Reform of fitness to practise procedures at the GMC:
The future of adjudication and the establishment of the Medical Practitioners Tribunal Service
Equality Analysis
July 2011

<table>
<thead>
<tr>
<th>Contents</th>
<th>page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Introduction</td>
<td></td>
</tr>
<tr>
<td>- The legal framework</td>
<td>2</td>
</tr>
<tr>
<td>- Background</td>
<td>3</td>
</tr>
<tr>
<td>- How adjudication currently works in the GMC</td>
<td>4</td>
</tr>
<tr>
<td>- People affected by these proposals</td>
<td>5</td>
</tr>
<tr>
<td>- Performance and audit data</td>
<td>7</td>
</tr>
<tr>
<td>2. Consultation and engagement</td>
<td>9</td>
</tr>
<tr>
<td>3. Equality analysis of our proposals:</td>
<td></td>
</tr>
<tr>
<td>1. Establishing the Medical Practitioners Tribunal Service (MPTS)</td>
<td>13</td>
</tr>
<tr>
<td>2. Creating strong leadership arrangements for the MPTS</td>
<td>15</td>
</tr>
<tr>
<td>3. Ensuring accountability and independence for the MPTS</td>
<td>18</td>
</tr>
<tr>
<td>4. Establishing close liaison between the MPTS and the GMC</td>
<td>19</td>
</tr>
<tr>
<td>5. Introducing a right of appeal for the GMC</td>
<td>19</td>
</tr>
<tr>
<td>6. Enhanced pre-hearing case management arrangements</td>
<td>20</td>
</tr>
<tr>
<td>7. Introducing legally qualified Chairs</td>
<td>22</td>
</tr>
<tr>
<td>8. Consent in review cases</td>
<td>23</td>
</tr>
<tr>
<td>9. A single centralised hearing centre</td>
<td>24</td>
</tr>
<tr>
<td>10. Additional efficiencies in the hearing process</td>
<td>25</td>
</tr>
<tr>
<td>4. Monitoring and review</td>
<td>27</td>
</tr>
<tr>
<td>5. Annex A. Key facts for each protected characteristic</td>
<td>29</td>
</tr>
<tr>
<td>Annex B. List of organisations who responded to the consultation</td>
<td>36</td>
</tr>
<tr>
<td>Annex C. Equality Analysis action plan</td>
<td>37</td>
</tr>
</tbody>
</table>
1. Introduction

What are we assessing through this equality analysis?

1. This document aims to provide an assessment of how our proposals for repositioning and modernising adjudication within the GMC comply with the three aims of the Equality Duty.

2. We undertook a public consultation on the proposals from 21 March to 13 June 2011. During the consultation, our engagement activity focuses on groups representing people who share protected characteristics and that engagement has informed this equality analysis.

The legal framework

3. The Equality Act 2010 (‘the Act) specifies nine groups of individuals who have ‘protected characteristics’ which are covered by this legislation: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

4. The public sector Equality Duty is set out in section 149 of the Act. It provides that a public authority must, in the exercise of its functions, have due regard to the need to:

   a. eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by or under the Act;

   b. advance equality of opportunity between people who share a protected characteristic and those who do not;

   c. foster good relations between people who share a protected characteristic and those who do not.

5. The GMC is listed as a public authority, with respect to its public functions, in an amendment to Schedule 19 in the Act.

6. All of the protected characteristics are relevant to the Equality Duty, except that in respect of marriage and civil partnership the duty is limited to paragraph (a) of the general duty – eliminating discrimination, harassment, victimisation and the other conduct prohibited by or under the Act.

7. Having ‘due regard’ means consciously thinking about the three aims of the Equality Duty as part of the process of decision-making, and ensuring that consideration of equality issues influences the decisions reached by public bodies.

8. Having due regard to the need to ‘advance equality of opportunity’ involves considering the need to:

   a. remove or minimise disadvantages suffered by people due to their protected characteristics;
b. meet the needs of people with protected characteristics;

c. encourage people with protected characteristics to participate in public life or in other activities where their participation is low.

9. ‘Fostering good relations’ involves tackling prejudice and promoting understanding between people who share a protected characteristic and those who do not.

Background

10. The GMC regulates doctors in the UK. We protect patients by ensuring that doctors practising medicine in the UK are qualified and fit to practise.

11. 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. If a serious concern about a doctor is reported, we are required by law to carry out an investigation. Adjudication describes the process for preparing and managing a case for a hearing to determine whether a doctor’s fitness to practise is impaired and, if so, any action necessary to protect the public.

12. A number of concerns about the independence of or the perception of the independence of adjudication emerged from the Shipman Inquiry\(^1\) and the subsequent Government White Paper\(^2\). Following publication of the White Paper, the GMC made a commitment to the principles of independent adjudication and supported the development of a new independent body called the Office of the Health Professionals Adjudicator (OHPA). We worked closely with OHPA and prepared to transfer our adjudication function to it in April 2011.

13. On 2 December 2010, following a consultation on the future of fitness to practise adjudication, the Coalition Government announced its decision not to proceed with the establishment of OHPA. The GMC retains responsibility for adjudication and repeal of the provisions relating to OHPA in the Health and Social Care Act 2008 is being pursued in the current Health and Social Care Bill.

14. On 21 March 2011, the GMC launched a consultation\(^3\) on proposals which can be broadly grouped as follows:

   a. Changes to our governance arrangements to create a new statutory committee of the GMC called the Medical Practitioners Tribunal Service (MPTS);

   b. The creation of strong leadership arrangements for the MPTS;

   c. Ensuring accountability and independence of the MPTS;

---

\(^1\) 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).

\(^3\) The future of adjudication and the establishment of the Medical Practitioners Tribunal Service (GMC, March 2011)
d. Establishing effective liaison between the MPTS and the GMC;

e. Introducing a right of the appeal for the GMC against decisions of medical practitioner tribunals;

f. Enhancing our pre-hearing case arrangements;

g. Introducing legally qualified Chairs;

h. Eliminating the need to refer review cases to an interim order or fitness to practise hearing where a doctor agrees with the GMC’s proposals;

i. Introducing greater use of written evidence and removing the need to read out allegations at the beginning of a hearing;

j. Moving to a single centralised hearing centre;

k. exploring other ways of making the hearing process more efficient.

15. Our intention in developing these proposals is to:

a. create greater separation between our investigation and adjudication functions, and underline the autonomy of the adjudication process;

b. streamline and speed up the hearings process;

c. create greater confidence in adjudication among the profession and the public.

16. Many of the changes would require a change to primary legislation. In these cases, we would 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 to the Privy Council and Parliament under section 60 of the Health Act 1999. The legislation itself would be subject to a separate consultation exercise by the Department of Health and, subsequently, debate in Parliament.

How adjudication currently works in the GMC

17. After a complaint is received about a doctor and an investigation has been carried out, the GMC decides whether to refer the doctor to a fitness to practise (FTP) panel. We will consider both the seriousness of the allegations and the likelihood of being able to prove the case at a hearing.

18. At the end of an investigation, if we are satisfied that there is a realistic prospect of establishing that the doctor's fitness to practise is impaired and that the case is not suitable to be concluded by way of undertakings, the case is referred to a fitness to practise panel.

19. Panel decisions are made by medical and lay panellists appointed to sit on our interim orders panels and fitness to practise panels. Panellists are independent, but are required to take account of the GMC’s policy and guidance.
Interim orders panels

20. Sometimes, if the GMC believes it is necessary, we ask the doctor to appear before an interim orders panel, which considers whether a doctor's registration should be restricted, either by suspension or by imposing conditions on their registration, while we undertake an investigation or prepare a case for a hearing. This ensures that we can take action to protect patients while questions about the doctor's fitness to practise are resolved.

21. Interim orders panels usually meet in private, unless the doctor requests a public hearing or the panel otherwise decides a public hearing is in the public interest.

What happens at a hearing

22. Fitness to practise panel hearings are the final stage of our procedures. FTP panels hear evidence and decide whether a doctor's fitness to practise is impaired.

23. If a panel concludes that a doctor's fitness to practise is impaired it may:
   a. accept undertakings offered by a doctor provided the panel is satisfied that such undertakings protect patients and the wider public interest;
   b. place conditions on a doctor's registration;
   c. suspend a doctor's registration;
   d. erase a doctor's name from the Medical Register, so that they can no longer practise.

24. If a panel concludes that a doctor's fitness to practise is not impaired it may issue a warning to the doctor or close the case with no further action.

25. Fitness to practise panels usually meet in public, except when considering evidence relating to a doctor's health or the panel otherwise decides it is in the public interest.

People affected by these proposals

26. Our role is to protect and promote the health and safety of the public. In this respect, the general public are one of our key interest groups. Only doctors and the GMC are parties to fitness to practise proceedings, but complainants and witnesses play a key role.

27. The Fitness to Practise Committee (formerly the Fitness to Practise Reference Group) signed off our Equality and Diversity Action Plan in June 2010. The plan identifies a number of activities to help understand the outcomes for and experiences of people who share a protected characteristic who are involved in our procedures. This work includes the following activities:
a. Undertaking a survey of doctors and complainants who have been through our fitness to practise process to gather feedback about their experiences.

b. Developing an engagement plan to increase our liaison with groups representing and made up of people who share protected characteristics.

c. Doing further analysis of the profiles and demographics of doctors involved in our fitness to practise procedures.

d. Improving the information that we collect about complainants and witnesses, in particular any special needs they have or additional support they may need by making changes to our case management system and by introducing a routine needs assessment.

e. Ensuring that case examiners and panellists are aware of and have received appropriate training in relation to the relevant issues and etiquette that may apply to witnesses and doctors who share particular protected characteristics.

28. We have done work to build our evidence base of the factors that would influence the perceptions of fairness of, and confidence in, the adjudication process by people who share relevant protected characteristics. Most of the research that we found focused on the experiences of diverse groups of people in attempting to access the criminal justice system, or their representation within those procedures.

“There is a distinct scarcity of robust, well-analysed data on what the general public thinks about civil and family courts and tribunals and what underlies those perceptions ... The evidence that exists suggests that outcomes, and the perceived fairness of those outcomes; attitudes and contextual issues (such as attitudes to crime and the quality of the court environment and support); and participant judgements about the fairness of court or tribunal process all have an independent relationship with (and so may ‘drive’) public and participant satisfaction with courts and tribunals. The evidence on whether demographic characteristics have an independent influence is more mixed.”

“Finally, all users were asked whether there was anything that could be done to increase their confidence in the tribunal system. Just under one-third (31%) said that there was, a little over half (56%) thought that there was nothing that could be done to increase confidence, and 13% could not say whether or not anything could be done to increase confidence. Interestingly, the responses to this question were completely unrelated to the outcome of the tribunal hearing so that almost identical proportions of successful and unsuccessful users felt that there were or were not things that could be done to improve confidence.

---

Similarly there was no difference between tribunals in the extent to which users felt that there were things that could be done to improve confidence.\footnote{Tribunals for diverse users. (Department for Constitutional Affairs Research Series 1/06, London 2006) — Genn, H., Lever, B., Gray, L. and others}

29. According to a report\footnote{As above} from the Department for Constitutional Affairs, among those who felt that there were things that could be done to improve confidence, the most common measures mentioned were better access to advice and representation, better information about the tribunal and what to expect at the hearing, improvement in panel composition or panel behaviour, and improvement in tribunal procedure. A handful of users mentioned improvements to tribunal facilities.

30. In relation to complainants within our fitness to practise procedures, we record whether a complainant is a person acting in a public capacity (e.g. employers of doctors, other regulators, and the police) or a member of the public.

31. In relation to members of the public our online complaints form asks complainants to provide equality and diversity data. However, completion of this part of the form is low. As a result we hold very little equality and diversity data about complainants and not enough to produce any meaningful feedback about trends.

32. As mentioned above, we intend to undertake a survey of complainants who have been involved in our fitness to practise procedures later this year and on a periodic basis to get feedback about their experiences. During this process we will seek to gather better equality and diversity information.

33. We will also review our collection and recording of complainant and witness information to see if we can encourage greater collection and analysis of complainant information within our fitness to practise process.

34. In 2009, we undertook a review of our provisions for witnesses in our fitness to practise procedures. As a result we have undertaken a programme of work to improve support for witnesses. This includes:

   a. updating our web-based and published information for witnesses;

   b. undertaking a witness mapping exercise to identify any gaps in our procedures where witnesses may be insufficiently supported;

   c. developing a needs assessment to identify any special communication needs that a witness may have. This is shortly to be piloted;

   d. amending our expenses policy for witnesses to provide improved reimbursement for witnesses with caring responsibilities or disabilities.

35. Last year we piloted a bespoke and confidential witness support service for any witness needing additional support while in our procedures. Following positive feedback from the pilot we have now implemented a full-time service.
36. We targeted groups representing the interests of complainants and witnesses (including those who share a protected characteristic) during our consultation on the future of adjudication. These groups included Victim Support, PohWER and the Independent Complaints Advocacy Service (ICAS) providers. We have had recent discussions with ICAS about working more closely together.

37. There are also some limitations to the data we hold about doctors. For example, our registration data records gender and time since qualification (as a proxy for age) but not information about religious belief, pregnancy and maternity, sexual orientation or gender reassignment. We also hold information about place of qualification. Over the last few years we have undertaken a data collection exercise and now have ethnicity data for just under 75% of doctors on the register. We are currently reviewing the data we collect from doctors through our registration process.

**Actions:**

- To undertake a survey of complainants and witnesses who have been involved in our fitness to practise procedures, and to gather more equality and diversity data on respondents.
- To review how we collect and record equality and diversity data on complainants and witnesses.

**Performance and audit data**

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

39. The most recent published annual statistics relate to 2009 and most data contained in this document are figures for 2009. 2010 figures will be published later this year. The main headlines which apply to each of the protected characteristics are identified in Annex A.

40. In 2007 the GMC commissioned King's College London to conduct an independent audit^7^ of decisions at the investigation stage. Although this report focussed on the investigation stage of our procedure, we think that it is relevant to this equality analysis, as this is the process by which a case reaches the adjudication stage. The audit did not find evidence of bias at the investigation stage, concluding that:

> "The audit findings demonstrate that at key decision points in the GMC’s fitness to practise procedures, cases are generally handled in a way that is transparent, consistent and appropriate in terms of the guidance and criteria provided by the GMC."

---

^7^ *External audit of decisions in the investigation stage of the GMC's fitness to practise cases* (King's College, London, July 2007)
41. We are also subject to periodic independent audits by the Council for Healthcare Regulatory Excellence (CHRE). The most recent audit of our fitness to practise procedures by CHRE in 2010\textsuperscript{8} found that our procedures are robust and reflect our guidance.

\textsuperscript{8} CHRE Performance Review Report 2009/10 (CHRE, July 2010)
2. Consultation and engagement

42. We targeted a range of people who share a protected characteristic (for example, BME doctors and doctors with health conditions, as part of our consultation activities.

43. Among respondents from groups with the protected characteristics of race, disability, sexual orientation and gender reassignment many thought the proposals would in general positively benefit both doctors and patients with protected characteristics by:
   a. through greater separation of function and by greater use of legally qualified Chairs; and
   b. minimising stress by reducing the length of hearings and removing the need for hearings in consensual review cases.

44. Only 38% of respondents answered specific questions about equality in the consultation. Of those, three quarters did not think that the proposals would positively advance equality of opportunity between people with protected characteristics, however, very few respondents identified specific points that they considered would have a potential negative impact.

45. One respondent commented that care would need to be taken to ensure that doctors understand what they are agreeing to under our proposals for consent in review cases. We propose that our implementation plans should include ensuring that information is delivered in accessible formats and that there is sufficient time within the process to enable a doctor to discuss it with an adviser.

46. Three respondents thought that, while the majority of proposals support the equality aims, the proposals for legally qualified Chairs, removal of legal assessors and the involvement of Chairs in pre-hearing case management may not. That said, the majority of respondents from groups who share a relevant protected characteristic supported the introduction of legally qualified Chairs as increasing confidence in the adjudication process and they are widely used in other jurisdictions. The involvement of Chairs in the pre-hearing process is also widely used in other jurisdictions and the role does not involve consideration of substantive issues. Where legal assessors are not appointed we envisage that Chairs will ensure that unrepresented doctors understand what is expected.

47. Three respondents commented that a single hearing centre would have a negative impact on witnesses and doctors living in the South. At present we hold 70% of hearings in Manchester so doctors in the South are likely to have to travel to Manchester for a hearing in any case. Although, if there are particular travel obstacles for a doctor, we try to accommodate their hearing in London. In the wake of the consultation we have considered how we might mitigate any disadvantage for such doctors and/or witnesses (including complainants) and/or lawyers, if Council decides to proceed with a single hearing centre in Manchester. Our view is that we should mitigate any disadvantage, if Council decides to proceed, by expanding our rules to give panels a power to make greater use of video link facilities in appropriate cases (for example where the defence agree) although we recognise the limitations
of this approach. We also propose to explore the possibility of hiring venues to hold hearings in regional locations on an exceptional basis and to consider extending our witness support scheme to doctors and their witnesses.

48. Four respondents highlighted the need for panels to be as representative as possible. Our current policy is that, as far as practicable, panels should be diverse, with a minimum requirement of gender diversity. Posts are advertised in the national and medical press and we also take steps to ensure that posts are advertised in a number of diverse media targeted towards minority groups. Panellists are recruited against competencies and are required to show an awareness of equality and diversity issues. Those issues are also addressed in panellists’ training sessions. We use a managed model for empanelment that aims to deliver actual and visible diversity in the composition of panels, the results of which are regularly monitored. We propose to ensure that the MPTS has arrangements for continuing to ensure diversity of tribunals.

49. The Faculty of Occupation Medicine stated that where the health of a doctor is at risk, there should be an occupational health physician on the panel. However, the role of panellists is not to provide specialist expertise. In health cases, an expert will present evidence to the panel about the doctor’s health.

50. In response to a specific question about the likely impact the proposals would have on the confidence in our procedures of any particular groups, 41% (16) of those who answered the question, thought the proposals would have a positive impact on confidence while a further 15% (6) did not think that there would be any significant impact on public confidence. 18% (7) of respondents who answered this question thought that the package of proposals as a whole may have a negative impact on confidence in our procedures however these respondents either did not give reasons or the reasons they gave were not matters relating to equality. The remaining respondents who commented identified one or two individual proposals which they felt may have a negative impact:

a. 5 respondents felt that the proposal to move to a single hearing centre would negatively impact confidence amongst both doctors and witnesses and we have set out in detail above how we would mitigate any disadvantage for those in the South East if Council decides to proceed.

b. 1 respondent felt that the proposal to deal with review cases by consent would reduce transparency and public confidence in our procedures would be negatively impacted. It would be important that we publish the outcome of the review process and that these cases would be subject to our audit process to ensure quality of decision making.

c. 2 respondents (both panellists) felt that the proposal to introduce legally qualified Chairs would reduce confidence in the procedures. However respondents from protected groups were largely supportive of the introduction of legally qualified Chairs which are widely used in other jurisdictions.

d. A further 2 respondents (also panellists) felt that the proposal to deal with review cases by consent and the proposals to introduce legally qualified Chairs would reduce public confidence in our procedures. We will ensure that
information for doctors is accessible and easy to understand and there is time for the doctor to seek advice.

51. MENCAP commented generally that people with learning difficulties do not have confidence in our procedures and we propose to discuss this with them further to identify any specific difficulties.

52. Engagement with groups representing people with protected characteristics highlighted the need to ensure that:

a. decision making by the MPTS is fair and takes account of people who share a protected characteristic;

b. anyone acting on behalf of the MPTS is aware of their responsibilities under the Equality Act;

c. appointment to roles with the new tribunal is fair, open and transparent;

d. the make up of tribunals is diverse;

e. systems to monitor and report on equality and diversity issues are put in place by the MPTS;

f. systems for making reasonable adjustments are put in place by the MPTS;

g. guidance about what happens during a hearing continues to be made in accessible formats;

h. consideration is given to whether additional information is needed to support certain groups of people in navigating the process;

i. Tribunal Chairs and case managers have a role in explaining to unrepresented doctors what is expected of them at the pre-hearing stage and in making reasonable adjustments where necessary.

53. The organisations that we targeted as part of our engagement plan included the following:

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Representing the views of people who share which protected characteristic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients Association</td>
<td>All</td>
</tr>
<tr>
<td>National Voices</td>
<td>All</td>
</tr>
<tr>
<td>The Carers Federation</td>
<td>All</td>
</tr>
<tr>
<td>Medical Women’s Federation</td>
<td>Sex</td>
</tr>
<tr>
<td>The British Association of Physicians of Indian Origin (BAPIO)</td>
<td>Race</td>
</tr>
<tr>
<td>The British International Doctors Association (BIDA)</td>
<td>Race</td>
</tr>
<tr>
<td>The BMA’s Staff and Associate Specialists Committee</td>
<td>Race, sex, age</td>
</tr>
<tr>
<td>The All British Pakistani Physicians Association</td>
<td>Race</td>
</tr>
<tr>
<td>Organization</td>
<td>Issue</td>
</tr>
<tr>
<td>------------------------------------------------------------------</td>
<td>------------------------------</td>
</tr>
<tr>
<td>The BMA’s Equal Opportunities Committee</td>
<td>All</td>
</tr>
<tr>
<td>The Indian Medical Association</td>
<td>Race</td>
</tr>
<tr>
<td>The Medical Association of Nigerian Specialists and General Practitioners in the UK (MANSAG)</td>
<td>Race</td>
</tr>
<tr>
<td>Sick Doctors Trust</td>
<td>Disability</td>
</tr>
<tr>
<td>Practitioner Health Programme</td>
<td>All</td>
</tr>
<tr>
<td>Gay and Lesbian Association of Doctors and Dentists (GLADD)</td>
<td>Sexual orientation</td>
</tr>
<tr>
<td>Stonewall</td>
<td>Sexual orientation</td>
</tr>
<tr>
<td>Lesbian and Gay Lawyers Association</td>
<td>Sexual orientation</td>
</tr>
<tr>
<td>The Gender Identity Research and Education Society</td>
<td>Gender reassignment</td>
</tr>
</tbody>
</table>

54. In the longer term we are currently developing plans to gather feedback on a regular basis from doctors and witnesses who have been through our fitness to practise procedures.
3. Equality analysis

55. An overview of the statistics and trends that we are aware of for each protected characteristic is attached at Annex A.

Proposal 1: Establishing the Medical Practitioners Tribunal Service

56. In the consultation we proposed to establish a new statutory body called the Medical Practitioners Tribunal Service (MPTS) that is recognisable as being operationally separate from the rest of the GMC.

57. We also proposed to place all aspects of operational management of adjudication under the control of the MPTS, which will further separate adjudication from the rest of our fitness to practise activities.

58. Our proposal is that 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 of case managers;
   d. the appointment and removal of tribunal members;
   e. the appointment of specialist advisers and the appointment, training and assessment of legal assessors; and
   f. the development of training, assessment and guidance for tribunal members.

Analysis

59. We have considered these proposals in light of the Equality Duty and each of the protected characteristics. The proposal to establish the Medical Practitioners Tribunal Service is designed to increase separation between our investigate and adjudication roles.

60. The main equality issues are likely to be ensuring that:

   a. decision-making by the new body is fair and takes account of the needs of people who share a protected characteristic;
   b. anyone acting on behalf of the MPTS (including staff, tribunal members, Chairs, specialist advisers and legal assessors) is aware of their legal responsibilities to carry out their roles in a manner that complies with the Equality Duty;
   c. appointment to roles with the MPTS reflects model good practice that we employ in all aspects of recruitment having due regard to the Equality Act and other relevant legislation and our own policy and procedures.
61. Putting the operation of our adjudication function in to the hands of a separate committee is designed to bolster the independence of panel decisions and reflects the good practice of other tribunals.

62. Groups representing BME doctors generally supported the proposal to establish the MPTS. Their key concern was the make-up of panels and the importance, in terms of perception, of encouraging diverse representation on panels. They also stressed the importance of effective performance management of panellists.

63. Our current policy is that, as far as practicable, panels should be diverse, with a minimum requirement of gender diversity. Posts are advertised in the national and medical press and we also take steps to ensure that posts are advertised in a number of diverse media targeted towards minority groups. Panellists are recruited against competencies and are required to show an awareness of equality and diversity issues. Those issues are also addressed in panellists’ training sessions. We propose to ensure that the MPTS has arrangements for continuing to ensure diversity of tribunals.

64. We propose to ensure that the MPTS has arrangements for continuing to ensure diversity of tribunals. Panellists are currently subject to 360 degree assessment every time they sit and we propose to discuss how performance management might be further strengthened with the Chair of the Shadow Committee once appointed.

65. A small number of individual BME doctors said they preferred a completely separate body to manage adjudication. A few of these cited concerns about the over-representation of international medical graduates in our procedures. However, research relating to this has shown that progression within our fitness to practise procedures is linked not to race, but to the fact that someone qualifies outside the UK (regardless of race (see paragraph 170).

66. Stonewall did not have a view on the creation of the MPTS but stressed the need to ensure that equality and diversity were central to the role of the MPTS, including training in equality and diversity issues, a fair and representative appointments process and raising awareness with MPTS members of equality and diversity legislation. The Gender Identity Research (GIRES) supported the creation of the MPTS, agreeing that increased separation between our investigation and our adjudication roles will increase confidence in the objectivity of our adjudication function.

67. The Multiple Sclerosis Society were supportive of the proposals to establish the MPTS.

68. We will ensure that the recruitment of the MPTS Chair and other members is based on a fair and transparent recruitment process. In addition, we will recommend that the MPTS ensures that decision-making is fair, transparent and non-discriminatory in the following ways:

   a. ensuring that recruitment of tribunal service members is based on clear selection criteria and competency based interviews, and that equality and
diversity data is collected, reviewed and analysed for each stage of the application, selection and recruitment process;

b. putting in place mandatory training to ensure that the Chair and tribunal service members are aware of their legal responsibilities in relation to equality and diversity, their role in ensuring that tribunal proceedings are compliant with the Equality Duty, and the issues relating to patients with protected characteristics that may arise during a hearing;

c. developing systems for monitoring and reporting on equality and diversity including tracking the decisions and outcomes for doctors with protected characteristics at each stage of its procedures;

d. putting in place systems to make reasonable adjustments for anyone involved in a hearing who has specific needs arising from a disability and adjustments to accommodate other needs arising from the protected characteristics where appropriate,

e. engages with interest groups and stakeholders representing people who share protected characteristics to enhance confidence in the work of the MPTS

Actions:

To ensure that the recruitment of the MPTS Chair is based on a fair and transparent recruitment process.

To take forward the actions identified in paragraphs 68.

To provide feedback to the Department of Health for use in future consultations on this issue.

Proposal 2: Creating strong leadership arrangements for the MPTS

69. The MPTS would need effective leadership to ensure that it manages adjudication work effectively and maintains a strong separate identity. Our proposals for creating strong leadership arrangements for the MPTS are designed to increase confidence in the decisions made by panels among all groups including protected groups.

70. In the consultation, we proposed that:

a. 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;

b. as well as an established reputation for leadership, the Chair should be legally qualified and have significant judicial or tribunal service experience;
c. the Chair should be supported by two active panel members (drawn from the existing pool of panel members) on the Governance Committee of the MPTS; and

d. 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.

Analysis

71. We have considered these proposals in the light of the three aims of the Equality Duty and each of the protected characteristics. Taking all the proposals together, the main equality issues are likely to be in the appointment of the Chair and panel members. The responses received to our consultation support that view with respondents confirming that the establishment of strong leadership along the lines proposed is likely to increase confidence in our adjudication process among people who share protected characteristics.

72. The key concern of groups representing BME doctors was the make-up of panels and the importance of encouraging diversity.

73. GMC policy is that panels should, as far as practicable be diverse, with a minimum requirement of gender and ethnic diversity. There is no evidence that certain groups make fairer decisions than others but we believe maintaining diverse panels is important in terms of perception and, this position was supported by BME groups during our consultation. There are also benefits in terms of advancing equality of opportunity for individuals who share protected characteristics who may wish to apply to be panellists.

74. Stonewall supported our proposals for leadership of the MPTS and stressed that leadership responsibilities should include equality and diversity issues. GIRES also supported our proposals for leadership and stressed that the Chair should be legally qualified and have significant judicial and tribunal experience. GIRES thought that panel members should have similar experience, preferably in a medical field, and stressed the need for the MPTS to provide equality and diversity guidance and training for members to include transgender issues.

75. Individual BME doctors who responded were keen that the Chair and board members should have legal qualifications and experience.

76. The Multiple Sclerosis Society supported our proposals and suggested that there should be an external member on the Governance Committee and highlighted leadership as a key skill for the Chair and other members.

77. We have proposed that MPTS board members be recruited from the current pool of fitness to practise panellists.

78. Our current policy is, as far as practicable, panels should be diverse, with a minimum requirement of gender diversity. We use a managed model for empanelment that aims to deliver actual and visible diversity in the composition of panels, the results of which are regularly monitored.
The diversity profile of this group of people is shown in the table below. We currently collect diversity data on panellists in terms of age, disability, race, and sex. We experience difficulty recruiting younger medical panellists as junior doctors find it difficult to commit the necessary time requirement. Although the split between male and female lay panellists is generally equal, we have less female medical panellists which tends to reflect the breakdown by gender on the register among older doctors. We are currently recruiting panellists and hope to attract some younger applicants and contacted the Medical Women’s Federation to ensure the adverts were accessible to younger female medical applicants.

Posts are advertised in the national and medical press and we also take steps to ensure that posts are advertised in a number of diverse media targeted towards minority groups. Recruitment of panellists reflects model good practice that we employ in all aspects of recruitment having due regard to the Equality Act and other relevant legislation and our own policy and procedures Panellists are recruited against competencies and are required to show an awareness of equality and diversity issues.

We use a managed model for empanelment that aims to deliver actual and visible diversity in the composition of panels, the results of which are regularly monitored.

FtP panellists as at 16 May 2011

<table>
<thead>
<tr>
<th>Protected characteristic</th>
<th>Number of panellists</th>
<th>% of the total pool</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>208</td>
<td>66.4%</td>
</tr>
<tr>
<td>Female</td>
<td>106</td>
<td>33.8%</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 35 years</td>
<td>1</td>
<td>0.3%</td>
</tr>
<tr>
<td>36-44 years</td>
<td>19</td>
<td>6%</td>
</tr>
<tr>
<td>46-55 years</td>
<td>63</td>
<td>20%</td>
</tr>
<tr>
<td>56-65 years</td>
<td>137</td>
<td>44%</td>
</tr>
<tr>
<td>Over 66</td>
<td>93</td>
<td>30%</td>
</tr>
<tr>
<td>Unspecified age</td>
<td>1</td>
<td>0.3%</td>
</tr>
<tr>
<td>Disability</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Declare a disability</td>
<td>23</td>
<td>7%</td>
</tr>
<tr>
<td>No disability</td>
<td>291</td>
<td>93%</td>
</tr>
<tr>
<td>Race</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Black and minority ethnic background</td>
<td>67</td>
<td>21%</td>
</tr>
<tr>
<td>White</td>
<td>247</td>
<td>79%</td>
</tr>
<tr>
<td>Total</td>
<td>314</td>
<td>100%</td>
</tr>
</tbody>
</table>
Action: To provide feedback to the Department of Health for use in future consultations on this issue.

Proposal 3: Ensuring accountability and independence for the MPTS

82. We consulted on the following proposals to provide assurance that the MPTS is operating effectively and that its tribunals are independent:

   a. The MPTS to be established as a statutory committee of the GMC.

   b. The MPTS to be required to report via the Privy Council to Parliament on an annual basis.

   c. The MPTS to be required to report to the Council of the GMC twice a year on its operations.

83. Setting up the MPTS as a statutory committee of the GMC and the reporting arrangements to Parliament via the Privy Council are designed to bolster the separation between our investigation and adjudication functions and bolster the independence of decisions made by panels among all groups including people with protected characteristics. They would require amendments to primary legislation and further consultation by the Department of Health on more detailed proposals. We will provide feedback to the Department of Health for use in future consultations on this issue.

84. The Department of Health will no doubt take account of the views of people with protected characteristics in that further consultation process.

Analysis

85. We have considered these proposals in light of the three aims of the Duty and the protected characteristics.

86. Mencap were supportive of proposals for the MPTS to report via the Privy Council to Parliament on an annual basis as a means of increasing confidence in the process and suggested that such a report should include data on those involved in our proceedings with a learning disability. The Multiple Sclerosis Society also supported these proposals and believed they would increase confidence.

87. GiRES supported proposals for the MPTS to be established as a statutory committee to give greater assurance of the independence of panel decisions.

88. A small number of individual BME doctors said they preferred a completely separate body to manage adjudication. A few of these cited concerns about the over-representation of international medical graduates in our procedures. However, research relating to this has shown that progression within our fitness to practise procedures is linked not to race, but to the fact that someone qualifies outside the UK (regardless of race (see paragraph 170).
89. The main equality and diversity issues in these proposals are likely to be ensuring that reporting is transparent and identifies any trends and significant issues for people who share protected characteristics. We will address this in the following ways:

   a. Requiring the MPTS to include trends for those who share a protected characteristic in its reporting to GMC Council.

   b. Publishing an annual summary of the key equality and diversity information from MPTS reports.

**Actions:**

To take forward the actions identified in paragraph 89.

To provide feedback to the Department of Health for use in future consultations on this issue.

**Proposal 4: Establishing effective liaison between the MPTS and the GMC**

90. In the consultation we proposed to establish a joint forum to facilitate the effective management of fitness to practise cases.

91. The forum will include the Chairs of the GMC and the MPTS. The Multiple Sclerosis Society supported our proposals.

92. There was support for our proposals for liaison with the MPTS from the majority of respondents (53%), although representatives of groups sharing protected characteristics did not comment specifically on this proposal.

93. A small number of individual BME doctors said they preferred a completely separate body to manage adjudication. A few of these cited concerns about the over-representation of international medical graduates in our procedures. However, research relating to this has shown that progression within our fitness to practise procedures is linked not to race, but to the fact that someone qualifies outside the UK (regardless of race (see paragraph 170).

**Proposal 5: Introducing a right of appeal for the GMC**

94. We also consulted on our proposal to introduce a right of appeal for the GMC to the High Court or Court of Session in Scotland against a decision reached by a medical practitioner tribunal. Our view is that this would be needed to reflect the clearer separation of our investigation and adjudication work, and help create a clear identity for the MPTS. This is designed to bolster public protection by enabling us to challenge unduly lenient decisions and to increase confidence in the separation between our investigation and adjudication roles among all groups including those with protected characteristics.

95. Such a change would require further investigation with the Department of Health and through them with the Ministry of Justice. We would also propose to discuss it further with the Council for Healthcare Regulatory Excellence (CHRE), an
umbrella body that oversees the work of the nine regulatory bodies that set standards for training and conduct of health professionals. We also propose to provide feedback to the Department of Health for use in future consultations on this issue.

96. Groups representing BME doctors were generally supportive of proposals for the GMC to have a right of appeal against panel decisions. There were mixed views amongst individual BME doctors who responded regarding the right of appeal for the GMC with some supporting the proposal while others expressed concern about the cost of such proceedings and pointing to the existing powers of CHRE to appeal decisions of any of the healthcare regulators which they consider to be unduly lenient.

97. The Multiple Sclerosis Society supported this proposal.

**Actions:**

To investigate further with the Department of Health and through them with the Ministry of Justice.

To provide feedback to the Department of Health for use in future consultations on this issue.

**Proposal 6: Enhanced pre-hearing case management arrangements**

98. 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. Currently case management is governed by rule 16 of our Fitness to Practise Rules 2004.

99. In the consultation, we proposed to introduce more active and rigorous case management. This would include:

a. Involving Chairs of tribunals in pre-hearing case management.

b. Making provision for case management hearings to deal with procedural or administrative matters where Chairs are involved in the pre-hearing stage,

c. A power for medical practitioner tribunals to be able to exclude evidence which is sought to be introduced in breach of pre-hearing directions without good reason.

100. Enhancing pre-hearing case management to deal more efficiently with preliminary legal matters will help to reduce the length of hearings and the number of hearings which are adjourned by resolving these matters at an earlier stage. It should also improve compliance with pre-hearing directions. This will enable more accurate timetabling of hearings and a narrowing of the issues earlier on in the process, rather than at the actual hearing. The overall effect should be to make the hearings process more effective and reduce the length of hearings.
Analysis

101. We have considered the proposals to make pre-hearing case management more streamlined and effective in light of the aims of the Equality Duty. The proposals are designed to make hearings more efficient and effective and reduce their length. This is designed to improve the experience for all involved in hearings including people who share a protected characteristic. A key equality consideration is likely to be whether certain groups of people who share protected characteristics would find it difficult to understand or navigate an enhanced pre-hearing process.

102. Doctors with health conditions (some of which would classify as disabilities under the legal definition\(^9\)) who had been through our consultation process, expressed strong support for these proposals. Their experience was that delays and inefficiencies made the proceedings more stressful and they welcomed moves that will make pre-hearing arrangements more efficient and robust and, ultimately, would make hearings shorter and avoid cases going part heard.

103. The Multiple Sclerosis Society supported these proposals and suggested that any Chair should be able to make pre-hearing binding decisions and not just the Chair who will ultimately hear the case.

104. A small number of individual BME doctors said they preferred a completely separate body to manage adjudication. A few of these cited concerns about the over-representation of international medical graduates in our procedures. However, research relating to this has shown that progression within our fitness to practise procedures is linked not to race, but to the fact that someone qualifies outside the UK (regardless of race (see paragraph 170).

105. Groups representing BME doctors supported our proposals to introduce more robust pre-hearing case management arrangements. They were concerned that many unrepresented doctors may be international medical graduates and stressed that unrepresented doctors may struggle to navigate pre-hearing arrangements. They were supportive of a role for the case manager in explaining to unrepresented doctors what is expected of them.

106. GIRES also supported the introduction of more robust pre-hearing case management and stressed the need for parties to be able to appeal against proposed directions at the pre-hearing stage.

107. We will therefore recommend to the MPTS that it takes steps to ensure that:

a. guidance about what happens during a hearing continues to be made available in accessible and user-friendly formats;

\(^9\) Under the Equality Act 2010, a person has a disability if they have a physical or mental impairment that has a substantial and long-term adverse effect on their ability to carry out normal day to day activities.
b. consideration be given to whether certain groups of people (for example, doctors without legal representation may need additional information and support to understand the process and what is expected of them;

c. tribunal Chairs or case managers have a role in explaining the process and what is expected at the pre-hearing stage, including how parties can make representations in relation to pre-hearing directions, and assessing whether any reasonable adjustments are needed in individual cases.

Actions:

To make the recommendations identified in paragraph 107 to the MPTS.

To target people who share relevant protected characteristics in future consultations on Rule changes.

Proposal 7: Introducing legally qualified Chairs

108. At present 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). The Medical Act 1983 requires a legal assessor to sit with each panel to advise on points of law. We do not require Chairs of panels to be legally qualified although a small number are.

109. We propose to introduce legally qualified Chairs in some or all cases. If a legally qualified Chair were appointed, our provisional view is that a legal assessor would no longer be required in that case.

Analysis

110. We have reviewed our proposal to introduce legally qualified Chairs in light of the three aims of the Equality Duty. Legislative change and further consultation would be required to support this proposal, for example, to remove the requirement for a legal assessor. The main equality considerations are likely to be:

a. ensuring that recruitment of legally qualified Chairs reflects the model good practice that we employ in all aspects of recruitment having due regard to the Equality Act and other relevant legislation and our own policy and procedures;

b. whether, in the absence of legal assessors, legally qualified Chairs manage the hearings process more effectively thereby increasing confidence in the process for people with protected characteristics;

c. whether legally qualified Chairs are able to explain the process to unrepresented doctors where necessary without undermining their impartiality. This is a role routinely undertaken by judges in the court process.

111. There was support for greater use of legally qualified Chairs among groups representing BME doctors. Individual BME doctors who responded were
unanimously in support of the use of legally qualified Chairs with a slight majority favouring the use of legally qualified Chairs in all cases.

112. GIRES also supported the introduction of legally qualified Chairs on a case by case basis and stressed the importance of the role of the legal assessor in providing information to unrepresented doctors in some cases.

113. Doctors with health conditions who we spoke to during the consultation process were divided on whether legally qualified Chairs would improve confidence in the process, with some favouring legally qualified Chairs as having a better understanding of matters of due process and therefore better able to manage hearings and others feeling that this would make the process more legal which they saw as an unhelpful trend. The Multiple Sclerosis Society was also unconvinced that the evidence to support legal Chairs was compelling, citing competence and effectiveness in managing cases as more important skills.

114. We agree that effectiveness in managing cases is a key skill for Chairs and would expect legally qualified Chairs to also demonstrate competence in managing cases. Despite individual concerns, more respondents from protected groups supported the proposals than not and it is a model widely used in other jurisdictions.

Actions:

To recommend to the MPTS Chair that the process for recruitment of legally qualified Chairs reflects model good practice that we employ in all aspects of recruitment having due regard to the Equality Act and other relevant legislation and our own policy and procedures;

Proposal 8: Consent in review cases

115. Review hearings form a significant proportion of fitness to practise panel hearings. Under the current provisions of the Medical Act 1983, all review decisions must be taken by fitness to practise panels, 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.

116. In the consultation we proposed 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. A hearing would be required only in cases where there is a dispute between the doctor and the GMC. We believe that this would bring benefits for all those involved in review hearings, including those who share a protected characteristic, by removing the need to attend a hearing and by streamlining and reducing the length of the review process.

Analysis

117. We have reviewed these proposals in light of the aims of the Equality Duty and the protected characteristics. The main equality consideration is likely to be whether removing the need for a hearing will have an impact on groups of doctors who share protected characteristics.
118. We know that many review hearings concern doctors who have been in our fitness to practise procedures for years, for example where their fitness to practise is impaired by reason of poor health. This includes doctors with certain types of mental health conditions which are classed as disabilities.

119. Our engagement during the consultation process with doctors with health conditions who had been through our procedures suggested that they may experience higher levels of stress during proceedings, particularly where they have mental health conditions, and that removing the need for a hearing in consent cases, while reducing stress for all doctors, may be particularly beneficial for this group.

120. Individual BME doctors were unanimous in the view that a power to vary or revoke review orders should be exercisable by the Chair rather than the Registrar. The Multiple Sclerosis Society shared this view.

121. GIRES supported the proposal and also preferred the power be exercised by the Chair of the panel rather than the Registrar.

122. MENCAP preferred to retain public hearings in all cases believing a move away from public hearings will undermine confidence in the process. This view was not generally shared by protected groups but we will ensure information for doctors at the review stage is accessible and easy to understand and that decision makers are trained to consider any special requirements and the need to make reasonable adjustments where necessary.

**Actions:**

- To provide feedback to the Department of Health for use in future consultations on this issue.
- To ensure information for doctors is accessible and easy to understand.
- To ensure decision makers are trained to consider any special requirements and to make reasonable adjustments where necessary.

**Proposal 9: A single centralised hearing centre**

123. In the consultation we proposed to move to a single site hearing centre, centralising our adjudication work in Manchester. This would generate approximately £1.8 million each year in savings, and would also reinforce the separation between our investigation and adjudication work.

124. The GMC currently operates two hearing centres in London and Manchester. The operational costs of the London centre are significantly higher. 70% of all hearings already take place in Manchester.

**Analysis**

125. At present we hold 70% of hearings in Manchester so doctors in the South East are likely to have to travel to Manchester for a hearing in any case. That said, if
there are particular travel obstacles for a doctor, we try to accommodate their hearing in London.

126. Doctors with health conditions that we spoke to during the consultation expressed concerns about these proposals. These doctors were located nearer to London and were concerned that the additional travel would make the process more stressful and make it more difficult for them to bring someone to support them at the hearing.

127. The Multiple Sclerosis Society and GIRES supported the proposals for a single hearing centre.

128. Individual BME doctors who responded to the consultation had mixed views with some expressing support and others not supporting the proposal on the basis that some doctors in the South East may find travelling to hearings in Manchester more difficult.

129. In the wake of the consultation we have considered how we might mitigate any disadvantage for such doctors and/or witnesses (including complainants) and/or lawyers, if Council decides to proceed with a single hearing centre in Manchester. Our view is that we should consider expanding our rules to give panels a power to make greater use of video link facilities in appropriate cases for witnesses who do not fall within the definition of a vulnerable witness where the defence agrees although we recognise the limitations of this approach.

130. We also propose to explore the possibility of hiring venues to hold hearings in regional locations on an exceptional basis. We believe that these adjustments will go a long way towards addressing concerns. We would also be willing to consider taking reasonable additional steps in particular, as mentioned above, extending our witness support scheme to doctors and doctors with health problems we spoke to during the consultation supported this suggestion.

131. A move to a single hearing centre may also affect fitness to practise panellists who share protected characteristics. As 70% of hearings are already held in Manchester, panellists are currently required to travel to Manchester for the majority of hearings. In our current recruitment round for panellists we are focusing on recruitment in the Manchester area while continuing to focus on achieving diversity within the pool of panellists including maintaining a four country perspective.

Actions:

To explore extending our witness support service to doctors and their witnesses.

To consider expanding our rules to give panels a power to make greater use of videolink evidence.

To explore the possibility of hiring venues in regional locations on an exceptional basis.
Proposal 10: Additional efficiencies in the hearing process

132. We are proposing to explore other opportunities to make the procedures more efficient, for example by:
   
a. removing the requirement for a panel secretary to read out the allegations at the start of a hearing;
   
b. accepting witness statements as evidence-in-chief in line with other jurisdictions.

Analysis

133. These changes are designed to streamline the hearings process for the benefit of all involved including those who share a protected characteristic. They are designed to reduce the amount of time spent by witnesses giving oral evidence and to reduce the length of hearings. This is likely to reduce stress for all involved, particularly vulnerable witnesses.

134. They would require a change to our rules and further consultation.

135. Where this creates barriers for individuals involved in hearings, we would make reasonable adjustments as appropriate in the individual circumstances and it will be important to ensure that the MPTS also takes this approach. We will discuss this with the Chair of the MPTS once appointed.

136. Groups representing BME doctors were supportive of proposals for greater use of written evidence. Few individual BME doctors commented on this proposal but those that did were also supportive.

137. Those representing BME doctors have expressed general concerns that a greater percentage of international medical graduates may be unrepresented than UK graduates. We envisage a role for Chairs and case managers in ensuring unrepresented doctors understand what is expected and making reasonable adjustments where necessary.

138. Doctors with health conditions who we spoke to during the consultation process welcomed measures to reduce the length of hearings and, in particular, to rely on written evidence in chief. The proposals were also supported by the Multiple Sclerosis Society and GIRES. GIRES suggested they could be available on a case by case basis.

Action:

To target people who share relevant protected characteristics in future consultations on Rule changes.

To discuss with the Chair of the Shadow Committee, once appointed, the need for there to be arrangements in place to make reasonable adjustments to address barriers for those involved in hearings.
4. Monitoring and review

139. A number of the initiatives contained in the consultation will require an amendment to the Medical Act. These would be enacted through a Section 60 Order. As such, if we decide to proceed, we will be constrained by the legislation reform process which is expected to take approximately 2 years.

140. Our Adjudication Reform project will support Strategic Aim Two of the 2011 Business Plan which includes that we will continue to review our fitness to practise procedures to ensure our processes remain proportionate, efficient and fit for purpose.

141. The GMC Adjudication Reform Project Board will be made aware of the requirements of the Equality Duty, and the obligation to comply with the Duty in their decision-making, reviewing performance and ensuring good governance of the project.

142. The requirements of the Equality Duty and people who share protected characteristics will be considered throughout the lifecycle of the project, including implementation and evaluation. If we decide to proceed the project would involve six main areas of work:

a. Implementing revised governance arrangements.

b. Establishing tribunal infrastructure, including changes to the existing management structure.

c. Issues relating to panellists and other associates.

d. Issues relating to the location of hearings.

e. Reforming adjudication.

f. Communication, consultation and legislation.

143. We will review and update this equality analysis in light of further feedback received, and at 6 monthly intervals afterwards.

Actions:

To make the Adjudication Reform Project Board aware of the requirements of the Equality Duty and what it means for their work.

To consider the Equality Duty and the needs of people who share protected characteristics throughout the lifecycle of the Adjudication Reform project.

To review and update this equality analysis at 6 monthly intervals.
To ensure that future work including amendments to our Rules and primary legislation targets and takes into account feedback from people who share protected characteristics.

Sign off:

<table>
<thead>
<tr>
<th>Equality Analysis lead</th>
<th>Anna Rowland, Assistant Director, Policy and Planning</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Email: <a href="mailto:arowland@gmc-uk.org">arowland@gmc-uk.org</a></td>
</tr>
<tr>
<td>Directorate</td>
<td>Standards and Fitness to Practise</td>
</tr>
<tr>
<td>Director</td>
<td>Paul Philip, Deputy Chief Executive</td>
</tr>
<tr>
<td>Date completed</td>
<td>13 July 2011</td>
</tr>
<tr>
<td>Date for review</td>
<td>13 January 2012</td>
</tr>
<tr>
<td>Version</td>
<td>10.0</td>
</tr>
</tbody>
</table>
Annex A. Key facts for each protected characteristic

144. As stated previously, alongside consultation and direct engagement exercises, we conducted desktop research to build our evidence base of the factors that would influence the perceptions of fairness of, and confidence in, the adjudication process by people who share relevant protected characteristics. Most of the research that we found focused on the experiences of diverse groups of people in attempting to access the criminal justice system, or their representation within those procedures.

Age

145. We do not currently have reliable information about the age of doctors in our fitness to practise procedures, but we have a fairly robust proxy for age in terms of time since qualification (“TSQ”).

146. Doctors who have been qualified for 40-50 years are slightly more likely than other groups to be referred for a hearing and to be suspended or erased from the register than other TSQ groups of doctors.

<table>
<thead>
<tr>
<th>Time since qualification</th>
<th>No referred to a hearing</th>
<th>Suspended</th>
<th>Erased</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 1 year</td>
<td>2 (7%)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>1-10 years</td>
<td>24 (19%)</td>
<td>10 (32%)</td>
<td>6 (19%)</td>
</tr>
<tr>
<td>10-20 years</td>
<td>65 (21%)</td>
<td>13 (22%)</td>
<td>14 (23%)</td>
</tr>
<tr>
<td>20-30 years</td>
<td>91 (20%)</td>
<td>18 (30%)</td>
<td>12 (22%)</td>
</tr>
<tr>
<td>30-40 years</td>
<td>66 (22%)</td>
<td>17 (24%)</td>
<td>18 (26%)</td>
</tr>
<tr>
<td>40-50 years</td>
<td>18 (24%)</td>
<td>7 (32%)</td>
<td>8 (36%)</td>
</tr>
</tbody>
</table>

147. Research commissioned jointly with the Economic and Social Research Council (ESRC)\(^\text{10}\) carried out a multivariate analysis and examined the specific factors associated with the progression of a case within our fitness to practise procedures. The researchers found that the key factor leading to more serious outcomes in our procedures is nature and seriousness of the allegation and that time since qualification is not independently linked to more serious outcomes.

\(^{10}\) C. Humphrey et al — *Clarifying the factors associated with progression of cases in the GMC’s Fitness to Practise process* (ESRC End of Award Report, RES-153-25-0101, 2009)
148. Allegations arising in this group are primarily professional competence issues rather than probity issues. It is not clear at this stage why doctors in this TSQ group are more likely to be subject to more serious allegations in relation to professional performance and we propose to undertake more analysis of our data to examine this.

149. We targeted people who shared the protected characteristic of age in our consultation on the future of adjudication and no concerns were raised about the impact on this group.

150. The GMC has policies to ensure compliance with the Equality Act. For example, we employ model good practice in all aspects of recruitment having due regard to the Equality Act and other relevant legislation and our own policy and procedures. We will ensure that the MPTS has a similar approach.

Disability

151. Under the Equality Act 2010, a disabled person does not have to disclose a disability. The GMC does not currently monitor doctors on the register by disability. We are currently reviewing the data we collect from doctors though our registration process.

152. When a doctor is referred into our fitness to practise procedures, the concerns may relate to their professional performance, their conduct, their health or a combination of these factors. Concerns about professional performance or conduct may be caused by an underlying health problem.

153. 55 of the 270 doctors (20%) who appeared before fitness to practise panels in 2009 had allegations of impairment arising from a health condition. The conditions largely related to substance dependence however a significant proportion also related to conditions classified as disabilities under the legislation\(^\text{11}\), including affective disorders, neuroses, schizophrenia or personality disorders.

154. 32 doctors who appeared before a fitness to practise panel in 2009 had these health conditions. Of those, 9 doctors (28%) received a high impact outcome (suspension or erasure) compared with 54% of all doctors who appeared before panels. These doctors are significantly under-represented in terms of receiving a suspension or erasure outcome at a hearing. This may be as a result of our approach to health cases where our rules provide that panels cannot erase a doctor where the concerns relate solely to health. We try to deal with health cases by way of voluntary undertakings, where this is appropriate and sufficient to protect the public.

\(^\text{11}\) Under the Equality Act 2010, a person has a disability if they have a physical or mental impairment that has a substantial and long-term adverse effect on their ability to carry out normal day to day activities.
155. There may also be doctors with disabilities where the fitness to practise concerns which have been raised do not arise from their disability. Our assessment of the hearing centre in Manchester is that it is as accessible via public transport from a main line hub station (Manchester Piccadilly) as the London hearing centre is (from London Euston). There is also stair free access, a hearing loop in the hearing rooms and staff can be made available to provide additional support.

156. We ensure that reasonable adjustments are made where needed. We have facilities for the use of video link evidence for vulnerable witnesses and we also ensure that case management guidance and information is available in accessible formats on request and will ensure the MPTS has similar arrangements.

**Witnesses and complainants**

157. We are in the process of introducing a witness need assessment to enable us to better assess the needs of witnesses, particularly disabled witnesses. We have recently amended our expenses policy to provide appropriate recompense for travel expenses incurred in getting to and from hearings.

158. Feedback from an evaluation of a pilot for our witness support project included comments that the experience of giving evidence at a hearing was very stressful and proposals to reduce the number and length of hearings should reduce stress accordingly, particularly for vulnerable witnesses who may have physical disabilities or be victims of sexual assault.

159. The GMC has policies to ensure compliance with the Equality Act for example, we employ model good practice in all aspects of recruitment having due regard to the Equality Act and other relevant legislation and our own policy and procedures. We will ensure that the MPTS has a similar approach.

**Gender reassignment**

160. There is little information available on doctors, witnesses or complainants who have had gender reassignment surgery. The British Medical Association (BMA) attempted to interview these doctors for a report on the barriers for diverse groups of people in medicine\(^\text{12}\), but none of the doctors who share this protected characteristic took up their offer to be involved in the project.

161. The GMC does not collect information on doctors on the register who identify themselves as having undergone gender reassignment. We also do not have evidence of individuals who have undergone gender reassignment within the adjudication stage of our procedures. We are currently reviewing the data we collect from doctors through our registration process and will seek to obtain better data. We are also reviewing our data collection for complainants and witnesses.

\(^{12}\) *Career barriers in medicine: doctors’ experiences* (BMA, June 2004)
162. We invited GIRES to comment on our proposals as part of the consultation. Their detailed feedback is contained throughout this analysis and they were generally supportive of the proposals.

163. The GMC has policies to ensure compliance with the Equality Act for example, we employ model good practice in all aspects of recruitment having due regard to the Equality Act and other relevant legislation and our own policy and procedures. We will ensure that the MPTS has a similar approach.

**Maternity and pregnancy**

164. We do not collect information on whether people involved in our fitness to practise procedures share this protected characteristic. We are currently reviewing the data we collect from doctors through our registration process and will seek to obtain better data. We are also reviewing the data collection for complainants and witnesses.

165. The consultation and engagement did not identify any particular concerns relating to people who share this protected characteristic.

166. The GMC has policies to ensure compliance with the Equality Act for example, we employ model good practice in all aspects of recruitment having due regard to the Equality Act and other relevant legislation and our own policy and procedures. We will ensure that the MPTS has a similar approach.

**Race**

167. We currently hold ethnicity data for just under 75% of doctors with current registration on the register. 26% of doctors currently registered have declared that they are from a black and minority (BME) background.

168. In 2009, 28% of enquiries were about BME doctors and 32% of the doctors involved in hearings were from BME groups.

169. Building on previous research, which identified that international medical graduates were over-represented in our fitness to practise procedures, we commissioned research jointly with the ESRC which examined specific factors associated with the progression of a case within our fitness to practise procedures. The research looked at all cases between 1 April 2006 and 31 March 2008.

170. The research concluded that it is the fact that a doctor has qualified outside the UK (regardless of their ethnicity) rather than their ethnic status that is linked to more serious outcomes in our fitness to practise procedures. The research report\(^\text{13}\) states that:

\(^{13}\) C. Humphrey et al — *Clarifying the factors associated with progression of cases in the GMC’s Fitness to Practise process* (ESRC End of Award Report, RES-153-25-0101, 2009)
After adjusting for other doctor-related characteristics, we did not find an association at any stage between ethnicity and outcome among UK-qualified doctors.

Among non-UK qualified doctors in adjusted analyses outcomes were generally similar for those whose ethnicity was white or black and minority ethnic.

171. We tested whether our proposals will impact disproportionately on this group by consulting with a range of BME groups representing doctors including the BMA’s Equal Opportunities Committee, the GMC's BME Doctors Forum, the British Association of Physicians of Indian Origin (BAPIO), and the British International Doctors Association (BIDA). The comments we received are included throughout the equality analysis and were generally supportive of the proposals, in particular the establishment of the MPTS, greater use of legally qualified Chairs, more robust pre-hearing case management arrangements and greater use of written evidence.

172. We currently have policies that seek to maintain diverse panels and recruitment and employment policies that seek to advance equality of treatment and opportunity. We propose that the MPTS should also reflect this approach and in particular ensures that:

a. decision-making by the new body is fair and takes account of the needs of people who share a protected characteristic;

b. anyone acting on behalf of the new tribunal service (including staff, tribunal members, Chairs, specialist advisers and legal assessors) is aware of their legal responsibilities to carry out their roles in a manner that complies with the Equality Duty;

c. appointment to roles with the new tribunal service reflects model good practice we employ in all aspects of recruitment having due regard to the Equality Act and other relevant legislation and our own policy and procedures for example posts are widely advertised and are subject to robust quality assurance procedures.

173. We propose a role for Chairs in identifying needs and making reasonable adjustments where necessary for international medical graduates. Particularly if they are unrepresented or if English is not their first language, we propose a role for the case manager or Chair in ensuring they understand what is required.

174. The GMC has policies to ensure compliance with the Equality Act for example, we employ model good practice in all aspects of recruitment having due

---

14 Time since qualification, gender, specialty.
15 C. Humphrey et al — Place of medical qualification and outcomes of UK General Medical Council 'fitness to practise' process: cohort study (BMJ 2011;340:d1817)
regard to the Equality Act and other relevant legislation and our own policy and procedures. We will ensure that the MPTS has a similar approach.

**Religion or belief**

175. We do not currently hold any data in relation to the religion or belief of doctors, witnesses or complainants involved in our fitness to practise procedures. We are currently reviewing the data we collect from doctors through our registration process and will seek to obtain better data. We are also reviewing the data collection for complainants and witnesses.

176. The consultation and engagement did not identify any particular concerns relating to people who share this protected characteristic.

177. We currently seek to make reasonable adjustments to accommodate the religious observance of individuals involved in fitness to practise hearings and will recommend that the MPTS continues to do so.

178. The GMC has policies to ensure compliance with the Equality Act for example, we employ model good practice in all aspects of recruitment having due regard to the Equality Act and other relevant legislation and our own policy and procedures. We will ensure that the MPTS has a similar approach.

**Sex**

179. Our Fitness to Practise Statistics 2009 show that male doctors are proportionately more likely to be referred to a fitness to practise panel (22%) than female doctors (16%).

180. At the adjudication stage there were 270 hearings in 2009 of which 86% of the practitioners were male and 14% were female.

181. Male doctors appearing before a fitness to practise panel hearing were proportionately more likely to receive an erasure outcome (26%) than female doctors (16%).

182. We commissioned research jointly with the ESRC which examined specific factors associated with the progression of a case within our fitness to practise procedures. The research report published in 2010, found that when other characteristics of doctors were taken into account, such as time since qualification, specialty, seriousness of allegations, being male was independently associated with high impact outcomes at the earlier stages of our fitness to practise procedures but not at the adjudication stage. The reasons for this are not known but we are continuing to analyse our data to better understand key trends.

---

16 C. Humphrey et al — *Clarifying the factors associated with progression of cases in the GMC's Fitness to Practise process* (ESRC End of Award Report, RES-153-25-0101, 2009)
183. Proposals to reduce the number and length of hearings and the amount of oral evidence witnesses are required to give should reduce the stress for vulnerable witnesses who may be victims of a sexual assault, a significant proportion of whom are female.

184. The consultation and engagement did not identify any particular concerns relating to people who share this protected characteristic.

185. The GMC has policies to ensure compliance with the Equality Act for example, we employ model good practice in all aspects of recruitment having due regard to the Equality Act and other relevant legislation and our own policy and procedures. We will ensure that the MPTS has a similar approach.

**Sexual orientation**

186. We do not currently hold any data in relation to the sexual orientation of doctors, witnesses or complainants involved in our fitness to practise procedures. We are currently reviewing the data we collect from doctors through our registration process and will seek to obtain better data. We are also reviewing the data collection for complainants and witnesses.

187. We consulted Stonewall as part of our consultation process and they were generally supportive of the proposals subject to the MPTS having appropriate equality and diversity policies in place.

188. Our current Equality and Diversity Plan includes plans for greater engagement with lesbian, gay and bisexual groups to increase our understanding of the issues that may arise for this group.

189. The GMC has policies to ensure compliance with the Equality Act for example, we employ model good practice in all aspects of recruitment having due regard to the Equality Act and other relevant legislation and our own policy and procedures. We will ensure that the MPTS has a similar approach.
Annex B. List of organisations who responded to the consultation

Action against Medical Accidents (AvMA)
Administration Justice and Tribunals Council
Berrymans Lace Mawers LLP
British Medical Association
Care Quality Commission
Council for Healthcare Regulatory Excellence
Faculty of Occupational Medicine of the Royal College of Physicians
Gender Identity Research and Education Society
General Teaching Council
Independent Doctors Federation
Medical and Dental Defence Union of Scotland
Medical Defence Union
Medical Protection Society
Medical Womens Federation
MENCAP
Multiple Sclerosis Society
National Clinical Assessment Service
NHS Employers
Nursing and Midwifery Council
Public Health Wales, Primary Care Advisory team
Radcliffes Le Brasseur
Royal College of General Practitioners
Royal College of General Practitioners Wales Patients Participation Group
Royal College of Obstetricians and Gynaecologists
Royal College of Ophthalmologists
Royal College of Paediatrics and Child Health
Royal College of Physicians
Royal College of Physicians of Edinburgh
Royal College of Radiologists
Scottish Government Health Directorate
Stonewall
Western Health and Social Care Trust
<table>
<thead>
<tr>
<th>Proposal</th>
<th>Action</th>
<th>Protected characteristic</th>
<th>Lead</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Establishing the MPTS.</td>
<td>a. To undertake a survey of complainants and witnesses who have been involved in our fitness to practise procedures, and to gather more equality and diversity data on respondents.</td>
<td>All</td>
<td>FtP Policy/ Research</td>
<td>Delivered by December 2012</td>
</tr>
<tr>
<td></td>
<td>b. To review how we collect and record equality and diversity data on complainants and witnesses.</td>
<td>All</td>
<td>FtP Policy</td>
<td>By March 2011</td>
</tr>
<tr>
<td></td>
<td>c. Ensure that the recruitment of the MPTS Chair is based on a fair and transparent recruitment process.</td>
<td>All</td>
<td>HR</td>
<td>By December 2011</td>
</tr>
<tr>
<td></td>
<td>d. Recommend to the MPTS Chair that: - recruitment of tribunal service members is based on clear selection criteria and competency based interviews, and that equality and diversity data is collected, reviewed and analysed for each stage of the application, selection</td>
<td>All</td>
<td>Director of Fitness to Practise</td>
<td>By June 2012</td>
</tr>
<tr>
<td>and recruitment process.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------------------------</td>
<td>-------------------------------</td>
<td>----------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- put in place mandatory training to ensure that the Chair and tribunal service members are aware of their legal responsibilities in relation to equality and diversity, their role in ensuring that tribunal proceedings are compliant with the Equality Duty, and the issues relating to patients with protected characteristics that may be considered during a hearing.</td>
<td>All</td>
<td>Director of Fitness to Practise</td>
<td>By June 2012</td>
<td></td>
</tr>
<tr>
<td>- developing systems for monitoring and reporting on equality and diversity including tracking the decisions and outcomes for doctors with protected characteristics at each stage of its procedures.</td>
<td>All</td>
<td>Director of Fitness to Practise</td>
<td>By June 2012</td>
<td></td>
</tr>
<tr>
<td>- putting in place systems to make reasonable adjustments for anyone involved in a hearing who has specific needs arising from a disability and adjustments to accommodate other needs arising from the protected characteristics where appropriate.</td>
<td>All</td>
<td>Director of Fitness to Practise</td>
<td>By June 2012</td>
<td></td>
</tr>
<tr>
<td>- engages with interest groups and stakeholders representing people</td>
<td>All</td>
<td>Director of Fitness to Practise</td>
<td>By June 2012</td>
<td></td>
</tr>
<tr>
<td>Sequence</td>
<td>Description</td>
<td>Responsible Party</td>
<td>Timeframe</td>
<td></td>
</tr>
<tr>
<td>----------</td>
<td>------------------------------------------------------------------------------</td>
<td>-------------------</td>
<td>--------------------</td>
<td></td>
</tr>
<tr>
<td>1.</td>
<td>Practise who share protected characteristics to enhance confidence in the work of the MPTS.</td>
<td>Practise</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>To provide feedback to the Department of Health for use in future consultations on this issue.</td>
<td>All</td>
<td>FtP Policy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. Creating strong leadership arrangements for the MPTS.</td>
<td>All</td>
<td>HR</td>
<td></td>
</tr>
<tr>
<td></td>
<td>To provide feedback to the Department of Health for use in future consultations on this issue.</td>
<td>All</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>3. Ensuring accountability and independence for the MPTS.</td>
<td>All</td>
<td>FtP Policy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>a. Require the MPTS to include trends for doctors who share a protected characteristic in its reporting to the GMC.</td>
<td>Age, disability, race, sex</td>
<td>Director of Fitness to Practise</td>
<td></td>
</tr>
<tr>
<td></td>
<td>b. Publish an annual summary of the key equality and diversity information from the MPTS' reports to Council.</td>
<td>Age, disability, race, sex</td>
<td>Director of Fitness to Practise</td>
<td></td>
</tr>
<tr>
<td></td>
<td>c. To provide feedback to the Department of Health for use in future consultations on this issue.</td>
<td>All</td>
<td>FtP Policy</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>5. Introducing a right of appeal.</td>
<td>All</td>
<td>FtP Policy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>a. Further investigation with the Department of Health and through them with the Ministry of Justice</td>
<td>All</td>
<td>By December 2012</td>
<td></td>
</tr>
<tr>
<td></td>
<td>b. To provide feedback to the Department of Health for use in</td>
<td>All</td>
<td>FtP Policy</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>By March 2012</td>
<td></td>
</tr>
<tr>
<td>6. Enhanced pre-hearing case management.</td>
<td>a. To recommend to the MPTS that it takes steps to ensure that:</td>
<td>Disability, race</td>
<td>Director of Fitness to Practise</td>
<td>By March 2012</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td></td>
<td>- guidance about what happens during a hearing continues to be made available in accessible and user friendly formats</td>
<td>Disability, race</td>
<td>Director of Fitness to Practise</td>
<td>By March 2012</td>
</tr>
<tr>
<td></td>
<td>- consideration be given to whether certain groups of people (for example, doctors without legal representation, may need additional information and support to understand the process and what is expected of them</td>
<td>Disability, race</td>
<td>Director of Fitness to Practise</td>
<td>By March 2012</td>
</tr>
<tr>
<td></td>
<td>- tribunal Chairs or case managers have a role in explaining the process and what is expected at the pre hearing stage, including how parties can make representations in relation to pre-hearing directions, and assessing whether any reasonable adjustments are needed in individual cases.</td>
<td>Disability, race</td>
<td>Director of Fitness to Practise</td>
<td>By March 2012</td>
</tr>
<tr>
<td></td>
<td>b. To target people who share relevant protected characteristics in future consultation on Rule</td>
<td>Disability, race</td>
<td>FtP Policy</td>
<td>Ongoing to be completed by 2013</td>
</tr>
<tr>
<td></td>
<td>Changes.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td>7. Introducing legally qualified Chairs.</td>
<td>a. To recommend to the MPTS Chair that the process or recruitment of legally qualified Chairs reflects model good practice that we employ in all aspects of recruitment having due regard to the Equality Act and other relevant legislation and our own policy and procedures.</td>
<td>All</td>
<td>HR</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Ongoing to be completed by 201</td>
<td></td>
</tr>
<tr>
<td>8. Consent in review cases</td>
<td>a. To provide feedback to the Department of Health for use in future consultation on this issue.</td>
<td>All</td>
<td>FtP Policy</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>By March 2012</td>
<td></td>
</tr>
<tr>
<td></td>
<td>b. To ensure information for doctors is accessible and easy to understand.</td>
<td>All</td>
<td>FtP Policy</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>By 2013</td>
<td></td>
</tr>
<tr>
<td></td>
<td>c. To ensure decision makers are trained to consider any special requirements and to make reasonable adjustments where necessary,</td>
<td>All</td>
<td>FtP Policy</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>By 2013</td>
<td></td>
</tr>
<tr>
<td>9. A single centralised hearing centre.</td>
<td>a. To explore extending our witness support services to doctors and their witnesses.</td>
<td>All</td>
<td>FtP Policy</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>By December 2011</td>
<td></td>
</tr>
<tr>
<td></td>
<td>b. To consider expanding our rules to give panels a power to make</td>
<td>All</td>
<td>FtP Policy</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Ongoing to be</td>
<td></td>
</tr>
<tr>
<td>10. Additional efficiencies in the hearing process</td>
<td>a. To target people with relevant protected characteristics in future consultation on Rule changes.</td>
<td>All</td>
<td>FtP Policy</td>
<td>By March 2012</td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>---------------------------------------------------------------------------------</td>
<td>-----</td>
<td>-----------</td>
<td>--------------</td>
</tr>
<tr>
<td>b. To discuss with the MPTS Chair, once appointed, the need for there to be arrangements in place to make reasonable adjustments to address barriers for those involved in hearings.</td>
<td>All</td>
<td>FtP Policy/ E&amp;D</td>
<td>By March 2012</td>
<td></td>
</tr>
<tr>
<td>11. Monitoring and review</td>
<td>a. To make the Adjudication Reform Project Board aware of the requirements of the Equality Duty and what it means for their work.</td>
<td>All</td>
<td>FtP Policy/E&amp;D</td>
<td>September 2011</td>
</tr>
<tr>
<td>b. To consider the Equality Duty and the needs of people who share protected characteristics through the lifecycle of the Adjudication Reform Project</td>
<td>All</td>
<td>FtP Policy/ E&amp;D</td>
<td>Ongoing</td>
<td></td>
</tr>
<tr>
<td>c. To review and update this equality analysis at 6 monthly</td>
<td>All</td>
<td>FtP Policy/ E&amp;D</td>
<td>Ongoing</td>
<td></td>
</tr>
<tr>
<td>intervals.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. To ensure that future work including amendments to our Rules and primary legislation targets and takes into account feedback from people who share protected characteristics.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All</td>
<td>FtP Policy/ E&amp;D</td>
<td>Ongoing to be completed by 2013</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>