Witness Name: Dr Michael Mulholland (on behalf of the Royal College of General Practitioners)
Statement No. WITN7249001
Exhibits: WITN7249002-WITN7249007
Dated: 01/11/2022

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF DR MICHAEL MULHOLLAND

I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 08 September 2022, and Supplemental Request dated 30 September 2022.

I, Dr Michael Mulholland, of the Royal College of General Practitioners, will say as follows: -

Introduction

1. I, Dr Michael Mulholland, DOB GRO-C 1969, am a practising GP, GMC number GRO-C I am a Partner in the Unity Health practice which has 5 surgeries in the Thames Valley region. For the purposes of this evidence, my professional address is 30 Euston Square, London, NW1 2FB. My professional qualifications are: BSc, MB, ChB, DRCOG, MSc (Med Ed), FRCGP.

2. I qualified as a doctor in 1994 and as a GP in 1998. I joined the practice now known as Unity Health Buckinghamshire in 1999. I had roles in Health Education England (HEE) as an Associate GP Dean until November 2018, when I was seconded to RCGP. I was also a Continuing Professional Development ("CPD")/Workforce Tutor until November 2021, at which point I

left HEE. I was RCGP Vice Chair for Professional Development and Standards from November 2018 to 2021 and am now the Honorary Secretary.

3. As the Honorary Secretary I work at RCGP for 4 half-day sessions per week.

4. My role as Honorary Secretary of RCGP is to support the Trustee Board in ensuring proper governance of the College across all four UK nations. Unless individual nations are specifically referred to, the information in this statement relates to the position across all UK nations.

5. The RCGP has a role in GP specialist training in that it "bookends" the GP training process: the College sets the curriculum and sets, administers and marks the exams. The curriculum has been approved by the GMC as meeting its curriculum standards.

6. Doctors wishing to specialise as GPs enter three years of supervised practise in hospitals and GP practices, employed by a single lead employer, where work-place learning and practical experience are supported via local Deaneries. The Deaneries are HEE bodies and separate from the College.

7. As well as completing three years of supervised training, trainees must also pass three assessments collectively known as the assessment for membership of the RCGP ("MRCGP").

8. The three MRCGP assessments are: (1) Work-place Based Assessment, which is the responsibility of local Deaneries; (2) Applied Knowledge Test, which is a computer-based clinical knowledge assessment run by RCGP and marked by computer; and (3) Recorded Consultation Assessment, which is run by RCGP and marked by its examiners and requires trainees to submit recordings of 13 real-life patient consultations.

9. On successful completion of the three components, doctors are issued a recommendation by RCGP and the GMC awards a Certificate of Completion of Training ("CCT") in General Practice (or for doctors who have initially

qualified outside of the UK, the Certificate Confirming Eligibility for General Practice Registration ("CEGPR")). The CCT/CEGPR is the licence to practise as a GP in the NHS.

10. In addition to its curriculum and examining roles, the College also produces (in common with many other organisations) continuing professional development resources. The College also accredits a wide variety of educational activities that are identifiable to health professionals as high quality, and associated with the high professional standards the RCGP embodies. The RCGP Accreditation Quality Mark is an identifiable symbol of quality assurance that associates educational activities with the professionalism, expertise and commitment to the highest possible standards of general practice.

11. However, RCGP has no leverage over which resources GPs choose to use for their CPD. Similarly, the College has no role in the CPD metrics with which GPs must comply, and which, along with enforcement of professional standards, is the remit of the GMC.

12. I am not, nor have I in the past been, a member of any committees, associations, parties, societies or groups relevant to the Inquiry's Terms of reference.

13. I have not provided evidence to, nor been involved in, any other inquiries, investigations or criminal or civil litigation in relation to HIV, HBV, HCV or vCJD in blood and/or blood products.

Section 2: Training

14. Questions 6, 7 and 8 of the Rule 9 Request relate to GP training. I will deal with each question as far as possible below, but it is important to note at the outset that the content and delivery of training is the responsibility of the Deaneries rather than RCGP. However, the College does have a very limited role in that regard, as explained below.

15. Question 6 of the Rule 9 request asks:

"What is the current system for ensuring that general practitioners are kept up to date with new guidelines, guidance and best practice? How effective is this? Please provide any audits or evaluations that have assessed this. What can be done to improve this?"

16. The RCGP does not have any regulatory or monitoring role in the currency of GPs knowledge. In England the position is that individual GPs have a statutory obligation to participate in annual appraisal and revalidation to ensure they are compliant with GMC requirements for independent practice. It is a mandatory requirement of GMC registration that GPs provide evidence of professional development in all scopes of their practice. It is expected that GPs will undertake continuing professional development and updates in areas of clinical practice which reflect the needs of the local population, and I refer to this in more detail below at paragraph 45. New guidelines are published by the National Institute for Health and Care Excellence ("NICE"), and relevant educational resources are provided by the Statutory Educational Bodies of the four nations (HEE, NHS Education for Scotland (NES), Health Education and Improvement Wales (HEIW) and Northern Ireland Medical and Dental Training Agency NIMDTA), by E-Learning for Health Care (an HEE programme), and also by the RCGP eLearning portal, which provides resources for members such as Essential Knowledge Updates, Self-Test, libraries pathways and toolkits. A number of commercial providers produce relevant material and have a significant part of the market.

17. By its very nature, most of our Clinical CPD offering covers new guidelines, guidance and best practise. We deliver Clinical CPD through events, both face to face and virtual, which are run locally and nationally across the UK. We also have a large amount of online learning via the e-Learning portal on our website, which covers all clinical areas. The most particularly relevant of RCGP products to cover new and changing guidelines and practise are the Essential Knowledge Update, and Knowledge Hubs (such as women's health, covid etc).

18. I have consulted my colleagues in RCGP Scotland, who confirm the position there is that any significant new guidance or actions required may be distributed via the Chief Medical Officer's updates to health boards and contractors. The Appraisal and Revalidation system is designed to monitor GPs' continued learning and it controls the work of individual appraisers who review continuing professional development logs and personal development plans, but it has not designated any mandated learning areas. Due to the vast number of new guidelines released it would be challenging for a GP to review all of them each year. The previous system of protected learning time for practices and their teams has not been running in Scotland since 2019. Despite RCGP Scotland's representations, I understand that the Government has no plans to restart the initiative.

19. My colleagues in Wales confirm the position there is that all GPs have an annual appraisal run by Health Education and Improvement Wales (HEIW) where they demonstrate evidence of learning and reflection, with outcomes documented. This equates to a minimum average of 50 hours of learning each year. Due to the vast breadth of knowledge required for GPs to stay abreast in General Practice, learning is generally focussed on a doctor's specific educational needs, and other opportunistic learning is triggered by patients presenting with conditions doctors are less familiar with. Every five years, a GP's appraisal documentation is reviewed by their responsible officer (who is appointed by the Associate Medical Director of the Local Health Board) and if the responsible officer finds it satisfactory, the GP is revalidated to practice for a further five years. Any significant new guidance or actions required are distributed via Chief Medical Officer Updates to Local Health Boards and from there to GPs and practices.

20. My colleagues in Northern Ireland have confirmed that practices there receive frequent emails from the Chief Medical Officer and Strategic Planning and Performance Group (SPPG), which has replaced the Board structure. A better model for disseminating learning in general practice in Northern Ireland is in development by GPNI.co.uk, which is a multi-disciplinary learning site with regular webinars and most government guidelines. It has been live for two

years, and has accumulated a wealth of academic resources with a true multi-disciplinary care ethos. RCGP (NI) was one of the initial sponsors of the scheme.

21. Question 7 of the Rule 9 request asks:
"How is best practice embedded into GPs' practice? What can be done to improve this?"

22. In relation to the position in England, my response to question 7 is the same as that for question 6: in short, the GMC's licensing and CPD requirements, coupled with updates from the various bodies and resources are an essential part of practise.

23. In relation to Scotland, a GP cluster model is being developed to ensure peer review of practice and encourage adoption of best practice systems. Clusters decide their own priorities depending on local need and would only focus on a specific area if it was thought to be of significant benefit to their population. Workforce capacity, funding and competing priorities have proved challenging.

24. In Wales, the Quality Assurance and Improvement Framework (QAIF) rewards contractors (ie GP practices) for the provision of quality care and helps to embed quality improvement into general practice. The Local Health Board for each practice approves quality improvement payments after assessing their submissions. It consists of four domains; Quality Assurance, Quality Improvement, Access and GP Collaborative. All practices engage with various quality improvement projects throughout the year and these are monitored by their Local Health Board. Practices share quality improvement findings and best practice with one another through Clusters – a typical group of about 3 to 8 GP practices covering between roughly 25,000 and 100,000 patients.

25. An "Accelerated Cluster" development plan is being developed by the new Strategic Body in Wales with the aim that it will enable the local workforce to work together even more collaboratively with quality improvement projects looking at the adoption of systems that support best practice. Clusters decide

their own priorities depending on local need and would only focus on a specific area if it was thought to be of significant benefit to their population. I understand that workforce capacity, funding and competing priorities have proved challenging.

26. In Northern Ireland, I understand that while many practises are doing a lot of quality improvement, they are not doing it on a formal basis and there are no structures in place to play a significant strategic role in quality improvement in Northern Ireland. The five Trusts in Northern Ireland have vast teams for quality improvement data searches but in general practise it gets added onto daily work so only gets adapted by those who pursue it. The Strategic Planning and Performance Group (SPPG) sets the Quality and Outcome Framework targets which are agreed after discussion with the General Practitioners Committee. This group is new and has taken over from the former Health and Social Care Board, and it introduced the new quality improvement aspect of the Quality and Outcome Framework. The SPPG is responsible for the Framework and inspects work done by practices. This means that practises will have to become more involved in quality improvement.

27. Question 8 of the Rule 9 request asks:

"Is the Royal College of GPs involved in providing training on candour, consent and effective communication to non-clinical senior leaders working in the NHS such as executive directors, chief executives, and trustees? If so, please outline who it is delivered to, what the training consists of and any details of any audits or evaluations to assess how effective the training is."

28. The RCGP curriculum includes standards for practice for GPs in these areas, but the College is not directly involved in training on those issues, which is provided by via the Deaneries.

29. The position in Scotland, Wales and Northern Ireland is the same as England: while these aspects come up in the curriculum, neither RCGP Scotland, RCGP Wales or RCGP Northern Ireland get involved in training on these aspects.

Section 3: Response to the recommendations of the Psychosocial Expert Group

30. Question 9 of the Rule 9 request asks:

"Does the duty of candour form part of new GPs' training, and/or part of GPs' continuing professional development? Please give details including as to which general practitioners are trained on these matters, what the training consists of, and any details of any audits or evaluations to assess how effective the training is."

31. It is hard to envisage how a duty of candour in the specific context of infected blood would fall upon 'normal' GPs. With the exception of military GPs and other GP colleagues working in pre-hospital emergency care (including charitable Air Ambulances and those involved with walking donor panels overseas), I cannot think why GPs would ever administer blood within their normal scope of work. I would expect the duty of candour over administration of infected blood to rest in the secondary care space and/or with the supplying national blood transfusion services.

32. More generally, the duty of candour is part of GMC licensing requirements (https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/candour---openness-and-honesty-when-things-go-wrong/the-professional-duty-of-candour), which I exhibit at WITN7249002.

33. All doctors, whether working in a hospital or general practice have to participate in being open and honest, and there is a criminal sanction for altering evidence or notes.

34. The position in England is that all trainee GPs are required to comply with the standards for Certificate of Completion of Training (or equivalent) before entering the GP workforce as independent practitioners. Once registered they are subject to the requirement of revalidation as outlined above.

35. I exhibit the RCGP Core Curriculum at WIT7294003 and which can be found at: https://www.rcgp.org.uk/getmedia/38f37bbe-f677-429f-90e9-37f855b0ae16/curriculum-being-a-gp-rcgp.pdf.

36. The RCGP curriculum requires demonstration of capabilities in the following areas:

'Being a GP' – the RCGP core curriculum:

- Knowing yourself and relating to others: Maintaining an ethical approach: Provide care with compassion and kindness –
  - Record, share and receive information in an open, honest, sensitive and unbiased manner
  - Recognise that your duty of concern for your patients extends beyond your immediate team and spans across organisations and services
  - Apologise open and honestly to a patient for any failure as soon as it is recognised, explaining the local complaints procedure if appropriate
  - Responds to complaints in a timely and appropriate manner, recognising your duty of candour to patients and families.

37. Delivery of training for these capabilities rests with the Statutory Education Bodies (SEB) and governance is undertaken through the Annual Review of Competency Progression, Summative Assessment, and Annual Appraisal. It is my understanding that all SEBs regularly audit their processes and outcomes, and they are externally quality assured by the RCGP through the Quality Management and Training Standards directorate.

38. In relation to work-place based assessment, I exhibit at WITN7294004 the RCGP's Work-Place Based Assessment Guidance, which RCGP makes available to the Deaneries and trainees (which can also be found at https://www.rcgp.org.uk/getmedia/073d0d80-a8fb-42ae-a23d-a8be6aa12572/WPBA-capabilities-with-IPUs-detailed-descriptors.pdf). The descriptors were made available as a decision aid for ARCP panels who

accredit evidence of satisfactory progress in training and CCT. It was intended as a "benchmark" to support consistent decision making against the curriculum capabilities approved by the GMC.

39. It is my understanding that work-place based assessment (which is the remit of Deaneries rather than RCGP) covers fitness to practice and communication skills and ethics. The capabilities that a trainee has to be found competent in to get their CCT and pass WPBA give details of all that is expected. They must be signed up as competent by their Deanery educational supervisor in their final year for all 13 capabilities which include fitness to practice, ethics and communication skills.

40. The capability descriptors within the WPBA Guidance exhibited at WITN7294004 detail what a trainee is expected to have achieved, and these have been mapped to the GMC professional capabilities. The trainee demonstrates that they have met these with evidence across assessments and learning logs.

41. In relation to Wales, the duty of candour forms part of the training of all GP trainees. GP training is overseen by HEIW but the duty of candour will also be encountered in the RCGP's curriculum. Within the GP placement trainees will be encouraged by their supervisor to reflect on candour, medical ethics and will be involved in Significant Event Analysis (SEA) and any patient complaint processes and reviews. SEA and complaints review forms part of the annual appraisal and revalidation process in Wales.

42. The position in Scotland is similar - the duty of candour is part of the training of all GP trainees, which is overseen by NHS Education for Scotland but will also be covered by the RCGP curriculum. Similar to Wales, within the GP placement trainees will be encouraged by their supervisor to reflect on candour, will be involved in SEA and any patient complaint processes and reviews. SEA and complaints review form part of the annual appraisal process in Scotland.

43. Question 10 of the Rule 9 Request asks:

"Does effective patient communication form part of new GPs' training, and/or part of GPs' continuing professional development? Please give details including as to which general practitioners are trained on these matters, what the training consists of, and any details of any audits or evaluations to assess how effective the training is."

44. Communication and consulting skills are essential components of GP training and CPD. Learning outcomes are specified in the RCGP curriculum (exhibited at WITN7294003) and grouped under the following headings:

'Being a GP' – the RCGP core curriculum:

- Knowing Yourself and Relating to others: Communication and consultation –
  - Establish an effective partnership with patients, and
  - Maintain a continuing relationship with patients, carers and families
- Caring for the whole person and the wider community: Practising holistically, promoting health and safeguarding –
  - Demonstrate the holistic mindset of a GP
  - Supporting people through experiences of health, illness and recovery

Topic guides on Professional issues:

- **Consulting in general practice**
  - GP consulting – attitudes feelings and biases; the consultation process; the wider context of the consultation
  - Knowledge and Skills guide – interpersonal skills; data gathering; clinical management
  - How to learn this area of practice – work-based learning methods; self-directed learning; learning with other healthcare professionals
  - Examples of how this area of practice might be assessed.

45. Qualified GPs are required to participate in medical appraisal, which is a key part of the framework of support and supervision of doctors regulated by the GMC and is a process by which doctors demonstrate their professionalism, insight, and reflective practice. Participation in annual appraisal enables doctors to demonstrate that they meet the values set out in the GMC's Good Medical Practice, which are captured under four headings (one of which is "Communication, Partnership and Teamwork"), and is a requirement for revalidation. For most doctors, appraisal is delivered through designated bodies, which include NHS organisations.

46. The medical appraisal process requires doctors to reflect on their communication skills with patients where it arises through complaints, compliments, significant events, patient feedback and case reviews. For revalidation purposes, the GMC requires all doctors to reflect on feedback from patients, collected using a formal feedback exercise at least once in each revalidation cycle.

47. At each appraisal the GMC suggests doctors should reflect on any other sources of patient feedback they can access which gives them helpful information about their practice, such as unsolicited feedback. A variety of feedback questionnaires are available for doctors to undertake a formal feedback collection, some provided commercially.

48. The RCGP does not have a role in regulating medical appraisal or patient feedback but provides guidance and support to its members and advocates for best practice.

49. All the readily available patient surveys ask for free text comments and have different questions to elicit communication skills. The results are benchmarked so that doctors can see if some of their scores identify a development need.

50. Below is a summary of the various questions asked in patient surveys:

With regards communication, the Agilio survey asks:

Q4. How the patient rated the GP's abilities:

- Being polite
- Making them feel at ease
- Listening to them
- Explaining their condition & treatment

The Edgcumbe Doctor 360 patient survey asks:

How effective am I in…

- making you feel at ease
- being polite and considerate
- speaking to you in a way that is easy to understand
- giving you enough time
- doing their best to find out what you might be worried about
- listening to you
- encouraging you to ask questions
- making sure you understand understanding your needs and worries
- explaining any risks to the treatment
- keeping you informed about the progress of your care

The FourteenF ish patient survey asks:

- Are you clear about what will happen next?
- Do you know what to do if your condition gets worse?
- How easy did you find it to understand what this doctor was telling you?

51. RCGP has no obligation to provide CPD on these topics and has no remit to monitor or regulate the clinical practise of its members. I am not aware that RCGP produces any specific or stand-alone CPD resources on effective patient communication.

52. In Wales, communication and consultation skills form a major part of GP training both provided by NHS Education and in practice placements. GP

trainees are regularly assessed on this in workplace-based assessments as well as part of MRCGP exam. After qualification, communication is reviewed as part of each GPs' GMC revalidation cycle as a patient satisfaction questionnaire, and annually doctors are expected to reflect on compliments and complaints they may have received. There are a large number of online and in person communication skills training events available in Wales each year.

53. Scotland is similar to Wales in that communication and consultation skills are a major part of GP training both provided by NHS Education and in practice placements. Trainees are regularly assessed on this in workplace-based assessments as well as part of MRCGP exam. Communication is reviewed as part of annual appraisal as a patient satisfaction questionnaire. GPs in Scotland also have the opportunity to submit consultation videos for peer review as part of their appraisal process. All prospective GP trainers in Scotland submit consultation videos for peer review to assess their communication and consultation skills, and they cannot continue on the new trainers' course without a satisfactory submission and report.

54. Question 11 of the Rule 9 Request asks:

"Do the ways in which implicit and explicit biases affect interactions with patients and families (including increasing awareness of the nature of stigma and its impacts on both patients and families/carers) form part of new GPs' training, and/or part of GPs' continuing professional development? If so, please give details including as to which general practitioners are trained on these matters, what the training consists of, and any details of any audits or evaluations to assess how effective the training is."

55. I refer again to the RCGP core curriculum exhibited at WITN7294003, which requires as follows:

'Being a GP' – the RCGP core curriculum:

- Knowing Yourself and Relating to others: Maintaining an ethical approach –

- Treat others fairly with respect, acting without discrimination – demonstrate a non-judgemental approach; recognise and take action to address prejudice, oppression and unfair discrimination in yourself and others.
- Provide care with compassion and kindness – demonstrate that you relate to people as individuals and challenge attitudes that de-humanise or stereotype others.

Professional Topic guides

- **Equality Diversity and Inclusion**
  - GP's role in reducing discrimination and enhancing inclusion – risks of diagnoses with potentially stigmatising conditions
  - How to learn this area of practice
  - Examples of how this might be assessed.

56. Issues of stigma are also addressed within relevant clinical topic guides such as Mental Health, Substance misuse, and Sexual Health.

57. Delivery of training is supervised by the Statutory Education Bodies and tailored according to the needs of individual practitioners. Training is not within the remit of the RCGP – it is the Statutory Education Bodies that are responsible for GP trainers and their training.

58. In relation to Wales, GP trainers have specific learning covering bias in the 'structure and governance' section of their initial training. This is further explored with GP trainers in ongoing trainer development sessions. Discussion around stereotyping and stigma occurs as part of case-based discussions in GP training and forms some of the detailed descriptors of workplace-based assessment capabilities. In practice, it is a requirement for many GPs (e.g. appraisers or trainers) to complete a 3 yearly equality, diversity & inclusion e-learning module. Bias is a common topic in GP study days now.

59. In Scotland, I am not aware of routine training in cognitive biases being part of GP training in an explicit way. This is a subject explored with GP trainers in previous advanced trainers' courses and trainer development sessions. Discussion around stereotyping and stigma occurs as part of case-based discussions in GP training and forms some of the detailed descriptors of workplace-based assessment capabilities.

60. Question 12 of the Rule 9 Requests asks:
"Do you have any comments to make on the recommendations made, or any recommendations to add to those the Expert Group listed above in relation to the two questions posed by Sir Brian to the Psychosocial Expert Group?"

61. I have nothing further to add.

Supplemental Rule 9 Request (dated 30 September 2022)

62. Question 1 of the Supplemental Rule 9 Request asks:
"What role, if any, does RCGP play in increasing awareness of HCV among GPs?"

63. The RCGP raises awareness of HCV by its inclusion in the RCGP curriculum, and hence eligibility for inclusion in formative and summative assessment. Learning outcomes related to hepatitis generally, and Hepatitis C specifically, can be found in the curriculum in the following sections:

Clinical Topic Guides

- Maternity and Reproductive Health
- Allergy and Immunology
- Gastroenterology – liver, gallbladder, and pancreatic disease
- Infectious disease and Travel Health
- Sexual Health
- Substance misuse

64. In addition, the RCGP website provides specific learning resources for members as follows:

- **Essential Knowledge Challenge and Update:** Screening, care and treatment of persons with Hepatitis C infection
- **Essential Webinar series** – Diagnosis and management of hepatitis B & C
- **RCGP Learning Courses** – Hepatitis B & C; Hepatitis C: Enhancing Prevention, Testing, and Care

65. In Wales, RCGP offers a variety of online education modules about Hepatitis C on its website. Many GPs state that the most valued aspect of their membership of RCGP is access to high quality, accessible learning resources.

66. In Scotland, there is a primary-care initiated treatment pathway that applies for dealing with hepatitis C. I exhibit the research at WITN7294005 and which can be found at https://bjgp.org/content/72/722/e668.

67. Question 2 of the Supplemental Rule 9 Request asks:
"Does increasing awareness of HCV form part of new GPs' training, and/or part of GPs' continuing professional development? Please give details including as to which general practitioners are trained on these matters, what the training consists of, and any details of any audits or evaluations to assess how effective the training is."

68. I am aware that in 2014 RCGP published a document "Guidance for the Prevention, Testing, Treatment and Management of Hepatitis C in Primary Care", which I exhibit at WITN7294006.

69. The RCGP produces the following eLearning for hepatitis:

(i) Viral hepatitis 5 min screencast:
(ii) Hepatitis B&C eLearning course:

(iii) Hepatitis C: Enhancing prevention, testing and care eLearning course.

70. While not specific to hepatitis, we have also produced the following:
    (i) Essential Knowledge update (number EKU2018.3): Management of abnormal liver blood tests[1]
    (ii) Essential Knowledge Update Podcasts: Management of abnormal liver blood tests[2].

71. In Wales, GPs may choose to update themselves on HCV if it is an educational need and a priority area for their population. RCGP learning provides appropriate e-learning and webinar resources for them to access. Blood-borne infections as a topic will be covered as part of training both in GP practice and hospital placement.

72. In addition, NHS Wales offers extra training resources on Hepatitis C.

73. Since 2010 the Welsh Government has conducted a number of initiatives in order to achieve its goal of eliminating Hepatitis C by 2030. I understand that the Blood Health Plan is the guidance currently being used there.

74. In September 2021 the Welsh Government published the circular Blood Health Plan, which described the risks and challenges associated with managing blood health condition. Though risk of infection is mentioned, Welsh Government explained it aimed to minimise this risk with good management of conditions, use of data and an emphasis on safety and quality.

75. It also described how it will place 'safety and quality at the core of care' by:
    - Establishing a robust incident reporting culture utilising national reporting systems.

[1] ELearning available to RCGP members and registered users at https://elearning.rcgp.org.uk/course/info.php?id=287
[2] Podcast available to RCGP members and registered users at https://audioboom.com/posts/7331987-eku2018-3-abnormal-liver-blood-tests

- Promoting active participation in audit programmes, both locally and nationally.
- Benchmarking against other organisations UK wide to achieve best practice
- Developing standardised procedures, guidelines and policies to reduce inappropriate variation and promote a consistent approach across Wales
- Supporting development and innovation by promoting evidence-based practice and cutting-edge processes
- Developing a Blood Health Education strategy for all staff involved in the transfusion process. Include innovative methods of education e.g. blood component app

  The plan also describes continuation of the Blood Health National Oversight Group (BHNOG).

76. In Scotland, GPs may choose to update themselves on HCV if it is an educational need and a priority area for their population. RCGP learning provides appropriate e learning and webinar resources for them to access. Blood borne infections as a topic will be covered as part of GPST training both in GP practice and hospital placement. I also understand that RCGP Scotland ran courses ("Certificate in Hepatitis B&C Detection, Diagnosis and Management") in Dundee on 17 January 2014 and in Inverness on 7 March 2014.

77. In 2008 Scotland also introduced a two-phase action plan for Hepatitis C, which I exhibit at WITN7294007. GPs are mentioned on page 43 of the plan, which, by action 10, requires (in summary) that NHS Boards work to improve Hepatitis C testing and referral activities by GP.

Statement of Truth

I believe that the facts stated in this witness statement are true.

Signed GRO-C

Dated 1/11/2022

TABLE OF EXHIBITS:

Date	Notes/Description	Exhibit Number
February 2022	GMC requirements: Duty of Candour	WITN7249002
August 2019	RCGP Curriculum	WITN7249003
Undated	Workplace-Based Assessment Guidance	WITN7249004
September 2022	Developing a primary care-initiated pathway hepatitis C pathway in Scotland	WITN7249005
2007	Guidance on Hepatitis C	WITN7249006
May 2008	Hepatitis C Action Plan for Scotland	WITN7294007