Audit of the fairness of decisions in the General Medical Council's fitness to practise procedure

July 2021
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1. Introduction

1.1 The purpose of the General Medical Council (GMC) is to protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine.

1.2 The GMC has four main functions under the Medical Act 1983:

(a) To set the educational standards for all UK doctors through undergraduate and postgraduate education and training.

(b) To decide which doctors are qualified to work here and maintain the public register of all those who are registered and licensed to practise.

(c) To set the professional standards for doctors in the UK and to make sure that they demonstrate on a regular basis that they are up to date and fit to practise (through the process known as revalidation).

(d) To take action when it believes a doctor may be putting the safety of patients, or the public’s confidence in doctors, at risk. This is often referred to as its “fitness to practise” process.

1.3 This Audit is part of an ongoing programme of work undertaken by the GMC to ensure that the application of its fitness to practise procedures are fair, consistent and robust. This review specifically considers whether the decisions made by GMC staff at key stages of its fitness to practise investigation process were consistent with the publicly available Guidance provided to them to help them reach these decisions.

The key question that this audit is designed to answer is: In relation to the evidence available to them at the point that a decision was taken, are the decisions by GMC staff at key points in the GMC’s FTP procedures in line with the Guidance provided to them for those decisions?

1.4 In responding to this question we have focused on decisions made at the following three key determinative stages of the investigations process:

(a) Triage decisions;

(b) Provisional enquiry decisions;

(c) Case examiner decisions.

This is not an audit of the process or decision-making leading up to each decision but rather this Audit focused on these key decision points.

1.4.2 Our report sets out a summary of our findings before explaining the GMC’s Investigation Process for fitness to practise cases, our project timelines and our methodologies both for sample selection and auditing. We conclude with our findings and our analysis and discussion.
2. Executive Summary

2.1 The Audit was commissioned to answer the question: "In relation to the evidence available to them at the point that decision was taken, are the decisions taken by GMC staff at key points in our fitness to practise procedures in line with the Guidance provided to them for those decisions?"

2.2 The Auditors’ careful case selection was designed to ensure that we audited a broad sample of cases with regard to (i) the category of case where key decisions were made (e.g. the types and sources of allegations); and (ii) the characteristics of the doctors about whom concerns were raised (e.g. ethnicity, the world region where the doctor gained their primary medical qualification (PMQ, world region and gender). The sample selection was undertaken by Annie Sorbie of the University of Edinburgh with administrative support provided by Fieldfisher, independently of the GMC and the members of the Audit team who then went on to audit these cases. Having received the redacted case files the Audit team were satisfied that the sample of cases included a good spread with respect to both the characteristics of doctors complained about and the types of cases that the GMC receive, and that all of the Guidance that we focused on in our Audit forms was engaged at least once.

2.3 We audited decisions against the framework of applicable Guidance to consider if decisions were appropriately aligned to that Guidance and fell within a range of reasonable decisions. The GMC Guidance supports decision making and does not mandate or determine what decision should be reached in any particular case. A range of possible outcomes is therefore possible and the audit examined whether each decision was within the bounds usually anticipated by the Guidance or whether an appropriate rationale had been provided for departing from the Guidance.

A detailed audit of 119 cases demonstrated to us that the decisions taken at key points between 1 November 2018 and 31 October 2019 were made in accordance with the GMC’s Guidance as set out in our audit forms.

2.4 The 119 cases consisted of 80 triage decisions, 15 provisional enquiry decisions and 24 case examiner decisions drawn from a sample frame of 14,936 decisions made by GMC decision makers in the period from 1 November 2018 to 31 October 2019 (Appendix A, Table 1).

2.5 The number of decisions we audited at each decision point reflected that far more concerns are initially received by the GMC and considered at the triage stage by GMC staff than are promoted through its investigative procedures. We looked at proportionally more provisional enquiry decisions than other types of decisions to interrogate this relatively new process that has been increasingly used since its introduction in 2014.

2.6 We found that Guidance was available to support all of the relevant decision-making and we particularly focused on key decisions. In the triage and provisional enquiries cases these were:

(a) the decision to characterise some matters a minor and then to close them, sometimes with the input of a medical case examiner;

(b) where no decision could be made without the provision of further information which was then communicated to the person raising the concerns;

(c) the identification and promotion of serious and/or persistent concerns for further forms of investigation (including the appropriate use of provisional enquiries);
(d) decisions in relation to convictions, cautions, determinations and other methods of police disposal;

(e) when and how to take a doctor’s fitness to practise history into account;

(f) the notification of Responsible Officers\(^1\) [ROs] or Employers in certain closed cases; and

(g) in rare cases, decisions about anonymous and confidential complaints and the decision to proceed with cases where events took place more than five years ago.

2.7 In the Case Examiner cases the key decisions, supported by Guidance were:

(a) the application of the realistic prospect test;

(b) again, when and how to take a doctor’s fitness to practise history into account;

(c) the circumstances in which undertakings might be offered;

(d) cases where warning or advice might be issued.

2.8 When answering the Audit question, having examined 119 cases we concluded that the decisions taken by GMC staff at key points in its fitness to practise procedures were in line with the Guidance provided to them for those decisions.

2.9 We found that there was no evidence of bias in the way decision-makers interpreted the guidance. Had we found non-compliance with the applicable Guidance, although our sample could not have yielded statistically significant results, we would have gone on to examine the personal characteristics of doctors involved. We would have explored whether there was anything we could observe about the nature of the cases or the characteristics of the doctor that might have shed light on the failure to follow Guidance and we would have conveyed our concerns to the GMC.

2.10 However, with no decisions being found to depart from GMC guidance, further analysis was unnecessary.

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\(^1\) ROs are senior doctors within an organisation, such as the Medical Director. The Medical Professional (Responsible Officers) Regulations 2010 describe their functions which include ensuring organisations have in place processes that provide a framework within which doctors are encouraged to maintain and improve their practice.
3. The Aims of the Project

3.1 The aim of this Audit was to select a suitable range of key decisions at key stages (initial triage, after provisional enquiries, and at the end of an investigation)\(^2\) of the GMC’s fitness to practise processes, which would allow us to undertake a detailed qualitative review of (i) the types of decisions that are considered at these stages, and (ii) the extent to which these decisions are either in line with Guidance or provide justifiable reasons for departing from this.

3.2 As such, a central consideration for the purposes of our Audit was that we wanted to scrutinise a reasonable range of the different types of decisions that are made about doctors by GMC staff at each stage, and thus the way that the Guidance is used in relation to these decisions.

3.3 To the extent that we did compare the proportion of particular types of cases in the sample frame to our Audit sample selection this was just as a broad reference point for our sampling decisions, rather than with the aim of creating a statistically representative sample.

3.4 It did not form part of our role to audit the numerous case handling decisions taken within any investigation and we are aware that the GMC has separate audit and quality assurance processes that review this work. Decisions were of course taken by decision makers within the GMC for example about exactly what lines of enquiry were to be pursued and how this was done but our work focused purely on the decision making at the end of each of the key stages.

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\(^2\) These are described in the next section of this report.
4. **Explanation of Investigation Process**

4.1 GMC decision makers (case examiners and on occasion Assistant Registrars) can, at the end of an investigation, decide that a case warrants referral to a tribunal of the Medical Practitioners Tribunal Service (MPTS). Such a referral is the most serious outcome available to case examiners at the end of the investigation stage. This Audit is restricted to a consideration of GMC decision-making. The decisions of MPTS and its panels are independent from the GMC and did not fall to be considered in this audit.

4.2 The GMC fitness to practise decision-making process is set out in diagrammatic form below.

**Investigation process**

![Diagram of Investigation Process]

4.3 Concerns can come to the attention of the GMC from a wide range of sources. Around 69% of complaints come from members of the public. The GMC is also alerted to concerns about a doctor’s practice by doctors’ employers, other organisations, other doctors/persons acting in a public capacity, the police, from press cuttings and as a result of self-notification by doctors.

4.4 The first stage on receipt of a concern is triage. Decisions are made by an Assistant Registrar (AR) who determines whether the case meets the threshold for investigation, which is that the allegation appears to raise a question as to whether doctor’s fitness to practise is impaired. Minor matters can be closed immediately (see more on the Guidance applied below) while other cases may require a better understanding of their nature before that decision can be made. Provisional enquiries (PE) are the process for gaining that additional understanding and can help the GMC decide whether further investigation is warranted.

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4.5 The triage stage (with or without provisional enquiries) will end with a decision either to close a case, to promote it to "Notify RO or Notify Employers" or to send it for full investigation as a Stream 1 investigation. Stream 1 complaints are complaints that have a serious and/or persistent element to them, and would, if proven, raise questions about the doctor’s fitness to practise. A case will be promoted to stream 1 if one or more of the following criteria applies:

(a) Persistent clinical errors;
(b) Persistent failures to provide appropriate treatment/care;
(c) Any single serious clinical error or failure to provide appropriate care;
(d) Any conduct which would fall into the category of ‘presumed impairment’ or where there is a presumption that the GMC will take some form of action such as allegations of dishonesty;
(e) Serious or persistent breaches of GMC Guidance on consent and/or confidentiality;
(f) Serious impairment by reason of ill health, to the extent that patient safety may be compromised.

4.6 In this Audit "Promoted cases" included not only those cases referred for investigation but also those "promoted" for provisional enquiries and those "promoted" to "Notify RO or Notify Employers". Notify RO or Notify Employers complaints are described as those complaints which, in and of themselves, do not appear to raise a question about the doctor’s fitness to practise, though they could potentially require action if part of a wider pattern of concerns.

4.7 Where a case is closed at the triage stage without any further GMC action a doctor may not know anything about the matter. In the small number of notify RO or notify Employers cases the GMC will share the concern with the doctor and their RO or Employer to ask that it be considered as part of ongoing appraisal and revalidation.

4.8 If a case meets the threshold, it is promoted for investigation. Further information is then gathered about the doctor and their current employment as well as more evidence to understand the concern. This information could include:

(a) further documentary evidence, eg medical records
(b) witness statements
(c) expert reports
(d) an assessment of the doctor’s health
(e) an assessment of the doctor’s knowledge of English
(f) an assessment of the doctor’s performance.

4.9 Once the investigation is complete the information is shared with the doctor to enable them to provide information, explanations and a response. Any response received is then part of the materials reviewed by the case examiners.

4.10 In the process of this Audit we observed, through the paper record, the investigative steps taken both during the provisional enquiries stage and the more formal Investigation stage, but these steps leading to the final key decision fell outside the scope of our audit. We would only have commented on the
investigation decisions if, as a direct result, the decision maker had not made a decision in line with the Guidance provided to them and as set out in the Audit form.

4.11 The case examiners decision-making stage involves the application of a ‘realistic prospect test’ (RPT). This test has two parts:

(a) whether the allegations are serious enough to warrant action on the doctor’s registration;

(b) whether the allegations are capable of proof to the required standard, namely that it is more likely than not that the alleged events occurred.

4.12 The case examiners ultimately decide whether to:

(a) conclude a case with no further action;

(b) conclude a case and issue advice;

(c) issue a warning;

(d) agree undertakings with the doctor to address a problem with their practice;

(e) refer to Investigation Committee (where warning not accepted);

(f) refer the case to the MPTS.
5. Project timelines

5.1 The project commencement date was 1 November 2019 and on 5 November 2019 the Audit team met with key individuals at the GMC to discuss our proposed approach and methodology and practical arrangements for the Audit. Throughout the project members of the Audit team have met with GMC staff virtually approximately every 6-8 weeks, to resolve practical matters and update on progress.

5.2 After the set-up meeting we received pseudonymised Excel spreadsheets of all GMC cases that had passed the relevant decision points in the relevant twelve month period. These spreadsheets included details such as the allegation source, the type of allegation and the relevant doctors’ ethnicity, place of primary medical qualification (PMQ), specialty, age/time since gaining their PMQ and gender. This sample frame was provided on 18 December 2019.

5.3 All relevant Guidance for the period was uploaded on 16 December 2019. Additional Guidance was provided in April 2020 in response to queries that had arisen during the Auditor’s regular ‘check in’ calls with the GMC.

5.4 Between November 2019 and February 2020 we developed and applied our sampling methodology, described in more detail below. By April 2020 we had largely completed the case selection process and the GMC were able to begin to prepare cases to be uploaded for auditing. By this point the Covid-19 pandemic had brought about altered working arrangements for all involved and the Audit team and GMC staff were working from home.

5.5 From March to June 2020 the Audit team reviewed the relevant Guidance materials and developed their Audit forms (Annex C). We had regular calls with the GMC to discuss these set up stages for the Audit. The GMC identified the guidance that was key to them and upon which the Audit was to focus. The resulting final Audit forms focused on specific aspects of the decision making process.

5.6 In June 2020 the Audit team began to receive uploaded redacted case files for review. Members of the Audit team regularly met remotely to review auditing progress and to consider any issues identified in cases.

5.7 As at 1 October 2020 we had completed the Audit forms for 23 triage decisions and 9 case examiner decisions. An interim progress report was delivered in November 2020 and Audit work continued. Miscellaneous queries and outstanding documents were resolved and all materials were available to the Audit team by 31 March 2021 at which point Audit work was finalised and the final report prepared.
6. Methodology for sample selection

6.1 The Audit was carried out in respect of decisions made by GMC decision makers in the period from 1 November 2018 to 31 October 2019. Pseudonymised details of these cases were provided to us in an Excel spreadsheet. Prior to provision of these details the GMC had removed the small number of cases where Fieldfisher had previously had any involvement on behalf of the doctor who was the subject of the case. The sample selection was undertaken by Annie Sorbie of the University of Edinburgh with administrative support provided by Fieldfisher, independently of the GMC and the members of the Audit team who then went on to audit these cases.

6.2 As data was captured at three key decision points a case that had progressed through each of these points would appear in the sample frame three times (if it had done so within the specified time period). To remove duplication (in order to maximise the number of different cases we audited) we checked the final sample to make sure that the same UID did not appear more than once.

6.3 The total number of decisions in the sample frame was 14,936 (Appendix A, Table 1). We were engaged to audit 80 triage decisions, 15 provisional enquiry decisions and 25 case examiner decisions.

6.4 The number of decisions to audit at each decision point was made both with reference to the quantity of cases that could be reviewed in sufficient depth within the time allowed, and to broadly reflect that far more concerns are initially received by the GMC and considered at the triage stage by GMC staff than are promoted through its investigative procedures. While we looked at proportionally more provisional enquiry decisions than other types of decisions this reflects the GMC’s desire to interrogate this relatively new process that has been increasingly used since its introduction in 2014.

Triage cases

6.5 There were 11,903 triage decisions in the sample frame (Appendix A, Table 1). We excluded all cases (126) where the allegation category was recorded as ‘not about a doctor’ (Appendix A, Table 2). Our revised population of triage cases comprised 7,577 decisions to ‘close’ a case and 4,200 decisions to ‘promote’ a case (Appendix A, Table 3).

6.6 Although proportionally more triage cases were closed than promoted, we decided to audit 40 closed cases and 40 promoted cases. This ensured that we were able to consider a good sample of cases that were found by a GMC decision-maker to be serious enough to progress, whilst a proportionate approach would have resulted in only a smaller number of cases in our sample.

6.7 Using functionality within Excel we randomly selected our initial sample of 40 cases from the closed triage case decision population and 40 cases from the promoted triage case decision population.

6.8 We then considered each of the two random samples of 40 cases that this generated in respect of (i) the categories of case these related to (e.g. the types and sources of allegations); and (ii) the characteristics of the doctors about whom concerns had been raised (e.g. ethnicity, world region where PMQ was obtained, gender and age), as outlined further below.

Initial random sample of 40 triage decisions to close

6.9 We first considered the types of cases in our initial random sample of 40 closed triage cases. We considered the seven potential sources of the concern (Doctor; Employer; GMC other; GMC press cuttings; Other;
Police; Public). In the initial sample four of these sources were included (excluding Employer; GMC press cuttings; Police). We then looked at the five potential types of allegation (Communication, partnership and teamwork; Knowledge skills and performance; Maintaining Trust; Not in Good Medical Practice (GMP); Safety and Quality). All of these were included apart from Safety and Quality. Next we considered the characteristics of the doctors about whom concerns had been raised.

6.10 Of the seven ethnic origin categories recorded for doctors in the triage data for decisions to close (Asian or Asian British; Black or Black British; Mixed; Not Stated; Other Ethnic Groups; Unspecified; White) all were represented, apart from Mixed and Other Ethnic Groups. There were cases across all five recorded PMQ world regions (Europe EU; Europe Non-EU; International; UK; Unspecified) and the sample included each of the data categories recorded in relation to gender (Men; Women: Unspecified).

6.11 Having considered the initial random sample of 40 decisions to close triage cases we decided we wanted to look at decision categories across all of the allegation types and concern sources, and in relation to doctors with all of the characteristics above. To achieve this we purposively swapped three cases into our sample. In choosing the three cases to swap out we chose those which included case categories and/or registrant characteristics that were slightly overrepresented in the initial sample, as compared to the full cohort of closed triage cases in the sample frame.

6.12 Having made these swaps we undertook a final check and were content that we had a good breadth of decisions to audit that broadly reflected the range of cases in the wider cohort of closed triage decisions. We observed the following about our final sample following the swaps described above:

- All of the allegation types and concern sources recorded in the triage data for decisions to close were included.
- All of the ethnic origin categories and PMQ world region categories recorded in the triage data for decision to close were included.
- All of the gender categories recorded in the triage data for decision to close were included.
- The age of the doctors at the time that a concern was raised ranged from 27 to 61 years.
- The time since PMQ to the enquiry ranged from 3 to 36 years.
- The sample included both GPs and those who practised across a range of specialities.

Initial random sample of 40 triage decisions to promote

6.13 We undertook a similar process of random case selection and review for triage decision to promote. This time the sample contained cases from all of the seven concern source types recorded in the triage data for decisions to promote, and cases from four of the five allegation categories (excluding Not in GMP).

6.14 The characteristics of the doctors about whom enquiries had been made included six of the seven ethnic origin categories recorded (excluding Not Stated), four of the five PMQ world region categories (excluding Unspecified), and two of the three recorded gender categories (excluding Unspecified).

6.15 Having considered the initial random sample of 40 promoted triage decisions we noted that while this contained decision types across all of the concern sources above, it omitted one allegation type and some doctors’ characteristics were not represented. We decided we wanted to look at decision types across all of the allegation types and concern sources, and in relation to doctors with all of the characteristics above. To achieve this we purposively swapped four cases into our sample. In choosing the four cases to swap out we chose those which included case types or registrant characteristics that were slightly overrepresented in the initial sample, as compared to the full cohort of promoted triage cases in the sample frame.
Having made these swaps we undertook a final check and were content that we had a good breadth of decisions to audit that broadly reflected the range of cases in the wider cohort of promoted triage decisions.

We observed the following about our final sample:

- All of the allegation types and concern sources recorded in the triage data for decisions to promote were included.
- All of the ethnic origin categories and PMQ world region categories recorded in the triage data for decision to promote were included.
- All of the gender categories recorded in the triage data for decisions to promote were included.
- The age of the doctors at the time that a concern was raised ranged from 26-65 years.
- The time since PMQ to the concern ranged from 3 to 42 years.
- The sample included both GPs and those who practised across a range of specialities.

Provisional enquiry decisions (15)

There were 892 provisional enquiry decisions in the sample frame. These were split between the cases where a decision was made to ‘close’ the case (408), to ‘close and notify the responsible officer (RO) / employer’ (224) and to ‘promote’ the case for further investigation (260) (Appendix A, Table 4)

As above we had agreed to audit 15 provisional enquiry cases in total. Although proportionally more decisions were made to close provisional enquiry cases we decided to select five cases from each of the three types of decision (to close; to close and notify RO/employer; to promote) in order to look at a range of each type of decision and the Guidance these decisions engaged.

For each of these three types of decision, we also wanted to look at cases relating to each of the four main allegation types which were represented in this cohort of cases: Communication, partnership and teamwork; Knowledge skills and performance; Maintaining Trust; and Safety and Quality. For both decisions to ‘close’ and to ‘close and refer to RO/employer’ we randomly selected one decision relating to each of these four allegation types. The decision to ‘promote’ cases contained an additional allegation type, Not in GMP, and so here we randomly selected one case across five allegation types. Having randomly selected 13 of the 15 decisions in our sample we purposively selected the final two decisions (one to ‘close’ and one to ‘close and refer to RO/employer’) as our sample did not include any cases relating to doctors who identified their ethnicity as Unspecified or Black British.

Given the small sample size we considered the types of cases our sample contained and the characteristics of the doctors about whom enquiries had been made across the sample of 15 cases selected, rather than by each of the three decision types.

The sample of 15 provisional enquiry cases contained types of cases across all five allegation categories recorded in the provisional enquiry data. It further contained cases from five of the seven ethnic origin categories recorded in the provisional enquiry data (excluding Mixed and Not Stated), four of the five PMQ world regions categories (excluding Unstated), and two of the three recorded categories relating to gender (excluding Unspecified).

Albeit that there was only one case in the full cohort of provisional enquiry cases where this allegation category was recorded.

Being the ethnic origin categories that did not feature in the sample of 13 cases but were the next most highly represented in the full cohort of provisional enquiry cases after those that already appeared in the sample.

Note that unlike for triage decisions, data on the source of the concern was not provided for provisional enquiry decisions.
6.22 Given the constraints of the number of provisional enquiry decisions to be audited, we decided not to make any swaps. In addition to the points observed above in relation to the final sample, we also noted as follows:

- The age of the doctors at the time that a concern was raised ranged from 39-74 years.
- The time since PMQ to the concern ranged from 13 to 51 years.
- The sample included both GPs and those who practised across a range of specialities.

Case examiner decisions (25)

6.23 There were 2,141 case examiner decisions in the sample frame. These were split between six decision types as follows: Conclude; Conclude with advice; Issue warning; Refer to hearing; Refer to IC; Undertakings (Appendix A, Table 5).

6.24 As above we had agreed to audit 25 case examiner decisions in total. Although proportionally more decisions were made to conclude cases we decided to select cases evenly across each of the six types of decision (four of each decision type, apart from decisions to ‘refer to hearing’ where we looked at five) in order to consider a range of each type of case and the Guidance these decisions engaged.

6.25 For each type of decision, we randomly selected one case from each of the four main allegation categories to ensure we looked at a good range of allegation types (i.e. Communication, partnership and teamwork; Knowledge skills and performance; Maintaining Trust; and Safety and Quality). Two cases in this cohort of 2,141 case examiner decisions fell outside of these allegation categories – one decision to conclude a case where the allegation category was Not in GMP (which we did not include in our sample) and one decision to refer to a hearing a case where the allegation category was Probity (which we did include).\(^7\)

6.26 Given the small sample size we considered the types of cases our sample contained and the characteristics of the doctors about whom concerns had been raised across the sample of 25 cases selected, rather than by each of the six decision types.

6.27 Considering the characteristics of the doctors about whom concerns had been raised in our sample we noted that it contained cases from six of the seven ethnic origin categories recorded in the data for case examiner decisions (excluding Mixed). The sample contained cases across all four of the recorded categories in relation to doctors’ PMQ world region\(^8\) and two of the three recorded categories relating to gender (excluding Unspecified).

6.28 Given the constraints of the number of preliminary enquiry decisions to be audited, we decided not to make any swaps. In addition to the points observed above in relation to the final sample, we also noted as follows:

- The age of the doctors at the time that a concern was raised ranged from 30-77 years.
- The time since PMQ to the concern ranged from 4 to 51 years.
- The sample included both GPs and those who practised across a range of specialities.

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\(^7\) This was a practical decision as the sample size meant we were only able to audit four closed cases (which we selected from the four main allegation types, excluding the single Not in GMP case) whereas we were able to audit five cases which were referred to a hearing (which gave scope to include the Probity case).

\(^8\) No doctors in this cohort recorded their PMQ world region as Unspecified.
Review of final sample

6.29 We checked our final sample section of 120 decisions in relation to all three cohorts of decisions (triage; provisional enquiry; case examiner) to make sure that the same case did not appear more than once. We did not identify any duplication in the final sample.

Sample adjustments during the Audit process

6.30 As this Audit was carried out during the period of the Covid-19 pandemic the papers in respect of three of the case examiner decisions that we had included in our sample were too voluminous to be accessed and then shared remotely. To avoid delay these cases were each swapped for a case with a similar profile. The description above of the types of cases our sample contained, and the characteristics of the doctors about whom enquiries had been made, was unchanged by these swaps save for in a minor respect. We again checked for duplicate cases across the updated final sample of 120 cases but none were detected.

6.31 Towards the end of the process, we identified that one case had been included in the sample where, in fact, no relevant decision took place during the time period agreed for the Audit. In discussion with the GMC we agreed to exclude the case. Specifically, the case had been thought to be a case examiner undertakings decision (relating to the allegation type: Communication, teamwork and partnership) but, in fact, in the relevant time frame, only an MPTS decision was taken. The exclusion of this case reduced our Audit sample to 119. We were content that the impact of this withdrawal was negligible.

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9 This change was that the sample now included one less doctor who recorded their PMQ region as UK and one more doctor who recorded their PMQ region as Europe EU. We also observed that these swaps slightly increased the range of cases we would consider in respect of the ‘time since PMQ to the concern’ which now ranged from 2 to 51 years.

10 The description above of the types of cases our sample of case examiner decisions contained, and the characteristics of the doctors about whom enquiries had been made, was unchanged by the withdrawal of this case, save that we did not audit a case examiner undertakings case where the allegation type was Communication teamwork and partnership. We audited other case examiner decisions in relation to this allegation type, and other case examiner undertakings decisions in relation to different allegation types.
7. **Methodology for Auditing**

7.1 The Audit team members were experienced, legally qualified members of Fieldfisher’s professional discipline teams in the UK and Ireland. This large, specialist group is highly rated in the legal directories for high-profile and complex professional disciplinary cases, as well as those involving the most serious risks to clients’ reputations. Fieldfisher acts for over 40 different regulators, including those in areas such as health, sport, surveying, policing, finance and law. Our Audit and review service, and our work for oversight bodies means we have trained and experienced auditors who undertake fitness to practise work and Audit such work regularly.

7.2 The GMC provided us with a full set of relevant Guidance prepared for and used by GMC decision makers. They also provided Information about any key changes, such as new policies or process, introduced during the sampling period that might affect the data.

7.3 Each member of the Audit team was provided with a full set of the GMC Guidance both in electronic and hard copy with which they ensured they were familiar. The electronic versions of the GMC Guidance were available to the Audit team in a searchable electronic format.

7.4 The 80 triage decisions, 15 provisional enquiry cases and 25 case examiner decisions were divided amongst the team members. While some members of the Audit team focused on single case types ie ‘triage closed’ other members of the Audit team audited across a broader cohort of case types.

7.5 Each member of the Audit team was provided with the template Audit form (Annex C) to reflect the case type the audit.

7.6 The Audit team met regularly, virtually, to discuss progress and to ensure a consistent and moderated approach throughout auditing. These meetings facilitated discussion of any cases where further information was required and would have served to highlight any decisions which might have been at variance with the Guidance.

7.7 The uploaded cases were reviewed with a full read of all the documents provided and then the Auditors focused on the key decision making for the purpose of completing the relevant Audit form. In certain cases it became apparent to the members of the Audit team that documentation was missing from the bundles provided or that we needed additional decision documentation. In other cases, where a complaint related to a number of doctors, it was sometimes unclear which of the complained doctors the Audit related to. These queries were submitted to the GMC and the relevant information was provided back to the Audit team.

7.8 The bespoke Audit forms supported a consistent audit approach, and drew on the relevant Guidance documents at each decision making stage. This allowed the team to consistently and objectively scrutinise the decision for Guidance compliance and to answer the Audit question. By involving subject experts, lawyers with extensive fitness to practise casework experience, we were able to provide a more qualitative assessment of the decision-making, in relation to whether, on the evidence available to them at the point that the decision was taken, decisions taken were in line with the Guidance provided. Audit team members highlighted and escalated decision making warranting discussion or greater consideration. In the preparation of the final report completed Audit forms and highlighted issues were reviewed by a Fieldfisher partner.
The triage and provisional enquiries stage audit form focused on the decision making at that stage, the key question being whether the allegation appears to raise a question as to whether the doctor’s fitness to practise is impaired.

7.9 Key decisions at these stages are whether:

(a) To close the case immediately
(b) To promote the case for investigation to case examiners

or, having undertaken provisional enquiries:

(a) To close
(b) To close and notify the Responsible Officer/Employer
(c) To promote for further investigation to case examiners.

7.10 The key pieces of Guidance for the Assistant Registrar (AR), who is the decision maker at the triage and provisional enquiries stages are the relevant versions of:

(a) The Triage manual
(b) GMC Thresholds Guidance
(c) The Provisional Enquiries manual
(d) Guidance on categorising Stream 1
(e) Allocating cases to the National Investigation Team and the Regional Investigation Teams
(f) Guidance for decision makers on when to take a doctor’s fitness to practise history into account
(g) Guidance for decision makers on Provisional Enquiries.

7.11 A full list of the Guidance documents available at this stage appears at Appendix 2.

7.12 The GMC Thresholds Guidance is intended to provide Guidance for Responsible Officers (RO), medical directors and other relevant staff who are involved in the employment, contracting or management of doctors. It seeks to clarify those matters where the GMC can, and cannot, take action. In theory the Guidance supports external decision makers to understand whether to refer a case to the GMC and should reduce referrals that do not raise a question about a doctor’s fitness to practice.

7.13 The Thresholds Guidance is however relevant to the GMC decision maker to ensure a consistent approach and that referrals that still reach the GMC, which do not meet the threshold, are closed at an early stage. Our Audit checked that minor matters were closed in accordance with the Thresholds Guidance. Conversely we looked at the application of principles in the Guidance intended to ensure that serious and/or persistent concerns were prioritised and were either promoted for investigation or sent for provisional enquiries to gain a fuller understanding.
7.14 Some decision making at this early stage requires the input of a medical case examiner where the concern relates to clinical care of a patient. We looked to see that cases were not closed without such input where the Triage Manual indicated that it should be sought.

7.15 We looked at compliance with the GMC Guidance on categorising enquiries and ensuring reflection and learning from lower level cases and addressing patterns of concern and in particular at the use of "Notify RO" of "Notify Employers" outcomes. We noted the presumption that cases about clinical care or treatment will be dealt with by Notify RO or Notify Employers unless they met criteria in para 9 of 'Guidance on categorising Stream 1 and Notify RO or Employers.

7.16 Although relatively rare, we looked as well at the discretionary decision about whether it was in the public interest to proceed if events took place more than 5 years ago, where the AR should consider seeking information regarding why the matter was only being raised now. We looked at the detailed Guidance for decision makers in such a case and at whether it was appropriately applied.

7.17 The GMC has specific Guidance about anonymous and confidential complaints and again we saw this applied in one of our sample.

7.18 Concerns which stem from convictions, cautions, determinations and other methods of police disposal require a number of specific considerations and there is detailed Guidance to apply in these cases to ensure appropriate referrals for possible interim orders and that the most serious offences can be sent to the MPTS directly in certain circumstances. At the lowest end of this spectrum there is Guidance about when Penalty Notices for Disorder and Fixed Penalty Notices may require investigation and when they can simply be closed.

7.19 We reviewed whether Guidance was appropriately applied in the decision making as to making provisional enquiries, looking particularly at the provisional enquiries Manual and Operational Guidance for this stage. A provisional enquiry is limited to gathering one or two discrete and "easily obtained" pieces of information such as medical records, a coroner’s report or a local investigation report.

7.20 Our Audit process also ensured we considered whether decision makers had appropriately considered and applied Guidance on when and how to take a doctor’s fitness to practise history into account. We were advised by the GMC that a doctor’s fitness to practise history is readily available on the GMC’s internal system but is not downloaded or copied across to the complaint part of the electronic file. As such the bundle provided to the Auditors did not always contain information regarding a doctor’s fitness to practise history; in many cases it was however evident from the bundle if the doctor had a fitness to practise history for example by way of case examiner reports. In certain cases we raised clarifications with the GMC. In other cases we proceeded on the basis that there was no fitness to practise history and that this would have been easy for the decision maker to check on the internal system even if it was not overtly referred to in our papers.

7.21 A different Audit form was used for case examiner decisions.

The Case Examiners decision audit form stage focused on the decision making at that stage, the key question being – is there a realistic prospect of establishing that a doctor’s fitness to practice is impaired to a degree justifying action on registration (the realistic prospect test or RPT).

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11 An Interim Orders Tribunal can impose conditions on a doctor to limit a doctor’s practise or behaviour or suspend the doctor while the allegations are investigated.
7.22 The key decision at this stage is whether or not a case passes the realistic prospect test (RPT). Where it does not the case may be:

(a) Closed with no further action

(b) Closed with advice

(c) Closed with a warning (If a doctor refuses to accept a warning, the GMC will send the case to an Investigation Committee hearing to decide the outcome. It has the power to place a warning on the doctor’s record or conclude the case with no further action.)

Where the realistic prospect test is met the case examiners may either:

(d) agree undertakings with the doctor to address a problem with their practice; or

(e) refer the case to the MPTS.

7.23 The key pieces of Guidance for the case examiners are:

(a) Making decisions on cases at the end of the investigation stage

(b) The realistic prospect test

(c) Guidance on the impact of health in misconduct, conviction, caution and performance cases

(d) Guidance for decision makers on single clinical incidents

(e) Guidance on police cases resulting in acquittal or a decision not to proceed to trial

(f) Types of cases where failure to meet the standards may lead to action

(g) Guidance on agreeing, varying and revoking undertakings

(h) Guidance on warnings

(i) Guidance on drafting warnings

(j) Giving written advice

(k) Guidance on withdrawal of referrals

7.24 A full list of the Guidance documents available at this stage appears at Appendix B.

7.25 There is detailed Guidance, in part derived from the case law, which supports the two stages of deciding if a case meets the realistic prospect test. Our case examiner decision Audit form ensured we considered whether the RPT has been applied in accordance with the established principles set out in the Guidance. We also checked if a case met the presumption of RPT in relation to fitness to practice and that it had either been referred to the MPTS or exceptional circumstances to avoid referral were identified.

7.26 Again for these decisions we looked to see that the decision makers had appropriately considered and applied Guidance on when and how to take a doctor’s fitness to practise history into account.

7.27 Where the RPT was met but undertakings were offered and accepted, we considered whether the decision makers applied the specific relevant Guidance. This explains that offering and accepting undertakings must
be considered sufficient to protect patients and maintain public confidence, and there should be reason to believe that the doctor would comply with the undertakings. We looked to check that undertakings addressed all the areas of concern and types of impairment identified in the allegation that met the realistic prospect test.

7.28 The Guidance is clear that undertakings may not be proposed where there is a realistic prospect that, if the allegations were referred to the MPTS, the doctor would be erased from the Register and there is a longer list of examples where undertakings would not usually be viewed as appropriate.

7.29 We reviewed cases where a warning might have been issued. This can only happen when, having taken account of any mitigation, a decision is made that there is no realistic prospect of establishing that the doctor’s fitness to practise is impaired to a degree requiring action on his or her registration. Warnings are appropriate for allegations that are just below the threshold for impaired fitness to practise and involve:

(a) a significant departure from Good Medical Practice, or

(b) a significant cause for concern following an assessment of the doctor’s performance.

7.30 Advice is an option for case examiners, again where they are satisfied that the doctor’s fitness to practise is not impaired in respect of this allegation. According to the Guidance decision makers should consider giving advice only where rule 7 disclosure\(^\text{12}\) has taken place and the doctor has made written submissions to the GMC indicating that the facts of an allegation are admitted or do not remain in dispute.

7.31 During the Audit and once the auditing was completed the Audit team reflected on the entirety of the materials reviewed and the internally completed Audit forms.

7.32 Had we identified any decisions which were not in line with the GMC’s Guidance we would have looked back at the data set and would have sought to identify or observe any particular characteristics associated with the case such as source of referral or nature of concern, or associated with the doctor. We did not undertake this exercise because we found no cases of non-compliance.

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\(^{12}\) Rule 7 of the Fitness to Practise Rules 2004 requires the GMC Registrar to inform the practitioner of the allegations of impaired fitness to practise and provide them with copies of any documents in support of the allegation.
8. Findings

40 Cases closed at Triage

8.1 In this part of the Audit we identified eight cases that were closed by the AR for lack of sufficient information from the referrer. When additional basic information was not forthcoming the case would be “closed” albeit the letter to the referrer would explain “At this time please note that your complaint has been closed however should you provide further information in the future we can re-assess your complaint at that time.”

8.2 We considered that such closures were made in accordance with the GMC Guidance particularly the “Non decision” section of the Triage manual. A number of these cases were potentially serious allegations but required further information. We did not audit the processes undertaken to gain that “Further Information” or “FI” but were aware that the Triage Investigation Assistant Manual sets out how an Investigation Assistant is allocated a request for FI, requests the information from the complainant or referrer, chases the request, and then deals with the information once it is received. We considered non-decision closures to be in line with the Guidance which acknowledges that “sometimes an AR will not have enough information to make a decision. In these circumstances, the AR might decide that a non-decision is appropriate. This is when we know that the FI will be, or could be, available in the future, but won’t be available for some time.”

8.3 We also found appropriate closure of the remaining cases that did not meet the Thresholds. We noted the appropriate use of the medical case examiner in clinical care cases, for example in a case involving the touching of a breast to assist with the assessment as to whether that conduct would seem to be a potentially criminal sexual assault.

8.4 We saw one case involving a minor (self-reported) motoring offence, relating to dangerous parking, for which the doctor was fined and given 3 penalty points. There was no fixed penalty notice because the doctor’s accumulated points resulted in them wishing to attend court to avoid losing their licence. The appropriate guidance was followed, resulting in closure. In another case the GMC could not identify, on the information provided, any misleading or dishonest conduct on the part of the doctor and the remaining issue, a failure to provide feedback, was deemed not to be sufficiently serious as to raise fitness to practise concerns. In a third example a member of the public was “agitated” by a doctor’s behaviour and it appeared that the matter was categorised as a ’minor non-clinical matter’ and dealt with accordingly. There were several examples of low level concerns raised by members of the public which were closed in accordance with the Guidance.

8.5 We audited one health case in this sample (categorised as a Safety and Quality case) in which an Employment Liaison Adviser (ELA) had notified the GMC of a doctor who was unfit to work due to their mental health. The RO indicated that the doctor was getting appropriate medical and pastoral care and the case was closed.

8.6 We audited one case where the referrer was anonymous (it appears they may have been a member of the same clinical team). In accordance with the relevant Guidance there was limited disclosure to the RO which resulted in the Trust being able to provide information about the incidents and also clarifying that they did not have concerns about the events or that particular doctor.
8.7 We audited one case in this category where the application of the 5 year rule had to be considered. We noted that there was an option to seek legal advice in relation to this (per the Guidance) which the AR opted not to do. This might have been useful given the potential difficulty in confirming when time should run from. However the AR did seek a reason for the delay in complaining from the complainant. The closure was made on the basis of not having received the requested further information and so the full application of the rule was not tested and non-compliance with GMC Guidance was not identified.

8.8 We found the cases closed at triage were closed in accordance with the applicable GMC Guidance as set out in our Audit form. The cases selected engaged all the Guidance identified in our Audit form including health and criminal cases. The Guidance for prioritising serious concerns was considered but did not apply in the cases in this selection.

40 Cases promoted at Triage

8.9 This sample of cases were all classed as "promoted" which in effect means that they were not closed at the first consideration. Nine were promoted to RO/Employer disclosure, 13 were promoted to provisional enquiries, 18 were promoted to Stream 1 for full investigation.

8.10 We were satisfied that the Threshold Criteria were appropriately considered and none of these cases ought to have been closed with no further action.

8.11 We reviewed each case against the applicable Guidance and were satisfied that the decisions taken were in accordance with the Guidance. Cases "promoted" to RO/Employer advice were actually being closed, but with this additional step being taken to ensure the issues were picked up locally and potentially within appraisal and revalidation.

8.12 Provisional enquiries were sought in thirteen cases. Again this was in accordance with the Guidance and was appropriate, particularly where documents such as medical records and sometimes an expert report were required to better understand the nature and/or seriousness of the concerns. Referral for provisional enquiry followed the principles that such enquiries may be suitable where the allegation itself is unclear and/or further information is needed to clarify whether the nature or seriousness raises a question of impaired fitness to practise.

8.13 We reviewed one case involving a whistleblower whose complaints related to two unnamed doctors. There was protracted correspondence with the referring person (themselves a doctor) but the complainant would not provide names. The GMC's Public Interest Concerns Review Group looked at the case and helped the AR develop targeted provisional enquiries in relation to two doctors who they were able to identify for further evidence to be gathered including an expert view.

8.14 We were aware that the triage decision makers have Guidance on how to approach single clinical incidents (SCI) and we reviewed whether cases fell into that category and then whether they were treated appropriately. We noted one case not thought to be suitable for consideration as an SCI as it would appear that two separate consultations occurred on two different days; one telephone consultation where pain medication was prescribed, and one home visit. It was promoted for usual provisional enquiries, in accordance with Guidance. In five cases, SCI were appropriately flagged and cases were sent for SCI-PE (a provisional enquiry relating to a single clinical incident) where, for example the seriousness of the incident remained unclear.

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13 Rule 4(5) of the Fitness to Practise Rules 2004 states that "No allegation shall proceed further if, at the time it is first made or first comes to the attention of the General Council, more than five years have elapsed since the most recent events giving rise to the allegation, unless the Registrar considers that it is in the public interest for it to proceed."
The cases which were sent for investigation were again done so in accordance with the Guidance and it was possible to discern the correct triggers of seriousness and or persistence. Within this sample we saw cases with possible health concerns and were satisfied that these were appropriately referred for investigation.

We saw one case promoted for investigation where the complaint was quite old ("from about 10 years ago") and related to the long term failure to properly store medical records (at home). If more than five years had elapsed since the most recent events giving rise to the allegation the AR would have needed to consider the 5 year rule advice. However we considered that the failure was likely to be ongoing which would have removed the need for this consideration, and we considered the promotion for investigation to therefore be appropriate. The AR made no express reference to this so it is uncertain whether the 5 year rule advice was considered.

Generally, we considered that the Triage Decision reasoning and recording was completed in accordance with the Guidance as set out in our Audit form, although as indicated above we could not always see evidence in the materials provided to us that the AR had considered the doctor’s fitness to practise history. See para 7.20 above in this regard.

The cases selected engaged the Guidance identified in our Audit form including health and criminal cases, the whistleblower (confidential) case and the conduct over 5 years.

15 Triage decisions after Provisional Enquiries

This sample of cases were all ones in which there had been an initial decision to promote the case for provisional enquiries. We then focussed on the AR decision at the conclusion of that process. Following our sampling methodology we reviewed five cases which at this point were closed with no further action, five closed with Notify RO/Employer and five which were promoted for Stream 1 investigation.

Again we were satisfied that the AR decision making in relation to these cases was in accordance with the relevant GMC Guidance.

By this stage in the GMC process, minor matters that did not meet the triage thresholds should, and in our sample cases had, been closed. In theory we might have seen cases that required provisional enquiries to understand the nature of health or criminal case but our sample did not contain such cases and this accorded with our observations that such cases could usually either be closed or promoted for investigation based on the initial information received.

In thirteen of the fifteen cases medical records were obtained and expert advice was sought, following which no concerns were identified about the care provided (the subject of the concerns raised). This suggested to us that this was a frequent and appropriate use of the provisional enquiry process. Cases were appropriately sent for Notify RO in the five selected cases, on the basis that while the records indicated that full consent had been obtained and full information provided to the patient, it appeared that the patient had not fully understood the information given to them by the doctor, or because of other apparent communications issues. Given the Guidance it was rightly suggested that these cases might be an opportunity for learning for the relevant doctors.

In this part of the Audit we did not see, and would not have expected to see, any anonymous complaints nor cases requiring engagement with the five year rule.
Case examiner decisions

8.24 As described above our sample selection was spread across each of the six types of decision so we considered four cases concluded with no further action, four concluded with Advice, four where Warnings were given, four that were referred to the Investigating Committee, three where undertakings were agreed and five which were referred to a hearing, in order to consider a range of each type of case and the Guidance these decisions engaged.

8.25 The case examiners must first and foremost understand and correctly apply the realistic prospect test (RPT) (described above). There is considerable specific Guidance that supports this crucial decision.

8.26 We found that the case examiners appeared to clearly understand the test and made decisions in accordance with the Guidance on this point. The decision documents demonstrated consideration of issues such as that case examiners:

(a) should bear in mind that before the Medical Practitioner Tribunal panel (MPT) the facts need to be proven ‘on the balance of probabilities’;

(b) are entitled to assess the weight of the evidence;

(c) should not, however, normally seek to resolve substantial conflicts of evidence;

(d) should proceed with caution (given that, among other considerations, the case examiners are working from documents alone and the evidence before them may be untested);

(e) should proceed with particular caution in reaching a decision to halt a complaint where the decision may be perceived as inconsistent with a decision made by another public body with medical personnel or input;

(f) should be slower to halt a complaint against a practitioner who continues to practise than against one who does not;

(g) if in doubt, should consider whether any further investigation is appropriate lean in favour of allowing the complaint to proceed to a MPT;

(h) should bear in mind that whilst there is a public interest in medical practitioners not being harassed by unfounded complaints, there is also a public interest in the ventilation before a MPT in public of complaints which do have a realistic prospect of establishing impaired fitness to practise. However this factor should be balanced against the undertakings Guidance, which provides for health and performance matters to be resolved without a hearing;

(i) where evidence relates to failures to practise in accordance with the principles set out in Good Medical Practice, will need to proceed to consider how serious or persistent the failure or failures are.

8.27 Appropriate reference was made to the Guidance which presumes referral in certain types of cases, such as dishonesty, in the absence of exceptional circumstances. This Guidance was also seen to have been followed in cases where it was suggested the circumstances were unlikely to give rise to a fitness to practise concern. The degree to which this Guidance (Making decisions at the end of the Investigation Stage - Presumption of RPT) was referenced in the case examiner decision documents was variable but our view

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14 The initial sample was to have been 25 cases but as set out above at 6.31 one case was excluded
was that the decisions we saw were within the range of reasonable decisions that could be made having had regard to it.

8.28 We saw that regard was had to decisions made by other bodies, including Coroner’s narrative verdicts, public inquiries, decisions within the criminal justice system and local investigations. The case examiners did not always make the same decision but we observed that they did appropriately exercise particular caution in reaching a decision to halt a complaint where the decision may be perceived as inconsistent with the other decision, and indeed to proceed with a case where others had determined not to take action.

Referred cases

8.29 In two of the five referred cases the case examiners were clear that one of the key triggers for referral was that there was an irreconcilable conflict in the evidence which required referral to resolve and in a third the value of or need for oral evidence was acknowledged as part of the reason for referral. In one of these cases the serious nature of the issues meant that following the guidance the issues also gave rise to a presumption that the realistic prospect test with regard to impairment would be met.

8.30 The referred cases included one case which involved conduct nearly 20 years ago but at the case examiner stage the potential mitigation of no subsequent concerns was not considered sufficient mitigation to impact on the decision to refer given the nature of the allegation.

8.31 Where cases were referred to the MPTS for a hearing it was clear that the case examiners had considered how serious and/or persistent failures to practise were, in accordance with the principles set out in GMP. In three of the cases there were allegations of dishonesty.

8.32 In all five referred cases there were outstanding, sometimes significant, disputes as to what had happened, and again noting that three involved dishonesty it was appropriate that undertakings were not contemplated. A decision that undertakings would not be a suitable disposal was not always expressly set out in decision documents. We do not however suggest that this is a failure to follow and apply the Guidance for the decision making.

Undertakings offered

8.33 Where the RPT was met, the case examiners could consider whether to offer undertakings but only if to do so would be sufficient to protect patients and maintain public confidence and there was reason to believe that the doctor would comply with the undertakings. We considered that this Guidance was clearly followed in those three audited cases where undertakings were pursued.

8.34 In one case there was a Performance Assessment\(^\text{15}\) which identified significant concerns with the doctor’s practice. But at the time of the decision he had been subject to, and had complied with interim conditions, involving supervision and development. A thorough and robust set of similar undertakings were agreed to.

8.35 The two other undertakings cases were health related. In such cases, if the allegations were referred to the MPTS, there is no prospect that the doctor would be erased from the Register as this is not permitted under the Rules. The Health Assessments which had been obtained concluded that the doctors would not be fit to practise without restrictions and each doctor accepted the Assessment and was willing to agree comprehensive undertakings.

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\(^{15}\) This is an assessment of the standard of a doctor's professional performance. It is conducted by an independent team of GMC-trained assessors
Closed cases – warnings issued

8.36 When cases were closed by the case examiners we checked what consideration had been given to issuing a warning or advice. The Guidance on when to potentially issue a warning is set out above at paragraph 7.29.

8.37 We effectively audited eight cases where warnings were issued. In four cases the warnings were accepted and in four others an initial refusal to accept a warning led to a decision to refer the case to the Investigation Committee who hear submissions and determine whether a warning should indeed be imposed (although we noted that in some cases after referral it appears the doctor subsequently accepted the warning without the need for the Investigation Committee to sit).

8.38 The warning cases required us first to consider whether the Guidance on the realistic prospect test had been appropriately applied. We considered that the Guidance on this had been followed and in all the reason why it was not met was in line with that Guidance.

8.39 In three cases the case examiners were considering criminal convictions. The Guidance suggests that a question of fitness to practise is likely to arise in: "Criminal convictions and cautions unless not proportionate to find a doctor’s fitness to practise impaired e.g. drink driving where there are no aggravating features, or lower level misconduct that might in other circumstances result in a fixed penalty notice but on this occasion has led to a conviction or caution". In these cases we audited whether these exemptions could apply (two were drink drive convictions where health concerns had been ruled out, and one was a breach of a non-molestation order).

8.40 Appropriately for warning cases, we observed that the case examiners did find that there were identifiable significant departures from Good Medical Practice, but for other reasons there were no realistic prospects of establishing that the doctors’ fitness to practise was impaired to a degree requiring action on their registration.

8.41 We saw the appropriate imposition of a warning in a case where the doctor used disparaging language that a majority of people or fellow practitioners would not condone a doctor using in any context and two other cases where there were conduct concerns but at the lower end of the scale. We saw a warning in two clinical cases that involved a single clinical incident and/or where there had been compelling remediation of the area of concern.

Closed cases – advice given

8.42 The format for giving advice is set out in an Annex to the Guidance and we did see that the case examiners did not follow this format in one of the cases we audited, although we did not consider this to be a failure to follow the Guidance in relation to decision making.

8.43 According to the GMC Guidance advice is intended to address a departure from Good Medical Practice, or other GMC supplementary Guidance, which does not reach the threshold for a warning or impairment. Advice should provide Guidance for future practice and is not an admonition in relation to past actions. Where an admonition is more appropriate, decision makers may wish to consider whether a warning should be issued.

8.44 Decision makers should consider giving advice only where there has been disclosure of the allegations to the doctor and the doctor has made written submissions to the GMC indicating that the facts of an allegation are admitted or do not remain in dispute, and they are satisfied that the doctor’s fitness to practise is not impaired in respect of this allegation.
We saw advice given appropriately in four cases. In two of these the case examiners were explicit that a warning was not appropriate. Although on the face of the cases the allegations in some appeared potentially serious matters (such as dishonesty or sexual harassment), the decision making followed the Guidance and reached the decision that the realistic prospect test was not met. In three cases there were allegations of dishonesty which would have triggered a presumption of a realistic prospect of impairment, but in each it was decided that there was no realistic prospect of establishing the facts. The Guidance acknowledges that despite the presumption, there may be instances where, following the investigation of the case, the case examiners decide that the case does not meet the realistic prospect test because there is no realistic prospect of establishing the case evidentially. We saw cases where this Guidance was followed. These decisions meant that it was appropriate not to refer and also not to take any further action.

In the performance case the remediation was cited as a reason for not finding a realistic prospect that a Tribunal would find impairment.

The advice cases adopted the Guidance on these issues. There had been disclosure of the allegations to the doctor and the doctor admitted certain elements of the concerns (about which advice was then given) but the case examiners were satisfied that the doctor’s fitness to practise did not pass the realistic prospect test for impairment in respect of these allegations.

### Closed cases – no further action

We noted that on occasion with closed cases there was no overt reference to the decision makers having considered but rejected giving advice. We do not consider this to be a failure but inclusion of such comments would provide more fulsome reasoning.

We looked at four cases which were closed by the case examiners with no further action. In two, again potentially serious allegations had been identified but the factual allegations lacked evidence. In another the case examiners accepted there had been a misunderstanding about an EU licensed doctor’s ability to prescribe. In each case the case examiners demonstrated compliance with the Guidance in that they considered the possibility of issuing a warning, the reasons for not doing so were provided and were in accordance with Guidance. As mentioned above the potential to offer advice was not always referenced; we saw this in only one of the four cases.
9. Analysis and Discussion

9.1 The key question that underpinned this Audit was whether, in relation to the evidence available to them at the point that a decision was taken, the decisions by GMC staff at key points in the GMC’s fitness to practise procedures were in line with the Guidance provided to them for those decisions.

9.2 Due to the volume of material involved in any case our Audit was only able to review a relatively small number of decisions from the thousands made in any year. However we sought to select a broad randomised sample of decisions from different key stages of fitness to practise procedures and we ensured that these included the different sources and types of allegation and the varied characteristics of GMC registered doctors about whom fitness to practise concerns are raised.

9.3 We did not seek to create a "representative" sample and the case numbers were too low to create a sample that would have given statistically significant outcomes. However, we were satisfied that we saw a range of cases and saw all of the Guidance that we focused on in our Audit forms engaged at least once.

9.4 Our Audit forms were developed in conjunction with the GMC so that we focused on the Guidance that was key to the decision making we were auditing.

9.5 We are aware that the decision-makers involved are given training and support, in addition to their Guidance materials. We realise that they will have a range of experience in doing this work and that an Audit based solely on a review of the documents produced, and in particular their decision document, may not fully reflect everything that they have considered during their decision making process.

9.6 We were however able to review the documents available to the decision makers and to consider their key point decisions. We scrutinised this against the Guidance that was key to that decision stage, and reviewed whether the decision appeared to have been made in compliance with the key Guidance, on the evidence available to the decision-maker at that point. The Audit team have extensive experience of fitness to practise decision making across a number of regulators and brought this expertise to bear in the scrutiny of decisions.

9.7 It was not within our Audit scope to review the investigative process or decision making prior to that point, although had it been contrary to the Guidance to make a decision at that point we would have highlighted this.

9.8 In the triage and provisional enquiries stage we saw the Thresholds Guidance working well to close minor matters and the Triage Manual supported decisions to prioritise serious concerns. We noted appropriate use of medical case examiners in cases with a clinical element. Where less common matters arose such as cases involving conduct more than 5 years ago, or anonymous or confidential complaints, the Guidance was again able to support decision making.

9.9 Decisions about notifying ROs or employers where complaints in and of themselves do not appear to raise a question about doctor’s fitness to practise involve a fine judgement as to whether there is an opportunity for reflection in appraisal via the RO or to make sure there is no wider pattern of concerns.

9.10 Whilst sometimes the exercise of discretion might have resulted in slightly different decisions we saw the appropriate use of provisional enquiries and a range of decisions that could be made following the obtaining of additional information. We have highlighted above the checking on previous fitness to practise history; we believe that it was checked by decision makers and we did not see decisions that disregarded the Guidance on when to take a doctor’s fitness to practise history into account, although the exact weight
given to this information in the context of wider information was not necessarily clear from the information recorded about the decision making.

9.11 We felt confident that the case examiners understood the crucial realistic prospect test to be applied at their stage of decision making and followed the Guidance which exists to ensure that they exercise their legal functions and the correct test. Guidance on cases where there should be a presumed referral to the MPTS unless there are exceptional circumstances appeared to support decision making or the awareness to identify the exceptional circumstances.
10. Conclusion

10.1 The Audit was commissioned to answer the question: "In relation to the evidence available to them at the point that decision was taken, are the decisions taken by GMC staff at key points in our fitness to practise procedures in line with the Guidance provided to them for those decisions?"

10.2 The careful randomised case selection was designed to ensure that we audited a broad sample of cases with regard to (i) the categories of case (e.g. the types and sources of allegations); and (ii) the characteristics of the doctors about whom concerns were raised (e.g. ethnicity, PMQ, world region, gender). We are confident that our sample achieved this.

10.3 We concluded that the decisions taken by GMC staff at key points in its fitness to practise procedures were in line with the Guidance provided to them for those decisions.

10.4 We found that there was no evidence of bias in the way decision-makers interpreted the guidance. Had we found non-compliance with the applicable Guidance, although our sample could not have yielded statistically significant results, we would have gone on to examine the personal characteristics of doctors involved. We would have explored whether there was anything we could observe about the nature of the cases or the characteristics of the doctor that might have shed light on the failure to follow Guidance and we would have conveyed our concerns to the GMC.

10.5 This secondary question did not arise given our initial Audit findings.

10.6 Had we identified a failure to follow guidance the ability to consider the types of case or the characteristics of the doctor in such cases could have contributed additional learning from this exercise.
Appendices
Appendix A: Sample Selection

Overview of sample frame

<table>
<thead>
<tr>
<th>Type of decision</th>
<th>Total cases in sample frame</th>
<th>Number of cases audited</th>
<th>% of total decisions audited</th>
</tr>
</thead>
<tbody>
<tr>
<td>Triage</td>
<td>11903</td>
<td>80</td>
<td>0.67</td>
</tr>
<tr>
<td>Provisional enquiry</td>
<td>892</td>
<td>15</td>
<td>1.68</td>
</tr>
<tr>
<td>Case Examiner decisions</td>
<td>2141</td>
<td>25</td>
<td>1.17</td>
</tr>
<tr>
<td>Total</td>
<td>14936</td>
<td>120</td>
<td>0.8</td>
</tr>
</tbody>
</table>

Table 1: Total number of decisions in the sample frame

Overview of Triage cases

<table>
<thead>
<tr>
<th>Total concluded triage decisions in sample frame</th>
<th>Closed</th>
<th>Referred (not about a doctor)</th>
<th>Unregistered doctor</th>
<th>Promoted</th>
</tr>
</thead>
<tbody>
<tr>
<td>11903</td>
<td>7652</td>
<td>12</td>
<td>7</td>
<td>4232</td>
</tr>
<tr>
<td></td>
<td>(75 of which were ‘not about a doctor’)</td>
<td>(All of which were ‘not about a doctor’)</td>
<td>(All of which were ‘not about a doctor’)</td>
<td>(32 of which were ‘not about a doctor’)</td>
</tr>
</tbody>
</table>

Table 2: Profile of total Triage decisions in the sample frame

<table>
<thead>
<tr>
<th>Total triage case population with exclusions</th>
<th>Closed</th>
<th>Promoted</th>
</tr>
</thead>
<tbody>
<tr>
<td>11777</td>
<td>7577 (c63.3%)</td>
<td>4200 (c35.7%)</td>
</tr>
</tbody>
</table>

Table 3: Profile of all Triage decisions in the sample frame excluding all cases (126) where the allegation category was recorded as ‘not about a doctor’.
### Profile of provisional enquiry cases

<table>
<thead>
<tr>
<th>Provisional enquiry decision types</th>
<th>Close</th>
<th>Close (notify RO/employer)</th>
<th>Promote</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of decisions</td>
<td>408</td>
<td>224</td>
<td>260</td>
<td>892</td>
</tr>
<tr>
<td>Number of decisions to be audited</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>15</td>
</tr>
</tbody>
</table>

Table 4: Profile of the total Provisional Enquiry decisions in the sample frame

### Profile of case examiner cases

<table>
<thead>
<tr>
<th>Total case examiner decisions</th>
<th>Conclude</th>
<th>Conclude with advice</th>
<th>Issue warning</th>
<th>Refer to hearing</th>
<th>Refer to IC</th>
<th>Undertakings</th>
</tr>
</thead>
<tbody>
<tr>
<td>2141</td>
<td>1156</td>
<td>82</td>
<td>114</td>
<td>605</td>
<td>34</td>
<td>150</td>
</tr>
<tr>
<td>Number of cases to be audited</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>5</td>
<td>4</td>
<td>4</td>
</tr>
</tbody>
</table>

Table 5: Profile of the total Case Examiner decisions in the sample frame.
## Appendix B: Table of GMC Guides

<table>
<thead>
<tr>
<th>GMC GUIDES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1.</strong> DC4315 Guidance for decision makers on assessing risk in cases involving health concerns (1)</td>
</tr>
<tr>
<td><strong>2.</strong> DC4319 Guidance on warnings</td>
</tr>
<tr>
<td><strong>3.</strong> DC4592 CE Decision Guidance - Annex B - Realistic Prospect Test</td>
</tr>
<tr>
<td><strong>4.</strong> DC11676 - Guidance for case examiners on the withdrawal of referrals under Rule 28</td>
</tr>
<tr>
<td><strong>5.</strong> Guidance for case examiners and the Investigation Committee on single clinical incidents</td>
</tr>
<tr>
<td><strong>6.</strong> Sanctions Guidance - Feb 2018</td>
</tr>
<tr>
<td><strong>7.</strong> DC4595 Undertakings - agreeing varying and revoking them - after 31.1.19</td>
</tr>
<tr>
<td><strong>8.</strong> DC4595 Undertakings - agreeing varying and revoking them - until 31.1.19</td>
</tr>
<tr>
<td><strong>9.</strong> DC4599 Making decisions on cases at the end of the investigation stage - after 1.3.19</td>
</tr>
<tr>
<td><strong>10.</strong> DC4599 Making decisions on cases at the end of the investigation stage - after 6.2.19</td>
</tr>
<tr>
<td><strong>11.</strong> DC4599 Making decisions on cases at the end of the investigation stage - after 20.6.18</td>
</tr>
<tr>
<td><strong>12.</strong> DC4599 Making decisions on cases at the end of the investigation stage - after 5.11.19</td>
</tr>
<tr>
<td><strong>13.</strong> DC4599 Making decisions on cases at the end of the investigation stage - after 5.8.19</td>
</tr>
<tr>
<td><strong>14.</strong> DC9107 PE manual – post 13.9.19</td>
</tr>
<tr>
<td><strong>15.</strong> DC7901 Pre-triage enquiries Rule 4-4</td>
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<tr>
<td><strong>16.</strong> DC9107 PE manual - post 3.4.19</td>
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<tr>
<td><strong>17.</strong> DC9107 PE manual - post 7.1.19</td>
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<tr>
<td><strong>18.</strong> DC9107 PE manual - post 13.9.19</td>
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<td><strong>19.</strong> DC9107 PE manual - post 30.5.19</td>
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<tr>
<td><strong>20.</strong> DC11440 Deciding the outcome of SCI PEs (Internal)</td>
</tr>
<tr>
<td><strong>21.</strong> DC11442 Assessing the suitability of allegations for referral to a SCI PE (Internal) - after 3.8.18</td>
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</table>
### Appendix C: Template Audit Forms

GMC Decision-Making Audit

**FORM 1 – DECISIONS AT TRIAGE AND PROVISIONAL ENQUIRY STAGE**

In relation to the evidence available at the point that decisions are taken, are the decisions taken at Triage and Provisional Enquiry stages in GMC fitness to practise procedures in line with the guidance provided for those decisions?

*Decision at Triage and Provisional Enquiry Stage*: whether allegation appears to raise a question as to whether doctor’s fitness to practise is impaired.

**Key decisions are whether:**

- To close the case immediately
- To promote the case for investigation to CE
- Having undertaken Provisional Enquiries:
  - to close
  - to close and notify the RO/Employer
  - to promote for further investigation to CE

| Name of case: | Complainant
|---------------|-------------
| Doctor        |             |
| Case number:  |             |
| Decision made:|             |

#### BRIEF SUMMARY OF ALLEGATIONS

| [ ] |

#### BRIEF OUTCOME

[The decision was reached on the basis of......]
<table>
<thead>
<tr>
<th>STAGE</th>
<th>KEY GUIDANCE</th>
<th>COMMENTS</th>
</tr>
</thead>
</table>
| 1. Steps before Closing Complaint  
(P15 Triage Manual for Assistant Registrar version 23) | Before closing complaint, did AR seek advice from medical CE if no suggestion that GMC guidance breached but:  
• Patient is demanding specific treatment/drugs  
• Patient complaining as still ill  
• Patient complaining of side effects where they are within acknowledged parameters  
• Patient only asking GMC to intervene in their treatment/care  
• Patient complaining of conflicted diagnoses  
• Complaint relates to failure to visit, no risk of serious/untoward harm and alternative suggested  
• Complaint suggests mental capacity of patient is an issue. | |
| 2. Minor Matter  
(GMC Thresholds para 6). | If minor matter, case to be closed without taking any further action (eg minor motoring offences not involving drugs or alcohol, delay of less than 6 months in providing a medical report, a minor non clinical matter and a complaint about the cost of private medical insurance). | |
| 3. Ensuring reflection and learning from lower level cases and addressing patterns of concern  
(GMC Thresholds para 9)  
(Guidance on Categorising enquiries) | Notify RO or Notify Employers where complaints in and of themselves do not appear to raise a question about doctor’s fitness to practice though there is an opportunity for reflection in appraisal via the RO or where no RO to make sure there is no wider pattern of concerns. Test is whether it would be more appropriate and proportionate for the concerns to be considered locally.  
If doctor has no Responsible Officer, was concern disclosed to employer or | |
<table>
<thead>
<tr>
<th>STAGE</th>
<th>KEY GUIDANCE</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>contractor to ensure concern not part of wider pattern of concern. Presumption that cases about clinical care or treatment will be dealt with by Notify RO or Notify Employers unless meet criteria in para 9 of ‘Guidance on categorising Stream 1 and Notify RO or Employers’.</td>
<td></td>
</tr>
<tr>
<td>4. Time since events – 5 Year Rule</td>
<td>If events took place more than 5 years ago, did AR consider whether it is in the public interest to proceed before doing so and did they seek information regarding why the matter only being raised now.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(Note that Guidance for decision makers in this regard (No 35) only applies post 31 Dec 2015)</td>
<td></td>
</tr>
<tr>
<td>5. Prioritising serious concerns</td>
<td>If allegation raises questions about doctor’s fitness to practise on the following grounds, was case sent for investigation under Stream 1 [or if seriousness or nature of concern was uncertain sent for Provisional Enquiry?] Such as: • Persistent clinical errors; • Persistent failures to provide appropriate treatment/care; • Any single serious clinical error or failure to provide appropriate care; • Any conduct which would fall into the category of ‘presumed impairment’ (as described in the Guidance on Criteria and Thresholds); OR where there is a</td>
<td></td>
</tr>
<tr>
<td>STAGE</td>
<td>KEY GUIDANCE</td>
<td>COMMENTS</td>
</tr>
<tr>
<td>-------</td>
<td>--------------</td>
<td>----------</td>
</tr>
<tr>
<td></td>
<td>presumption that the GMC will take some form of action, i.e. allegations of dishonesty; • Serious or persistent breaches of GMC guidance on consent and/or confidentiality; • Serious impairment by reason of ill health, to the extent that patient safety may be compromised. If concerns about patient safety or doctor's welfare, investigation to be opened without delay.</td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>Anonymous and confidential complaints (Para 21 Anonymous and confidential complaints guidance)</td>
<td>Where it is not possible to obtain more information from the complainant, in certain circumstances, may be appropriate to make limited disclosure to the RO. The decision maker should apply paragraphs 18-23 of the guidance in these circumstances.</td>
</tr>
<tr>
<td>7.</td>
<td>Health (Guidance for decision makers on assessing risk involving health concerns paras 5-11)</td>
<td>Health issues to be managed at a local level without need for GMC investigation but if risk to patients or to public confidence which cannot or is not being managed locally, GMC investigation is appropriate. Were factors at para 11 a) to h) considered before deciding not to investigate ie • Type and severity of health problem unlikely to affect doctor's fitness to practise • No evidence of impact on performance to date • Evidence of insight, receipt of support and compliance with treatment</td>
</tr>
<tr>
<td>STAGE</td>
<td>KEY GUIDANCE</td>
<td>COMMENTS</td>
</tr>
<tr>
<td>-------</td>
<td>--------------</td>
<td>----------</td>
</tr>
</tbody>
</table>
|       | • Evidence that employer, ROs are aware of health problems and continuing to provide an appropriate level of support to mitigate potential risks  
• Stable, long term employment or works only in supervised environments  
• Effect locally managed action plan in place  
• Doctor not working and not actively seeking employment  
• No relevant GMC history. |  
| 8. Convictions (Lots of detail in the Guidance - Tab 31 and 32). | Consider extent to which compliance with "Guidance on Convictions, cautions, determinations and other methods of police disposal". |  
| 9. Guidance on Convictions, Cautions, determinations and other methods of police disposal – para 4 | Refer all complaints resulting in custodial sentence (immediate or suspended) to the MPTS and consider whether should be referred to the Interim Orders Tribunal.  
In practical terms, triage team promote these cases to Stream 1 and criminal convictions team obtain evidence of conviction and then they send custodial cases direct to MPTS. |  
And Guidance for Decision Makers on | Apart from minor convictions which are closed at triage, convictions are promoted to Stream 1 and Convictions Team assess if there are non custodial cases that should be sent direct to MPTS rather than to CEs – only arises occasionally [Note they do this under rule 5(2) for very serious case where no custodial sentence for example child sex offences where put on sex offenders register but no custodial sentence] |  
<p>| | | |
|  |  |  |</p>
<table>
<thead>
<tr>
<th>STAGE</th>
<th>KEY GUIDANCE</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Closing Criminal Case at Triage Triage Manual</td>
<td>Note: Presumption of impairment category indicates a serious offence. Aggravating factors more relevant when offence is at the lower end of the serious offences category.</td>
<td></td>
</tr>
<tr>
<td>12. Guidance on when to take a doctor’s fitness to practise history into account</td>
<td>Complaints that were similar to current allegation and resulted in formal action. Complaints have been closed as insufficient to amount to impaired fitness to practise or there is a history of isolated clinical incidents/concerns which in themselves were insufficient to amount to impairment may be relevant if: • Previous allegation is similar to the current allegation and/or paints a pattern of concern that, in totality, indicates a pattern of persistence that could give rise to an allegation of impaired fitness to practise and the reason that the previous case was closed relates to seriousness (including where considered to be an isolated incident) rather than the credibility of the allegation. Consensual outcomes agreed at CE stage may be taken into account. Not appropriate to take history into account: • Where the previous matter was closed because there was insufficient evidence to support it, without it being re-opened under Rule 12 (for example, based on the current allegation amounting to new information). • Where the factual allegations had been found not proved. If previous</td>
<td></td>
</tr>
<tr>
<td>STAGE</td>
<td>KEY GUIDANCE</td>
<td>COMMENTS</td>
</tr>
<tr>
<td>-------</td>
<td>--------------</td>
<td>----------</td>
</tr>
<tr>
<td></td>
<td>history related to clinical practise, not appropriate to consider new matters as a single clinical incident unless the previous matter was found not proved, was a long time ago or where the nature of the incidents are very specialised or non related.</td>
<td></td>
</tr>
</tbody>
</table>

**ANY OTHER COMMENTS**

Please flag up in bullets (referring to relevant boxes above) issues which may be relevant; learning points; Examples of best practice.

Any issues which do not relate to any of the criteria above.
GMC Decision-Making Audit

FORM 2 – DECISIONS OF CASE EXAMINERS

In relation to the evidence available to them at the point that decisions are taken, are the decisions taken by Case Examiners at key points in GMC fitness to practise procedures in line with the guidance provided to them for those decisions?

Decision at CE stage – is there a realistic prospect of establishing that a doctor’s fitness to practice is impaired to a degree justifying action on registration.

Name of case:
Complainant
Doctor
Case number:
Decision made:

<table>
<thead>
<tr>
<th>1. Realistic Prospect Test</th>
<th>Case Examiner:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>- should bear in mind that before the MPT the facts need to be proven ‘on the balance of probabilities’.</td>
</tr>
<tr>
<td></td>
<td>- is entitled to assess the weight of the evidence;</td>
</tr>
<tr>
<td></td>
<td>- should not, however, normally seek to resolve substantial conflicts of evidence;</td>
</tr>
<tr>
<td></td>
<td>- should proceed with caution (given that, among other considerations, the case examiners are working from documents alone and the evidence before them may be untested);</td>
</tr>
<tr>
<td></td>
<td>- should proceed with particular caution in reaching a decision to halt a complaint where the decision may be perceived as inconsistent with a decision made by another public body with medical personnel or input</td>
</tr>
<tr>
<td></td>
<td>- should be slower to halt a complaint against a practitioner who continues to</td>
</tr>
</tbody>
</table>
practise than against one who does not;

- if in doubt, should consider whether any further investigation is appropriate

- lean in favour of allowing the complaint to proceed to a MPT;

- should bear in mind that whilst there is a public interest in medical practitioners not being harassed by unfounded complaints, there is also a public interest in the ventilation before a MPT in public of complaints which do have a realistic prospect of establishing impaired fitness to practise. However this factor should be balanced against the undertakings guidance, referenced below, which provides for health and performance matters to be resolved without a hearing.

Where evidence relates to failures to practise in accordance with the principles set out in Good Medical Practice, the case examiners will need to proceed to consider how serious or persistent the failure or failures are. Good Medical Practice states that ‘serious or persistent failures to follow this guidance will put your registration at risk’.

<table>
<thead>
<tr>
<th>2. Presumption of RPT (Guidance: Making decisions at the end of the Investigation Stage. Consider this Guideline in detail)</th>
<th>Guidance presumes referral to MPTS unless in exceptional cases for the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Sexual assault/violence/improper sexual or emotional relationship</td>
</tr>
<tr>
<td></td>
<td>• practising without a licence</td>
</tr>
<tr>
<td></td>
<td>• unlawful discrimination</td>
</tr>
<tr>
<td></td>
<td>• dishonesty</td>
</tr>
<tr>
<td></td>
<td>• gross negligence. Exceptional circumstances are needed to avoid referral to MPTS.</td>
</tr>
<tr>
<td></td>
<td>A question of fitness to practise is likely to arise in:</td>
</tr>
</tbody>
</table>
- Criminal convictions and cautions unless not proportionate to find a doctor’s fitness to practise impaired *e.g. drink driving where there are no aggravating features*, or lower level misconduct that might in other circumstances result in a fixed penalty notice but on this occasion has led to a conviction or caution.

- A doctor’s performance has harmed patients or put patients at risk of harm e.g. persistent technical failings or other repeated departures from good practice which are not being, or cannot be, safely managed locally or local management has been tried and failed.

- A doctor has shown a deliberate or reckless disregard of clinical responsibilities towards patients - an isolated lapse from high standards of conduct –such as an atypical rude outburst –would not normally, in itself, suggest that the doctor’s fitness to practise should be in question.

- Lack of integrity, an unwillingness to practise ethically or responsibly or a serious lack of insight into obvious problems of poor practice will bring a doctor’s registration into question.

- A doctor has abused a patient’s trust or violated a patient’s autonomy or other fundamental rights.

- Conduct which shows that a doctor has acted without regard for patients’ rights or feelings, or has abused their professional position as a doctor.

- A doctor’s health is compromising patient safety. The key is whether the doctor is managing the risks posed by their health.

- A doctor’s knowledge of English is compromising patient safety. The key is whether the doctor is managing the risk posed by their lack of knowledge of English.
**Ease of remediation**, steps taken to remediate and the likelihood of repetition of the failing are all relevant in considering impairment. Ease of remediation and the steps taken are usually inter-related and normally occur together.

In a few cases, a doctor’s failings (including serious performance concerns) may be so serious or persistent that, regardless of any attempts at personal remediation made by the doctor, action must be taken in order to address the damage that has been done to public confidence.

| 4. History (Guidance on when to take a doctor’s fitness to practise history into account) | Was doctor’s FTP history taken into account if relevant to the current decision and fair in the circumstances?

Cases closed with formal action may be relevant when determining if realistic prospect test is met if prior event is similar.

Cases closed where insufficient in themselves to amount to impaired fitness or isolated prior event may be relevant in determining if realistic prospect met. Not appropriate to take account of previous cases if closed due to insufficient evidence or factual allegations found not proved, unless reopened in Rule 12. |
|---|---|
| 5. Guidance on Undertakings | Where realistic prospect test is met, undertakings only to be proposed when to do so would be sufficient to protect patients and maintain public confidence.

Undertakings may not be proposed where there is a realistic prospect that, if the allegations were referred to the MPTS, the doctor would be erased from the Register.

Is there reason to believe that the doctor will comply with the undertaking ie check history of non compliance (although history of non compliance should not in itself preclude the possibility of agreeing undertakings).

Undertakings should address all heads of impairment that meet the realistic prospect test.

Undertakings not usually appropriate if:

- Doctor has shown deliberate or reckless disregard of clinical responsibilities towards patients |
- Doctor has abused a patient’s trust or violated a patient’s autonomy or other fundamental rights
- Doctor has behaved dishonestly, fraudulently or in a way designed to mislead or harm others
- Undertakings not likely to be suitable if any significant disagreement on the facts.

| 6. **Guidance for decision makers on assessing the impact of health in misconduct, conviction, caution and performance cases** | When determining whether an allegation of poor performance or misconduct can be dealt with by solely addressing the health grounds by way of undertaking, has:

- the seriousness of the alleged misconduct/performance,
- the behaviour leading to the conviction/caution,
- the potential risk to future patients been taken into account?

Consider doctor’s insight re misconduct, performance and their health and likelihood of misconduct/poor performance being repeated before determining to proceed with the events via health undertaking only.

Health related undertakings are unlikely to be appropriate where:

- the case examiners have determined undertakings will not be sufficient to protect patients and maintain public confidence
- evidence is disputed
- a doctor does not agree to undertakings.

When deciding to resolve cases involving health concerns through undertakings, case examiners should also take into account any other mitigating or aggravating factors. |
7. **Guidance on Warnings**

Warning only to be considered once, having taken account of any mitigation, decision made that there is no realistic prospect of establishing that the doctor’s fitness to practise is impaired to a degree requiring action on his or her registration.

Warning are appropriate for allegations that are just below the threshold for impaired fitness to practise and involve:

- a significant departure from Good Medical Practice, or
- a significant cause for concern following an assessment of the doctor’s performance.

8. **Guidance on Advice**

Decision makers should consider giving advice only where rule 7 disclosure has taken place -

- the doctor has made written submissions to the GMC indicating that the facts of an allegation are admitted or do not remain in dispute, and
- they are satisfied that the doctor’s fitness to practise is not impaired in respect of this allegation

**ANY OTHER COMMENTS**

Please flag up in bullets (referring to relevant boxes above) issues; learning points; Examples of best practice. Any issues which do not relate to any of the criteria above.
Appendix D: CVs of Audit Report Authors

Sarah Ellson
Partner – Manchester
Co-Head of Public and Regulatory Group

Qualifications:
Admitted as a solicitor in England and Wales 1997
Legal Practice Course (1995) and Post Graduate Diploma (1994)
Nottingham Trent University MA (Cantab)
University of Cambridge 1994

Sarah is a Partner in and is co-head of Fieldfisher’s Regulatory Group and as such, has extensive exposure to its work, from the prosecution of cases before fitness to practice committees, to developing and delivering strategic objectives through legislation, innovation and training. She has done this work for the General Medical Council and a range of other health and social care regulators for 20 years.

Sarah has also conducted various audit and review projects on matters such as complaints handling and licence procedures for public bodies in addition to working on judicial reviews, appeals, and Professional Standards Authority cases. This has given Sarah a well-rounded knowledge of, not only the type of guidance and standards that should be upheld and followed in certain scenarios, but also the reasoning behind those standards and the ability to highlight where adherence to those standards might have fallen below expectations.

Sarah’s far-reaching knowledge and understanding of the healthcare industry has led her to provide training for leaders and decision-makers in the industry including training for the General Dental Council, the General Optical Council, the General Pharmaceutical Council, General Osteopathic Council, Northern Ireland Social Care Council as well as the Taxation Disciplinary Board, Financial Reporting Council and British Association of Acupuncture. She has chaired and spoken at national and international conferences on regulatory frameworks in health and social care and for eight years was a Committee member for the Association of Regulatory and Disciplinary Lawyers.

Sarah is ranked as a leading individual in the Legal 500 directory with a client remarking “The utterly professional Sarah Ellson is a standout leader and a very clever lawyer”, and Sarah sits in Band 1 for Professional Discipline and Regulatory Healthcare in Chambers and Partners, with sources noting “She possesses very detailed knowledge and her strategy proposals are well thought out and effective”.

Sarah’s experience includes:

• Nearly 20 years of work with the GMC on a vast range of projects and cases, most recently overseeing the work of the team in the initial stage decision maker under Rule 12 and the FTP audit in 2017.

• Training for clients such as the General Optical Council’s Case Examiners and Investigating Committee, staff, secretariat and Investigating Committee training for the General Dental Council, Conduct Committee (a screening committee) of the Financial Reporting Committee and Case Manager training for the United Kingdom Council for Psychotherapy.

• Regular judicial review work, acting for public bodies to defend the reasonableness and fairness of their decision making or representing those adversely impacted by a decision about a public function.
• Advising the Professional Standards Authority on various aspects of their functions and wider advice to government as well as long-standing involvement in their s29 committees and High Court cases brought to challenge Regulator’s decisions which are insufficient to protect the public.

• Audits, detailed case reviews and statutory reviews for the GMC, other health care regulators, Phonepaid Services Authority looking at compliance with guidance, procedures and legal function.

• Advising public bodies such as Local Authority oversight and scrutiny committees and Police and Crime Commissions on the proper exercise of public functions.

• Sarah has worked with a number of regulatory bodies in the development of fair and lawful procedures including extensive work with Universities on their Student Fitness to Practise processes, work with psychotherapy regulators, the Financial Reporting Council, the Royal Institution of Chartered Surveyors and a number of overseas Health ministries.

As well as regular blogs her publications include:

• Healthcare Law Review – for which she is the Global Editor and co-author of the England Chapter, 1-3rd Editions 2017-2019


• David TJ, Ellson S, Quirk H. Supporting students attending a fitness to practise committee by ensuring procedural fairness. Excellence in Medical Education 2012; 1(3):56-59.

• David TJ, Ellson S. Grounds for expulsion of health and social care students at a University student fitness to practise committee meeting. Quarterly Bulletin of Association of Regulatory & Disciplinary Lawyers, Spring 2015, 1-5.

• David TJ, Ellson S. Refusal to grant provisional General Medical Council registration to UK medical graduates. Medico-Legal Journal 2015; 83(3): 142-146.

• David TJ, Ellson S. Fitness to practise procedures for medical students. British Journal of Hospital Medicine 2015; 76(7):405-408.

• David TJ, Ellson. Approaches to handling health and social care student fitness to practise. Professional Standards Authority Newsletter - Viewpoint, 2017; Spring issue.

• David TJ, Ellson S. General Medical Council refusal to grant provisional registration - reasons, prevention and what to do if it happens. British Student Doctor, 2017; 1(2):36-40.

• David TJ, Ellson S. Avoidable pitfalls and procedural errors when dealing with pre-registration health and social care students whose behaviour has called into question their suitability for a professional career. Journal of Health Science & Education 2018; 2(1):1-9.

• David TJ, Ellson S. Extreme adverse behaviour by physiotherapy students and qualified physiotherapists and the risk of termination of an individual’s career. Journal of Yoga and Physiotherapy 2018; 4(3):1-5.

Eimear Burke
Partner – Ireland
Public and Regulatory Group

Qualifications:
Admitted as a solicitor in England and Wales, 2010
Diploma in Employment Law, University College Dublin, 2005
Admitted as a solicitor in Ireland, 2004
LLB (Ling. Germ.), Trinity College Dublin, 1999

Eimear is a Partner in Fieldfisher’s Public and Regulatory Group and her main area of focus for the past 13 years has been healthcare regulation; in particular she advises the Medical Council, the Nursing and Midwifery Board of Ireland (NMBI) and also the Health and Social Care Professionals Council in respect of all aspects of their fitness to practise functions, from screening stage through to sanction stage.

Eimear has significant experience in advising statutory bodies including the Medical Council in respect of the discharge of their functions, the prosecution of offences, the investigation of fitness to practise complaints and running fitness to practise inquiries. She provides advice and representation to statutory bodies in District Court prosecutions, High Court and Supreme Court appeals, judicial review proceedings, internal appeals and enforcement and confirmation applications.

Eimear manages a team of solicitors who investigate and prepare statutory inquiries for oral hearing ensuring that there is clear guidance for her team in terms of their day-to-day decision-making to ensure that the team’s decisions are consistent with client instructions and policy.

Eimear is noted in Chambers 2019 as “personable, direct and very knowledgeable of professional disciplinary law”, and in Legal 500 EMEA 2019 as having “represented a regulatory body in a high-profile fitness to practise inquiry”.

Eimear’s experience includes:

Audit

• In conjunction with Fieldfisher in the UK, Eimear conducted an audit in respect of a healthcare regulator’s decisions, assessing the consistency and appropriateness of decision-making at various stages of the complaints process up to and including an oral hearing. This project involved working closely with colleagues in the UK and culminated in a report containing a detailed analysis of the issues identified by the NMC.

• Eimear prepared an Action Plan on behalf of the CEO of NMBI following a 2014 Professional Standards Authority (PSA) Report in respect of the NMBI. Eimear conducted a full review of the NMBI complaints process from screening through to sanction stage and she managed a team that implemented the recommendations of the PSA in the areas of governance, training and audit. At the same time, Eimear advised in respect of the transition by NMBI to a new legislative regime which introduced new parameters to the fitness to practise function of NMBI. As part of that project, Eimear drafted template documents, information booklets and guidelines to support the legislative function of the NMBI. Eimear drafted “decision trees” and guidance documents for decision makers to ensure consistency and best practice decision making.

Training

• Eimear regularly runs bespoke training sessions and workshops for staff members of regulatory bodies and also Committee members including the Medical Council, Dental Council and the Royal Institute of Architects
of Ireland. The training sessions cover principles of good governance and decision making, providing practical guidance and support to attendees. Eimear has also organised seminars for public bodies focusing in particular on the area of bias in decision-making. The training focuses on all stages of decision-making from screening through to sanction.

- By way of example of recent events run by Eimear, she led a workshop this summer on the topic of: “When the Personal Becomes Professional” – A regulatory perspective on private lives of registered professionals.
- Eimear regularly speaks at conferences and seminars in the area of regulation including at the annual CLEAR professional regulation conference in the US.

Preparation and presentation of cases referred to Fitness to Practise Committees

- Eimear has advised NMBI, Health and Social Care Professionals Council and the Medical Council in respect of the management and investigation of complaints from screening to inquiry stage ranging from complaints of relevant medical disability, sexual misconduct, fraud and dishonesty, to breach of trust and performance-related concerns. In this regard, Eimear advised in respect of the scope of complaints, managing complainants/victims, the discovery and production of documentation, interviewing witnesses as well as engaging with legal representatives for key stakeholders such as unions, representative bodies and other state agencies.
- She has provided significant strategic advice to the CEOs of the Medical Council, NMBI and the Health and Social Care Professionals Council in terms of Inquiry presentation.

Judicial Review and Appeal proceedings related to Fitness to Practise

- Defended appeals and judicial review proceedings on behalf of the Medical Council, including seminal cases of Herman v Medical Council, Barry v Medical Council, WF v Medical Council, T v Medical Council and Prendiville and Murphy v Medical Council and also a challenge to the publication by the Medical Council of a sanction imposed on a registrant. These cases focused on key principles of regulatory law.

Blogs and publications

Eimear co-authored the only Irish legal textbook on professional regulation - “Disciplinary Procedures in the Statutory Professions” (Bloomsbury, 2011). This text draws together applicable principles of law (such as questions of practice and fair procedure) and considers in details the relevant sections of the applicable legislation.

Summary of roles:

Annie trained in London as a solicitor at Capsticks LLP, a leading firm specialising in health and social care law, undertaking work in a range of legal departments including medical negligence and clinical advisory work, as well as more broadly in delivering commercial and property litigation advice to health care providers. In 2003, she qualified as a solicitor in the Dispute Resolution department, acting for clients in the NHS, regulatory, private and charity sectors. As a Partner, Annie was one of a handful of experts that was recognised as an expert personally and as part of a specialist regulatory (professional discipline) legal team, by both of the legal directories: Legal 500 and Chambers and Partners. Please note that she is no longer practicing as a solicitor.

Academic: 2016 – date

Annie is currently a full-time Lecturer in Medical Law and Ethics at the University of Edinburgh School of Law (Since August 2017). She is a Deputy Director of the Mason Institute for Medicine, Life Science and the Law, and Director of Edinburgh Foundation for Women in Law. Annie is a Lay Advisor to the Royal College of Surgeons of Edinburgh and sits on their Patient Safety Group (June 2018 – present). Her active workload includes research and teaching. For her full teaching, research and publication profile please see: [https://www.law.ed.ac.uk/people/ms-annie-sorbie](https://www.law.ed.ac.uk/people/ms-annie-sorbie)