



Handbook for performance assessors

Working with doctors Working for patients

General
Medical
Council

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How to use this handbook

This handbook sets out the key roles played by team leaders, medical assessors and lay assessors as performance assessors in our fitness to practise procedures. It does not cover all possible situations that a performance assessor may face, but it does give practical advice on what we expect of a performance assessor who has been appointed to assess a doctor's professional performance.

Our fitness to practise rules potentially give assessors a wide remit. Schedule one says: *'The Assessment Team or, as the case may be, the individual performance assessor shall, having regard to the nature of the practitioner's employment or as appropriate previous employment, adopt such procedures as appear necessary in order to assess the standard of the practitioner's professional performance'*.

Nonetheless, the handbook does provide practical advice on the expectations of a team leader, medical and lay performance assessor when a doctor is required to undergo a performance assessment.

The handbook should be used as a point of reference when carrying out the role alongside the Standards for performance assessors. You can find these standards at **www.gmc-uk.org/DC6510_Standards_for_performance_assessors_58293147.pdf**.

The handbook also makes reference to associated guidance. These will be updated periodically so you should make sure that you are familiar with and refer to the guidance when necessary.

Who's involved in a performance assessment?

The doctor

The doctor's performance is the focus of the performance assessment. The doctor is expected to comply with the reasonable requirements of the assessment team. The doctor will be advised by the performance assessment officer about what will be expected and what arrangements are being made.

We'll provide all the necessary information and timetables the doctor needs to prepare before their assessment. It is the responsibility of the assessment team to make sure the doctor understands what is required of them during the assessment.

We'll send a copy of the completed assessment report to the doctor.

The doctor's supporter

A doctor can ask somebody to accompany and support them on the days of the assessment.

The doctor's supporter may be present at meetings where the doctor is interviewed by the full team, except the case based discussion or where the interview relates to discussion of particular cases or named patients.

A supporter may intervene if the doctor needs to compose themselves, or if the doctor has not understood a question. But supporters can't answer questions for the doctor.

It is the doctor's decision on whether to have a supporter and who that should be.

Performance assessment officer

The first point of contact you'll have is normally with a performance assessment officer. They'll contact you by telephone or email to arrange dates, including the number of days needed for the assessment.

Another performance assessment officer is allocated to each case to arrange the assessment. They send out formal letters of appointment and are the main point of contact and support for the assessment team. Before the assessment begins, there will be no direct contact between the assessment team and the doctor. The role of the performance assessment officer (in conjunction with the team leader) includes:

- liaison between all the parties involved in arranging the assessment
- making sure the assessment runs smoothly
- making sure that data is gathered from the assessment and is ready for data entry
- giving you advice on best practice and the assessment process.

Team leader

The team leader is a medical assessor who may be in or out of specialty. The team leader leads the performance assessment team and is responsible for planning the assessment with the performance assessment officer and the medical and lay assessor(s). The team leader completes the report and sends it to us. They are also responsible for any interim reports that need to be sent to us (see the guidance on page 35–36). If the case is heard

by a medical practitioners tribunal, the team leader may appear before the tribunal to present the report. The team leader must hold a licence to practise.

Medical assessor

We select medical assessors, taking into consideration the doctor's specialty. Medical assessors are trained appropriately to their role. They may need to give evidence at an MPTS hearing and must hold a licence to practise.

Lay assessor

The lay assessor has been trained with the medical assessors but brings a layperson's perspective to the assessment. Lay assessors have a particular role in chairing specific interviews. They may record clinical evidence but must not make judgements on clinical issues. Lay assessors may also be asked to give evidence at MPTS hearings.

Research Department for Medical Education (RDME)

RDME writes the reports for the tests of competence for the fitness to practise procedures, using specific tests that have been designed to reflect the practice of the doctor being investigated.

RDME is responsible for the development and maintenance of a bank of questions used in the tests of competence.

Professional role players

Professional role players can be used to act as simulated patients in objective structured clinical examinations or the simulated surgery at the tests of competence.

Shorthand writers

A shorthand writer or stenographer is responsible for producing a full transcript of the performance assessment team's questions and interviewees' responses.

The trust, practice or health board

The trust, practice or health board may be contacted by the performance assessment officer to assist them making the necessary arrangements for the assessment. This includes:

- arranging meeting rooms at the hospital or practice for the parts of the assessment to be carried out there
- making sure medical records are available in advance or when the team visits and that copying facilities are adequate
- explaining that we have a legal right to ask for records carry out an assessment
- making sure a trained computer operator is on hand for the medical record review if there are computerised records
- explaining to those involved that the team will aim to keep the visit as confidential as possible but will require substantial cooperation from those involved in the trust or practice
- writing to the trust or practice after the visit to thank them for their help and cooperation.

If you have concerns about another doctor's performance or the systems where the visit took place, you should follow the guidance on pages 19 and 35–36.

Employer liaison adviser

Our Employer Liaison Service creates closer working relationships with employers. The role of the employer liaison adviser includes:

- establishing good links with responsible officers and their teams to support two way exchange of information about under- performing doctors, therefore improving patient safety and the quality of referrals
- sharing our data about under-performing doctors, including regional trends
- helping responsible officers and their teams understand our thresholds and procedures
- providing support to responsible officers and employers in relation to revalidation.

Employer liaison advisers cover an assigned geographical area.

Case examiner

Information that we gather on a case will be considered by two of our senior members of staff, known as case examiners (one medical and one non-medical). If threshold for impairment is not reached, they can:

- conclude the case with no further action
- issue a warning.

If threshold for impairment is reached, they can:

- agree undertakings to address a problem
- refer to the Medical Practitioners Tribunal Service (MPTS) for a hearing.

Investigation manager

When a decision has been taken to open a case and investigate, it will be allocated to an investigation officer. In cases where a performance assessment is needed, the performance assessment officer will organise the assessment but the investigation officer will retain overall ownership. The investigation officer retains ownership until it passes to the case examiners for a decision.

Performance assessment manager

The performance assessment manager oversees the performance team and the relevant processes. They also act as an assistant registrar and sign out assessor's reports.

Investigation officer

When a decision has been taken to open a case and investigate, it will be allocated to an investigation officer. In cases where a performance assessment is needed, the performance assessment officer will

organise the assessment but the investigation officer will retain overall ownership. The investigation officer retains ownership until it passes to the case examiners for a decision.

Investigation assistant

The investigation assistants are responsible for inputting the assessment team's handwritten entries into a database that is appended to the assessors' report. They will contact you directly if they need clarifications.

Planning the performance assessment

Depending on the doctor's circumstances, a performance assessment usually includes a peer review and tests of competence.

A **peer review** assesses the doctor's performance in the workplace. The visit can last for approximately three to four days. It takes place at or near the doctor's place of work, although some parts of the assessment may be conducted elsewhere.

The **tests of competence** are designed to assess a doctor's knowledge and skills.

The tests are not pass or fail. Where appropriate, the doctor's results are compared to reference groups of other doctors who undertook the stations or questions used in the test. Other standard-setting exercises are used (eg the Angoff method) to help to define acceptable standards. Testing takes place in a clinical skills centre, usually in Manchester.

Before the assessment begins, the doctor must complete a portfolio – we'll send this to them in advance. It asks for information about the doctor's qualifications, employment history and continuing professional development.

What information will I be given?

The performance assessment officer will give the assessment team (as a minimum):

- a summary of the alleged performance issues
- a completed portfolio
- a portfolio checklist.

You will be sent information through our secure online portal, GMC Connect. For information on this, please see our associated guidance.

While reviewing the portfolio, each performance assessor must complete the portfolio checklist. You should bring your copy with you to the first team meeting (see page 29).

Once the assessment team has this information, you should actively engage in making team decisions, work together, by phone and email to start planning the assessment. The performance assessment officer will make the arrangements for you to do this.

One of the first steps in planning is to choose the assessment instruments that will be the most helpful in the circumstances of the case. You can find full details of each instrument in the following section.

Performance assessment officers can provide advice and should be included in all discussions.

As a minimum, the team must consider and if appropriate decide:

- the level at which the doctor will be assessed
- where to base the assessment
- samples of records to review (see page 16), their sources and if they can be reviewed before the visit
- who to interview
- if it is possible to observe the doctor in practice
- scenarios that reflect the doctor's background and experience to be included at a tests of competence.

Working with the performance assessment officer, you can then plan a workable timetable.

Declaring a conflict of interest

A conflict of interest is one that might influence, or could be perceived to influence, your independence or impartiality in assessing the doctor.

A conflict of interest may arise in several ways. For example, if you know:

- the doctor under assessment
- the complainant or referrer
- a third party interviewee
- any senior decision makers involved in the case (eg through education or training, working relationships, membership of committees, attendance at meetings or conferences, or socially).

You must give us details of any perceived conflict of interest including the dates and extent of contact and an opinion on whether this poses a risk to the objectivity of the assessment.

If you're not sure whether a conflict of interest might exist, you should send the details to the performance assessment officer who will advise you.

What if the doctor's practice is restricted?

If the doctor's practice is restricted when you carry out the assessment, the team should consider whether the sample of records requested should cover a period of unrestricted practice.

What happens when doctors fail to cooperate?

Sometimes, a doctor will refuse to undergo a performance assessment or fail to cooperate with the assessment process.

When this happens, the case may be referred to the MPTS, where a medical practitioners tribunal will consider whether the doctor's fitness to practise is impaired and if action is required on their registration.

Assessment instruments

This section details each instrument available to the assessment team.

Peer review: to assess the doctor's performance in the workplace.

- First interview with the doctor
- Medical records review
- Site tour
- Third party interview
- Observing the doctor's practice
- Case based discussions
- Second and third interviews with the doctor

Tests of competence: to assess the doctor's knowledge and skills.

- Knowledge test
- Objective structured clinical examination
- Simulated surgery (general practice only)
- Reporting module

You should use any instrument that is appropriate to the doctor's specialty and circumstances and that will add significant value to the assessment. The team may also wish to include additional assessment tools that aren't part of our suite, such as the use of high-fidelity simulation to assess specialist practical skills.

Peer review instruments

First interview with the doctor

This interview is an opportunity for the assessment team to introduce themselves and explain the assessment process. It is also an opportunity for the doctor to ask questions but not to replay the matters raised in the complaint.

It is usual for the assessors to ask clarification questions about the topics covered in the doctors completed portfolio. The purpose of these questions is to establish matters of fact regarding context of the doctor's practice; no judgements are recorded at this stage.

Medical records review

Access to medical records

The *Medical Act 1983* gives us powers to inspect and copy medical records to carry out an assessment. We can share these records with an assessment team.

A medical records review lets medical assessors establish the doctors' professional performance, particularly their clinical care and record keeping.

Making sure samples are fair

The sample of records you request must be fair – it should be a sample of records that reflects all of the doctor's professional performance (including private practice, out of hours and sub-specialties). You should take information from the portfolio into account. For example, if surgery takes place in one hospital and follow-up in another, you should ask for sets of notes from both sites to make sure the review is complete.

The medical records review will assess the doctor's most recent work available at the time of the assessment.

The records must be from cases in which the doctor has been involved. For example, the sample might include specified number of surgery consultations, surgical procedures, home visits or patients seen in a particular clinic.

If the team decides to include records relating to the complaint, these should usually be in addition to the sample.

Reviewing the records

Medical performance assessors will independently assess the same records.

Where possible, the performance assessment officer will provide you with this information as soon as possible through GMC Connect so you can conduct the review remotely.

From the beginning of the medical records review, medical performance assessors should agree a consistent way to identify patients and stick to this throughout.

You will usually be able to review secondary care records from the original file during a workplace visit. The performance assessment officer will contact the relevant department to make sure you have adequate access to any computer systems.

When reviewing medical records, you should use the shortlisting sheet (provided by the performance assessment officer) to shortlist possible cases for discussion and record possible questions in an attempt to cover all assessment categories.

Site tour

A site tour lets the assessment team clarify any matters that have arisen from the portfolio about the working environment. Site tours can help the team to address the statement in the report:

The team did not find any evidence to suggest that Dr X's working conditions prevented an acceptable level of professional performance.

The site tour should interfere as little as possible with the normal running of the department or practice.

When describing factors that might compromise acceptable professional performance, the assessment team should distinguish between factors outside the control of the doctor and those for which he or she might bear some responsibility, for example as a medical manager or principal in general practice.

If, during the course of the assessment, the team has concerns about systems in the healthcare provider, they should highlight these accordingly. If necessary, we'll share these concerns with the Care Quality Commission.

Third party interview

The assessment team can choose who they would like to interview. Choices should be limited to those who appear to have worked closely with the doctor, eg colleagues of the doctor who have recent, first-hand knowledge of the doctor's performance.

We let the doctor nominate up to two interviewees. We recommend no more than seven interviewees are invited in total.

We will write to third party interviewees to arrange the interview and give them the information they need.

Assessors should record what interviewees say and record a judgement that reflects the opinion of the interviewee, not the assessor. Where it is within your expertise, you may also record your own opinion based on the interviewee's response but this must be clearly marked as such. Please refer to the specific instructions on the instrument.

Interviews can take place face to face, or over the telephone if this is not practical.

Interviewees can have a supporter present during the interview.

Observing the doctor's practice

If the doctor has a licence to practise in the UK and is currently working, you can observe them in a typical clinic, ward round or during their other duties. If this is not possible but recordings of the doctor in practice exist, such as out of hours telephone consultations, you can use these instead.

All performance assessors are involved in this part of the process.

You should only intervene in an observed consultation if you believe there is an immediate risk to patient safety.

The doctor should get written or verbal consent from patients to allow you to sit in on consultations. If this has been done in advance, you must make sure verbal consent is also given at the time of the consultation. It is the doctor's responsibility to explain to the patient that refusal will not jeopardise their care.

The patient doesn't need to be told that the doctor is subject to a GMC investigation, but they must be told whether you are a lay or medical performance assessor.

Issues that arise from an observed consultation can be used to further explore the doctor's reasoning in the case based discussion.

Case based discussions

Case based discussions let you probe and describe the doctor's reasoning across assessment categories.

Planning the case based discussion

You and your fellow performance assessors must shortlist cases to discuss with the doctor, then create questions that reflect the doctor's work.

Using the shortlisting sheet and a case based discussion planning grid, the whole team usually selects 12 cases from which 36 questions are asked.

If the team decides to include records relating to the complaint it should, as a rule, be in addition to the sample of 12 cases.

The completed planning grid should demonstrate that the case based discussion is fair and balanced and will be included in the report.

Questions should assess reasoning, rather than factual knowledge or a description of what the doctor did. They should focus on the doctor's decisions, and they should be discriminating – in the sense that they will let assessors distinguish between acceptable and unacceptable performance.

You should agree the purpose of each question and satisfy yourself that the text of the questions adequately reflects this purpose.

You should plan questions carefully to avoid having to ask a clarification question. Clarification questions should not be planned, but if they are asked they should be recorded by a nominated performance assessor on the appropriate document provided by the performance assessment officer.

Case based discussion questions are:

- clear
- unambiguous
- case based
- non-confrontational
- open.

Case based discussion questions do not:

- ask the doctor to repeat the evidence already recorded by assessors in the medical records review
- seek an apology
- give feedback.

Questions based on OSCE or simulated surgery

You should base your questions on your observations of the doctor during the objective structured clinical examination or simulated surgery. Questions should be crafted to explore the doctor's reasoning behind their decisions or actions taken during the tests.

You may ask questions in assessment categories that are not directly addressed in the station task. For example, if the doctor's task was to assess a patient, you may wish to ask a question that addresses management options. You should be mindful to the opportunity to cover a range of assessment categories.

The number of questions will vary, but it's usual for the assessment team to ask between one and three questions for each scenario that the team choose – you don't need to ask questions on every station.

You should be mindful to preserve the integrity of the item bank and not divulge specific details of the scenario in the question.

The performance assessment officer will give the doctor a copy of the medical records, or extracts before the case based discussion. This gives them time to become familiar with the content.

Questions for the discussion

To make sure that there is no ambiguity about questions that are asked, copies of the planned questions will be given to all assessors.

Second and third interviews with the doctor

The second and third interviews lets the assessment team add the doctor's comments to the evidence gathered from other instruments.

The team should plan questions carefully to make sure:

- questions are generally open rather than closed to allow the doctor to describe their performance in their own words
- answers are likely to make useful contributions to the database for report writing
- answers are likely to help assessors distinguish acceptable and unacceptable performance when making judgements.

Questions might:

- explore areas that haven't been fully explored by other instruments, such as audit, appraisal, keeping up to date, or teaching
- be an opportunity for the doctor to comment on general criticisms made by others or in third party interviews (bearing in mind that the assessment is not an investigation of complaints)
- explore the doctor's understanding of his or her professional performance
- contextual issues, such as factors that might affect the doctor's performance (eg workload or locum work), or career plans.

If necessary, the assessment team might remind the doctor of any previous agreement to produce additional information such as a personal development plan or audit report.

The interviews are also an opportunity for the doctor to give the team feedback about the overall conduct of the assessment so far. The doctor may also ask questions of the team and offer new, relevant information.

You should tell the doctor about the next steps of the process including, where appropriate, the opportunity to submit written comments on third party interview transcripts or on receipt of the report.

Tests of competence instruments

Knowledge test

The knowledge test is normally made up of single best answer questions selected from an item bank.

The questions are chosen to reflect, as closely as possible, the work the doctor actually does in practice. Knowledge tests are tailored to the doctor's grade and any areas of specialisation.

Each question has a list of possible answers and the doctor is asked to choose which answer they consider to be the single best answer. A time limit will be given.

There is no negative marking for the knowledge test.

Objective structured clinical examination

During the objective structured clinical examination (OSCE), the doctor is presented with scenarios that could arise in the course of a normal working day. They are designed to test the doctor's practical skills, clinical method and interpersonal skills.

Each scenario is set up in a separate area – these areas are known as OSCE stations. The stations can use medical models and equipment and role players as patients and colleagues.

Medical assessors normally select OSCE stations from a list provided by RDME. The selection should cover as full a range of the areas of *Good medical practice* as possible. RDME is available to support medical assessors in this process.

Each scenario in the OSCE is designed to last about seven minutes. The team leader will tell the doctor of the time allocated.

The skills assessed in the OSCE may include:

- history taking
- clinical examination
- practical communication
- written communication
- diagnostic and management skills.

Depending on the doctor's specialty, they may be tested on emergency situations, as well as palliative and terminal care.

Simulated surgery (general practice only)

This test involves the doctor conducting ten simulated general practice (GP) surgery consultations with pre-briefed role players acting as patients.

The simulated consultations take place in a typical GP surgery setting.

They are designed to test the doctor's overall knowledge, data gathering, technical and assessment skills, clinical management skills and interpersonal skills in scenarios that they are likely to come across in a normal working day.

Each simulated consultation is designed to last ten minutes. The team leader will tell the doctor of the time allocated.

Reporting module

For specialties such as pathology, microbiology or radiology reports, there will be a series of images or slides on which the doctor must make a diagnosis. In some cases, they must also discuss how they would manage these cases.

Carrying out the assessment

First meeting of the team

The team leader will chair the meeting and introductions. It is the **team leader's** responsibility to make sure that all assessors understand:

- the standards described in *Good medical practice* and its supplementary guidance
- that unless we direct otherwise, the assessment will look at the doctor's competence and performance in the specialty or specialties in which he or she has practised, up to and including the date of the assessment
- the role of each assessor and the performance assessment officer
- the importance of reaching fair, objective and transparent decisions, avoiding stereotypes or making assumptions
- that assessors should keep in mind the questions asked on the formal opinion page and make sure that the content of the report provides a clear opinion as to the doctor's fitness to practise
- the assessment may only be one part of an investigation into the doctor's fitness to practise. There may be aspects of the case that the assessors have intentionally not been told about
- the rules for carrying out the assessment (see pages 32–34).

During the meeting, the performance assessment officer will explain the practical arrangements for the assessment. They will also give you the opportunity to comment on any further relevant information received.

You and your fellow assessors should review the assessment materials, in particular the instructions on the instruments the team will use for the assessment and the timetable, so that everyone is clear about what has to be done.

Finally, you should discuss the completed portfolio checklists with the other assessors, then agree the questions you wish to ask the doctor during the first interview.

If you have any concerns that the doctor may not be fit to continue the assessment for any reason, your main concern should be for the doctor's wellbeing. The assessment team should make sure the doctor experiences as little stress as possible.

If you have concerns about the standard of the doctor's knowledge of English, which may be affecting their performance, we can arrange an assessment of the doctor's English language as part of the performance assessment process.

If the doctor won't cooperate with the team, the team leader should report this to the performance assessment officer and send us a report that outlines what has happened.

How you'll capture evidence during the assessment

Qualitative entries

All assessors should capture qualitative entries, which describe what the doctor did or did not do.

It is essential that your entries are accurate, comprehensive and comprehensible.

All assessors should circle and categorise entries for the database.

Where it is appropriate to your role and within your expertise you should use A or U judgements (A being acceptable and U being unacceptable). Please refer to the individual judgement criterion and assessment categories in the appendices (pages 61–64).

When recording other evidence, perhaps outside of your expertise (with the exception of third party interviews), assessors may wish to:

- use the 'context' category OR
- use an assessment category but record the entry as 'no judgement'.

When scoring stations medical assessors qualitative entries should expand on their scores.

Assessing the OSCE and simulated surgeries

You must make independent judgments about the doctor's performance in OSCE and the simulated surgeries.

Scoring

Only medical assessors score the OSCE and simulated surgery stations. You must score on the mark sheets using the scales provided. Each alphabetical letter on the scale has a numeric value which RDME use to generate the histograms in their reports.

You should use the points for consideration on the OSCE mark sheets for guidance only and not as a checklist.

Assessors should check they have put a score in every box on the mark sheet.

Rules for the assessment

The team leader along with the performance assessment officer should make sure all **assessors** understand:

- the instructions on each instrument provided to you when gathering evidence during the assessment
- out of specialty team leaders do not judge the doctor's clinical practice where it is beyond their area of expertise
- the need to maintain a professional relationship with the doctor. This includes not using first names in the doctors presence, or becoming involved in giving advice or acting in any other way that could compromise your role in judging the doctor's performance
- the team is responsible for deciding whether to accept further information offered to them during the assessment process and consider its relevance to the assessment.
- the need to maintain confidentiality as far as possible
- the requirement to give copies of any documents collected or accepted (for example, from interviewees) during the assessment to the doctor
- the timetable has been set out to take into account practicalities and people's availability. You should stick to the timetable and discuss any changes with the performance assessment officer
- you must not alter tests of competence scenarios unless you have had a discussion with RDME to make sure validation is unaffected

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- you should concentrate on recording database entries and not reach conclusions before the team leader reviews all the evidence during the report writing stage of the process
 - the assessors may not take an audio or video recording of any part of the assessment
 - throughout the assessment, you should make notes in your files of any matter that you might want to discuss with the doctor at the second or third interview. You shouldn't remove or destroy these notes, as documents in your files are disclosable
 - you should fully complete your documentation as you go along and all documents must be returned to the performance assessment officer
 - the team leader or performance assessment officer should answer questions about the process
 - assessors must not communicate alone with the doctor, the doctor's supporter or third party interviewees
 - no assessor should be alone with the doctor unless expressly instructed to do so by the performance assessment officer
 - you should immediately tell us about any observations from the tests of competence that pose a risk to patient safety. Please see guidance on page 35.

It is the team leader's responsibility to make sure the **doctor** understands:

- although the team is aware of the complaint and will assess relevant issues, the assessment is of the doctor's overall performance. Although the index cases may be assessed this is an objective assessment, not an investigation of the complaint
- the process for the assessment and next steps
- when they can have a supporter present: at the first, second and third interview as well as briefings with the team
- the doctor or their supporter may not take an audio or video recording of any part of the assessment
- they will not be given any feedback
- the procedures before each test
- the format of the knowledge test:
 - how it will be marked and the time limits of the test. This may be done using sample questions that will be provided with the test paper
 - how to correctly complete the answer sheet
 - highlighting there is no negative marking and it is recommended the doctor answers all questions.
- they can request a break at any time
- there will be opportunities to ask questions.

What happens if patient safety issues arise?

There is always a possibility of patient safety issues arising during a performance assessment.

The assessment instruments focus on sampling the doctor's performance, rather than identifying individual cases where patient safety might be at risk. However, you must immediately tell us about any observations you make that could pose a risk to patient safety.

The team leader may consider it appropriate to discuss concerns with the medical or clinical director, practice manager or clinical governance lead. This conversation should be limited to issues that need to be addressed immediately – emphasising that the team cannot provide any other feedback about the doctor's performance at this stage. In most cases, we will follow up this conversation in writing.

The team leader will need to write to us detailing:

- the name of the doctor under assessment
- the dates of the assessment
- specific examples of the patient safety issues identified
- details of any action taken
- if appropriate, recommendations for further action.

The performance assessment officer will tell the team leader if they need to prepare a short interim report for us. If so, this should outline the team's concerns and provide clear supporting examples.

If the team get information that calls the fitness to practise of another doctor into question, the team leader should liaise with the performance assessment officer and, if appropriate, send us the details.

It remains the responsibility of the employing trust to investigate concerns that we highlight and to consider further appropriate action.

Record of the day's events

The lay assessor uses the record of the day's events to log the interactions between the doctor and the team during the tests of competence. This may include any deviations from the timetable or the brief, and any further interactions with the doctor must also be recorded.

It is the lay assessor's responsibility to manage this record.

Who invigilates the knowledge test?

The lay assessor or performance assessment officer should invigilate the knowledge test.

It is the invigilator's responsibility to time the test and announce it at 60 minutes, 30 minutes and five minutes before the end, and at the end of the allowed time.

The invigilator will collect the test papers at the end of the knowledge test. Additional time is not allowed for the knowledge test.

Keeping information secure

It's important that you don't leave assessment materials or paperwork unattended at any time. Please refer to our guidance on information security, which you can find at www.gmc-uk.org/DC6422_Information_security_policy_for_associates_and_contractors.pdf_57912264.pdf.

The performance assessment officer will arrange for the secure storage and disposal of your confidential assessment documents.

At the end of the assessment

If the team has any constructive suggestions about the assessment (eg materials, instruments), this is an opportunity to feed them back via the performance assessment officer.

If you have not already done so, you should agree a date for the report review day.

We transcribe assessors' handwritten entries into an electronic database. These entries contribute to evidence that can be used and appended to the report. We'll contact you if there is unclear handwriting or if judgments or categories are missing.

Writing the final report on the doctor's fitness to practise

The team leader will write a draft report, highlighted with areas for discussion, and share it with the assessment team. You will then meet at a report review day to discuss the report, address discrepancies and agree conclusions.

We'll arrange the report review day on a day that gives the team leader enough time to prepare and circulate the report to the other members of the team.

The assessors' report

The assessors' report informs our decision on what, if any, action should be taken in the case.

The report describes the doctor's performance. It should:

- describe strengths and weaknesses with illustrative references to the database
- be fair and balanced giving the team's clear professional opinion and how it was reached.

We'll invite the doctor to comment on transcripts of third party interviews and let you consider their comments.

The team leader will send the completed report to us. We'll then send the report to the doctor and anyone who the doctor contracts with to provide medical services.

Report writing

The team leader accesses the completed database via the assessor portal. The team leader can search the database in many ways to enable them to write the report.

All reports must:

- include comprehensive and thematic analysis of the evidence
- include findings based on what the team has assessed
- avoid speculation or conjecture
- cite appropriate database entries that add value to your evaluation of the doctor's performance as illustration only. As the database is an appendix to the report, there is no need to include every entry.
- only refer to a database item once and only pass judgement on a deficiency once, even if comments about it appear under more than one category
- include unique reference numbers with each example so that it can be traced back to the database and, if necessary, to the assessor's original notes
- be written using our current report template
- include the tests of competence report data
- comply with our style guides (Tahoma 12 font with 1.5 line spacing)
- include paragraph numbering where appropriate
- never quote the number of individual A or U judgements in a category
- use case/objective structured clinical examination station numbers in the prose.

It is not sufficient to copy and paste entries from the database without comment. The nature of your comments may be influenced, for example, by:

- patterns of performance
- the strength of the evidence
- the consequences for patient safety
- whether or not the actions in question meet accepted standards in
- *Good medical practice*.

Example category

Best practice for the content and structure of a report is shown in the example category below.

Performance in the category of CLINICAL MANAGEMENT

Overall assessment: UNACCEPTABLE

Evidence for this category came from:

First interview	Third party interviews
Medical record review	Second interview
Case based discussion	Simulated surgery
Site tour	Objective structured clinical examinations
Observation of practice	Third interview
Other: Knowledge test	

All of the comments recorded by the assessment team under this category have been considered and weighted. Those considered the most significant examples are discussed below. Further potential examples of the performance being described have also been referred to.

For a complete list of all the comments recorded under the category of clinical management refer to page xx of appendix 5/6: *Comments and judgements*.

Overview:

- Contextual factors that affect the scope of practice assessed under this category.
- Strength of evidence gathered and how it was weighted.

Lead with the overall judgement of an assessment category and the evidence for this.

Evidence of unacceptable performance

- Performance that may put patients at risk.
- Describe and use examples of potentially harmful practices explaining why such examples may harm patients.
- Avoid the following phrases.
 - 'It is acceptable/unacceptable' rather 'the team judged this as acceptable/unacceptable.'
 - 'The team felt.'
 - 'It appears.'

Subheading (theme/pattern)

- Describe performance with reference to strong illustrative examples.
- Explain why this is unacceptable – include the significance and consequences for patient safety as it may not be clear to a lay reader.
- Provide further examples if they can be found in the database. They can be listed here by database reference.

Evidence of acceptable performance:

Subheading (theme/pattern)

- Describe performance with strong illustrative examples.

Conclusion

- Summarise the themes/patterns of acceptable and unacceptable performance.
- Do the actions comply with the standards of *Good medical practice*? Quote *Good medical practice* here if necessary.
- Recap on areas where patients have been put at risk.
- Comment on corroboration with other categories.
- Give the team's opinion, based on the evidence, of the doctor's performance in this category. You may refer to the definitions of A, C, U for overall judgements.

Summary and recommendations

The summary and recommendations in the report are what we will rely on when deciding what action, if any, to take on the doctor's registration. We can't enforce any recommendations made if the team decides the doctor is fit to practise generally. For the majority of cases where the team's opinion is that the doctor is fit to practise on a limited basis, we will try to agree undertakings with the doctor and we will use your recommendations as the basis of these restrictions.

Always keep in mind that if the recommendations you make are so stringent that there is no realistic chance of the doctor securing employment, this is equivalent to suspending their registration. In these types of cases you should consider recommending erasure.

In this section:

- clearly link recommendations to the conclusion
- as a minimum, include the type of restrictions required to ensure patient safety. If it is within an assessors expertise they may also recommend remediation measures
- use GMC terminology and refer to our *Glossary for undertakings and conditions* when writing recommendations
- make clear and unambiguous recommendations for a restriction. Set out the degree of independent decision making the doctor should be permitted and the level of supervision they require
- if recommending that the scope of the doctor's practice be curtailed, be specific about the types of procedure the doctor should stop doing
- recommend which areas require remediation rather than how the remediation should be carried out.

Before the report review day

All members of the assessment team must read and carefully consider the report before the report review day.

Once the team leader has written the report it is his or her responsibility to circulate it to the rest of the team, including the performance assessment officer, by email at least seven days before the report review day.

On the report review day

Report review days allow all members of the assessment team to work on the report together.

Discrepancies between lay and medical assessors' entries are expected.

Where there are discrepancies between medical assessors', team leaders may include this in the report acknowledging the difference of opinion and attempts to resolve this at the report review day.

All members of the assessment team should attend, supported by the performance assessment officer. Occasionally an assessor may only be able to attend by telephone conference call.

We will provide:

- a projector connected to a laptop for the team to collectively edit the report. A second projector can be requested to view the database
- information that was provided to the assessment team including: assessment instruments, third party interview transcripts, doctor's portfolio, copies of medical records used in the case based discussion and any additional information received during the assessment.

The team is expected to:

- agree the preliminary sections of the report (context, complaint, conduct of the assessment)
- discuss elements of the assessment where all assessors were not involved eg medical record review, third party interviews
- consider the doctor's comments on the third party interview transcripts
- highlight patient safety concerns
- make sure evidence is weighted appropriately
- include illustrative database entries
- check the fairness and robustness of evidence used
- identify and explain areas of weakness in the evidence and the report including discrepancies between assessors and other contentious areas
- incorporate language from *Good medical practice*
- analyse the content and agree overall judgements for each assessment category

-
- check that conclusions reflect the content of the database
 - show in the summary and recommendations section how the conclusions are based upon the evidence
 - take the *Glossary for undertakings and conditions* into account when making recommendations
 - agree their formal opinion
 - proofread each section of the report.

The report review day is also an opportunity for each assessor to reflect on their own contribution to the assessment. For example, you might want to consider your ability to capture data that contributes effectively to a fair and robust qualitative description of the doctor's overall professional performance.

The team leader should also use the report review day to provide feedback to each assessor, so they can reflect on the quality of their contribution to the assessment.

After the report review day

The team leader must submit a completed report that complies with the guidance in this section. Performance assessment officers will then add a signed formal opinion page, appendices, page numbers and a contents page.

Reassessing a doctor

If a doctor has had restrictions placed on their registration following a previous assessment, they are normally required to undergo a reassessment to discover whether they have improved sufficiently to allow them to return to unrestricted practice.

Methods for reassessment

The assessment team should take account of instructions and information that we give to them. If the reassessment is being carried out towards the end of a period of undertakings or conditional registration, the team should consider the requirement of the restrictions.

The team leader, performance assessment officer and RDME should liaise closely about the format of the reassessment.

We ask the doctor to submit a reassessment portfolio. This document asks for information about the context of the doctor's work, and includes a section that records learning activities undertaken since the previous assessment. In the case of secondary care medicine, we ask the doctor to complete a log of cases.

You must be prepared to justify the approach to a medical practitioners tribunal. It is good practice to choose to repeat some stations to act as a comparison to a previous assessment.

Scope of reassessment

Even if the initial assessment found deficiencies in only one or two areas of the doctor's performance, the assessment team still need to assess all areas of practice, unless we instruct otherwise.

We'll provide assessors with:

- the previous report
- a summary of the doctors activities following the previous assessment.

Restrictions on the doctor's practice

The doctor's registration status has an impact on what work they can do. If they are suspended, they cannot do anything that requires registration. Bear in mind that any conditions or undertakings will restrict what the doctor can do.

Showing that deficiencies in performance have been addressed

There should be clear evidence that the doctor has taken steps and made progress towards remedying their performance deficiencies. Where a doctor has been under supervision, the team may wish to interview those in a supervisory role as a third party interviewee.

After reassessment, the doctor may be allowed a further opportunity to take remedial action, after which there would be another reassessment.

The reassessment report

The team will need to submit a reassessment report, which should be a standalone document. It should not refer back to previous reports in a way that requires the reader to consult earlier reports. It may however, make comparisons, quoting from earlier reports or repeating information.

The team's reassessment report should follow guidance as detailed in *Writing the final report on the doctor's fitness to practise* (pages 38–47).

Giving evidence at a tribunal hearing

Where the assessment report identifies serious concerns about a doctor's fitness to practise, the case will be referred to a hearing before the Medical Practitioners Tribunal Service (MPTS).

Team leaders will be required to give evidence about the assessment to the tribunal. Where the team leader is out of specialty the medical assessor will also be required to give evidence. We will not ordinarily call the lay assessor to give evidence, but the doctor or tribunal may require them to attend.

You will be required to attend the tribunal hearing in person to give oral evidence (see the section *Giving evidence* on pages 56–58).

Pre-tribunal hearing communication

The case will be assigned to a legal adviser who works in our legal team. The legal adviser will be your main point of contact once the case has been referred to tribunal.

The legal adviser will:

- contact you and provide their contact details (usually by email)
- ask you if you have ever given evidence before and provide you with a high level overview of how a tribunal hearing runs if you have not
- request your availability to attend a hearing. You will usually be given a range of dates (eg over a 3–4 month period) and asked to provide any dates of unavailability
- notify you of the tribunal hearing dates once the hearing is listed. This will usually be 7–14 days after you provide your dates of unavailability

-
- ask you to hold 3–4 days free to attend the hearing. In some cases, you may be asked to hold a longer period of time. This is based on an initial estimate of when you will be required to attend
 - confirm the dates you will need to attend – typically 2–4 weeks before the hearing starts
 - make sure you have access to the final assessment report give you:
 - a copy of the GMC witness booklet
 - the associated expenses policy
 - a link to the MPTS website where you can find further information about giving evidence, including a virtual tour of the hearing centre **www.mpts-uk.org/virtualhearing**.

Conference with Counsel

Before the tribunal hearing, we'll invite you to attend a conference with the GMC barrister (GMC Counsel) to discuss the assessment report. This will usually take place approximately 4–6 weeks before the hearing.

The conference will usually last 1–3 hours and will take place in Manchester. We'll ask you to attend the conference in person. Where that is not possible, we can arrange for a telephone conference to take place. We'll invite all of the assessors who need to attend the hearing to come to the conference.

The conference is a good opportunity for you to ask any questions you may have about the procedure at the hearing.

The Bar Standards Code of Conduct, to which all barristers must adhere, states that 'you must not rehearse, practise with or coach a witness in respect of their evidence'. Therefore, while GMC Counsel will advise you of the process of giving evidence, they cannot rehearse any potential questions or speculate as to what questions may be put to you by the doctor. The evidence given to the tribunal must be your own independent, unhindered by any suggestion or opinion held by anyone else.

The conference will be led by GMC Counsel. Counsel for the GMC will vary and you may find they adopt different approaches. However, for all conferences the expectations of those attending is as follows.

The legal adviser will:

- make sure all parties know the time, date and venue of the conference
- liaise with the assessors to agree fees for attendance
- have read the report and identified any areas for further clarification
- give you any additional documents to be considered during the conference. This can include your own notes or mark sheets completed during the assessment or copies of medical records you have reviewed. This will usually occur where the doctor's representatives have asked for disclosure of this material
- make a full note of the conference which is potentially disclosable to the doctor or their representative.

GMC Counsel will:

- have read the report and have a thorough knowledge of the conclusions reached
- identify any weaknesses or areas of concern that need further explanation
- request that the assessors explain any areas of the report or additional documentation that they would like to clarify.

You should:

- arrange your travel
- have read the report and identified any areas of particular concern or important issues to be drawn to the tribunal's attention
- be familiar with describing and explaining the terminology used within the assessment report and the different stages of the assessment
- be able to talk through the report in detail and explain the reasons why the overall conclusions were reached
- have considered any additional material sent in advance of the conference such as notes, mark sheets or medical records
- come prepared with any questions.

Hearing preparation

We have published guidance for experts on attending a hearing to give oral evidence www.gmc-uk.org/DC6998_Guidance_for_GMC_experts__Section_9__Providing_expert_oral_evidence.pdf_59599081.pdf.

Although assessors are not experts as such, many of the principles set out in this guidance apply and it will assist you to familiarise yourself with the standards.

The MPTS website contains lots of information about being a witness. Visit www.mpts-uk.org/witnesses.

The majority of hearings are held in public. You are free to attend the hearing as a member of the public and sit in should you wish to observe proceedings.

We recognise that being a witness is a difficult process and can offer you independent support. Our witness support service is run by volunteers from the charity Victim Support. The witness support service can provide a number of different services including:

- telephone support
- home visits or face to face support in your local community
- an opportunity to talk to someone confidentially about how you are feeling
- signposting to other organisations who can provide further support.

Full details are at www.gmc-uk.org/concerns/witnesses/before_hearing.asp. You can contact them directly on 0161 200 1956.

Hearings are held at the MPTS in Manchester. You can find full address and directions at www.mpts-uk.org/hearingcentre. The tribunal sits from 9.30 am to 5 pm, although the legal advisor will have told you what time you are required to attend.

When you arrive at the hearing centre, you should make your way to the 7th Floor. Please sign in at the MPTS reception. Staff will give you a pass, which gives you access through the secure doors. A tribunal assistant will take you to a waiting area where the legal adviser will come to speak with you. The legal adviser will give you regular updates about the progress of the hearing and any delays.

Giving evidence

When the tribunal is ready to hear your evidence, the tribunal assistant will collect you from the waiting area and show you to the hearing room.

The legal adviser and GMC Counsel will have spoken to you about the sequence of events at the hearing and the roles of each in the hearing room.

The tribunal assistant will ask you to give a religious oath or make a general affirmation before giving your evidence. You should remain standing by the witness chair and the tribunal assistant will bring you the wording of the oath or religious book.

Once you have made your oath, you'll be asked to sit down. At the start of your evidence the chair of the tribunal will introduce you to those present in the hearing room. The assessment report will be in a file in front of you on the witness desk. If you have annotated your own copy of the assessment report, you can take it in to the hearing with you. But if you wish to review your own notes during your evidence you should ask permission to do so.

Your evidence will begin with questions from GMC Counsel. The doctor or his representative will then be given the opportunity to ask questions and thereafter the tribunal. The GMC Counsel and the doctor will be able to ask you further questions from any matters arising from the tribunal's questions.

When giving evidence remember to:

- listen carefully to the questions asked; if you do not understand the question ask for clarification
- give clear and concise answers
- speak loudly – although there is a microphone, this is for recording purposes and does not amplify your voice
- address the tribunal with your answers irrespective of who has asked the question
- ask for a break at any point if it would assist you.

The tribunal may take a break while you are giving evidence or you may be asked to leave the hearing room while the tribunal discusses legal matters. While you are still giving evidence, you remain on oath even though you are not in the hearing room. During this time, neither the legal adviser nor GMC Counsel will be able to discuss anything with you. If you have any queries, you should speak with the tribunal assistant.

We will usually ask you to attend the hearing to give evidence in person. In very limited circumstances, we can make an application to the tribunal for your evidence to be given by videolink. It would only be in exceptional circumstance that we would consider making this application, which we would need to justify, for example due to illness (which may require a letter from your treating doctor) or severe weather/travel problems.

The decision to hear your evidence by videolink can only be made by

- a case manager, where all parties are in agreement and a formal direction is made
- the tribunal, where the application is contested and therefore cannot be guaranteed by the us.

Post hearing

After your evidence has finished, the tribunal will formally release you and the tribunal assistant will take you back to the waiting area. The legal adviser will come to speak with you, so please don't leave the building.

The legal adviser will tell you the outcome of the hearing once it is known. Published determinations are available on the MPTS website (usually published 4–6 weeks after the conclusion of a case) and are available at **www.mpts-uk.org/recentdecisions**.

Equality and diversity

We have statutory obligations to make sure our fitness to practise activities are fair. Anyone acting on our behalf is expected to be aware of, and adhere to, the spirit and letter of equality and human rights legislation. This includes compliance with the aims of the public sector equality duty.

The opinions and recommendations you provide must be fair and untainted by bias or prejudice on the grounds of gender, race, disability, lifestyle, culture, religion or beliefs, sexual orientation or age.

Doctors must treat colleagues and patients fairly, whatever their life choices and beliefs. Our guidance on this is at paragraphs 48, 54 and 59–60 of *Good medical practice*. Your conduct as an assessor or examiner must also be in line with the our *Equality and diversity policy* and *Dignity at work policy*.

We will make reasonable adjustments for disabled people.* If you would like us to consider making reasonable adjustments for a doctor you are assessing or for yourself, please let us know as soon as possible.

The *Equality Act 2010* defines a person as disabled if they have a physical or mental impairment, which has a substantial and long term (ie, has lasted or is expected to last at least 12 months) and adverse effect on the person's ability to carry out normal day-to-day activities.

Appendix 1: Assessment categories

Name	Description
Maintaining	1a) Develop and maintain professional performance: including educational activities, keeping up-to-date, knowledge of guidelines and regulations, audit and appraisal
Assessment	1b) Assessment: including history taking, examination, initial investigations and reaching a diagnosis
Management	1c) Clinical management: including providing treatment, advice or a referral to patients, safety netting, investigations as part of follow-up or ongoing care, and working within the limits of competence
Skills	1d) Operative/technical skills: including non-invasive procedures, minor surgery, giving injections, administering an anaesthetic, slide preparation
Records	1e) Record keeping
Safety	2a) Safety and quality: Taking action if patients are at risk (including inadequate care, policies and systems). Consultants, GP principals and others who are responsible for service delivery must take responsibility for ensuring systems of risk management and clinical governance are in place

Name	Description
Patients	3a) Relationships with patients (carers and relatives) : including information sharing, obtaining consent, supporting self-care and treating patients with fairness and respect
Colleagues	3b) Working with colleagues : including multi-disciplinary teamwork, leadership, communication (including written), teaching
Context	

Appendix 2: Assessment scale definitions

Guidance for GMC performance assessors

Assessment scale definitions

Assessment of the doctor's performance is based on the GMC guidance in the publication *Good medical practice*, which sets out the standards expected of doctors. During the assessment the doctor is expected to demonstrate safe and competent practice, appropriate to the grade and position in which they are, or were, working.

For individual judgements assigned to comments, assessors must use the following scale:

A Acceptable – performance that is consistent with the performance described in *Good medical practice*.

U Unacceptable – performance which clearly departs from the performance described in *Good medical practice*.

For overall judgements of the doctor's performance at each assessment category in the report, teams must use the following scale.

Acceptable means that the evidence demonstrates that the doctor's performance is consistently above the standards described below. This grade should only be entered if you are satisfied that all or almost all of the criteria are satisfied in all or almost all of the examples that you have seen or heard reported.

Cause for concern means that there is evidence that the doctor's performance may not be acceptable but there is not sufficient evidence to suggest deficient professional performance. The grade should be entered if you have evidence of some instances of unacceptable performance but which, in the view of the assessing team, do not amount overall to unacceptable performance. The reasons for using this grade, rather than unacceptable, for this aspect of performance should be described.

Unacceptable indicates that there is evidence of repeated or persistent failure to comply with the professional standards appropriate to the work being done by the doctor, particularly where this places patients or members of the public in jeopardy (ie deficient professional performance). This grade should be entered either if you have evidence that the criteria for an acceptable level of performance are regularly NOT being met OR if negative criteria are being met.

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