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How to use this handbook

This handbook is for performance assessors. It should be used as a point of reference when carrying out the role alongside the Standards for performance assessors.

This handbook does not cover all possible situations that you may face, but it does give practical advice on what we expect of a performance assessor.

Planning the performance assessment

Under our Fitness to Practise Rules we can set broad parameters for the assessment. The performance assessment officer will tell you if any of these decisions have been taken.

It is for the team to choose the format and content of the assessment, taking into account the doctor’s specialty, grade, the nature of their work and whether they are currently practising.

The rules say that The Assessment Team……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.

The performance assessment officer will provide the team with:

- an assessment planning form giving a summary of the background to the assessment
- a portfolio completed by the doctor with information about their qualifications, employment history, current practice and continuing professional development
- the most recent report from each GMC-approved supervisor (assurance assessments only)

You will be sent information through our secure online portal, GMC Connect.

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

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

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, their sources and if they can be reviewed before the visit
- whether colleagues of the doctor should be asked to take part
- if it is possible to observe the doctor in practice
- scenarios that reflect the doctor’s background and experience to be included at a test of competence

Working with the performance assessment officer, you can then plan a workable timetable. You should also pencil in a date for a report review day, in case you need to meet in person to discuss the draft report. This should be no later than 5 weeks after the database will be completed.

### Considering the impact on the doctor

The performance assessment process should be fully inclusive and meet the needs of everyone who is participating. The GMC will make reasonable adjustments for assessors, doctors and other participants with a disability\(^1\). We will also endeavour to meet any religious, health or other needs. See [equality and diversity section](#).

When planning the assessment you should, as far as possible, ensure that the doctor has the opportunity to perform to the best of their ability and they are not subjected to avoidable stress. You should ensure, for example, that they have sufficient breaks, and activities are scheduled to avoid leaving them waiting around for long periods.

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\(^1\) 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.
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

You must give us details of any potential conflict of interest including the dates and extent of contact, as well as 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 happens when a doctor fails to cooperate?

Sometimes, a doctor will refuse to undergo a performance assessment or fail to cooperate with the assessment process. When this happens and the assessment was directed as part of an investigation, the case may be referred to the MPTS. A medical practitioners tribunal will consider whether the doctor’s fitness to practise is impaired and if action is required on their registration.
Assurance assessments and reassessments

Assurance assessments

Assurance assessments are a type of performance assessment. Where a doctor’s practice is subject to restrictions, they will usually be asked to undergo an assurance assessment before those restrictions are removed. We will arrange an assurance assessment when we have information which suggests that they are ready to return to unrestricted practice.

The assessors’ report will be used to assist the case examiner or a medical practitioners’ tribunal in reaching a decision on whether it is appropriate to lift the restrictions on the doctor’s practice.

Assurance assessments differ from other assessments because their purpose is to provide objective evidence of successful remediation and assurance that the known concerns have been successfully remediated. Known concerns are areas of deficient practice that have been identified through an investigation, a previous assessment, or have emerged during the period of restrictions.

Unlike other assessments, assurance assessments are tailored to focus on the known concerns, rather than assessing all areas of a doctor’s practice. They should be tailored, reasonable and proportionate in relation to the known concerns. When planning the assessment, it is important to select only the instruments that will provide the best evidence of whether the doctor has remediated the areas of concern. This is likely to include providing the doctor with the opportunity to demonstrate what they ‘do’ in practice by selecting peer review instruments. You should also consider sample sizes and whether they are proportionate. You may choose, for example, to review fewer records or select fewer OSCE stations than you would do for a less focused assessment.

Proportionality needs to be balanced with the need to obtain sufficient evidence to make a recommendation about whether the doctor is fit to practise without restrictions. A minimum of two instruments should always be selected to ensure that the assessment is reliable.

Although you will plan the assessment to focus on the known areas of concern, assessors are still required to provide an overall opinion on the doctor’s fitness to practise. Therefore, you must record everything that you find during the course of the assessment, regardless of the assessment category it falls in to. All data should then be considered during the report writing process, with judgements provided in each assessment category (where possible).
Reassessments
Reassessments are usually carried out as part of a scheduled review of the restrictions placed on a doctor’s registration following a previous performance assessment. They may be directed by a medical practitioners’ tribunal to inform a review hearing of the doctor’s progress.

The assessment team should assess all areas of the doctor’s practice, unless we instruct otherwise.

When making recommendations the team should consider the remediation measures the doctor has already been subject to, and whether further measures are likely to improve their performance.
Assessment instruments

The component parts of an assessment are chosen by the assessment team from a list of assessment instruments. Some instruments, collectively referred to as a peer review, are designed to assess the doctor’s performance in the workplace whilst others, known as tests of competence, offer an objective assessment of their knowledge, clinical and consultation skills.

It is often necessary to visit the doctor’s workplace to carry out the peer review elements of an assessment. This visit can last up to four days. Tests of competence usually take place in one of our clinical skills centres in Manchester.

The team should choose the instruments that are appropriate to the doctor’s specialty and circumstances and that will add significant value to the assessment. This may include assessment tools that aren’t part of our list of assessment instruments, such as those provided by a royal college or medical school. High-fidelity simulation, or a procedure using cadaverous material, for example, might be used to assess practical skills.

This section gives an overview of the GMC instruments available to the assessment team.

**Peer review:** to assess the doctor’s performance in the workplace.
- Medical records review
- Site tour
- Third party interviews
- Colleague questionnaires
- Observing the doctor’s practice
- Case based discussions
- Assessed 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

Tests of competence are not pass or fail. In some tests standard-setting exercises are used (eg the Angoff method) to help to define acceptable standards.
Medical Records Review

Access to medical records
We have the statutory 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 collect a range of data about the doctor’s professional performance, particularly about their clinical care and record keeping.

Making sure samples are fair
The medical records review should assess the doctor’s most recent work. An exception to this might be where the doctor’s practice is restricted at the time of the assessment. In this case, the team should consider whether the sample of records requested should cover a period of unrestricted practice.

The sample of records you request must be fair and it should reflect 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.

Reviewing the records
Medical performance assessors should independently assess the same records.

Where possible, the performance assessment officer will provide the records to you through GMC Connect so you can review them remotely. Secondary care records often have to be reviewed on site during a workplace visit. The performance assessment officer will arrange access to the paper notes and computer systems you will need.

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

When reviewing medical records, you should shortlist possible cases for the case based discussion and note possible questions. Attempt to select cases and draft questions that cover the scope of the doctor’s work and each of the categories being assessed.
Site tour

A tour of the doctor’s workplace 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.*

It is also an opportunity to clarify any matters that have arisen from the portfolio about the working environment.

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 the doctor might bear some responsibility, for example as a medical manager or principal in general practice.

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

If, during the assessment, the team become concerned that the healthcare provider is putting patients at risk through inadequate systems or practices, they should email these concerns to us through the Performance Assessment Officer. We have a Memorandum of Understanding with the Care Quality Commission and, where appropriate, we’ll share the concerns with them.

Third party interviews and colleague questionnaires

The assessment team may choose third parties to take part in the assessment. The team should decide whether each third party should give an interview or complete a colleague questionnaire.

Choosing third parties and how they should give their evidence

The doctor should provide a list of the colleagues they work most regularly with as part of their portfolio. You may choose third parties that are not on this list. If you need more information about how closely a colleague works with the doctor, ask the PAO to obtain this.

Third parties should have worked regularly and closely worked with the doctor in a clinical, educational or managerial capacity within the last 2 years.

It is recommended that the team choose no more than five third parties. In addition, the doctor will be invited to nominate one colleague. The doctor’s nominee will be asked to complete a questionnaire, unless the team choose to interview them.
A questionnaire is far briefer than an interview. Interviews should be reserved for those that will be able to comment on the doctor’s performance in a broad range of areas e.g. supervising consultants.

If carrying out an assurance assessment, the team should interview the GMC-approved clinical supervisor unless there is a reason not to. Clinical supervisors will have provided written reports: a questionnaire may not provide any additional information or assurance about the doctor’s performance.

**Third party interviews**

The team should select an interview script for each interviewee. Up to four questions from the third party question bank can be added to each script.

Interviews will take place face to face, or by videocall or telephone if this is not practical. The PAO will contact the third party interviewees to arrange the interview and give them the information they need. Interviewees can have a supporter present during the interview.

A transcript of all third party interviews will be produced by a professional transcription service. The transcript is disclosed to the doctor after the assessment so that they may comment.

**Colleague questionnaires**

Up to four additional questions from the third party question bank can be added to each questionnaire. Consider adding questions about areas that may not be sufficiently covered by other instruments, or where the third party will have particular insight.

Where an approached third party shares responsibility for managing or supervising the doctor, they will have the option of conferring with their counterpart and providing a joint response. This option is open to them whether or not the team have nominated both supervisors.

Where necessary third parties can be asked to clarify or expand a response. If this might be required, it should be discussed with the PAO. The PAO can send an email or, where only matters of fact need clarifying, make a documented phone call. If neither of these will suffice, they can arrange for an assessor to call the third party. Follow-up calls will be recorded, transcribed and disclosed to the doctor.

Third parties who have provided a questionnaire should not be subsequently asked to give an 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 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.

The team should discuss the arrangements for the observation of practice with the doctor and check that the doctor understands that it is their responsibility to ensure patients:

- have consented to an observer being present. If this has been done in advance, where practical, verbal confirmation should ideally also be obtained at the time of the consultation.
- are made aware if the observer is not a clinician.

The fact that the doctor is undergoing a GMC assessment is confidential information.

If patient safety concerns arise, you should discuss these with the rest of the team and the PAO in order to decide the most appropriate course of action. Only intervene in an observed consultation if you believe there is an immediate risk to the patient.

Case based discussions

Case based discussions let you probe and describe the doctor’s reasoning. Assessors must choose the cases to discuss with the doctor. Cases may be drawn from the medical record review, the observation of practice, the tests of competence or a combination of these.

Planning the discussion

If the discussion is to include reviewed medical records you will use the shortlisting worksheets completed by the medical assessors as your starting point. The whole team usually selects 12 cases about which 36 questions are asked. If the team decides to include records relating to the complaint these should be in addition to the sample of 12 cases.

The number of cases and questions is usually lower if the discussion is based on material from an observation of practice, a simulated surgery or an OSCE.

In advance of the discussion, the performance assessment officer will inform the doctor which cases and stations the team have chosen. The doctor should be provided with copies of any medical records, or the patient ID numbers if they have access to the clinical system, and given adequate time to familiarise themselves with the content. If lengthy patient records are provided the doctor should be allowed several hours, or overnight, to read these. OSCE and simulated surgery paperwork is not provided in advance to preserve the integrity of the
tests. The doctor should be given time to read the material, which is very brief, during the discussion. They must not be given any assessor or role player instructions.

**Crafting the questions**

Questions should:

- Be focused on the doctor’s decisions and assess reasoning, rather than factual knowledge or a description of what the doctor did
- Be clear, direct and unambiguous
- Be open
- Be non-confrontational
- Assist in distinguishing between acceptable and unacceptable performance.

Questions should not:

- ask the doctor to repeat evidence already observed and recorded eg in the medical records review
- seek an apology

Giving feedback to the doctor should be avoided, but this needs to be balanced against the need to obtain the evidence you require and carry out a thorough and fair assessment.

Questions based on medical records should explore the reasoning behind the doctor’s decisions and actions in that case.

Questions based on OSCE or simulated surgery scenarios should explore the reasoning behind the doctor’s decisions or actions during the tests. You may also explore categories that are related to the actions observed. For example, if the doctor’s task was to assess a patient, you may ask a question which addresses management options.

Only ask the planned questions. Craft questions carefully to avoid the need for additional or follow-on questions as these cannot be accurately recorded during the discussion. Make a note of anything you wish to explore further and do this during one of the assessed interviews.

**Assessed interviews with the doctor**

The team should plan questions for these interviews carefully to make sure:

- questions are generally open to allow the doctor to describe their performance in their own words
- answers are likely to help assessors distinguish acceptable and unacceptable performance and make a useful contribution to the report
The teams’ questions might:

- explore areas that haven’t been fully explored by other instruments, such as the doctor’s engagement with audit and appraisal, keeping their practice up to date, or teaching
- be an opportunity for the doctor to respond to 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 their professional performance
- explore contextual issues, such as career plans, or factors that might have affected the doctor’s performance (e.g., workload or locum work)

If relevant, the assessment team should 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 conduct of the assessment so far, ask questions 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 any third party interview transcripts or colleague questionnaires.

**Knowledge Test**

The knowledge test questions are chosen by an expert panel from a bank to reflect, as closely as possible, the doctor’s practice, grade and areas of specialisation.

They are single best answer questions; each 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 they would encounter as part of their role. 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 involve medical models and equipment, and role players as patients and colleagues.
The assessors select the OSCE stations, normally from a list provided by the Assessment Development Team (ADT). The selection should cover as full a range of the areas of Good medical practice as possible. ADT are available to support the assessors in this process.

Each station 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
- communication with patients and colleagues
- 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 simulated consultations with pre-briefed role players as patients.

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

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

**Reporting module**

This test is for doctors working in pathology, microbiology, diagnostic radiology and related specialties. The doctor is presented with a series of images or slides and asked to provide a likely diagnosis and, in some cases, discuss what advice they would give regarding clinical management.
Carrying out the assessment

The doctor’s wellbeing and participation

The team should endeavour to alleviate the stress on the doctor as far as possible. You should discuss the steps that you can take as a team and be mindful of the doctor’s wellbeing throughout the assessment.

Concerns about a doctor’s health or wellbeing should be emailed to us through the PAO. If you are concerned that the doctor may not be fit to undergo or continue the assessment you seek advice through the PAO. You should consider whether activity involving the doctor should be paused while a decision is made.

The team should make sure the doctor understands what is required of them throughout the assessment and they have the opportunity to perform to the best of their ability.

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

If you have concerns that the doctor’s knowledge of English may be affecting their performance, you should pass these concerns to the performance assessment officer. In some circumstances we can direct that the doctor undergoes an English language assessment.

Rules for the assessment

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

- the instructions for gathering evidence, which are provided on each instrument
- the need to maintain a professional relationship with the doctor. This includes not using first names in the doctor’s presence, 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 written information offered to them during the assessment process, taking in to account its relevance to the assessment.
- the requirement to give copies of any documents collected or accepted (for example, from interviewees) during the assessment to the doctor
- the need to maintain confidentiality
- 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 ADT to make sure validation is unaffected
- no assessor should be alone with the doctor. Assessors must not communicate alone with the doctor’s supporter or third party interviewees
- you should immediately tell us about any observations that pose a risk to patient safety.

**First meeting of the team**

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

- the standards by which the doctor is being assessed
- the scope, remit and purpose of the assessment
- the role of each assessor and the performance assessment officer
- the importance of reaching fair, objective and transparent decisions
- that assessors should keep in mind the questions asked on the formal opinion page
- where the assessment is part of an investigation into the doctor’s fitness to practise there may be aspects of the case that the team have intentionally not been told about
- the rules for carrying out the assessment (see above)

During the meeting, the performance assessment officer will explain the timetable and practical arrangements for the assessment.

The team should discuss the content of the doctor’s portfolio, then agree the questions to ask the doctor during the first interview. No judgements can be recorded at this stage, so the purpose of these questions is for the team to better understand the doctor’s training, experience and the context of their practice. Questions may be used to clarify information given in the portfolio and other matters of fact.

The team should also review the assessment materials, in particular the instructions for the instruments you will use so that everyone is clear about what must be done.

**First interview with the doctor**

This introductory interview is an opportunity for the assessment team to:

- introduce themselves and explain the assessment process
- put the doctor at ease as far as possible
- ask any planned questions
■ to discuss the arrangements for any observation of practice, including patient consent, with the doctor
■ to request written information, such as any audits or appraisals mentioned in the portfolio that have not already been provided.

The interview is normally chaired by the team leader and it is their responsibility to make sure the doctor understands:
■ this is a broad and objective of assessment of their practice, not an investigation of any allegations
■ the timetable for the assessment and when they need to attend
■ when they can have a supporter present: during interviews and briefings with the team
■ neither they, nor their supporter, may not take any audio or video recordings
■ they will not be given any feedback
■ they can request a break at any time.

The doctor should be invited to:
■ ask questions
■ tell the team about anything that they feel is relevant to the assessment, such as any recent training or any personal or professional difficulties that affected their work.
Tests of competence

The doctor should be briefed before each test to explain:

- the format of the knowledge test, how it will be marked and the time limit
- This may be done with the aid of the sample questions that are provided with the test paper
- how to complete answer sheet, that there no negative marking and it is recommended the doctor answers all questions
- the OSCE and simulated surgery procedures – including what to do if they forget the task, would normally carry out an intimate examination, or would use a resource which isn’t available (such as a patient information sheet)
- that they may take a break at any time.

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.

Record of the day’s events

The record of the day’s events is used to log any deviations from the timetable or the briefs during the tests of competence. It should include any questions or requests from the doctor and the response given.

It should be completed by the lay assessor or the performance assessment officer.

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 patients might be at risk. However, you must immediately tell us if you observe something that could put 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 email the PAO 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 PAO and, if appropriate, email the details to the PAO.

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

**How you’ll capture evidence**

All assessors will record entries for the assessment database based on their observations. Entries consist of:

- a comment, which must be comprehensive and clear
- a category from the list in appendix 2 and,
- a judgement of A (for acceptable) or U (for unacceptable), where appropriate to your role and within your expertise. When recording evidence outside of your expertise select ‘no judgement’.

Out of specialty team leaders should not judge the doctor’s clinical practice where it is beyond their area of expertise.

Your entries must be typed into forms, known as eWorkbooks, which will be provided during the assessment. You will need to bring a laptop or device that allows you to edit Microsoft Word and Excel files and connect to the internet for this purpose.
Keeping information secure
You must follow our Information Security Policy for Associates and Contractors and be mindful of information security at all times. Your laptop or device must comply with sections 32-36 of this policy.

Don’t leave assessment materials or paperwork unattended.

At the end of the assessment
Before you leave at the end of the assessment you must:

■ Check that your eWorkbooks are complete and the data is ready to be transferred to the database. You can amend, add and remove data until to you submit your eWorkbooks

■ Upload your completed eWorkbooks to your GMC Connect Personal Folder, await confirmation that this was successful and then delete all eWorkbooks and rough notes from your laptop or device

■ Hand any paperwork back to the performance assessment officer.

We transcribe assessors’ entries into a database which is used by the team leader to draft the report. The database will be provided to the doctor with the team’s report. We’ll contact you if any judgements or categories are missing from your entries.

If you have any constructive suggestions about the assessment (eg materials, instruments) please feed them back via the performance assessment officer.
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 and it must:

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

The report should be a comprehensive evaluation of the doctor’s performance based on the evidence gathered. 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.

Reports must be drafted in our current report template found on GMC Connect. The template provides a structure for the report and advice on best practice in presenting your evidence. You are expected to follow the thematic structure except in cases where your evidence has been drawn from a limited number of sources. In these cases, where patterns of performance are harder to identify, it may be more appropriate to structure your evidence by source. Your PAO can provide advice.

Using evidence from the assessment database

The database is an appendix to the report so there is no need to refer to every entry.

Each strength or deficiency discussed should be illustrated with examples from the database. It is not sufficient to just copy and paste the entry from the database without comment.

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. You should not attempt to quantify the acceptable or unacceptable judgements. Some evidence, such as that about dangerous practice, should be weighted more heavily.
Summary and recommendations

We rely on your summary and recommendations when deciding what action, if any, to take on the doctor’s registration. We can’t enforce any recommendations if you find the doctor to be fit to practise generally. For the majority of cases, where the team’s opinion is that the doctor is fit to practise with restrictions, 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 this scenario you should consider recommending erasure.

Your recommendations should:

■ be clearly linked to your conclusions
■ be clear and unambiguous
■ set out the areas of the doctor’s practice that require remediation. If it is within an assessor’s expertise, you may also recommend how this remediation should be carried out
■ use GMC terminology - refer to our Glossary for undertakings and conditions when writing them.

If you are recommending that the doctor’s practice be restricted:

■ you must, as a minimum, state the restrictions required to ensure patient safety
■ set out the degree of independent decision making the doctor should be permitted and the level of supervision they require
■ be specific about the types of procedure the doctor should stop doing.

Discussing the draft report

The team leader will write the draft report, including the report’s conclusion, highlighted with areas for discussion, and share it with the assessment team. It is the team’s report: each assessor must contribute to finalising it and must ensure they agree with the content. You should carefully consider the draft including:

■ the fairness and robustness of evidence used and whether it is weighted appropriately
■ whether that patient safety concerns have been highlighted and sufficiently explained
whether that the judgements given for each assessment category and the summary and recommendations reflect your professional opinion and interpretation of the evidence gathered

whether any comments received from the doctor about colleague questionnaires or third party interviews raise any issues which should be taken into account

Consider any areas highlighted by the team leader for discussion. You should also note your suggestions for any amendments and areas you would like to discuss with the team.

The team should then discuss the draft, address any discrepancies and agree their conclusions. This discussion can take place through email or telephone conversations, a virtual meeting, or in person. In fairness to the doctor, you should take into account how quickly the report will be produced when considering which of these alternatives would be most suitable.

Report review days
A report review day is a meeting to discuss the draft report, which can be held virtually or in person. All members of the assessment team should participate, supported by the performance assessment officer. We encourage you to hold a report review day when:

- a hearing is anticipated (this includes any case where you are considering opining that the doctor is not fit to practise)
- any member of the team feels that significant amendments are required
- discussion will be required to reach unanimity.

A report review day offers the opportunity to discuss:

- elements of the assessment where all assessors were not involved
- the fairness and robustness of evidence used and how it has been weighted
- patient safety concerns
- discrepancies between assessors and any contentious areas
- overall judgements for each assessment category and check that the conclusions reflect the evidence gathered
- the summary and agree recommendations and a formal which comply with the guidance

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2 Discrepancies between lay and medical assessors’ entries are expected. Where there are significant differences of opinion between medical assessors, the team may wish to acknowledge this in the report.
A report review day is also an opportunity for assessors to reflect on their own contribution to the assessment, and the team leader should provide feedback to encourage this. For example, an assessor might consider how effectively the data they recorded contributed to a fair and robust description of the doctor’s overall professional performance.

**Submitting the report**

The team leader must promptly submit to us a completed report. The performance assessment officer will add a signed formal opinion page, appendices, page numbers and a contents page. We’ll then send the report to the doctor and, depending on the circumstances, their responsible officer and/or supervisors.
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 usually be required to attend the tribunal hearing in person to give oral evidence. If you are unable to attend, 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.

Please note that some hearings at the MPTS are still taking place virtually in response to the COVID-19 pandemic. Parties will be contacted directly about the specific arrangements for their hearing. Further information can be found the MPTS FAQs webpage.

Pre-tribunal hearing communication

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

The legal adviser or a member of the legal case team will:

■ contact you and provide their contact details (usually by email)

■ ask 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 8-10 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 and a link to the MPTS website where you can find further information about giving evidence, including a virtual tour of the hearing centre.

**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/virtual 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.

**Giving evidence**

Hearings are held at the MPTS in Manchester. You can find full address and directions at [www.mpts-uk.org/hearingcentre](http://www.mpts-uk.org/hearingcentre). The tribunal sits from 9.30 am to 5 pm, although the legal adviser 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.

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 person 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 affirmation, 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.
**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.

Within 14 days of the hearing concluding the legal adviser will complete feedback on each assessor that gave evidence which is reviewed by the Associates Appraisal and Training Team (‘AATT’).

**Information and support**

We have published guidance for experts on attending a hearing to give oral evidence.

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.

You can find more information about being a witness online:

- **GMC website**: [https://www.gmc-uk.org/concerns/hearings-and-decisions/help-for-witnesses](https://www.gmc-uk.org/concerns/hearings-and-decisions/help-for-witnesses)
- **MPTS website**: [www.mpts-uk.org/witnesses](http://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. If you would like to talk to someone as you go through this process, we can arrange a referral for you or, you can contact our independent support service by calling 0300 303 3709.

This is a free, confidential and independent telephone support service provided by Victim Support. You can find more information on this service here: [www.victimsupport.org.uk/gmcnmc](http://www.victimsupport.org.uk/gmcnmc)
Engaging with the Associate Appraisal and Training Team (AATT)

AATT are responsible for arranging training, providing appraisals and managing feedback about our performance assessors. You can contact us at AATT@gmc-uk.org.

Training

You will be contacted when training has been arranged and you are required to attend. Training is mandatory and we will aim to give as much notice as possible. Please let us know if you can or cannot attend the arranged date(s) at your earliest convenience so that we can try to make separate arrangements.

Training is led by another performance assessor in a training role. The training agenda is formed by looking back on assessments, report audits and feedback throughout the year. If you come across a situation which you feel could be helpful to be addressed at training, please let AATT know.

Please provide feedback after a training event when we request this. It allows us to reflect on successes and improvements to be made.

Appraisal

AATT are responsible for providing each performance assessor with an annual appraisal document. The appraisal document will be visible in your Cornerstone account and you will receive an automated email when this is ready to view.

The appraisal document summarises:

- the work you have done for the GMC within a 12 month period
- any feedback you have been given and reflected upon
- report audit scores (for team leaders)
- an overall rating of your contribution throughout the year of *meets expectations* or *further reflection required*
Feedback

360 feedback
Feedback helps to identify learning needs and trends in these. After each assessment, you will be requested to complete 360 feedback where you will provide ratings and comments based on set criteria for your fellow assessors, the performance assessment officer and yourself. You will be issued a report when all feedback has been received and you should reflect on this. AATT will also review the feedback and may wish to discuss it with you. Where concerns are raised we may (the below list is non-exhaustive):

- Request that you provide your reflections in writing
- Request that you attend a training course or complete an e-learning module
- Provide you a contract warning
- Suspend your contract with the GMC

Audit of reports
We audit the assessors’ reports we receive and make this information available to the team leader. The audit is concerned with the clear, consistent and timely presentation of evidence in the report; it is not about whether we agree with the team’s opinion or the planning or conduct of the assessment.

The performance assessment officer will conduct a basic audit on the draft report and an Assistant Registrar will provide high-level feedback on the final report from the perspective of an end user. The criteria we apply, which includes explanations of our expectations, is available in GMC Connect.
Equality and diversity

We have statutory obligations to make sure our fitness to practise activities are fair. All of our work must be fair and seen to be 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 under the Equality Act 2010.

The opinions and recommendations you provide must be free from bias, prejudice and discrimination. They must also be free from any perception of bias. We expect you to treat each case or situation on its own merits, to be objective, and to provide information that is relevant. When you provide opinions, these should be based on factual evidence, not on assumptions. This helps our decision makers to be clear about how you have reached your recommendations and why.

Your conduct as an assessor or examiner must be in line with our standards and policies. Paragraphs 48, 54 and 59–60 of *Good medical practice* sets out that doctors must treat colleagues and patients fairly, whatever their life choices and beliefs. You must also ensure that you adhere to the principles set out in our *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.

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3 The Equality Act 2010 legally protects 9 groups of people from discrimination in the workplace and in wider society. These groups are referred to as ‘protected characteristics’ – these are age, sex, race, disability, pregnancy and maternity, marriage and civil partnership, sexual orientation, religion or belief, and gender reassignment’.

4 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: 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’s supporter

A doctor can ask somebody to accompany and support them on the days of the assessment. It is the doctor’s decision on whether to have a supporter and who that should be.

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.

Senior performance assessment officer

The first point of contact you’ll have is normally with the senior performance assessment officer. They’ll contact you by telephone or email to arrange dates, including the number of days needed for the assessment and formally appoint you to a team. They are also responsible for the management of the investigation assistants on the team and the data input process.

Performance assessment officer

Once a team is appointed, the assessment is allocated to a performance assessment officer. They 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 includes:

- making the practical arrangements
- liaison between all the parties involved in the assessment
- advising the doctor about what to expect and what arrangements are being made

In conjunction with the team leader they will also:

- make sure the assessment runs smoothly
- provide advice on best practice and the assessment process.
Team leader

The team leader is a medical assessor who may, or may not, practise in the same specialty as the doctor. The team leader is responsible for:

- for planning the assessment with the help of the performance assessment officer and the medical and lay assessor(s)
- writing the team’s report on the doctor’s performance
- giving evidence if the case is referred to a Medical Practitioners Tribunal.

Medical assessor

We select medical assessors, taking into consideration the doctor’s specialty, and provide them with training. They may need to give evidence at a Medical Practitioners Tribunal Service (MPTS) hearing and must hold a licence to practise.

Lay assessor

The lay assessor has been trained with the medical assessors but brings a lay person’s perspective to the assessment. 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.

Assessment Development Team (ADT)

The ADT are responsible for developing and managing the content of the tests of competence (TOC). This includes creating the knowledge tests, working with the assessment teams to prepare for the OSCEs and Simulated Surgery, processing the mark sheets and generating the TOC reports.

The ADT also work with a panel of experts, made up of doctors from different specialties to write new content, test content on pilot days, set the standards and ongoing editing and improvement work.

Professional role players

Professional role players are used as simulated patients in objective structured clinical examinations and simulated surgeries.

The doctor’s employer

The performance assessment officer will liaise with the doctor’s employer, or former employer, to make the necessary arrangements for the assessment where required.
Employer liaison adviser

Our Employer Liaison Service works to improve the exchange of information between the GMC and employers. The performance assessment officer may liaise with an employer liaison adviser because they will already have a close working relationship with the responsible officer at the doctor’s place of work.

Case examiner

Information that we gather on a case, including the performance assessment report, will be considered by two of our senior members of staff, known as case examiners (one medical and one non-medical).

Investigation or case review officer

A performance assessment may be part of an investigation, which will be managed by an investigation officer. Or they may be to help us review undertakings or conditions which have been placed on the doctor’s registration. These cases are managed by case review officers. In both scenarios the performance assessment officer will be your point of contact.

Performance assessment manager

The performance assessment manager oversees the performance team and the relevant processes. They act as an assistant registrar and sign out assessors’ reports.

Investigation assistant

The investigation assistants are responsible for inputting the evidence gathered by the assessment team into a database that is appended to the assessors’ report. They will contact you directly if they need clarification of something you’ve written.
## Appendix 2: Assessment categories

<table>
<thead>
<tr>
<th>Category</th>
<th>Examples of areas included</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Maintaining Professional Performance</strong></td>
<td>Developing performance, educational activities, audit, appraisal, keeping up-to-date, knowledge of guidelines and regulations</td>
</tr>
<tr>
<td><strong>Assessment of patients’ condition</strong></td>
<td>History taking, examination, initial investigations and reaching a diagnosis.</td>
</tr>
<tr>
<td><strong>Clinical Management</strong></td>
<td>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</td>
</tr>
<tr>
<td><strong>Operative/Technical Skills</strong></td>
<td>Surgical skills, non-invasive procedures, giving injections, administering an anaesthetic, slide preparation</td>
</tr>
<tr>
<td><strong>Record Keeping</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Safety and Quality</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Relationships with Patients (and carers and relatives)</strong></td>
<td>Information sharing, obtaining consent, supporting self-care and treating patients with fairness and respect</td>
</tr>
<tr>
<td><strong>Working with Colleagues</strong></td>
<td>Multi-disciplinary teamwork, leadership, communication (including written), teaching.</td>
</tr>
<tr>
<td><strong>Context</strong></td>
<td>Factual information about the context of the doctor’s practice, which will not be judged.</td>
</tr>
</tbody>
</table>
Appendix 3: 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 the overall assessment of performance in each category, the following scale must be used:

- **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 (i.e. deficient professional performance). This grade should be entered if:
  - you have evidence that the criteria for an acceptable level of performance are regularly *not* being met or
  - negative criteria are being met.
- **Acceptable** means that the evidence demonstrates that the doctor’s performance is consistently above the standard described above. This grade should only be entered if:
  - all, or almost all, of the criteria are satisfied in all, or almost all, of the examples gathered.
- **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 reasons for this grade, rather than ‘unacceptable’, should be described. This grade should be entered if:
  - there is evidence of some instances of unacceptable performance but which, in the view of the assessing team, do not amount overall to unacceptable performance.