Faculty of Forensic and Legal Medicine

Report on the credentialing pilot for

The General Medical Council

1. Background to the development of the Faculty

1.1 The Faculty of Forensic and Legal Medicine (FFLM) was established in April 2006 and has been founded to achieve the following objectives:

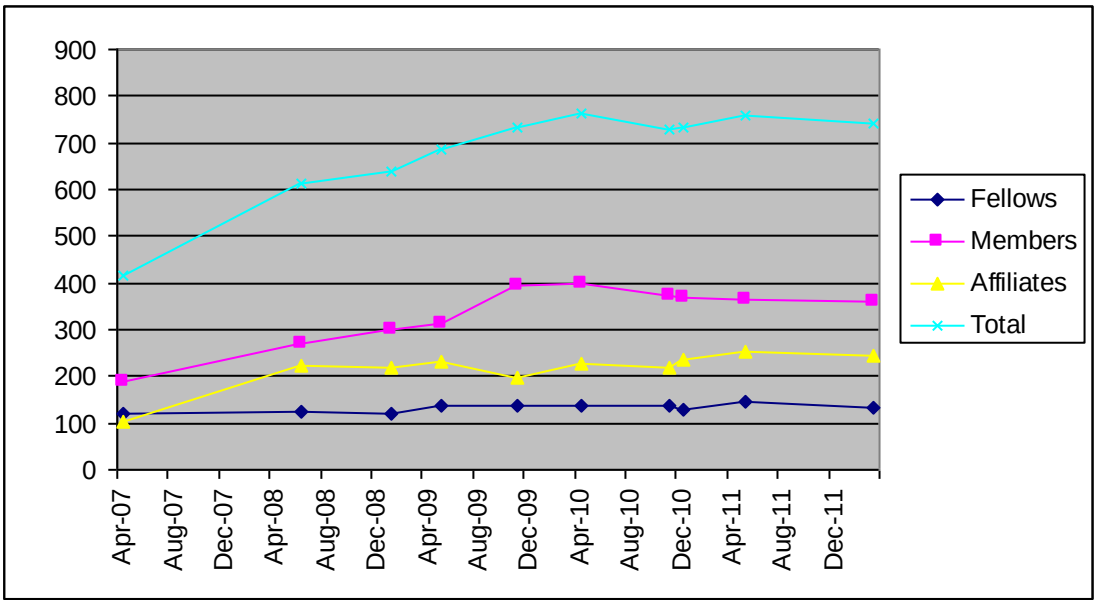
- To promote for the public benefit the advancement of education and knowledge in the field of forensic and legal medicine;
- To develop and maintain for the public benefit the good practice of forensic and legal medicine by ensuring the highest professional standards of competence and ethical integrity.

1.2 The Faculty includes three different professional groups:

- Forensic practitioners
- Medically qualified coroners
- Medico-legal advisers to the medical defence organisations.

Forensic practitioners include Forensic Physicians, Forensic Pathologists and nurses and paramedics who work in the forensic field.

1.3 There are presently three categories of membership – affiliates, members and fellows. Currently, there are 245 affiliates, 360 members and 135 fellows. Affiliates cannot use post-nominals. Changes to the Faculty's membership base are shown in the chart below:



1.4 One of the requirements of creating the FFLM was to have a professional membership examination (MFFLM) in place within three years. This was achieved in 2009 and is a two part examination with part 1 being an MCQ common to all forensic practitioners and medico-legal advisers and part 2 being separate written papers and an Objective Structured Clinical Examination (OSCE) for sexual assault medicine (SOM) and general forensic medicine (GFM) and an Objective Structured Practical Examination (OSPE) for medico-legal advisers (MLA). Part 1 was first held in October 2009 and part 2 in April 2010 and they have continued on an annual basis.

1.5 Forensic medical services were traditionally provided by doctors working on an item of service basis directly contracted to police forces. Following the publication of the Audit Commission Report – *The Doctor's Bill – the provision of forensic medical services to the police*[1] in 1998, service provision of forensic medical services has changed considerably. Over half of the UK Police Forces now provide forensic medical services via private companies, often with a mixed doctor/nurse/paramedic workforce. Some doctors undertake this work on a part time basis, whilst currently, a minority are employed full time.

1.6 Following the production of the Bradley Report[2], work is ongoing in England and Wales in relation to proposals to transfer the commissioning of forensic medical services from the Home Office to the NHS. In Scotland it is being proposed to transfer the service provision to the NHS.

2. Forensic and Legal Medicine as a specialty

2.1 In May 2007, the Faculty made a first-stage application seeking approval from the Department of Health to create a new specialty of forensic and legal medicine in order to improve the quality and consistency of the forensic assessment and care provided to detainees in police custody and the complainants of sexual assault. In June 2008, the Department informed the Faculty that:

> *"…the areas of practice that you have defined represent a distinct field that requires a discrete knowledge, set of skills and level of expertise. It was acknowledged there is also an increasing demand for such practitioners.*
>
> *That said, while we concluded there should be a recognised curriculum, training and qualification in Forensic and Legal Medicine, it was not felt there was necessarily a compelling argument for this to be through a new Certificate of Completion of Training (CCT), and hence a new specialty. Rather, it was felt more appropriate that this expertise should be recognised as a sub-specialty."*

2.2 In the light of this response, and following helpful advice from Postgraduate Medical Education Training Board (PMETB), the Faculty Board identified a number of existing CCT specialties that would best equip doctors with the basic skills to undertake forensic medicine (and thus be the 'parent' CCTs to the sub-specialty). Foremost amongst these was general practice, as we considered that forensic medicine is a speciality best practised by generalists, a fact supported by FFLM research, indicating that about 80% of forensic physicians have a background in general practice.

2.3 The Faculty subsequently learnt that general practice was excluded from developing sub-specialities under current legislation. This was an anomaly that we viewed as a major obstacle to the establishment of a successful sub-specialty in forensic medicine as the other parent CCTs we identified were unlikely to provide sufficient numbers of practitioners to meet anticipated service requirements.

3. The concept of credentialing

3.1 Recent years have seen growing interest in the concept of credentialing in UK medicine. As reported in the PMETB Credentialing Steering Group Report[3], during 2007, the GMC Specialist Register Review Group considered this topic and identified potential benefits of credentialing:

[1] The Doctor's Bill – provision of forensic medical services to the police. Audit Commission. March 2008.
[2] The Bradley Report. Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system. April 2009.
[3] Postgraduate Medical Education and Training Board. Credentialing Steering Group Report. April 2010.

- Registering specialist credentials would enable recording of competencies acquired throughout a doctor's specialist careers and not just at the award of a CCT/CESR;
- Specialist credentialing might be used to reflect the increasing modularisation of specialist training and the more flexible training opportunities that will be necessary because of the changing demographics of the medical profession;
- Credentialing would provide a way of giving formal recognition of the additional qualifications acquired by doctors;
- The recording of that additional training would make the expertise of specialists more easily recognised and the register more transparent;
- Specialists credentials would enable the recognition of specialist competencies in the fields of practice for which it is not possible to obtain a CCT and where regulation has been identified as weak;
- Credentialing offers a more agile means of responding to developments in medicine than is possible through the recognition of CCT specialties;
- It should be possible to extend the principles of credentialing to apply to GPs with special interests.

3.2 The debate was given further impetus by Lord Darzi's 2008 report *A High Quality Workforce: NHS Next Stage Review* which stated that credentialing *'gives assurance to patients and employers that professionals have the right skills to deliver high quality care, whilst giving the recognition to professionals themselves.*[4]

3.3 PMETB initially defined a credential as:

> *"….being a marker of attainment of competences (which include knowledge and skills) in a defined area of practice at a level that would allow the holder of the credential to work with limited direct supervision in that area of practice".*

3.4 Most Forensic Physicians work without direct supervision. Following representation by the Faculty, PMETB agreed to review the definition of a credential.

3.5 For the purposes of the pilot, the PMETB Credentialing Steering Group Report suggested a working definition of medical credentialing as follows:

> *"Credentialing is a process which provides formal accreditation of attainment of competences (which includes knowledge, skills and performance) in a defined area of practice, at a level that provides confidence that the individual is fit to practise in that area in the context of effective clinical governance and supervision as appropriate to the credentialed level of practice."*

3.6 Four areas of medicine were considered to pilot credentialing: forensic medicine, breast disease management, musculo-skeletal medicine and cosmetic surgery. Ultimately, the first three areas were selected and agreed to take part in a pilot to explore the benefits or otherwise of credentialing.

4. The pilot

4.1 Representatives of the Faculty met with Richard Marchant (Assistant Director, Regulation Policy, GMC) on three occasions - 17 March 2011, 6 July 2011 and 7 October 2011. The first of these

[4] A High Quality Workforce: NHS Next Stage Review. Department of Health. Page 16. 2008.

meetings was also with the representatives of the other two credentialing pilots (Breast Disease Management and Musculoskeletal Medicine) when it was useful to share ideas in relation to the pilots.

4.2 The Faculty established one pilot to encompass a range of service provisions for forensic medicine incorporating the four nations as follows:

i. A Sexual Assault Referral Centre (SARC) – Treetops in Portsmouth led by Dr Sandy Fielding (who leads the Faculty's Sexual Offences Forum and represented the Faculty on the DH National Support Team meetings for SARCs);
ii. Northern Ireland – led by Professor John Farnan – lead Forensic Medical Officer for Northern Ireland and one of our MFFLM examiners;
iii. An out sourced provider – Reliance Medical – led by Dr Janet Young in South Wales but overseen by Dr Nigel Callaghan, Medical Director;
iv. Scotland – expanded to include both Lothian and Borders and Central regions jointly led by Dr George Fernie and Dr Alan Grant;
v. Northamptonshire - a more traditional forensic medical service in England – led by Dr Frank Voeten, Principal Forensic Physician for Northamptonshire Police .

4.3 The Faculty were of the view that to credential by practitioner competence an agreed entry requirement (based on the Faculty's standards paper[5]) was required which involved a knowledge assessment (the MFFLM examination[6]), followed by work placed based assessments[7] and linked to the Faculty's proposals appraisal and revalidation[8].

4.4 Additionally the Faculty considered it essential that those doctors who undertake these assessments should be properly trained to do these assessments. We met with the Royal College of Physicians Director of Education and developed a bespoke course to train assessors to be able to undertake Work Placed Based Assessments (WPBA). This was held on 28 October 2011.

4.5 All those doctors identified in the pilot as well as other key personnel within the Faculty attended the course and have been trained in the relevant assessments. As there was spare capacity on the course additional places were offered to other members of the Faculty and several Members took advantage of this.

4.6 We appointed Dr Jenny Holmes, a member from Merseyside as the Work Placed Based Assessment Lead for the Faculty.

5. Work Place Based Assessments

5.1 In conjunction with the RCP Education Unit we developed assessment guidance and documentation for the following assessments:

- Direct Observation of Procedural Skills (DOPS)
- Mini-Clinical Evaluation Exercise (mini-CEX)
- Case-based Discussion (CbD)
- 360º colleague feedback
- Statement Writing.

[5] FFLM. Quality Standards in Forensic Medicine. 2010. www.fflm.ac.uk
[6] FFLM. MFFLM Regulations. 2009. http://fflm.ac.uk/upload/documents/1240234476.pdf.
[7] Norcini J. Workplace-based assessment in clinical training. Association for the Study of Medical Education series.
[8] FFLM. Core competencies for revalidation. https://fflm.ac.uk/upload/documents/1225279849.pdf

For the 360º colleague feedback, the Faculty selected the MSF tool validated by the RCP and, following advice from the RCP medical education unit, it would be expected that doctors would circulate the assessment form to at least 20 colleagues to achieve a minimum of 12 and ideally 15 responses. These different assessments and guidance notes are enclosed as appendix 1.

5.2 During the course, Assessment Systems were developed for both General Forensic Medicine (GFM) and Sexual Offence Medicine (SOM) in order to provide a comprehensive global assessment system for each branch of clinical forensic medicine. These are enclosed as appendix 2. Work is on going in consultation with the Forensic Science Regulator (as this was also a piece of work he was planning on exploring) to develop assessment guidance for Court Room Skills. The proposed assessment process has also been mapped to the GMC competency domains for appraisal and revalidation at Appendix 3.

5.3 Following discussion with the GMC in October 2011, it was concluded that:

- possession of the MFFLM;
- completing all of the assessments in either GFM or SOM;
- satisfactory enhanced appraisal;
- revalidation (when in place) being met and revalidation being maintained;

should reach a standard where the award of a "credential" would be appropriate. As the doctors would not be trainees and would be working in a largely unsupervised capacity, it is proposed that the assessments would all be summative, now referred to as Assessments of Performance (AoPs)[9].

5.4 The doctors who took part in the pilot were asked to undertake some of the assessments and to complete an evaluation form to try and answer the following questions:

- Were the assessments appropriate and of the requisite standard?
- Were there any jurisdictional issues that arose?
- Were there any issues in relation to assessors being allowed to attend a different Force area e.g. security clearances etc?
- What are the resource implications of undertaking assessments?
- Would 4.3 above be appropriate?

5.5 The Faculty's Academic Committee (AC) was asked to give a view on the following:

- Should all assessments be done by assessors from a different area?
- Should all assessments be done by assessors from the same area?
- Should there be a mixture of some assessments being done by doctors from the same area and some from doctors from another area?
- If a doctor does not give evidence in Court (in the majority of cases the doctor's written Witness Statement is agreed and the doctor does not give oral evidence) would Statement Writing Skills alone be sufficient?
- Would 4.3 above be appropriate?

5.6 Review of the feedback from the doctors who took part in the pilot was that the assessments were appropriate and 4.3 above would be met. This was also supported by the Academic Committee and finally the Faculty Board.

[9] General Medical Council. Learning and assessment in the clinical environment – the way forward. November 2011. http://www.gmc-uk.org/Learning_and_assessment_in_the_clinical_environment.pdf_45877621.pdf

6. Specific findings identified in the pilot

6.1 Seven trained assessors undertook 36 different assessments on eight different forensic physicians, some of whom did general forensic medicine, some sexual assault medicine and some both. Of these eight assessees, seven were post MFFLM and very experienced and one was at diploma level i.e. pre MFFLM in experience. Of the assessments of the post MFFLM forensic physicians, 28 assessments were scored at the level expected for completion of a credential post MFFLM and 3 assessments at the level expected on gaining membership. The one doctor at diploma level performed at this level on the one assessment that was carried out.

6.2 Several assessors commented that the tools provided within the Faculty WPBA documentation and guidance were robust enough to arrive at an accurate assessment of an individual's level of performance.

6.3 In order to treat patients detained in the custodial setting or assess patients who may have been sexually assaulted, security clearance of the doctor is required. This is normally restricted to the police force where the doctor works. In many cases the security clearance is at a very high level, particularly in relation to persons detained under terrorist legislation. Forensic physicians are therefore restricted to working in specific geographical areas where they have security clearance. Thus a forensic physician working in one county may not be able to enter another police force area where he/she does not have security clearance. This may also occur with doctors who might work for private provider companies. Thus it may not be possible to undertake mini-CEX and DOPS WPBA's outside of an assessor's normal working area.

6.4 Jurisdictional issues – there are different jurisdictions in the UK and no specific issues were identified in the pilot; this was because doctors in the same country assessed each other. If credentialing were to be implemented, doctors would need to be aware of this potential problem.

6.5 Disclosure – forensic records are potentially subject to disclosure in the criminal justice system and this could be a problem. As an example, if a hospital doctor was undertaking an operative procedure as part of a DOPS and it became apparent to the assessor that it was being done incorrectly or complications were developing, the assessor would be obliged to take over the procedure. In the forensic medicine context, if the assessor identified that the doctor was undertaking a procedure incorrectly, this would need to be corrected and noted and potentially could be disclosable in criminal justice proceedings.

7. Resource implications

7.1 The pilot has, so far, cost £24,200 including 27 days of Officer time.

7.2 These significant resource implications, particularly in relation to the assessor's time, would need to be addressed. The Faculty is of the opinion that the assessee will be required to meet some of these costs as he/she is ultimately likely to benefit from a credential.

7.3 An assessment is likely to cost the individual between £1000 and £1500.

8. Recommendations

8.1 The Academic Committee (AC) recommended that in order to ensure consistency of standards and prevent any collusion, some WPBAs should be done by doctors in the same working area (internal assessors) and a number should be done by external assessors. The AC concluded that it should not be compulsory to provide evidence of Court Room Skills if a court appearance were not made providing that Statement Writing Skills were passed and the doctor has produced suitable evidence of having completed a Court Room Skills course.

8.2 To overcome the problem of access, the AC recommended that DOPS would be done by internal assessors but that some of the mini-CEX and CbDs should be done by external assessors.

8.3 To complete a credential, it is proposed that forensic physicians should complete WPBAs in each of the 16 different categories in the assessment system grids (with the possible exception of Court Room Skills).

8.4 If credentialing were accepted, the overall assessment process would be managed via the Chief Examiner's Committee who would make a recommendation to the FFLM Board (in just the same way as for MFFLM) for ratification and recommendation to the GMC for the award of a "credential".

8.5 The AC concluded, and this was endorsed by the Faculty Board, that completion of the relevant Assessments System(s) following attainment of the MFFLM and linked to satisfactory appraisal and revalidation (when in place) being met and revalidation being maintained could lead to the award of a specialist "credential" and the process should be recommended to the GMC.

8.6 As outlined in paragraphs 2.1 to 2.3, the Faculty has spent six years in pursuit of raising standards and initiatives to improve patient safety by trying to develop a speciality of forensic and legal medicine. If the GMC decides not to pursue credentialing as an option, the Faculty would welcome suggestions from the GMC as to how patient safety can be improved and specialty status achieved. Any further delay here would, in the Faculty's view, be to the detriment of patients and we cannot see the justification for not adopting credentialing as a route to specialist status.

Professor Ian Wall FRCP FRCGP FFFLM MFMLM DMJ **April 2012**
FFLM Credentialing Lead and Past President

Appendix 1 – Work Place Based Assessments

Both guidance documentation and pro forma follow for:

- Direct Observation of Procedural Skills (DOPS)
- Mini-Clinical Evaluation Exercise (mini-CEX)
- Case-based Discussion (CbD)
- 360^{o} colleague feedback
- Statement Writing

Direct Observation of Procedural Skills (DOPS) Guidance

A DOPS is an assessment tool designed to evaluate the performance of an assessee in undertaking a practical procedure. The assessee should be given an immediate feedback to identify strengths and areas for development. All WPBAs are intended primarily to support learning and best practice so this feedback is very important.

Assessors can be anyone with expertise in the procedure but for Credentialing purposes this should be another doctor with MFFLM or FFFLM.

Not all elements need to be assessed on each occasion. You may explore an assessee's related knowledge where you feel appropriate.

Please ensure that the detainee/complainant/complainer knows a DOPS is being carried out where appropriate.

The form includes a rating of the level of independent practice the assessee has shown for the procedure, based on what has been observed.

Examples of procedures in Clinical Forensic Medicine in which DOPS might be used:

SOM

- Documentation of examination findings, especially with respect to injury
- Harvesting of forensic samples
- Aftercare - sexually transmissible infections - screening and investigation
- Aftercare - contraception - fitting of an IUCD
- Use of the colposcope and photodocumentation

GFM

- Road Traffic Medicine - taking of body fluid samples, assessment under S4 Road Traffic Act
- Documentation of examination findings, especially with respect to injury
- Harvesting of forensic samples

Descriptors of competencies demonstrated during CbD:

Demonstrates understanding of indications including the application of relevant law, relevant anatomy and technique	Does the assessee know the relevant indications, anatomical landmarks, and techniques relevant to the procedure?
Obtains informed consent	Is there a clear explanation of the proposed procedure to the patient, with the patient given an opportunity to ask questions? Where informed consent is sought, is this documented appropriately? Does the assessee avoid giving legal advice during this process?
Demonstrates appropriate preparation pre-procedure	Does the assessee demonstrate appropriate selection of samples and equipment?
Minimises risk of cross contamination	
Technical ability	Does the assessee show the requisite technical skills and techniques?
Aseptic technique	The cleansing of hands and, where relevant, equipment before and after every physical patient episode is mandatory.
Seeks help where appropriate	Does the assessee recognise his/her limitations and request assistance when appropriate?
Post procedure management	Does the assessee label and package samples/body charts adequately? Does the assessee maintain the Chain of Continuity?
Communication skills	Is the assessee polite, and exhibits a sense of self within a team structure? Is he/she able to convey understanding to others?
Consideration of patient/professionalism	Responds to patients feelings, shows respect, compassion, empathy, establishes trust; attends to patient's needs of comfort, modesty, confidentiality of information.
Overall ability to perform procedure	

Direct Observation of Procedural Skills (DOPS)

Date of assessment *(DD/MM/YY)*

☐☐/☐☐/☐☐

Assessee's surname

Assessee's forename

CFM Qualification: DFCASA / MFFLM / Other *specify*

Assessee's GMC # ☐☐☐☐☐☐☐

Assessor's registration # *(e.g. GMC, NMC, GDC)* ☐☐☐☐☐☐☐

Assessor's name

Assessor's email

Assessor's position:

Consultant or post-MFFLM / DFCASA or other diploma *specify* _____

Nurse or paramedic / Other

Clinical setting *(e.g custody, SARC, examination suite, A&E, etc.)* **:**

Procedure:

Please score the assessee on the scale shown. Please note that your scoring should reflect the performance of the assessee against that which you would reasonably expect at their stage/year of training and level of experience. Please mark 'Unable to Comment' if you feel you have not observed the behaviour.

Well below expectation for stage of training/level of experience	Below expectation for stage of training/level of experience	Borderline for stage of training/level of experience	Meets expectation for stage of training/level of experience	Above expectation for stage of training/level of experience	Well above expectation for stage of training/level of experience	Unable to comment
Demonstrates understanding of indications, relevant anatomy, technique of procedure						
☐	☐	☐	☐	☐	☐	☐
Obtains informed consent						
☐		☐	☐	☐	☐	☐
Demonstrates appropriate preparation pre-procedure						
☐	☐	☐	☐	☐	☐	☐
Minimises risk of cross contamination and labels and packages samples correctly						
☐	☐	☐	☐	☐	☐	☐
Technical ability						
☐		☐	☐	☐	☐	☐
Aseptic technique						
☐		☐	☐	☐	☐	☐
Seeks help where appropriate						
		☐	☐	☐	☐	☐
Post-procedure management						
☐		☐	☐	☐	☐	☐
Communication skills						
☐		☐	☐	☐	☐	☐

Consideration of patient/professionalism						
☐	☐	☐	☐	☐	☐	☐
Overall ability to perform procedure						
☐	☐	☐	☐	☐	☐	☐

Based on this observation please now rate the level of independent practice the assessee has shown for this procedure:

Level of Independent Practice	
Rating	
☐	Unable to perform the procedure
☐	Able to perform the procedure under direct supervision/assistance
☐	Able to perform the procedure with limited supervision/assistance
☐	Competent to perform the procedure unsupervised and deal with complications

Which aspects of the encounter were done well?

Any suggested areas for improvement?

Agreed Action:

Assessee's signature **Assessor's signature**

Mini-CEX Guidance

This tool evaluates a clinical encounter in forensic medical practice to provide an indication of competence in skills essential for good clinical care in a forensic setting such as history taking, examination, clinical and forensic reasoning. The assessee should be given immediate feedback to identify strengths and areas for development. All WPBAs are intended primarily to support learning and best practice so this feedback is very important.

Each assessment should cover a different clinical or forensic problem so as to sample different areas of the curriculum.

In SOM this includes: Consent, capacity and confidentiality

- Safeguarding for children, young people and vulnerable adults
- Process, content and documentation of history taking
- Process and documentation of examination
- Mental health assessment, especially suicide risk
- Aftercare - sexually transmissible infections
- Aftercare - contraception
- Communications

In GFM this includes:

- Consent, capacity and confidentiality
- Safeguarding for children, young people and vulnerable adults
- Fitness to detain including management of substance misuse, alcohol dependence, diabetes, head injury
- Fitness to interview
- Preliminary assessment and management of those detained under TACT provisions
- Road Traffic Medicine
- Documentation and interpretation of injuries - findings
- Mental health assessments and mental illness - process
- Scene of suspicious death
- Continuity of care

Assessors can be any doctor with suitable experience but for Credentialing purposes this should be another doctor with MFFLM or FFFLM.

Please ensure that the detainee/complainant/complainer is aware that a mini-CEX is being carried out where appropriate.

Descriptors of competencies demonstrated during mini-CEX:

Medical Interviewing Skills	Active listening skills including facilitating patient's telling of story; effectively using questions/directions to obtain accurate and adequate information; responding appropriately to patients affect and non-verbal cues.
Physical Examination Skills	Follows efficient, logical sequence; balances screening/diagnostic steps for problem; informs patient; sensitive to patient's comfort, modesty.
Counselling and Communication Skills	Agrees plan with patient, explains rationale for test/treatment, obtains patient's consent, educates/counsels regarding management.
Consideration for Patient/Professionalism	Responds to patients feelings, shows respect, compassion, empathy, establishes trust; attends to patient's needs of comfort, modesty, confidentiality of information.
Clinical Judgement	Selectively orders/performs appropriate diagnostic and forensic investigation, appropriate prescribing including consideration of risks and benefits.
Organisation/Efficiency	Prioritises; is timely; succinct
Overall Clinical Competence	Demonstrates judgement, synthesis, caring, effectiveness, and efficiency.

Mini-Clinical Evaluation Exercise (mini-CEX)

Date of assessment *(DD/MM/YY)*
☐☐/☐☐/☐☐

Assessee's surname

Assessee's forename

CFM Qualification: DFCASA / MFFLM / Other *specify*

Assessee's GMC # ☐☐☐☐☐☐☐

Assessor's registration # *(e.g. GMC, NMC, GDC)* ☐☐☐☐☐☐☐

Assessor's name

Assessor's email

Assessor's position:

Consultant or post-MFFLM / DFCASA or other diploma *specify* _____

Nurse or paramedic / Other

Brief summary of case:

Setting for Assessment *(e.g. custody, SARC, examinations suite, A&E, etc.)*:

Please score the assessee on the scale shown. Please note that your scoring should reflect the performance of the assessee against that which you would reasonably expect at their stage/year of training and level of experience. Please mark 'Unable to Comment' if you feel you have not observed the behaviour.

Well below expectation for stage of training/level of experience	Below expectation for stage of training/level of experience	Borderline for stage of training/level of experience	Meets expectation for stage of training/level of experience	Above expectation for stage of training/level of experience	Well above expectation for stage of training/level of experience	Unable to comment
Medical record keeping						
☐	☐	☐	☐	☐	☐	☐
Clinical assessment						
☐	☐	☐	☐	☐	☐	☐
Investigation and Referrals						
☐	☐	☐	☐	☐	☐	☐
Treatment / Management Plan						
☐	☐	☐	☐	☐	☐	☐
Follow-up and Future Planning						
☐	☐	☐	☐	☐	☐	☐
Professionalism						
☐	☐	☐	☐	☐	☐	☐
Overall Clinical Judgement						
☐	☐	☐	☐	☐	☐	☐

Based on this observation please rate the level of overall clinical judgement the assessee has shown:

Overall Clinical Judgement		
Rating	**Description**	
Below level expected during Introductory Training	Demonstrates little knowledge and lacking ability to evaluate issues resulting in only a rudimentary contribution to the management plan	☐
Performed at the level expected post-introductory training/training for DFCASA/other diplomas	Demonstrates some knowledge and limited evaluation of issues resulting in a limited management plan	☐
Performed at the level of DFCASA or equivalent in GFM	Demonstrates satisfactory knowledge and logical evaluation of issues resulting in an acceptable management plan consistent with early Higher Training	☐
Performed at level expected on gaining MFFLM	Demonstrates detailed knowledge and solid evaluation of issues resulting in a sound management plan	☐
Performed at level expected for completion of Credential post-MFFLM	Demonstrates deep up-to-date knowledge and comprehensive evaluation of issues resulting in an excellent management plan consistent with completion of Higher Training	☐

Which aspects of the encounter were done well?

Any suggested areas for improvement?

Agreed Action:

Assessee's signature **Assessor's signature**

Case Based Discussion (CbD) Guidance

The CbD assesses the performance of an assessee in their management of a patient to provide an indication of competence in areas such as clinical reasoning, decision-making and application of medical knowledge in relation to patient care. It also serves as a method to document conversations about, and presentations of, cases by assessees.

The assessee should be given immediate feedback to identify strengths and areas for development. All workplace-based assessments are intended primarily to support learning so this feedback is very important.

The assessee can suggest cases for discussion but the assessor makes the choice of case for the CbD and leads the discussion. Assessees in post-MFFLM should be able to discuss any case with which they have had significant, recent involvement.

The CbD should focus on a written record (such as written case notes, admission letter, or witness statement). A typical encounter might be when presenting a person detained in custody or under the Mental Health Act, or a complainant of an alleged sexual assault.

Assessors can be any doctor with suitable experience but for Credentialing purposes this should be another doctor with MFFLM or FFFLM.

Examples of the subjects which might be covered by CBD in clinical forensic medicine includes:

SOM

- Consent, capacity and confidentiality
- Safeguarding for children, young people and vulnerable adults
- Mental health assessment, especially suicide risk
- Aftercare - sexually transmissible infections
- Aftercare - contraception
- Triage of cases
- Interpretation of findings
- Management/teaching
- Audit

GFM

- Consent, capacity and confidentiality
- Safeguarding for children, young people and vulnerable adults
- Fitness to detain - all aspects
- Fitness to interview - all aspects
- Assessment and management of those detained under TACT provisions
- Road Traffic Medicine
- Interpretation of findings
- Mental health assessment and mental illness
- Scene of suspicious death
- Intimate searches
- Management/teaching
- Audit

Descriptors of competencies demonstrated during CbD:

Medical record keeping	Does the assessee: • produce records in line with GMC standards in *Good Medical Practice*; • show an understanding of Caldicott guardian arrangements; • store records securely in line with Caldicott/data protection regulations; • produce written care plans legible and populated with sufficient information to be useful to the Custody Staff and another HCP; • ensure the detainee understands the limits of confidentiality of the records and what will happen to them.
Clinical and forensic assessment	Does the assessee: • take a thorough clinical and forensic history; • demonstrate a high standard of risk assessment of physical and mental health problems and manage these risks appropriately both in the custodial setting and on release; • show an understanding of the forensic implications of the information obtained; • make detailed clinical and forensic assessment and recording of injuries; • organise information obtained into an effective care plan.
Investigations and referrals	Does the assessee: • use the limited tools available for investigation e.g. blood pressure monitors, blood glucose monitors, peak flow meters, urinalysis etc judiciously; • understand and use assessment tools such as those for opiate and alcohol withdrawal appropriately; • make use of other sources of information e.g. from mandatory drug testing, mental health agencies etc to inform their assessment; • make appropriate onward referrals to healthcare partners in their locality and communicate effectively with these agencies.
Treatment / Management Plan	Does the assessee: • maintain as high a degree of confidentiality as possible in communicating with Custody Staff; • give written and verbal feedback to the Custody Officer.
Follow-up and future planning	Does the assessee: • engage in future planning of care for the detainee's or complainant's physical and mental health problems; • ensure the detainee or complainant understands what follow up may be useful for their conditions; • provide written and verbal information on agencies available to the detainee or complainant.
Overall Clinical Judgement	Quality of the assessee's integrated thinking based on clinical and forensic assessment, investigations and referrals resulting in the detainee/complainant/ complainer's management plan.
Overall Clinical Competence	Demonstrates judgement, synthesis, caring, effectiveness, and efficiency.

Case-based Discussion (CbD)

Date of assessment *(DD/MM/YY)*
☐☐/☐☐/☐☐

Assessee's surname

Assessee's forename

CFM Qualification: DFCASA / MFFLM / Other *specify*

Assessee's GMC # ☐☐☐☐☐☐☐

Assessor's registration # *(e.g. GMC, NMC, GDC)* ☐☐☐☐☐☐☐

Assessor's name

Assessor's email

Assessor's position: **Consultant or post-MFFLM / DFCASA or other diploma** *specify* _____

Nurse or paramedic / Other

Brief summary of case:

Please score the assessee on the scale shown. Please note that your scoring should reflect the performance of the assessee against that which you would reasonably expect at their stage/year of training and level of experience. Please mark 'Unable to Comment' if you feel you have not observed the behaviour.

Well below expectation for stage of training/level of experience	Below expectation for stage of training/level of experience	Borderline for stage of training/level of experience	Meets expectation for stage of training/level of experience	Above expectation for stage of training/level of experience	Well above expectation for stage of training/level of experience	Unable to comment
Medical record keeping						
☐	☐	☐	☐	☐	☐	☐
Clinical assessment						
☐	☐	☐	☐	☐	☐	☐
Investigation and Referrals						
☐	☐	☐	☐	☐	☐	☐
Treatment / Mgment Plan						
☐	☐	☐	☐	☐	☐	☐
Follow-up & Future Planning						
☐	☐	☐	☐	☐	☐	☐
Professionalism						
☐	☐	☐	☐	☐	☐	☐
Overall Clinical Judgement						
☐	☐	☐	☐	☐	☐	☐

Based on this observation please rate the level of overall clinical judgement the assessee has shown:

Overall Clinical Judgement		
Rating	**Description**	
Below level expected during Introductory Training	Demonstrates little knowledge and lacking ability to evaluate issues resulting in only a rudimentary contribution to the management plan	☐
Performed at the level expected post-introductory training/training for DFCASA/other diplomas	Demonstrates some knowledge and limited evaluation of issues resulting in a limited management plan	☐
Performed at the level of DFCASA or equivalent in GFM	Demonstrates satisfactory knowledge and logical evaluation of issues resulting in an acceptable management plan consistent with early Higher Training	☐
Performed at level expected on gaining MFFLM	Demonstrates detailed knowledge and solid evaluation of issues resulting in a sound management plan	☐
Performed at level expected for completion of Credential post-MFFLM	Demonstrates deep up-to-date knowledge and comprehensive evaluation of issues resulting in an excellent management plan consistent with completion of Higher Training	☐

Which aspects of the encounter were done well?

Any suggested areas for improvement?

Agreed Action:

Assessee's signature **Assessor's signature**

Colleague multi-source feedback questionnaire

	Unacc-eptable	Below Average	Good	Out-Standing	U/C
1. Reliability: Conscientious and reliable; available for advice and help when needed; time management	☐	☐	☐	☐	☐
2. Professional Development: Commitment to improving quality of service; keeps up-to-date with knowledge and skills	☐	☐	☐	☐	☐
3. Teaching and Training: Contributes to the education and supervision of students and junior colleagues	☐	☐	☐	☐	☐
4. Verbal Communication: Spoken English; communication with colleagues, patients, families and carers	☐	☐	☐	☐	☐
5. Empathy and Respect: Is polite, considerate and respectful to patients and colleagues of all levels; compassion and empathy towards patients and their relatives	☐	☐	☐	☐	☐
6. Team Player: Values the skills and contributions of multi-disciplinary team members	☐	☐	☐	☐	☐
7. Leadership: Takes the leadership role when circumstances require; delegates appropriately	☐	☐	☐	☐	☐
8. Do you have any concerns about the probity or health (physical or mental) of this doctor? (If yes, please specify in the text box below)	Yes ☐			No ☐	

For statements above with an 'unacceptable' or 'outstanding' rating, you must give specific examples. This is a very important and useful part of the appraisal process. All your comments will be anonymous but will be reported back verbatim, so there is a risk of your identification from the nature of your comments.

Scale
'Unacceptable' – I have concerns
'Below average' – Improvement needed
'Good' – Doing a good job
'Outstanding' – Excellent performance
'U/C*' - unable to comment

Witness Statement and Report Writing Assessment

Date of assessment *(DD/MM/YY)*
☐☐ / ☐☐ / ☐☐

Assessee's surname Click here to enter text.

Assessee's forename Click here to enter text.

CFM Qualification: DFCASA / MFFLM / Other *specify*

Assessee's GMC # ☐☐☐☐☐☐☐

Assessor's registration # *(e.g. GMC, NMC, GDC)* ☐☐☐☐☐☐☐

Assessor's name Click here to enter text.

Assessor's email Click here to enter text.

Assessor's position: **Consultant or post-MFFLM / DFCASA or other diploma** *specify*_____

Nurse or paramedic / Other

Clinical setting *(e.g custody, SARC, examination suite, A&E, etc.)*:

Click here to enter text.

Specific facts:

Number	Item	Yes	No	N/A
1	Correct legal declaration	☐	☐	☐
2	Authors name	☐	☐	☐
3	Authors address	☐	☐	☐
4	Qualifications	☐	☐	☐
5	Experience	☐	☐	☐
6	Incident date	☐	☐	☐
7	Incident time	☐	☐	☐
8	Location	☐	☐	☐
9	Name of suspect/complainant	☐	☐	☐
10	Age or DOB of suspect/ complainant	☐	☐	☐
11	Request for examination	☐	☐	☐
12	Background information	☐	☐	☐
13	Consent	☐	☐	☐
14	History from suspect/ complainant	☐	☐	☐
15	Attendance time	☐	☐	☐
16	Consultation start	☐	☐	☐
17	Consultation end	☐	☐	☐
18	Examination findings	☐	☐	☐
19	Conclusion	☐	☐	☐
20	Each page signed	☐	☐	☐
21	Dated	☐	☐	☐

Overall quality:

	Unacceptable	Below Average	Good	Out-Standing	Unable to comment
1. Structure & Format Appropriate format used. Well written and clearly laid out.	☐	☐	☐	☐	☐
2. Content & Accuracy All evidence reported and explained accurately.	☐	☐	☐	☐	☐
3. Adherence to boundaries of expertise Remains within field of expertise	☐	☐	☐	☐	☐
4. Technical Information Technical explanations provided where relevant in layman's terms	☐	☐	☐	☐	☐
5. Professional Standard No hearsay, opinion or assumptions. Avoids speculation. Demonstrates impartiality and is ethical.	☐	☐	☐	☐	☐
6. Expert Opinion Careful separation of fact and opinion, provision of general discussion which might assist the Court, accurate referencing of assertions					
6. Overall rating	☐	☐	☐	☐	☐

Which aspects of the statement were done well?

Any suggested areas for improvement?

Agreed Action:

Assessee's signature: **Assessor's signature:**

Appendix 2 – Assessments Systems for General Forensic Medicine (GFM) and Sexual Assault Medicine (SOM)

Assessment Systems for FFLM

General Forensic Medicine	Mini-CEX	DOPS	CbD	MSF
Consent, capacity, confidentiality and disclosure	☑		☑	☑
Safeguarding for children, young people and vulnerable adults	☑		☑	
Fitness to detain including management of substance abuse, alcohol dependence, diabetes, head injury	☑		☑	
Fitness to interview	☑		☑	
Road Traffic Medicine	☑	☑	☑	
Documentation and interpretation of injuries - findings	☑	☑	☑	
Mental Health Assessments and mental illness - Process	☑		☑	
Harvesting of forensic samples		☑		
Scene of suspicious death	☑		☑	
Statement writing			☑	
Giving evidence in Court				?
Intimate searches			☑	
Continuity of care	☑			☑
Interpretation of findings			☑	
Management / teaching			☑	
Audit			☑	

Assessment Systems for FFLM

Sexual Offence Medicine	Mini-CEX	DOPS	CbD	MSF
Consent, capacity, confidentiality and disclosure	☑		☑	☑
Safeguarding for children, young people and vulnerable adults	☑		☑	
Process, content and documentation of history taking	☑			
Process and documentation of examination	☑	☑	☑	
Harvesting of forensic samples		☑		
Mental health assessment, especially suicide risk	☑	☑	☑	
Aftercare – sexually transmissible infections	☑	☑	☑	
Aftercare – contraception	☑		☑	
Communications	☑			☑
Statement writing			☑	
Giving evidence in Court				?
Use of colposcope		☑		
Triage of cases			☑	
Interpretation of findings			☑	
Management / teaching			☑	
Audit			☑	

Appendix 3 – GMC Domains

Domain 1 – Knowledge, Skills and Performance

Numbers following generic standards in this framework refer to paragraph numbers in GMP, except where preceded by MfD which refers to the booklet *Management for Doctors*; or Research which refers to *Research: the role and responsibilities of doctors*

Attributes	Generic Standards	Possible sources of evidence
Maintain your professional performance	**All doctors** • Maintain knowledge of the law and other regulation relevant to practice (13) • Keep knowledge and skills up to date (13) • Participate in professional development and educational activities (12). • Take part in regular and systematic audit (14)	Evidence from WPBA; CPD Audit Validated tools for feedback about doctors' practice
Apply knowledge and experience to practice	**All doctors** • Recognise and work within the limits of your competence (3a) **Doctors with management, teaching or research roles** • Follow appropriate national research governance guidelines (71) • Apply the skills, attitudes and practice of a competent teacher/trainer (16) • Work effectively as a manager (MfD 12, 17) **Doctors with clinical roles** • Adequately assess the patient's conditions (2a) • Provide or arrange advice, investigations or treatment where necessary (2b) • Prescribe drugs or treatment, including repeat prescriptions, safely and appropriately (3b) • Provide effective treatments based on the best available evidence (3c) • Take steps to alleviate pain and distress whether or not a cure may be possible (3d) • Consult colleagues, or refer patients to colleagues, when this is in the patient's best interests (2c, 3a, 3i, 54,55) • Support patients in caring for themselves (21e)	Evidence from training or assessment of skills CPD Audit Validated tools for feedback about doctors' practice
Keep clear, accurate and legible records	**All doctors** • Keep clear, accurate and legible records (3f) • Make records at the same time as the events you are recording or as soon as possible afterwards (3f) **Doctors with clinical roles** • Record clinical findings, decisions, information given to patients, drugs prescribed and other information or treatment (3f)	Anonymised records viewed at appraisal and WPBA

Domain 2 – Safety and Quality

Attributes	Generic Standards	Possible Sources of Evidence
Put into effect systems to protect patients and improve care	**All doctors** • Respond constructively to the outcome of audit, appraisals and performance reviews (14e) • Take part in systems of quality assurance and quality improvement (14) • Comply with risk management and clinical governance procedures • Co-operate with legitimate requests for information from organisations monitoring public health (14i) • Provide information for confidential inquiries, significant event reporting (14g) **Doctors with management roles** • Make sure that all staff for whose performance you are responsible are properly supervised. (17) • Ensure systems are in place for colleagues to raise concerns about risks to patients (45) **Doctors with clinical roles** • Report suspected adverse drug reactions (14h) • Ensure arrangements are made for the continuing care of the patient where necessary (40, 48)	WPBA, appraisal Validated tools for feedback about doctors' practice CPD – reflective practice
Respond to risks to safety	**All doctors** • Report risks in the health care environment to your employing or contracting bodies. (6) • Safeguard and protect the health and well-being of vulnerable people, including children and the elderly and those with learning disabilities. (26,28) • Take action where there is evidence that a colleague's conduct, performance or health may be putting patients at risk. (43,44) **Doctors with clinical roles** • Respond promptly to risks posed by patients • Follow infection control procedures and regulations	Information collected for folder, Evidence of level 3 safeguarding training, BLS training
Protect patients and colleagues from any risk posed by your health	**All doctors** • Make arrangements for accessing independent medical advice when necessary. (77) • Be immunised against common serious communicable diseases where vaccines are available (78)	Appraisal Health declaration.

Domain 3 – Communication, Partnership and Teamwork

Attributes	Generic Standards	Possible Sources of Evidence
Communicate effectively	**All doctors** • Communicate effectively with colleagues within and outside the team (41b) • Explain to patients when something has gone wrong (30) **Doctors with management roles** • Encourage colleagues to contribute to discussions and to communicate effectively with each other (MfD 50) **Doctors with clinical roles** • Listen to patients and respect their views about their health (22 a 27a). • Give patients the information they need in order to make decisions about their care in a way they can understand. (22b, 27) • Respond to patients' questions (22c, 27 b) • Keep patients informed about the progress of their care (22c) • Treat those close to the patient considerately. (29) • Pass on information to colleagues involved in, or taking over, your patients' care (40, 51-53)	WPBA, appraisal, Significant Event Analysis. Validated tools for feedback about doctors' practice
Work constructively with colleagues and delegate effectively	**All doctors** • Treat colleagues fairly and with respect (46) • Support colleagues who have problems with their performance, conduct or health (41d) • Act as a positive role model for colleagues (41) • Ensure colleagues to whom you delegate have appropriate qualifications, experience (54) **Doctors with management roles** • Provide effective leadership (MfD 50)	Information for folder
Establish and maintain partnerships with patients	**Doctors with clinical roles** • Encourage patients to take an interest in their health and take action to improve and maintain it (4, 21f) • Be satisfied that you have consent or other valid authority before you undertake any examination or investigation, provide treatment or involve patients in teaching or research. (36)	Review of anonymised records, WPBA, appraisal

Domain 4 – Maintaining Trust

Attributes	Generic Standards	Possible Sources of Evidence
Show respect for patients	**All doctors** • Implement and comply with systems to protect patient confidentiality. (37) **Doctors with research roles** • Respect the rights of patients participating in research. (Research 2, 5) **Doctors with clinical roles** • Be polite, considerate and honest and respect patients' dignity and privacy (21a, b, d) • Treat each patient fairly and as an individual (38-39, 21 c)	Appraisal, WPBA
Treat patients and colleagues fairly and without discrimination	**All doctors** • Be honest and objective when appraising or assessing colleagues and when writing references (18-19) • Respond promptly and fully to complaints. (31) **Doctors with clinical roles** • Provide care on the basis of the patient's needs and the likely effect of treatment (7-10)	Appraisal, Diversity training, evidence from complaints
Act with honesty and integrity	**All doctors** • Ensure you have adequate indemnity or insurance cover for your practice (34) • Be honest in financial and commercial dealings (73) • Ensure any published information about your services is factual and verifiable (60, 61) • Be honest in any formal statement or report, whether written or oral, making clear the limits of you knowledge or competence. (63-65, 67-68) **Doctors with research roles** • Obtain appropriate ethical approval for research projects (Research 5). • Be honest in undertaking research and reporting research results (71 b) • Ensure that your research is audited regularly. (research 43) **Doctors with clinical roles** • Inform patients about any fees and charges before starting treatment (72a)	Probity declaration