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## GMC thresholds

- 1 This guidance is for responsible officers, medical directors and other relevant staff who are involved in the employment, contracting or management of doctors. It has been designed to clarify those matters where we can, and cannot, take action. This guidance explains the thresholds for referral to the General Medical Council (GMC). Our overriding obligation is to ensure patient safety – we do not aim to resolve individual complaints or punish doctors for past mistakes, but rather to take action where we need to in order to protect patients or maintain the public's confidence in the medical profession.
- 2 A detailed explanation of our fitness to practise procedures, including decision making at the end of a GMC investigation, can be found on our website, [www.gmc-uk.org](http://www.gmc-uk.org).
- 3 We can act on any information we receive from any source, which raises a question about a registered doctor's fitness to practise. Common sources of information include patient complaints, referrals from responsible officers, employers, media reporting and notifications from the police and other bodies acting in a public capacity.

Section 35C(2) of the Medical Act 1983 as amended states that a doctor's fitness to practise can be impaired by any or all of the following:

- a. misconduct
- b. deficient professional performance
- c. 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)
- d. physical or mental ill-health

- e. not having the necessary knowledge of English
  - f. 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.
- 4 During an investigation we can consider all aspects of a doctor's fitness to practise. In many cases we may consider not only the matters raised in the original complaint, but also any other concerns that have come to light during the investigation.

### **Cases closed at an early stage**

- 5 In some cases, it is clear from the outset that there is no need for us to investigate because the complaint is about matters that cannot raise an issue of impaired fitness to practise. We will normally close these cases without taking any further action.
- 6 Examples of cases closed without any investigation are:
- a. minor motoring offences not involving drugs or alcohol
  - b. a delay of less than six months in providing a medical report
  - c. a minor non-clinical matter
  - d. a complaint about the cost of private medical treatment
- 7 Where the events that gave rise to the concerns took place more than five years ago, we would only investigate if there is a public interest in progressing the matter despite the difficulties that arise as a result of the delay.
- 8 Some concerns would not on their own raise a question about the doctor's fitness to practise unless they were to be repeated. Although these concerns do not require a GMC investigation, they are matters that a doctor should reflect on as part of their appraisal and revalidation. We usually disclose these concerns to the doctor and their responsible officer, subject to having first notified the complainant of how we use their information and considering any concerns or specific requests they share with us about that use, unless it is impracticable or undesirable to do so for public interest reasons.
- 9 If a doctor has no responsible officer, we disclose them to the doctor's employers or contractors to satisfy ourselves that a complaint is not part of a wider pattern of concerns. We would only open an investigation if the information provided by the responsible officer/employer/contractor raised a question about the doctor's

fitness to practise.

- 10** Examples of cases disclosed to the doctor and their responsible officer or shared with employers are:
- a.** complaints about the quality of treatment received where there is no indication of any serious risk to the patient or that the doctor acted significantly below appropriate standards.
  - b.** complaints about doctors' poor attitudes to patients, or failing to take their preferences into account.

## Provisional enquiries

- 11** Some cases that appear to meet the threshold for an investigation are referred for provisional enquiries. These are cases where, although the allegation initially appears to be serious, we need more information to decide whether to investigate further. This may be because it isn't clear whether there will be sufficient evidence to support the allegation, or because it isn't clear if the allegation is serious enough to raise a question about the doctor's fitness to practise and obtaining further information such as expert medical advice might clarify that the allegation is not as serious as it first appeared.
- 12** If clarification is likely to be achieved by obtaining one or two pieces of discrete information that can be accessed relatively quickly then that information will be requested. This will help us make a decision about whether an investigation is needed or whether we close the case.
- 13** Types of cases that typically lead to provisional enquiries are those:
- a.** where expert input is needed to confirm the seriousness of the concerns
  - b.** where an allegation may be based on a misperception or it contains information that suggests it may not raise a question about a doctor's fitness to practise and this can be checked by swiftly obtaining more information which is readily available.

## Full investigation

- 14** For the remainder of cases, we carry out a full investigation into the doctor's fitness to practise before we decide what action to take. This may include taking witness statements, obtaining expert reports, or undertaking an assessment of the doctor's health and/or performance. We must then decide whether we

should conclude the case with no further action (with or without advice to the doctor), issue a warning, offer the doctor undertakings or refer the doctor for a hearing by a Medical Practitioners Tribunal.

## Cases where we are likely to take action

- 15** In some cases, the allegations about a doctor are so serious that, if proven, they are likely to result in us taking action on the doctor's registration. These types of case tend to fall within five main headings:
- a.** sexual assault or indecency
  - b.** violence
  - c.** improper sexual or emotional relationship with a patient or someone close to them
  - d.** dishonesty
  - e.** knowingly practising without a licence.
- 16** Although the majority of concerns can be safely managed at a local level, allegations that fall within any of these five categories are likely to meet the threshold to be referred to us.
- 17** Many of the cases we investigate concern the standard of the doctor's medical practice, including the quality of the care and treatment provided by the doctor. Not all breaches of Good Medical Practice will require us to take formal action because many issues can be dealt with adequately by the responsible officer, employer or contractor. GMC action is more likely to be required where the allegations are of serious or persistent failures to meet the standards set out in Good Medical Practice.
- 18** Allegations of serious or persistent failures to practise in accordance with the principles set out in Good Medical Practice can be categorised under the following domains:
- a.** knowledge, skills and performance
  - b.** safety and quality
  - c.** communication, partnership and teamwork
  - d.** maintaining trust.

**19** Our Employer Liaison Advisers (ELAs) provide advice to responsible officers on how to handle concerns about doctors and whether the threshold for referral is met on individual cases. They will also advise on the appropriate point at which a referral should be made depending on the seriousness of the concerns and the doctor's willingness to engage in local remediation. The GMC threshold for referral is likely to be met when any of the following features occur and it is no longer appropriate to manage the concerns locally:

- a.** a doctor's conduct or performance falls below the standard set out in Good Medical Practice and (including where attempts to improve the doctor's performance locally have failed) there remains an unacceptable risk to patient safety.
- b.** a doctor about whom the responsible officer, employer or contractor has developed significant concerns disconnects from the responsible officer or leaves the employer or contractor's employment and the responsible officer, employer or contractor is not confident that alternative safeguards are in place.
- c.** local measures to address the concerns have failed either because the doctor is not complying with them or the concerns are too significant to be remediated at a local level.
- d.** a doctor has shown a deliberate or reckless disregard of clinical responsibilities towards patients that is too serious to be dealt with at a local level.
- e.** a doctor has abused a patient's trust or violated a patient's fundamental rights for example by performing a procedure or examination without consent or breaching their confidentiality.
- f.** a doctor has behaved dishonestly, fraudulently or in a way designed to mislead or harm others.
- g.** the doctor's behaviour was such that public confidence in doctors generally might be undermined if we did not take action.
- h.** a doctor's health is compromising patient safety and the risk cannot be safely managed at a local level – see below.
- i.** a doctor's lack of knowledge of the English language is compromising patient safety and the risk to patients cannot be addressed locally.

## Health

- 20** A GMC investigation may have a significant impact on the welfare of a doctor and it should be possible, where the doctor is willing to discuss their health with their responsible officer, for the majority of health issues to be managed at local level without the need for a GMC investigation.
- 21** There is no need for our intervention if there is no risk to patients or to public confidence because a doctor with a health issue has insight into the extent of their condition, and is seeking appropriate treatment, following the advice of their treating physicians and/or occupational health departments in relation to their work, and restricting their practice appropriately.
- 22** There will however be circumstances in which a doctor's health poses a clear risk to patients and that risk is not able to be, or is not being, effectively managed locally. Examples include:
- a.** the doctor is currently or has recently been detained under the Mental Health Act 1983 and remains very unwell or at high risk of relapse
  - b.** there are serious performance and/or conduct concerns where health is likely to have been a contributory factor
  - c.** the doctor has been recently convicted, cautioned or was the subject of a determination for an offence where health may be a contributory factor (eg drugs, alcohol, violence) <sup>1</sup>
  - d.** the doctor lacks insight, has failed to seek appropriate treatment, or has ceased to engage with support.
- 23** We have also developed guidance for our decision makers when a health concern has been raised with us from any source. This is published on the GMC website to aid ROs and employers who are familiar with the GMC's procedures for dealing with concerns. ELAs can provide further advice based on this guidance to ROs and employers when concerns about a doctor's health arise locally.

## Convictions, cautions and other methods of police disposal

- 24** We investigate all convictions and police cautions received by doctors and our rules

<sup>1</sup> [http://www.gmc-uk.org/DC4594\\_CE\\_Decision\\_Guidance\\_Annex\\_D\\_Convictions\\_Guidance.pdf\\_58067974.pdf](http://www.gmc-uk.org/DC4594_CE_Decision_Guidance_Annex_D_Convictions_Guidance.pdf_58067974.pdf)

contain specific provisions for the management of these cases. If a doctor receives a custodial prison sentence (whether immediate or suspended), their conviction is referred directly for a hearing by a Medical Practitioners Tribunal.

A certificate of conviction is conclusive evidence that the doctor committed the offence and we do not need to re-prove the underlying events.

**25** Under paragraph 75 of Good Medical Practice, doctors are required to notify us if they have accepted a caution or been charged with or found guilty of a criminal offence. Doctors are also required to tell us about the following<sup>2</sup>:

- Penalty Notices for Disorder at the upper tier (England and Wales)
- Penalty notice under the Justice Act (Northern Ireland) 2011
  
- Bind overs
- Community resolution orders
- Discretionary disposals (Northern Ireland)
- Fiscal fine (Scotland)
  
- Cannabis warning (England and Wales)
- Anti-Social behaviour orders

These are alternative methods of disposal by the police for low level offences and do not result in a criminal conviction. We currently investigate the above as allegations of misconduct to see whether they raise any issues about the doctor's fitness to practise which may require action.

**26** We do not currently investigate the following:

- Speeding offences unless there are aggravating features
- The offence of urinating in public unless there are aggravating features
- Minor motoring offences including traffic light offences, talking on a mobile phone while driving, not wearing a seatbelt and careless driving (which is distinct from dangerous driving) unless there are aggravating features.
- Penalty notices for disorder at the lower tier penalty level

<sup>2</sup> As outlined in our supplementary guidance Reporting criminal and regulatory proceedings within and outside the UK

- Fixed penalty notices for road traffic offences
- Fixed penalty notices issued by local authorities (for example, for offences such as dog fouling or noise)

**27** If a doctor has been acquitted of a serious charge such as sexual assault or gross negligence manslaughter, we still investigate to establish if there are any fitness to practise issues arising from the offence that may require action on their registration.

## Criticisms by official inquiries

**28** Paragraph 75 of Good Medical Practice also requires doctors to inform us without delay if they have been criticised by an official inquiry.

Doctors may seek advice from you about what we mean by an official inquiry and what we would consider to be criticism possibly requiring investigation by us. This is set out in our guidance Reporting criminal and regulatory proceedings within and outside the UK. Generally speaking, the criticism would have been made by the person leading either a public/formal inquiry or a tribunal in the public domain. Examples include an inquiry conducted under the Inquiries Act 2005, a Coroner's inquest, a Parliamentary Select Committee or a non-statutory inquiry in the public interest such as the Bichard inquiry (issues arising from the Soham murders). The criticism would relate to serious matters which may call a doctor's fitness to practise into question.

## Determinations by other regulators/professional bodies

**29** We will also investigate if another regulator or professional body has made a finding (determination) against a doctor's registration as a result of fitness to practise procedures. This could be in the United Kingdom or overseas.

## Summary

**30** If a doctor connected to your designated body or working for or contracted by your organisation appears to have reached, or be close to, any of the thresholds (see paragraphs 15–29), you should contact us for advice on how to proceed. You can contact your employer liaison adviser (ELA) on 0845 375 0022 or by email at [liaison@gmc-uk.org](mailto:liaison@gmc-uk.org).

**31** If you decide to make a referral, you should read the guidance on our website for responsible officers and others making referrals on behalf of an organisation. This can be found at [www.gmc-uk.org](http://www.gmc-uk.org) under the section entitled Concerns about doctors. Referrals should be made by completing the referral form in GMC Connect. If a referral is urgent and GMC Connect cannot be accessed, the referral information should be sent by e-mail to [practise@gmc-uk.org](mailto:practise@gmc-uk.org) in the first instance. Our Fitness to Practise



directorates can also be contacted by telephone on 0845 357 0022.

- 32** Any employer who is not the doctor's designated body should consider speaking to the doctor's responsible officer in the first instance unless the concerns are very serious or urgent. Many concerns can be appropriately dealt with by the responsible officer without the need for referral to the GMC. Where appropriate, the responsible officer will discuss whether the threshold for referral is met with their ELA and provide feedback to the non designated body.

## **Further information**

- 33** This guidance summarises other guidance we have produced for our decision makers.
- 34** More detailed guidance for Case Examiners, the Investigation Committee and Medical Practitioners Tribunals is available on our website, as is all our other guidance on the standards expected of doctors (including Good Medical Practice).

## Annex - Case studies to support Thresholds guidance

The purpose of these case studies is to illustrate the principles in the guidance and help responsible officers, medical directors and others involved in the employment, contracting or management of doctors to apply them in practice.

### Case study one – Relationship with patient

Dr Nottingham is a consultant in Rheumatology who has provided medical care to Ms R for several years. He is aware that Ms R has been treated for depression by her general practitioner which was linked to severe pain caused by her condition. In recent months, Dr Nottingham has prescribed increasing amounts of Co-codamol to Ms R to address her pain. Her GP has written to Dr Nottingham to express concern that Ms R has become dependent on Co-codamol which has the potential for addiction. Dr Nottingham discussed the GP's concerns with Ms R but decided to continue prescribing Co-codamol as she became very distressed saying she simply could not manage without it.

Dr Nottingham has developed feelings for Ms R and broached the subject with her at a recent consultation. Ms R indicated that she feels the same way and, as a result, Dr Nottingham decided to end their long standing doctor-patient relationship. He subsequently entered into a full sexual and emotional relationship with Ms R.

However, Dr Nottingham's secretary is concerned about the probity of his actions and the appropriateness of his decision to no longer provide medical care to Ms R. The secretary escalates her concerns to the Trust's Medical Director and Responsible Officer (RO). The RO is unsure whether the threshold for referral to the GMC is met as Dr Nottingham appears to have acted responsibly by ending the doctor-patient relationship to pursue a personal one with Ms R.

### GMC guidance

Although most concerns about doctors can be adequately dealt with at a local level, paragraph 15 of the Thresholds guidance identifies five categories of case which are likely to meet the threshold for referral. These include an allegation that a doctor had an improper sexual or emotional relationship with a patient or someone close to them.

In Good medical practice we say:

53. You must not use your professional position to pursue a sexual or improper emotional relationship with a patient or someone close to them.

More detailed guidance is provided in our 2013 publication, [Maintaining a professional boundary between you and your patient](#). This contains the following advice to doctors:

- You must not pursue a sexual or improper emotional relationship with a current patient [paragraph 4]
- You must not end a professional relationship with a patient solely to pursue a personal relationship with them [paragraph 7]

The guidance further states that personal relationships with former patients may also be inappropriate depending on factors such as:

- a. the length of time since the professional relationship ended (see paragraphs 9–10)
- b. the nature of the previous professional relationship
- c. whether the patient was particularly vulnerable at the time of the professional relationship, and whether they are still vulnerable (see paragraphs 11–13)
- d. whether you will be caring for other members of the patient's family

### **Is the threshold met?**

This case is perceived by the RO as a difficult decision on whether referral is merited as Dr Nottingham ended his doctor-patient relationship with Ms R when he developed personal feelings for her. There is no evidence to suggest that an inappropriate relationship was occurring while Dr Nottingham was providing medical care to Ms R.

On balance, our advice would be that this case should be referred to us as Dr Nottingham has breached the guidance in Maintaining a professional boundary between you and your patient. He has ended the doctor-patient relationship solely to pursue a personal relationship and the fact that Ms R was known to be vulnerable having received treatment for depression as a result of the condition for which Dr Nottingham was treating her is an aggravating factor.

However, the key factor supporting a referral is that Ms R had become dependent on increasing amounts of Co-codamol to manage the pain from her arthritis and was increasingly reliant on Dr Nottingham continuing to issue prescriptions for the drug. This illustrates the unequal nature of the previous professional relationship between Dr Nottingham and Ms R. It also highlights the patient's vulnerability and the potentially exploitative nature of Dr Nottingham's actions in starting a personal relationship with her.

In these circumstances, the threshold for referral is met as Dr Nottingham has committed a significant breach of our guidance that cannot be adequately dealt with at a local level. The vulnerability of Ms R is an aggravating feature which means that the doctor's actions would meet the threshold for investigation under our fitness to practise procedures.

## Case study two – Bullying/harassment of colleagues to the detriment of patient care

Dr Sheffield has been the subject of allegations of bullying and harassment from three nursing staff. It is alleged that she has intimidated staff by shouting at them in front of patients and copying in the whole department to e-mails complaining about the standard of their work. There have been four reported incidents of Dr Sheffield confronting nursing staff in enclosed spaces about perceived errors in their work using aggressive body language such as jabbing her finger in their faces and advancing towards them. This behaviour has made them feel threatened and victimised and the nurses' working relationship with Dr Sheffield has almost completely broken down.

Dr Sheffield's actions have had a direct impact on patient care in the following ways:

- Patients have been present during incidents when Dr Sheffield shouted at nursing staff and questioned their competence by (incorrectly) accusing them of making basic errors e.g drug dosage, using incorrect equipment. This increased the patients' anxiety about their health conditions by undermining their confidence in the basic nursing care being provided.
- The dysfunctional relationship between Dr Sheffield and the three nurses means they will no longer communicate directly with her. This absence of teamwork has made patient care much less effective and has the potential for a serious clinical error to occur. There was a recent near miss when a delay was caused in the nursing staff relaying a highly abnormal blood test result to Dr Sheffield as they sent an e-mail rather than bleeping her directly.

The Clinical Director has been working with the Hospital's HR department to address the problem and identify a solution which will enable the nurses to work effectively with Dr Sheffield. However, Dr Sheffield refuses to accept that her behaviour has been unacceptable and maintains the nurses are incompetent and placing patients at risk and she has a duty to draw any errors to their attention. Dr Sheffield has refused to attend proposed mediation meetings and courses on interpersonal skills and effective team working.

Dr Sheffield's refusal to engage at a local level led the Clinical Director to seek formal advice from NCAS who recommended using their behavioural assessment tools and inviting Dr Sheffield to agree to a behaviour contract. An Occupational health assessment was also carried out which did not identify any health issue that could be affecting Dr Sheffield's behaviour in the workplace.

There were several attempts to implement the suggestions from NCAS but Dr Sheffield remained unco-operative and refused to sign a behaviour contract. No improvement in her behaviour was observed and the Trust has started formal disciplinary proceedings which have been significantly delayed by Dr Sheffield's solicitors raising numerous queries about their fairness and collusion between the three nurses. In the light of the delay and the potential risk to patient care from Dr Sheffield's behaviour, the Responsible Officer is considering whether to refer her to the GMC.

### **Is the threshold for GMC referral met?**

Paragraph 19 of the Thresholds guidance highlights that ELAs can provide advice to responsible officers on whether the threshold for referral is met on individual cases and the appropriate point to refer a case depending on the seriousness of the concerns and the doctor's willingness to engage in local remediation.

In the first instance, it was appropriate for the concerns about Dr Sheffield's bullying and harassment of colleagues to be managed locally with input from NCAS. However, given Dr Sheffield's refusal to admit her behaviour has been inappropriate or engage in any remediation, it is now appropriate to refer the case to the GMC. This is because Dr Sheffield is not complying with local measures and the risk to patient safety has become unacceptable as the nursing staff will no longer communicate directly with her leading to delays in treatment.

## Case study three – Doctor with health concerns

Dr Edinburgh (a Specialist Registrar in General Medicine) has requested a meeting with his Responsible Officer to disclose that he was diagnosed with bi-polar disorder two years ago and sectioned under the Mental Health Act. Dr Edinburgh advised that he is seeking advice after a recent crisis when he climbed on to the ledge of a multi-storey car park (believing he could fly) and the Police were called.

Following further discussion, Dr Edinburgh confirmed that his medication has been reviewed and he is compliant with treatment. He is under the care of a consultant psychiatrist attending monthly appointments.

The RO advises Dr Edinburgh to contact the Trust's Occupational Health department which he does the next day and gives his consent for them to request reports from his GP and treating psychiatrist. The reports confirm that Dr Edinburgh's condition is now being adequately managed with medication and he is being closely monitored for potential signs of a relapse or non-compliance with his treatment.

Dr Edinburgh agrees to attend monthly meetings with the Occupational Health department and notifies his supervising consultant of his condition. Together, they agree some measures to modify his clinical responsibilities and working practices to minimise the possibility of a relapse occurring in his health condition.

### **Is the threshold for GMC referral met?**

Paragraph 22 of the Thresholds guidance provides advice on the circumstances in which a doctor with a health concern may need to be referred to us. This is only necessary in a small number of cases where the doctor does not have insight into their condition and patients are being placed at risk as a result. Referral may also be appropriate if there is a significant risk of relapse or there is a misconduct issue such as stealing controlled drugs.

In Dr Edinburgh's case, the threshold for referral is not met. At present, there is no risk to patients or to public confidence as Dr Edinburgh has insight into the extent of his condition. This is evidenced by the fact he is receiving and is compliant with treatment and has sought the advice of the Trust's Occupational Health department who are monitoring him on a monthly basis.

The situation should be kept under review, however, as the threshold may be met should Dr Edinburgh become non-compliant with his treatment and refuse to engage with the Occupational Health department.

## Case study four – Criticism by an official inquiry

Dr Exeter, a GP in Devon, has recently been the subject of criticism by the Coroner in their summing up at the inquest into the death of a 28 year old patient. Ms M, a known intravenous drug user, had a telephone consultation with Dr Exeter at which she complained of severe pain, fever and discomfort from an abscess in her groin area. Dr Exeter prescribed Flucloxacillin over the telephone but did not ask Ms M to attend the surgery for a physical examination or refer her to hospital for assessment. The abscess burst two days later and Ms M suffered severe blood loss which led to a fatal cardiac arrest.

The Coroner was critical of the standard of care provided by Dr Exeter and found that Ms M would have survived if Dr Exeter had examined her in person or asked her to attend Accident and Emergency so that her abscess could be assessed and appropriate treatment instigated.

Dr Exeter has sought her Responsible Officer's advice on whether she should make a self-referral to the GMC.

### **Is the threshold for GMC referral met?**

Paragraph 28 of the Thresholds guidance states that doctors should inform us without delay if they have been criticised by an official inquiry as this is a requirement of Good Medical Practice.

Dr Exeter should be advised by her Responsible Officer to seek advice from her Medical defence organisation about making a self-referral as the following criteria are met:

- a Coroner's inquest is considered an official inquiry for the purpose of paragraph 75 of Good Medical Practice
- the criticism by the Coroner relates to serious matters with the potential to call Dr Exeter's fitness to practise into question. In this case, the Coroner found that Ms M would have survived if Dr Exeter had arranged for a physical examination of her abscess to take place.

## Case study five – Performance concerns

Dr Bristol was working as a single handed General Practitioner in a busy practice with over 2,800 patients and a large proportion of elderly patients. For several months, Dr Bristol had struggled to keep on top of the general practice administration and paperwork including repeat prescriptions and reviewing the results of his patients' blood tests and other investigations. He also found it difficult to get to grips with recent changes to the electronic systems for recording test results and other important patient information. Dr Bristol was initially reluctant to ask for help and felt isolated and overwhelmed.

Matters came to a head when Dr Bristol took time off for a minor operation. Upon his return, Dr Bristol belatedly acknowledged the situation had become unacceptable as the locum who covered his absence drew his attention to a significant backlog of pathology results and hospital letters which had not been actioned including changes to medication advised by patients' consultants. As a result, three incidences of potential harm to patients were identified by Dr Bristol.

Dr Bristol arranged a meeting with his Responsible Officer to advise him of the ongoing problems his Practice was experiencing which were now placing patients at risk of serious harm. The Responsible Officer referred the matter to an NHS England Performance Advisory Group where a local investigation was initiated.

Dr Bristol has fully engaged with the NHS England investigation and agreed to local Performers List undertakings and an action plan to address the failings at his practice. This includes a four week timetable to clear all the outstanding test results and hospital letters. Dr Bristol has also arranged for himself and his practice staff to attend training sessions on the new software and has recruited an additional member of staff to input data and organise the practice's administrative systems.

### **Is the threshold for GMC referral met?**

Although the concerns about Dr Bristol are serious, they relate primarily to inadequate administrative systems at his practice which have led to a deteriorating situation where patients were put at risk due to an increasing amount of unactioned test results and hospital letters. There are no specific concerns about Dr Bristol's professional knowledge and skills.

The Thresholds guidance advises that the majority of concerns can be safely managed at a local level and it is usually only necessary to refer concerns to us where attempts to improve the doctor's performance locally have failed. Paragraph 19 provides examples of scenarios where local management may not be appropriate.



However, in Dr Bristol's case, immediate referral to the GMC is not indicated as he is engaging with the local investigation and has put in place an effective action plan to address the concerns about his practice.

The case should be kept under discussion with the ELA as referral may become appropriate if Dr Bristol stops co-operating with local measures to improve his Practice's performance or if it becomes apparent that the concerns are more deep rooted than a failure to maintain adequate administrative systems and procedures which is remediable.