitate this process. HEE has committed to not only ensuring compliance with the past CoP, but also improving to comply with a new deadline 4 weeks earlier and to deliver 90% compliance with trainee information being shared with employers 12 weeks prior to trainees’ deployment into new posts. Employers should then provide information at 8 weeks to trainees and avoid the need for fixed leave.

b. **Deployment issues, Inter Deanery Transfers and joint applications.** These will be developed through the UK MDRS Programme.

c. **Opportunities for LTFT training** - to allow trainees to opt for reduced training in a much wider range of circumstances, including heavy workload.

d. **Variability in Study Leave.** Creating a consistent process – with definition of the categories of training which should be covered by study leave budgets, including mandatory training

e. **Induction and Mandatory Training** - will be addressed by NHS employers.
f. **Gender inequality and time out of training.** Support for doctors returning to training so that they have the confidence and capabilities to re-enter with a minimal loss of pace. All trainees who take time out for non-training reasons should have a mentor who will support them, and ensure that their training needs are discussed and planned in advance of their return date. While on leave trainees can be offered the opportunity to consolidate their previous learning and ensure they are brought up to speed with any developments in their absence. HEE will work with stakeholders and individual Colleges to define and such training. Some specialties have already done a lot with the use of simulation and learning programmes.

g. **Post foundation and pre-specialty** - There are a changing and expanding cohort of junior doctors not in traditional training posts, where a new approach is needed, including international graduates new to the NHS, doctors with progression problems in a chosen career, doctors wanting more time to choose a career specialty and doctors wanting time out with less pressured working.

h. **Other training concerns** include - Being a valued part of a team, Variable Educational Supervision, Time in one training location, ARCP process issues, Difficulties with out of Programme/Return to programme/ Flexibility in and out of training, Transitioning in training, Time on routine tasks, Lack of awareness of management of Quality issues, Rota gaps and management.

5. **Guardians of Safe Working Hours**

5.1 Although arising from the new contractual provisions, the development of ‘Guardians of Safe Working’ appointed in all English trusts promises a **significant new focus on time for education** and training. The guardian will:

a. act as the champion of safe working hours for doctors in approved training programmes and ensure that action is taken to ensure that the working hours within the trust are safe.

b. provide assurance to the trust board or equivalent body that doctors are safely rostered and are working hours that are safe and in compliance with the TCS.

c. record and monitor compliance with the restrictions on working hours stipulated in the TCS, through receipt and review of all exception reports in respect of safe working hours.

d. ensure that exception reports regarding training hours, as set out in the work schedule, are sent to the DME or equivalent officer.

e. work in collaboration with the DME and the LNC to ensure that the identified issues, concerning both working hours and training hours, are properly addressed by the employer and/or host organisation.

f. escalate issues in relation to working hours raised in exception reports to the relevant executive body for decisions where these have not been addressed at a local level.

g. require a work schedule review to be undertaken where there are regular or persistent breaches in safe working hours that have not been addressed.

h. directly receive exception reports where there are immediate or serious risks to safety and ensure that the organisation at a local level has addressed the concerns that led to the exception report. Where this is not addressed within the timescales identified in Schedule 5, and the guardian deems it appropriate, the guardian will raise this with the executive of the employing and/or host organisation.
i. review the reports received when a manager does not authorise payment for hours worked beyond those described in the work schedule in order to secure patient safety, and recommend action where appropriate.

j. have the authority to intervene in any instance where the guardian feels the safety of patients and/or doctors is compromised, or that issues are not being resolved satisfactorily.

k. distribute monies received as a consequence of financial penalties to improve the training and working experience of all doctors. These funds must not be used to supplement the facilities, study leave, IT provision and other resources that are defined by HEE as fundamental requirements for doctors in training, and which should be provided by the employer/host organisation as standard.

l. Prepare, no less than quarterly, a report for the trust board or equivalent body, which summarises all exception reports, work schedule reviews and rota gaps, and provides assurance on compliance with safe working hours by both the employer and doctors in approved training programmes.

m. Prepare, no less than annually, a plan for improvement on rota gaps, and submit the plan in a statement in the trust’s quality account, which will also need to be signed off by the trust’s chief executive.

n. Submit details of the disbursement of fines for inclusion in the organisation’s annual report, including clear detail of where fines have been spent.

o. Jointly establish with the DME, a junior doctors forum (or fora), to include relevant representatives from the LNC, including the chair, and other elected junior doctor members to provide quality assurance of safe working practice, and scrutinise the distribution of fines.

p. Oversee all diversity and equality issues associated with ensuring safe working practices. This will include liaison with the DME to ensure that a member of the educational faculty in the trust is designated as a champion for flexible training

6. GMC Review of ‘Flexibility’ in Training

6.1 As noted above the General Medical Council is taking forward a review of ‘flexibility’ in the pathways through training, referred to in the 2016 SoMEP Report.

6.2 The GMC has been clear from the outset that any such review would require to be developed on a 4-Nation basis, and that it would be limited to those areas under the control of the regulator.

‘...the GMC stands ready to work with doctors in training and their organisations, such as the BMA, employers, education funders and providers, medical royal colleges and others with an interest in this area. There is a need for a UK-wide conversation, to understand fully the views of doctors in training as well as the perspective of employers, educators and others. From this should emerge a detailed action plan to reform the way education and training are organised so that they match the needs and expectations of the doctors and the healthcare systems they serve.’
Our sixth annual report on the state of medical education and practice in the UK sets out an overview of issues that feature prominently in healthcare, and examines the GMC’s data relating to the changing medical register and explores the patterns of complaints about different groups of doctors.

A challenging time
This year’s report comes after a prolonged period of upheaval in the health sector, with growing service and financial pressures in the National Health Service (NHS) and a long dispute over new contracts for junior doctors in England.

Growing numbers of people living with multiple, complex, long-term needs, combined with severe financial and staffing pressures in many areas of the healthcare sector, have left many health services unable to cope with rising demand.

A profession not at ease
Many doctors are feeling the pressure, and need to be supported at all levels. Work environments under pressure can have an impact on professional standards and the well-being of doctors. The level of dissatisfaction among doctors seems to be higher than ever before.

Pressure on doctors in training
The 2015 survey revealed that 83% of doctors in training throughout the UK rated the quality of experience in their post as ‘excellent’ or ‘very good’. Yet 98% of those doctors who responded to a ballot called by the British Medical Association (BMA) voted to take industrial action. We are working to do more to listen to doctors in training and identify their concerns. There is a risk that doctors in training might leave the profession if the pressure is too great.

What next?
We are the independent regulator of the medical profession across all four countries of the UK and are committed to doing what we can to ensure good professional standards in this difficult environment, and have set the areas we believe we can deliver on. These include:

- making sure education and training matches the needs of doctors and healthcare systems
- engaging with what professionalism means for doctors in the 21st century
- developing a risk-based model of regulation
- engaging with workforce planning
- building on progress with revalidation and making sure regulatory bureaucracy is minimised.
Our data on doctors working in the UK

In this section we show an overview of doctors on the UK medical register, looking at age, gender, place of primary medical qualification and ethnicity. We look at patterns within specialties and changes to the workforce, as well as the revalidation outcomes of different groups of doctors.

**Figure 1: Demographic characteristics of licensed doctors on the register and medical students in 2015**

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<thead>
<tr>
<th></th>
<th>Medical students</th>
<th>Doctors in training</th>
<th>Doctors not on the GP or Specialist Register and not in training</th>
<th>Doctors on the GP Register</th>
<th>Doctors on the Specialist Register</th>
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<td><strong>AGE</strong></td>
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<td>9,105</td>
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<td><strong>PLACE OF PRIMARY MEDICAL QUALIFICATION</strong></td>
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<td>UK graduates</td>
<td>85%</td>
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<td>EEA graduates*</td>
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<td>13%</td>
<td>16%</td>
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<td>IMGs†</td>
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<td>11%</td>
<td>18%</td>
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<td>57%</td>
<td>54%</td>
<td>44%</td>
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</table>

**GP = general practitioner.**

* 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 (IMGs) 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.
**Executive summary**

**Number of licensed doctors remains steady**

Although the register continued to grow, with an 11% increase in the period 2011 to 2015, the trebling of the number of unlicensed doctors, largely following revalidation means the number of doctors licensed to practice in the UK has remained steady, increasing by only 1% over the period.

**An already ethnically diverse profession becoming more so**

The ethnic diversity of the profession appears to be increasing. Over the period 2011–15, there was a 22% increase in the number of specialists who described themselves as black and minority ethnic (BME)* against an 8% increase in specialists generally, and an 18% increase in the number of GPs defining themselves as BME, against a 2% increase in GPs generally.

Among GPs and specialists who were UK graduates, a higher proportion described themselves as BME (18% and 16% respectively) than in the UK population overall (13%).

**Fewer doctors coming from abroad to work in the UK**

The fact that certain specialties rely on non-UK qualified doctors has implications for workforce planners, as the UK is reducing its reliance on doctors who qualified outside the UK over time.

Of the doctors licensed to practise and work in the UK, fewer were from abroad – 10% fewer IMGs and 2% fewer EEA graduates in 2015 compared with 2011. The number of UK graduates had increased by 6%.

**The trend for increasing numbers of EEA graduates to come to the UK from southern European countries, such as Italy, Spain, Greece and Portugal, has reversed, with an 11% decrease in 2014–15 after several years of increase.**

**The growth in female doctors is slowing**

Previously we had predicted that the proportion of female doctors would pass the 50% mark by 2017 in the UK, but this may now take longer.

Our analysis this year found that the proportion of registered female doctors grew from 43% in 2011 to 45% in 2015. But the growth in younger female doctors slowed compared with the growth in younger male doctors – the proportion of male doctors under 30 years old increased by 28%, from 2011 to 2015, while that of female doctors increased by only 6%.

Some countries in the UK had already reached gender parity: female licensed doctors made up 51% and 50% in Scotland and Northern Ireland respectively. England had 46% while Wales had 44%.

**Update on revalidation**

In 2015, almost 70,000 doctors had a recommendation approved by the GMC. Of these doctors 83% were revalidated, while the remainder were deferred. A tiny proportion – 209 doctors – failed to engage. Doctors connected to a locum agency for revalidation were more likely to be deferred than those connected to most other organisations.

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* BME includes Asian, black, mixed ethnic groups and other ethnic groups.
In this section we explore the changes in the numbers of medical students and doctors in training, looking at who the doctors were (age, gender, ethnicity, place of qualification) as well as the make-up of specialties where doctors were training and trends in part-time working in training posts.

Data in this section are shown from 2012 onward, when the national training survey was updated.

In 2015, there were 40,078 medical students at UK universities in 2015, a reduction of 3% since 2012.

Medical students and doctors in training in the UK

The specialties in which doctors are training are gradually changing

Psychiatry – as well as obstetrics and gynaecology – saw a drop of 10% in the number of doctors in training between 2012 and 2015. Over a third (41%) of psychiatrists in training were non-UK graduates – the highest proportion of any training programme.

The demographic make-up of doctors in training is changing

Doctors in training were increasingly likely to have gained their medical degree (primary medical qualification) in the UK, with UK graduates making up 85% of all doctors in training – up from 80% in 2012. Of those doctors in foundation training, 96% were UK graduates.

In particular, in 2015 compared with 2012, there were fewer doctors with an Asian ethnicity in training, mirroring the broader trend that of all licensed doctors non-UK graduates were now less likely to work in the UK – including south Asian doctors, who had historically made up a large part of the workforce.
Executive summary

In this section we analyse complaints received by the GMC in 2015 and how these complaints were resolved. We also examine trends over the period 2011–15 and changes in the source of these complaints.

A slowing of a rapid increase in complaints

In 2015, there were 8,269 complaints about doctors’ fitness to practise – a 7% reduction since 2014.

Complaints about doctors rose sharply in the two years to 2013, after which they gradually reduced, falling in both 2014 and 2015.

Around one in seven complaints from the public result in investigation

The majority of complaints (68%) came from the public in 2015. This group also accounted for the largest number of complaints in previous years, peaking in 2013 and declining in the following two years. In 2015, 9% of complaints came from other doctors, 6% from employers and 6% from self-referrals.

The percentage of complaints leading to a full GMC investigation varied substantially, depending on the source of the complaint. Just 15% of complaints made by the public in 2015 met the threshold for a full investigation by the GMC, compared with 80% of complaints made by employers, 51% made by the police and 31% made by other doctors.

Outcomes of investigations have remained fairly constant

Of the 2,808 investigations concluded in 2015:

- 5% led to warnings
- 6% led to conditions or undertakings
- 7% led to suspension or erasure.

More than two-thirds were closed with no further action and 14% were closed with advice given to the doctor.
Groups of doctors at higher risk of complaints and investigations

In this section we examine the relative risk of a doctor being complained about, investigated and receiving a sanction or a warning. We also consider variations in risk by register type, source of complaint, age, gender and allegation type.

Risk of complaint and investigation by register

Only 3% of licensed doctors were subject to a fitness to practise complaint in 2015. This rose to 5% for those on the GP register and was lower for those on neither register.

Complaints and investigations are not homogeneous

Some groups of doctors were more likely to have complaints from particular sources and were more likely to be investigated in relation to certain issues than others as shown in figure 3.

Cases about health, criminality, honesty and fairness are more likely to end in a sanction or a warning – and are more likely to come from sources other than the public

Nearly half (45%) of cases stemming from concerns raised by employers involved health, criminality, honesty or fairness, while these types of cases accounted for only one in six (16%) of cases arising from complaints from the public.

These types of cases had a much higher probability of resulting in a sanction or a warning than those involving only issues of clinical competence, which accounted for nearly a third (30%) of investigations arising from public complaints, but less than one in ten (9%) of cases stemming from concerns raised by employers. More than half (55%) of all cases involving a doctor’s health resulted in a sanction or a warning compared with 4% of clinical competence cases.

Figure 2: The percentage of doctors complained about and having their complaints investigated, by type of doctor, 2015

<table>
<thead>
<tr>
<th>% complained about</th>
<th>Number complained about</th>
<th>% of complaints investigated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctors on the GP Register</td>
<td>5%</td>
<td>2,755</td>
</tr>
<tr>
<td>Doctors on the GP and Specialist Registers</td>
<td>4%</td>
<td>51</td>
</tr>
<tr>
<td>Doctors on the Specialist Register</td>
<td>3%</td>
<td>2,319</td>
</tr>
<tr>
<td>Doctors not on the GP or Specialist Register and not in training</td>
<td>2%</td>
<td>819</td>
</tr>
<tr>
<td>Doctors not on the GP or Specialist Register and in training</td>
<td>1%</td>
<td>405</td>
</tr>
<tr>
<td>Total</td>
<td>3%</td>
<td>6,349</td>
</tr>
</tbody>
</table>
Risks of complaint, investigation and warning or sanction for different groups of doctors

Less than one in a hundred doctors actually received a sanction or a warning between 2011 and 2015.

The risk of receiving a sanction or a warning was higher for older and male doctors. Doctors aged 50 years and over were consistently complained about more than younger doctors – and this was true of women and men alike for doctors on the GP, Specialist and neither register. A higher percentage of investigations about younger doctors led to sanctions or warnings.

Compared with white doctors who graduated in the same area of practice, doctors who graduated outside the UK and BME doctors were more likely to receive a sanction or a warning from the GMC.

Figure 3: Proportion of male and female doctors by age who were complained about, had the complaint investigated and received a sanction or a warning during 2011–15

<table>
<thead>
<tr>
<th>AGE</th>
<th>Doctors on the Specialist Register</th>
<th>Doctors on the GP Register</th>
<th>Doctors not on the GP or the Specialist Register</th>
<th>Doctors on both the GP and the Specialist Registers</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;50</td>
<td>88%</td>
<td>78%</td>
<td>93%</td>
<td>82%</td>
</tr>
<tr>
<td>50+</td>
<td>81%</td>
<td>71%</td>
<td>87%</td>
<td>79%</td>
</tr>
<tr>
<td>Not complained about</td>
<td>12%</td>
<td>22%</td>
<td>7%</td>
<td>18%</td>
</tr>
<tr>
<td>Complained about</td>
<td>9%</td>
<td>29%</td>
<td>13%</td>
<td>21%</td>
</tr>
<tr>
<td>RESULT OF COMPLAINT</td>
<td>Closed immediately or referred back to employer</td>
<td>Investigated then closed without a sanction or a warning</td>
<td>Investigated then closed with a sanction or a warning</td>
<td></td>
</tr>
<tr>
<td>&lt;50</td>
<td>65%</td>
<td>67%</td>
<td>43%</td>
<td>69%</td>
</tr>
<tr>
<td>50+</td>
<td>63%</td>
<td>64%</td>
<td>45%</td>
<td>67%</td>
</tr>
<tr>
<td>&lt;50</td>
<td>30%</td>
<td>28%</td>
<td>41%</td>
<td>18%</td>
</tr>
<tr>
<td>50+</td>
<td>33%</td>
<td>31%</td>
<td>42%</td>
<td>26%</td>
</tr>
<tr>
<td>FEMALE DOCTORS COMPLAINED ABOUT</td>
<td>Not complained about</td>
<td>93%</td>
<td>89%</td>
<td>96%</td>
</tr>
<tr>
<td>Complained about</td>
<td>7%</td>
<td>11%</td>
<td>4%</td>
<td>11%</td>
</tr>
<tr>
<td>RESULT OF COMPLAINT</td>
<td>Closed immediately or referred back to employer</td>
<td>Investigated then closed without a sanction or a warning</td>
<td>Investigated then closed with a sanction or a warning</td>
<td></td>
</tr>
<tr>
<td>&lt;50</td>
<td>71%</td>
<td>75%</td>
<td>54%</td>
<td>86%</td>
</tr>
<tr>
<td>50+</td>
<td>72%</td>
<td>69%</td>
<td>53%</td>
<td>75%</td>
</tr>
<tr>
<td>&lt;50</td>
<td>26%</td>
<td>22%</td>
<td>34%</td>
<td>14%</td>
</tr>
<tr>
<td>50+</td>
<td>25%</td>
<td>28%</td>
<td>37%</td>
<td>21%</td>
</tr>
<tr>
<td>&lt;50</td>
<td>3%</td>
<td>3%</td>
<td>12%</td>
<td>0%</td>
</tr>
<tr>
<td>50+</td>
<td>3%</td>
<td>3%</td>
<td>10%</td>
<td>4%</td>
</tr>
</tbody>
</table>
### Executive summary

**Figure 4:** Proportion of doctors who were complained about, had a complaint investigated and received a sanction or warning during 2011–15, by place of primary medical qualification and ethnic group.

<table>
<thead>
<tr>
<th></th>
<th>Doctors on the Specialist Register</th>
<th>Doctors on the GP Register</th>
<th>Doctors not on the GP or the Specialist Register</th>
<th>Doctors on both the GP and the Specialist Registers</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>BME</td>
<td>White</td>
<td>Not known</td>
<td>BME</td>
</tr>
<tr>
<td><strong>UK GRADUATES</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not complained about</td>
<td>86%</td>
<td>86%</td>
<td>88%</td>
<td>80%</td>
</tr>
<tr>
<td>Complained about</td>
<td>14%</td>
<td>14%</td>
<td>12%</td>
<td>20%</td>
</tr>
<tr>
<td><strong>RESULT OF COMPLAINT</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Closed immediately or referred back to employer</td>
<td>65%</td>
<td>70%</td>
<td>66%</td>
<td>67%</td>
</tr>
<tr>
<td>Investigated then closed without a sanction or a warning</td>
<td>32%</td>
<td>27%</td>
<td>30%</td>
<td>29%</td>
</tr>
<tr>
<td>Investigated then closed with a sanction or a warning</td>
<td>3%</td>
<td>3%</td>
<td>3%</td>
<td>4%</td>
</tr>
</tbody>
</table>

| **EEA GRADUATES**     |     |       |           |     |       |           |     |       |           |     |       |           |
| Not complained about | 87% | 91%   | 92%       | 72% | 81%   | 77%       | 89% | 95%   | 92%       | 93% | 82%   | 78%       |
| Complained about     | 13% | 9%    | 8%        | 28% | 19%   | 23%       | 11% | 5%    | 8%        | 7%  | 18%   | 22%       |
| **RESULT OF COMPLAINT** |     |       |           |     |       |           |     |       |           |     |       |           |
| Closed immediately or referred back to employer | 54% | 58%   | 41%       | 62% | 63%   | 58%       | 38% | 44%   | 36%       | 100%| 67%   | 54%       |
| Investigated then closed without a sanction or a warning | 35% | 33%   | 46%       | 31% | 30%   | 32%       | 37% | 42%   | 53%       | 25% | 38%   |           |
| Investigated then closed with a sanction or a warning | 11% | 10%   | 13%       | 7%  | 7%    | 10%       | 25% | 14%   | 11%       | 0%  | 8%    | 8%        |

| **IMG GRADUATES**     |     |       |           |     |       |           |     |       |           |     |       |           |
| Not complained about | 85% | 85%   | 88%       | 73% | 75%   | 72%       | 92% | 91%   | 92%       | 69% | 87%   | 82%       |
| Complained about     | 15% | 15%   | 12%       | 27% | 25%   | 28%       | 8%  | 9%    | 8%        | 31% | 13%   | 18%       |
| **RESULT OF COMPLAINT** |     |       |           |     |       |           |     |       |           |     |       |           |
| Closed immediately or referred back to employer | 59% | 65%   | 57%       | 61% | 63%   | 57%       | 42% | 46%   | 36%       | 67% | 50%   | 33%       |
| Investigated then closed without a sanction or a warning | 35% | 31%   | 38%       | 33% | 33%   | 36%       | 43% | 42%   | 45%       | 11% | 0%    | 67%       |
| Investigated then closed with a sanction or a warning | 5%  | 3%    | 5%        | 5%  | 4%    | 7%        | 15% | 12%   | 20%       | 22% | 50%   | 0%        |
Regional differences in the types of doctor

In this section we look at how the workforce of GPs and specialists, and doctors who were neither, varied between different parts of the UK and regions in England.

Doctors broadly reflect their local ethnic population

The profession as a whole is more ethnically diverse than the UK, but broadly countries of the UK with higher ethnic diversity have higher diversity in their doctors.

Northern Ireland and Scotland had a very low proportion of doctors who were BME or non-UK compared with the UK average, while England had the highest proportions of both. The English regions with the highest proportions of non-UK doctors were the West Midlands and the East of England (40% each).

Wales has very slightly older GPs

The age profile of doctors varied relatively little between the four countries of the UK. Wales had the oldest profile of GPs, though the difference was small: 43% of GPs in Wales were aged 50 years and over compared with a UK average of 39%.

Wales had fewer GPs than Northern Ireland, despite similar population density. This difference may indicate capacity issues or lower use of GPs in Wales. The Welsh government is planning a campaign to increase GP numbers. The Welsh government are planning a campaign to increase GP numbers.
Executive summary

The future of healthcare regulation in the UK

Why change?
The GMC’s role in protecting the public must be shaped by the expectations of the society on whose behalf we regulate, while at the same time retaining the consent of the doctors. Regulation is changing and the GMC must be involved in these changes.

Increased expectations of regulators
The GMC must support doctors in the work that they do. The best way to do that is not by taking action when things have gone wrong and patients (and often doctors themselves) have already been harmed. It is by directing our resources to support good practice and, where we can, mitigate the risks of harm occurring.

Promoting professionalism
We seek to instill the standards of behaviour for good medical practice. Our proposals for a new medical licensing assessment support this approach, while allowing medical schools the flexibility to go beyond our requirements if they wish to do so. The proper aim of regulation should go beyond the assurance that practising doctors are not ‘bad’, and promote the sort of professionalism that most of us would want to take for granted.

Preventing harm
The work of our Regional Liaison Service and offices in Scotland, Wales and Northern Ireland is a good example of engaging with the profession to promote good practice across the profession. The same is true of our work in medical education and training, and revalidation.

Risk-based regulation
Following the work of the Better Regulation Executive, regulators have been increasingly focused on making sure their regulatory activities are guided by an understanding of risk in the regulated area. Risk-based regulation offers a more proportionate regulatory response to problems, and it enables regulators to put in place interventions that can help prevent risks materialising as actual harms.

Improved data and intelligence sharing will help regulators target their activities more effectively. It should also mean that the demands on individual doctors and the wider healthcare system to provide the same or similar data for multiple agencies can be reduced because data can be collected once and used for multiple purposes.

The future shape of regulation
The UK government’s latest initiative to examine the future of professional regulation is therefore welcome. It promises to consider the purpose of regulation, alongside issues of autonomy, efficiency and cost-effectiveness.
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