

Glossary for undertakings and conditions

This glossary is intended to support consistency in the General Medical Council (GMC) and Medical Practitioner Tribunal Service's (MPTS) use of terms featured in the guidance:

- Agreeing a doctor's undertakings
- Imposing conditions on a doctor's registration
- Imposing interim conditions on a doctor's registration.

This document outlines the wording that decision makers (GMC and MPTS) should use when restricting or placing requirements on a doctor in relation to their practice, behaviour, supervision and training. The glossary will also be helpful to:

- doctors and their representatives
- GMC associates
- responsible officers / employers / contracting bodies
- the public.

Given the pace of change in the UK health sector, this glossary should be regarded as a living document. Please send any comments about this document to FTPPolEnq@gmc-uk.org

Admitting rights

A formal arrangement with a private hospital or organisation for a doctor to admit their own private patients for inpatient care. Overall responsibility for the patient's care remains with the admitting doctor.

Case-based discussion

The case-based discussion assesses the performance of a doctor in their management of a patient to give an indication of competence in areas such as clinical reasoning, decision making and application of medical knowledge in relation to patient care. It serves as a method to document conversations about, and presentations of, cases by doctors who must be supervised as a requirement of conditions or undertakings.

Chaperone

A chaperone is an impartial observer who is present, wherever possible, when the doctor with restrictions carries out an **intimate examination**. This applies whether or not the doctor is the same gender as the patient. A relative or friend of the patient is not an impartial observer and so would not usually be a suitable chaperone, but the doctor should comply with a reasonable request to have such a person present, as well as a chaperone.

A chaperone should usually be a suitably trained person who will:

- be familiar with the procedures involved in a routine intimate examination
 - stay for the whole examination and be able to see what the doctor is doing, if practical
 - be prepared to raise concerns if they are concerned about the doctor's behaviour or actions
 - be sensitive and respect the patient's dignity and confidentiality
 - reassure the patient if they show signs of distress or discomfort.
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Contracting body

An organisation or individual with which a doctor has a contract to provide services in, or in relation to, any area of medicine. For example, a general practitioner (GP) may have a contract with National Health Service (NHS) England to provide primary care services to a group of patients, and a private doctor may have a contract with an individual patient to provide medical services directly to them.

Clinical supervision

Clinical supervision is carried out by a named clinical supervisor (either a Consultant or a practising GP approved by the Responsible Officer), who takes overall responsibility for the arrangements of a doctor's supervision. They will give constructive feedback to the doctor and will lead the review of their clinical practice throughout the period of supervision. The clinical supervisor must give the GMC regular feedback about the doctor's progress.

The roles of clinical supervisor and workplace reporter may be merged. The appointment of the clinical supervisor must be approved by the Responsible Officer (or their nominated deputy) and the GMC must be informed of these arrangements.

The clinical supervisor is responsible for ensuring that the doctors they supervise are not expected to take responsibility for, or perform, any clinical activity or technique if they do not have the appropriate experience and expertise.

The tables below outline three possible levels of clinical supervision for a doctor with conditions or undertakings working in a GP or hospital context. In exceptional circumstances, the GMC may agree different clinical supervision arrangements. The GMC must be satisfied that the other arrangements give the same level of assurance and feedback as the requirements set out in the tables below.

It is possible for the clinical supervisor to delegate some of the duties involved in supervision to a named deputy or deputies, typically providing support/assistance when the supervised doctor is carrying out any activity that involves patient contact such as consultations, examinations and procedures.

For all levels of supervision in the table below the named deputy or deputies must:

- be a senior doctor with appropriate experience. The decision about appropriate experience is at the discretion of the clinical supervisor
- be informed of the doctor's conditions or undertakings
- provide feedback to the clinical supervisor about the doctor's clinical practice.

Clinical supervision requirements for GPs

<p>What level should the clinical supervisor be?</p>	<p>Practising GP approved by the Responsible Officer (RO), who is not an employee of the supervised doctor.</p>
<p>Which organisation should the doctor and supervisor work for?</p>	<p>Any practising GP approved by the Responsible Officer.</p>
<p>How should the clinical supervision arrangements be carried out?</p>	<p>Supervised</p> <p>The doctor's clinical work must be supervised. The supervised doctor must not work as a single-handed practitioner. The supervised doctor may make unsupervised home visits to patients.</p> <p>Whoever carries out the active supervision of clinical work may be off site at a particular time but must be available to give advice and/or assistance (eg by phone). This can be either by the clinical supervisor or by a suitable named deputy/deputies, under the same established arrangements made and overseen by the clinical supervisor.</p> <p>If the clinical supervisor is away for more than a working week, the Responsible Officer must approve another practising GP to take over overall responsibility for clinical supervision under the same established arrangements.</p> <p>The clinical supervisor must:</p> <ul style="list-style-type: none"> • take overall responsibility for the arrangements for the doctor's supervision • meet with the doctor formally, in person, at least once a fortnight for a case-based discussion. <p>The named deputy or deputies must:</p> <ul style="list-style-type: none"> • be a senior doctor with appropriate experience. The decision about appropriate experience is at the discretion of the clinical supervisor • be informed of the doctor's conditions or undertakings • be available to give advice and/or assistance as required • provide feedback to the clinical supervisor about the doctor's clinical practice.

Closely supervised

The doctor's clinical work must be closely supervised. The supervised doctor must not work as a single-handed practitioner. The supervised doctor must not make unsupervised home visits to patients.

Whoever carries out the active supervision of clinical work must be on site and available to the supervised doctor at all times. This can be either by the clinical supervisor or a suitable named deputy/deputies, under the same established arrangements made and overseen by the clinical supervisor.

If the clinical supervisor is away for more than a working week, the Responsible Officer must approve another practising GP to take over overall responsibility for clinical supervision under the same established arrangements.

The clinical supervisor must:

- take overall responsibility for the arrangements for the doctor's supervision
- meet with the doctor formally, in person, at least once a fortnight for a [case-based discussion](#)
- meet with the doctor, in person, at least once a week for a [feedback session](#).

The named deputy or deputies must:

- be a senior doctor with appropriate experience. The decision about appropriate experience is at the discretion of the clinical supervisor
- be informed of the doctor's conditions or undertakings
- be on site and available to give advice and/or assistance as required
- provide feedback to the clinical supervisor about the doctor's clinical practice.



Directly supervised

The doctor must be directly supervised. This means that any activity that involves patient contact such as consultations, examinations and procedures must be supervised in person at all times. This can be either by the clinical supervisor or by a suitable named deputy/deputies, under the same established arrangements made and overseen by the clinical supervisor.

If the clinical supervisor is away for more than a working week, the Responsible Officer must approve another practising GP to take over overall responsibility for clinical supervision under the same established arrangements.

The clinical supervisor must:

- take overall responsibility for the arrangements for the doctor's direct supervision
- make and oversee arrangements for a suitable deputy or deputies to directly supervise in person all aspects of the doctor's clinical work. The arrangements must include mechanisms for the named deputy or deputies to feedback to the clinical supervisor about the doctor's clinical practice. This feedback should be reviewed with the doctor at each feedback session.
- take responsibility at all times for all aspects of the doctor's clinical work
- ensure that all of the supervised doctor's prescribing is monitored, in a manner that the clinical supervisor feels provides suitable safeguards
- meet with the doctor formally, in person, at least once a fortnight for a [case-based discussion](#)
- meet with the doctor, in person, at least once a week for a [feedback session](#)

The named deputy or deputies must:

- be a senior doctor with appropriate experience. The decision about appropriate experience is at the discretion of the clinical supervisor
- be informed of the doctor's conditions or undertakings
- be available to give advice and/or assistance at all times
- provide feedback to the clinical supervisor about the doctor's clinical practice.

Clinical supervision requirements for doctors working in a hospital

<p>What level should the clinical supervisor be?</p>	<p>Consultant</p>
<p>Which organisation should the doctor and supervisor work for?</p>	<p>The clinical supervisor must work for the same healthcare organisation as the doctor under supervision.</p>
<p>How should the clinical supervision arrangements be carried out?</p> 	<p>Supervised</p> <p>The doctor's clinical work must be supervised.</p> <p>Whoever carries out the active supervision of clinical work may be off site at a particular time but must be available to give advice and/or assistance (eg by phone). This can be either by the clinical supervisor or by a suitable named deputy/deputies, under the same established arrangements made and overseen by the clinical supervisor.</p> <p>If the clinical supervisor is away for more than a working week, the Responsible Officer must name another Consultant to take over overall responsibility for clinical supervision under the same established arrangements.</p> <p>The clinical supervisor must:</p> <ul style="list-style-type: none"> • take overall responsibility for the arrangements for the doctor's supervision • meet with the doctor formally, in person, at least once a fortnight for a case-based discussion. <p>The named deputy or deputies must:</p> <ul style="list-style-type: none"> • be a senior doctor with appropriate experience. The decision about appropriate experience is at the discretion of the clinical supervisor • be informed of the doctor's conditions or undertakings • be available to give advice and/or assistance as required • provide feedback to the clinical supervisor about the doctor's clinical practice.

Closely supervised

The doctor's clinical work must be closely supervised. This means that whoever carries out the active supervision of clinical work must be on site and available to the supervised doctor at all times. This can be either by the clinical supervisor or by a suitable named deputy/deputies, under the same established arrangements made and overseen by the clinical supervisor.

If the clinical supervisor is away for more than a working week, the Responsible Officer must name another Consultant to take over overall responsibility for clinical supervision under the same established arrangements.

The clinical supervisor must:

- take overall responsibility for the arrangements for the doctor's supervision
- meet with the doctor formally, in person, at least once a fortnight for a [case-based discussion](#)
- meet with the doctor, in person, at least once a week for a [feedback session](#).

The named deputy or deputies must:

- be a senior doctor with appropriate experience. The decision about appropriate experience is at the discretion of the clinical supervisor
- be informed of the doctor's conditions or undertakings
- be on site and available to give advice and/or assistance as required
- provide feedback to the clinical supervisor about the doctor's clinical practice.



Directly supervised

The doctor must be directly supervised. This means that any activity that involves patient contact such as consultations, examinations and procedures must be supervised in person at all times.

The active supervision of clinical work may be carried out either by the named clinical supervisor or by a suitable named deputy/deputies, under appropriate arrangements made and overseen by the clinical supervisor.

If the clinical supervisor is away for more than a working week, the Responsible Officer must name another Consultant to take over overall responsibility for clinical supervision, as described in this Glossary, under the same established arrangements. The clinical supervisor or named deputies must be on site and available to the supervised doctor at all times.

The clinical supervisor must:

- take overall responsibility for the arrangements for the doctor's direct supervision
- make and oversee arrangements for a suitable deputy/deputies to directly observe in person all aspects of the doctor's clinical work. The arrangements must include mechanisms for the named deputy/deputies to provide feedback to the named clinical supervisor about the doctor's clinical practice. This feedback must be reviewed with the supervised doctor at each feedback session
- take responsibility at all times for all aspects of the doctor's clinical work.
- ensure that all of the supervised doctor's prescribing is monitored, in a manner that the clinical supervisor feels provides suitable safeguards
- meet the doctor formally, in person, at least once a fortnight for a [case-based discussion](#)
- meet the doctor, in person, at least once a week for a [feedback session](#).

The named deputy or deputies must:

- be a senior doctor with appropriate experience. The decision about appropriate experience is at the discretion of the clinical supervisor
- be informed of the doctor's conditions or undertakings
- be available to give advice and/or assistance at all times
- provide feedback to the clinical supervisor about the doctor's clinical practice.

Educational supervision

Doctors whose fitness to practise is impaired as a result of deficient professional performance must all have an educational supervisor when they are in a medical post. Educational supervision may also be required in other cases where a doctor's fitness to practise is found to be impaired.

Educational supervision is given by an educational supervisor who is an approved trainer appointed within the postgraduate training arrangements at a trust or board, led by the directors of medical education. The educational supervisor is responsible for the overall supervision and management of a doctor's learning and educational progress throughout the period of supervision. The educational supervisor must agree to give the GMC regular feedback about the doctor's educational progress, with reference to the aims of their [personal development plan](#) however the educational supervisor is not responsible for the supervision of the doctor's clinical practice.

English language tests acceptable to the GMC

The GMC routinely accepts two English language tests as evidence of English language competence – the academic version of the International English Test System (IELTS) and the medical version of the Occupational English Test (OET).

Both tests have four parts – listening, reading, writing and speaking and there is no pass or fail score for either test.

International English Language Testing System

Doctors sitting an IELTS will receive individual scores of between 9 and 1 for each of the four parts, and an overall score of up to 9 for all parts. We accept a score of at least 7 in each of the four parts, and an overall score of at least 7.5.

If doctors choose to submit an IELTS scores they must show evidence that:

- a they achieved a score of at least 7.0 in each testing area (speaking, listening, reading and writing), and an overall score of at least 7.5
- b they have achieved these scores in the same test
- c they took the academic version of the test.

Occupational English Test

Doctors sitting an OET will receive individual scores of between A and E, or a numerical score of between 500 and 0, for each of the four testing areas. We accept at least a grade B or a numerical score of at least 350 in each testing area.

If doctors choose to submit OET scores they must show evidence that:

- a they have achieved at least a grade B or a numerical score of at least 350 in each testing area (speaking, listening, reading and writing)

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- b they have achieved these scores in the same test
 - c they took the medicine profession version.

Feedback session

This is a structured discussion which is part of the arrangements for [clinical supervision](#) of a doctor who has close or direct supervision as a requirement of conditions or undertakings. The session is led by the clinical supervisor and the doctor, who may both select cases on which to structure the discussion. The emphasis on the session is to give feedback, identify learning points, and give advice and support.

Intimate examination

For the purposes of undertakings and conditions an intimate examination is an examination of breasts, genitalia or the rectum, or an examination that requires exposure of these areas.

Locum

A doctor who is standing in for an absent doctor, or who is temporarily covering a vacancy, in an established post or position. A locum is often, but not always, employed by a locum agency and carries out a locum placement at a hospital or GP practice etc.

For a doctor with restricted registration, the GMC considers:

- a fixed-term contract to be the same as a locum contract
- where a minimum duration is specified in an undertaking or condition, a zero hours contract is not an acceptable alternative to a locum post or fixed-term contract
- where a minimum duration is specified in an undertaking or condition, the locum post must require the doctor to work at least five sessions per week for the duration of the post or contract
- a locum appointment for training (LAT) post and a locum appointment for service (LAS) post to be the equivalent of a substantive post, therefore not a true locum post in the case of fully registered doctors, ie not provisionally registered doctors.

Locum appointment for service (LAS)	A short-term appointment used to fill a service gap in a training programme. LAS posts must not be taken on by provisionally registered doctors.
Locum appointment for training (LAT)	An appointment to fill a gap in a training programme. LAT posts are typically only available to those in the second year of the Foundation Programme (F2).
Logs	<p>A record of an individual clinical consultation, examination or procedure that is made at the time the consultation, examination or procedure is undertaken.</p> <p>The log must always include the:</p> <ul style="list-style-type: none"> • doctor's name • date of the consultation, examination or procedure • patient's anonymous identifier (e.g. NHS or hospital number) • patient's clinical signs and symptoms • procedure carried out or diagnosis • outcome • any other information needed to meet the restriction on the doctor's practise (eg signature of chaperone, supervising consultant, or workplace reporter to verify the information).
Medical supervision	<p>Medical supervision is the framework the GMC uses to monitor a doctor's health and progress during a period of restricted practise. Doctors whose fitness to practise is impaired as a result of adverse physical or mental health must have a medical supervisor.</p> <p>The medical supervisor is appointed from an approved list held by the GMC. The medical supervisor is not responsible for or involved in the doctor's treatment or care. The supervisor meets with the doctor regularly to discuss their progress, and liaises with any treating doctors, as well as the workplace, clinical or educational supervisors. The medical supervisor will obtain information from a variety of sources but will not disclose confidential information to an employer without the doctor's consent.</p> <p>The medical supervisor reports to the GMC on a regular basis, setting out their opinion about the doctor's progress under treatment, whether the doctor is complying with conditions or undertakings and the doctor's fitness to practise in general.</p>
Mentor	A more senior and experienced colleague who is able to offer guidance to a doctor. Mentoring is wide-ranging, covering clinical work, professional relationships and career plans. The relationship between the doctor and mentor is confidential and the GMC do not expect the mentor to give reports or feedback, other than to confirm that a mentoring relationship is in place.

Misuse of Drugs Regulations 2001

Drugs controlled under the *Misuse of Drugs Act 1971* are placed in schedules 1–5 of the *Misuse of Drugs Regulations 2001* based on:

- an assessment of their medicinal or therapeutic usefulness and the need for legitimate access
- their potential harms when misused.

The more harmful a drug can be when misused, the higher the schedule and the stronger the regime around its availability.

Schedule 1: covers drugs that have no therapeutic value and are usually used in research under a Home Office licence. Examples include cannabis, MDMA (ecstasy) and lysergamide.

Schedule 2: covers drugs that have therapeutic value, but are highly addictive. These are strictly controlled and subject to special requirements relating to their prescription, dispensing, recording and safe custody. Examples include potent opioids such as diamorphine and morphine.

Schedule 3: covers drugs that have therapeutic value, but have slightly lighter control, special requirements relating to their prescription, dispensing, recording and safe custody (where applicable). Examples include temazepam, midazolam and buprenorphine, and methylphenobarbitone.

Schedule 4: Part 1 covers benzodiazepines (examples include bromazepam, diazepam (Valium) and triazolam) and Part 2 covers anabolic and androgenic steroids (examples include prasterone, testosterone, nandrolone and bolandiol), which is subject to lighter regulation with no possession offence.

Schedule 5: covers weaker preparations of Schedule 2 drugs that present little risk of misuse and can be sold over the counter as a pharmacy medicine (without prescription). Examples include codeine, medicinal opium or morphine (in less than 0.2% concentration).

For further information and a full list of drugs classified in each schedule, please refer directly to the legislation. Please note: Though the above list was correct at the time of publication of this document, drugs may sometimes be reclassified.

Non-NHS post

Any paid or unpaid position where a doctor is employed or contracted to provide services in, or in relation to, any area of medicine within a private organisation or private setting. This includes providing services to NHS patients in a private setting.

On-call duties	<p>For hospital doctors A doctor is on call when, as part of an established arrangement with their employer or contracting body, they are available outside their normal working hours, either at the workplace, at home or elsewhere, to attend work to deal with unplanned patient care.</p>	<p>For GPs A GP may be on call when, as part of an established arrangement, they are available in normal working hours to deal with unplanned patient care. The on-call GP may be required to consult patients in the GP practice, over the telephone, or at a patient's home.</p>
One month	Any period of one calendar month, on a rolling basis.	
One session	A half day. Where this period is not appropriate, a session can be a continuous period of work of 3.5–5 hours.	
One week	Any period of seven days, on a rolling basis.	
Out of hours work	<p>Work carried out during 18:30–08:00 on weekdays, and all day at weekends and on bank holidays.</p> <p>The GMC may approve a different work pattern when the normal hours of a doctor's employer or contracting body do not match this time range. For example, a GP practice may normally be open from 07:00–19:00.</p>	
Over the counter drugs (in the UK)	<p>A medicinal product which is not a prescription-only medicine, not on the general sale list (GSL) and may only be sold or supplied from registered pharmacies in the UK. Over the counter drugs include, but are not limited to:</p> <ul style="list-style-type: none"> • Any combination of codeine, ephedrine, morphine, antihistamine. This includes medicines such as Voganin, Do-Do, Phensedyl, Codeine Linctus, Gees Linctus, Pulmo Bailly, Day Nurse, Night Nurse, Medinite, Kaolin and Morphine Mixture, Dimotane Co, Feminax, or any other similar preparations. • Antihistamines alone. This includes Avomine, Dramamine, Phenergan, Medinex, Nyton, Nytol One-a Night, or any other similar preparations. • Cyclizine preparations. This includes Valoid, or any other similar preparations. • Sympathomimetics. This includes Sudafed, Actifed, Mucron, Sinutab, or any other similar preparations. 	

Prescribing practices

There are three ways a doctor may have responsibility for or come into contact with drugs. These are:

To administer - To give a drug to a patient by any prescribed route. This includes administering a drug that has been prescribed by another healthcare practitioner, for example an intravenous painkiller in Accident and Emergency, in which case the doctor will come into direct contact with the drug.

To have primary responsibility - A doctor has primary responsibility for a drug when:

- they hold the drug for transportation for the purposes of future administration
- they are the practitioner with overall responsibility for the administration and disposal of a drug.

To prescribe - To authorise the administration of a drug to a patient by signing a document setting out:

- the name of the drug
- the route of administration
- the amount to be administered
- the timing of administration.

The doctor may give the prescription to the patient or another healthcare practitioner, in which case the doctor may never come into direct contact with the drug which they have prescribed.

Personal development plan (PDP)

A prioritised list of a doctor's educational needs, intended learning aims and plans for continuing professional development over a defined period. All doctors should have an active PDP that is reviewed regularly throughout their appraisal process.

For doctors with conditions or undertakings, the PDP is a starting point for remediation or retraining. The plan should cover all areas of the GMC core guidance for doctors, *Good medical practice*, but must specifically set out an action plan for addressing the deficiencies listed in the relevant condition or undertaking.

Against each action, the PDP should set out measures that will help assess whether the action has been achieved and a target date for completing the action. The doctor's responsible officer (or their nominated deputy) can give a doctor advice on how to prepare a PDP. But it is the doctor's responsibility to:

- prepare the PDP
- seek the responsible officer's approval on the prepared PDP
- carry out the activities needed
- reflect on the impact of their learning on their performance and practice.

Post

Any paid or unpaid position where a doctor is employed or contracted to provide services in any area of medicine, or in relation to any area of medicine, e.g. research, teaching or pharmaceuticals. A post can be on a locum or a substantive basis and includes work carried out in a private hospital, organisation or setting where the doctor holds practising privileges and/or admitting rights.

Practising privileges

A formal arrangement with a private hospital or organisation for a doctor to consult with or treat their own private patients on the premises of the hospital or organisation.

Provisional registration

Under the *Medical Act 1983*, a UK medical graduate is entitled to provisional registration with a licence to practise so long as their fitness to practise is not impaired. The purpose of provisional registration is to enable a graduate to participate in and complete an acceptable programme for provisionally registered doctors.

The only acceptable programme for provisionally registered doctors that the GMC recognises is the first year of the Foundation Programme (F1). Provisionally registered doctors are only allowed to take up F1 posts in the Foundation Programme and to do so they must also hold a licence to practise.

According to the GMC guidance *The Trainee Doctor*, F1 doctors are not allowed to take on any form of locum appointment, except a locum appointment for training (LAT) post approved by the F1 doctor's postgraduate deanery, local education and training board (LETB) or foundation school, and their medical school. LAT posts are however, typically only available at F2.

Responsible officer

Most doctors who are registered with a licence to practise in the UK are linked to a Responsible Officer (RO) – a senior doctor who makes sure the doctor is meeting the GMC's standards, including keeping their skills and knowledge up to date. The RO must be registered with a licence to practise in the UK and have been practising for more than five years. In some cases, this may mean that the role is an extension of the current role of the medical director.

As part of our system of checks on a doctors' revalidation, the RO makes a recommendation to the GMC, usually every five years, about whether the doctor should continue to be registered with a licence to practise. The RO is also responsible for making sure the systems of local clinical governance and appraisal in their organisation are appropriate for revalidation.

If a doctor's RO and their employer/contracting body has agreed that arrangements will be made for a doctor with restrictions or requirements on their practice to continue in or return to medical practice, ROs play a role in monitoring a doctor's compliance with restrictions and ensuring that return to practice is appropriately and safely managed. The restrictions ensure that ROs (or their nominated deputies) are involved in approving those arrangements.

If the doctor who is subject to restrictions (undertakings and/or conditions) on their practice does not have a RO, the doctor may identify another person with the necessary expertise to fulfil this role subject to their agreement (such as a Director of Medical Education or Dean). Any such arrangement must be agreed with the GMC prior to the doctor starting/restarting work. If the doctor does not have a RO and cannot identify an appropriate person to fulfil this role, they should inform their GMC caseworker and should not start/restart work until alternate or other arrangements have been agreed with the GMC.

More information about the role of a RO in monitoring a doctor's compliance with restrictions may be found at http://www.gmc-uk.org/concerns/employers_information.asp.

Training programme

A programme is a formal alignment or rotation of placements, which together comprise a programme of training in a given specialty (including GP and foundation training) or sub-specialty. A programme may either deliver all of the curriculum through linked stages in an entirety to Certificates of Completion of Training, or the programme may deliver different component elements of the approved curriculum.

The GMC approves programmes of training in all specialties, including general practice and foundation, which are based on a particular geographical area (which could cover one or more postgraduate deaneries or local education and training boards). They are managed by a training programme director (TPD) or their equivalent. A programme is not a personal programme undertaken by a particular doctor in training.

Workplace reporting

Every doctor who is working and has conditions or undertakings on their registration must have a workplace reporter, approved by their responsible officer and the GMC. The workplace reporter would normally be the doctor's immediate line manager or a senior colleague. In exceptional circumstances, the workplace reporter may be a senior administrator in the GP practice or hospital, or from the trust or board.

The workplace reporter must give regular feedback to the GMC, the medical supervisor and the responsible officer (or nominated deputy). Feedback should include:

- confirmation that the doctor is complying with their practice-related conditions or undertakings
- any information which shows the doctor is progressing and which may suggest that restrictions may be relaxed or removed
- confirmation and details of complaints or concerns received about the doctor which reach the *GMC thresholds* guidance
- any other relevant information and documentation.

More detailed information and guidance can be found in the document *Workplace reporting for doctors with restrictions on their practice*.
