

Agenda item:	5
Report title:	Draft proposals to reduce the impact of our fitness to practise processes
Report by:	Anna Rowland , Assistant Director, Policy, Business Transformation and Safeguarding arowland@gmc-uk.org , 020 7189 5077
Action:	To consider

Executive summary

In September 2015 we asked Professor Louis Appleby, a leading mental health expert, to advise us as we carried out a fundamental review of our approach to cases relating to a doctor's health and in our interactions with doctors who may be vulnerable. The draft proposals were discussed at a stakeholder workshop in April 2016. Tracked changes to that document, at Annex A, contain some minor amendments responding to the feedback received at that event.

Recommendation

The Strategy and Policy Board is asked to agree the amended proposals, as set out in Annex A.

Issue

- 1 At the end of 2014 we published the report of an independent review, commissioned by the GMC, of doctors who took their own lives while under a GMC fitness to practise investigation. The independent review produced a number of recommendations for the GMC which we agreed to take forward and one for the wider healthcare system where we agreed to facilitate discussion (the National Support Service). We are clear that our role is to protect patients and uphold confidence in the profession, and where a doctor's health poses a risk to patients we must continue to take effective action. However, there are steps we can take to reduce the impact we have on vulnerable doctors that will not affect our ability to effectively protect patients and we believe we have a responsibility to take those steps to minimise the stress on those involved.

Engagement with Professor Appleby

- 2 In September 2015 we asked Professor Louis Appleby, a leading mental health expert, to oversee a fundamental review of our approach to cases relating to a doctor's health and help us develop proposals for improvement. He also advised on more general improvements we might make to our procedures to reduce the impact on doctors and others.

April stakeholder workshop

- 3 Following our work with Professor Appleby, we arranged a workshop event (the report of which can be found at Annex B), with representatives from a range of stakeholder groups, to present the draft proposals, at Annex A.
- 4 Overall, we received a very positive response to our proposals and there was constructive discussion about the benefits and challenges. There was a general consensus that matters should be dealt with locally where possible, and the group discussed the importance of the Responsible Officer role, not only in dealing with local matters, but also in providing the appropriate input during any GMC investigation.
- 5 The group were particularly positive about the proposed case coordinator role, highlighting the importance of tailoring the approach to the individual doctor. There was also support for seeking early input from case examiners to identify key issues and focus any investigation.
- 6 Following the workshop, we made some amendments, shown in track changes, to the draft proposals, at Annex A, to take account of the workshop discussions. These changes are set out below. We also met directly with Healthwatch and AvMA

following the event to ensure that our proposals took account of the views of patient representatives and received support for our approach.

Direct communication with doctors and their legal representatives

- 7** We proposed considering direct communication with doctors and their legal representatives early in the investigation, to explain what was likely to happen (given the information available at the time), the GMC's concerns and encourage early information sharing to promote faster resolution. Following feedback at the workshop we have clarified that first we will explore the practicalities of this proposal with the medical defence organisations to ensure that appropriate safeguards for doctors can be established.

Pausing investigations where appropriate

- 8** We proposed pausing an investigation to enable a doctor to get treatment, with appropriate interim protection if necessary. Following feedback at the workshop that this may not be appropriate in all cases, we have clarified that this will be considered on a case by case basis and discussed in advance with the doctor, and their treating physician/legal representative, where appropriate.

Myth busting

- 9** We proposed raising awareness of the approach to investigating cases to tackle misconceptions and reduce overall anxiety about being subject to a GMC complaint. Following feedback at the workshop, we have agreed we will pay particular attention to cases involving a doctor's health.

Equality and diversity

- 10** We have considered the three aims of the equality duty and the potential impact of the proposals on people from protected groups.
- 11** The changes will provide greater support to those in our processes, and are therefore likely to provide a beneficial impact to overrepresented groups. The changes should reduce the stress for all doctors involved in our procedures, particularly doctors with certain mental health conditions.
- 12** The changes proposed should also provide a more consistent approach to the management of cases involving health concerns.

Next steps

- 13** A paper will be submitted to the Performance and Resources Board in August 2016 outlining the implementation plan.

5 – Draft proposals to reduce the impact of our fitness to practise processes

5 – Annex A

Key aims

- 1 Reduce overall number of full investigations.
- 2 Avoiding full investigations whenever possible in cases that are (solely or primarily) about a doctor's health¹.
- 3 Strengthen medical input to decision-making in cases about a doctor's health.
- 4 Reduce stress in all investigations through changes to process, communication, and duration.
- 5 Pursue consensual conclusion as the preferred outcome.
- 6 Work more closely with employers on the number & appropriateness of referrals.
- 7 Expand support for doctors during the fitness to practise process including a tribunal hearing.
- 8 Promote the need for mental health services for doctors nationally.
- 9 Ensure supervision of doctors with restrictions and publication & disclosure after the fitness to practise case has concluded are proportionate.
- 10 Improve learning when doctors die by suicide.

¹ A doctor's health condition is not in itself a matter that would require investigation - only where there is a risk to the public for example because it is not being treated or the potential risks are not being effectively managed. All references to cases about a doctor's health in this document should be read as cases about health conditions that pose a risk to the public.

Key proposals

The GMC

- 1 Make mental health safety a strand that runs throughout the way the GMC performs its role, influencing culture, leadership, standards and training.
- 2 Greater use of early enquiries to improve information and reduce full investigations.
- 3 Front-load enquiry/investigation decisions with medical expertise where appropriate.
- 4 A senior medical appointment to oversee training, guidance, audit, case examiners, medical supervision.
- 5 A case co-ordinator role initially in cases about a doctor's health and exploring the practicability in all cases going forward – a personal approach, early meetings, extent & timing of investigations to be proportionate, closure.
- 6 Review publication & disclosure for sanctions and particularly in cases solely or primarily about a doctor's health.

Working with others

- 7 Health providers/employers: local handling where possible, especially in performance cases; strengthening the RO role supported by GMC employer liaison adviser; providing referral numbers to the CQC.
- 8 Support: promote & fund increased use of doctor support services; greater focus on unsupported doctors at Medical Practitioner Tribunal Service hearings.
- 9 Services: raise with the NHS the need for all areas to services for doctors with mental illness or addiction, which may include dedicated services, occupational health, nominated local services.
- 10 Work with national data sources (e.g. ONS, GRO): to identify all doctors who die by suicide during & after investigation; improve information & learning.

Proposed changes to our process

Ensure complaints and concerns dealt with at the right level, with local handling where possible

- 11 Review the information for complainants in the online complaints form and continue to engage with responsible officers through employer liaison advisers to ensure complaints and referrals are appropriate.

Guidance for staff at the early stage of the process to support a proportionate approach

- 12 Guidance for staff on signs a doctor may be unwell and amending guidance for assessing risk from adverse health to identify it early and only investigate if there is an ongoing risk.

Avoiding unnecessary investigation

- 13 Undertake more provisional enquiries as proposed in paragraph 2 of the Key Proposals to improve the information available when deciding if a full investigation is needed, including specialist input in relation to adverse health.

Greater specialist co-ordination of and communication in cases about a doctor's health

- 14 A specialist team of GMC health investigators for cases about a doctor's health, acting as a single point of contact for doctors throughout the process as proposed in paragraph 5 of the Key Proposals. Staff will have access to specialist medical advice about dealing with unwell doctors during an investigation. Carry out a further tone of voice review of letters about a doctor's health to acknowledge the health context in which the concerns have arisen, avoiding investigatory terms where possible.

A faster, more sensitive, consensual process for cases about a doctor's health

- 15 For cases about a doctor's health, moving to consensual undertakings as quickly as possible, referring to a hearing only where, despite efforts to resolve an issue consensually, a doctor has not engaged and there are continuing risks or where there are concerns about conduct or performance in addition to health that are serious.
- 16 In some cases about a doctor's health ([in discussion with the doctor and their treating physician/legal representative where appropriate](#)), pausing an investigation to enable a doctor to get treatment, with appropriate interim protection if necessary. Where independent health experts differ, facilitating the sharing of reports.
- 17 Explore legislative change to remove the need to obtain two independent health reports that are currently required in all cases where a doctor's health needs to be assessed.

Faster investigation of all cases

- 18** Speeding up the process as proposed in paragraph 3 of the Key Proposals by frontloading investigation through earlier case examiner involvement, to identify the key issues early and focus the investigation, demonstrating and communicating about improved timescales, including with doctors under investigation.

Better communication in all cases

- 19** All GMC correspondence with a doctor to be sent via the investigation officer when doctors are under investigation, to enable the number and timing of letters to be managed. Developing proposals for direct communication with doctors and their legal representatives early in the investigation, to explain what is likely to happen (given the information available at the time), the GMC's concerns and encourage early information sharing to promote faster resolution. [Exploring the practicalities of this proposal with the medical defence organisations](#). Notify doctors as early as possible of the outcome of investigations and explore mechanisms to discuss with the doctor any conditions or undertakings to explain their impact on the doctor's practice. More support during an investigation in all cases
- 20** To increase support as proposed in paragraph 8 of the Key Proposals, investigation staff and particularly case co-ordinators to actively promote the Doctor Support Service and the MPTS legal helpline to increase uptake. Explore the practicalities of a single point of contact in all cases.

Consent to be the preferred route in all cases

- 21** The GMC has sought legislative powers to enable it to agree consensual arrangements in all cases – to continue to press for those powers.

Advice and support for Medical Practitioner Tribunal Staff

- 22** Access for MPTS staff to specialist advice about unwell doctors before and during a hearing including exploring links with local services where immediate care is needed.
- 23** MPTS staff to promote the Doctor Support Service to improve support for doctors at hearings.
- 24** Trained MPTS staff to liaise with some doctors during hearings (those who are unrepresented or do not have supporters with them) to reduce stress and isolation.

Monitoring restrictions on practice

- 25** An enhanced role for medical supervisors in monitoring doctors who have restrictions so that their direct contact with GMC staff is reduced. Providing guidance for medical supervisors who believe a doctor is not receiving appropriate medical treatment.

Ensuring publication and disclosure of sanctions is proportionate

- 26** Taking forward work to reduce the length of time that sanctions are published and disclosed as proposed in paragraph 6 of the Key Proposals, particularly in cases about a doctor's health.

Seek improvements to data about cause of death

- 27** To support learning as proposed in paragraph 10 of the Key Proposals, obtain better information about deaths of doctors during or after an investigation to strengthen the serious incident enquiry process.

Myth busting

- 28** Raise awareness of the approach to investigating cases, [and in particular our approach to cases involving a doctor's health](#), to tackle misconceptions and reduce overall anxiety about being subject to a GMC complaint.

5 – Draft proposals to reduce the impact of our fitness to practise processes

5 – Annex B

GMC workshop on changes to reduce the impact of our fitness to practise processes on doctors

Introduction

- 1 At the end of 2014 we published the [report](#) of an independent review, commissioned by the GMC, of doctors who took their own lives while under a GMC fitness to practise investigation. We commissioned the review to help us understand and assess the impact of our investigations on vulnerable doctors and look for improvements. The independent review produced a number of recommendations for the GMC which we agreed to take forward and one for the wider healthcare system where we agreed to facilitate discussion.
- 2 As part of our response to the recommendations, we commenced a fundamental review of our approach to cases relating to a doctor's health¹. Last autumn we approached Professor Louis Appleby, a leading mental health expert, and in December 2015 we appointed him to oversee the review and help us develop proposals to improve how we deal with cases involving concerns about a doctor's health. He also advised on more general improvements we might make to our procedures to reduce the impact on doctors, where we already have a significant reform programme underway.
- 3 We arranged a workshop event, with representatives from a range of stakeholder groups, to present these proposals (which can be found at Appendix B), to discuss:

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- a The stressors on a doctor's mental health during an investigation.
- b The benefits and challenges of the draft proposals.
- c Whether there are any further viable improvements we could make to the process to reduce impact on doctors, while maintaining effective patient protection.

Summary of discussions

Having discussed a set of case studies at the workshop, there was broad support for the proposals. There was specific discussion in relation to some of proposals; an overview of the comments made is set out below.

Ensure complaints and concerns are dealt with at the right level, with local handling where possible

- 4 There was a widespread view that matters should be dealt with locally where possible, unless escalation is necessary.
- 5 The group discussed the value of the role of Responsible Officers, not only in dealing with local matters, but also in providing the appropriate input during any GMC investigation, and stressed the importance of:
 - a Continuing education about thresholds for GMC referral and what should be dealt with locally.
 - b Better engagement and support for the doctor ahead of any referral to the GMC – following appropriate local policing in this regard.
 - c Ensuring involvement of the employer liaison service in advising on referrals.
- 6 It was stressed that the GMC needs to have a clear understanding about what steps have been taken locally – for example, if the employer has tried to engage the doctor or encourage them to seek support, such as occupational health.

Importance of the GMC's Employer Liaison Service

- 7 The Employer Liaison Service was considered to play a key role in ensuring closer working relationships between the GMC and employers. They provide a valuable link with Responsible Officers and their teams to help them understand GMC thresholds and procedures. It was considered important that the GMC continue to build on this model.

Guidance for staff at the early stage of the process to support a proportionate approach and avoid unnecessary investigation

Medical input during the fitness to practise process

- 8** Appropriate use of specialist input during the fitness to practise process was welcomed. There were mixed views about the nature of such specialist input including psychiatrists, GPs with special experience and occupational health physicians. Although the benefits of seeking advice and support from a specialist in determining a doctor's fitness to practise were welcomed, there were concerns that the specialist should also assess whether the doctor is getting an appropriate level of treatment.
- 9** The importance of a good functioning occupational health service being an essential part of the process was stressed. If a case was to progress to an investigation, an opinion from occupational health was considered to be important.
- 10** It was thought that careful consideration needs to be given to the nature of the specialist medical advice available to staff about doctors in the fitness to practise process if they haven't seen the patient, and the reliance placed on that advice.

Avoiding unnecessary investigation

- 11** The proposal to undertake more early enquiries to improve the information available when deciding if a full investigation is needed was welcomed, while the importance of ensuring that patient safety risks are addressed and managed was stressed. One attendee raised concern about perception. They felt that an individual doctor may not distinguish between an early enquiry and an investigation, so careful thought should be given to the approach, particularly around communication and terminology.

Greater specialist co-ordination or and communication in cases about a doctor's health

- 12** The proposal to establish case co-ordinators in cases about a doctor's health, acting as a single point of contact for doctors throughout the process, was welcomed.
- 13** The point was raised that strategies will be needed to provide someone familiar with the case to cover sickness and leave.

Single point of contact

- 14** A single point of contact in cases relating to a doctor's health, throughout the process, is a positive step, but it is important that there is robust training and guidance and the individual has good skills in communication. The individual should take a sensitive approach – evidence of this from some current investigation officers was mentioned.

Tailoring the approach

- 15** Tailoring the approach taken to the individual doctor was supported. It was raised that speaking to doctors will be important as what may work for one individual may be cautious over-intervention for another. Some flexibility was seen as important.

Support for case coordinators

- 16** It was acknowledged that staff undertaking work involving doctors with health problems would require detailed training and support. One attendee suggested a mental health training course might be helpful in ensuring these staff know how to have conversations with, and about, those experiencing mental illness.

A faster, more sensitive, consensual process for cases about a doctor's health

- 17** One attendee stated that reducing the stress of investigations was less about speed and more about 'proportionate regulation'.

Pausing an investigation where necessary

- 18** Pausing investigations in some cases (with appropriate interim protection if necessary) were considered to be beneficial in allowing the doctor to seek treatment and get better before continuing, including to develop insight where loss of insight was a result of their ill health. However, there was concern it may ultimately cause stress if there is a delay in final resolution. There was a view that it may not be suitable in some cases and careful thought needs to be given to the approach, paying particular attention to the involvement of the doctor (and their treating physician and legal representative where appropriate) in any decision.

Faster investigation of all cases

Frontloading investigations

- 19** Frontloading investigations, making use of early input from case examiners to identify the key issues and focus the investigation, was supported as having a significant impact. However, there was some discussion about the approach to an early teleconference with the doctor and their representative and it was agreed that, while welcome in principle, the details of how it would work would need careful thought. There should be flexibility around how and where these meetings take place, whether that be face-to-face or by phone, and at the GMC office, or at another site.

Better communication in all cases

Keeping doctors informed

- 20** It was agreed that doctors need regular updates about the status of their case and that doctors should be provided with the range of likely outcomes for their case, to reduce the anxiety for less serious concerns.

Increase support

- 21 Active promotion of the Doctor Support Service and the MPTS legal helpline was agreed to be important, but it was also considered important to signpost people to other support, both legal and emotional.
- 22 The Doctor Support Service currently provides two days of hearing support to doctors – it was thought that consideration should be given to increasing this period.
- 23 The point was made that the GMC can play a role in destigmatising restrictions on registration (conditions and undertakings) relating to health for the doctors involved.

Role of confidentiality through both local and GMC processes

- 24 While there was support for proposals to better support doctors, where that involved sharing information with others to facilitate that support, there were concerns about confidentiality, and an explanation of what will be kept confidential throughout the process was considered extremely important.

Exposing GMC investigation staff to frontline clinical practice

- 25 There was some discussion around the practicalities of taking this forward. Further work needs to be done to explore how this could be addressed within the time and financial constraints faced by both GMC staff and clinical settings.

Next steps

- 26 The proposals for change to the fitness to practise process will be reviewed in light of the feedback we have received and an update and plans for implementation will be brought to the GMC's Strategy and Policy Board. Work will now begin on developing those plans likely to include some immediate changes, some changes that require re-engineering of the fitness to practise process that can be undertaken in the medium term and those that require legislative change that are likely to take longer.

(Appendix A)**Delegate list**

Name	Organisation
Mark Hope	British Dental Association
Dr Mike Peters	BMA Doctors for Doctors
Dr Alasdair Young	Sick Doctors Trust
Steve Crone	Royal Medical Benevolent Fund
Dr Jane Marshall	South London and Maudsley NHS Foundation Trust
Professor Clare Gerada	NHS Practitioner Health Programme
Dr Louise Freeman	Doctors' Support Network
Dr Umesh Prabhu	Wrightington, Wigan and Leigh NHS Foundation Trust
Dr Robert Donald	British Dental Association
Dr Anthony Garelick	Tavistock and Portman NHS Trust and MedNet
Dr Jo Jones	Health Education England
Professor Keith Hawton	The University of Oxford
Lucille Shackleton	Royal College of Psychiatrists
Dr Adrian James	Royal College of Psychiatrists
Dr Debbie Cohen	Cardiff University School of Medicine
Dr Harjinder Kaul	University Hospitals of Leicester NHS Trust
Dr David Snashall	Guy's & St Thomas' NHS Foundation Trust
Dr Neil Margerison	The National Clinical Assessment Service
Dr Ruth Chapman	NHS England London Regional Team
Mary-Lou Nesbitt	Medical Defence Union
Dr John Holden	<i>The Medical and Dental Defence Union of Scotland</i>
Dr Geoff Payne	NHS England South (South Central)
Dr David Finch	NHS England – London region
Dr Jane Fryer	NHS England – London region
Dr Vicky Banks	NHS England South
Dr Nancy Redfern	Association of Anaesthetists of Great Britain and Ireland
Tim Gunning	Equality and Human Rights Commission

Dr Tina Ambury	The Montague Practice, Blackburn
Paul Jebb	NHS England
Katherine Murphy	Patients Association
Dr Peter Bennie	BMA Scotland
Sam Stone	Parliamentary and Health Service Ombudsman
Dr Andrea Hearn	Newcastle Addictions Service
Dr Mike Higgins	Scottish Association of Medical Directors
Dr Deepak Dwarakanath	Royal College of Physicians of Edinburgh
Simon Dinnick	<i>The Medical and Dental Defence Union of Scotland</i>
Tom Reynolds	Medical Protection Society
Philip Banfield	BMA Wales
Dr Jane Fenton May	Royal College of GPs
Dr Martin Tohill	Consultant in Occupational Medicine
Mike Tidley	Princess of Wales Hospital
Dr Ken Lowry	Northern Health and Social Care Trust
Dr Paddy Woods	Department of Health, Social Services and Public Safety
Dr Anthea Lint	NHS Education for Scotland
Fiona MacKenzie	Scottish Government
Dr Jude Halford	The Royal College of Psychiatrists in Scotland
Sushee Dunn	Royal College of Physicians of Edinburgh
Leona Walsh	Wales Deanery
Dr Gerry Lynch	Royal College of Psychiatrists
Dr Kathryn Booth	Health and Social Care Board
Dr Helen Rogers	Health and Social Care Board
Dr John O'Kelly	Royal College of General Practitioners
Dr Camille Harron	Northern Ireland Medical and Dental

(Appendix B)

Draft proposals to reduce the impact of our fitness to practise processes

Key aims

- 1 Reduce overall number of full investigations.
- 2 Avoiding full investigations whenever possible in cases that are (solely or primarily) about a doctor's health².
- 3 Strengthen medical input to decision-making in cases about a doctor's health.
- 4 Reduce stress in all investigations through changes to process, communication, and duration.
- 5 Pursue consensual conclusion as the preferred outcome.
- 6 Work more closely with employers on the number & appropriateness of referrals.
- 7 Expand support for doctors during the fitness to practise process including a tribunal hearing.
- 8 Promote the need for mental health services for doctors nationally.
- 9 Ensure supervision of doctors with restrictions and publication & disclosure after the fitness to practise case has concluded are proportionate.
- 10 Improve learning when doctors die by suicide.

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Key proposals

The GMC

- 1 Make mental health safety a strand that runs throughout the way the GMC performs its role, influencing culture, leadership, standards and training.
- 2 Greater use of early enquiries to improve information and reduce full investigations.
- 3 Front-load enquiry/investigation decisions with medical expertise where appropriate.
- 4 A senior medical appointment to oversee training, guidance, audit, case examiners, medical supervision.
- 5 A case co-ordinator role initially in cases about a doctor's health and exploring the practicability in all cases going forward – a personal approach, early meetings, extent & timing of investigations to be proportionate, closure.
- 6 Review publication & disclosure for sanctions and particularly in cases solely or primarily about a doctor's health.

Working with others

- 7 Health providers/employers: local handling where possible, especially in performance cases; strengthening the RO role supported by GMC employer liaison adviser; providing referral numbers to the CQC.
- 8 Support: promote & fund increased use of doctor support services; greater focus on unsupported doctors at Medical Practitioner Tribunal Service hearings.
- 9 Services: raise with the NHS the need for all areas to services for doctors with mental illness or addiction, which may include dedicated services, occupational health, nominated local services.
- 10 Work with national data sources (e.g. ONS, GRO): to identify all doctors who die by suicide during & after investigation; improve information & learning.

Proposed changes to our process

Ensure complaints and concerns dealt with at the right level, with local handling where possible

- 11 Review the information for complainants in the online complaints form and continue to engage with responsible officers through employer liaison advisers to ensure complaints and referrals are appropriate.
-

Guidance for staff at the early stage of the process to support a proportionate approach

- 12** Guidance for staff on signs a doctor may be unwell and amending guidance for assessing risk from adverse health to identify it early and only investigate if there is an ongoing risk.

Avoiding unnecessary investigation

- 13** Undertake more provisional enquiries as proposed in paragraph 2 of the Key Proposals to improve the information available when deciding if a full investigation is needed, including specialist input in relation to adverse health.

Greater specialist co-ordination of and communication in cases about a doctor's health

- 14** A specialist team of GMC health investigators for cases about a doctor's health, acting as a single point of contact for doctors throughout the process as proposed in paragraph 5 of the Key Proposals. Staff will have access to specialist medical advice about dealing with unwell doctors during an investigation. Carry out a further tone of voice review of letters about a doctor's health to acknowledge the health context in which the concerns have arisen, avoiding investigatory terms where possible.

A faster, more sensitive, consensual process for cases about a doctor's health

- 15** For cases about a doctor's health, moving to consensual undertakings as quickly as possible, referring to a hearing only where, despite efforts to resolve an issue consensually, a doctor has not engaged and there are continuing risks or where there are concerns about conduct or performance in addition to health that are serious.
- 16** In some cases about a doctor's health, pausing an investigation to enable a doctor to get treatment, with appropriate interim protection if necessary. Where independent health experts differ, facilitating the sharing of reports.
- 17** Explore legislative change to remove the need to obtain two independent health reports that are currently required in all cases where a doctor's health needs to be assessed.

Faster investigation of all cases

- 18** Speeding up the process as proposed in paragraph 3 of the Key Proposals by frontloading investigation through earlier case examiner involvement, to identify the key issues early and focus the investigation, demonstrating and communicating about improved timescales, including with doctors under investigation.

Better communication in all cases

- 19** All GMC correspondence with a doctor to be sent via the investigation officer when doctors are under investigation, to enable the number and timing of letters to be

managed. Developing proposals for direct communication with doctors and their legal representatives early in the investigation, to explain what is likely to happen (given the information available at the time), the GMC's concerns and encourage early information sharing to promote faster resolution. Notify doctors as early as possible of the outcome of investigations and explore mechanisms to discuss with the doctor any conditions or undertakings to explain their impact on the doctor's practice. More support during an investigation in all cases

- 20** To increase support as proposed in paragraph 8 of the Key Proposals, investigation staff and particularly case co-ordinators to actively promote the Doctor Support Service and the MPTS legal helpline to increase uptake. Explore the practicalities of a single point of contact in all cases.

Consent to be the preferred route in all cases

- 21** The GMC has sought legislative powers to enable it to agree consensual arrangements in all cases – to continue to press for those powers.

Advice and support for Medical Practitioner Tribunal Staff

- 22** Access for MPTS staff to specialist advice about unwell doctors before and during a hearing including exploring links with local services where immediate care is needed.
- 23** MPTS staff to promote the Doctor Support Service to improve support for doctors at hearings.
- 24** Trained MPTS staff to liaise with some doctors during hearings (those who are unrepresented or do not have supporters with them) to reduce stress and isolation.

Monitoring restrictions on practice

- 25** An enhanced role for medical supervisors in monitoring doctors who have restrictions so that their direct contact with GMC staff is reduced. Providing guidance for medical supervisors who believe a doctor is not receiving appropriate medical treatment.

Ensuring publication and disclosure of sanctions is proportionate

- 26** Taking forward work to reduce the length of time that sanctions are published and disclosed as proposed in paragraph 6 of the Key Proposals, particularly in cases about a doctor's health.

Seek improvements to data about cause of death

- 27** To support learning as proposed in paragraph 10 of the Key Proposals, obtain better information about deaths of doctors during or after an investigation to strengthen the serious incident enquiry process.

Myth busting

Raise awareness of the approach to investigating cases, to tackle misconceptions and reduce overall anxiety about being subject to a GMC complaint.