Assurance assessments - alternative objective/robust evidence

Introduction

1 It is our policy to ask for an objective assessment of a doctor’s performance prior to considering whether to remove restrictions on their practice and return them to unrestricted registration. This is in order to give assurance that any identified failings or issues leading to undertakings being placed on a doctor’s registration have been remediated, and the doctor’s fitness to practise is no longer impaired. However, we will only do so where it is relevant, reasonable and proportionate. We will use an assurance assessment, which is a type of performance assessment, to obtain objective evidence of remediation where there have been concerns about a doctor’s performance. There may also be circumstances in which an assurance assessment is not required; for example, if a doctor has recently completed an alternative form of objective assessment which is independent and verifiable, and which the case examiners consider sufficient to provide them with the objective assurance that the doctor is ready to return to unrestricted practice in the particular circumstances of the case.

2 The purpose of this document is to ensure consistency in our approach for all cases where we are deciding whether to invite a doctor to undergo an assurance assessment or whether we can rely on an alternative form of independent and reliable evidence provided by the doctor as objective and robust assurance that the known concerns have been remediated.

Step 1: Local support for the revocation of the doctor’s undertakings

3 Before we will consider inviting a doctor to undertake an assurance assessment, we need to have seen positive reports from the workplace reporters and any clinical and/or educational supervisors supporting the doctor’s remediation and confirmation that the Responsible Officer (RO) supports revocation of the doctor’s undertakings. This provides us with an indication that the doctor may be ready to return to unrestricted practice and avoids us putting doctors through the demands of an assessment before they are ready.
Step 2: Invite the doctor for an assurance assessment

4 Once we are satisfied that there is local support for the revocation of the doctor’s undertakings, the doctor will normally be invited for an assurance assessment unless there is alternative objective and robust evidence available. Please see Step 3 below which provides a list of evidence types that we have accepted in place of an assurance assessment.

5 Undertakings should not be revoked without either

- an assurance assessment, or
- alternative objective and robust evidence that the doctor has remediated the failings or issues leading to restrictions being placed on their registration.

Step 3: Alternative evidence that demonstrates that the doctor has remediated the concerns leading to undertakings being placed on their registration

6 The type of evidence is likely to vary according to the doctor’s specialty or grade, and the failings or issues that led to undertakings being placed on their registration. This will determine what evidence and how much of it they will need to provide to demonstrate remediation of those failings or issues.

7 A decision not to direct an assurance assessment will often be based on a combination of independent and verifiable evidence types from the list below to provide assurance that the doctor is ready to return safely to unrestricted practice. Other factors that are considered alongside this evidence are that the doctor has insight into the concerns leading to undertakings being agreed.

Examples of alternative objective or robust evidence accepted

- Completion of or participation in recognised training or re-training programmes. Such training programmes include (please note that this list is not intended to be exhaustive):

  - Passing Membership of the Royal College of Physicians (MRCP) Part 2 written exam (which is a higher standard of knowledge testing than the knowledge test set as part of an assurance assessment for doctors of this seniority)

  - Passing Membership of the Royal College of General Practitioners (MRCGP) exam at the end point of GP training. The exam has three parts.

    1. the applied knowledge test which is a multiple-choice exam
2. the clinical skills assessment which is an OSCE-type practical exam using actors

3. the workplace-based assessment which requires the completion of a range of assessments marked and supervised by the trainee’s trainer.

Passing different elements of this exam can be used to demonstrate the doctor’s remediation. However, it will depend on the individual case and the type and level of remediation required as to which element(s) of the exam will be more important in deciding whether or not we need to direct an assurance assessment.

- Completion of the GP induction and refresher scheme which includes a career review interview, multiple choice assessments, simulated surgeries, placements and workplace-based assessments, observational placements and a number of mandatory e-learning modules.

- Completing a comprehensive re-training programme of sufficient duration to remediate the concerns leading to undertakings being agreed with the doctor. These re-training programmes could be recognised programmes agreed with a relevant or recognised training authority that assesses against agreed standards and have a defined outcome or structured local re-training programmes where evidence will be provided through direct observation of procedural skills, case-based discussions, mini clinical evaluation exercises, the acute care assessment tool and other evidence sources identified elsewhere on this list.

- Where concerns came to light during the doctor’s foundation programme the subsequent achievement of FY2 competencies.

- Passing workplace assessments carried out to Intercollegiate Surgical Curriculum Programme (ISCP) standards.

- Successful completion of the interview and assessment to gain entry onto Health Education England’s training scheme which demonstrates the doctor is fit to practise at the grade they will be working at.

- Full Practitioner Performance Advice (formerly National Clinical Assessment Service, NCAS) assessment and action plan signed off as complete.

- Evidence of positive multi-source feedback, including case-based discussions, direct observations of procedural skills and mini-clinical evaluation exercises.

- Medical records audits.
- A targeted remediation training programme supported by evidence of successful learning outcomes.

- The lifting of local conditions.

- Indication from the relevant NHS body in the four countries that voluntary restrictions are likely to be lifted. If NHS decision is contingent on action taken by the GMC, this should not be considered as part of the evidence to support the doctor’s remediation.

- Confirmation from the doctor’s educational supervisor that the doctor has completed their PDP satisfactorily and that it has addressed all the concerns identified in the schedule of undertakings.

- Satisfactory annual appraisal or revalidation.

8 This list is not intended to be exhaustive but instead provides examples of the types of objective evidence considered or considered in combination to provide robust assurance.

9 Annex A provides examples of where alternative evidence submitted by doctors has been accepted in place of an assurance assessment. It also provides examples where we have decided that the evidence submitted does not provide sufficient objective assurance of remediation of the concerns and an assurance assessment has been directed.
Annex A

Alternative objective evidence submitted by a doctor that was accepted in place of an assurance assessment

Example 1

10 The doctor was working as a consultant general surgeon in the NHS. His employer had concerns about his clinical judgement and technical ability. The employer managed these concerns locally by providing the doctor with support. Further concerns were raised 12 months later about the doctor’s technical ability in an unrelated area of surgery. The Trust asked the doctor to complete the surgical procedures in this new area of concern under supervision while a local investigation was completed. Further concerns were raised a year later about post-operative complications and an investigation highlighted a high complication rate for the doctor’s surgeries in this area.

11 The doctor completed a GMC performance assessment. The assessment team concluded that the doctor was fit to practise on a limited basis. The doctor agreed undertakings in January 2016. The undertakings required the doctor to have a PDP and identified areas of practice for remediation:

- Maintaining professional performance
- Assessment
- Clinical management
- Operative/technical skills

12 The doctor was also required to have a clinical supervisor and an educational supervisor. For surgeries in the two areas where concerns had been raised he was limited to only conducting them as part of an approved retraining programme to the standards defined by ISCP.

13 The doctor’s Trust worked with NCAS to develop a remediation plan for the doctor. The Practitioner Action Plan included remediation in the two areas of surgery where concerns had been identified. Requirements for the GMC PDP were incorporated into the plan. The plan also confirmed that the doctor would have protected time for learning and development.

14 The retraining programme started in October 2016. The clinical supervisor confirmed the means of assessment for the programme would be procedure-based, clinical evaluation and case-based discussion. He further confirmed that the level of
assessment would be ‘day 1 consultant’. The retraining programme would last six months.

15 While the doctor’s restrictions were in place, we agreed a variation to them to allow more independent practice to expand the doctor’s experience as part of the remediation plan.

**Evidence submitted in place of assurance assessment**

16 The doctor successfully completed the six month retraining programme which was to ISCP standards. He was able to provide evidence of multi-source feedback, patient feedback, clinical evaluation exercise feedback, 13 reflective case-based discussions, five ISCP assessments, 12 procedure-based reflections and feedback, 23 Joint Advisory Group formative direct observations of procedural skills, a surgical log book including over 170 cases. He also submitted evidence of continued professional development.

17 The doctor completed the NCAS Practitioner Action Plan and it was signed off in May 2017.

18 The clinical supervisor (who was also the doctor’s RO) and educational supervisor provided positive reports throughout their period of supervision and were supportive of the doctor returning to unrestricted practice. The clinical supervisor noted the doctor’s ‘extra-ordinary performance’ as early as February 2017. The supervisors had identified no major issues or significant concerns. The clinical supervisor also confirmed that the doctor was working independently at consultant level in January 2018.

19 Case examiners were satisfied that the assistant registrar could consider the revocation of undertakings without the doctor completing an assurance assessment of his performance. This was based on the evidence of robust objective workplace assessment to ISCP standards, which is comparable to that used for senior trainees and had been signed off as complete by the clinical supervisor (who was also the doctor’s RO). It was the view of the case examiners that the doctor had undergone adequate objective assessment of his performance. This was demonstrated as he had met the desired standards compatible with him being awarded a CCT for general surgery. The doctor’s undertakings were revoked in May 2018.
Example 2

20 The doctor was working as a salaried GP at a practice in London. We received a referral from the doctor’s RO in August 2018 raising a number of concerns about the doctor’s practice. These concerns had been identified following complaints received from patients and an audit of the doctor’s consultation records.

21 We commissioned an expert (an experienced GP) to review the referral and comment on the care provided to 23 patients. The expert concluded that elements of the doctor’s care of 13 of the patients fell below the expected standard and seriously below in another three cases. The expert found the care given to the other seven patients did not fall below the standard expected. The expert noted concerns in the following areas:

- History taking
- Prescribing
- Failure to carry out appropriate examinations
- Inappropriate diagnosis and treatment

22 The doctor agreed with the expert’s comments but suggested that some of the alleged failings may have resulted from record keeping failures.

23 The doctor agreed undertakings in August 2019, which included the requirement to have a PDP designed to address areas of deficiency in her performance. She was also required to have a workplace reporter, an educational supervisor and a clinical supervisor.

Evidence submitted in place of assurance assessment

24 In June 2020, the doctor’s legal representative requested the doctor’s undertakings were revoked. The doctor had engaged with NHS England to develop her PDP. She worked closely with NHS England to develop her record keeping skills and completed an online course on the subject. Her consultation records were audited every month (by an independent GP) from the point of her undertakings being agreed and results were positive. She provided to the GMC reports of case-based discussions, evidence from patient satisfaction surveys and copies of complaints and responses and submitted comments on the deficiencies identified in the expert report. The doctor successfully completed her annual appraisal in March 2020.

25 NHS England’s Performance Advisory Group (PAG) confirmed the doctor had achieved the objectives in her PDP in April 2020 and made specific comment on the PDP and evidence being ‘exemplary’.
26 The educational supervisor provided positive reports in all areas throughout the period of undertakings, noting the doctor’s progress against PDP objectives. The educational supervisor also confirmed positive audit outcomes, case-based discussions and the doctor’s good insight.

27 The workplace reporter/clinical supervisor provided positive reports. They reported the value and popularity of the doctor in the practice which was evidenced through patient satisfaction survey results. Furthermore, examples of the doctor’s good practice were submitted for consideration.

28 In April 2020, the educational supervisor and workplace reporter/clinical supervisor told us that they supported the doctor’s return to unrestricted practice. The doctor’s RO also confirmed their support for the revocation of undertakings at this time.

29 Case examiners were satisfied that the assistant registrar could consider the revocation of undertakings without the doctor completing an assurance assessment of her performance. This recommendation is based on the following evidence. The clinical supervisor and educational supervisor had conducted assessments of the doctor’s performance which included case-based discussions, video consultation reviews, medical record reviews and educational discussions around the doctor’s PDP. These assessments, carried out by doctors who are accredited GP trainers, are in keeping with the workplace-based assessment component of the MRCGP exam. Although the case examiners noted that the doctor had not been assessed in the same way as a GMC assurance assessment or a candidate sitting the MRCGP exam (there has been no assessment carried out similar to the applied knowledge test or the clinical skills assessment components of the exam, for example), they concluded that the assessments the doctor had undergone had assessed and challenged to an adequate standard the areas of deficient professional performance that were identified in the case examiners’ original decision: history taking, prescribing, failure to carry out appropriate examinations, and inappropriate diagnosis and treatment.

30 By her efforts to adhere to the undertakings offered to her by the GMC and address the failings that led to them and by engaging with her supervisors, the doctor had demonstrated insight into the concerns about her performance and had made active efforts to remediate. She had also demonstrated the ability to improve how she works.
Alternative objective evidence submitted by a doctor which provided insufficient objective evidence of remediation of the concerns and an assurance assessment directed

Example 1

31 The doctor is an experienced GP. He was working in a salaried GP role when we received a complaint about his treatment of a patient. Employer feedback revealed that they had further concerns which had been evidenced by an NCAS assessment suggesting deficient performance.

32 The NCAS report identified the following concerns with the doctor’s performance:

* Poor practice
  - Record keeping

* Inconsistent practice
  - Assessment of the patient’s condition
  - Communication with patients and the practitioner-patient relationship
  - Leading and managing teams
  - Arranging cover and delegation/Management of the practice

33 We commissioned an expert (an experienced GP) to review the complaint and comment on the care provided to the patient. The expert concluded that the care provided to the patient was seriously below the standard expected. Areas of deficiency highlighted by the expert were in line with those identified in the NCAS report (above).

34 The doctor agreed undertakings in June 2018, including the requirement to have a PDP designed to address the areas of deficiency.

Evidence submitted in place of assurance assessment

35 The doctor completed a six-month retraining programme. Feedback from those involved in the retraining programme was extremely positive.

36 The doctor requested revocation of undertakings in January 2019. At this time, the case examiners acknowledged the improvements that the doctor had made but noted that it was still early days in the doctor’s remediation. The case examiners advised that they would need to be satisfied that learning from the retraining programme had
been absorbed into the doctor’s practice and that the improvement had been sustained. The undertakings were maintained at this time pending receipt of further evidence.

Example 2

37 The doctor is a consultant cardiologist working in the NHS. She had been employed at the hospital since June 2008. The GMC received a complaint about the doctor’s clinical practice. Feedback from the doctor’s employers revealed longstanding concerns including inadequate documentation, operative complications, inadequate/inappropriate management plans, failure to perform ward rounds, being uncontactable when on call, inadequate supervision, inappropriate delegation and poor handover of care. In total, 18 examples of substandard clinical care were submitted by the doctor’s employer.

38 To obtain an objective assessment of the technical and clinical issues raised by the investigation, the GMC commissioned an independent report from an expert in the same specialty as the doctor. The expert concluded that in the majority of cases the doctor’s performance fell below what should be expected in some areas of practice and in two of the cases it fell seriously below the standard.

39 The doctor agreed undertakings in November 2016. The undertakings required the doctor to develop a PDP to address areas of deficiency including:

- History taking and assessment of presenting complaints
- Assessment and management of clinical emergencies
- Differential diagnosis
- Managing plans and rationale for arranging investigations
- Feedback and information given to patients
- Communication skills/relationship with colleagues
- Record keeping

40 The doctor was also required to have a workplace reporter, an educational supervisor and a clinical supervisor.
Evidence submitted in place of assurance assessment

41 In October 2018, the doctor’s legal representative requested that undertakings were revoked. She cited positive reports from supervisors and reporters throughout the period of undertakings, together with their recent recommendations for revocation of undertakings; the RO’s support for revocation of undertakings; and the doctor’s compliance with undertakings since they were agreed, as a basis for the request.

42 The assistant registrar explained that we view positive workplace reports as an indication that the time is right for an objective assessment but not as sufficient assurance of remediation in themselves. This is because we have found (in a significant percentage of cases) that although a doctor’s supervisors thought that we could remove restrictions, there were still concerns that the doctor hadn’t remediated fully and posed a risk to patients.

43 In this example, we have no evidence of the doctor completing a recognised training or retraining programme which may provide objective assessment of performance. Furthermore, there is no evidence submitted of remediation of known concerns that we would consider objective or robust (see list here) such as medical record audit outcomes, multi-source feedback or successful completion of the PDP approved by the educational supervisor.

44 The doctor’s undertakings were maintained at this time and the doctor was invited to an assurance assessment.