MUCKAMORE ABBEY HOSPITAL INQUIRY
WITNESS STATEMENT

MODULE M3: Professional Regulation

Statement of Charles Hamilton Massey

Date: 8 March 2024

I, Charles Hamilton Massey, make the following statement for the purpose of the Muckamore Abbey Hospital (MAH) Inquiry ('the Inquiry').

The statement is made on behalf of the General Medical Council, 3 Hardman Street, Manchester, M3 3AW in response to a request for evidence by the Inquiry Panel. There are no accompanying documents.

This is my first statement to the Inquiry, and I welcome the opportunity to contribute information. I would like to begin by extending my deepest sympathy to the patients and families who have suffered terribly because of the failings in care at Muckamore Abbey Hospital.

Qualifications and positions

1. My name is Charles Hamilton Massey. I am the Chief Executive and Registrar of the General Medical Council ('the GMC'), and I have held this role since 1

November 2016. Prior to this, I worked in a variety of roles across government and the wider public sector.

About the GMC and our response to the Inquiry

2. The GMC is the independent regulator of doctors in the UK. We work with doctors, their employers, their educators, and others to:

    i. set the standards of patient care and professional behaviours doctors need to meet;
    ii. make sure doctors get the education and training they need to deliver good, safe patient care;
    iii. check who is eligible to work as a doctor in the UK and check they continue to meet the professional standards we set throughout their careers;
    iv. give guidance and advice to help doctors understand what is expected of them;
    v. investigate where there are concerns that patient safety, or the public's confidence in doctors, may be at risk, and take action if needed.

3. The UK government has brought forward legislation that will extend our remit to include the regulation of physician associates and anaesthesia associates. This will come into force towards the end of 2024.

4. The GMC is independent of government and the medical profession and accountable to Parliament. Our powers are given to us by Parliament through the Medical Act 1983 ('the Act'). The Act sets out the requirements for us to publish and submit to the Privy Council an annual report, annual fitness to practise statistics, and a strategic plan.

5. We have previously disclosed information to the Inquiry in April and December 2022.

6. I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006, dated 8 February 2024. My evidence relates to paragraphs 10 to 13 of the Inquiry's Terms of Reference. I have been asked to address several questions and will address each of these in turn.

Q1. Please provide an explanation of the GMC Registration process.

7. The GMC holds the register of medical practitioners who are eligible to practise in the UK. To practise medicine in the UK a doctor must be both registered with the GMC and hold a licence to practise.

8. The GMC's powers to register doctors are set out in the Act and a range of secondary legislation. Amendments to legislation mean our processes have evolved over time. An overview of the current main registration processes in place for doctors applying to practise in the UK is provided below.

9. Registration with a licence to practise is the legal status that allows doctors to exercise the rights and privileges associated with practising as a doctor in the UK. Doctors wishing to practise in the UK are required to make an online application for registration with a licence to practise, and as part of this they must satisfy the GMC that they meet a number of key criteria:

    a. Hold an acceptable primary medical qualification (PMQ) that meets our criteria.
    b. Possess the knowledge, skills and experience for practice in the UK.
    c. Their fitness to practise is not impaired.

d. Have the necessary knowledge of English to practise safely in the UK.

10. The licence to practise was introduced in November 2009 as part of the introduction of revalidation. It is not possible to practise medicine without a licence, but it is possible to hold registration without a licence. Doctors who hold registration only remain in good standing with the GMC but are not allowed to exercise any of the legal privileges of a registered medical practitioner, such as prescribing, signing death certificates or working as a doctor in the NHS.

Types of Registration

There are five main types of registration:[1]

a. **Provisional Registration (PR)** is for doctors who have graduated from medical school but have not completed an internship/Foundation Year 1(FY1). On 1 April 2015, legislation came into force that introduced a time limit of 3 years and 30 days on the maximum period of time that a doctor may be provisionally registered.[2]

b. **Full Registration in an Approved Practice Setting (FRAPS)** is for doctors who have completed their internship/FY1 but are required to work for a further period in a supported environment. This status is usually removed after the first successful revalidation.

c. **Full Registration (FR)** is for doctors who have successfully completed their initial training but have not completed a full specialty or general practice training programme.

d. **Full and Specialist Registration (FRSR)** is for doctors who have successfully completed a full specialist training programme and gained entry

[1] There are also a number of rarer registration types such as visiting eminent specialist, special purpose and temporary registration in an emergency which are used in particular circumstances. We have not included these in this answer but can provide detail to the Inquiry if necessary.
[2] The GMC (Maximum Period of Provisional Registration) Regulations Order of Council 2015

to the Specialist Register.

e. **Full and General Practitioner Registration (FRGP)** is for doctors who have successfully completed a GP training programme and gained entry to the GP Register.

Routes to Registration

11. Doctors who apply for registration have a route to registration defined in the Act. The routes to registration used by the majority of applicants are explained below and are defined by the applicant's country of qualification and level of experience.

    a. UK – for graduates of UK medical schools, regardless of nationality. Most graduates of UK medical schools will go on to complete the two-year UK foundation programme. They are able to make an online application for PR as soon as they graduate. After successfully completing their first year of the foundation programme (FY1) they will need to make a further online application for FRAPS to allow them to move on to their second year (FY2). Provided the applicant's fitness to practise is not impaired, they are entitled to registration. They can only be refused registration on fitness to practise grounds.

    b. IMG (International Medical Graduates) - doctors who have qualified outside the UK are known as IMGs. The onus is on them to provide the required evidence to satisfy the GMC that they have the knowledge, skill and experience to practise in the UK and that their fitness to practise is not impaired. If they do not do this, they will be refused registration.

12. Most applications follow a very similar process:

    a. Almost all applications, and supporting evidence, are submitted online;

    b. A submitted application will be assessed by an application adviser;

c. The adviser will request further information as required by the specific route to registration and type of application;

d. It is up to the applicant to ensure this evidence is provided within specified time periods;

e. Most applications are completed in a few weeks, but a small number can take longer (for example where a question arises as to the doctor's fitness to practise). The GMC aims to issue a decision on all complete applications within three months of submission.

13. If an application is problematic, or where there may be concerns about the evidence, it may be referred for a more in-depth review. The case may be referred to an Assistant Registrar for consideration. The Assistant Registrar may ask a Registration Panel for advice or may reach a decision to approve or refuse the application.

14. The vast majority of applications will be granted, or closed because the applicant does not provide the required evidence. In some cases, applications may be refused by an Assistant Registrar and in these situations the applicant has the right to appeal the decision to a Registration Appeal Panel (RAP). The RAP can choose to uphold the GMC decision, remit the decision back to the GMC or substitute a decision of its own.

Applications for registration

15. Applicants for the five types of registration set out above are required to provide certain basic evidence and do certain things as part of their application. Namely:
    a. Evidence of qualification;

b. Proof of identity;

c. Most recent five years employment history;

d. Employer's reference from their most recent employer;

e. Evidence of good standing from any jurisdiction where they currently hold registration or have done so within the most recent five years;

f. Complete an insurance and indemnity declaration;

g. Complete a fitness to practise declaration and sign a declaration giving the GMC wide ranging powers to conduct further investigations and enquiries as we deem appropriate during the application.

16. In addition, there are specific requirements for the different registration types. We have not provided this level of detail here but would be happy to provide this information should you so wish.

17. Our medical register provides a reliable source for who is qualified to work as a doctor in the UK, their registration status (for example, whether they hold a current licence to practise), their Designated Body and Responsible Officer, as well as whether they are a GP or specialist.[3] This can be accessed online in a simple, easy read and accessible format.[4] In addition, we offer a free online

[3] A **designated body** is an organisation that is required to appoint and resource a responsible officer for revalidation. Designated bodies support and facilitate the revalidation process for doctors. **Responsible officers** are experienced senior doctors who are responsible for making sure that doctors with a connection to their designated body are competent in what they are doing and fully up-to-date. They make recommendations to the GMC about each of their doctor's revalidation. Responsible officers work with us to ensure that systems are in place to evaluate doctors' practice; that doctors have regular appraisals; and that there are processes to investigate and refer any fitness to practise concerns to the GMC.

[4] The Medical Register.

resource (the GMC data explorer) providing all our non-sensitive data on the makeup of the medical register, revalidation, training and fitness to practise.[5]

Q2. Please provide an explanation of the GMC Revalidation process.

18. Revalidation for doctors was introduced in December 2012 and every licensed doctor who practises medicine must revalidate. Revalidation requires doctors to demonstrate that they are up-to-date and fit to practise. It supports doctors to develop their practice, drives improvements in clinical governance and helps give their patients confidence in their skills and knowledge.

19. In general, doctors revalidate through a process of annual appraisals and a five yearly recommendation from experienced senior doctors called responsible officers (ROs) or 'suitable persons', although the exact process will depend on the nature of the doctor's employment.

20. Doctors collect examples of their work to understand what they're doing well and how they can improve. This includes feedback from patients and colleagues, learning from training and any complaints about them. Every year, doctors review and discuss their work with a specially trained doctor called an appraiser. They agree a plan for how the doctor can improve and build on what they do well during the next year.

21. ROs work with us to make sure doctors are reviewing their work. They also receive other information about the doctor's work from their employer. If the doctor needs extra support, or if there are any serious problems, ROs take action to address this straight away. Every five years, the RO tells us whether the doctor is keeping up-to-date and providing good care. Based on this, we decide if the

[5] GMC Data Explorer.

doctor can keep their licence. Failure to comply with the requirements for revalidation can result in a doctor losing their licence to practise.

22. Doctors without a connection to a RO or a 'suitable person' follow a similar process with annual appraisals, but also must provide information directly to the GMC, and sit a five-yearly assessment.

23. In 2016 the GMC commissioned a review by Sir Keith Pearson on the operation and impact of revalidation. His report was published in January 2017 and was followed by our Taking Revalidation Forward ('TRF') programme of improvements, which concluded in November 2018.[6]

24. The GMC's Protocol for making revalidation recommendations provides guidance for ROs.[7] This guidance sets out information sharing principles and recognises that the consistent sharing of information about doctors supports patient safety as well as the doctors involved. It also promotes public confidence in the medical profession. The information sharing principles in the guidance emphasise that patient safety is paramount when deciding whether to share information about doctors. Individuals with governance responsibility for doctors working in any setting have a duty to share information of note about a doctor with that doctor's RO.

25. We have reviewed our revalidation guidance to reflect our updated professional standards that came into effect in January 2024.[8] This includes duties for all medical professionals to be aware of the clinical governance arrangements where they work and to continuously engage with them. We also published an updated Clinical Governance Handbook. The handbook outlines the principles

[6] *Taking revalidation forward: improving the process of relicensing for doctors*. (January 2017)
[7] *The GMC protocol for making revalidation recommendations*
[8] Supporting in revalidation.

underpinning effective clinical governance for the medical profession and provides further information for how those principles can be applied and evaluated in practice.

Q3. How many referrals did the GMC receive in respect of doctors working at MAH across the time period covered by the Inquiry's Terms of Reference, that is between 02 December 1999 and 14 June 2021? What were the outcomes of GMC investigations in relation to those referrals?

26. We have searched our complaint management system and hardcopy file system for both referrals and complaints about doctors working at MAH across the time period specified, regardless of their relevance to the Inquiry's terms of reference.

27. We have identified six complaints and referrals. One referral remains open at present. Relevant information about five of these referrals and complaints was provided to the Inquiry as part of the information that we disclosed in April and December 2022.

28. Our current complaint management system was introduced in early 2006. Complaints dating prior to this time are held in hardcopy, making it harder to search these. The most accurate way to search both systems is with a doctor's name and unique identifier (UID) also known as a GMC reference number. This is a seven-digit reference number provided to doctors when they first make contact with us, and they keep this throughout their professional career.

29. The search of our current complaint management system was based on MAH being recorded as the incident location site, referring organisation or practise history site. The search of our hardcopy file system, which returned no relevant

results, consisted of a key word search of the complainant field using the key words ‘Muckamore’ and ‘Belfast’.

Q4. Can doctors make whistleblowing reports to the GMC?

30. Yes, doctors can make whistleblowing reports to the GMC and guidance for doing so is available on our website.[9] Whistleblowing reports are also known as raising public interest concerns.

31. Concerns must relate to one of our four key functions: registration and medical licensing (including revalidation), medical education, standards of medical professionalism and fitness to practise.

32. The disclosure must also involve specific information relating to any of the following six criteria: a criminal offence, a failure to comply with a legal obligation, a miscarriage of justice, a risk to the health and safety of any individual, environmental damage, or attempts to conceal or suppress any of the above.

33. Concerns which may be relevant to share with us include a doctor raising concerns that trainee doctors are not provided with adequate supervision or a doctor raising concerns about a consultant’s clinical practice and clinical outcomes, which their employer has failed to investigate.

34. We also provide guidance for doctors on what to do if they have a concern, and we support and encourage doctors to do so through appropriate channels.[10] In

[9] Whistleblowing guidance (gmc-uk.org)
[10] *Raising and acting on concerns about patient safety*

accordance with our guidance, doctors are expected to take prompt action where patient safety, dignity or comfort is, or may be, compromised. It is critical that healthcare employers and organisations have the systems and policies in place to allow concerns to be raised and investigated.

35. Our website contains guidance on speaking up, and we have published a practical decision tool to help medical leaders, and all doctors, decide how to raise concerns and access the appropriate support.[11] We have a confidential helpline for doctors, which has received almost 3,000 concerns from doctors about colleagues they believe pose a risk to patients since its launch in 2012. Each year the National Training Survey, issued to all doctors in training, provides another channel for doctors to confidentially voice patient safety concerns about where they work.

36. We have a statutory obligation to publish an annual report on whistleblowing disclosures and we do this alongside eight other regulators of healthcare professionals. The latest report was published in September 2023 and is available on our website.[12]

i. If the answer to this question is yes, were any whistleblowing reports received by the GMC in relation to MAH across the time period covered by the Inquiry's Terms of Reference, that is between 02 December 1999 and 14 June 2021?

37. We have searched our records, including electronic and hardcopy files, for receipt of any whistleblowing reports in relation to MAH between 02 December 1999 and 14 June 2021, but none have been identified. This search has encompassed referrals to us relating to MAH as well as any concerns raised by

[11] Speaking up - ethical topic - GMC (gmc-uk.org).
[12] *Whistleblowing disclosures report 2023* (https://www.gmc-uk.org/news/news-archive/healthcare-regulators-annual-whistleblowing-report-published)

doctors under investigation. Given this, we have not gone on to address the Inquiry's further questions at 4(ii) and 4(iii).

Q5. Do you wish to draw to the attention of the Panel any other matters not covered by the above questions that may assist in the Panel's consideration of paragraphs 10-13 of the Terms of Reference?

38. We have no specific comments on whether there were failures in the early identification, investigation and resolution of issues raised about the treatment of patients at Muckamore Abbey Hospital. However, it may be helpful for us to explain our expectations in respect of raising and acting on concerns, and the ways in which we are supporting this.

Shared Intelligence Framework and Emerging Concerns Protocol

39. As part of our work in 2023, we continued to co-chair and provide secretariat to the Northern Ireland Joint Regulators Forum. The forum enables regulators to:
    - share information to improve the identification of patient safety issues;
    - support continuous improvement;
    - inform policy development within healthcare systems.

40. The forum comprises the Nursing and Midwifery Council (NMC), the Regulation and Quality Improvement Authority (RQIA), the Pharmaceutical Society of Northern Ireland, the Northern Ireland Social Care Council, the General Dental Council, and the Health and Care Professions Council.

41. Via the forum, we participated in an exercise held by the RQIA to scope a Shared Intelligence Framework and commented on their proposed model for an emerging concerns protocol for Northern Ireland.

42. The purpose of the Shared Intelligence Framework, and its embedded Emerging Concerns Protocol, is to make sure that risks are identified, reviewed and addressed at the earliest opportunity. It is expected to be launched in the second quarter of this year.

Our professional standards for doctors to support a culture of raising and acting on concerns about patient safety

43. Our standards define what makes a good doctor by setting out the professional values, knowledge, skills, and behaviours required of all doctors working in the UK. We work closely with doctors, patients, groups representing their interests, and other stakeholders to develop and agree these standards, which are set out in *Good medical practice* (GMP).[13] A revised version of the guidance was published in summer 2023 and came into effect on 30 January 2024. In the process of revising the guidance, we undertook engagement with a range of health organisations, healthcare professionals, patients, carers and their relatives and members of the public. We commissioned independent researchers ICE Creates to deliver a group discussion with demographically mixed patients from Northern Ireland. We also held stakeholder events in Northern Ireland and user involvement sessions in partnership with the Patient Client Council. A consultation on the revised guidance attracted over four-and-a-half thousand responses from across the UK. Archived copies of GMP, including those that were in effect during the period to which the Inquiry relates, can be found on our website.[14]

44. Our professional standards highlight that all doctors have a duty to raise concerns where they believe that patient safety or care is being compromised by the practice of colleagues or the systems, policies, and procedures in the organisations in which they work. Doctors must promote and encourage a culture that allows all staff to raise concerns openly and safely. They must take prompt action if they think that

[13] *Good medical practice*
[14] Archived professional standards.

patient safety, dignity, or comfort is or may be seriously compromised. This expectation includes:

i. immediately telling someone who is in a position to act right away if a patient is not receiving basic care to meet their needs;
ii. raising concerns in line with our guidance (further outlined below) and their workplace policy if patients are at risk because of inadequate premises, equipment, other resources, policies, or systems;
iii. asking for advice from a colleague, their defence body, or the GMC if they have concerns that a colleague may not be fit to practise and may be putting patients at risk. They must report this in line with our guidance and their workplace policy if they are still concerned.

45. Doctors also need to record all steps that they have taken in raising concerns under points (b) and (c) above.

46. The 2024 version of *GMP* introduces some new expectations on doctors in relation to responding to safety risks and raising concerns. In domain two – where we outline the duties of a doctor in relation to their patients, partnership and communication – we have highlighted the need for doctors to act promptly on any concerns that they might have about a patient. We have strengthened expectations on how all doctors must act when they have any concerns about a patient – or someone close to them – who may be at risk of abuse or neglect.

47. The latest version of *GMP* states that if a patient is not receiving basic care to meet their needs, all doctors ‘must act’ to make sure the patient is cared for as soon as possible, for example, by asking ‘someone who delivers basic care to attend to the patient straight away.’ This is an improvement from the 2013 version which stated that, under the same circumstances, all doctors were under a duty to immediately ‘tell someone’ in a position to act.

48. In domain three, we have introduced a greater emphasis on the important role that doctors have to create a working and training environment that is compassionate, supportive, and fair, where everyone feels safe to ask questions, talk about errors, and raise concerns.

49. On responding to safety risks, our professional standards explain that doctors must act promptly if they think that patient safety or dignity is, or may be, seriously compromised. In the revised version of *GMP*, we included a new paragraph to emphasise the roles of doctors who are in formal leadership and management positions. If doctors hold these roles, they must take active steps to create an environment in which people can talk about errors and concerns safely. This includes making sure that any concerns raised with the doctor are dealt with promptly and adequately in line with their workplace policy and our more detailed guidance on *Raising and acting on concerns about patient safety*.[15]

50. *Raising and acting on concerns about patient safety* provides advice on raising concerns if patients might be at risk of serious harm. It also sets out the help and support available to the doctor raising a concern and explains doctors' responsibilities when their colleagues or others raise concerns to them. The guidance states that 'If you have a management role or responsibility, you must make sure that: […] all other staff are encouraged to raise concerns they may have about the safety of patients, including any risks that may be posed by colleagues or teams'. The guidance also outlines some potential obstacles that doctors might experience while raising a concern, including fear that there will not be action taken in response the concern or that reporting a concern could damage working relationships. We also provide advice on how doctors can raise their concerns so that they are listened to and to ensure that concerns are acted upon.

[15] *Raising and acting on concerns about patient safety*

Our guidance on the professional duty of candour

51. In 2015 we published joint guidance with the Nursing and Midwifery Council (NMC) *Openness and honesty when things go wrong: The professional duty of candour*.[16] This guidance highlights that every healthcare professional must be open and honest with patients when something goes wrong with their treatment or care, and causes, or has the potential to cause, harm or distress. It also places duties on managers to ensure there are systems and a culture that supports open reporting of adverse incidents. The guidance outlines professional obligations to report a colleague whose working practices and/or behaviour are a matter of concern. The guidance draws on other GMC and NMC guidance, including *GMP*, *Raising and acting on concerns about patient safety*, and *Leadership and management for all doctors*.[17]

52. The guidance was updated in 2022 to reflect the introduction of the statutory duty of candour in England, Scotland, Wales, and the proposals for this in Northern Ireland. We also set out the latest arrangements and terminology for reporting adverse incidents and near misses across the UK.

53. It is important for medical students to understand the requirements of candour and raising concerns early on in their education, so we require education providers to promote a culture of candour. In our standards for medical education and training, *Promoting excellence* (2016), we say that 'Organisations must demonstrate a learning environment and culture that supports learners to be open and honest with patients when things go wrong – known as their professional Duty of Candour – and help them to develop the skills to communicate with tact, sensitivity and empathy.' Similarly, we set expectations for newly qualified UK medical graduates to be able to 'raise and escalate concerns through informal communication with

[16] Openness and honesty when things go wrong: The professional duty of candour.
[17] Leadership and management for all doctors

colleagues and through formal clinical governance and monitoring systems about: patient safety and quality of care; bullying, harassment and undermining.'

54. We aim to ensure that we are collecting doctors' views and providing them with an opportunity to tell us safely and formally about their experiences of working in healthcare environments across the UK. As referenced earlier, we have published a topic on our online Ethical Hub on speaking up, which contains a toolkit to help doctors tackle unprofessional behaviour and case studies showing the positive impact that raising concerns has on patient safety.[18]

Working with partners to support an open culture

55. We aim to foster a culture in which openness and honesty is the norm and that concerns are shared and acted on as soon as possible. To achieve this, we are working with partners in the health services in England, Northern Ireland, Scotland, and Wales to ensure that doctors at all career stages feel supported to raise and act on concerns.

56. In 2023, we facilitated sessions with 1,226 doctors and 1,207 medical students across Northern Ireland which covered raising and acting on concerns and how to speak up. In order to meet doctors' and students' needs, we provide the sessions through a hybrid delivery model that combines face-to-face and online participation. This new approach has enabled us to increase the number of sessions we can deliver and allows for greater engagement with doctors who may not be able to travel due to work commitments. Our raising and acting on concerns workshops explore our guidance and some practical steps to empower those working in healthcare environments to know when and how to raise concerns. We know that raising concerns is not easy, so we use case studies and practical skills application to help doctors to build their skills in giving feedback, calling out

[18] Ethical hub guidance on speaking up.

unprofessional behaviour, looking at what they can do to effect change, or where needed, escalating a concern.

57. We are supportive of the Department of Health (NI)'s Being Open Framework proposals. We welcome the focus on routine openness rather than the exceptional circumstances when mistakes may lead to harm or death. We believe that establishing a network of Freedom to Speak Up Guardians in Northern Ireland would be a beneficial addition to this framework. The National Guardian leads, trains and supports the network of Freedom to Speak Up Guardians in England and provides challenge and learning to the healthcare system on matters related to speaking up.

58. We also run half day Professional Behaviour and Patient Safety (PBPS) workshops for doctors. These workshops enable doctors to consider and discuss their perceptions of unprofessional behaviours, how to identify them with the use of case studies, and consider their impact on patient safety. The sessions also give participants an opportunity to practise using the verbal and behavioural skills needed to challenge these behaviours. We worked closely with a number of medical royal colleges which have run initiatives in this area, and with workplace culture experts, to design a workshop that gives doctors the space to focus on this important and challenging aspect of their work. After a successful pilot in England, we started delivering the programme in Northern Ireland in 2023. The first sessions were held in September 2023 in collaboration with the NMC, and were attended by doctors, midwives and human resource leads at the Southern Health and Social Care Trust. And in October 2023 we facilitated a dedicated PBPS session for senior doctors at the Belfast Health and Social Care Trust.

59. We engage with around 45,000 doctors each year. We feel encouraged that 94% of doctors find our workshops very good or good, with 79% reporting that they will change their practice as a result.

When and how we investigate concerns about doctors

60. When a concern is raised about a doctor's performance, behaviour, or health, we can take action to prevent a doctor from putting the safety of patients, or the public's confidence in doctors, at risk.

61. We have a legal duty under the Medical Act to protect the public. The Act splits public protection into three distinct parts. It says that we must act in a way that:

    i. protects, promotes and maintains the health, safety and wellbeing of the public;
    ii. promotes and maintains public confidence in the profession;
    iii. promotes and maintains proper professional standards and conduct for members of the profession.

62. We can act on information we receive from any source that raises a question about a registered doctor’s fitness to practise. Common sources of information include patient complaints, referrals from ROs, employers, media reporting, and notifications from the police and other bodies acting in a public capacity.

63. As set out in the Act, we will only take forward a concern if it falls into one of the following:
    i. misconduct ;
    ii. deficient professional performance;
    iii. a criminal conviction or caution in the British Isles (or elsewhere for an offence which would be a criminal offence if committed in England or Wales);
    iv. adverse physical or mental health;
    v. not having the necessary knowledge of English;

vi. a determination (decision) by a regulatory body either in the UK or overseas to the effect that fitness to practise as a member of the profession is impaired.

64. We will investigate where the matter raised is sufficiently serious to raise a question about a doctor's fitness to practise. Further information on what we can and cannot investigate can be found on our website and in our GMC threshold guidance.[19]

65. When we receive a concern, we are legally required to assess if the doctor may pose any current and ongoing risk to one or more of the three parts of public protection outlined above. We do this by considering the following, which is often referred to as an assessment of a doctor's fitness to practise:

i. a doctor's overall ability to perform their individual role;
ii. their professional and personal behaviour;
iii. the impact of any health condition on their ability to provide safe care.

66. As part of assessing fitness to practise concerns, and to reach a decision on whether a doctor poses any risk to public protection, we consider:

i. the seriousness of the concern – this includes looking at how far a doctor has departed from the professional standards set out in *GMP*. Or, if relevant, it includes considering if a health condition is having an impact on their ability to practise safely;
ii. any relevant context – we consider any relevant context of which we are aware. By 'context', we mean the specific setting or circumstances that surround a concern;
iii. how the doctor has responded to the concern.

[19] GMC Threshold guidance.

67. Further information on how we assess concerns can be found either on our website or our guidance for decision makers on deciding whether an investigation is needed.[20]

68. We can take action to make sure we protect patients, maintain confidence in the medical profession, and uphold the standards we expect of doctors. We can give doctors a warning when a doctor's behaviour or performance is significantly below the standards expected of doctors and should not be repeated, but when restricting a doctor's practice is not necessary. In certain cases, we can agree undertakings, which are agreements between us and a doctor about the doctor's future practice (for example, limiting a doctor's practice in some way or committing to only working while supervised). We can also refer the matter to a Medical Practitioner's Tribunal (MPT) hearing at the Medical Practitioner's Tribunal Service.

69. At an MPT hearing, if a doctor's fitness to practise is found to be impaired, tribunal members have to decide whether to impose a sanction, and if so, what sanction to impose. The MPT has the power to restrict (by way of conditions), suspend, or erase a doctor's registration in the UK. Our sanctions guidance sets out further advice for decision makers.[21]

How patients, families, and the public and employers can raise concerns about patient safety and managing concerns locally

70. Anyone can raise a concern with the GMC. Those raising concerns might include patients or their families, employers, doctors or other healthcare professionals. It is vital that anyone can raise concerns about patient safety promptly, easily, and feel listened to. We provide a range of channels and support (further described

[20] Guidance for decision makers.
[21] Sanctions guidance.

below) to help anyone who raises a concern to understand how to disclose information so we can consider whether action needs to be taken.

71. Over the past several years, we have received a high number of enquiries from patients and the public that do not meet our fitness to practise thresholds and/or are not issues the GMC can address. Often, such concerns could be more appropriately dealt with locally by the doctor's employer or contracting body.

72. We provide advice for patients, families, and the public on our website to make sure that we are the right organisation to deal with their concern. We also signpost to other organisations who may be better suited to help if we are not the right organisation to deal with their concern. This includes, where appropriate, the doctor's employer, trust, or other regulators, such as the RQIA and the Care Quality Commission. In Northern Ireland, we regularly engage with the Patient and Client Council to support their programme of patient advocacy.

73. To support patients and the public raising their concerns, we have implemented several initiatives, including updating the local help pages on our website to help patients direct their complaint to the relevant organisation.[22]

74. Patients and the public can raise concerns with us by completing our online form or by speaking to one of our contact centre advisers. We are also able to provide a leaflet to help people decide where and how to raise their concern. This includes information about the support available to them. If we decide to investigate a concern raised by a patient, we will invite them to a meeting either online, by phone, or in person at one of our offices in Belfast, Cardiff, Edinburgh, London or Manchester to explain our investigation process and answer any questions they

[22] Find help services in your area.

might have. Once we have finished our investigation, we offer another meeting to talk to the patient about the outcome.

Declaration of Truth

75. The contents of this witness statement are true to the best of my knowledge and belief. I have produced all the documents which I have access to and which I believe are necessary to address the matters on which the Inquiry Panel has requested me to give evidence.

Signed:

Date: 8 March 2024