House of Commons

Health Committee

2012 accountability hearing with the General Medical Council: General Medical Council Response to the Committee's Fourth Report of Session 2012–13

First Special Report of Session 2012–13

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The Health Committee

The Health Committee is appointed by the House of Commons to examine the expenditure, administration, and policy of the Department of Health and its associated bodies.

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The Committee is one of the departmental select committees, the powers of which are set out in House of Commons Standing Orders, principally in SO No 152. These are available on the Internet via www.parliament.uk.

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The Reports and evidence of the Committee are published by The Stationery Office by Order of the House. All publications of the Committee (including press notices) are on the Internet at www.parliament.uk/healthcom.

The Reports of the Committee, the formal minutes relating to that report, oral evidence taken and some or all written evidence are available in printed volume(s).

Additional written evidence may be published on the internet only.

Committee staff

The staff of the Committee are David Lloyd (Clerk), Martyn Atkins (Second Clerk), Stephen Aldhouse (Committee Specialist), Frances Allingham (Senior Committee Assistant), and Ronnie Jefferson (Committee Assistant).

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1 Mr Stephen Dorrell was elected as the Chair of the Committee on 9 June 2010, in accordance with Standing Order No. 122B (see House of Commons Votes and Proceedings, 10 June 2010).

First Special Report

On 3 December 2012, the Health Committee published its Fourth Report of Session 2012–13, *2012 accountability hearing with the General Medical Council*. The General Medical Council's response to the Report was received by this Committee on 22 March 2013 and is published as the Appendix to this Report. The Government's response was published on 25 February 2013 as Cm 8520.

The Committee will be taking evidence from the GMC again in the autumn of 2013 as part of its function of holding medical regulators accountable on behalf of Parliament.

Appendix

The GMC is the independent regulator for doctors in the UK.

We register doctors to practise medicine in the UK. Our purpose is to protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine. We are accountable to Parliament through the Health Select Committee.

The Health Select Committee published its accountability report on the GMC on 3 December 2012. We welcome the Committee's scrutiny of our work, and this document sets out our response to each of the Committee's main recommendations.

Since the publication of the report, Robert Francis QC has published his report on Mid Staffordshire, exposing the fundamental failings that allowed very poor care to go unchecked and a culture to develop which led to catastrophic results for patients and their families.

Professional regulation has an important but limited role in helping to prevent another tragedy like the one at Mid Staffordshire. We believe that by working with patients, the profession, employers and other organisations, we can play a part in fostering a culture which encourages openness, which learns from mistakes and which supports front-line staff to deliver high quality, safe and compassionate care.

Traditionally professional regulation has been largely reactive – without imposing more burdens on professionals or provider organisations we need to use the lessons from the Francis report to engage actively with the service. This will mean building on the progress we have made, noted in the Francis report, on revalidation, our Employer Liaison Service, investment in information systems and the National Training Survey and other education work. We are determined to work more closely with those providing and receiving care and to improve information sharing with other key players such as the Care Quality Commission.

Law Commission

1. Report recommendation: We welcome the Law Commissions' proposal that the Health Committee should play a role in the accountability process for professional regulation in the health and care sector. We stand ready to work with the Law Commission to prepare workable proposals which make this accountability effective. (Paragraph 14)

The GMC welcomes the Law Commissions' work. It provides an opportunity to enhance the effectiveness of the regulation of healthcare professionals in the UK.

Like the Committee, we support the Law Commissions' recognition of the importance of our accountability to Parliament.

Professional regulation should be about patient safety and the quality of care – as such it needs to be independent of the professions it regulates and of the other interests such as employers or governments who are responsible for funding and providing healthcare services. But it does need to be accountable and we welcome scrutiny by the Select Committee.

Revalidation

2. Report recommendation: We welcome the fact that the system of medical revalidation is at last ready to be implemented. The purpose of the system should be to give the public greater assurance that the medical professionals treating them are being consistently and regularly appraised for their competence and fitness to practise. Although commencement of revalidation is a welcome first step towards providing this assurance, it is essential to recognise that its benefits will only be realised if the system is effectively managed and rigorously monitored. (Paragraph 20)

3. Report recommendation: Our previous reports have underlined the importance we attach to the role of the GMC as the "owner" and "leader" of the revalidation process. As revalidation is implemented, we look to the GMC to maintain this leadership role. This will involve actively monitoring and upgrading the operation of the new system to ensure that it fulfils its objective of providing greater assurance to patients about the quality and professionalism of doctors who provide care. (Paragraph 52)

We are pleased that, with the Committee's support, revalidation has started. As Robert Francis noted, in his report on the Mid Staffordshire care scandal, revalidation should, over time, provide the public with greater assurance that medical professionals are competent and fit to practise.

We accept that we have a key leadership role, working with doctors, employers and the public to ensure that the system works efficiently and effectively.

We also agree with the Committee that the system of revalidation needs to be effectively managed and rigorously monitored if it is to realise the benefits for patients, doctors and employers. To this end, we are working with the system regulators across the UK to ensure that robust clinical governance arrangements are in place to support revalidation throughout the healthcare system. We have also launched a major programme of work that

focuses on monitoring the implementation of revalidation and assessing and evaluating its impact.

To support this programme, we are developing mechanisms for analysing and reporting key data and intelligence that will help indicate how revalidation is working in practice. This will include, for example, analysis of the types of doctor being recommended for revalidation, the nature of the organisations in which they work, the area of the country in which they practise as well as their own personal characteristics (ethnicity, gender, place of qualification etc). Our Employer Liaison Service will also play a key role in working with Responsible Officers to capture feedback on the operation of revalidation which will be used to inform the future development of the revalidation model. In addition we will be looking at trends in our complaints and fitness to practise data to determine if the introduction of revalidation has an impact.

Separately, we have tendered for a consultancy or academic partner to work with us to develop a structured evaluation framework for revalidation. This will then form the basis of a longitudinal evaluation of the programme. The framework will incorporate evaluation of the key design features of revalidation, including supporting information such as patient and colleague feedback.

To help us interpret and act effectively upon this data and feedback, we are establishing a Revalidation Implementation Advisory Board with representation from patients, doctors, employers and professional bodies. The Board will have an independent chair and will provide advice to the GMC on issues affecting implementation and on how we might best improve and strengthen the process over time.

We will also continue to work with the four UK health departments, designated bodies and Responsible Officers to drive consistency and ensure that, over time, revalidation contributes to improved medical practice.

Our work with the Care Quality Commission and Monitor in England, and their counterparts in the other parts of the UK is also very important. We have recently published a jointly-badged handbook which sets out our shared view of what we expect from boards and governing bodies to support revalidation. We will continue to collaborate with the system regulators, in each of the four countries, to understand how their regulatory programmes will monitor and support the effective delivery of revalidation.

Once revalidation has been in place for some time, we will commission research to identify if the introduction of revalidation has improved a range of measures across medical practice including patient experience.

We will report to the Committee about the progress we have made on revalidation at the next accountability hearing.

4. Report recommendation: We welcome the approach which the GMC is taking to ensure that all organisations responsible for doctors are engaged in the revalidation process from the outset, and that the doctors identified for revalidation are representative of the doctors across each organisation. We recommend that the practical implementation of this approach is monitored to ensure that candidates presented for revalidation are in fact properly representative. (Paragraph 27)

We agreed a set of principles for the implementation of revalidation with the four UK health departments in May 2012. One of the key principles is that the population of doctors having recommendations made about them by a given Responsible Officer throughout the first cycle of revalidation should be representative of the medical workforce covered by that Responsible Officer, and that Responsible Officers should be engaged with the revalidation process from the beginning.

We invited all Responsible Officers to engage with us on planning revalidation dates during 2012, when we asked them to propose a schedule for submitting their doctors for revalidation. All licensed doctors, including those without a prescribed connection, have now been allocated a date and we have notified all licensed doctors of that date. The revalidation date for the vast majority of doctors falls between January 2013 and March 2016. A small number of doctors in postgraduate training have been allocated dates in late 2016 and 2017 to coincide with their completion of training.

We are monitoring and analysing data on revalidation recommendations received thus far. As the volume of recommendations increase, we will be able to analyse how different groups of doctors are being affected by revalidation. This data, together with a range of qualitative intelligence, gleaned through our engagement with employers, doctors and educators will form an important part of how we monitor revalidation to ensure that the implementation principles are being fulfilled.

5. Report recommendation: The introduction of employer liaison advisers to support responsible officers in assessing concerns around a doctor's practice is welcome. We expect this initiative to support earlier and more robust action in identifying such concerns and ensuring that they are appropriately dealt with. (Paragraph 33)

The Employer Liaison Service is a key part of our strategy to be more proactive and responsive and we were pleased it was noted as a positive development by the Committee and by Robert Francis in his report on Mid Staffordshire.

Our Employer Liaison Advisors have been well received by employers – they support Responsible Officers in their role of ensuring that all the doctors for whom they have responsibility are competent and fit to practise. A key part of this is helping them identify and act upon concerns at an early stage and supporting them as they develop and manage information and appraisal systems to support revalidation.

We will follow-up on any apparent inconsistency in applying GMC guidance and criteria on revalidation. We are also developing ways of analysing data to promote learning and improvement. This will then be fed back to Responsible Officers and employers to inform the future operation of revalidation.

6. Report recommendation: Revalidation is a process which is designed to encourage continuing evaluation of a doctor's practice at the local level. We support the General Medical Council's message that all doctors should be considering now the steps which revalidation will require them to take in relation to their practice, irrespective of the date on which their revalidation recommendation falls due. (Paragraph 28)

7. Report recommendation: We consider that the requirement to seek feedback from patients at least once every five years does not sufficiently reflect the aspiration of the

GMC, which we share, to ensure that every doctor seeks periodic feedback from patients. The GMC should consider setting a more challenging target which will provide greater assurance to patients that their views are regularly sought and reflected upon by their doctors. (Paragraph 67)

At the end of January 2013, we wrote to all licensed doctors to tell them their revalidation date and to reinforce that, regardless of when they revalidate, they should now be actively engaging with appraisal and clinical governance. We have the power to require doctors to provide us with any information that we reasonably request to support their revalidation. We can also remove a doctor's licence for failing to engage with us or failing to provide us with this information.

We believe that patients have an important role to play in providing information for the appraisal and revalidation of doctors. We know that patients can and do give valuable feedback that can help doctors understand what they do well and what they could do better. Although many doctors already ask their patients for this type of feedback, now that revalidation has begun, we expect every doctor to be doing this on a regular basis.

Patient feedback is one of six types of supporting information that a doctor must collect for revalidation. Doctors will need to review this feedback with their appraiser, reflect and act on what it says about their practice and performance. In addition, we require every doctor to work with their employers to collect structured feedback from a subset of their patients at least once in every revalidation cycle, usually every five years. This will mainly happen through the use of formal questionnaires designed to assess various aspects of a patient's experience with a doctor.

Doctors are also expected to bring a review of complaints and compliments they have received from patients to their annual appraisal. In this way revalidation will use feedback from patients every year.

The introduction of revalidation means that, for the first time, all licensed doctors must seek feedback from patients. We regard this as a significant first step. In designing the process, we have sought to balance the aspirations of patients and others with the concerns from doctors and employers about the cost in time and resources of conducting formal objective reviews. However, we do recognise the need to keep this aspect of revalidation under review. This will form part of the evaluation and we will examine not only the frequency, but also the methods of obtaining feedback.

In addition, we will continue to work with local and national organisations to raise awareness of revalidation and the role patients can play in providing feedback. This is one of the key roles for our new team of Regional Liaison Advisors in England and for our offices in Scotland, Wales and Northern Ireland. In addition, this year we are launching our first guide to *Good medical practice* for patients. This will set out what they can expect from their doctor and how the patient perspective will be built into revalidation.

All of these measures will be kept under review, and we look forward to reporting the progress to the Committee at the next accountability hearing.

Remediation

8. Report recommendation: Although we recognise the danger of focussing on form rather than substance, we believe that it is an essential element of good practice for all organisations which employ doctors to have clear and effective procedures for reskilling, rehabilitation and remediation of medical staff when that is necessary. We expect the GMC to ensure that this condition is satisfied as part of its continuing programme for the development of revalidation and we shall seek assurances about the progress made in this area at our accountability session with the GMC next year. (Paragraph 43)

We agree with the Committee that, from a patient safety perspective, it is important that there are systems in place to help doctors who need remediation. Remediation is not a new phenomenon and it is not a consequence of revalidation; it has been a feature of the NHS for many years.

The provision of funding and resources for remediation is a matter for the four health departments, the NHS Commissioning Board in England and employers. However, we do know that the introduction revalidation has already encouraged healthcare organisations to ensure they have a formal remediation policy in place.

Our Employer Liaison Advisors are supporting Responsible Officers as they identify, initiate and assess the outcomes of remediation processes where concerns are identified about a doctor's practice. This will help to ensure that the impact of revalidation is constructive and encourage effective early intervention where concerns are identified about professional practice.

9. Report recommendation: We continue to believe that the arrangements for informing patients of circumstances where a doctor has been required to undertake remediation measures are not sufficiently clear. In view of the imminent implementation of the revalidation process we recommend that the GMC take steps to clarify these procedures as a matter of urgency, and certainly before our accountability session next year. (Paragraph 63)

It is important to make a distinction between remediation and concerns about a doctor's fitness to practise. Where the revalidation process highlights serious or persistent failings which put a doctor's fitness to practise in doubt, the doctor will be referred to us for investigation. If we believe that patient safety may be at risk we will take immediate steps to suspend the doctor or restrict his or her practice. In addition, following an investigation, if we take action against a doctor's registration this decision is open and transparent – we issue a press release and the decision will appear on the register beside the doctor's name. Any member of the public can access the register on our website which will give details of any restrictions that we impose, any warning we issue and any suspension or erasure of the doctor's registration. These details can still be accessed on the online register on our website even where the restriction or suspension has been lifted.

Local healthcare organisations are responsible for operating an effective and equitable appraisal and remediation process. There is a balancing act that they need to strike between the rights of the doctor and the rights of the patients – when investigating unproven

concerns about a doctor they will need to decide whether that information should be made available to patients.

Language

10. Report recommendation: We consider that the proposed legislative changes to require responsible officers to assure themselves of the language competence of the doctors for whom they are responsible should be made as soon as possible, pending satisfactory amendment of the European Professional Qualifications Directive. In any event, we expect that should any issue about a doctor's language skills be identified, the responsible officer should be alerted immediately and should take appropriate action at once. The GMC and the Government should both confirm that this is their intention. (Paragraph 55)

The Government recently concluded its consultation on amendments to the Responsible Officer Regulations which place a duty on Responsible Officers to ensure that doctors have the necessary language skills to undertake their role. These revised regulations come into effect on 1 April 2013.

We welcome the Committee's support in helping us to ensure that all doctors have the necessary language skills to enable them to practise safely in the UK.

11. Report Recommendation: We are disappointed that no substantive progress seems to have been made at European level in addressing the underlying issue of language testing of doctors with primary qualifications from elsewhere in the EEA and in Switzerland. We continue to look to the Government, the GMC and the relevant EU institutions to produce a long-term solution to this problem within a timescale which reflects the potential risks to patients across Europe which are inherent in the present unsatisfactory situation. We ask the Government to set out in its response to this report the steps it is taking to seek amendment of the relevant Directive and the expected timetable. (Paragraph 57)

We have been engaging with the UK Department for Business, Innovation and Skills, the Department of Health (England), the European institutions and other regulators on the current ongoing review of the Recognition of Professional Qualifications Directive to ensure that regulators such as the GMC have an explicit role in assessing the language skills of doctors from the European Economic Area before granting them access to the profession. We are committed to doing whatever we can to ensure that the revised Directive will enhance patient safety in the UK while respecting the rights of migrating professionals within the European Union. Recent developments in the European Parliament have been encouraging and we are pleased that MEPs have clarified that regulators should be given explicit powers to assess the language skills of all healthcare professionals after their qualifications have been recognised but before they have access to the profession. In the case of doctors this would mean before they were given a licence to practise in the UK.

The new Directive is unlikely to be implemented into UK law until 2015 at the earliest and hence our commitment – with the Department of Health – to change the Medical Act (which applies across the UK) and the Responsible Officer Regulations (for England) as soon as possible. We expect the changes to the Medical Act to come into force in 2014.

This will give us new powers to check the language skills of doctors from Europe where concerns about their proficiency in English have been identified.

We have argued for some time that if doctors cannot speak English to a safe standard then we must be able to protect patients by preventing them from practising in the UK. At present we can do that for doctors who have qualified outside Europe but not for doctors from within the European Economic Area. We hope that we can agree the detail of how the new powers will work as soon as possible.

Standards

12. Report recommendation: We consider that the GMC is uniquely placed to exercise a leadership function in the medical profession, and the healthcare professions more generally, and we applaud its willingness to do so. We encourage the Council to continue its leadership activities in concert with professional representative organisations. (Paragraph 79)

We believe that we have a key role to play alongside other organisations in providing leadership and guidance to the profession. It is a core part of our statutory duties to provide guidance to doctors on medical ethics, foster good medical practice and promote high standards of medical education and training. We will continue to work with others to provide leadership and drive up standards of care.

In 2012, we launched our Regional Liaison Service which will work across England, supplementing the work of our offices in Scotland, Wales and Northern Ireland, in engaging with doctors, medical students and patients to provide guidance and challenge on professional standards.

The Committee's support for this work is greatly appreciated.

13. Report recommendation: We welcome and applaud the steps which the GMC has taken and continues to take to develop a broader understanding of professional obligation among doctors. We regard this ongoing process as the indispensable foundation of high quality care and we applaud the steps being taken by the GMC to encourage and support doctors to raise concerns when high professional standards are not met. We look to other regulators, and to health and care managers in both the public and private sector, to foster a culture in all health and care organisations where it is unacceptable not to raise such concerns when they arise. (Paragraph 73)

As the Francis report makes clear, an open culture is key to driving up professional standards. We are committed to working with doctors, their professional bodies and employers to improve professional standards and create a culture in which raising concerns is normal and expected and where doctors and other health professionals feel empowered to act whenever they have any concern about patient safety.

Since our appearance before the Committee we have launched two new services to support doctors to recognise and fulfil their obligations in this area. First, we have launched a confidential helpline for doctors seeking advice or wishing to raise concerns when they feel unable to do this at the local level. The helpline is able to take forward information that can

be investigated by the GMC or refer callers to other organisations, such as the Care Quality Commission.

Since it was launched in December 2012 the helpline has received more than 240 calls. One in 7 calls have led to further inquiries, including 13 investigations into serious allegations which suggest there may be a risk to patient safety. This early response suggests there is a need for this service.

Secondly, we have created an online tool which provides practical help for doctors in deciding how and where they should report concerns about patient safety. The tool uses case studies to illustrate what to do when dealing with issues of patient safety or dignity.

These two services build on the new guidance, *Raising and acting on concerns about patient safety,* which we sent to every doctor in the UK in 2012.

One further initiative is worth mentioning here. This year for the first time we used our annual National Training Survey (which is completed by 95% of doctors in training) to ask respondents to inform us of any concerns they had about patient safety in their training environment. This resulted in more than 2444 reports all of which have been followed up (three quarters of which were already known about locally but one quarter were new). We believe it is important that all doctors, including those in training have opportunities to raise concerns and have them acted upon. We will repeat this exercise in the 2013 survey.

14. Report recommendation: The Chair of the GMC has written to all doctors to remind them that in the new world of commissioning, their decisions must not be influenced by a conflict of interest, and that patients come first. This unambiguous statement is commendable. We look to the GMC to take action on any evidence of conflicts of interest that have the potential to affect patient care adversely. (Paragraph 75)

The risk of a conflict of interest is not new for doctors. Our core guidance for doctors *Good medical practice* is clear that doctors must be honest in financial and commercial dealings.

We have recently consulted on a revised version of *Good medical practice*, which we will be launching in March 2013. It will take effect for all doctors in April. This includes supplementary guidance on *Financial and commercial arrangements and conflicts of interest* which sets out in more detail how to comply with these principles.

It includes a specific section on commissioning of services in the NHS. It says if a doctor is involved in commissioning services they must;

- satisfy themselves that all decisions are fair, transparent and comply with the law;
- keep up to date with and follow the guidance and codes of practice that govern the commissioning of services where they work;
- formally declare any financial interest in accordance with the governance arrangements where they work;

- and take steps to manage any conflict between their duties as a doctor and commissioning responsibilities, if necessary by excluding themselves from the decision-making process.

We will be working with doctors and patients to ensure this guidance is understood, followed and where concerns exist provide a means of escalation.

The new arrangements in England in which many GPs will have additional responsibilities for commissioning services are likely to mean more doctors are faced with such conflicts. We will monitor developments in this area and if further advice or guidance is required we will provide it.

We will also use the evidence from complaints about doctors to highlight how undeclared conflicts of interest can damage the profession and patient care.

Fitness to Practise

15. Report recommendation: We welcome the intention of the GMC to commission further research to understand the sustained upwards trend in complaints against doctors. The GMC should seek to learn lessons from this research to inform its regulatory practice. We look forward to discussing the outcomes of such research at the next accountability hearing. (Paragraph 84)

We are committed to doing what we can to understand the rise in complaints about doctors. The Francis report also calls for more work to understand the trends in healthcare complaints and for a greater sharing of insights among regulators and healthcare providers.

In September 2012, we published our second annual report on *The state of medical education and practice in the UK*, which assessed our data on complaints about doctors. Complaints to the NHS and the other regulators are also rising.

We have published a study into the factors driving complaints from medical directors and others acting in a public capacity (such as the police) and we have just commissioned research into complaints from members of the public, which will be completed later this year. Rising patient expectations, easier online access to make a complaint and the heightened profile of the GMC may contribute to this increase and will be explored more fully in the study.

We will be happy to share the findings of this research at the next accountability hearing.

16. Report recommendation: We note the proposal to pilot arrangements where a doctor may accept a sanction in a 'clear-cut' case without requiring a panel hearing. We recommend that the GMC evaluate such pilots carefully to ensure that there is no detriment to the public interest in not holding a hearing, and publish detailed and clear guidance on the circumstances in which such a procedure may be considered appropriate. (Paragraph 88)

We believe that if a doctor both accepts that there is a problem with their practice and the proposed action needed to protect patients, then the case for holding a hearing – which is often stressful for patients, their relatives and the doctor – is hard to make.

The important point here is that any action taken as a result of our investigation would be made public. The decision and the reasons for it would be published on the GMC's website and marked clearly in the doctor's record in the public register, available 24 hours a day, 365 days a year.

Where there is a dispute between the GMC and a doctor about the outcome of our investigation or where the doctor will not accept the proposed sanction, the case will still go to a public hearing of the Medical Practitioners Tribunal Service.

We agree that it is important to assess the impact of the pilots. We will therefore conduct an independent evaluation and ensure that any action we take protects the public interest.

We will ensure the Committee remain informed on the progress of these pilots.

17. Report recommendation: We continue to believe that the present fifteen-month target set for the GMC to conclude 90 per cent of its cases is insufficiently challenging; we invite the GMC to report to us in 2013 on the proportion of cases concluded within 12 months in 2012. (Paragraph 90)

We will report to the Committee in 2013 on the proportion of cases concluded within 12 months in 2012.

We have just consulted on a range of proposals to speed up our hearings process which builds on best practice from other jurisdictions such as the courts and tribunals service. This includes reducing the time witnesses need to spend giving evidence and improved pre-hearing case management. Responses to the proposals have been positive and we are aiming to roll-out the changes in early 2013. We are also taking forward work to improve the efficiency and effectiveness of our fitness to practise operation more generally using Lean business improvement techniques.

Both of these initiatives should support our commitment continuing to speed up the time it takes to conclude a case and to improve the experience of patients involved.

We are currently reviewing our Key Performance indicators in this area and will report to the Committee at our next accountability hearing.

Medical Practitioners Tribunal Service

18. Report recommendation: We are encouraged by the establishment of a functionally independent MPTS, which we believe will provide greater assurance to the public about the quality of decisions made by the regulator about the fitness to practise of doctors. (Paragraph 94)

19. Report recommendation: The emphasis placed by the Chair of the MPTS on the consistency of its decision making, the effective management of its cases and the dissemination of best practice throughout the service is welcome. We look forward to examining the progress of the MPTS in 2013. (Paragraph 95)

20. Report recommendation: We welcome the commitment of the Government to propose legislation to enable the GMC to appeal against decisions made by the Medical Practitioners Tribunal Service. We ask the Government to make clear when it intends to introduce legislation to fulfil this commitment. (Paragraph 96)

We welcome the Committee's support for the establishment of the Medical Practitioners Tribunal Service (MPTS).

The GMC and the MPTS believe the GMC should have a right of appeal against decisions made by the MPTS. We believe this will enhance the operational separation between the two functions of medical regulation, and is the logical expression of that separation. The Government has expressed an intention to bring forward the necessary legislation by the beginning of 2015. We continue to work with the Government to expedite this work and would hope that the legislation might be introduced by the middle of 2014.

In anticipation of this change, the MPTS has set up the MPTS 'User Group', a regular meeting at which the various medical defence organisations, legal firms and the GMC can all voice concerns and discuss the operation of the MPTS. In addition, we will continue to work with the Professional Standards Authority for Health and Social Care to ensure the new procedures for appealing decisions complement to the work of the Authority.