Fitness to Practise Committee, 26 May 2011

Models of Adjudication

Executive summary and recommendations

Introduction

At its meeting in October 2010, the Fitness to Practise Committee considered a paper which reviewed the Department of Health Consultation document on 'Fitness to Practise Adjudication for Health Professionals: Assessing different mechanisms for delivery.' That paper reviewed the HPC's position as a result of that consultation.

The Coalition government subsequently announced on 2 December 2010 that the Office of the Health Professions Adjudicator (OHPA) programme will not proceed. Since that date, the Secretary of State for Health requested under Section 26A of the National Health Service and HealthCare Professional Act that the Council for Healthcare Regulatory Excellence (CHRE) provide advice on options for modernising and improving the efficiency of fitness to practise adjudication. CHRE asked its wider stakeholder community and the professional regulators to provide their thoughts on how to modernise and improve the efficiency and effectiveness of fitness to practise adjudication. HPC responded accordingly and a copy of that response is attached to this paper as an appendix.

Since that announcement, the General Medical Council (GMC) has issues a consultation document on the 'Reform of the fitness to practise procedures at the GMC: The future of adjudication and the establishment of the Medical Practitioners Tribunal Services.' That paper makes specific proposals for change to the GMC's FTP structure which reflect the original reasoning which the previous government had used to establish OHPA. As the Committee will be aware, much of that reasoning have limited impact upon the HPC.

Furthermore, OHPA published three new papers on 9 May 2011 that set out OHPA's initial thinking on Fitness to Practise adjudications. Those papers are also attached.

Decision

The Committee is asked to consider the papers attached and discuss what if any further work the Executive should undertake on this issue.

Background information

The paper considered by the Committee at its meeting in October 2010 responding to the Department of Health consultation on the future of fitness to practise adjudication can be found at:

http://www.hpc-uk.org/assets/documents/10003156201010 21FTP05-responsetoOHPAconsultation.pdf

Resource implications

To be identified in any future paper on this topic.

Financial implications

To be identified in any future paper on this topic.

Appendices

Appendix One – Response to CHRE
Appendix Two – GMC Consultation document
Appendix Three – OHPA Papers

Date of paper

16 May 2011

Briefing Note: Call for Ideas re Adjudication

1.0 Proposals from other regulators that will affect adjudication

1.1 We have not yet had opportunity to review the GMC's proposals in its most recent consultation '*Reform of the fitness to practise procedures at the GMC: The future of adjudication and the establishment of the Medical Practitioners Tribunal Service'*. Given that, we plan to ask our Fitness to Practise Committee to consider that consultation document and any changes HPC may wish to consider making to its model of adjudication at its next meeting.

1.2 A number of the reforms suggested by the GMC in its *Response to the Department of Health (England)'s Consultation on Fitness to Practise Adjudication for Health Professionals* are either reforms which have already been introduced by the HPC or are solutions to problems which HPC does not encounter. We believe it is necessary to ensure that any reforms made are proportionate and reasonable to the needs of the regulator (including consideration as to costs) and the professions that it regulates whilst also ensuring public protection and fairness and justice to those who are involved in the process.

1.3 We have reviewed the consultation document '*Reform of the fitness to practise procedures at the GMC: Changes to the way we deal with cases at the end of an investigation*' and in 2008 implemented a similar model of consensual disposal of cases. A copy of the practice note '***Disposal of cases via consent***' can be found at http://www.hpc-uk.org/assets/documents/10002473PRACTICE_NOTE_ConsentOrders.pdf.

1.4 Our view is that such an approach is a very valuable element of an adjudication process and enables appropriate solutions to case to be put in place in cases than would otherwise be possible. It is of course important to ensure that the appropriate levels of public protection and the wider public interest are maintained through such a process. Consequently, cases disposed via consent at the HPC will appear on the register in the same way as other decisions with a statement provided on the website as to why that decision was reached.

2.0 OHPA's view: Long term ambitions

2.1 Our consultation response referred to above, provided comment on our views of OHPA's long term ambitions. There are no provisions for cost awards within the Health Professions Order 2001 and we would be concerned if such a change was made to our legislation to provide for it.

3.0 **OHPA's view: Adapting the GMC's procedures to facilitate the transfer of existing cases, processes and resources from the GMC to OHPA**

3.1 We have commented below on OHPA's ambitions with respect to avoiding unnecessary delay and formality.

3.2 **The ability for a panel to proceed to a determination on the papers in the confirmed absence of the parties from the hearing**

3.2.1 This seems sensible. We would nevertheless want to ensure that such an approach still ensured public faith in the regulatory process. Given that the question of impairment is dependent on all of the facts and surrounding circumstances, we would be reluctant to implement a process which would discourage registrants from appearing in person and providing them with the ability and opportunity to put their case in the clearest possible terms.

3.3 **A broadened opportunity for the referring regulator to withdraw particulars or reference**

3.3.1 In December 2010, we issued a practice note on the subject of '***Discontinuance of Proceedings'***, that practice note can be found at http://www.hpc-uk.org/assets/documents/10003293DiscontinuanceofProceedings.pdf.

3.3.2 That Practice note provides more guidance on when it is appropriate to apply for the discontinuance of all or part of proceedings that have been referred to a final hearing committee for consideration. It provides that

> *'Occasionally, after the Investigating Committee has determined that there is 'case to answer' in respect of an allegation, objective appraisal of the detailed evidence which has been gathered since that decision was made may reveal that it is insufficient to sustain a realistic prospect of proving the whole or part of the allegation . As a public authority, HPC should not act in a partisan manner and seek to pursue an allegation which has no realistic prospect of success. Where such a situation arises, the HPC should discontinue the proceedings.*'

It goes on to state that

> '*A Panel cannot simply agree to discontinuance without due inquiry, as it needs to be satisfied that it does not represent 'under prosecution'*

3.3.3 We believe that a wider use of such a process will help to improve the efficiency and effectiveness of adjudication, whilst ensuring fairness and justice to the registrant concerned. It also ensures that unnecessary time is not spent on dealing with matters at a final hearing which could have been dealt with in another arena.

3.4 **The panel to be able to deliver their decision orally to the parties at the end of the hearing, with the written copy served by OHPA as soon as reasonably practicable after the hearing**

3.4.1 HPC has never "reserved judgement" in a case. The full written decision is provided at the conclusion of the hearing. It is our view that By announcing a formal decision at the end of each hearing, proceedings are seen to be concluded in a fair and transparent manner It is also important to ensure the registrant is clear to as his or her rights of appeal (which include providing reasons for the decision made)

3.4.2 It is important to undertake a regular review of the reasons that hearings are adjourned or part heard to ensure the expeditious management of cases. A copy of HPC's most recent paper on this topic can be found at http://www.hpc-uk.org/assets/documents/1000315E20101021FTP13-adjournedpartheardcancelledhearings.pdf

3.5 **A clearer discretion to the Panel in relation to the circumstances in which it could decide to hold the hearing in private**

3.5.1 We agree with OHPA's suggestion. Our rules and guidance reflect the current case law. The Practice note ***Conducting hearings in Private*** which can be found at http://www.hpc-uk.org/assets/documents/1000289EConductingHearingsinPrivate.pdf provides guidance to panels on the circumstances in which all or part of a hearing should be held in private. It is of course important to recognise that the extent to which hearings can be held in private are constrained by the European Convention on Human Rights.

4.0 **HPC's view: How to modernise and improve the efficiency and effectiveness of fitness to practise adjudication**

4.1 The proper use of case management powers are central to ensuring the efficiency and effectiveness of fitness to practise adjudication. We already make good use of our case management powers, both pre hearing and as proceedings progress.. Whist more can always be done, we do not believe fundamental reform is required in this area of our work.

4.2 There is no evidence from HPC's case management experience that the process would be improved by having legally qualified Panel Chairs as opposed to experienced Chairs appropriately supported by the Legal Assessor.

4.3 In any model of adjudication it is key to respect concept of 'equality of arms' and HPC has ensured that lawyers who regularly appear as presenting officers in fitness to practise cases are not involved in HPC policy development or the training of panellists. The HPC has also never had any form of review or 'sign off' arrangements for individual Panel

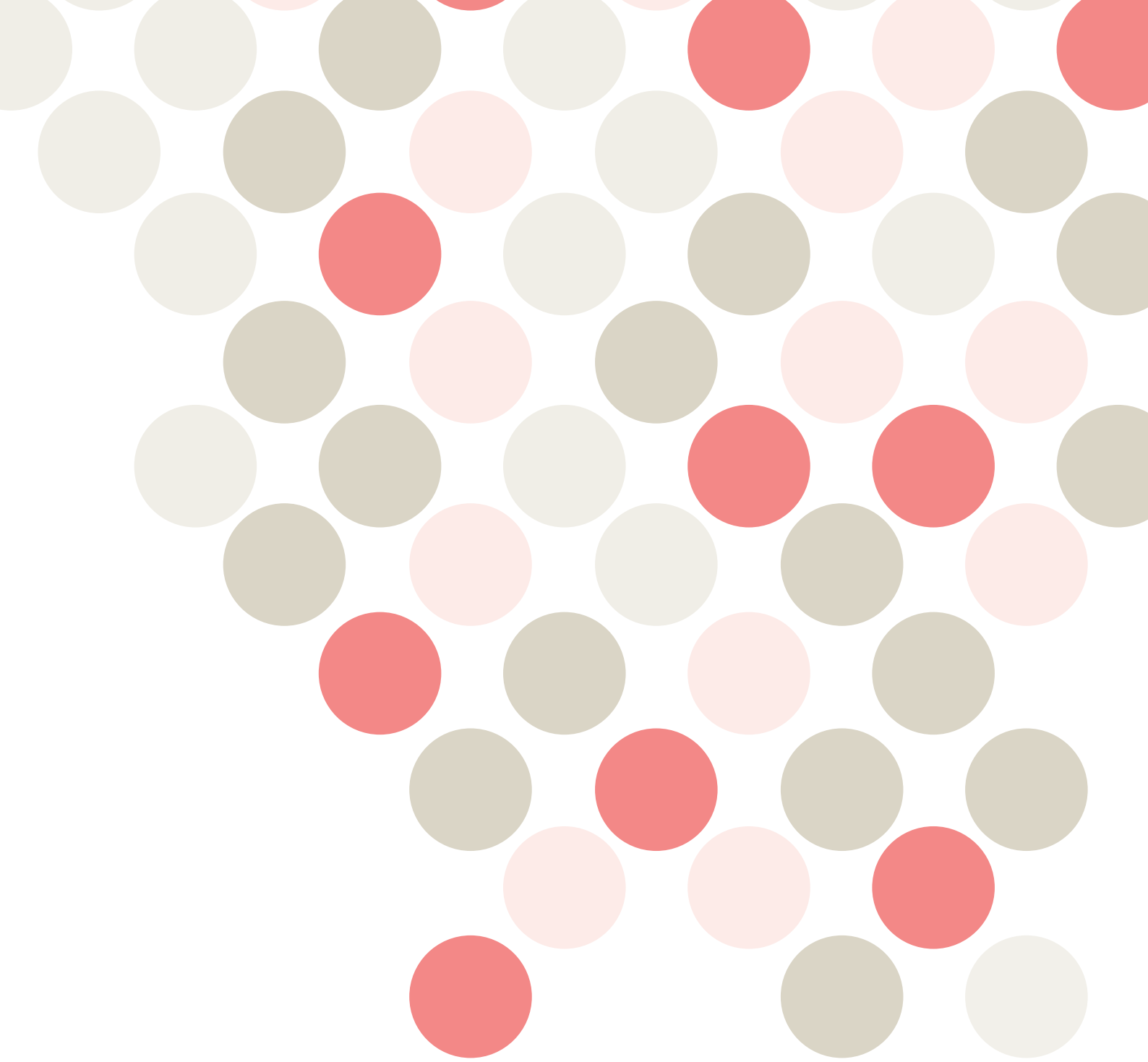
decisions; recognising that any such process would undermine their independence and impartiality.

4.4 It is undoubtedly the case that Panels could be made even more independent through the mechanism being proposed by the GMC. Further, for the HPC this might provide a useful means to deal with the potentially different adjudicative process which may apply to herbal medicine dispensers. However, as noted earlier in this document, our Committee and Council have not considered any potential change to our approach in this area. Any changes that we may make would need to be clearly supported by the evidence for such a change.

4.5 We also believe that there are potentially other mechanisms of resolving disputes. As part of our work for 2010-11 and for 2011-12 we have looked at and are looking at alternative ways of resolving complainants, including but not limited to, exploring processes for mediation and alternative dispute resolution. This work will explore whether such arrangements have a place in the Fitness to Practise process or whether there are other steps that the HPC could take in order to help 'resolve' issues and concerns about registrants.

4.6 In February 2011, our Fitness to Practise Committee considered a work plan for this piece of work. This includes commissioning further research on the appropriateness of the use of mediation in regulatory proceedings. A copy of that paper can be found at http://www.hpc-uk.org/assets/documents/10003331201102 16FTP05-alternativemechanismsfordisputes.pdf

4.7 This work links to a number of pieces of work that arose out of the research we commissioned from IPSOS Mori looking at the expectations of complainants when making complaints as part of our Fitness to Practise process.



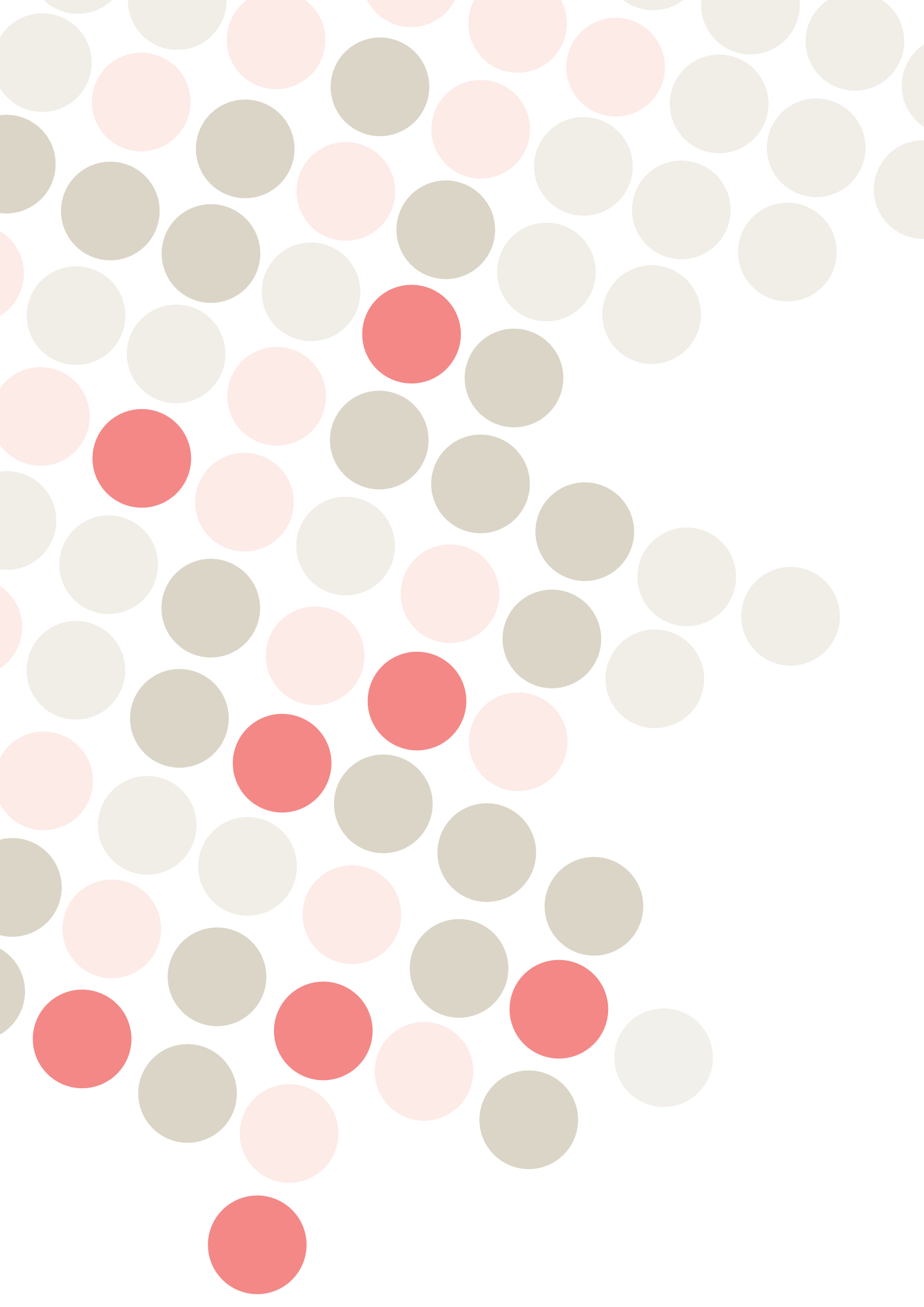
Reform of the fitness to practise procedures at the GMC

The future of adjudication and the establishment of the Medical Practitioners Tribunal Service

A paper for consultation

General Medical Council

Regulating doctors
Ensuring good medical practice



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Foreword

The General Medical Council (GMC) protects patients by ensuring that doctors practising medicine in the UK are qualified and fit to practise. Within this work, we investigate where there are concerns about a doctor's fitness to practise. Adjudication, which involves public hearings, is the final stage of our fitness to practise procedures and is designed to protect patients and uphold standards in medicine.

Our procedures changed significantly in 2004. These reforms included the introduction of a single set of rules and fitness to practise panels that consider all aspects of concerns about a doctor together (which might include issues relating to health, conduct or performance). We have also reformed the structure of the GMC so that the investigation of fitness to practise concerns and decision-making at the adjudication stage are clearly separated. As a result of these reforms, combined with further procedural changes such as the move to the civil standard of proof, we believe our current adjudication function is robust and effective, although we are committed to making further improvements wherever possible.

Following the proposals outlined in the previous Government's 2007 White Paper, *Trust, Assurance and Safety – the Regulation of the Health Professions in the 21st Century*, we had been expecting to transfer our adjudication function to a new independent body called the Office of the Health Professions Adjudicator (OHPA). However, following consultation, the Government has recently confirmed that it does not intend to proceed with the establishment of the new body. Repeal of the provisions relating to OHPA in the Health and Social Care Act 2008 is being pursued in the Health and Social Care Bill 2011. If passed, this would mean that adjudication would remain with the GMC.

In the meantime, we believe it is appropriate to consult on proposals for repositioning and further modernising adjudication within the GMC. An outline of these proposals was set out in our response to the Government's consultation (see Annex A) and recognised that, while the current adjudication function is effective, further reform is required.

There has been significant change to the external environment in which we operate, which has resulted in many more cases being referred for adjudication. There has also been an increase in the length of hearings. The proposals in this consultation paper, therefore, aim to underline and reinforce the autonomy of the adjudication function and the clear separation between investigation and adjudication, and also to modernise existing procedures. Our aim is to simplify the system and create greater confidence in adjudication among the profession and the public. We also believe the proposals will reduce the stress and anxiety for doctors and witnesses involved in our proceedings.

Some of our proposals would require a change to primary legislation or to our fitness to practise rules to be made if we decided to proceed with them. This means it would be necessary to consult on the detailed proposals before implementation. In the case of amendments to primary legislation, it would be necessary to ask the Department of Health to prepare the amending legislation.

We are consulting for three months until 13 June 2011. We are keen to hear from a wide range of individuals and groups and to encourage as much participation in this debate as possible. Although some of the proposals are expressed as preferred options, it is important to stress that any preferences are provisional. We will carefully consider all responses to the consultation and welcome comments which test and challenge our preferences or presumptions.

Professor Sir Peter Rubin
GMC Chair

Executive summary

1. We are consulting on proposals for repositioning and modernising adjudication within the GMC following the Government's decision not to proceed with the establishment of the Office of the Health Professionals Adjudicator (OHPA).

2. Reform of adjudication remains a key aim of the GMC and until recently involved us preparing to transfer our adjudication function to OHPA in April 2011; a recommendation of the previous Government's 2007 White Paper, *Trust, Assurance and Safety – the Regulation of Health Professionals in the 21st Century*.

3. Following consultation which ended in October 2010, the Government has confirmed that it intends to repeal legislative provisions relating to OHPA and, in separate legislation, take forward steps to enhance the independence of adjudication and modernise existing processes at the GMC.

4. The Health and Social Care Act 2008 contains the provisions to establish OHPA. The Government has included provisions repealing this legislation in the current Health and Social Care Bill, which is expected to become law by the end of 2011.

5. Meanwhile, we believe it is time for us to consult on proposals for repositioning and modernising adjudication within the GMC. This will help us develop the proposals we set out in our response to the Government's consultation last year (see Annex A). You can find helpful background there.

6. The consultation document is in two sections: the first considers proposals to reposition adjudication within the GMC and how this might be achieved; the second explores proposals for modernising our adjudication work.

Proposals for repositioning adjudication

7. This consultation document sets out the following main proposals for repositioning adjudication within the GMC:
   a. the establishment of the Medical Practitioners Tribunal Service (MPTS) to oversee the adjudication function
   b. a Chair and two further members to sit on the MPTS governance committee. It is our ambition to make these appointments through a process that is open, transparent and independent and we are currently looking into ways this may be achieved
   c. management and reporting arrangements that support the separation between our investigation and adjudication work
   d. subject to agreement of the Ministry of Justice and the Scottish and Northern Ireland courts' administrations, a right of appeal for the GMC against tribunal decisions.

8. In developing our approach we have drawn on best practice from other jurisdictions, such as the Courts and the Tribunals Service. We have also taken into account the work undertaken by OHPA which stimulated a useful debate on the future of adjudication.

Proposals for modernising adjudication

9. Specific proposals for modernising adjudication include:
    a. reform of our pre-hearing case management arrangements
    b. the introduction of legally qualified chairs
    c. making further efficiencies within the hearing process, including review hearings
    d. a single centralised hearing centre.
10. While we believe that our procedures are robust, we know we can improve the way we operate to deliver better value for money and introduce best practice from other tribunals.

How to comment

11. You can take part in an online version of the consultation on our website at **www.gmc-uk.org/ftpreformconsultation**.
12. Or you can download or request a copy of the consultation documents and respond by emailing or by posting your response to:

    James Ewing
    Policy and Planning Manager —
    Fitness to Practise
    The General Medical Council
    350 Euston Road
    London NW1 3JN

    email: ftpconsultation@gmc-uk.org
13. This consultation runs from 21 March to 13 June 2011.

Further information

14. Further information regarding our existing fitness to practise procedures can be found on our website: **www.gmc-uk.org/concerns**.
15. If you have any questions about the consultation or require any further information please contact James Ewing on 020 7189 5146 or by email at **ftpconsultation@gmc-uk.org**.

Introduction

16. This consultation document has two sections: the first considers proposals for changing our governance arrangements in order to reposition adjudication within the GMC; the second explores proposals for modernising our existing adjudication work.

Our role

17. The GMC regulates doctors in the UK. Our purpose is to protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine. We do this in four ways:
    a. keeping up-to-date registers of qualified doctors
    b. fostering good medical practice
    c. promoting high standards of medical education and training
    d. dealing firmly and fairly with doctors whose fitness to practise is in doubt.

Our current fitness to practise procedures

18. The GMC's fitness to practise procedures aim to deal firmly, fairly and promptly with those doctors whose fitness to practise is called into question.

19. If a serious concern about a doctor is reported, we will investigate it. At the end of the investigation process the case can be dealt with in one of four ways:
    a. we can conclude it with or without advice
    b. we can issue a warning to the doctor
    c. we can agree undertakings with the doctor (a formal agreement between a doctor and the GMC which is published online in the list of registered medical practitioners)
    d. we can refer the case for a public hearing where an independent decision about the allegations is made by a fitness to practise panel.

20. We are currently also consulting on major changes to the way in which we deal with cases at the end of an investigation to introduce greater discussion with doctors in order to encourage them to accept our proposed sanction as an alternative to referring their case for a public hearing. That consultation can be found on our website at **www.gmc-uk.org/ftpreformconsultation.**

What happens at a hearing

21. At a fitness to practise hearing the panel considers the allegations against the doctor, decides whether they are proven and, if so, whether the doctor's fitness to practise is impaired. Should the panel conclude that the doctor's fitness to practise is impaired, it then decides what, if any, sanction is appropriate. If it does not reach a finding of impairment it may consider whether to issue a warning to the doctor.

22. A fitness to practise panel includes both medical and non-medical members. Panels normally have three to five members. Every panel must include a Chair (who may be medical or non-medical), a medical panellist and a non-medical panellist. There are currently 296 medical and lay panellists eligible to sit on our panels. Panellists are appointed by a process overseen by the Office of the Commissioner for Public Appointments. It should be noted that members of the GMC Council cannot serve as panellists.

23. The Medical Act 1983 requires a legal assessor to sit with each panel to advise on points of law. One or more specialist advisers may also be present to advise the panel on issues regarding the doctor's health or performance.

24. If at any stage during our investigation, or before a fitness to practise panel hearing, we consider that the allegations against the doctor present a serious risk to the public, or it is in the public interest or the doctor's own interests, we will refer the case to an interim orders panel. An interim orders panel can either suspend or seek restrictions on the doctor's registration until the allegations are resolved. Interim orders panels are substantially the same in composition as fitness to practise panels and, as well as applications for interim orders, they undertake reviews of interim orders during an investigation and while a substantive fitness to practise panel hearing is pending.

25. The case against the doctor is presented by a lawyer instructed by the GMC. The doctor is invited to attend. Most doctors choose to attend and do so with legal representation. Both parties may call witnesses to give evidence and, if they do so, the witness may be cross-examined by the other party. The panel may also put questions to the witnesses.

26. In general, interim orders panels hear cases in private and fitness to practise panels hear cases in public. Panels must hear cases in private when considering the making of an interim order or when considering matters relating to a doctor's health unless the practitioner requests, or the panel consider, it would be appropriate to hear the matter in public. Fitness to practise panels may also exclude the press and public from the proceedings or part of the proceedings where they consider that there are interests that outweigh the public interest in holding the hearing in public.

What happens at the end of a hearing

27. Once a fitness to practise panel has heard the evidence, it must decide:
    a. whether the facts alleged have been found proven on the balance of probabilities
    b. whether, on the basis of the facts found proven, the doctor's fitness to practise is impaired
    c. if so, whether any action should be taken in relation to the doctor's registration.

28. If the panel concludes that the doctor's fitness to practise is impaired, the following sanctions are available:
    a. conditions on the doctor's registration for up to three years
    b. suspension of the doctor's registration for up to a year (during which the doctor cannot practise)
    c. erasure of the doctor's name from the medical register (so that they can no longer practise).

29. The panel may accept written undertakings offered by the doctor, as an alternative to imposing a sanction, if it considers the undertakings sufficient to protect patients and the public interest. Undertakings require a doctor to do or stop doing something (for example to undertake retraining or to stop doing a particular type of work) and operate in the same way as conditions. The difference is that undertakings are agreed by a doctor rather than imposed. The doctor must also agree to the disclosure of those undertakings (except undertakings relating to the doctor's health).

30. It is open to a panel to decide to take no further action against a doctor's registration.

31. If there has been a serious or persistent departure from the standards expected of a doctor, and a panel concludes that a doctor's fitness to practise is impaired, it may take action on the doctor's registration. Where a panel finds a doctor's fitness to practise is not impaired, it may issue a warning to the doctor if there has been a significant departure from the standards expected, or where there is cause for concern following an assessment of the doctor's performance.

32. Panels arrive at their decisions independently. They hear witnesses, assess their credibility and reach their findings of fact on the basis of the evidence presented at the hearing.

33. Fitness to practise panels also review sanctions on a doctor's registration to consider whether they should continue, be amended or revoked. They also consider applications from doctors who have been erased from the register and who are seeking to have their name restored to the register.

34. A more detailed explanation of our procedures can be found on our website: **www.gmc-uk.org/concerns.**

Why do we need to reposition adjudication within the GMC?

35. A number of concerns about the independence of adjudication were expressed in the Fifth Report of the Shipman Inquiry[1] and the subsequent Government White Paper[2].

36. Following consultation on the White Paper in 2007, the desire for greater separation between our investigation and adjudication roles was widely shared and we confirmed our commitment to the principles of independent adjudication. When the Government confirmed its intention to establish OHPA, we supported the programme of work which was introduced to transfer our adjudication function to OHPA.

37. In 2010, the Government announced that it had reviewed the case for OHPA and was not persuaded that the creation of a new body was the most appropriate way forward. The Government proposed that steps could be taken to enhance the independence of adjudication and modernise existing systems within the GMC to deliver substantially the same benefits as OHPA. The Government consulted on the proposal from August to October 2010[3].

38. It has since confirmed[4] its intention to proceed with that proposal and to repeal the statutory provisions relating to OHPA in the Health and Social Care Act 2008.

39. We therefore believe it is now appropriate to consult on proposals to reposition and modernise adjudication within the GMC.

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1 *The Fifth Report of the Shipman Inquiry* (The Shipman Inquiry, 2004)

2 *Trust, Assurance and Safety – the Regulation of the Health Professions in the 21st Century* (Department of Health, 2007)

3 *Fitness to Practise Adjudication for Health Professionals: Assessing different mechanisms for delivery* (Department of Health (England) August 2010)

4 *Fitness to Practise Adjudication for Healthcare Professionals: Assessing different mechanisms for delivery — Consultation Report: November 2010* (Department of Health, 2010)

Why do we need to modernise adjudication?

40. In the last three years the number of referrals to fitness to practise panels has increased, as has the average length of a fitness to practise hearing[5]. This has provided significant challenges for our systems and procedures.

41. While these challenges have shown our procedures to be robust, it is clear that there are opportunities to improve the way in which they operate. There is much we can learn from best practice in other jurisdictions which will help us to deliver improved service and value for money.

42. Further changes to our procedures, including changes to pre-hearing case management, may help reduce the time a case takes to reach a hearing and the time each hearing takes.

43. There are also questions about whether the dual-site operation that we run is cost effective. Our work is split between London and Manchester, with most hearings taking place in Manchester. Our provisional view is that there is potential for significant savings and greater operational efficiency if we move to a single site in Manchester.

How would we do this and how long would it take?

44. This consultation paper contains some proposals which, if pursued, would require changes to the primary legislation governing the medical profession contained in the Medical Act 1983, changes to our fitness to practise rules or simply to our day to day operational approach. This would affect the likely implementation timetable if we determine to proceed following consultation.

45. At this stage we are consulting on the principles relating to the changes we are considering. Once we have established a direction of travel, we would need to approach the Department of Health to seek the UK Government's agreement to the changes we would like to make to the primary legislation. The Department would then need to prepare an Order for the approval of Parliament and the Privy Council under section 60 of the Health Act 1999.

46. The GMC and the Department of Health would establish a joint working group to develop necessary legislation, and the legislation itself would be subject to a separate consultation and debate in Parliament. Current projections are that such changes to primary legislation would be implemented during 2013.

47. In the case of rule changes, the Privy Council's approval and further consultation would also be required, which, on current projections, would be likely to be implemented from around mid 2012.

48. In the case of proposals which only involve changes to our day to day operational approach and do not require a change to legislation or rules, subject to the outcome of the consultation, we would proceed to implement these changes as quickly as possible.

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5 During the period January to June 2008, the average number of sitting days per closed hearing each month was 5.46 days. This increased to 5.5 days in the same period in 2009. In 2010 it rose to 6.41 days.

Proposals

Proposals to establish the Medical Practitioners Tribunal Service

49. This section covers our proposals to establish the Medical Practitioners Tribunal Service (MPTS) including how and by whom it would be run, how we would ensure its separation from our investigation work, and how the GMC would work with it.

50. Our aim is to establish a body that will be recognisable as being operationally separate from the rest of the GMC. By creating a clear separation between our investigation role in bringing proceedings and the function of adjudicating on those cases, we believe we can strengthen public confidence in panel decisions.

51. While we believe we have already achieved a strong degree of separation to ensure fairness and impartiality of panels since the new procedures were introduced in 2004, we are confident that further separation is possible.

52. At present, fitness to practise panels make their decisions independently of the GMC. Panellists are appointed by an appointments process overseen by the Office of the Commissioner for Public Appointments and make their decisions in private without any involvement of GMC staff. They can and sometimes do make decisions that do not accord with our preferred outcome. We propose to strengthen further the separation between our investigation and adjudication work by placing all aspects of operational management of adjudication under the control of the Chair of the MPTS and separating the management of the rest of our fitness to practise activity from that of adjudication.

53. At present, while panels make their decisions independently, our adjudication function is managed within the same directorate as our investigation work. The MPTS would assume responsibility for the day-to-day management of adjudication and would be accountable for the decisions made by interim orders panels and fitness to practise panels, which we propose should in future be called medical practitioner tribunals. In practice, this will mean that, once a case has been referred for a hearing, it will be managed by the MPTS rather than the Registrar of the GMC (the keeper of the medical register). This would be supported by a service level agreement agreed between the Chair of the MPTS and the Registrar.

54. In our response to the Government's consultation on the future of adjudication, we used the provisional working title of the Doctors' Disciplinary Tribunal (DDT). The inclusion of the word 'disciplinary' is, however, problematic. The purpose of adjudication panels is to protect the public and not to punish doctors. In the 1970s the Merrison Committee, which conducted an inquiry into the regulation of the medical profession, took pains to emphasise that words like 'discipline', 'punishment' and 'offence' should be avoided. The view that the role of the GMC is not centrally concerned with punishment of doctors but protection of patients and of the reputation of the profession was confirmed by the Privy Council in *Gupta v General Medical Council [2002] 1 WLR 1691* and more recently reflected in the Court of Appeal case of *Raschid and Fatnani v The General Medical Council [2007] 1 WLR 1460*.

55. The responsibilities of the MPTS will include:
    a. the quality of decision-making by medical practitioner tribunals
    b. the day-to-day operational management of the adjudication function
    c. the appointment and removal of tribunal members and case managers
    d. the appointment of specialist advisers and the appointment, training and assessment of legal assessors
    e. the development of training, assessment and guidance for tribunal members.

56. There are presently a number of statutory committees of the GMC, established by the Medical Act 1983, comprising interim orders panels, registration panels, registration appeals panels, the Investigation Committee and fitness to practise panels. We propose to establish the MPTS as a new and separate statutory committee of the GMC to oversee adjudication of fitness to practise cases. Medical practitioner tribunals will in future hear cases that are currently heard by interim orders panels and fitness to practise panels. Putting the MPTS on a statutory footing will further protect the separation of the MPTS from our investigation procedures, indicate the different status of the MPTS and underline that it is distinct from our other non-statutory Council committees.

57. Together with the proposals set out at paragraphs 59–76 below, we believe this will help to create a much clearer separation between the adjudication function and other aspects of fitness to practise work.

58. Establishing the MPTS in statute will take time and will require further consultation; and, in any event, we are unlikely to see primary legislative changes until 2013 at the earliest. Consequently, in the first instance we are proposing to establish the MPTS as a general committee of the GMC. This will allow us to establish the MPTS in shadow form and enable members of the MPTS to be involved in the design of the new operating model and the reform of the adjudication procedures. It should also allow the MPTS to assume operational responsibility for the adjudication function earlier before any change in primary legislation can be made.

Question 1

Do you agree with our proposal to create a new tribunal service for fitness to practise adjudication?

Question 2

Do you agree that the tribunal service governance should be vested in a new statutory committee? If not, please give reasons and any alternative suggestions.

Question 3

Do you agree with the specific responsibilities of the tribunal service as set out in paragraph 55? If not, please give reasons and any alternative suggestions.

Question 4

Do you have any views on what the new tribunal service should be called?

Leadership of the MPTS

59. The MPTS will need effective leadership to ensure that it manages adjudication work effectively and maintains a strong, separate identity. We propose that the MPTS should be led by a Chair who will build on the strengths of the current adjudication arrangements and introduce appropriate improvements to the way our adjudication work is managed.

60. The Chair will need to have strong leadership skills to inspire confidence in the MPTS, a clear vision of how it will develop and the ability to drive change, while maintaining operational effectiveness. As well as an established reputation for leadership, the Chair should be legally qualified and have significant judicial or tribunal service experience.

61. Our provisional view is that, on the governance committee of the MPTS, the Chair should be supported by two active panel members drawn from the existing pool of panel members. We believe this is the right structure to begin with, and is similar to that used by a number of other tribunals.

62. GMC Council members should be excluded from sitting on the MPTS and medical practitioner tribunals just as they are currently excluded from sitting on any of our fitness to practise panels. This will help ensure the separation of the MPTS.

63. It is our ambition to appoint all three members of the governance committee (the Chair and two panel members) through a process that is open, transparent and independent and we are currently looking into ways this may be achieved.

Question 5

Do you agree with the proposed membership of the MPTS governance committee? If not, please give reasons and any alternative suggestions.

Question 6

Do you agree with our ambitions to appoint the Chair and the other members of the MPTS through an open, transparent and independent recruitment process? If not, please give reasons and any alternative suggestions.

Question 7

What skills, qualifications and experience do you think should be required for:

a. the Chair of the MPTS?

b. the other members of the MPTS governance committee?

Accountability and independence

64. As is the case now for fitness to practise panels, we intend that decisions of medical practitioner tribunals can be challenged in court by way of appeal by a doctor or judicial review by a complainant. In future, as now, the Council for Healthcare Regulatory Excellence (CHRE) will also be able to review and scrutinise the operation of the system as a whole.

65. In order to provide assurance that the MPTS is operating effectively and that the independence of its tribunals is secure, we are proposing that the MPTS be required to report directly to Parliament on an annual basis. In its 2011 Command Paper *Enabling Excellence: Autonomy and Accountability for Health and Social Care Staff*, the Government announced its intention to explore how the GMC and other regulators can be made accountable to Parliament and we see this direct reporting arrangement as fitting in with that general direction of policy. At this stage we envisage that the report from the MPTS could include details of the nature and volumes of cases that have been dealt with by the MPTS and points of learning for the future. We are discussing this with the Department of Health and Privy Council to ensure that this is a viable option and are interested in views on whether, in principle, this form of reporting would be an appropriate way to provide assurance.

66. We also propose that the MPTS be required to provide a twice yearly report to the Council of the GMC on its operations. This would be a publicly available report which would include details of tribunal activity and any significant issues that have arisen during the period. This would enable our Council to be confident that the MPTS is carrying out its statutory duties to a high standard.

67. The MPTS will be separated from our role of investigating and presenting cases. Administrative support for the MPTS will be the subject of a service level agreement between the Registrar of the GMC and the Chair of the MPTS which will contain terms designed to support the separation of function between our investigation and adjudication work.

68. We believe these steps will provide a transparent approach and give confidence in the arrangements.

69. The establishment of the MPTS as a statutory committee and the proposed reporting arrangements to Parliament would require amendments to primary legislation and more detailed proposals will be subject to a further consultation prior to implementation.

Question 8

Do you agree that the proposed reporting arrangements for the MPTS are appropriate, if agreed by all necessary authorities? If not, please give reasons and any alternative suggestions.

Establishing close liaison between the MPTS and the GMC

70. Although the MPTS will operate separately from the GMC, we will need to establish an effective working relationship to support the smoothest possible management of fitness to practise cases. In order to support effective communication between the other functions of the GMC and the MPTS, we intend to establish a joint forum which will be responsible for ensuring joint working arrangements are established and operate effectively. The forum will include the Chair of the GMC and the Chair of the MPTS. Its role will be to:

    a. provide the Council of the GMC with assurance that the MPTS is delivering against its stated role

    b. resolve any policy or operational issues that may arise

    c. identify and take forward areas of joint working

    d. provide an internal feedback mechanism between the other functions of the GMC and the MPTS.

71. It might also be possible to include independent members on the forum to give external assurance that arrangements are working effectively.

Question 9

Do you agree with our proposals for establishing close liaison between the GMC and the MPTS? If not, please give reasons and any alternative suggestions.

Right of appeal

72. There will no doubt be occasions in the future, as now, where the decision of a medical practitioner tribunal differs from that called for by the GMC in its role in presenting the case. At present the doctor has a right of appeal against panel decisions but the GMC has no such right. However, we believe that introducing a right of appeal for the GMC to the High Court or Court of Session in Scotland would reinforce the clear separation of investigation and adjudication work and help to create an independent identity for the MPTS. The circumstances for an appeal would be similar to the current Council for Healthcare Regulatory Excellence (CHRE) right of appeal to the High Court. The grounds for CHRE's right of appeal are to be found at section 29 of the National Health Service Reform and Health Care Profession Act 2002.

73. We wish to discuss the feasibility of this further with the Department of Health, the Ministry of Justice and the Scottish and Northern Ireland courts' administrations. In principle, we do not see any incompatibility between this proposal and the continuation of CHRE's right of appeal.

74. We have explored the arrangements used by other regulators. The Solicitors Regulation Authority, which operates within a similar governance and funding structure to the one that we are proposing, has a right of appeal against the decisions of the Solicitors Disciplinary Tribunal (both are partially funded by the Law Society). This has helped to support our provisional view that there is no reason, in principle, why the GMC should not be given a right of appeal.

75. This change would require amendments to primary legislation and would, therefore, be subject to further consultation before it could be implemented. We believe the number of cases the GMC is likely to appeal would be small, but, given the separation of the MPTS from the other aspects of fitness to practise work, we believe this would be appropriate and would further signal that separation.

76. If, in the future, following public consultation, a power was introduced for medical practitioner tribunals to make awards for costs (see paragraph 91), we believe it would be beneficial for both the GMC and individual doctors to have a right of appeal against any order for costs. Again, we would wish to discuss the feasibility of this further with the Department of Health, the Ministry of Justice and the Scottish and Northern Ireland courts' administrations.

Question 10

Do you agree that, in principle, if feasible, the GMC should have a right of appeal against decisions of the MPTS on the same grounds as CHRE has? Please give reasons and any alternative suggestions.

Proposals to modernise adjudication

77. This section covers our proposals to modernise adjudication including enhancing our working arrangements before hearings, making greater use of written evidence and introducing legally qualified chairs.

78. One of our strategic priorities is to maintain confidence that doctors are fit to practise and ensure that we use our resources efficiently and effectively. We are committed to creating an effective and modern adjudication function.

Enhanced pre-hearing case management arrangements

79. Pre-hearing case management refers to the steps that need to be taken prior to a hearing in order to make effective arrangements to support the smooth running of the hearing. These range from disclosing documents to be relied on at the hearing, agreeing what evidence each party will present and whether the doctor intends to attend the hearing. These arrangements help us to estimate how long the case will take so we can list it for an appropriate length of time. A case manager will usually issue instructions to the parties with time limits for the steps to be taken which are known as pre-hearing case management directions.

80. Currently, case management is governed by rule 16 of our Fitness to Practise Rules 2004 (Annex B and see our website at **www.gmc-uk.org/about/legislation/ ftp_legislation.asp**).

81. We have a pre-hearing case management process which consists of two teleconferences between ourselves and the doctor or their representatives in order to agree the information that needs to be exchanged and the steps that need to be taken before the hearing commences.

82. This process is only partially effective and, in the past, if pre-hearing directions have not been complied with, there has been a lack of effective enforcement. This has made it difficult to predict the timing and length of hearings. It also means that preliminary legal matters, such as admissibility of evidence, often need to be dealt with at the hearing, which adds to its length.

83. Within the current process the only enforcement mechanism available to panels where a party fails to comply with a pre-hearing case management direction is to draw an adverse inference from the failure (for example they can place less weight on evidence that is presented late). In practice, this power is rarely used. There are no other sanctions in the current system if parties refuse to engage with pre-hearing case management directions. Consequently the system lacks teeth and, if they choose not to do so, there is little incentive for the parties to engage constructively.

84. As set out in our response to the Government's consultation (Annex A), we believe our case management procedures need reform.

85. We have recently taken steps to improve the way in which our case management procedures are enforced. We have issued further guidance on the use of our current powers to draw adverse inference from the failure to comply with directions or submissions made to the panel without prior notice and have included this in the panellists' training programme.

86. We propose to introduce more active and rigorous case management and we believe this would have significant benefits. This would include:

    a. involving Chairs of tribunals in pre-hearing case management, where timetabling constraints allow
    b. making provision for case management hearings, in those cases where the Chair is acting as the case manager, to deal with preliminary issues.

87. These changes would provide a greater link between the setting of pre-hearing case management directions and their enforceability. We believe it would lead to more effective enforcement and matters relating to procedural or administrative steps would not need to be dealt with at the hearing itself. This should reduce the length of hearings.

88. Taken together these changes should also result in better predictions about timing and length of hearings and, alongside agreement on witness and expert evidence, should significantly improve our procedures. Additionally, the possibility of pre-hearing meetings with experts and the potential for joint or agreed expert positions could make our proceedings both more cost effective and less stressful for those involved.

89. We believe effective case management would be further supported by consequences for breach of directions and propose a power for tribunals to exclude evidence which is sought to be introduced in breach of directions, exercising a broad discretion and taking account of all the circumstances of the case.

90. All this would require changes to the primary legislation and rules and would be the subject of further consultation prior to implementation.

91. We consider that a power to make costs orders could further support effective case management. This is a complex matter and proposals in this regard will be consulted on in due course.

Question 11

Do you agree that, where possible, Chairs should have a role in pre-hearing case management? If not, please give reasons and any alternative suggestions.

Question 12

Do you agree that there should be provision for case management hearings to deal with procedural or administrative matters, where Chairs are involved in the pre-hearing stage? If not, please give reasons and any alternative suggestions.

Question 13

Do you agree that medical practitioner tribunals should have a power to exclude evidence which is sought to be introduced in breach of directions without good reason in order to encourage reasonable behaviour? If not, please give your reasons and any alternative suggestions.

Introducing legally qualified chairs

92. We believe that the introduction of legally qualified chairs could further assist improvements in our case management arrangements at least in some cases. At present, we do not require chairs of panels to be legally qualified, although a small number are. We do, also, have competent and professional non-legally qualified chairs.

93. The number of cases referred by employers, the police and other public bodies has more than doubled in the last three years (from 630 in 2008 to 1,367 in 2010). These cases tend to be more complex and detailed legal arguments may be raised. In view of this, we are considering whether to introduce legally qualified chairs for some or all cases.

94. If a legally qualified chair were appointed, our provisional view is that a legal assessor would no longer be required in that case. If so, this would deliver significant cost savings. We would, however, need to amend the Medical Act 1983 (which currently requires that a legal assessor be present to advise all panels on questions of law), define and make clear to all parties the role of legally qualified chairs and ensure that legally qualified chairs receive appropriate training to allow them to discharge their role effectively. Such changes to the Medical Act 1983 would be subject to further consultation prior to implementation.

95. Legally qualified chairs may be better equipped to deal with cases where legally complex arguments are raised or the case is large and the documents voluminous; this view was supported by OHPA.

96. If it were decided to use legally qualified chairs only in certain cases, the MPTS could develop criteria for when a legally qualified chair should be appointed based on the types of cases in which they are likely to add value.

97. Under current arrangements, in cases where a respondent doctor is present but unrepresented, the Legal Assessor, sometimes in tandem with the GMC Counsel, will usually take steps to ensure that the doctor understands the procedure before the start of the hearing. As the hearing progresses, the Chair may provide the unrepresented doctor with further clarification of the procedure or ask the Legal Assessor to do so. However, in cases with a legally qualified chair, there would be nothing to prevent GMC Counsel taking steps on their own to provide unrepresented doctors with information on hearing procedure, that is, in circumstances where no legal assessor is present. Nor is there any reason to prevent a legally qualified chair from providing clarification as necessary, a practice that is commonplace in most tribunals.

Question 14

Do you believe legally qualified chairs should be used in

a. certain cases? If so, do you have any views on what criteria should be applied in deciding whether to appoint a legally qualified chair?

b. in all cases?

Please give reasons for your answer and any alternative suggestions.

Consent in review cases

98. Where an interim orders panel or fitness to practise panel places conditions on a doctor's registration or suspends them from the register, the case must be reviewed before the sanction may be lifted at the end of the sanction period to ensure that the doctor is fit to practise. Review hearings form a significant proportion of fitness to practise panel hearings. Many such hearings concern doctors who have been within our fitness to practise procedures for a number of years, for example when their fitness to practise is impaired by reason of poor health. When there has been no significant change in circumstances or no new additional evidence, the panel will normally extend the existing sanctions for a further period, with a requirement for further review at the end of that period.

99. Under the current provisions of the Medical Act 1983, all review decisions must be taken by a fitness to practise panel, even where the doctor agrees with our proposals. Similarly, interim orders must be reviewed by an interim orders panel or by a fitness to practise panel at least every six months, even when the doctor agrees with proposals to extend an existing order.

100. We are proposing that, when the doctor agrees with our proposals, it should not be necessary to refer review cases to an interim order or fitness to practise hearing. If we were to proceed with this proposal, only in cases where there is a dispute between the doctor and the GMC about the existing sanctions would a hearing be required. This is in line with our proposals in a separate consultation exercise about changes to the way we deal with cases at the end of an investigation where we are proposing to encourage doctors to agree our proposed sanction as an alternative to a hearing. That consultation can be found on our website at **www.gmc-uk.org/ftpreformconsultation.**

101. We propose that a power to extend, vary or modify existing sanctions by relying on the papers without any hearing where the parties are both in agreement as to the outcome should be introduced. This could be carried out by either:

a. the Registrar (the keeper of the medical register)

or

b. the Chair of the panel which imposed the sanctions.

102. These changes would create a more targeted approach to adjudication by reducing the number of unnecessary hearings where the doctor consents to our proposals and would be less stressful for the doctors involved. If we decide to proceed with these changes they would require a change to primary legislation which would be subject to prior consultation in due course.

Question 15

Do you agree with our proposals to introduce powers for sanctions imposed by a fitness to practise or interim orders panel to be extended, varied or revoked when both parties are in agreement without the need for a review hearing? If not, please give reasons and any alternative suggestions.

Question 16

Do you think the power to extend, vary or revoke sanctions in these circumstances should be exercised by

a. the Registrar

or

b. the Chair of the panel which imposed the sanctions acting alone?

If not, please give reasons and any alternative suggestions.

A single centralised hearing centre

103. We currently operate two hearing centres (in London and Manchester). Manchester has a maximum of fourteen hearing rooms in the St James's Building, which is separate from our new Manchester office, and London has six in the GMC's offices in Euston Road.

104. We are considering a proposal to move to a single site hearing centre, centralising our adjudication work in Manchester. The operational costs of the London hearing centre are considerably higher than those of the Manchester centre, with a London hearing day costing over £1,300 more than a Manchester hearing day. Our initial analysis suggests that by moving to a single hearing centre in Manchester we are likely to save in the order of £1.8 million a year. A single site hearing centre in Manchester, separate from the rest of the GMC offices, would also help to establish the separate identity of the MPTS and enhance the separation between our investigation and adjudication work.

105. Our staffing costs are typically 20% lower in Manchester than in London and panel expenses and catering costs are also lower. Economies of scale would also bring reductions in office support costs. However, the greatest saving would come from accommodation, including rent, service charges and rates. In addition, a centralised hearing centre in Manchester would have increased hearing room capacity, allowing us to reduce significantly the cost of hiring external venues. (Annex C provides a high-level breakdown of the potential savings and other benefits that might be achieved). Possible drawbacks include the loss of experienced and skilled staff, less engagement with third parties in London and additional travel for some.

106. In addition to the proposal to run a single site operation from Manchester, we have considered a number of other options, including a dual operation from London and Manchester, running a single site from London and the possibility of establishing a small network of local hearing centres across the UK. Running a single site operation from London would significantly increase our costs and have no significant benefits. Establishing a network of local hearing centres would increase accessibility for doctors and witnesses, but it would fragment the provision of adjudication and the cost, resource and time requirements for this reform would be substantial. We believe this option does not, therefore, represent a proportionate solution. Our provisional view is that a single centralised hearing centre would offer better value for money, through economies of scale. As we are already established in Manchester, where well over half of hearings already take place and where associated costs are lower than in London, as set out above, our provisional view is that holding all hearings in Manchester makes economic sense and would involve relatively little disruption.

107. Money is not, of course, the only factor. Apart from the potential savings outlined above, a single hearing centre offers a number of other benefits, such as improved operational efficiency and more effective internal communication. In addition, having a separate hearing centre located away from our investigation work will reinforce the separation between our investigation and adjudication role.

108. We do recognise that a significant number of panellists and legal teams on both sides are based in the South East of England and may find London more convenient than Manchester. We also recognise that South East based doctors, particularly those whose hearings are scheduled to run for weeks rather than days, would find attendance more demanding were we to move the MPTS to Manchester. However, our initial view is that, overall, the advantages associated with the change would outweigh the disadvantages, although we are interested to hear views and, in particular, whether there are alternative ways to make similar savings to our hearing costs and underpin the identity of the MPTS.

Question 17

Do you agree that, taking all factors into account, we should explore moving to a single hearing centre in Manchester? If not, please give reasons and set out alternative proposals indicating their (cost and other) advantages and disadvantages.

Additional efficiencies in the hearing process

109. There are also other opportunities to make the procedures more efficient. For example, it should be possible to remove the requirement for a panel secretary to read out the allegations at the start of a hearing and routinely we could accept witness statements as evidence-in-chief. These measures would reduce the time spent by both sides presenting evidence at the hearing. These changes would require a change to our rules and further consultation.

Question 18

Do you have any views on the suggestions made above to make the current hearing process more efficient?

Question 19

Do you have any other suggestions for making the hearing process more efficient that we might explore?

What is the likely impact of these proposals on different groups?

110. We are in the process of carrying out an initial equality impact assessment (EQIA) which looks at the potential impact of these proposals on diverse individuals and groups, further details of which are attached at Annex D. In carrying out our assessment we are considering the requirements of the Equality Act 2010 and our duties under that Act as outlined in Annex D.

111. We recognise that the principles of equality, diversity and fairness will need to be embedded in the work of the Medical Practitioners Tribunal Service and that appropriate safeguards and systems will need to be put in place to ensure that decision-making is fair, transparent and non-discriminatory.

112. We are keen to receive views in response to this consultation paper on the likely impact of these proposals. In addition, as part of the consultation process, we propose to have discussions with a range of individuals and organisations representing diverse groups of people, including doctors, patients and the public, to obtain further views.

Question 20

Do you think that any of the proposals will further one or more of the following aims:

a. *eliminating discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Equality Act 2010?*

b. *advancing equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it?*

c. *fostering good relations between persons who share a relevant protected characteristic and persons who do not share it?*

If yes, could the proposals be changed so that they are more effective in furthering those aims?

If not, please explain what effect you think the proposals would have and whether you think the proposals could be changed so that they do further those aims?

Question 21

Do you think these proposals will impact on the confidence in our procedures of any particular groups of people? If so, which groups and why?

Consultation questions

Question 1

Do you agree with our proposal to create a new tribunal service for fitness to practise adjudication?

Question 2

Do you agree that the tribunal service governance should be vested in a new statutory committee? If not, please give reasons and any alternative suggestions.

Question 3

Do you agree with the specific responsibilities of the tribunal service as set out in paragraph 55? If not, please give reasons and any alternative suggestions.

Question 4

Do you have any views on what the new tribunal service should be called?

Question 5

Do you agree with the proposed membership of the MPTS governance committee? If not, please give reasons and any alternative suggestions.

Question 6

Do you agree with our ambitions to appoint the Chair and the other members of the MPTS through an open, transparent and independent recruitment process? If not, please give reasons and any alternative suggestions.

Question 7

What skills, qualifications and experience do you think should be required for:

a. the Chair of the MPTS?

b. the other members of the MPTS governance committee?

Question 8

Do you agree that the proposed reporting arrangements for the MPTS are appropriate, if agreed by all necessary authorities? If not, please give reasons and any alternative suggestions.

Question 9

Do you agree with our proposals for establishing close liaison between the GMC and the MPTS? If not, please give reasons and any alternative suggestions.

Question 10

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Question 14

Do you believe legally qualified chairs should be used in:

a. certain cases? If so, do you have any views on what criteria should be applied in deciding whether to appoint a legally qualified chair?

b. In all cases?

Please give reasons for your answer and any alternative suggestions.

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b. advancing equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it?

c. fostering good relations between persons who share a relevant protected characteristic and persons who do not share it?

If yes, could the proposals be changed so that they are more effective in furthering those aims?

If not, please explain what effect you think the proposals would have and whether you think the proposals could be changed so that they do further those aims?

Question 21

Do you think these proposals will impact on the confidence in our procedures of any particular groups of people? If so, which groups and why?

Annex A

GMC's Response to the Department of Health (England)'s Consultation on Fitness to Practise Adjudication for Health Professionals: Assessing Different Mechanisms for Delivery (September 2010).

Thank you for inviting our comments on how best to proceed with fitness to practise adjudication for health professionals. Our comments on the specific questions posed in the consultation document are set out below.

Question 1

Should the Government proceed with its preferred option 2?

1 Yes, we believe this is the most sensible and cost effective approach. The creation of a new organisation inevitably duplicates functions and adds costs that would have to be borne both by doctors and, in the initial phase, by taxpayers.

Accordingly we agree with the Government that this is not the most appropriate or proportionate approach.

Question 2

Do you have any comments on the identified benefits, costs and risks of the options that are detailed in this document and its accompanying impact assessments and are there any other considerations that the Government should consider?

2 We believe our adjudication function is effective but accept that further significant reform is both possible and desirable. We consider that ensuring greater independence of adjudication within the GMC, while delivering the key changes envisaged under OHPA, is the most appropriate way forward.

3 The start-up costs associated with the establishment of OHPA and the increased ongoing costs associated with a separate organisation is clearly a key consideration; costs will be incurred not only by the taxpayer, but also by doctors, who will be expected to pay for the additional running costs of the new organisation.

4 Figures set out in the impact assessment accompanying the consultation document suggest that the net benefit of not taking forward the current proposals around OHPA, but instead strengthening and modernising the GMC's systems and procedures, is in the region of £45million – £59 million[6] over a five year period. This is a significant sum and reinforces the argument for option two.

6 *Fitness to Practise Adjudication for Health Professionals: Assessing different mechanisms for delivery – Impact Assessment* (Department of Health, August 2010).

Changes at the GMC

5 Until 2004 the GMC's fitness to practise procedures were governed by three separate pieces of legislation and supported by three committees covering different aspects of a doctor's fitness to practise: health, conduct and performance. Following a review of the fitness to practise procedures, in 2002 Council approved the measures which later became the Fitness to Practise Rules 2004. The key elements of the new Rules are:

a. A holistic approach to concerns about doctors based on the concept of impaired fitness to practise, with a single set of rules and a single fitness to practise panel to consider the whole range of allegations.

b. The introduction of professional decision makers (case examiners) to refer a case to a fitness to practise panel and a single test for referral, the "realistic prospect" test.

c. A staged decision making process based on formal criteria and supported by extensive guidance allowing for thorough audit of case progression.

d. The separation of governance from adjudication decision making by excluding Council members from fitness to practise panels.

6 We have kept the operation of the Fitness to Practise Rules 2004 under review and further changes have been implemented over the last few years. Perhaps most significantly was the move to the civil standard of proof, in line with the 2007 White Paper, Trust, Assurance and Safety, on 31 May 2008.

7 In 2007, the power to agree undertakings with doctors was extended to misconduct cases. In appropriate cases the aim was to increase the opportunity for remediation and rehabilitation of doctors whose fitness to practise was impaired without the need for a fitness to practise panel hearing.

8 Additionally, the infrastructure supporting the fitness to practise procedures has been significantly enhanced. Following the introduction of the present rules in 2004, a more robust process for monitoring and supporting those doctors who are subject to undertakings and conditions was introduced.

9 In April 2006 an electronic case management system was introduced across the GMC. All case documents are now stored electronically, allowing for the rapid retrieval of the information pertaining to a doctor's fitness to practise held by the GMC, including previous and current concerns, hearings or sanctions.

10 The GMC's adjudication function is subject to a series of service targets which enable its Council to assess and review its performance. In 2007, the GMC commissioned King's College London to audit our investigation stage decisions to provide external assurance that fitness to practise decisions were consistent with relevant guidance. We intend to repeat this exercise.

11 There is an active training and development programme for panellists and for staff. Regular training events are held for panellists to brief and update them on changes to legislation, case law and policy, with the aim of ensuring more consistentand robust decision making. Panellists are also subject to 360 degree assessment following every hearing. Staff are supported in a number of ways including a thorough induction training and by manuals which set out in detail the procedures governing the handling of cases.

12 The governance of the GMC itself has changed considerably over the last few years. The Council is smaller, with 24 members, half of whom are lay. Members no longer have a role in either the investigation of cases or in adjudicating. Their role is to provide strategic leadership and to hold the executive to account. All of the members are independently appointed by the Appointments Commission, acting on behalf of the Privy Council.

Evidence of our performance

13 Current data[7] suggests that the decisions made by the GMC's Fitness to Practise Panels are robust — only a small proportion of cases are challenged before the higher courts, and a smaller proportion are successful in such challenge.

14 A recent independent report on the performance of the health regulatory bodies, prepared by the Council for Healthcare Regulatory Excellence (CHRE), gave a positive report about the GMC's performance. The 2009/10 report[8] notes that:

The GMC has continued to perform well, demonstrating excellence in several areas across its functions in a year of significant change. It is impressive that the GMC has maintained its commitment to continuous improvement, even in areas where it was already performing to a good standard, and to addressing challenges in medical regulation.

GMC proposals to increase the independence of adjudication

15 In order to increase the independence of adjudication, we would propose the establishment of a new Committee of the GMC: the Doctors' Disciplinary Tribunal. This would be established as a statutory committee of the GMC. It would have overall responsibility for appointing and training lay and medical panellists, case managers, legal assessors (if required) and specialist advisers, and would be responsible for quality assurance of panellists and their work. The DDT would comprise the Tribunal Chair and further membership yet to be defined, but possibly drawn from the pool of fitness to practise panellists. It would not include GMC Council members.

16 The concept of a Tribunal Chair is taken directly from the approach that is used in other tribunals where the Chair is responsible for the day-to-day judicial administration of the tribunal. We suggest that the appointment of this individual is overseen by an independent body such as the Judicial Appointments Commission.

17 The separation of functions would also be further demonstrated through changes to the GMC's current management structure.

18 We propose that the Committee should provide a bi-annual report to the GMC Council in order to give assurance that the Tribunal service is operating effectively and that the independence of its panels is secure. We also suggest that the Chair provides a report to Parliament together with the GMC on an annual basis – this would include assurance that arrangements for ensuring the Tribunal service's independence of judgement are effective.

19 The GMC should have a right of appeal against decisions made by the Tribunal's panels. This would be an important demonstration of the separation of the investigation and presentation of cases from the adjudication function. It would further underline the independence of both, provide a clear division of roles and responsibilities and demonstrate to the profession and the outside world that while the Tribunal is part of the GMC structure its decisions are its own and are subject to challenge by the 'prosecuting' authority.

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7 Table 1 of the impact assessment: CHRE Stats on referred decisions, provides the figures.

8 Performance review report 2009/10. *Enhancing public protection through improved regulation*. CHRE. July 2010.

Reforming the Adjudication process

20 The GMC is fully committed to reforming our current adjudication procedures and have been working closely with colleagues at OHPA and the Department of Health to identify measures that will streamline and modernise the way in which adjudication is delivered. These include:

a. Shorter and more streamlined hearings, through the introduction of significantly enhanced case management and pre-hearing arrangements (including consideration of the introduction of costs sanctions where appropriate).

b. More active case management through the introduction of legally qualified chairs on certain types of cases.

c. Improved use of resources by reducing the number of panellists required to sit on panels.

d. The appointment of panellists on a more permanent basis to make it easier to provide panellists for longer cases.

e. Enhanced performance management and support for panellists through a "tribunal-style" model.

f. Reduced hearing length through the introduction of specimen charges.

Enhanced case management and pre-hearing arrangements

21 It is clear from the work that we have done with OHPA that our case management procedures, in particular, need to be reformed. The current approach can result in unnecessary delays at hearings (due to issues such as poor witness scheduling and lack of agreement about expert evidence); issues that should ideally be dealt with at the pre-hearing stage. This can serve to extend the length and cost of hearings.

22 The longer-term answer to this may be to enforce case management through a cost regime that would penalise delay or failure to adhere to pre-hearing case management directions. We would, however, need primary legislative change in order to take this forward.

The introduction of legally qualified chairs on certain types of cases

23 There is a strong case for legally qualified chairs to be involved in certain types of case. The qualities required to chair adjudication panels can be found in persons who are not legally qualified, however legally qualified chairs may lead to shorter hearings and more active case management before hearings than the current model of non-legal chair and legal assessor. As a legal assessor would not be appointed in cases where there was a legally qualified chair, the process may be more cost-effective.

A reduction in the number of panellists required to sit on a panel

24 The current quorum for GMC panels is three members. Until recently the current practice has been to begin hearings which are scheduled to run for less than 10 days with three panel members. Cases which were scheduled for more than 10 days would have five panel members. The aim was to protect the quorum, should one or more members need to step down after a hearing had started.

25 This policy has recently been changed so that hearings that are expected to last up to 20 days have three panel members. This will be reviewed after six months to determine whether it is appropriate to extend three member panels further.

Enhanced performance management and support for panellists

26 The establishment of a "tribunal-style" style model of hearings should help to enhance the performance of panellists and provide greater support to new panellists on appointment. The establishment of a Chair of the tribunal will provide visible leadership to panel chairs and panellists.

27 The Tribunal would have a system of annual appraisal for its panellists which would enhance the 360 degree feedback system already in place. It would be important to ensure this did not compromise the independence of panellists' decision-making. Oversight of the process by the Chair of the Tribunal, and transparent criteria against which individual panellists would be assessed should guard against this. We would hope to work closely with the Judicial Studies Board to design a system of appraisal.

Specimen charges

28 One of the key factors contributing to length of hearings is the large number of charges that may be brought against each doctor. These result in significant volumes of evidence which the Panel must consider in order to make a finding of fact in relation to each charge.

29 OHPA identified this as a key issue and suggested that a 'specimen' charges approach might be more appropriate and proportionate. This would involve limiting the number of charges, to include only the stronger heads of charge which, if proven, would lead to a finding of impairment and secure the appropriate sanction. Other jurisdictions, such as the criminal courts, use this approach.

30 This approach has significant advantages although there are risks associated with it. The most obvious is that the GMC could be accused of under-prosecution if the charges selected did not secure the appropriate sanction. We propose to pursue the introduction of specimen charging to the extent we believe we can do so without compromising the successful prosecution of cases.

Timescales

31 Although some of the initiatives, such as the implementation of a cost regime and legally qualified chairs, will need a change in primary legislation, a substantial number of initiatives can be progressed within the current legislative framework.

32 Our intention, subject to the government's final decision, would be to put in place a reform programme that would begin to deliver substantial changes from April 2011. In some areas this build on work that we are already taking forward, in other areas, it will involve either a simple change to the GMC's current procedural guidance or changes to our procedural rules. The later will require a period of public consultation to ensure the views of key interested parties are taken into account.

Conclusion

33 The GMC is committed both to further reform and to a clear separation of adjudication from our other work. We believe these proposals provide a viable and more proportionate way forward in line with the government's objectives.

34 We are confident that we have the capability to deliver the reforms that are needed and remain committed to the principle of independent adjudication. We believe the establishment of the Doctors' Disciplinary Tribunal will achieve this.

Annex B

Rule 16 of the General Medical Council (Fitness to Practise) Rules Order of Council 2004

1 The Registrar shall appoint one or more legally qualified Case Managers for the purposes of this rule.

2 Following the referral of a case to a FTP Panel for

(a) a hearing to consider an allegation in accordance with rule 17;

(b) a review hearing to consider an allegation in accordance with rule 22; or

(c) consideration of an application for restoration in accordance with rule 24, the Registrar may list the matter for a case review before a Case Manager.

3 Unless the parties agree otherwise, the practitioner shall be given no less than 14 days' notice of any case review.

4 A case review may be conducted by telephone or by such other method as may be agreed between the parties or, where the parties fail to agree, as decided by the Case Manager.

5 The Case Manager shall act independently of the parties and may give directions to secure the just, expeditious and effective running of proceedings before the FTP Panel.

6 Directions issued by the Case Manager may include, but are not limited to, such of the following as he considers appropriate having regard to the nature of the allegation, any representations made by the parties and all other material factors

(a) that each party disclose to the other

(i) any documentary evidence in their possession or power relating to the allegation,

(ii) details of the witnesses (including the practitioner) on whom they intend to rely and signed witness statements setting out the substance of their evidence,

(iii) a curriculum vitae and an expert report in respect of any expert on whom they intend to rely, and

(iv) skeleton arguments;

(b) that each party provide an estimate as to the likely length of the hearing and the date or dates on which they propose that the hearing should take place;

(c) that the parties state whether or not the health of the practitioner is to be raised as an issue in the proceedings;

(d) that the practitioner indicates, so far as is practicable

(i) whether the allegation is admitted,

(ii) which facts are admitted and which facts remain in dispute,

(iii) which witness evidence is admitted and which witnesses are required for cross examination, and

(iv) whether any preliminary legal arguments are to be made;

(e) where the allegation is admitted, a direction that the parties produce a statement of agreed facts;

(f) where the parties agree, a direction that a witness statement shall stand as the evidence-in-chief of that witness;

(g) a direction that a particular witness should be treated as a vulnerable witness, and directions as to how the evidence of such witness should be obtained or presented to the FTP Panel;

(h) a direction for an adjournment of the case review or an additional case review where the circumstances of the case require; and

(i) time limits for compliance with any of the directions listed above.

7 Within the period of 7 days beginning with the date of a case review, the Case Manager shall serve on the parties a record of the directions issued by him.

8 A FTP Panel may draw such inferences as it considers appropriate in respect of the failure by a party to comply with directions issued by the Case Manager.

Annex C

Summary of estimated annual costs and savings for a single centralised hearing centre

	Year 1 2011 £000[1]	Year 2 2012 £000	Year 3 2013 £000	Year 4 2014 £000	Year 5 2015 £000	Total
Annual costs / (savings)[2]						
Staffing costs[3]	-141	-572	-581	-590	-598	-2,482
Office support costs[4]	-232	-940	-954	-968	-983	-4,077
Leasehold operating costs[5]	-214	-867	-880	-894	-907	-3,762
Panel and assessment costs[6]	-55	-225	-228	-231	-235	-974
Additional travel and accommodation costs: GMC Legal Team[7]	30	123	125	127	128	533
Additional travel and accommodation costs: Panellists[8]	60	244	247	251	255	1,057
Additional leasehold costs: hearing rooms and office space[9]	44	179	181	184	187	775
Net annual cost/(savings)	-507	-2,059	-2,090	-2,121	-2,153	-8,931
Average annual cost/(savings)						**-1,786**

Notes to Annex C

1 The business case assumes that operations will revert to the single centralised hearing centre from 3 October 2011 onwards. The costs and savings presented in the year one column therefore relate to the final quarter of 2011 only. All other columns present full year costs and savings.

2 All annual savings and costs have been increased by 1.5% per annum.

3 Our staffing costs are typically 20% lower in Manchester than in London. Staffing cost savings include salary costs, National Insurance contributions and superannuation contributions. We also expect to be able to run operations from a single hearing centre with a modest reduction in staffing levels, realising an additional £200,000 saving per annum.

4 Office support cost savings include reductions in the section's photocopying, stationery, IT support and telephony costs. In addition, the proposed centralised hearing centre will have increased hearing room capacity allowing us to significantly reduce the costs of hiring external venues.

5 Leasehold operating cost savings include rent, service charges and rates currently payable on the London office and hearing room accommodation.

6 The costs of running hearings and assessments in Manchester are less than in London. Panel assessment cost savings relate to lower fees, expenses and catering costs.

7 The GMC's legal team are located in the London and Manchester offices with 40% of staff based in London and 60% in Manchester. Over half of hearings are held in Manchester which already requires some of our London-based legal team to travel to Manchester on a regular basis to attend hearings. This increase accounts for the extra travel and accommodation costs that will be incurred.

8 This figure accounts for the anticipated increase in the travel, accommodation and expenses costs of our panellists and Legal Assessors.

9 We will need to expand our office space within our current Manchester premises. We plan to increase Manchester's hearing capacity by two extra hearing rooms and four ancillary rooms, increasing our total capacity to 16 hearings rooms. The additional leasehold costs for this expansion are included within the financial analysis.

Annex D

Equality and diversity

Following concerns about the independence of adjudication expressed in the Fifth Report of the Shipman Inquiry, the previous Government confirmed its intention to establish OHPA and transfer our adjudication function to that body in the 2007 White Paper *Trust Assurance and Safety – the Regulation of the Health Professions in the 21st Century*. We supported work to prepare for that transfer, which was expected to take place in April 2011. In 2010, the Government reviewed the case for OHPA and, following consultation, at the end of 2010 the Government confirmed its intention to abolish OHPA and enhance independence and modernise existing systems within the GMC.

As a result of that announcement, we recently commenced work to consider how we might increase separation between our investigation and adjudication roles and modernise our procedures.

This consultation document outlines our initial proposals for modernising and repositioning adjudication within the GMC, although the majority of the proposals will require changes to legislation or rules and will be subject to further consultation before implementation if we determine to proceed.

We are in the process of developing an equality impact assessment (EQIA) which looks at the potential impact of these proposals on diverse individuals and groups. This will be informed by the outcomes of this consultation.

The legal framework dealing with the equality duties of public bodies is itself about to change. From 6 April 2011 there will be a new general duty which is set out in section 149(1) of the Equality Act 2010.

The general duty in section 149(1) provides that a public authority must, in the exercise of its functions, have due regard to the need to:

a. eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Equality Act 2010

b. advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it

c. foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

The remainder of section 149 provides more detailed explanation of the expressions used in this general duty. In particular, the expression 'protected characteristic' in this context means:

a. age

b. disability

c. gender reassignment

d. pregnancy and maternity

e. race

f. religion or belief

g. sex and

h. sexual orientation.

Having due regard to the need to advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it involves having due regard, in particular, to the need to:

a. remove or minimise disadvantages suffered by persons who share a relevant protected characteristic that are connected to that characteristic

b. take steps to meet the needs of persons who share a relevant protected characteristic that are different from the needs of persons who do not share it

c. encourage persons who share a relevant protected characteristic to participate in public life or in any other activity in which participation by such persons is disproportionately low.

The steps involved in meeting the needs of disabled persons that are different from the needs of persons who are not disabled include, in particular, steps to take account of disabled persons' disabilities.

Having due regard to the need to foster good relations between persons who share a relevant protected characteristic and persons who do not share it involves having due regard, in particular, to the need to:

a. tackle prejudice, and

b. promote understanding.

The equality questions contained in this consultation are therefore intended to be aligned with the new general duty.

We are also reviewing our knowledge of the trends for diverse groups of doctors involved in our current fitness to practice procedures, and will be conducting further analysis to develop our evidence base in this area. The headline trends that we are aware of include:

- 27% of doctors referred to our fitness to practise procedures are from a black and minority ethnic background, compared with 27% on the medical register.
- 23% of doctors referred to our fitness to practise procedures are women; compared with 41% on the medical register.
- 77% of doctors referred to our fitness to practise procedures are men, compared with 59% on the medical register.
- 30% of doctors referred to our fitness to practise procedures are IMGs, compared with 28% on the medical register.

The GMC publishes annual figures and analysis of the outcomes at key decision points in our fitness to practise procedures broken down by gender, race and place of primary medical qualification: **www.gmc-uk.org/publications/7263.asp**

We also recognise that the principles of equality, diversity and fairness will need to be embedded in the work of the Medical Practitioners Tribunal Service. Our recommendation would be that the appropriate safeguards and systems are put in place to ensure that decision-making is fair, transparent and non-discriminatory. This would include the following measures:

- Ensuring that the Chair and members of the Medical Practitioners Tribunal Service are made aware of their legal responsibilities with respect to equality, diversity and human rights legislation, and receive training around how these issues apply to their role.
- Developing transparent criteria against which panellists would be assessed to help to ensure that their decisions are fair and non-discriminatory.
- Developing systems for monitoring decisions to ensure that they are fair, robust and transparent for both doctors and members of the public, and that any outcomes for persons with protected characteristics are monitored and carefully considered.
- Making reasonable adjustments available for medical practitioner tribunal members, doctors and witnesses as required.

As part of the consultation process we propose to have discussions with a range of individuals and organisations representing the views of diverse groups of people, including doctors, patients and the public. We are currently developing a communications plan and our equality impact assessment will include details of the diverse groups and organisations that we plan to engage with.

We will be seeking their views on the consultation questions 20 and 21. We will wish to hear their views on the full range of issues related to the consultation, including:

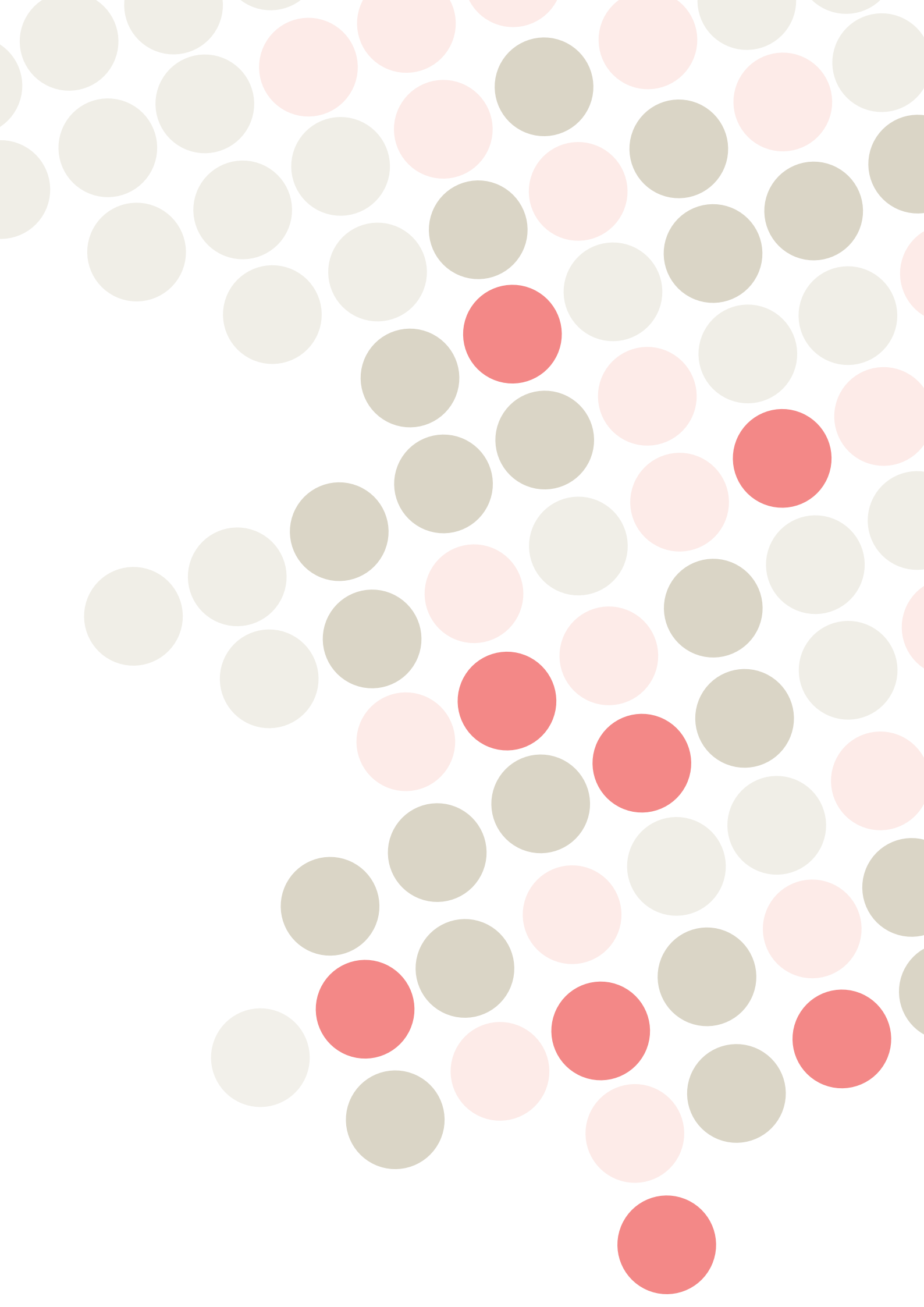
- Whether dealing with cases more quickly will reduce the stress and anxiety for diverse groups of doctors and witnesses.
- How the proposed modernisation and repositioning our adjudication procedures will impact on diverse groups of doctors or patients.
- Whether improving mechanisms for witness timetabling will provide greater clarity for vulnerable witnesses who have been the victims of a sexual assault and who may need to attend a hearing.
- How the proposal to establish a single hearing site in Manchester could impact on diverse groups of people participating in the hearings.

For more information about how we are considering equality and diversity in developing our thinking about the way forward, please contact:

James Ewing
Policy and Planning Manager —
Fitness to Practise
The General Medical Council
350 Euston Road
London NW1 3JN

Email: ftpconsultation@gmc-uk.org
Telephone: 020 7189 5146

Textphone users. Please use the Text Relay Service:
Dial Prefix 18001 + 020 7189 5146.



LONDON
Regent's Place, 350 Euston Road, London NW1 3JN

MANCHESTER
3 Hardman Street, Manchester M3 3AW

SCOTLAND
5th Floor, The Tun, 4 Jackson's Entry, Holyrood Road, Edinburgh EH8 8PJ

WALES
Regus House, Falcon Drive, Cardiff Bay CF10 4RU

NORTHERN IRELAND
9th Floor, Bedford House, 16-22 Bedford Street, Belfast BT2 7FD

Telephone 0161 923 6602
Email gmc@gmc-uk.org
Website www.gmc-uk.org

General Medical Council

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GMC/AFTP/0311

Early considerations for the establishment of OHPA – the style & format of adjudication

The Shipman Inquiry had been the catalyst for the establishment of OHPA.

The Inquiry had followed other Inquiries of Neale, Kerr-Haslam, and Ayling, and other high-profile cases such as Allitt and Ledward. The then Government responded to the numerous recommendations emanating from all of these, in particular accepting the need to separate adjudication from, initially, the medical profession.

At around the same time of the Shipman Inquiry, the Chancellor had asked Philip Hampton to consider the scope for reducing the administrative burden of regulation, to promote more efficient approaches without compromising regulatory standards or outcomes. The resulting report (Reducing Administrative Burdens, March 2005)[1] sought to raise the quality and effectiveness of the regulatory system, simplifying or consolidating processes.

Building upon these principles, a report, this time by the Better Regulation Task Force (Less is More, March 2005)[2] recommended a cultural change; to improve transparency and understanding by adopting a framework for managing regulation that provided a better balance between the creation of new measures and the simplification of existing rules and regulations.

Unrelated but relevant, in the early 2000s the Lord Chancellor established a review of tribunals, undertaken by Sir Andrew Leggatt. The resulting Leggatt Review (Tribunals for Users: One System, One Service, March 2001)[3] set out the need for reform, with the primary objectives of:

- making clear the complete independence of the judiciary and their decision-making, from Government,
- speeding up the delivery of justice,
- making processes easier for the public to understand, and,
- bringing together the expertise from each tribunal.

The Tribunals Service was created in April 2006 for the purpose of unifying administration of the tribunals system. Most of the changes resulting from the Leggatt Review consequently affected the operations of the tribunals rather than what happens at individual hearings. Operations spanned from provision of premises, training, and IT, to common standards and a presidential system to promote consistency of decision-making and uniformity of procedure. There was therefore, much synergy between the recommendations for the establishment of OHPA and the reforms the tribunals were to implement.

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[1] Reducing administrative burdens: effective inspection and enforcement. Philip Hampton. March 2005. HM Treasury

[2] Regulation – Less is More. Reducing Burdens, Improving Outcomes. March 2005. A BRTF report to the Prime Minister

[3] Tribunals for Users: One System, One Service. Report of the Review of Tribunals by Sir Andrew Leggatt. March 2001.

The synergy does not end there. In 2010, the Ministry of Justice consulted on merger proposals, bringing together Her Majesty's Courts and Tribunals Services[4]. Whilst the purpose of the merger was primarily financial, other benefits of unification were identified:

- improved public understanding via a single point of access,
- greater utilisation of a shared estate,
- flexible deployment of staff, and opportunities to share best practice, and,
- opportunities for further efficiencies by increasing the use of back-office functions which in turn will improve efficiency on the front line.

It was against this backdrop of change and the various recommendations that OHPA considered the style and format that it might adopt for adjudication.

The Tribunals, Courts & Enforcement Act 2007 put in place a flexible tribunals structure which allows tribunals currently sitting outside the Ministry of Justice to transfer into the new system, as well as allowing new jurisdictions to be added. Since then, the Tackling Concerns Nationally working group opined that OHPA was akin to a tribunal and as such could sit under the Administrative Justice and Tribunals Council[5]. Our early focus was therefore placed upon AJTC with whom we had fruitful discussions. However, this was not to explore whether we should be located within the Tribunals Service from day one (although it should be acknowledged here that this was an aspiration for the longer term) but rather to consider the style and format adopted by the existing tribunals.

Subsequently, we went on to consider the style and format of disciplinary tribunals for other non-health professional groups such as solicitors, police, and actuaries. And finally, we considered how adjudication of health professionals is managed internationally.

The Tribunals Service

The Tribunals Service provides administrative support for the tribunals judiciary who hear cases and decide appeals. Within the Tribunals Service structure, jurisdictions are grouped under Chambers. For example, the Health, Education and Social Care Chamber comprises care standards, mental health, special educational needs and disability, and primary health lists. The General Regulatory Chamber comprises charity, claims management services, consumer credit, environment, estate agents, gambling appeals, immigration services, information rights, local government standards in England, and transport.

We considered the style of one jurisdiction from each of these two chambers, Primary Health Lists (PHL), and Estate Agents (EA), as both deal with the performance and practice of professional practitioners.

[4] A platform for the future. A consultation on a unified Courts & Tribunals Service. November 2010. Ministry of Justice

[5] Tackling Concerns Nationally: Establishing the Office of the Health Professions Adjudicator. March 2009. Department of Health

PHL is completely independent of the Department of Health, and is not accountable to the Secretary of State. Its decisions can be directly appealed against to a Judge of the Upper Tribunal. PHL hears applications or appeals from health professionals relating to locally managed performers lists held by Primary Care Trusts, and its panels normally consist of a Tribunal Judge, a Specialist Member, and a Member. The panels will only hold oral hearings into the matters referred to them when both the Applicant and Respondent want one.

Conversely, EA only hears appeals against decisions made by the Office of Fair Trading relating to an order prohibiting a person acting as an estate agent, an order warning a person that they have not met their duties under the Estate Agents Act 1979, or a decision refusing to revoke or vary a prohibition or warning order.

Professional Disciplinary Tribunals

Somewhat confusingly given the title, not all tribunals do indeed sit within the Tribunals Service but rather function as adjudicators within or external to a professional body or regulator. The Police Disciplinary Tribunal and the Actuaries Disciplinary Tribunal are equivalent to a healthcare regulator final stage fitness to practise panel or committee in that they reside within the respective regulator. Both have procedural rules updated in 2008. Their hearings are not held in public.

The Solicitors Disciplinary Tribunal (SDT) is constituted as a Statutory Tribunal under the Solicitors Act 1974. It adjudicates upon alleged breaches of rules or code of professional conduct, and has the power to strike off a solicitor from the Roll, suspend from practice, fine or reprimand. The SDT decisions can be subject of appeal to the High Court; the time limit for appeal is 28 days from the date of receipt of the Tribunal's Findings.

The SDT is wholly separate from and independent of the Solicitors Regulation Authority, which instigates over 90 per cent of the cases dealt with by the SDT. Hearings are usually in public, and the evidential procedures are broadly in line with those of the High Court.

The Law Society collects from individual solicitors an amount to fund the Tribunal as part of its exercise to collect fees in connection with the issue of practising certificates. (OHPA too needed to establish a funding mechanism, underwritten in full by the referring regulators, so there was also more for us to learn from here.)

Healthcare practitioner regulation in other countries

In 2009, the GMC commissioned a comparative study of ten international medical regulatory systems (Rand Corporation)[6]; a purposive sample of the countries of origin of the ten largest groups of non-UK qualified doctors registered in the UK. The published report describes a number of

[6] International Comparison of Ten Medical Regulatory Systems. 2009 RAND Corporation; Technical Reports

different medical regulatory systems, from a unitary state authorised body through to the decentralised polycentric systems where regulation is the prerogative of the medical associations. Unsurprisingly given the range of style of regulation, the extent of independence varies significantly. Although all countries included in the study have disciplinary procedures, a substantial variation in the structure of the bodies responsible was also noted.

The New Zealand Health Practitioners Disciplinary Tribunal hears and determines disciplinary proceedings brought against all health practitioners. Its hearings are held in public. The route of appeal is to the High Court. This was the closest equivalent to OHPA we found. It was also of interest that the New Zealand Tribunal routinely awarded costs against those whose cases it considered, as provision had also been made for OHPA to exercise a costs jurisdiction.

A preferred style & format for OHPA

There is a wide range of styles of adjudicating body, with no one format currently predominating. The consideration of the different professions was undertaken to review the processes and procedures utilised, and whether these sat well with the need for better, less burdensome regulation, and were transferrable to the health sector.

Having considered in detail the differing organisations and systems alongside, what was then, an urgent need to move final stage adjudication to an independent body, OHPA defined some outline criteria to shape its style and format. OHPA also pledged to speed up proceedings, and to deliver publicly accessible and transparent decision-making, not only bringing it in line with the Hampton principles, but also closely aligning itself with the Tribunals Service.

OHPA decided to adopt a format analogous to the Solicitors Disciplinary Tribunal. There are many similarities between the legislation, the relationship with the referring and professional bodies, and the overall approach to adjudication. In the longer-term, OHPA also hoped to work toward a more inclusive model involving all health practitioners more akin to the current New Zealand model.

A way forward without OHPA?

Returning to health professional regulation in the UK, the processes are well advanced when compared both with non-health professional regulation and health professional regulation at an international level. Where the UK regulators remain out of step is with the wider agenda to simplify and consolidate regulation.

Historically, healthcare professions have captured regulation and accumulated procedural rules without considering what perhaps might be simplified or consolidated. The Department of Health (DH) has contributed to this: it has neither made procedural change a legislative priority nor a simple exercise for those seeking to achieve it. It would certainly have assisted OHPA, and in the future could assist the individual regulators, if the DH adopted the BERR recommendations toward

deregulation, removing regulations from the statute book. Greater liberalisation, consolidation and rationalisation should bring the regulations into a more manageable form, and improve transparency and reduce costs.

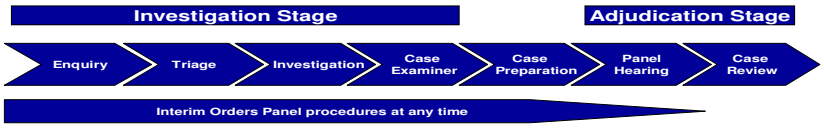
In the absence of OHPA to introduce unification, and given the current economic climate, health professionals should look to the regulators to reduce their spending on adjudication. If organisations as large and culturally different as HM Courts and Tribunals Services can merge and share back-office functions and estate, and deploy their staff to manage need and workload, then why can't the regulators achieve this too?

Wendy Harris

Possible changes to adjudication procedures and the impact upstream on initial FtP processes

Introduction

The Fitness to Practise procedure is, in crude terms, a relatively linear exercise (as illustrated below).



However, beneath each of these stages sits a plethora of activities and procedural requirements. In working to establish OHPA, the style and format of other adjudicators was reviewed in order to identify possible models and efficiencies OHPA might introduce. Whether OHPA did indeed seek to introduce new or adapted ways of delivering adjudication rested in part upon the impact of such changes on the preceding investigatory and preparation stages. Of course, there were other and more important considerations for OHPA to make; for example, the fundamental principle of a right to a fair hearing within a reasonable timeframe, and the ease and cost of implementing the proposed changes either individually or collectively.

The following list provides an outline of only those procedural changes proposed by OHPA that were assessed as having an impact on the activities and legislative requirements of the stages preceding adjudication of the referring regulatory body. OHPA also made other proposals and held future ambitions for other changes such as the appointment of a Tribunal President. These matters are not discussed within this paper, and the reader should refer to the OHPA Policy Ambitions discussion paper for further information.

Procedural changes proposed by OHPA

Administrative trigger for an adjudication referral

Cases are referred for adjudication by various routes:

- Following investigation
- As a result of a prior finding
- Non-compliance with a health or performance assessment
- Breach of undertakings.

A referral to an independent body for adjudication would require a duplication of the notice of referral issued by the referring body – to both the practitioner (and/or their legal representative) and to the independent adjudicating body. Notice can be served by a number of means and media, and simple duplication represents a negligible additional activity. More important is the need for the independent adjudicating body to determine a consistent approach with all of the regulatory bodies making referrals to it.

Timing of a referral for adjudication

OHPA had proposed that referrals would only be made to it when a case investigation was complete. A referral would then trigger pre-hearing case management as provided for in OHPA day one rules. The current practice of many regulators is to refer in preparation for case listing and empanelment, while continuing the investigatory process. This can lead to cases being withdrawn as (a) not proven once investigations are completed, (b) requiring more time to complete investigation, or (c) the parties reach an agreement as to an appropriate consensual disposal arrangement.

Requiring referral when investigation is complete does not impact upon the investigation process *per se*, but would affect any existing KPI or service targets determined by the respective referring regulator.

Referral following completion of investigation was supported by both complainants and respondents, and their professional representatives, as the substance and tenor of the case is obviously much better understood than a referral prior to the investigative completion.

Case management following referral

OHPA proposed to hold pre-hearing cases management meetings for every case referred to it, bar in some exceptional circumstances. The model to be adopted closely mirrored the practices of other judicial proceedings we had previously investigated (sister paper on style & format of adjudication refers). In particular, the use of standard directions to provide for the mutual disclosure of evidence, lines of argument and agreement of expert advice. The filing of such information provides the necessary groundwork for effective case management directions to then be given. OHPA was also of the view that this process would enable the adjudication of some cases to take place on the papers, without recourse to its FtP Panel, via consensual disposal.

In common with OHPA's proposal regarding the timing of a referral, this change also required the case investigation to be complete. It also needed the interested parties to meet disclosure requirements. The widespread utilisation of case management afforded other opportunities to ensure proportionality, cost reduction, and improved efficiency and timeliness as described in the following paragraphs.

Specimen charging and impact statement

It was proposed to reduce the number of allegations charged to the most important matters, and to restrict the number to those a prosecutor could get home on to achieve the sanction competed for. This can already be achieved in part under 'Joinder' rules (that is to say, when two or more charges are similar in nature and are proven by common facts they can be joined together as a single allegation). However, the OHPA proposal was for this to be taken further and for only the most important or serious matters to be charged.

This would have been a controversial change, especially to those affected by the behaviours or practice of a practitioner referred for adjudication. It is possible some victims would have felt that they had not 'had their day in court' on the grounds that the practitioner had not been charged with a matter that affected them personally. OHPA therefore decided to introduce a further change and carve impact statements into the hearing procedure. (The analogy was to the victim impact statements now routinely heard in the criminal courts.)

These changes would have affected the case preparation of the referring regulator, in selecting the matters to be charged and ensuring that, where matters were not included, the relevant complainants were afforded the opportunity to make an impact statement. OHPA was not afforded the time to test whether this might best be achieved prior to case referral or at the pre-hearing case management discussions.

Consensual disposal & other routes to disposal prior to adjudication

The proposed changes above hinged upon the timing of referral to OHPA and the preparation of the case in readiness for adjudication. However, this assumes that a formal adjudication is actually necessary. OHPA was firmly of the belief that some cases did not need to be referred; rather, that the regulator should use all options and sanctions available to appropriately dispose of the matters charged. OHPA promoted itself as an adjudicator of last resort that would deal with the most serious cases, or those cases where agreement could not be reached or an argument needed to be heard.

Whereas other changes outlined in this paper were predominantly administrative, the desire to reduce the number of hearings as a whole represented a significant change to existing procedures, and more broadly to the organisational culture of the regulators. It would have been far from straightforward as it would have necessitated the regulator defining

what a serious case might constitute. Due to the lack of harmonisation of sanctions across the regulators, it could also have resulted in practitioners of different regulators receiving different outcomes on matters which were essentially identical.

Given the cultural change this proposal required of the referring regulator, it might be seen as the reform facing the greatest hurdles. However, reducing the number of formal adjudications is now proving to be a popular proposal, with both the GMC and GOC currently consulting upon possible routes to consensual disposal and other means to dealing with cases without recourse to a hearing. However, a problem continues to persist in the lack of harmonisation of sanctions - despite CHRE efforts in this direction.

Ethical defence

In trying to assist with a view on serious cases, OHPA suggested the use of ethical defence in certain case types. This is applied when an individual convicted of a serious crime against another individual, such as sexual or physical abuse, does not offer a defence when the adjudicating panel subsequently hears the matter. Deferring to the moral principles of ethical behaviour, specifically the human duty of respect of others, prevents the need to re-hear evidence previously presented in a higher place (a court), and removes the distress which a material witness might otherwise be re-subjected to. In essence the matter is proven and the sanction is striking off.

Costs management

Costs management is the principle of limiting the amount of money a party is entitled to incur during the course of proceedings. Overall costs escalate with the number of allegations charged, the length of the hearing, and the seniority of the legal representation retained by each party. Civil litigation case management includes cost capping, and OHPA thought an alignment to this might be useful.

Capping does not prevent any party spending more than the capped amount, but this would be the maximum that could be applied for and awarded if costs were to be sought. OHPA suggested the value of the cap would be determined by the legally qualified chair at the case management stage.

The purpose of this change was to ensure proportionality to the seriousness of the matter of impairment charged. The impact on the referring regulator would have been that, in preparing their case, they would need to select their presenting Counsel or legal representative in proportion and relation to the matters of charge.

Costs jurisdiction

The Health & Social Care Act 2008 made provision for OHPA to exercise a costs jurisdiction. Classically, regulators are keen to request costs awards

against those practitioners who fail to engage with or obfuscate the FtP process (often because they fail to, or are unwilling to, recognise that their behaviour or performance renders them unfit to practise).

However, OHPA was also given the power to make wasted costs awards. This refers to the costs of a legal representative of any party, and that their costs may be disallowed by reason of their conduct of the proceedings. The effect of wasted costs orders is that the legal representative is not able to charge their client for the work subject to the order. With respect to the referring regulator, this again would have encouraged a more proportionate approach to the proceedings.

Reporting determinations and making changes to the register
Whilst OHPA would have published the determinations of its panels, it would also have been for the referring regulator to report the findings and to make any annotations to the register entry of the individual(s) adjudicated upon. No significant impact was predicted.

Reducing the number of IOP reviews
Where an Interim Order has been made that affects an individual's ability to carry out their profession, it is right that the Order is reviewed at intervals as defined by rules or procedural practice (normally 3 – 6 monthly). Where the regulator or practitioner believes that circumstances have changed, a review can be requested at any time without need to wait until the next scheduled date. However, no similar opportunity exists for a review to be declined or deemed unnecessary on the grounds that there has been no change since the previous occasion.

GMC published FtP statistics (2009) indicated that in the region of 500 Interim Order reviews took place during the year. This is the single largest case type to be referred for adjudication. OHPA was keen to see the review schedule bypassed where there had been no change in the practitioner's circumstances - both on the grounds of fairness and to reduce unnecessary expenditure on unnecessary hearings.

Wendy Harris