

Health and Social Care Committee

Oral evidence: The work of the General Medical Council, HC 1611

Wednesday 21 January 2026

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Members present: Layla Moran (Chair); Dr Beccy Cooper; Jen Craft; Josh Fenton-Glynn; Andrew George; Paulette Hamilton; Alex McIntyre; Gregory Stafford.

Questions 1-124

Witnesses

I: Charlie Massey, Chief Executive and Registrar, General Medical Council; and Anthony Omo, General Counsel and Director of Fitness to Practise, General Medical Council.

Examination of witnesses

Witnesses: Charlie Massey, Chief Executive and Registrar, General Medical Council; and Anthony Omo, General Counsel and Director of Fitness to Practise, General Medical Council.

Chair: Welcome to the Health and Social Care Committee's one-off session with the General Medical Council. I welcome our witnesses; thank you so much for sparing the time. Could you start by introducing yourselves and your roles, please?

Charlie Massey: I am Charlie Massey, the chief executive and registrar at the GMC.

Anthony Omo: Good afternoon. I am Anthony Omo, the general counsel and director of fitness to practise at the GMC.

Q1 **Chair:** Thank you for coming today. We aim to roam across a host of issues, but it may not surprise you to know that we will start with physician associates and anaesthesia associates, simply because of the controversy over the past few years.

I will start with a retrospective question, to better understand how we have got to where we are. Your stated aim on your website, which I checked this morning, is "to support good, safe patient care", and yet much of the controversy has been centred on that exact issue. When you decided to take this on, what kind of risk assessment was done of whether it would undermine your stated aim?

Charlie Massey: It had been quite a long-standing ambition of various Governments to change our legislation, and to bring those roles—

Chair: Yes, they have been around for a while, but needed regulating.

Charlie Massey: At the heart of your question is taking a step back. What was the aim of regulation? The aim of regulation was to say, "Here are a group of healthcare professionals who are not regulated, but regulation will help patients, employers and colleagues to realise that PAs and AAs are safe to practise and, indeed, can be held to account if serious concerns are expressed."

On your question about what assessment was made of some of the concerns, at the time when Government consulted on regulation for PAs and AAs, none of the concerns was raised. Only really in the aftermath of the previous Government's long-term workforce plan, when there were some ambitions to increase significantly the number of PAs and AAs in the system, did concerns begin to be expressed in some quarters. There were concerns about the degree to which having PAs and AAs leads to a blurring of the boundaries between the role of a doctor and the role of PAs and AAs. There were concerns about the scope of practice and whether there should be a tightening of that scope, in particular because of some tragic stories about patients, and particularly Emily Chesterton, who lost her life



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being treated by a PA. There were also some concerns linked to the prevailing industrial unrest at the time—the industrial action by resident doctors—about the degree to which PAs and AAs might have an impact on training opportunities for doctors. It is worth repeating that all those concerns emerged after the Government consultation.

- Q2 **Chair:** Are you seriously saying that those concerns were not foreseeable? The GMC is full of very knowledgeable people who understand this space, and your primary stated aim is “good, safe patient care”. I understand that other people were late to this party, but there was a direct ask from Government to you. Did you feel that you could say no? Did anyone consider saying no?

Charlie Massey: It was a decision by my council to say that we would say yes, when we were asked by Government. We were very clear—

- Q3 **Chair:** But at that point, did no one do a pros and cons list at board level? That is basic, right?

Charlie Massey: We did. I do not have the paperwork to hand—

- Q4 **Chair:** Can you send it to us?

Charlie Massey: I am sure we can, yes. We will have had—we did have—a council conversation to say, “Government will ask us to take on the regulation of those groups. Are we prepared to do that?” We were very clear at the time that we would be prepared to do it, if Government funded the set-up costs, because we needed to be clear that we were not funding the regulation of PAs and AAs through the licence fees we collect from doctors—that would be the wrong thing to do.

Some of the issues that I described—the blurring of boundaries and workforce expansion—did not belong to the GMC. The anxieties about PAs being grown to substitute for doctors’ roles were really aimed more at the Government. The problem that we had was that at the time the GMC was the only game in town, in terms of organisation, so it was being asked by the Government, and ultimately by Parliament, to take on the regulation of these roles.

- Q5 **Chair:** But it is also kind of not your problem, if you look at what the Government are asking you to do. You are an independent body funded by fees, not by the Government. You could therefore have said no, but you chose to say yes. I appreciate that you might want to write to me about this, but I just do not fully accept that you could not have seen some of this coming and thereby avoided some of the issues that you have seen.

Charlie Massey: We did say yes, and part of the reason we did so was that PAs and AAs work within the medical model alongside doctors. We did anticipate some of the issues around training opportunities. Our view, which I would maintain now, was that the best way to ensure that doctors’ training opportunities were not adversely affected by PAs and AAs was to have the same regulator responsible for regulating both groups. That was a very explicit part of the conversations that we had when we were agreeing to take that on from the Government. I would not want the

Committee to reach the view that these were issues that we did not think about, discuss and consider, but my council decided that we would say yes, and I think they would stand by that decision now.

- Q6 **Chair:** I would definitely appreciate seeing papers from the time, just so we can better understand what was going through people's minds.

Let us come to the present day, sort of. Since then, we have had the Leng review, whose implementation has been held up by various court cases. I was trawling through your website this morning, and you are still using the old nomenclature. The Government is not, though: it is using the new "assistants" nomenclature, and then saying "who are legally known as" until these cases are resolved. Can you explain why you are still using the old nomenclature?

Charlie Massey: Because the regulation of PAs and AAs is set by Parliament, and the order that we operate under is the Anaesthesia Associates and Physician Associates Order. We took the view that there would be quite considerable confusion as a result of adopting new titles that were not the titles set in legislation. We have been very clear to the Government, and I think they are determined to change the law. The title needs to be changed in law. We are expecting the Government to consult within the coming weeks on legislation that will both make that name change for PAs and AAs and will also—

Chair: Do all the rest.

Charlie Massey: —modernise, which I am sure we may come on to a bit later. In the meantime, we are making sure we are clear about where we need to change all that. As you will appreciate, we have literally thousands of web pages and things on our website. We have registers that related to physician associates and anaesthesia associates, so changing all that is not a trivial task.

- Q7 **Chair:** Just as a premise, though, you fully accept the recommendations in the Leng review, and you are preparing to implement them in full. Is that fair to say?

Charlie Massey: Yes. We welcomed the Leng review when it was published last July, and we will be taking forward the recommendations that relate to us. As you alluded to earlier, the fact that there have been some legal challenges subsequently—

- Q8 **Chair:** Are they over?

Charlie Massey: No.

- Q9 **Chair:** What is ongoing, just so that we are clear?

Charlie Massey: I am not sure of the exact status, but the United Medical Associate Professionals union understandably launched pre-judicial review proceedings in the summer because they were anxious that their members would be losing their jobs in the very immediate term. That has had the effect of slightly slowing things down, in terms of using the Leng review as a bit of a reset moment, which is what I had hoped it would be. Although



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there has been considerable and genuine anxiety from a number of doctors about the PA and AA set of issues and the Leng review, genuine anxieties and concerns have been expressed by members of the PA and AA community.

Chair: Understandably.

Charlie Massey: Of course, I hear a lot of those at first hand, and some of the behaviours that people have been subject to have been completely unacceptable.

Chair: They have been let down too.

Charlie Massey: Everybody has been let down. Obviously, our job is to regulate those PAs and AAs. We have about 4,000 of them now on our register. The vast bulk of those are PAs, not AAs.

My hope—this is a point I have made to the Government—is that the 10-year workforce plan, when it is published in the spring, will set out a bit more clarity from the Government about these roles and multidisciplinary roles more generally. I am not expecting the Government to set out specific numbers on the expansion of the workforce—I think that that is highly unlikely, given what happened before—but I am hopeful that the workforce plan will help to reset things and enable people to move forward in such a way that courtesy is extended to all members of our healthcare professions.

Q10 **Chair:** The reason I started with the nomenclature is that it felt like it was the easiest thing for you to change on the website to show that you are resetting and moving on. I appreciate the explanation, but do you understand, from the point of view of the doctors who are looking with interest at what is happening, that it feels like you might be dragging your feet?

I am trying to get a better steer on how ready you are for December '26. You have explained the name change thing. The Leng review is very clear about the bits that you are responsible for. I am going to go through each one, so could you just tell me very briefly where you have got to with each, and whether any of them is on your risk register for not getting to the right place by the December '26 deadline? We have done the name change, and you have explained it, although perhaps many people watching would urge you to take the approach that the Government have. Where are we with the curriculum and training changes and the relationship with the royal colleges?

Charlie Massey: We have been talking to royal colleges and the PA Schools Council. I met the PA Schools Council in August. We are not actually sure that there is a need to change issues in the PA curriculum to take account of the Leng recommendations. Certainly, that has been part of the preliminary conversation we have had. The question that we have been talking about with it has been about the recommendation on not seeing undifferentiated patients, and to what degree that might need to be reflected in the curricula.

We actually think that, even in a world where PAs and AAs are seeing differentiated patients, the curricula would still want them to look at the totality of the patient in front of them and to be able to use the wide set of diagnostic skills and experiences that they would have built up through their education. That is a work in progress, but we have been having those conversations with the PA Schools Council. At the moment, I think our view is that there probably does not need to be any significant change to curricula on the back of it.

- Q11 **Chair:** Interesting. You mentioned undifferentiated patients. This was really the nub of the issue, particularly with PAs, wasn't it? The worry is that someone is going to present at a GP surgery with a cough, but that it will actually be something much more nefarious. The Leng review makes it very clear that there is strong evidence that it is about the intuition that you develop through long-standing practice and study, which even novice doctors have but PAs just do not. It is that first diagnosis that can be the most concerning. Are you and the royal colleges confident that that is bottomed out and that the risk is now mitigated as a result of what is going to come? If you are not going to make any changes, how will these risks be better mitigated?

Charlie Massey: The question of differentiation is really a matter for employers and how they deploy PAs, and about the way in which doctors operate in their supervisory role with PAs. Some of the issues that we have seen with PA practice have been partly about PAs seeing undifferentiated patients, but they are also about the clinical governance environment in which they have been working.

Chair: I was going to come on to supervision, because that is the other side of this.

Charlie Massey: Yes. I do not think that that has always worked as well as we might have wanted. Many employers have been working well in making sure that PAs are working in appropriate clinical governance environments, but not all have.

- Q12 **Chair:** Where, specifically, is the GMC role in that? You are the regulator, so presumably you have a line. At some point, if someone is not doing it properly, you have the ability to go, "You're not doing that right." You have that somewhere. Where is that going to be written down? How are you going to get that across so that everyone is working from the same hymn sheet?

Charlie Massey: Part of that is around work that we are still doing on how we think about the clinical governance that we expect from PAs and AAs.

- Q13 **Chair:** The issue of AAs is easier, right? In the Leng review, it is 1:1, and then, two years later, there is a conversation. With PAs, it is not as clear, is it?

Charlie Massey: I think some of the same issues apply to both, actually. With doctors, for example, we have revalidation, which is a mechanism by

which every five years they need to be able to demonstrate that they are up to date and fit to practise, and that the scope of their work fits their knowledge and skills, recognising that people's knowledge and skills change through their career. Revalidation is supported by appraisal, and we will introduce something very similar to that regime for PAs and AAs. It has to be a little bit different, because we do not have the same underlying clinical governance architecture; we do not have responsible officers for PAs and AAs as we do for doctors.

Those questions about how we spot whether PAs are being deployed appropriately, in terms of differentiation, are really part of the clinical governance expectations that we set, and part of what we police through the relationships that we have with medical directors, who will ultimately be responsible for those clinical governance environments, including for PAs and AAs. Of course, we will be setting out clarity through the curriculum, which we have talked about already, on what PAs and AAs know and what they should be thinking about, around where their practice begins and ends. We produce "Good medical practice", which sets out the standards for PAs, AAs and doctors in people exercising their professional judgment on what they should or should not be doing.

Finally, we have the backstop of our fitness-to-practise processes. Anthony and his team will take referrals—whether they are from the public, doctors or organisations—where there are concerns that something has not happened as it should have. Those issues are always considered on their own individual merits when we get them. There are a variety of ways into that, and all of those relate to your question.

- Q14 **Chair:** Are you considering doing some sort of best practice guide that says, "This is what we're aiming for—this is the gold standard." I am hearing from a number of different sources that it would be helpful to understand this. Is a phone call sufficient at this point in someone's training? Is the expectation that they should be able to have access to their supervisor in real time, or is a once-a-month check-in sufficient? All those things could legitimately be considered supervision, and that is what I am trying to understand. In practice, what will it mean for a patient who is wondering, "Am I safe or not?"?

Charlie Massey: This is where it becomes quite complicated, because we have PAs and AAs working in a very wide variety of different clinical settings.

- Q15 **Chair:** Let's just take one: the GP surgery, which some identify as potentially being why they will not be allowed to work in those community settings for a couple of years, or indeed mental health, according to the Leng review. That is the slightly higher-risk end of the spectrum. What is your view? In the setting of a GP surgery, what is best practice according to the GMC?

Charlie Massey: With general practice, as with emergency medicine and surgery, we would look to the royal colleges to hold that expertise in determining issues relating to scope of practice and what is or is not

permissible. I do not want to suggest that the GMC has the clinical expertise in every single specialty to be able to define that in a level of detail. It would also be disproportionate for us to do that for a group who currently number 4,000 overall.

We have always been really clear—you will know that we were legally challenged on scope of practice—that we will not do that for PAs and AAs, and we do not do that for doctors either. We look to the royal colleges and specialist faculties for their expertise on the precise detail of a PA working within a primary care setting.

Q16 Chair: So would you expect the supervision bit of it, in my example of GPs, to be covered by the Royal College of GPs saying, “This is what good supervision looks like, therefore this is what you do”? There is going to be a separate body that is looking at PAs, so which college gets which bit?

Charlie Massey: On the supervision, we are very clear that PAs and AAs work under the supervision of doctors. Obviously, the specialty within which they work will determine which doctors’ supervision they work under. Employers are responsible for deploying PAs and AAs appropriately, and they are also responsible for ensuring that they have proper and effective supervision.

One of the other concerns that has been raised with supervision is what the doctor accountability is if something goes wrong. Again, we have been really clear—there is material that we have put on our ethical hub specifically on the supervision of PAs—that doctors are not accountable for the actions and decisions of PAs and AAs, provided that they have delegated responsibility to them in line with our guidance. We have tried to be as clear as we can, but as I was saying earlier about the general practice example, we have to be somewhat generic in the way in which we set out, “These are your responsibilities for providing supervision.”

Q17 Chair: Principles-based—understood. On “Good medical practice”, you will know that there is an active debate—well, perhaps not “active”—in so far as there seems to be a real push from doctors to have a separate guide for PAs and AAs, so that it is clear. The Leng review basically said that it should be differentiated and clearer. I read “Good medical practice” this morning, and it is absolutely not at all clear, as it stands. The end product will, I assume, be published in December this year. Is that what you are aiming for, or are you aiming to publish a new one sooner? What is the deadline for that?

Charlie Massey: I do not know the exact deadline. We are working on all our material—

Q18 Chair: Will it be one document or two?

Charlie Massey: It will be one document. We were challenged legally about whether there should be separate documents for doctors, PAs and AAs. That claim was brought against us by the BMA and went to the High Court, which dismissed the claim on all counts. The reason why is that “Good medical practice” relates to standards and values. It is not a scope-

of-practice document; it is about the standards, values and behaviours that we expect.

The Leng review also said, however, that we should be clearer in differentiating on our website and in some of the materials associated with “Good medical practice” about where that relates to PAs, AAs and doctors. We are in the process of doing so, as we speak. We have already updated a number of bits of guidance on our public-facing materials, and we are continuing that work.

Some of this relates to the earlier point about name change because, as I say, we have thousands of pages and hundreds of different guidance documents that we need to update. That is not a trivial task. I want to make sure that when we do it, we do it well and properly. That is therefore exactly the process that we are embarked on.

Q19 Chair: Finally, where are we with management training being built into curricula?

Charlie Massey: Again, that is part of the conversation that we have been having with the PA Schools Council. Actually, quite a lot is already built into curricula—

Chair: But that is more about the doctors, isn’t it?

Charlie Massey: Sorry, yes. Bits of that are about PA and AA curricula, and for doctors we built it into their curricula, but there is also some specific guidance that we produce on management and leadership. That is the piece that is being updated at the moment.

Q20 Chair: In points out of 100, how confident are you that all of that will get done by December this year?

Charlie Massey: I am absolutely confident that we will deliver all the recommendations for which we are responsible, which came out of the Leng review. I have met Gill Leng on a number of occasions, and I have given her that assurance directly. A number of things remain unresolved on implementation. They are not issues that the GMC owned, but issues where we have given our commitment to work with Professor Leng, her review team and Government to make sure that they are all taken forward.

Chair: Thank you for the update.

Q21 Andrew George: To go back to the nuts and bolts, you are halfway through the transition period for registration. How is that going? Do you know what population is likely to register and what proportion of them have registered so far?

Charlie Massey: As of the end of December, we have registered about 3,900 PAs and nearly 200 AAs. We think that that accounts for the majority of those who are in practice at the moment. The reason for that is the incentive for PAs and AAs to have registration with us. Indeed, in advance of all the controversy that we talked about earlier, PAs and AAs



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were one of the groups that wanted to be regulated by the GMC, because being regulated gives them status and makes employers feel safe about employing them.

PAs and AAs have still felt incentivised to be registered with us, and I would say that that accounts for the vast bulk of PAs and AAs out there in practice. Obviously, I cannot give you the exact number, because we do not know how many are not registered with us. That is one of those unknown unknowns, but I would guess that we probably have upwards of 80% of PAs and AAs in practice already registered with us.

Q22 Andrew George: But isn't it really a known unknown? Someone knows, and that is presumably the employers at the local level. Surely it is not beyond the wit of any man or woman to corral that data pretty quickly.

Charlie Massey: I absolutely understand the point that you are making. I don't think the data enables us to interrogate it in quite the way you suggest, but I don't think there is a problem there. I don't think there is an issue with PAs and AAs not being registered with us who are out there in practice. As you said, we are halfway through, so by December this year, in order to be able to practise as a PA or AA, you must be registered with the GMC. That date is also driving some of the legislative timetables for the Department of Health and Social Care, in terms of the name change we were talking about earlier.

Q23 Andrew George: If that is the case, there is no need for delay, is there? If you think the majority are registered, presumably the nomenclature issue is no reason why you cannot start referring—

Charlie Massey: We already have. As soon as you register, you are regulated by us. We already have concerns that have been raised with Anthony's team in relation to PAs and AAs—not very many. As soon as you are registered, the full panoply of regulation applies.

We are also already regulating PA and AA courses. We have to approve those courses, which we have not always done. We have applied some conditions to some courses. One could argue that that is a really good argument for the benefits that regulation brings, because where we are concerned about, for example, the breadth of the clinical placement experience that is being offered by a course, we are able to step in and say, "You need to get better at that if you're going to be able to maintain your record."

Q24 Andrew George: And you could call them assistants rather than associates—there is nothing stopping you, but you are saying that in law you cannot.

Charlie Massey: The thing that governs our law is the Anaesthesia Associates and Physician Associates Order.

Chair: No, no—we have been through this.

Q25 Andrew George: Okay. In terms of parallels with the nursing profession, how do you think that is proceeding? Do you share notes with the NMC?



Charlie Massey: We do. Nursing associates have been around for some time. There was not the same degree of controversy around nursing associates as there has been with physician associates. There has been perhaps a wider debate on the back of some of the concerns that were expressed about PAs and AAs that has begun to get into anxiety about other roles and substitutions. There is a generalised level of anxiety, whether from doctors or nurses, about whether other professional roles are increasingly being used to take roles from other professionals. This is a really tricky area, because practice is always evolving, whether you are a doctor or a nurse. There are things that only doctors could do 20 or 30 years ago that a range of healthcare professionals can do now.

Q26 **Andrew George:** There are budgetary pressures to find intermediate people on lower salaries to undertake the functions that a higher-paid person was undertaking before. You mentioned anxiety and controversy. To what extent do you think the GMC has a role in quelling or resolving the controversies and anxieties within the profession? Do you think you have a role at all, or are you simply an observer standing outside that?

Charlie Massey: We are not simply an observer, but equally we do not hold all the levers for the things that people have anxieties about. We do see ourselves having a role, which is why I said earlier that we hoped the Leng review would help to reset the narrative; it became very toxic, and there were genuine anxieties on all sides.

For our part, we have tried to be really clear. Take the training of resident doctors, for example. We have some really important roles in overseeing the quality of postgraduate training environments. Those are roles that we take really seriously. We advocate very much, and it is part of an ongoing conversation with the Government, about the workforce plan and ensuring that formal postgraduate training is of as high a quality as possible. You may have seen that we are not afraid to take action and put trusts into enhanced monitoring where we do not feel those things are happening.

We have a role in getting the message out that we are here to protect doctors' training and ensure that it is of as high a quality as it can possibly be. Equally, those questions about substitution, ambitions about workforce growth and skills mix are not questions that belong to the GMC. Those are questions for Government to answer, and I hope the long-term workforce plan will begin to set out a clearer story about the Government's position on all of that.

Q27 **Andrew George:** But you have responsibility to ensure patient safety—that is fundamental to your purpose. Surely it is your role both to inform the Government and to respond back to NHS providers in circumstances where patients are being put in danger as a result of decisions about the skills mix and staffing levels operating within those environments.

Charlie Massey: Yes. You will appreciate that there are a number of conversations that we are part of, behind the scenes, to try to ensure that Government policy is properly informed by the evidence base we can bring.



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One of the things we have put a huge amount of investment into at the GMC over the last decade or so has been our data and our analysis, because that helps exactly with your question about ensuring that, when Government are making policies—whether to address bottlenecks in postgraduate training or to think about the skills mix—we are bringing evidence into some of those conversations.

We will do much of that behind closed doors. We do not see ourselves as an organisation that should occupy a shrill lobbying position, because we want to bring real objectivity to the points we are making.

Q28 Andrew George: But part of the evidence base is the controversy, anxiety and the turf wars going on between professions for which you, as the GMC, are responsible for regulating. Surely that is very much the focus of your responsibility.

Charlie Massey: Yes. I think what I was saying is that those are exactly the sorts of conversations we have been in, but we will not necessarily be publishing or publicising every detail of every conversation.

Q29 Andrew George: What can you say to reassure us that you are having those conversations, and that you are not just saying there are conversations behind closed doors where we are supposed to imagine what they are?

Charlie Massey: We know that for some time the Government have been thinking about what their next long-term workforce plan should say. We have been talking in great detail about some of the things on our wish list and that need to happen within that.

To give you a very concrete example, we believe there needs to be greater capacity and investment in the educator and trainer workforce, for doctors, PAs and AAs. We can see in our data that educators and trainers, while they take a huge amount of pride in their jobs, are feeling more burnt out and under heavier workloads than many others. They often do not have their training responsibilities clearly set out within their job plans, so they do not feel valued. Part of the conversation we then have with the Department is how to do that, help employers feel incentivised to build that workforce, and think about the education that could be provided to the non-formal training workforce as well.

Andrew George: Okay, but that has happened on your watch. There is still controversy and anxiety, so do you not think you owe it to the industry—to those who are regulated by you—to acknowledge that you perhaps could have done more, to apologise, and to say that you have a role in repairing those relationships going forward?

Charlie Massey: Yes, and I think I said earlier that I do believe we have a role in that reset, but I do not believe we own all the levers that have caused some of the anxiety. We definitely have a role—

Q30 Chair: For what part are you responsible, and are you sorry?



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Charlie Massey: I would love to turn the clock back and ask how we can be even clearer in distinguishing between PAs, AAs and—

Q31 **Chair:** The Leng review itself says, “How do we make sure this does not happen again?” Even in the review, it puts it to you and everyone in the system; you are not the only one, and we fully understand how this knits together. But for your part, are you sorry?

Charlie Massey: I am sorry, with the benefit of hindsight, that we were not clearer about distinguishing between those roles. We made a decision to have different reference numbers for PAs and AAs than for doctors, but we could, and with the benefit of hindsight should, have gone further in terms of that differentiation than we did.

In terms of getting regulation up and running, I am really proud of the team at the GMC for doing a really excellent job. It was a really difficult and big job, under very difficult circumstances, and all my colleagues at the GMC were utterly professional, despite sometimes being on the receiving end of some pretty unprofessional behaviours themselves. I need to put on record that I believe my team did a really excellent job, and continues to do an excellent job in the task that Parliament has asked us to take on.

Q32 **Andrew George:** Moving on to the legislation under which you operate, you have described it as antiquated, and you are certainly running two parallel frameworks at the moment. The Government have acknowledged—certainly the previous Government did, but I believe the present one also have—that it is unacceptable that the GMC can appeal against the conclusions of a tribunal, for example. All of that needs to be brought up to speed, modernised and made more effective.

In your risk register, you indicate that you are concerned about the extent to which that is likely to be brought forward, and to be brought forward in a manner that is of sufficient quality to give you confidence that you can go forward with governance instruments that are fit for purpose. Is that right?

Charlie Massey: The legislation is quite complicated. As I speak to you now, we have been engaging the Department in detail on the drafting of the legislation that they intend to consult on soon, and I think it is in pretty good nick. The Government’s plan is to consult on that before purdah periods begin in Scotland and Wales, so that they can get the changes on the statute book by the end of the year, particularly because of that name change piece for PAs and AAs.

We have—in fact, it is not just us; the Law Commission, back in 2014, described the existing legislation as “fragmented, inconsistent, poorly understood”, as well as “cumbersome and expensive”. I would agree with all of that. The legislation that we operate under is highly prescriptive, and it is over 40 years old. It means that we are not able to resolve fitness-to-practise cases as swiftly as we would like, and it means that we cannot avoid unnecessary adversarial tribunals as often as we would like. As a result, it chews up resource that we would rather be putting into more of



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our upstream activity to support doctors, essentially to enable them to be great doctors before they get into trouble.

The right of appeal that you described is something that we have been operating for about 10 years. It was the Williams review that suggested that our right of appeal should be taken away, and we are reconciled to that. The Williams review did say that we have always used our right of appeal proportionately and appropriately, and I think the numbers bear that out; we have been successful in about three quarters of the appeals that we have taken. As I say, part of the Government's plan is to take that away, which is fine. We will therefore make sure that, if there are cases that we would have wanted to appeal, our regulator, the PSA, is aware of our views on those cases.

Q33 Andrew George: You want a regulatory environment that gives you greater flexibility, and there certainly seems to be an environment in which you are either exonerated or publicly hanged and flogged. There seems to be no in-between way of resolving issues so that you are supporting doctors. How would you see that being delivered?

Charlie Massey: The changes we will get through the legislation will give us more discretion about deciding which fitness-to-practise cases we take on. It will give us much more discretion in how we conclude those cases, so we will be able to conclude cases more quickly than we could before. It will give us a power to come to an accepted outcome. Where there has been a fitness-to-practise concern, and we and the doctor can agree to erasure, suspension or conditions, we can do that without going through a tribunal process, which is also good for any patients or others involved, because it is an adversarial process. It will give us more targeted and focused powers in our quality assurance role of education and training. It will also create new duties of transparency and accountability. There are lots of things in there that we think will benefit both doctors and patients.

Q34 Andrew George: I have one final question on this. In your risk register, the risk of delay and omission is given the red rank. What types of omissions are you concerned may be made, and how has the Department responded to your concerns?

Charlie Massey: It is about getting the legislation right. As I said, it is complicated. Because we are a profession regulator, we are a fairly risk-averse organisation; we do not want to do things that get us into a position where we are not taking appropriate action where we should, particularly in terms of fitness to practise. Therefore, a process that fundamentally rewrites all our rules and processes about those core operational functions is one that we must get right. Therefore, where there is a process of legislative drafting that is going more to the wire than we might ideally want, that raises concerns with us about risk. That is what you are seeing reflected in the risk register that you are quoting.

Q35 Gregory Stafford: Can you tell me how many people are employed by the GMC?



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Charlie Massey: Gosh. I do not have a number immediately at my fingertips, but it is about 1,800, roughly speaking.

Q36 **Gregory Stafford:** About 1,800. And do you know how many were employed at the start of the last Government, in about 2010?

Charlie Massey: I don't, off the top of my head.

Gregory Stafford: To the nearest 100?

Charlie Massey: Probably about 1,000, but that is a guess. I would have to come back to you on that.

Q37 **Gregory Stafford:** The figure from your report is 605. Why has your staffing ballooned by 280% or 300% in those 14 years?

Charlie Massey: I do not know whether you have it in front of you, but the number of doctors that we register has gone up entirely proportionately with the volume of staff we have.

Gregory Stafford: Sorry, are you saying that the number of doctors you register has gone up by nearly 300%?

Charlie Massey: When I started this job, I think we had about half as many doctors registered as we do now.

Gregory Stafford: Right, so a 50% increase.

Charlie Massey: Well, I started this job in 2016. I think you were quoting numbers from 2010.

Q38 **Gregory Stafford:** My understanding is that the doctor numbers have gone up by around 50%, but your staffing numbers have gone up by nearly 300%. I am just trying to decide whether this is an efficient regulator. On the basis of those very basic numbers—I accept that they are basic—I would suggest that it does not seem very efficient.

Charlie Massey: Well, I do think there will have been an increase in the doctor population between 2010 and 2016, but I can come back to you with the precise numbers on all that. As we have just been describing, we have also taken on the regulation of a new profession—this has involved a lot of resource, which has been funded, as I said earlier, from Government—in taking on the regulation of PAs and AAs.

We have always been very diligent about thinking about the licence fee we charge for doctors. One of the very first things I did when I arrived as chief executive was to put in place a fee freeze for a year, but other than that, certainly while I have been at the GMC, we have kept fees in line with inflation. We have not been increasing our cost base by more than inflation, which I think is probably the most important measure.

Q39 **Gregory Stafford:** One of the areas that you do not appear to have a grip on is doctors who are subject to regulatory action overseas. There was a big report in *The Times* at the back end of last year showing that significant numbers of doctors who are registered with you have received



overseas actions that you were not aware of. I understand that you have started to put some processes in place. I would like to probe that a bit further and understand what actions you have taken to deal with the problem, as well as what steps you have taken to go back and check that there are no others you have missed.

Charlie Massey: We have worked at pace to review each of the cases provided to us by *The Times*, and we have taken action. In a number of cases, we have held interim order tribunals and have been able to suspend or place conditions on doctors' practice. We have added an alert to the record of each doctor identified by *The Times* as well. In our processes generally, we do very significant checks in relation to a doctor's employment and registration history before they join our register. That means that we ask for their employment history and certificates of good standing from regulators overseas.

What is quite interesting about *The Times* piece is that, among the doctors we were not aware had had sanctions overseas, the vast majority were doctors who had already joined our register and who maintained dual registration in another country overseas. In all our requirements of doctors, we are clear about their responsibility to disclose information to us about sanctions or convictions overseas, and we have tightened the wording of those expectations of doctors. It is also worth saying that we are reliant on regulators overseas disclosing that information to us.

It is an imperfect system; not all regulators are willing or able to share that information with us. I have, none the less, been very ambitious about trying to get that information. I have written to regulators worldwide, and to Government Ministers asking them to make access to the European internal market information system part of their trade negotiation with the European Commission. Going back just over a decade, the GMC was essentially the organisation that drove the creation of the IMI system that led to better information sharing between European healthcare regulators. We lost access to that after Brexit. We continue to proactively share information, but not all regulators are prepared to share that back.

Q40 Gregory Stafford: Could you give me a flavour of the overseas regulators that are not sharing information with you?

Charlie Massey: Some of them simply do not engage. Others have said that it is too much of an administrative burden to provide that information. Others have said that it is fine, so as long as we write to them, and then they will react to that on a monthly basis.

Q41 Gregory Stafford: When I said "flavour", I meant can you give me the list of countries that are not sharing that information?

Chair: Can you create one, if you do not have it?

Charlie Massey: Some of this is a work in progress, because some of these conversations are live with regulators. I am conscious that I do not want to create a diplomatic incident, as I believe happened from one of these sessions that the GMC attended in the past. But I believe that

Finland said that they would not be able to do it because of the administrative burden.

- Q42 **Gregory Stafford:** It would be useful to have a list of all those who are currently not sharing that data with you, for whatever reason. Given that, with patient safety being your priority, do you think it is acceptable to continue to register doctors who are dual registered in those countries that do not provide that information to you?

Charlie Massey: The problem is that we do not know what we do not know. A doctor could be registered in another country that we do not know about—that is part of the problem.

- Q43 **Gregory Stafford:** I understand the limits on what you know and what you do not know, but could part of your requirements be that a doctor must tell you if they are registered with another regulator—is that something that is listed in your rules at the moment?

Charlie Massey: We are very clear, and we have made the wording even clearer to doctors about their responsibilities to disclose that information to us.

- Q44 **Gregory Stafford:** So you do know if they are registered with a regulator in another country.

Charlie Massey: We know what the doctors have told us. My point is, in answer to your question, we do not know if doctors have not told us, even though we are being clear to doctors that they must tell us if those things exist. That is why we are looking at other steps that we can take. As well as writing to regulators worldwide, we are also engaging with IAMRA—the International Association of Medical Regulatory Authorities—about how they can support us with that. There is also a federation of state boards that tries to corral information from overseas regulators.

We are pulling every lever we possibly can in order to get that information. We are also pulling every lever to tell doctors of their responsibilities to us, and we are considering what else we can do. For example, can we use AI in a more intelligent way to do more trawling of the internet to find more information about whether doctors may have sanctions or convictions overseas? But even that is not straightforward, because there may be many Dr Smiths or equivalent in different countries. Worldwide there will be hundreds of different languages to navigate. This is difficult stuff, but we are absolutely clear about our desire to really get on top of it.

- Q45 **Gregory Stafford:** I accept that this is difficult stuff, but *The Times* managed it. If it can manage it, it should not be beyond the wit of the medical regulator.

Charlie Massey: On the back of *The Times* piece we have asked ourselves exactly those questions, which is why we are doing all the things that we are. The Professional Standards Authority, which is our regulator, looked very closely at this as part of its assessment of our role in

regulation. It said that it recognised, “the swift and thorough action taken by the GMC to restrict the practice of the doctors concerned.”

Q46 **Gregory Stafford:** But it also says that it is still an area of risk.

Charlie Massey: Yes, and I do not disagree with that at all. What the PSA said is that we should be considering whether we should be looking for longer employment and regulatory histories and those are exactly the things that we are doing.

Q47 **Chair:** In what timeframe are you looking at making those changes?

Charlie Massey: We are looking at all of those right now and have been since those stories in *The Times*. We have done things since *The Times* stories. The issues around strengthening language on our website, implementing further checks with the Federation of State Medical Boards, and exploring the use of AI tools are all things that we have been actively doing.

I am not in the least bit complacent. It would be wrong for me to say that we will have nailed this by March or April. I do not think that this is something that we are ever going to stop asking ourselves difficult questions about regarding how we get more and better assurance on these issues. It is a fundamental part of our job to recognise that we work within a global system where not all regulators share information in the way that we would like. Any assistance that this Committee could provide to improve that would be very welcome.

Q48 **Chair:** Give us the list of regulators and we will see what we can do to help.

Charlie Massey: It is the list of regulators, but it is also the IMI piece I talked about earlier, because it was a loss to us not having access to the European regulatory information. While we still proactively share all our information, that is not something that we are getting back in the same way.

Q49 **Gregory Stafford:** I just want to confirm: do you share registration and fitness to practise with all the other regulators?

Charlie Massey: Yes, we do.

Q50 **Gregory Stafford:** Is that proactively, or if they ask?

Charlie Massey: It is proactive.

Q51 **Gregory Stafford:** Finally, on the 92 doctors, was there any correlation between where they were registered, which countries they were operating in and the type of fitness-to-practise issues that they had been subject to?

Charlie Massey: They were quite varied. Of the 92, 65 were doctors who we were already aware of, so the 92 was whittled down to 27, and there were eight doctors specifically named in the original article in *The Times* and against whom we have taken action. Of those 27, all but two or three were doctors who had already registered with us when those sanctions



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and convictions arose. That is a really important part of the ongoing exam question. In terms of your question about patterns, we have not been able to see particular patterns in relation to those.

Anthony Omo: No, they were from various different countries.

Q52 **Alex McIntyre:** I declare an interest. In my previous role, before I came into this House, I was a lawyer acting for healthcare providers up and down the country, often in relation to misconduct by senior clinicians and sometimes involving cases that went to the GMC. I will not be referring to any of those cases, but to be clear, I do not act for those providers any more.

To take a step back, would you not say that it is a fairly high bar to be referred to the GMC on fitness-to-practise grounds?

Charlie Massey: Yes, I would. The GMC operates as a backstop. It is really important that employers are seen to be, and act as, the first line of defence when things go wrong.

Q53 **Alex McIntyre:** How many referrals does the GMC receive on fitness-to-practise grounds each year?

Charlie Massey: I will defer to Anthony to take the Committee through the numbers.

Anthony Omo: Last year we received over 13,000 concerns. When you say “referrals”, we get them from different places, but 13,000 concerns came in.

Q54 **Alex McIntyre:** How many of those cases resulted in a restriction on practice or a suspension of duties pending investigation?

Anthony Omo: Are you asking about interim orders?

Alex McIntyre: Yes.

Anthony Omo: I do not have precise details. The challenge is that of the 13,000 that we received in 2025, some will have worked their way through to 2026. I can get the Committee the details on that.

Alex McIntyre: If you could please write to the Committee with the details.

Chair: It would be helpful if you could give us several years, so we will start to see that.

Q55 **Alex McIntyre:** At the moment, from the details in front of me, we have several cases now that are more than a year old. The time taken to deal with some of these cases is increasing—that is correct, isn’t it?

Anthony Omo: That is not strictly correct, no.

Q56 **Alex McIntyre:** In the last five quarters, the number of cases that had been open for more than a year has gone up quarter by quarter; is that correct?



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Anthony Omo: Yes, that is correct.

Q57 **Alex McIntyre:** There are 13,000 concerns, but we have agreed that there is a high bar for referral to the GMC in the first place.

Charlie Massey: The high bar is not about referral to the GMC. It is about the conversion of a referral to an investigation, because somebody could refer a doctor to us about something that does not need us to be involved.

Q58 **Alex McIntyre:** How many investigations did you start in the last year?

Charlie Massey: Of the 13,500, we typically investigate about 1,000 doctors a year. Those will not necessarily be the same volume—

Q59 **Alex McIntyre:** Roughly, what percentage of that 1,000 had interim orders placed on their licence to practise?

Charlie Massey: If I can answer that on not interim orders, but ultimate fitness-to-practise decisions, which I think is probably the better—

Q60 **Alex McIntyre:** We can come to that in a moment, but I am particularly interested in the interim orders for now. Do you have a rough percentage on that? I appreciate that you might not have the specific figures, but anecdotally, what percentage of the 1,000 who are investigated have interim orders placed on them?

Anthony Omo: I would have to come back to you on that.

Q61 **Alex McIntyre:** Okay. The point I am trying to draw out is that we have a system where we have 13,000 concerns—I appreciate that some of those will be more substantiated than others—and 1,000 doctors investigated a year, some of whom have cases open for 156 weeks or above, which is longer than three years, but the percentage of cases that actually go to an interim order and get a suspension on licence is quite low in comparison. Do you think that, as a regulator, you are reassuring the public that where consultants—or any independent medical professional; I used “consultants” because that is the world I used to live in—are potentially a risk to patients and there is a concern, those people are dealt with appropriately?

Anthony Omo: I think we can, and I will come back to the Committee on that, because we have annual statistics that break it down so you can see that. We risk assess every case and every concern we get in. The decision is then made on whether to refer it to a tribunal, and the independent tribunal makes a decision on whether to impose an interim order. We do that in every case, and in those cases where we get the order, that is reviewed and we investigate.

In terms of the delay and the length of time taken, our statistics show that the vast majority of those delays are third-party delays, where either the police are involved or other inquiries are ongoing and we have to wait for them to do what they are doing before we can do that. In each of those cases, we assess whether we need to impose an interim order while we wait or while we investigate, so we do that.



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When you look through the numbers—it is probably worth putting the numbers together—that big 13,000 becomes a relatively small number through the year, and those that go to a tribunal for a final hearing are in the 300s or less. Throughout the investigation, we are always looking at risk—to patients, to the public and to public confidence—and we make those assessments as we go along. We can refer to interim orders at any stage, so it is not quite a direct—

Q62 Alex McIntyre: We would be interested to see the data on where third parties are involved, the numbers for that and who is responsible, because we would be very happy to take that up with other third parties. The numbers I have in front of me show that, at Q2 2024-25, 760 cases had been open for more than a year.

We have established that 1,000 cases a year are investigated, that it is a high bar and that those are generally medical professionals where there are clear concerns, but my concern is that a lot of them are continuing to practise while under investigation. I appreciate that you are saying that risk assessments are done, although I can say with some professional experience that some of them are questioned at hospital or provider level, but would you say that any system where we have 760 doctors waiting for more than a year, whether they have a suspension or restriction on their licence or are just waiting for an investigation, is good for our workforce and for the system?

Anthony Omo: No is the short answer, but in part it relates to what Charlie was describing. You probably know this, but if you take a case under our current legislation, the in-built delay during which we have to back and forth before we can get to any decision is at least six months. The vast majority of our investigations are concluded within six months. In those cases where we cannot, because of third-party involvement or where we are waiting for information, they go longer. That is regrettable, but that is part of what Charlie was saying: with regulatory reform, we are hoping to be able to short-circuit some of that.

There is also something about the cases that we receive that are not ready to proceed, in the sense that there is an ongoing trust investigation or an NHSE investigation, where again we do not have the information and they will not give it to us until they complete what they are doing. In the vast majority of those cases—

Q63 Alex McIntyre: Presumably, though, we cannot have a situation in which we have serious concerns about a clinician. We also know, in the modern world, clinicians practise across various different sites at various different times, with varying communications at times where they are operating at one trust, but have a private practice elsewhere, still in the UK, or increasingly private practices abroad. The regulator might then, in effect, say, “They’re still investigating whether the clinician is safe or not. That is nothing to do with us.” Surely that is putting the cart before the horse, isn’t it?

Anthony Omo: No, that is not what we do. That is where the interim orders come in. The two things that happen when we receive a complaint



are: we assess the risk—do we need to impose an interim order? Can it be managed locally?—and our outreach service connects the dots that you are talking about. Our outreach colleagues speak to responsible officers across the private and public sectors, and they will connect the dots and make sure that there are no holes in our patient safety armoury. It is not about us saying, “They’re investigating, so we’ll leave it”; the risk assessment will happen once we are seized of the information.

Q64 Alex McIntyre: I still think there are a lot of concerns. If the general public were aware of some of the delays, I think that they would be concerned that such things are not being dealt with quickly. But let us move on to the other side of the coin. I am conscious of the wellbeing of doctors who are waiting—on these numbers, 180 people have been waiting for three years or more to find out whether they are going to be able to continue their livelihoods. That is clearly not acceptable. What is the GMC doing to support those doctors or to signpost them to support? Where their ability to practise is restricted, what steps are you taking to ensure that they will get the reskilling and retraining that they will need to get back into the workplace?

Anthony Omo: Again, we will only restrict where we need to restrict. If you are restricted—to your first point—it means that there is a risk that probably cannot be managed locally. If you are restricted, there is an in-built check: every six months, the order is reviewed to make sure that it is still appropriate. We also work with local employers, if you are on conditions, for example, or restrictions to a licence, to make sure that you have the support to practise within those restrictions and get that retraining. We do that.

On your point about delay and people waiting, there are a range of reasons why the cases take time. In some cases, it is because the practitioner cannot deal with the hearing themselves—for example, when they are unwell, and we have to wait for them to get better—and in other cases, third-party delays are causing it, be that the police or other inquiries. A range of factors affect our ability. I agree with you on the general point: we would rather deal with those things as quickly as possible, and we would rather not deal with some of it and let employers deal with it. I do not think that we disagree, but I think that there are reasons behind some of this—some of it is also the legislation that we are operating under currently.

Alex McIntyre: I am conscious that we are about to have a vote, so I will leave my questioning there. I very much look forward to seeing the data that you can share with the Committee. I am sure we will be able to follow up afterwards.

Chair: As suggested, we have had some intel that votes are imminent, so I will suspend—

Josh Fenton-Glynn: May I declare my interest?

Chair: Yes, go ahead.



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Josh Fenton-Glynn: We can get that on the record before I get to my questions. I declare my interest that I worked for the GMC for five years. I found that everyone who worked at the organisation was committed to safe medical regulation, the best for doctors and the best for patients. My questions will primarily be about fitness to practise, which was not an area that I worked on; my career was predominantly on medical training.

Chair: Thank you. We will suspend for the votes.

Sitting suspended for Divisions in the House.

On resuming—

Chair: I will go to Josh Fenton-Glynn.

Q65 **Josh Fenton-Glynn:** Thank you. To reiterate, I declared my interest earlier: I spent five years working for the GMC immediately before becoming an MP, although none of my role was about fitness to practise.

Last year, I was interested to find out a bit more about how the GMC manages sexual harassment and misconduct claims, and I looked at all the regulators on that. I quickly found that the publicly available data is very limited, so I did an exercise where I sifted through individual case reports online to get an idea of what was found. In the end, the only option I had was to submit a number of FOI requests, which I am sure you were briefed about before this meeting.

Do you think that the GMC could do more to be transparent about the high-level data on fitness to practise, and particularly sexual harassment and misconduct cases?

Charlie Massey: That is a good question. As you know, we are really clear that sexual misconduct is unacceptable, and you will also know that we have done a lot of work over recent years to tighten our guidance and expectations of doctors, setting out a new duty for them and adding a new duty for those who witness such behaviour.

We do publish our fitness-to-practise statistics every year—normally in July—and this year we want to make as much of that as we can, and be as transparent as we can. So we will reflect on how we can improve some of that. I am conscious that you have made an FOI request, which I think is being answered today, and I have not seen the answer.

Q66 **Josh Fenton-Glynn:** It should have been answered yesterday.

Charlie Massey: I think the legal deadline was today, but I know that is incoming. Anthony might have more to say on the numbers, but we will always act where we think it is the right thing to do in relation to sexual misconduct. As I am sure you have seen from the Royal College of Surgeons report, we do not always get the outcome we seek from tribunals. Obviously, we are disappointed if we do not, but we recognise that tribunal decision making operates independently from us, and we will appeal where we believe we need to.



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Q67 **Josh Fenton-Glynn:** To move on to that, would you commit to publishing slightly more data on sexual harassment and misconduct in the workplace?

Charlie Massey: I can commit to thinking about what we can publish, but I would want to sit down and think through what we do and whether we can pull it together in a more transparent way.

Q68 **Josh Fenton-Glynn:** In terms of the high level of numbers that I was able to get after asking FOIs, there is nothing in there that could not have been in the public domain.

Charlie Massey: Can I defer to Anthony, as the person who pulls all this data together for us?

Anthony Omo: It is a good question. On the back of the FOI requests, we realised that some of our data and the way that we capture it is insufficiently clear. That is the starting point: we need to ensure that we can capture the data and then publish. We will think about what we may be able to publish in this space and then be more transparent about it.

Q69 **Josh Fenton-Glynn:** Charlie, you said that you take sexual harassment and misconduct incredibly seriously—you said that it was unacceptable. From my FOI, we know that between January 2018 and August 2025, 997 complaints linked to sexual assault were logged, but only 53 resulted in suspension or erasure. Is that good enough?

Charlie Massey: I will probably defer to Anthony on the details, but an allegation is not the same thing as reaching a conclusion that there is a clear fitness-to-practise action that needs to be taken. I think it would be wrong to conflate the number of allegations made to us with allegations that were all upheld.

Q70 **Josh Fenton-Glynn:** Okay, but the scale is quite extraordinary. I do not think that you are sitting in front of this Committee saying that 94% of allegations are unfounded.

Charlie Massey: No. This is tricky territory, because all sexual misconduct and harassment is unacceptable, but there are varieties. The Royal College of Surgeons report talks about moving from clumsy to creepy to criminal. Obviously, the GMC is an organisation that exists to make decisions about taking doctors' licences away, and there are other players, such as employers, that perhaps operate at the end of that spectrum that is more about clumsy.

Q71 **Josh Fenton-Glynn:** It is not simply taking licences away; it is about putting other conditions in as well.

Charlie Massey: Yes. But my point is that the GMC is not the only organisation that takes action where these sorts of allegations are upheld in any degree. Anthony, do you want to say anything more on the numbers?

Anthony Omo: The process we operate is a legal one. Where allegations are made, we take them seriously and we consider them, but, ultimately, we have to prove that allegation to a certain standard by a tribunal.

Josh Fenton-Glynn: I understand that is the civil standard, so it is the balance of probability.

Anthony Omo: It is the civil standard, on the balance of probability. Absolutely.

Q72 **Josh Fenton-Glynn:** You would expect claims in GMC tribunals to be upheld at a much higher rate than sexual assault claims in the ordinary courts, in terms of how many cases you take.

Anthony Omo: Yes, but the same challenges that courts face—in terms of evidence, witnesses and being able to prove it—are the ones that we face. We prosecute those cases where we have the evidence, and where we have witnesses who are willing to help us. Sometimes witnesses, although they report it, do not want to put themselves through that process, quite rightly. There are a number of factors that affect the success rate. That is why, as Charlie says, the numbers in, which we will always look at seriously, and the numbers out don't necessarily match up.

Q73 **Josh Fenton-Glynn:** To stick to that theme, from my FOI requests we found that 90% of complaints concluded with no formal sanction, but two thirds of those that you prosecuted ended up with a serious sanction. Does that suggest that you could perhaps prosecute more and you should think about a lower threshold for how many you prosecute?

Anthony Omo: The threshold that we use to refer to a tribunal is statutory. It is about whether there is a realistic prospect of proving it to the civil standard, such that action will be required. We do not set that, so we have to take into account the seriousness and evidence before we go to a tribunal.

Q74 **Josh Fenton-Glynn:** Are you doing anything to check that you are not filtering out too many cases too early?

Anthony Omo: Yes. The PSA, which we have mentioned before, is our oversight body; it does audits on our cases from time to time. We run internal and external audits on our cases and decisions to make sure that we are in the right space. Of course, we are also challenged through judicial review and there are appeals on some of these cases, so the judiciary has an oversight on some of them.

Q75 **Josh Fenton-Glynn:** Going back to Alex's points about interim orders, I will bring up a case of a doctor who has now been erased. Dr Emmanuel Hakem was a gynaecologist who practised with a chaperone for a year after being arrested for a sexual offence. Does that seem like an appropriate interim measure?

Anthony Omo: Sorry—he had an interim measure?

Josh Fenton-Glynn: He had an interim measure and has since been

erased, but he was allowed to practise for a year with just a chaperone. Does that seem appropriate for a gynaecologist?

Anthony Omo: On the face of it, no. I do not know the facts of that case, but I think the Committee needs to understand that we send the case to the interim orders tribunal and we seek orders. We do not then make the decision, and we have no means of challenging a decision that we do not like at the interim orders tribunal.

Q76 **Josh Fenton-Glynn:** Another issue that comes up, thinking about the victims here, is the long delays. There are also quite long delays for appeals. The average appeal wait is 406 days. Could more be done to support victims through that process?

Anthony Omo: I think yes. We do a number of things, including working with victim support to support victims, but it is never going to be easy and, of course, the length of appeal times is not within our gift. Where we do decide to take an appeal, we make sure that the witnesses and victims are aware of that, and we try to help them through what is a difficult process.

Q77 **Josh Fenton-Glynn:** My final question is to Charlie, because it is more of a strategic one. We have a high number of complaints that are going nowhere—90% of sexual harassment complaints. We have long delays, with the average appeal wait being 406 days. We have inconsistent sanctions. We have a lack of transparency. Do you think the GMC is doing enough to make sure that female patients are safe in doctors' offices?

Charlie Massey: There is always more that we should be doing and challenging ourselves to do, and I think we have been doing things. You talk about inconsistent sanctions; one thing that was introduced in November was new sanctions banding guidance for medical practitioner tribunal panels. You will know, because I am on record as saying, that we have been concerned about the quality and consistency of some of that decision making. Those decisions are not for us; the tribunal panel operates independently of the GMC. The new banding guidance for tribunal panels is much clearer about what the appropriate sanction should be if they find impairment.

The timing on appeals is a really tricky thing, because we do not control the passage of time it takes for an appeal to be scheduled with the High Court. If you can think of any leverage that I could use, I would absolutely want to embrace that. It is a sad fact of the level of demand in the legal system. As Anthony said, we could always be thinking about how much more support we can provide to victims.

On the broader question, taking a step back, the level of sexual misconduct we see in the medical workforce is staggering and should give us all real pause for thought. We have been collaborating with a range of organisations on how we can best address that. My view is that it is about getting upstream and being able to take action before these terrible things are perpetrated on women.

Q78 Josh Fenton-Glynn: I appreciate the getting upstream thing, but there is a high level of sexual harassment and offences in the medical community.

Charlie Massey: Yes. We need to do both.

Q79 Josh Fenton-Glynn: We have this problem of powerful men—and yet 90% of complaints go nowhere. Could you be doing more?

Charlie Massey: We can always do more. As Anthony said, the threshold for deciding when we investigate is a statutory one. I would argue that we are operating on all sides of this. We are operating to prove the quality and consistency of tribunal decision making and making sure through our own audits and through external people being involved that the decisions we are making about escalation of investigation and the sanctions we seek are appropriate. We have also produced much stricter guidance for doctors on good medical practice. We have gone further than most in introducing new duties for those who witness such behaviour. Our leadership and management guidance creates new duties for those in leadership and management positions, obliging them to speak up where they witness such behaviour.

We are trying to act on all this, but I am not in the least bit complacent. We should always be challenging ourselves more to think about what we can do.

Q80 Jen Craft: This is a brief follow-up on that note. You have placed conditions on my local acute hospital's anaesthetics and training programme, and thank you very much for writing to keep me updated on that. The reason why you have attached conditions is mainly concerns about misogyny and sexually inappropriate remarks and behaviour from consultants. Aggression was listed as well, as was worry that people would be learning improper practices and reports that consultants were repeatedly acting in a chaotic fashion. The hospital trust's response was initially to remove the trainee anaesthetists from that particular hospital. The conditions placed on it are that no training programme will run there until you are assured that certain conditions are met.

However, it strikes me that the people who will have been engaging in those misogynistic and sexually inappropriate behaviours are consultants at the hospital, and no kind of sanctions or action appears to have been taken against them. I am coming at it from a patient safety point of view. I, my friends, my family and my constituents all use that hospital. Can you say to them, particularly female patients, that they will be safe under the care of the consultants who have been engaging in this behaviour?

Charlie Massey: Sadly, we do sometimes see that, and we have used our enhanced monitoring powers in a couple of hospitals in relation to training environments where we have had reports of racist and misogynistic behaviours. Where we do that, our first priority is to make sure that we are safeguarding trainees and patients in that particular department, which I believe we have acted swiftly to do. Separately—this is not necessarily in the public gaze—we also have conversations with the responsible officer, which is normally the medical director in a hospital.



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Sometimes allegations do not relate to individual doctors who are easily identifiable. Some of this data comes out of our national training survey. We follow that up through our outreach teams, which Anthony mentioned earlier. We have massively grown that capacity over the last decade. Through that, we have an individual relationship with every single responsible officer and medical director across the United Kingdom.

We will have conversations about individual doctors, where we have been able to identify them, where those sorts of unacceptable behaviours have taken place. If that requires investigation, we will take that forward, but we do not publish all the details of a live process until we have reached an outcome. As we talked about before, we do not reach an instant outcome when we are investigating doctors under our fitness-to-practise rules.

- Q81 Jen Craft:** The question is really about whether people who have been engaging in this behaviour will be held accountable, rather than how we change the culture. People have been perpetuating this kind of behaviour, and all that seems to have happened thus far is that the victims of it have been moved to an alternative hospital in the trust. It does not necessarily look like people have paid for it.

Charlie Massey: Sorry, when I talk about the responsible officer, it is not just about culture; it is because that responsible officer is the individual who makes referrals of individual doctors to hold them to account. We will be having the conversation about that individual accountability and the culture questions within the trust. We are doing both those things at the same time. I assure you that we will not close our eyes to those questions about holding individual doctors to account where we are able to establish that they have been behaving in that sort of way.

Chair: A point of clarification from Alex McIntyre before we move on.

- Q82 Alex McIntyre:** To go back to the point made about interim orders tribunals, the fact that they are independent and how people go to them, I think all in the room agree that sexual predators should not practise as doctors. You will recognise the point that the GMC has to play across the practices, because if someone is being reported in their NHS practice, it might not come through to their private practice or other institutions. I was struck by something you said about how, if an interim orders tribunal says, "We're not going to put any restrictions on," there is nothing that the GMC can do. I have two points to ask about. First, the GMC has the right to appeal to the High Court, don't you, if you do not agree with the interim orders tribunal or think there has been a mistake on a public point?

Charlie Massey: No.

Alex McIntyre: You do not have any right to appeal.

Charlie Massey: Not on interim orders.

- Q83 Alex McIntyre:** Secondly, what work is being undertaken by the GMC to get the standard of the representations made in the interim orders tribunal improved? If someone is a sexual predator, surely that is a pretty slam-



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dunk case for some restriction of practice. Is the issue that the GMC is not making appropriate representations to the interim orders tribunal?

Anthony Omo: I do not think that that is the issue, but for QA and training, we use senior external counsel, not our in-house lawyers, to make it, and we do QA and training with them on what is expected. We review the decisions, including what representations to make, to ensure that they have presented the case in the best light. We feed back as necessary.

Charlie Massey: It also relates to the sanction banding point that I made earlier. We are trying to support the Medical Practitioners Tribunal Service and to improve the quality and consistency of its decision making, particularly in cases such as sexual misconduct, which is a specific conversation that I have had with the new MPTS chair, who arrived in post just a few weeks ago. That should give the tribunals clearer lanes to operate within when thinking about the sanctions that they dish out when we come to them.

Q84 **Chair:** Does it remain the position that you will still not be able to appeal under the new legislation, in your understanding?

Charlie Massey: We have never had a right of appeal on interim orders tribunals; at the moment, we have a right of appeal on the final fitness-to-practise decisions made by tribunals. The Government have said that they intend to remove the right of appeal that we have, when they legislate. As I said, we believe that we have always used that right proportionately and appropriately, and we will continue to make our views known through the PSA, which will continue to have a right of appeal on fitness to practise, so it can exercise that right of appeal should the Government decide to proceed with removing our existing one.

Q85 **Paulette Hamilton:** Good afternoon. My questions relate to the response to the maternity review. To start, failures in maternity services across the piece over many years meant that many trusts got into problems, and so the Donna Ockenden independent review was carried out. Last year, I think in June, you at the GMC gave an apology. You said that the apology was to families for not responding quickly enough to the Ockenden review into maternity services. Given that apology, what were the lessons learned? Yes, you and the NMC gave an apology, but what were the lessons learned?

Charlie Massey: I will start and then hand over to Anthony, because he has been spearheading work that goes exactly to your point. We have been engaging directly with the families affected in Nottingham, where Donna Ockenden is currently undertaking her review. We are also engaging with families involved with some of the other maternity trusts that Baroness Amos is looking at, and we are engaging with Baroness Amos and other organisations about maternity services generally.

In terms of your specific question, we have been meeting families in Nottingham. I have myself met families in Nottingham, as has Anthony. The feedback I received directly from those families was that we had not



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been as good as I would like us to be at making ourselves visible to families and making our processes accessible to them. If families find themselves in that terrible tragic position where they faced traumatic experiences as a result of unsafe and uncompassionate care, we need to make it as easy as possible for those families to raise concerns with us.

Q86 Paulette Hamilton: Moving you on quickly, how have you started to do that?

Charlie Massey: We have been working with national charities to develop a range of materials. We have been working through our outreach team to engage with registrants. We have also been setting up surgeries in Nottingham to engage directly with families and give them an opportunity to come in. Anthony can probably give chapter and verse.

Anthony Omo: The starting point, as you say, is that what happened to those families should never have happened and that is what we are trying to ensure doesn't happen again. What has been really insightful for us and the families is, as Charlie said, what they need. It is not about the system and not about the GMC; it is what they need. What they said to us was, "You need to come to us and hear our experience. We don't want to keep repeating it to different bodies." So we contacted the coroner, Donna Ockenden's team at the review and the police and gathered as much information as we could. Then we set up meetings in Nottingham where families could come and talk to us and the NMC. Once we had the details, they could then tell us what they wanted to go forward with.

Q87 Paulette Hamilton: From what they told you they wanted to go forward with, what have you actually done?

Anthony Omo: We have opened a number of inquiries and investigations.

Q88 Paulette Hamilton: So you have opened more inquiries.

Anthony Omo: Yes, after meeting the families. Donna's review is not complete. It is still ongoing.

Q89 Paulette Hamilton: It will complete this summer.

Anthony Omo: In about June. She gave us about 312 case files late last year, in which she had gathered information from the families. We are reviewing those and connecting the dots with the families we have met. Then we will consider those through our processes.

Charlie Massey: On other things we have done, we have been attending family days—there was one last weekend. We have been holding family clinics in Nottingham throughout 2025 and into this year. We have been in direct contact with the affected families about developing an action plan, which we shared with them, about improving communication—

Q90 Paulette Hamilton: Can I stop you there? I get very frustrated, and I'll tell you why. The Ockenden review might have been the second to last review, because we did one on the Health Select Committee, but there have been so many reviews over the years, and you tell me you're doing



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yet another inquiry. Is there nothing that you have actually implemented?

Anthony Omo: We are not doing an inquiry. We are working—

Q91 **Paulette Hamilton:** You said you are doing further inquiries into the cases you got on the families. Did I mishear?

Anthony Omo: Our role is to consider whether or not the doctors involved in the care are fit to practise. That is our role. We have received information from the families and from the review, which we are now considering and looking at to make sure that the doctors who they complained about, or who have been referred to us, are fit to practise. That is what we are doing. It is not a review. It is working with the families—

Q92 **Paulette Hamilton:** I am only going by your words. That is what I was told.

Anthony Omo: We are reviewing the case files, but the process we follow is whether or not the information we now have suggests that a doctor is not to practise.

Paulette Hamilton: I am not an expert on this. Forgive me if I have misunderstood, but you made an absolute apology and you, from the GMC, said that you were going to look at lessons learnt. From the lessons learnt I thought that some of the structure—some of the way you did things—would change. What I am getting is that you are looking at the individual cases now and if the doctors have done something wrong, they will be struck off. I don't know what will happen. But the reason this happened is that the structure—the way that things are dealt with—is fundamentally wrong, so tell me just one thing that you have done as an organisation to say, "Look, this was not going right. This could happen again. This is what we have done to ensure that this never happens again." I will hand over to you, Anthony.

Anthony Omo: What we have done is work with the trust and others on the structural challenges. As you rightly say, your Committee identified exactly the same themes that we did: a lack of leadership, interpersonal tensions, a poor blame culture, a lack of candour—the list goes on. That applies across all these maternity sites, unfortunately. What we have done and continue to do is to work with the trust, the doctors, the NMC, the CQC and others to say, "How do we support better care going forward?"

I was talking about the individuals who have come to us and the lessons learned. I was the one who issued the apology in June to the families for the way we had been engaging with them, which we changed. That is what I tried to outline to you. So in terms of the structure—

Q93 **Paulette Hamilton:** Has anything changed in your structure since last June? If it has happened before, can it not happen again?

Anthony Omo: Sadly, I think it can, but the changes I talk about are about how we interact with families who come to us. That is what is within our control. We can't change the structures in a trust.

Q94 **Paulette Hamilton:** You can't change the structures in your organisation?

Anthony Omo: No, no, we are not—

Paulette Hamilton: I am just asking.

Charlie Massey: The fitness-to-practise cases take on their own form and structure, in terms of approaching the questions about investigating whether doctors continue to be fit to practise. That is what the 312 case files that Anthony described relate to. The questions about how we improve our engagement with families were very much in our mind when we issued the apology, and we have taken a series of steps to improve that, including holding family surgeries, clinics and so on.

The broader question of how we play our role in improving maternity services in the UK is a big exam question. I do believe we have a role in that. That is not about our structures in terms of fitness to practise; it is about things like how we use our data to better inform others about where things might be going wrong. We initiated a data-sharing process with the NMC and the CQC about three or four years ago, in which we tried to pool all our data in a shared data platform. My view was that if we pool our data, we could get better insight, better intelligence and better early warning, and we could anticipate where things are going wrong.

Q95 **Paulette Hamilton:** You know why I am asking you that. You are starting to hit the point. It is because, to go back to what Alex and Josh were saying, you have doctors there whose practice is not the best it could be for whatever reason, and they have carried on practising not for weeks or months but for years after something has gone in about them. On the other hand, you have women and families who have been complaining about the treatment they have been getting, and we have been getting report after report backing them up. But in your structures, the way in which they are examined does not seem to be changing in any way so that we can give doctors who are not performing in the best way they could the training they need, or drum very poor doctors who should not be practising out of the system a lot quicker.

Charlie Massey: I respectfully disagree. I think we have made a lot of changes in how we engage with families. We have made it easier for them to access our processes. We have also been working very hard at the system level. What happens is that families are let down by a system of which the GMC is part. We are part of a system that has failed families—I am clear about that. That is why we have been initiating conversations with organisations like the CQC and the NMC, bringing our data to the table. When we did that, we were able to see, for example, some workforce metrics that were more indicative of future maternity problems.

The question, then, is: what do you do with that? I sat down just a few months ago with Mike Richards, the chair of the Care Quality Commission, and said, "Let's have a better conversation together about all that." As of a couple of months ago, I have also been sitting on the National Quality Board, because I said to Mike Richards and Penny Dash, "I think the GMC has a real role in contributing to improving healthcare, and particularly



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maternity care, where, frankly, too many tragedies continue to happen and lessons continue not to be learned.” Successive inquiries on maternity have come up with the same issues around culture, leadership and so on.

Paulette Hamilton: My time is up. You have spoken to me for the last eight to ten minutes, and I have asked you about what you have done practically to ensure that, if doctors are not performing, we do not keep talking about it, but we do change the system or the structure—whatever you want to call it—to ensure that those doctors are not allowed to practise until they get the training they need, or perhaps lose their numbers for a while or whatever it is. You have not been able to give me an answer that I feel happy with, but on that note, I will hand back to the Chair, and others will come in with further questions.

Q96 **Jen Craft:** I now turn to antisemitism in the NHS. First, how are you engaging with Lord Mann’s rapid review into tackling racism and antisemitism?

Charlie Massey: I met Lord Mann just before Christmas with Anthony. We have also written to Lord Mann, I think on a couple of different occasions, both ahead of that meeting and immediately afterwards. We have also been engaging with the officials who are supporting Lord Mann. I do not know what he is concluding. I know that his report is due imminently, but I feel that we have been able to set out to him very clearly, and hopefully convincingly, that we view any form of antisemitism, Islamophobia or other forms of racism as unacceptable, and that we have zero tolerance of racism.

Q97 **Jen Craft:** Who in your organisation has expert knowledge of antisemitism? What training has been undertaken by some of your assessors in that regard?

Charlie Massey: We have been doing a lot of training. Anthony can say more, because there is another programme that he is leading for us. We have, for a number of years, been training all our decision makers in fairness and bias in our processes. Specifically in relation to antisemitism, we invited the Community Security Trust and Tell MAMA to come and meet with our decision makers—I think that was in early December. That is something that we intend to continue to repeat through the organisation. We have also invited the Community Security Trust and Tell MAMA to come to our council meeting—that is our board meeting—next month, where they will deliver the same training to the senior team, including both of us, and all our council members.

Q98 **Jen Craft:** But would it be fair to say that there is no one in the GMC at the moment who has expertise in antisemitism?

Charlie Massey: This is probably where I will turn to Anthony, because we have drawn on a lot of expert advice in dealing with the cases of antisemitism that have come to us. I should probably hand to Anthony at this point.



Anthony Omo: We have worked with the Community Security Trust to enable our decision makers to gain more experience in it, as Charlie said. We have also worked with the Jewish Medical Association and others on understanding the concerns and how we might approach it. We have worked with senior King's Counsel barristers who are experts in this field to ensure that, again, we are on top of what we need to be in the law.

Q99 **Jen Craft:** Are you confident that the MPTS have the understanding and expertise? Are you satisfied with the outcomes where you refer cases of antisemitism to them?

Charlie Massey: You might not be surprised that that is something I talked about with Fiona Monk, the incoming MPTS chair, in the week that she started her job earlier this month.

We have not always achieved the outcomes we want in some of the interim order tribunals we have had, where we have tried to temporarily take action against a doctor's licence while our investigation continues. As we established earlier, we do not have a right of appeal on interim order tribunals. On one or two of those, with new evidence coming in, we have been able to take a further case from an interim order tribunal and ultimately been successful.

You ask a really good question about whether decision makers—at our end or in the Medical Practitioners Tribunal Service—have specific skills, expertise and knowledge in relation to cases such as antisemitism. I think you can make the same argument about sexual misconduct too. That is part of a live conversation that we are having with the MPTS. They operate independently from the GMC, so it is not for me to tell the MPTS what they need to be doing, but I do believe that those issues are well understood by the incoming chair, and I expect to speak to her more about that in the coming weeks.

Q100 **Jen Craft:** Have you taken steps to assure yourself that your internal procedures and the things that have prompted the Mann review do not reflect an organisational weakness in how you handle cases of racism and antisemitism?

Charlie Massey: We are always reflecting on whether we are doing all the things we should be doing. In relation to antisemitism specifically, we had a big influx of cases after October 2023, and we wanted to make sure that in our handling of those cases we were bringing an expert and proper legal perspective to the way in which we made decisions about our fitness-to-practise cases. Indeed, that is why, as Anthony said, we have used external legal counsel to help us with that. That did cause some delays with those cases initially, but I think that was probably the right thing to do to ensure that we had a consistent and more expert approach.

As with all things relating to training, you should never view yourself as having reached the end of that road. Any decision making is the function of a collection of human biases, so we need to be constantly refreshing our training and making sure that we are bringing an expert perspective on issues like antisemitism, but also a perspective of understanding our own



biases when we face particular decisions. We have put huge effort into all that at the GMC over recent years, because my view is that we should be looking for bias with the expectation that it exists, rather than trying to find evidence that suggests it doesn't—if that makes sense—so this is a job that will never be complete. It is something that we need to continue to focus on.

Q101 Jen Craft: Do you imagine that, following the Mann report, you will have to make significant changes in the way you handle these kinds of investigations?

Charlie Massey: I really don't know. We had a conversation with Lord Mann that related to not just regulatory responsibilities, but the responsibilities that employers have. Remember: employers are the first line of defence when people are behaving in an offensive or racist way. I know that Lord Mann will be considering whether changes to our underlying legislation might be required.

If the Government decide they do want to go down that route, they will need to make decisions relatively quickly, given the process that I described earlier and the timetable for new legislation. If that happened, it would be part of the consultation for legal change that the Government would want to get out the door before purdah periods begin in Scotland and Wales. But I can't honestly, right now, give you a prediction of where Lord Mann might land, because I just don't know.

Q102 Jen Craft: I will explain what I would be interested in as a bit of self-reflection. I have been speaking to people I know who would fall under your regulatory frameworks—doctors and so on—and they feel that the way the GMC has approached the scale of antisemitism over the last couple of years has perhaps not been as robust or dynamic as it could have been. It is not just the GMC but the wider regulatory bodies in the medical profession—the PSA, the MPTS and all the ones that regulate the various professions. Do you think that together you have the ability to tackle antisemitism and racism, at their root cause, in the NHS or do you expect the Mann review to tell you things that you were not expecting?

Charlie Massey: Tackling antisemitism, at its root cause, in the NHS goes well beyond a single professional regulator, because what we are talking about is, sadly, a lot of beliefs and behaviours that permeate society. I am not trying to excuse the GMC from having a role to play; we do have a role to play, and part of that is about how we express our expectations of doctors' behaviour. In fact, we are currently updating some guidance on religious beliefs, where I expect us to go into more detail on all that. So we definitely have a role to play, but it is not for the GMC alone—solely—to have the responsibility for rooting out racism in the NHS. We should all be ashamed of the level of racism that exists in the NHS. The GMC—for absolute clarity—wants to play the biggest possible role that it can in addressing that, but it is about much more than us.

In terms of fitness-to-practise cases, there is always the question of whether we are being sufficiently pacy in dealing with them. There are

also some questions that we talked about earlier. We had a big influx of those cases and we wanted to take expert legal advice. We now have that—and that expertise—which has meant that we are much better able to move those cases forward at pace in future.

Q103 Jen Craft: Returning to the other regulatory bodies, does the ability exist for co-ordination between you all to tackle this kind of significant issue, or is that a wider issue for someone else to answer?

Charlie Massey: There is, and I meet with all the other chief executives of the regulatory bodies. We have had explicit conversations about how we are each approaching questions of antisemitism, to what degree there are differences in our approach, whether those differences are right and whether we should be aiming for a consistent approach. Each of the regulators currently operates under a slightly different legal framework, which does not help in terms of consistency.

Particularly on issues such as racism, my view is always that collaboration and alignment are better than being misaligned and not collaborating. If we collaborate and are aligned, we can have much greater consistency in the messaging that we are putting out to our different registrant groups. We can also have a much better ability to say exactly the same thing to our registrants as system regulators say to employers.

Q104 Jen Craft: It is great that you all agree on why co-ordination is beneficial. The question is: do you think that it exists? Is the potential for co-ordination to tackle these issues there, or does more work need to be done?

Charlie Massey: We hosted a roundtable with all the professional and system regulators last year. We will imminently publish some joint regulatory principles, which I think is an admission that we agree there is more that we could be doing together. What you will see when we publish those principles is that we have actually been working on precisely that exam question. None the less, there will still be some differences in approach because each organisation will use different definitional boundaries or whatever. There is always more to do, and I am keen that we play our role in doing that.

Q105 Chair: Could you please include the Committee on your stakeholder list for that release?

Charlie Massey: Yes.

Q106 Jen Craft: On those definitions and work, where is the line to be drawn between the free speech and opinions of medical professionals—not just doctors—and where those play into questions of fitness to practise?

Anthony Omo: Freedom of speech does not cross into fitness to practise. People have a right to free speech and can be offensive in that. I think that where it crosses over is when what they are saying or posting is objectively antisemitic or Islamophobic. That is where we use the definitions that exist to help us make those judgments, but it is a judgment that then must be made. It does not necessarily cross over.



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There is a point at which political free speech—which is protected—is not a matter of opinion.

It is quite clear that doctors hold opinions and that they can hold and share those. But if you are objectively antisemitic and/or Islamophobic, we are interested in that. We need to consider that in context. Even if something is not objectively antisemitic, we also consider whether it is offensive and/or becoming of a professional. Doctors hold a particular status in society, so the question is whether you are upholding our standards and behaving as patients and the public would expect you to. That is something we also look at.

Q107 Jen Craft: Are those boundaries fairly clearly defined or are they constantly evolving? When is something an opinion and when does it impact on your ability to carry out your job as a medical professional?

Anthony Omo: You have hit on one of the challenges, because it is not necessarily static. That is why I use the word “objectively” antisemitic or Islamophobic, because that is quite clear for everybody, but there are times when it might be on the line. That is where we need to consider what I said is a secondary concern, which is where we ask, even if it is not objectively antisemitic, is it of the standard that we would expect of a doctor?

Jen Craft: Thank you. I will leave it there.

Q108 Chair: I have a quick supplementary question. When you say objectively Islamophobic, there is not an accepted definition for Islamophobia, even in part. So what do you mean by “objectively” Islamophobic?

Anthony Omo: We use the dictionary definition and examples, and the APPG definition, to help us with that. As you say, there is not a universally accepted example. We use those, but it comes down to assessing the words you use in the context and so on.

Q109 Dr Cooper: For the record, I have to declare an interest as I have a licence to practise on the GMC register.

I want to move us on, and I appreciate that we are coming to the end of the session. I would like to focus your attention on the registration of internationally qualified doctors. As I am sure you are aware, we have the Medical Training (Prioritisation) Bill coming to Parliament next week.

Mr Massey, you have previously said, “It is vital that workforce policies do not inadvertently demoralise or drive out the talent on which our health services depend. Doctors who qualified outside of the UK make up 42% of those working in the UK. If we see even a small percentage increase in them leaving, our health services will end up with huge holes that they’ll struggle to fill.”

To put that in context, we are seeing larger numbers of internationally qualified doctors already leaving. In 2024, 4,880 internationally qualified doctors left, a 26% increase compared with 2023’s number. My question is, do you think that the Bill risks having an adverse impact, and if so, how



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can that risk best be addressed?

Charlie Massey: I will say a couple of things—although you have already said some of what I would say, so thank you for that. I think it is entirely legitimate that the Government set out plans about the allocation of training places, with a priority given towards UK-trained doctors. It costs a lot of money to train a doctor, both through medical school and their postgraduate training. Indeed, we said in our evidence to phase 1 of the medical training review that the bottleneck in training needs to be addressed.

We also said that that needs to be done with a really good understanding of the evidence base. We know, for example, that in general practice, half of first-year trainees are doctors who qualified overseas. In psychiatry, which is a specialty that has traditionally been more reliant on international medical graduates, 42% of trainees qualified overseas.

To your question, I think it is absolutely legitimate of the Government, but conversations about prioritising UK graduates need to be accompanied by clear statements that recognise and value the contribution that international medical graduates make in our NHS.

Q110 Dr Cooper: Pragmatically, Mr Massey, how do you see that working in practice? For example, we will be making offers in 2026 that will have that prioritisation; then, from 2027 onwards, we will be undertaking interviews where we will prioritise. How do you feasibly see the balance between legitimately saying that UK graduates cost a lot to train, and therefore should be prioritised, alongside the need for international recruitment? How do you see that playing out?

Charlie Massey: It is less about international recruitment than it is about the doctors who are already working in the NHS. It is about that 42%.

Dr Cooper: So this is not about new people coming in, this is existing people—

Charlie Massey: We are seeing a number of international doctors joining our register. We had about 20,000 last year, compared with about 8,000 coming out of UK medical schools. But the point that you quoted earlier was me saying that we need to be really careful about those doctors who are already working in the UK. There are 140,000 of them, but remember that they are highly mobile individuals; they have uprooted themselves, their lives and their families to come work in the UK.

If only a small proportion of those doctors feel that they are not getting adequate access to learning, development and training, and that they are not being supported and valued in the workplace, there is a good chance that more of them may leave. Indeed, in our data last year we saw that there was an increase of 26% of overseas doctors leaving. The question is what Government should do about it—

Q111 Dr Cooper: You are making a differentiation between people already working in the national health service who have qualified from



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international medical schools, and those people who might be coming afresh. To perhaps assuage your concerns—please tell me if this assuages them—in the Bill, the priority list has UK medical graduates, and it has persons in priority groups, such as people who have right to remain—for example, those who are from Ireland and did most of their training here. There is a list of four countries that we have a special relationship with. The Bill also says, “persons who have completed, or are currently on, a relevant qualifying UK programme,” and it goes on to talk about people who have had substantive training in the national health service. Do you feel that that covers your concerns about international recruits who have been in the NHS for some time?

Charlie Massey: For this year, the Government are using visa status as a proxy for experience; for future years, they have wisely left the door open in terms of defining what significant experience means, so that they can be much more nuanced about making sure that those hard-to-fill specialties get the doctors they need.

It is not just about the Bill and formal postgraduate training. The other thing that we have been saying for some time is that we have seen a massive shift over recent years to many more doctors being locally employed and in SAS roles. The significant growth of locally employed doctors has been fuelled, to a large extent, by international migration. Those doctors have not historically had access to the learning and development that I believe they should have had; I think it should be much more attainable for doctors not in formal training to develop their clinical skills and experience and step into specialist roles in future

That is not at the cost of formal training—I need to be clear that this is a both/and position. This is a particular position that we are advocating for with Government in relation to the workforce plan that we expect in the spring. That goes to the point about doctors feeling confident that they have the career progression and are valued in the workplace. We know from our research that those are really important factors in determining doctors’ decisions to stay in the UK.

Q112 Dr Cooper: Absolutely. To return to my colleagues’ queries, is there any risk with the Medical Training (Prioritisation) Bill? We have been here before; this is not the first time that we have looked at the issue of UK graduates. Is there any risk that you can see whereby we end up with a two-tier system, so to speak, where the specialties that are very hard to fill—you have already alluded to a couple of them—are filled by international graduates and we inadvertently end up perpetuating a form of racism that nobody would like to see?

Charlie Massey: I think it is too early to say. The Bill has only just landed in Parliament and there is quite a lot to be fleshed out in terms of what significant NHS experience means.

Chair: You will have to do it very quickly.

Dr Cooper: It is happening on Tuesday.



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Charlie Massey: I know, but my point is that I don't think the Bill is the only thing that you should be looking at to answer that question. The question about what the offer is for the entirety of our medical workforce, whether they are in formal training or not, is the missing bit of the equation for reaching that judgment about whether we have a two-tier workforce.

Q113 Dr Cooper: I absolutely appreciate that, Mr Massey, but you will appreciate that we are parliamentarians so we have to pass legislation to the best of our ability.

Charlie Massey: I do.

Dr Cooper: This is the Bill that is in front of us. For the General Medical Council, are there any practical considerations of the Bill that you would like to make us aware of?

Charlie Massey: No, I don't think so. I have made all the points that I would make—and have made—to senior officials and Ministers.

Q114 Dr Cooper: Before we move away from the Bill, there is one small point that is of interest to me because it is my specialty. The Bill refers specifically to public health as an area that is exempt from the legislation: "UK specialty training programme" means a programme of training required for or leading towards the award of a certificate of completion of training—a CCT—"but does not include...a programme wholly in the area of public health". The reason, as I understand it, is because there are medics and non-medics who go through this specialty area. Can you foresee any issues arising as a result of this exemption?

Charlie Massey: I cannot off the top of my head. The other point is that we need to make sure that we are continuing to make other routes to a CCT or to coming on to the specialist register attainable. What I mean by that is that people who get on to our specialist register are not just those doctors going through a formal postgraduate training programme. One of the bits of work that we have been doing with all royal colleges and faculties has been to make sure that we are really clear about the criteria that need to be assessed, in terms of the skills and experience, to make it easier for those doctors to demonstrate that they have the skills and experience to join the specialist register. I do not see anything specifically in relation to public health that is immediately worrisome about the Bill.

Q115 Dr Cooper: Thank you; that is clear. Quickly, before we finish, I want to move on to education, training and development, which is a large area but I will give a précis. Obviously, we hear a lot—and I hear a lot from colleagues—about burnout, people being dissatisfied with their day-to-day work, and all sorts of issues. In your 2024 GMC survey, 74% of those responding said that they were likely to make a change to their career in the next 12 months, including 19% who indicated plans to leave the UK. Perhaps that gives us pause for thought when we get to the Bill next Tuesday as well. My question is, based on the fact that we are now in the NHS 10-year strategy period and the 10-year workforce plan is coming forward, what considerations arising from your insights into education,



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training and retention should be foremost in our minds as we look at the 10-year workforce plan?

Charlie Massey: I will take those in reverse order, if I may, and start with retention. For a number of years, we have been publishing our data about doctors' experience in the workplace and we have used that to hold a mirror up. We have reported high levels of burnout and high workloads, particularly following the pandemic. Last year's report actually showed some gradual improvement in some of the data, but many doctors face real challenges and struggle to provide the patient care that is ultimately what drives us.

We have tried to use those reports, that data and that insight to have bigger conversations about inclusive working environments. I believe the commitment in the 10-year plan to introduce staffing standards is important and something we should all put our shoulder behind.

Q116 Dr Cooper: To be clear, Mr Massey, are there no staffing standards currently?

Charlie Massey: I hope most employers will think about staffing standards and the wellbeing of their workforce. The 10-year plan wanted to introduce more hardwired staffing standards—more consistency of data and accountability for boards that threaded through regulation and system regulation—

Q117 Dr Cooper: So it is fair to say that the standards are variable at the moment.

Charlie Massey: Yes, and I am a big fan of that, because I think that standards are variable, and employers do not always put as much intention on creating inclusive, supportive workplaces as they should. That is fundamental to those questions around retention.

Q118 Dr Cooper: Specifically, can you consider GPs, who you mentioned earlier? In terms of making that a career choice that is more appealing, how does the GMC consider its role in building up the education, training and support available to newly qualified GPs?

Charlie Massey: In last year's report we talked specifically about the challenges faced within general practice. Forty-four per cent of GPs are struggling with workload, and 60% found it hard to provide sufficient care to patients at least once a week—that was much higher than for other specialties. It is not for us to determine the Government's plans for GP numbers or the wider workforce in primary care, but we use our data to enable people to reach those conclusions—

Q119 Dr Cooper: Is it fair to say, from your data, that there should be more GPs in primary care?

Charlie Massey: I think it is a bit more complicated than that, because it is about the much broader workforce that work within primary care. Primary care now looks very different than it did a decade ago in terms of

the range of healthcare professionals. It would be wrong, even as the regulator of doctors, to say that the answer is x thousand more GPs.

Q120 Dr Cooper: I appreciate that. However, if we are moving from hospital to community—and at the moment, as you know, ICBs are getting ready to be the strategic commissioner and are looking at primary care to be their lead provider—would you not say that that is an additional burden on general practitioners, and therefore that increasing either the resources available to them or the numbers that are there to be able to do the work is not an unfair summary?

Charlie Massey: To be fair to successive Governments, they put a lot of effort into getting more GP training places and more GPs in. The problem is the leaky bucket at the other end. The problem is that the workforce pressures that we have discussed—and the wellbeing issues and burnout—are driving too many GPs out of practice at the other end. I come back to those questions about addressing working environments and workplaces. It is about making sure that people feel properly valued, and that doctors have the time to do the thing that they became doctors to do—to provide patient care. It is much more an issue of attrition and retention. You mentioned earlier the data about doctors saying they would leave. We saw the number of doctors saying they were taking hard steps to leave the profession—that means applying for a job or downloading application forms—double from 7% to 15% between '21 and '24.

Q121 Dr Cooper: Absolutely. This is not a new problem. I appreciate that we had a pandemic—and that was very stressful for frontline healthcare professionals along with the rest of us. But why have these issues, which you rightly outlined, not been addressed previously?

Charlie Massey: That is a complicated and difficult question. Sadly, I think working environments are not consistently good, whether in primary or secondary care. It is much harder to get a handle on that in primary care, because there are many more employers—

Q122 Dr Cooper: But I think there is consistency in what general practitioners are saying, and it has been pretty consistent for a number of years as the pressures have increased. Why are we now, in 2026, saying the same things—the definition of insanity is saying the same thing and expecting a different outcome—when nothing appears to have changed? In your role at the GMC, you speak to a lot of clinicians. Why has this not been addressed?

Charlie Massey: I think the issues around wellbeing, workload and work environment in general practice have become significantly worse since the pandemic. The pandemic drove massive changes in the way that general practitioners work and the way that primary care is delivered in this country. Many of those changes have been positive, but I know from talking to GPs that too many of them feel that the only way that they can survive—and we see this in our data—is by reducing their hours in order to cope.

Q123 Dr Cooper: Is that burnout of clinicians, changing expectations or under-



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resourcing of primary care—or all three?

Charlie Massey: I think there will be elements of all of those factors that we need to take account of. I appreciate being asked what the reasons and the solutions are, but it is complicated. There are some structural issues in relation to primary care. There are far fewer GPs who want to become GP partners, which raises questions about the structure and funding for primary care. Those are not issues that the GMC has particular expertise in.

Q124 **Dr Cooper:** I appreciate that, but as a regulator—

Charlie Massey: As a regulator, I am worried about what I am seeing in terms of the data—and that general practice has consistently come out as one of the most hard-pressed specialties.

Dr Cooper: Sure. There is stuff around discrimination, but I think we are out of time.

Chair: Thank you so much for coming, and for bearing with us while we had votes—you waited very patiently. Thank you to the audience and everyone who is here.