Revalidation:
The way ahead

Consultation Document

General Medical Council

Regulating doctors
Ensuring good medical practice

Revalidation:
The way ahead

Contents

The following documents should be read in conjunction with this consultation document. They can be downloaded from our website at **www.gmc-uk.org/thewayahead**

Foreword

Doctors are among the most trusted of all professionals. However, we practise in a less deferential age where patients are more questioning and where the knowledge of what medicine can do increases expectations and we have to ensure that the trust in doctors continues to be justified.

For the past 150 years, the General Medical Council has sought to provide assurance through the register of medical practitioners. It remains today one of the most robust and well used registers anywhere in the world. But it has always been a record of qualification not of competence or performance. It is a historical record of examinations passed and qualifications earned. As such, it offers limited public assurance about how each of us is maintaining the high standards expected of us throughout our careers.

Revalidation will plug this gap. It will provide visible assurance of, and a focus for, every one of us to maintain and improve our practice. It will also provide a driver for the organisations in which we work to support us in doing this. In this way it should contribute to improvements in the quality of patient care.

In the difficult financial climate of the next few years, when the pressure on doctors and other healthcare professionals is certain to grow, revalidation must not be a bureaucratic or costly exercise which diverts attention and resources away from front line care. But it does not need to be either bureaucratic or costly.

In one sense what is being proposed is no more than what should be happening in every doctor's practice. Revalidation will not involve a point-in-time assessment of a doctor's knowledge and skills but will be based on a continuing evaluation of their practice in the context of their every day working environment. It will be based on local systems of annual appraisal over a five year period and will simply affirm periodically what has already been demonstrated through the appraisal process.

I do hope you will respond to the proposals and contribute to the consultation. This is the start of a process – we will not get everything right from the outset but with further input from the medical profession and others and opportunities to test these proposals in practice we believe we can create a robust and workable system that will command the confidence of doctors and support the public's continuing trust in the profession.

Professor Peter Rubin
Chair, General Medical Council

Executive summary

The way in which doctors are regulated is changing. This document sets out the General Medical Council's (GMC) proposals for a new process to assure patients and the public, employers and other healthcare practitioners that licensed doctors are up to date and fit to practise. The process is called revalidation.

1. In future, all licensed doctors will need to revalidate regularly if they wish to keep their licence to practise.
2. Revalidation is a new way of regulating the medical profession that will provide a focus for doctors' efforts to maintain and improve their practice, facilitate the organisations in which doctors work to support them in keeping their practice up to date, and encourage patients and the public to provide feedback about the medical care they receive from doctors. In these ways, revalidation will contribute to the ongoing improvement in the quality of medical care delivered to patients throughout the UK.
3. The subject of the consultation is how revalidation will work in practice. The consultation is not about whether revalidation should be introduced; instead it outlines our proposals for putting revalidation into place. The UK Parliament has already passed legislation to ensure that revalidation will be introduced for all doctors in the UK.
4. This consultation document is divided into four parts:

Section 1 – How revalidation will work.

This section describes how the process will work and the basis on which decisions to revalidate will be made.

Section 2 – What doctors, employers and contractors of doctors' services will need to do.

This section describes the standards that doctors will need to meet to maintain a licence to practise and the supporting information that doctors will need to provide to demonstrate that they meet those standards. Further detail is set out in Annex 1 and Annex 2. It also describes the key role that local systems of appraisal and clinical governance will play and clarifies what employers and those who contract or commission services will need to do to ensure that these systems are fit for purpose.

Section 3 – Patient and public involvement in revalidation.

This section describes how patients and the public have been involved in the development of our revalidation plans and the role that patient and colleague questionnaires will play in providing feedback on a doctor's performance. The criteria that these questionnaires would need to meet is set out in Annex 3.

Section 4 – How and when revalidation will be introduced.

This section describes the current timetable for the introduction of revalidation and how revalidation will be rolled out, over time, for all doctors.

5. We have included three appendices to this consultation document to help guide readers through the document, including a **Process diagram** (Appendix A), a **Glossary of terms, organisations and acronyms** (Appendix B) and **Frequently Asked Questions** (Appendix C).

6. The approach set out in the consultation is designed to achieve a modern system of registration and licensing that is acceptable to patients and the public. We believe that this will provide greater assurance that will be good for the profession as well as the public.

7. The key is to enable greater assurance to be derived, as far as practicable, from existing professional activities that are worthwhile in themselves rather than new activities devised for the GMC's purposes. That is important, both to ensure that doctors engage in and support the process and also to minimise additional costs on the healthcare service and the time doctors have to spend away from their patients.

8. The proposals for revalidating doctors should not exist in isolation from other systems designed to assure the quality of care. They will focus on affirming good practice for the vast majority of doctors but will also complement other systems for detecting poor practice.

9. The proposals in this consultation document are intended to enable us to make a start. The system will need to develop and strengthen over time.

Responding to the consultation

10. We are inviting a wide range of organisations to take part in the consultation. We are also keen to hear the views of individual patients, carers, doctors and other healthcare professionals as well as members of the public. You can respond online via our website (**www.gmc-uk.org/thewayahead**). Alternatively, you can reply by email to **thewayahead@gmc-uk.org** or in writing.

11. The consultation runs from 1 March 2010 to 4 June 2010.

12. If you require further information about the consultation, please contact **thewayahead@gmc-uk.org** or telephone 020 7189 5280.

Introduction and summary

This section provides an introduction to the consultation and a summary of our proposals.

The General Medical Council

13. The GMC is the independent regulator for doctors in the UK. Our purpose is to protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine. We do this in four ways:

a. By controlling entry to and maintaining the list of registered and licensed medical practitioners.

b. By setting the educational standards for medical school.

c. By determining the principles and values that underpin *Good Medical Practice*.

d. By taking firm but fair action against doctors' registration where the standards of *Good Medical Practice* have not been met.

Revalidation: purpose and principles

14. The purpose of revalidation is to assure patients and the public, employers and other healthcare professionals that licensed doctors are up to date and are practising to the appropriate professional standards. Although it is widely understood that the delivery of medical care to patients will always involve an element of risk, revalidation will help doctors, employers and the GMC to provide further assurance to patients and the public that doctors working in the UK are fit to practise.

15. In 2008, the Chief Medical Officer for England (Professor Sir Liam Donaldson) published the report of his working group on medical revalidation (*Medical Revalidation – Principles and Next Steps*) which set out key principles for the way revalidation should operate. The working group concluded that revalidation:

- must support doctors in meeting their personal and professional commitment to continually sustaining and developing their skills;
- should include within it a strong element of patient and carer participation and evaluation;
- should be seen primarily as supportive, focused on raising standards, not a disciplinary mechanism to deal with the small proportion of doctors who may cause concern;
- must include remediation and rehabilitation as essential elements of the process for the very few who struggle to revalidate, giving them help wherever possible;
- should be a continuing process, not an event every five years, so that problems can be identified and resolved quickly and effectively;
- should avoid bureaucracy, add value and provide a reasonable level of reassurance to colleagues, employers, patients and the public;
- should be introduced incrementally through piloting to ensure that it works well;
- should provide reasonably consistent assurance of standards across the United Kingdom, whatever the practice model;
- should be based on supporting information drawn from local practice, with robust systems of clinical governance to support it; and
- will depend on the quality, consistency and nature of appraisal to ensure the confidence of patients and doctors.

16. We have worked to ensure that these principles are reflected in the proposals set out in this consultation document.

Registration and licensing of doctors in the UK

17. Patients trust doctors with their lives and wellbeing. They need to have confidence that doctors are competent and abide by high ethical standards. One of the ways in which the GMC ensures that trust is through the registration and licensing of doctors in the UK.

18. Being registered with the GMC shows that a doctor has the necessary qualifications for medical practice in the UK. It is essentially a historical record of those qualifications.

19. Holding registration alone does not allow someone to work as a doctor in the UK. A doctor must also have a licence to practise to undertake the sort of activities normally associated with medical practice, such as prescribing medicine, signing death certificates and holding medical posts.

20. All doctors who wish to practise medicine in the UK must be both registered and licensed with the GMC. This applies whether they practise full-time, part-time, as a locum, privately or in the NHS, or whether they are employed or self-employed.

21. Information about whether a doctor is registered and licensed can be found on the GMC's website at **www.gmc-uk.org**

22. When revalidation is introduced, doctors who wish to keep their licence to practise will need to demonstrate to the GMC periodically, normally every five years, that they are up to date and fit to practise.

23. All doctors are under a professional duty set out in our guidance, *Good Medical Practice*, to keep up to date, and the vast majority strive to do so. But, for a modern system of registration and licensing to be acceptable to the public, a greater degree of assurance is needed. We believe that greater assurance will be good for the profession as well as the public.

Consultation summary

24. To meet its aims, revalidation must be relevant to doctors' day-to-day medical practice and build upon systems that already exist in the workplace to support high quality care. It must not create unnecessary burdens which hamper doctors in fulfilling their main concern of caring for their patients.

25. For this reason, revalidation will not involve a point-in-time assessment of a doctor's knowledge and skills, but will be based on a continuing evaluation of a doctor's practice in the place in which the doctor works. It will be based on local systems of appraisal and clinical governance. The local appraisal systems will need to include an evaluation of the doctor's performance against the generic standards set by the GMC and the specialist or general practice standards set by the medical Royal Colleges and Faculties and agreed by the GMC.

26. The generic and specialist standards that doctors will be expected to meet are set out in Section 2 of this consultaion document. This section also outlines the types of supporting information that doctors will need to bring to their annual appraisals to demonstrate that they meet the standards that are relevant to their day-to-day practice.

27. For the most part, that supporting information will be based on data generated in the doctor's workplace. Doctors will need to maintain a portfolio of supporting information and this will be reviewed annually by the doctor's appraiser.

28. In order to be revalidated, doctors will need to engage in an annual appraisal process and will need to link to a Responsible Officer who will usually be based in the organisation in which the doctor works or with which he or she is contracted to provide services. For the majority of doctors in clinical practice, the Responsible Officer will be a senior medical manager in the organisation in which the doctor works.

29. The post of Responsible Officer is a new statutory role. A consultation covering England, Scotland and Wales has been carried out by the Department of Health (England), and the Department of Health, Social Services and Public Safety has recently consulted in Northern Ireland, on how Responsible Officers will undertake their role. The secondary legislation and guidance outlining the detailed role of the Responsible Officer will be laid before Parliament and the Northern Ireland Assembly later this year. You can find out more information on the role of the Responsible Officers on the websites of the Department of Health (England) and the Department of Health, Social Services and Public Safety (Northern Ireland).

30. All designated organisations that employ or contract with doctors will need to appoint a Responsible Officer. This Responsible Officer will confirm to the GMC (usually every five years) that a doctor is up to date and fit to practise.

31. Organisations that employ or contract with doctors will need to ensure that all of their doctors have an annual appraisal and that at least part of that appraisal involves an evaluation of the doctor's performance against the professional standards set by the GMC and the medical Royal Colleges and Faculties. A standard framework for appraisal and assessment has been developed for these purposes (see Section 2 of this consultation document) and this framework will need to form part of the appraisal system for all doctors to ensure that there is a consistent approach across the UK.

32. Responsible Officers will base their recommendations for revalidation on the outcome of a doctor's annual appraisals over the course of five years, combined with information drawn from the clinical governance systems of the organisation or organisations in which the doctor has worked. Appraisers and/or the Responsible Officer may choose to take advice, at any stage, from the medical Royal Colleges and Faculties and others on the relevant standards and supporting information.

33. A key element in the revalidation process is the supporting information that doctors will provide from their day-to-day practice in order to demonstrate that they are complying with the professional standards. The information required will vary depending on the nature of the doctor's practice, but will include material such as audit data, outcome data, and evidence of participation in Continuing Professional Development (CPD). This information should be brought together with other relevant clinical governance information to the annual appraisal. Further information about what doctors will need to do is provided in Section 2 of this consultation document.

34. Feedback from colleagues and patients on a doctor's performance will also form part of the supporting information. This will usually be gathered by asking colleagues and patients to complete questionnaires on the doctor's practice and performance. Further information on how colleague and patient questionnaires might be used is provided in Section 3 of this consultation document.

35. Because revalidation is concerned with how doctors perform in practice, workplace systems of clinical governance and appraisal need to be sufficiently mature to enable doctors to collect the information they need for their revalidation and for that data to be properly evaluated in the workplace. We know that this is not currently the case everywhere.

36. For this reason, we are proposing that revalidation should be rolled out on an incremental basis. It is important that where it is introduced the systems and structures are in place to support doctors in providing the necessary information for revalidation. We believe roll-out can be best achieved using a phased approach following extensive piloting of the model.

37. We have begun to test how revalidation will work in practice. Pilots and projects are underway across the UK involving thousands of doctors working in different specialties and sectors. We will use the lessons learnt from this to shape and inform the implementation of revalidation.

38. Revalidation should only be rolled out when local healthcare organisations are ready and local systems of appraisal and governance are in place and sufficiently robust.

39. There is a shared responsibility for the delivery of revalidation across a range of stakeholders, including the GMC, the health departments in England, Northern Ireland, Scotland and Wales, the medical Royal Colleges and Faculties, the NHS and other employers, and the medical profession. Organisations across the UK health services will need to ensure that the systems necessary to support revalidation are fit for purpose. Further information about how and when revalidation will be introduced is provided in Section 4 of this consultation document.

Section 1 – How revalidation will work

This section describes how the process will work and the basis on which decisions to revalidate will be made.

40. This section also covers how the process might work for those doctors in training roles or non-mainstream practice (paragraphs 80 –111).

Revalidation, relicensing and recertification

41. All doctors who wish to keep their licence to practise must revalidate.

42. When the Government published its proposals for revalidation in 2007, it divided revalidation into two elements – relicensing and recertification. We are now proposing a single system.

43. The original idea was that all doctors who held a licence to practise would be required to relicense by demonstrating that they are practising in accordance with generic standards of practice set by the GMC. However, many of those licensed doctors are also on either the specialist register or general practitioner register (the 'GP register') held by the GMC. Under the original proposals these doctors, in addition to meeting the generic standards required for relicensing, would also have to demonstrate that they were meeting the particular standards relevant to their specialty or general practice. This process was referred to as recertification. If doctors did not recertify, they would risk losing their entry in the specialist or GP registers.

44. Since the Government published its proposals, considerable work has been undertaken to develop the standards and processes to support both elements of revalidation. This work has involved the GMC, the medical Royal Colleges and Faculties, specialist associations and others. As a result of this work, we have concluded that revalidation will be simpler, more effective and more efficient if it operates as a single set of processes rather than as the two separate strands of relicensing and recertification that were originally envisaged. There are several reasons for this.

45. First, revalidation is based on an evaluation of doctors' actual performance in the workplace. This means surgeons are evaluated in their work as surgeons, and GPs are evaluated against the applicable standards for GPs. Although there are generic standards for all licensed doctors (as set out in our guidance to the profession *Good Medical Practice*), doctors across all levels of practice apply those standards in a way that is appropriate to the particular work that they do. When GPs communicate with patients, they do so in the context of their work as GPs and to the standards expected of GPs. There are not two separate standards for communication, one generic and one specific to their role as GPs.

46. Our work with the medical Royal Colleges and Faculties on revalidation has reinforced this conclusion. The specialist standards that they have developed are not separate from the GMC generic standards but build upon them and are specialty-specific iterations of the principles and values of *Good Medical Practice*. It therefore makes sense for there to be a single evaluation for revalidation, rather than separate evaluations for relicensing and recertification.

47. Second, the information that doctors will use to show that they are practising to the appropriate standards will be largely drawn from their day-to-day work in their specialty or field of practice. They will not use different supporting information for relicensing and recertification. Separating these elements therefore adds no value.

48. Third, the separation of relicensing and recertification risks unfairness for some. After they have been included in the specialist or GP register, most doctors will have another 20 or more years of medical practice before they retire. During that time, their practice may diversify into other fields or narrow to focus on a particular subspecialty. For example, a doctor may move out of surgery and into medical management. In such a case, it would be of no benefit to patients, employers or the doctor, and would waste valuable resources, if we required that doctor to demonstrate continuing competence in a specialty which was no longer part of their practice, simply in order to remain on the specialist register as a surgeon.

49. Finally, maintaining relicensing and recertification as separate elements within revalidation risks complexity and confusion. Doctors should not need to clear two different hurdles: one to relicense and one to recertify. Revalidation should be a single set of processes with a clear outcome, which doctors, their patients and those who employ or contract doctors' services can understand.

50. Doctors who are no longer working in the specialty for which they were originally listed in the specialist or GP registers will not lose their register entry if their revalidation has been secured on the basis of supporting information of practice in another field. The specialist or GP register entry will remain as a historical record of a doctor's achievement. But the register will also show the field in which a doctor most recently demonstrated fitness to practise through revalidation.

51. You can find further information on how doctors who no longer work in the specialty in which they originally qualified might revalidate at paragraphs 101 to 111 of this section and in the Frequently Asked Questions (FAQs) in Appendix C.

Question 1:

- *Do you agree that revalidation should be based on a single set of processes for evaluating doctors' performance in practice, rather than split into the separate elements of relicensing and recertification?*

Revalidation: an overview of the process

52. The following paragraphs provide an overview of the revalidation process. See also the diagram in Appendix A.

53. Because the nature of medical practice and the settings in which doctors work are so varied, it is not possible to describe in this summary how revalidation will work for each doctor in every situation. Instead, the summary sets out how the process will look for the vast majority. You can find more detail on doctors whose practice is non-standard at paragraphs 90–100 of this section and in the Frequently Asked Questions (FAQs) in Appendix C.

Collection and evaluation of information in the workplace through appraisal

54. Revalidation will be based on a local evaluation of doctors' performance against national generic and specialty standards approved by the GMC. The proposed standards are described in Section 2 of this consultation document.

55. Doctors will be expected to participate in a process of annual appraisal in the workplace. Most doctors already have an annual appraisal. However, for the purposes of revalidation, it will be essential that there is an effective appraisal system that includes an evaluation of each doctor's performance against the relevant standards.

56. Doctors will need to maintain a folder or portfolio of information drawn from their practice to show how they are meeting the required standards. Because each doctor's practice is different, the information collected will vary. Guidance on the sort of information that doctors in different specialties might draw on is given in Section 2 of this consultation document. The information collected in their portfolio will provide the basis for discussion at their annual appraisal.

57. For most doctors, this annual evaluation of their practice through appraisal will be nothing new. In future, it will help them and their appraisers to link their performance to national standards and identify any areas for action and address any concerns long before they are required to revalidate.

58. Doctors practising in both the NHS and independent sectors should undertake whole practice appraisal which will take account of their work in both sectors. In most cases, the annual appraisal will take place in the sector within which they do the bulk of their work.

Question 2:

- *Do you agree that revalidation should be based on a continuing evaluation of doctors' performance in the workplace?*

The revalidation recommendation and the role of the 'Responsible Officer'

59. To revalidate a doctor, the GMC will require assurance that he or she is meeting the required standards and that there are no known concerns about the doctor's practice. The revalidation recommendation will come to the GMC via the local Responsible Officer.

60. The Responsible Officer will be a senior, licensed doctor. In a healthcare organisation, this is likely to be the Medical Director. For GPs, the Responsible Officer is likely to be from the healthcare organisation on whose performers' list they are included.

61. The Responsible Officer will have statutory responsibility for evaluating the fitness to practise of doctors associated with that organisation. In England, Wales and Northern Ireland they will also be responsible for ensuring that the system of clinical governance (including appraisal) in their healthcare organisation is capable of supporting doctors in meeting the requirements of revalidation. They will not have this additional role in Scotland as this area of responsibility is covered by existing legislation and organisations.

62. To make a revalidation recommendation to the GMC, the Responsible Officer will rely on the outcome of a doctor's annual appraisals over the course of five years, combined with information drawn from the clinical governance systems of the organisation in which the doctor works.

63. In a large organisation, the Responsible Officer may have responsibility for several thousand doctors spread across a range of different specialties. It is not realistic to expect one Responsible Officer to be familiar with the practice of every doctor in that organisation. The role of the person conducting the appraisal (who will usually be from the doctor's own specialty) will therefore be crucial in informing the Responsible Officer's recommendation.

64. The Responsible Officer will also be able to draw on advice from others such as the medical Royal Colleges and Faculties in relation to the specialty standards. There is further information on these specialty standards in Section 2 of this consultation document. He or she will also be able to take advice from the relevant clinical directorate lead.

65. The Responsible Officer will make a recommendation to the GMC about a doctor's revalidation, normally every five years.

66. Some doctors will be in wholly independent practice, or working in organisations which do not provide an appropriate appraisal system or a Responsible Officer. These doctors will need to make alternative arrangements to ensure they undergo an appropriate and regular appraisal and that they link up with a Responsible Officer. This will make their revalidation more straightforward. In particular, it will help to ensure that they are meeting the requirements for revalidation before the time comes for them to revalidate. That way there will be no surprises.

67. The Responsible Officer regulations, subject to approval by the UK Parliament and the Northern Ireland Assembly, will designate a small number of organisations whose members are mainly independent practitioners. There are a number of organisations which may be able to help with this. The Independent Doctors Federation, the Royal Society of Medicine, and some medical Faculties are considering providing appraisal or Responsible Officer facilities for their members. The Responsible Officers of these organisations will have functions only for their members who are not linked to a Responsible Officer in another way.

68. You can find out more information about the role of the Responsible Officer on the websites of the Department of Health (England) and the Department of Health, Social Services and Public Safety (Northern Ireland).

The revalidation decision by the GMC

69. Although the Responsible Officer will make the recommendation, it will be for the GMC to decide whether the doctor concerned should be revalidated.

70. We also need to be confident that the recommendations we receive are robust, fair and consistently applied. Both the process leading to the recommendations and the recommendations themselves will therefore be subject to quality assurance.

71. We are confident that the vast majority of doctors will have no difficulty meeting the standards for revalidation. These doctors will retain their licence to practise until their next revalidation is due. This will generally be after a further five years.

No positive recommendation from the doctor's Responsible Officer

72. For a small minority of doctors, revalidation may be more difficult and there will be exceptional cases where the Responsible Officer is not in a position to make a positive recommendation to the GMC. There are likely to be three main scenarios where this might happen, although the particular circumstances will undoubtedly differ from case to case:

a. There may be exceptional cases in which a doctor has not been in active practice and has clearly not engaged with any appraisal process or with his or her Responsible Officer. In these circumstances, there will be little or no evidence on which a Responsible Officer could make a positive recommendation that a doctor is up to date and fit to practise. In these circumstances the doctor will need to take an alternative route for revalidation (see paragraphs 90-95 of this section) or can expect to have his or her licence to practise withdrawn. Any decision to withdraw a licence will be subject to an appeal process.

b. If there are gaps in the evidence provided by the doctor, the GMC, based on the recommendation of the Responsible Officer, may decide to defer revalidation to enable the doctor to collect the necessary information. In the absence of negative information indicating that the doctor's fitness to practise is impaired, there would be insufficient grounds for referring the case to the GMC's fitness to practise procedures, but, equally, it would not be appropriate to renew the doctor's licence where there were significant gaps in the evidence required to show that the doctor was competent and fit to practise.

c. Where there are concerns about a doctor's practice these should be identified as early as possible and, where possible, addressed through appraisal and the relevant local clinical governance processes. Action on concerns should not wait until a doctor is due to be revalidated by the GMC. Of course, if there are serious concerns about a doctor's practice, then the Responsible Officer would want to engage with the National Clinical Assessment Service or refer the doctor to the GMC, where there are concerns about patient safety. It is unlikely that these issues would simply come to light at the point in the process when the Responsible Officer is due to make a recommendation to the GMC. If any concerns are ongoing at the time of revalidation, the recommendation could be deferred until such time as local, National Clinical Assessment Service or GMC processes have been concluded.

Question 3:

- *Do you agree with the proposals for dealing with the most common situations where a Responsible Officer may not be in a position to make a positive recommendation?*

The role of the medical Royal Colleges and Faculties

73. The medical Royal Colleges and Faculties have a key role in the revalidation process. Their principal responsibilities can be summarised as follows:

a. Defining the relevant specialty and general practice standards.

b. Validating specialty tools for the evaluation of doctors' practice.

c. Describing the types of supporting information that doctors will need to provide to meet the relevant specialty standards.

d. Providing specialty guidance for appraisees, appraisers and Responsible Officers.

74. The proposals from the Colleges and Faculties on specialty standards, evaluation tools and supporting information can be found in Section 2 of this consultation document.

75. There remains the issue of College and Faculty involvement in the local appraisal process and the recommendation that the Responsible Officer makes to the GMC.

76. The Colleges and Faculties have discussed a number of potential models for their engagement in the local workplace-based processes that lead to a recommendation from the Responsible Officer on whether an individual doctor should be revalidated. All Colleges and Faculties feel that their role should focus on the setting of standards and agreeing the relevant supporting information for doctors in their specialty. This role would also involve providing guidance and advice to appraisers and Responsible Officers on the specialty standards and supporting information.

77. Additionally, some Colleges are proposing that they have direct input into the recommendations made by the Responsible Officer. This could be either by way of the quality assurance of the process and an auditing/sampling of some of the underlying information or having direct involvement in the recommendation for each of the doctors in their specialty by way of a local panel that would involve the Responsible Officer, College or Faculty representative and perhaps a non-medical patient representative.

78. It is clear that the statutory and legal responsibility for making the recommendation to the GMC lies with the Responsible Officer. Our preferred model is based on the Colleges' involvement in a quality assurance and advisory role rather than having a direct role in the evaluation of every doctor or input into every recommendation to the GMC by the Responsible Officer. Responsible Officers should seek specialty advice in cases where there are concerns or questions about a doctor's specialist practice from the relevant College or Faculty to help inform their recommendations.

79. This model does not preclude those Colleges/Faculties whose specialists work predominantly outside managed healthcare environments (such as the Faculty of Occupational Medicine and the Faculty of Pharmaceutical Medicine) providing appraisal and Responsible Officer facilities where these would not otherwise be available. In such cases, the Faculties would clearly have direct input into individual recommendations to the GMC.

Question 4:

- *Do you agree that the Colleges and Faculties should not be directly involved in the recommendations made by the Responsible Officer to the GMC?*

Question 5:

- *If so, what do you think their role should involve? Please tick one or more of the following options:*

a. Setting standards and defining specialty information ☐

b. Advice and guidance for appraisers ☐

c. Advice and guidance for Responsible Officers ☐

d. Audit and quality assurance of the recommendation process ☐

Doctors in non-standard or training roles

80. This section of the consultation considers a number of specific policy questions and also looks at how revalidation will work for doctors who are in training posts or non-mainstream roles.

81. The basic architecture of revalidation has been established. The model and process for revalidation will be relatively straightforward for the majority of doctors undertaking clinical work within the NHS or the independent sector.

82. However, we also need to ensure that the revalidation model works for the significant minority of doctors whose practice is different in one way or another but who still wish to maintain a licence to practise. This is an area where more work is needed and there are a number of policy issues that still have to be resolved. In each case, we have outlined proposals that are very much a starting point and that we will review in the light of responses to the consultation.

83. This section covers the following areas:

a. Revalidation of trainees (see paragraphs 84 to 89 of this section).

b. Revalidation of doctors with no medical practice of any kind (see paragraphs 90 to 95).

c. Revalidation of doctors working in non-clinical practice (see paragraphs 96 to 100).

d. Revalidation of doctors working outside their registered specialty (see paragraphs 101 to 111).

Revalidation of trainees

84. Doctors in postgraduate training will hold licences to practise. They will therefore need to participate in revalidation.

85. However, trainees are already among the most closely regulated group of doctors. They are supervised and subject to regular assessment. Revalidation must not create additional burdens for trainees which would add little value.

86. There are around 40,000 doctors in the UK on training programmes leading to the award of a Certificate of Completion of Training (CCT) in general practice or their chosen specialty. Their progression through training is governed by the Annual Review of Competence Progression (ARCP). Work is ongoing with the medical Royal Colleges and Faculties to ensure the robustness of the ARCP process for revalidation. Our intention is that the ARCP process, in conjunction with feedback from the local clinical governance supervisor or medical director that there are no outstanding concerns about fitness to practice, should provide the vehicle through which trainees would be able to revalidate. In effect, revalidation would be the by-product of successful progression through training.

87. Work is being undertaken to ensure that the training framework reflects a number of the key elements of revalidation. The medical Royal Colleges and Faculties will embed the framework for assessment and appraisal based on *Good Medical Practice* that has been developed for revalidation in the revised Certificate of Completion of Training curricula. See further information in Section 2 of this consultation document.

88. There may also need to be some enhancement of the ARCP process so that it incorporates patient and colleague feedback.

89. We are proposing, therefore, that the ARCP process (suitably enhanced) should provide the vehicle through which trainees would be able to revalidate. Trainees' first revalidation will be either at the point they are awarded their Certificate of Completion of Training (CCT) or five years from the date they are granted full registration, whichever is the sooner.

Question 6:

- *Do you agree that for trainees, successful progression through training should be the means of securing revalidation?*

Revalidation of doctors with no medical practice of any kind

90. A key principle of our proposals for revalidation is that it is an evaluation of a doctor's practice based upon what they actually do in the workplace.

91. Doctors who do not undertake any medical practice do not require a licence to practise. However, it is clear that some doctors who do not practise have taken a licence. Similarly, some doctors currently in practice may cease to do so at some point in the future, but wish to retain their licence to practise.

92. For those doctors with no medical practice of any kind, there will be no opportunities to draw upon supporting information from their practice in order to revalidate. We need, therefore, to consider how we enable such doctors to revalidate.

93. The Professional and Linguistic Assessments Board test (PLAB test) is the main route by which International Medical Graduates (IMGs) demonstrate that they have the necessary skills and knowledge to practise medicine in the UK. We admit doctors to the register, and provide them with a licence to practise, on the basis of a pass in a PLAB test. The PLAB test has a shelf-life of three years.

94. We are proposing therefore that, for the small minority of doctors with no medical practice and who are unable to draw on supporting information from their actual practice, success in one of the following examinations or assessments should be regarded as sufficient for revalidation:

a. The PLAB test or any postgraduate qualification accepted by the GMC for the purposes of full registration (within the shelf-life of the examination permitted for entry to the register).

b. Successful completion of knowledge and skills assessments developed for the GMC's Fitness to Practise performance procedures.

95. There may also be other examinations or assessments that we would be able to accept in the specific circumstances outlined above. However, any such examination or assessment would need to be quality assured by the GMC.

Question 7:

- *Do you agree with our proposals for the revalidation of doctors with no medical practice of any kind?*

Revalidation of doctors working in non-clinical practice

96. Many doctors work in non-clinical roles. These include, but are not limited to, work in medical management, medical research, medical education, and providing expert guidance such as medico-legal advice.

97. These doctors will revalidate in much the same way as their colleagues who work in clinical practice in that they will need to link to a Responsible Officer, engage in a system of annual appraisal based on professional standards and bring supporting information to that appraisal to show that they meet those standards.

98. Ideally these doctors should undertake a single appraisal process that covers the different elements of their clinical and academic work. The appraisal process should comply with the Follett principles.

99. Just as the medical Royal Colleges and Faculties have developed specialty-specific standards for doctors working in different specialties, and have described the types of information doctors will need to provide to show that they are meeting these standards, the same will need to be developed for doctors' non-clinical roles.

100. Work has begun on this, but we will need to take advice from the main organisations working with doctors in these fields before we consult more widely later this year on a proposed framework of standards and supporting information for doctors in non-clinical roles. (See further information at paragraph 143 in Section 2 of this consultation document.)

Revalidation of doctors working outside their registered specialty

101. The list of registered and licensed medical practitioners on the GMC's website shows the public whether or not a doctor is registered and has a licence to practise.

102. It also shows whether a doctor is on either the GP register or specialist register. A doctor must be on one or other of these registers in order to work as an NHS GP or an NHS consultant.

103. If a doctor is on the specialist register, the specialty for which they are registered will be shown. For example, if a doctor has completed specialist training in psychiatry, this specialty will be included in his or her register entry.

104. At present, the registers show the specialty in which a doctor has completed training. But this is essentially a historical record. It does not always accurately reflect a doctor's current practice. That is because, as their careers progress, doctors often diversify into other areas, or they may sub-specialise.

105. Revalidation will help us to make the registers a more accurate statement of a doctor's current practice, by reflecting what a doctor is actually doing in practice, and confirming that he or she is continuing to practise to the required standards.

106. In order to revalidate, doctors will use information drawn from their medical practice to show that they are working to the appropriate professional standards. Thus, doctors who are working as GPs will use information from their work as GPs. Doctors working in occupational medicine will use information about their work in that specialty.

107. Our intention is that the registers should show, in broad terms, the field of medical practice that has provided the basis for a doctor's revalidation. This will need to recognise that many doctors practise across more than one discipline.

108. Doctors who are no longer working in the specialty for which they were originally listed in the specialist or GP registers will not lose their register entry if their revalidation has been secured on the basis of supporting information of practice in another field. The specialist or GP register entry will remain as a historical record of a doctor's achievement. But the register will also show the field in which a doctor most recently demonstrated fitness to practise through revalidation.

109. For example, the register entry for a doctor on the GP register who has moved into occupational medicine might include the following:

GMC Reference number: 1234567

Given names: Alfred Tennyson

Surname: Smith

Gender: Male

Status: Registered with a licence to practise; this doctor is on the GP register

GP Register entry date: From 31 March 2006

Revalidated field of practice: Occupational medicine (1 Jan 2015)

110. This approach may be particularly useful if the doctor's recent practice for the purposes of revalidation has been in a non-clinical discipline without any patient involvement, such as medical management.

111. It will also help to acknowledge the continuing competence of doctors who are meeting the professional standards required in their specialty, but who have not previously had that competence acknowledged. This might apply, for example, to staff grade doctors who provide specialty services in the NHS.

Question 8:

- *Do you agree that the list of registered and licensed medical practitioners should indicate the field of practice on the basis of which a doctor has secured revalidation?*

Section 2 – What doctors, employers and contractors of doctors' services will need to do

This section describes the standards that doctors will need to meet to revalidate and the supporting information that they will need to provide to demonstrate that they meet those standards.

112. This section also describes the key role that local systems of appraisal and clinical governance will play and clarifies what employers and contractors of services will need to do to ensure that these systems are fit for purpose.

Doctors

113. This section summarises what doctors will need to do to revalidate. The wide variety of roles that doctors perform, and the different settings in which they work, mean that this summary cannot address every possible scenario. You can find more detail on doctors whose practice is non-standard at paragraphs 143 – 144 of this section, at paragraphs 80 – 111 of Section 1 and in the Frequently Asked Questions (FAQs) in Appendix C.

Collecting information and meeting standards

114. All doctors who hold a licence to practise will be required to revalidate.

115. Our proposals for revalidation are based on existing local systems of appraisal and clinical governance. We need to ensure that these systems are consistent and fit for purpose but also feasible, practicable and proportionate as far as doctors, employers and other contracting organisations are concerned.

116. Local systems of appraisal will need to include an evaluation of the doctor's performance against generic professional standards set by the GMC and the specialist or general practice standards set out by the relevant medical Royal Colleges or Faculties.

117. The standards that doctors will be expected to meet are set out in Annex 1 and Annex 2. These annexes also include proposals on the supporting information that doctors need to bring to their annual appraisal to demonstrate that they meet those standards.

118. For the most part, the supporting information will be based on data generated in the doctor's workplace. Doctors will need to maintain a portfolio of that supporting information and this will need to be reviewed annually by the doctor's appraiser. Doctors practising in both the NHS and independent sectors should collect supporting information for whole practice appraisal which will take account of their work in both sectors.

119. Doctors will need to engage in an appraisal process annually and will need to link to a Responsible Officer who will usually be based in the organisation in which the doctor works or with which he or she is contracted to provide services (see paragraphs 59–68 in Section 1).

120. This following paragraphs focus on:

a. The *Good Medical Practice* (GMP) Framework that has been developed for appraisal and assessment (see paragraphs 121 to 132 of this section and Annex 1).

b. The specialty standards and proposals on supporting information that have been developed by each of the medical Royal Colleges and Faculties (see paragraphs 133 to 142 of this section and Annex 2).

The *Good Medical Practice* Framework

121. Our guidance for doctors, *Good Medical Practice* (GMP), sets out the principles and values on which good practice is founded. It is used to inform the education, training and practice of doctors. Serious or persistent failures to follow the guidance in *Good Medical Practice* can put a doctor's registration and licence at risk.

122. The UK Government's 2007 White Paper on professional regulation (*Trust, Assurance and Safety*) tasked the GMC with developing a GMP Framework, based on *Good Medical Practice*, against which doctors' practice could be appraised and objectively assessed (White Paper, paragraph 2.21).

123. The GMP Framework was developed and published in 2008. The GMP Framework can be found in Annex 1.

Purpose of the *Good Medical Practice* (GMP) Framework

124. The GMP Framework provides a foundation to develop the system of appraisal and assessment for doctors on which recommendations to revalidate will be based.

125. Current systems of appraisal reflect the diversity of practice settings and employers of doctors. We recognise that a single approach or format for appraisal will not be suitable for all doctors in all settings. However, the key principles of professionalism, set out in *Good Medical Practice*, are broadly relevant to the whole profession. The GMP Framework has been developed as the basis for a standardised model to be incorporated in all appraisal systems.

126. The GMP Framework can be used by doctors to:

- **a.** Reflect on their practice and their approach to medicine.
- **b.** Identify areas of practice where they could make improvements.
- **c.** Demonstrate that they are up to date and fit to practise.

127. The attributes and generic standards are drawn from *Good Medical Practice* and do not replace it. *Good Medical Practice* will continue to fulfil its existing, wider functions, for example in relation to our fitness to practise procedures. *Good Medical Practice* is organised under seven headings; and each of the seven sections contains different kinds of guidance, from statements of high-level principle, to practical advice. For the purposes of revalidation, we are proposing to use 12 attributes, divided into four key domains of practice. The attributes relate to aspects of practice for which it is possible, and reasonably practicable, to produce evidence of compliance. *Good Medical Practice* itself, with its broader purposes, has no such constraints, and includes all the principles and values identified as contributing to good practice.

128. We have organised the GMP Framework under four domains, which broadly fit with the approach taken by other UK inspection and regulatory bodies' regimes. *Good Medical Practice*, with its wider purposes, continues to use the existing seven headings.

129. The generic standards in the GMP Framework are pared down from the full advice in *Good Medical Practice* and other guidance booklets. We have included paragraph reference numbers so that they can be read in their original context. We have added some standards from the booklets *Management for Doctors* and *Research: The role and responsibilities of doctors*, to provide comparable standards for doctors working in non-clinical roles.

130. The generic standards can be divided into three main types:

- **a.** Those that will apply to the overwhelming majority of doctors, irrespective of the nature of their practice, such as 'keeping knowledge and skills up to date'.
- **b.** Those that apply only where doctors work with patients, act as managers or work in research. These are highlighted within the GMP Framework.

c. Those that depend on particular circumstances or events arising, for example, reporting risks in the healthcare environment.

131. No doctor will be able to provide evidence of compliance with every generic standard. A number of pilots and projects have been running to test the GMP Framework and possible sources of supporting information in a variety of settings. More information about these pilots is available on the GMC website.

132. The supporting information column contains the kinds of supporting information that doctors in the pilots brought to their appraisals to demonstrate that they met the relevant standards. These are not definitive in any way and are included to show what types of information doctors might bring to appraisal to demonstrate their practice.

Question 9:

- *Do you agree that, for the purposes of revalidation, the Good Medical Practice Framework is an appropriate basis for appraisal and assessment?*

Question 10:

- *Do you have any further comments on the proposed use of the Good Medical Practice Framework?*

Specialty and General Practice Frameworks

133. The *Good Medical Practice* Framework has been used as the basis for the development by the medical Royal Colleges and Faculties of specialty-specific standards and supporting information requirements for revalidation.

134. The Academy of Medical Royal Colleges has worked with each of the Colleges and Faculties in order to ensure consistency between individual submissions on specialty standards, as far as practicable, whilst recognising the differences between specialties.

135. The information submitted by each College or Faculty provides detail of the types of supporting information that might be submitted in order to demonstrate compliance with the standards for revalidation. It might be drawn from a range of sources and activities, including clinical audit, outcomes data, knowledge tests, patients' and colleagues' feedback, Continuing Professional Development (CPD) or observation of practice.

136. Specialty standards for each College and Faculty were subsequently evaluated by the GMC against the following criteria:

a. Consistency
b. Confidence
c. Fairness, objectivity, transparency and fairness from unfair discrimination
d. Practicality and proportionality
e. Robustness

137. We have worked closely with the Academy to ensure that each submission meets these principles. The sources of supporting information to demonstrate compliance with specialty standards that are described in the submissions represent good, rather than mandatory, practice.

138. We have received submissions from the following Colleges and Faculties:

- The College of Emergency Medicine
- The Faculty of Occupational Medicine
- The Faculty of Pharmaceutical Medicine
- The Faculty of Public Health
- The Royal College of Anaesthetists
- The Royal College of General Practitioners
- The Royal College of Obstetricians and Gynaecologists

- The Royal College of Ophthalmologists
- The Royal College of Paediatrics and Child Health
- The Royal College of Pathologists
- The Royal Colleges of Physicians
- The Royal College of Psychiatrists
- The Royal College of Radiologists
- The Royal Colleges of Surgeons.

139. The standards and supporting information proposed by the Colleges and Faculties should apply to the vast majority of doctors who are in active clinical practice. We would expect all doctors to meet these standards and to be guided by the supporting information proposed by the Colleges and Faculties in relation to their own particular area of practice. The standards and supporting information should be relevant and applicable to all doctors in clinical practice regardless of whether they are on the Specialist or GP Registers or whether they work as consultants or specialist doctors.

140. It is unlikely that any doctor will be able to provide evidence of compliance with every standard and they will not be expected to do so; nor will any doctor be expected to provide all of the information at each annual appraisal. The core information should be provided over the five-year cycle.

141. The standards reflect good practice expected of a doctor in each specialty. Doctors should use the specialty frameworks to demonstrate that their practice meets the standards by providing supporting information for their appraisal. Individual doctors will need to select supporting information that is appropriate to their personal practice to demonstrate their compliance with the standards.

142. You can find more information from the individual Colleges and Faculties on the detail of their proposals on specialist and general practice standards and supporting information. You will find a link to the relevant pages of their websites at: **http://www.aomrc.org.uk/revalidation.aspx**

Doctors in non-clinical roles

143. The Academy of medical Royal Colleges also undertook extensive work on developing a framework and detailing supporting information that might apply to doctors in five key areas of non-clinical practice:

- Medical Management
- Medical Research
- Medical Education
- Specialist Expertise (e.g. clinical guidance development, policy formulation)
- Civil Service.

144. We are intending to use these frameworks as a basis for detailed discussions with those doctors who work in these areas and those organisations which have a particular interest, or employ doctors, in these areas of work. We hope to be in a position to consult on these frameworks later this year.

Question 11:

- *Is the overall approach to the development of standards and supporting information for revalidation reasonable? If not, what else is necessary?*

Question 12:

- *Is the supporting information proposed by the Colleges and Faculties meaningful, practicable and proportionate for the majority of doctors in clinical practice?*

Continuing Professional Development (CPD) and Revalidation

145. *Good Medical Practice* requires doctors to keep their knowledge and skills up to date and encourages them to 'take part in educational activities that maintain and further develop' their competence and performance. In future, revalidation will provide a focus for this activity. These things are brought together through appraisal and Continuing Professional Development (CPD) and through each doctor's personal development plan.

146. By its nature, CPD must be tailored to the specific needs and interests of individuals and their practice. It would not be appropriate for revalidation to set detailed and prescriptive requirements for all doctors which may add little value and put effective CPD at risk.

147. But revalidation does need to provide assurance that doctors are up to date and fit to practise. Evidence of participation in appropriate CPD, as brought to appraisal, is one way of doing this.

148. In developing the specialty standards for revalidation the medical Royal Colleges and Faculties have described participation in CPD as one of the ways in which doctors will be able to show that they are meeting the required standards. We endorse this approach and doctors may find that participation in College or Faculty CPD schemes is helpful both in keeping up to date and in demonstrating compliance with the standards.

149. However, the GMC will not require doctors to be members of a College or Faculty in order to revalidate. Nor will we require them to participate in a College- or Faculty-run CPD scheme, though they will need to be able to show through appraisal how they are keeping up to date. This is the case regardless of whether a doctor is working part-time or full-time. Doctors cannot have less regard to maintaining their competence and performance just because they are not in full-time practice.

150. Although we do not believe that setting prescriptive requirements for CPD in revalidation would be helpful, doctors and those appraising them need to know the principles that should guide their activity. We have identified the following core principles:

- **Personal learning:** CPD should be developed and undertaken as part of doctors' personal development. Doctors should identify their professional needs and competencies and should take account of the needs of patients and the healthcare system when planning their CPD.
- **Scope of practice:** Doctors should plan and participate in a wide range of CPD covering the scope of their practice. The learning must be relevant to the current and emerging knowledge and skills required for their specialty or practice, professional responsibilities and areas of development and work. CPD should be linked to the domains and attributes of the *Good Medical Practice* Framework for Appraisal and Assessment.
- **Reflection:** *Good Medical Practice* requires doctors to reflect on their practice and whether they are working to the relevant standards.
- **Outcomes:** CPD should focus on outcomes or outputs rather than on inputs and a time-served approach. Doctors should evaluate what they have learned and understood from their CPD activity and how it may impact on and improve their performance.

- **Needs-based:** Doctors should identify and participate in CPD based on their day-to-day work and what they perceive will be needed in the future to undertake their roles and responsibilities. CPD should also prepare doctors to address the unpredictable and changing nature of medical practice. Some CPD should be based on developing and considering new areas of competence, knowledge and skills. Doctors should also participate in CPD that meets the needs of their patients (where appropriate), colleagues and their employer.
- **Appraisal and clinical governance:** Doctors should make sure that their CPD is influenced by their participation in clinical governance processes, individual, organisational and national audit, workplace-based assessments, and other mechanisms that shed light on their professional and work practices.
- **Equality and diversity:** Doctors have a professional and ethical duty to treat patients and colleagues with respect whatever their life choices and beliefs. Some aspect of doctors' learning and development should aim to make sure they are aware of the statutory requirements and good practice relating to all areas of equality and discrimination and how these could be applied to their professional lives.

Question 13:

- *Do you agree that these are the appropriate principles to guide doctors' Continuing Professional Development (CPD) activity in relation to revalidation? If not, what alternative approach is required?*

Employers and contractors of doctors' services

151. Revalidation will provide a focus for doctors' efforts to maintain and improve their practice. In this way, it will contribute to improvement in the quality of patient care. The organisations in which doctors work must therefore support doctors in meeting the requirements for revalidation.

152. Organisations must ensure that they have in place robust and properly resourced and supported systems of clinical governance (including appraisal) and arrangements to enable doctors' Continuing Professional Development. Doctors must also be able to monitor their practice through performance information, including clinical indicators relating to patient outcomes, through feedback from patients and colleagues and in a range of other ways.

153. NHS and other designated organisations (including some independent sector organisations that employ doctors) will have a statutory duty to appoint a Responsible Officer, who will support doctors in meeting the requirements of revalidation and make recommendations to the GMC.

154. For these reasons employers and other healthcare providers, as well as doctors, will have an interest in the standards and information needed for revalidation described in this section of the consultation. Organisations need to be confident that these are realistic and that doctors will be able to generate the information for their revalidation through the systems that exist in the workplace.

Section 3 – Patient and public involvement in revalidation

This section considers the ways in which patients and the public could be involved in revalidation, both in terms of providing specific feedback on doctors' performance and in the revalidation process more broadly.

155. One of the aims of revalidation is to assure patients and the public that licensed doctors are continuing to practise to the appropriate professional standards. Patients will need to have confidence in the way that revalidation will work.

156. One of the ways of achieving this is through patient and public involvement in revalidation. This could take a number of different forms:

a. Through patient representation and input into the development of revalidation policies, data collection methods and on boards and committees overseeing the implementation of revalidation.

b. By providing feedback to doctors about their performance which can be used in doctors' annual appraisals.

c. Through involvement in the work of the Responsible Officers, who will make recommendations to the GMC about whether a doctor should be revalidated, and in quality assurance.

d. Through involvement in the GMC decision-making process when concerns are raised about a doctor's practice which may require the removal of a doctor's licence to practise.

Involvement through feedback to doctors

157. Patient involvement in the revalidation of individual doctors will come in the form of feedback on doctors' performance provided by their patients. This will be obtained by inviting patients to complete standard questionnaires giving feedback on different aspects of their doctor's performance. Many doctors already use such methods to obtain feedback from both patients and colleagues. For revalidation, the feedback will be used as part of the appraisal process to show that doctors are meeting the required standards.

158. More detailed information about how feedback from patients and colleagues will be used in revalidation is provided in this section at paragraphs 170–186.

Involvement in the Responsible Officer's recommendation and quality assurance

159. A key role of the Responsible Officer in a healthcare organisation will be to make a recommendation to the GMC on whether a doctor should be revalidated. The Responsible Officer will be a licensed doctor, such as the Medical Director of a Trust or Board. In a large

organisation it is unlikely that the Responsible Officer will carry out this role in isolation. He or she will probably be supported by a team of people. See Section 1 of this consultation document for more detail about the role of the Responsible Officer.

160. The statutory responsibility for making the recommendation to the GMC lies with the Responsible Officer. Our preferred model is based on patient or lay involvement in an advisory or quality assurance capacity rather than in individual recommendations made by the Responsible Officer. This might happen locally in a number of ways and we have been looking at whether GMC Affiliates and the local Regional Medical Regulation Support Team might have a role to play.

161. An important recommendation of the Government White Paper concerned establishing a network of GMC Affiliates at a regional level. The White Paper built on earlier recommendations in Professor Sir Liam Donaldson's report, *Good Doctors, Safer Patients*.

162. The White Paper envisaged that GMC Affiliates would form part of a new 'Tackling Concerns Locally' architecture for dealing with concerns about doctors, involving:

a. Regional Medical Regulation Support Teams (RMRSTs): would operate at a regional level, providing a forum for medical directors and others to discuss medical poor performance and fitness to practise issues.

b. Responsible Officers: would be a new role providing a focus to strengthen local clinical governance and establishing a conduit for information exchange with the GMC on revalidation and fitness to practise issues.

c. GMC Affiliates: would provide support, advice and guidance to employers and the commissioners of the services in managing concerns about doctors.

163. In autumn 2008, we initiated two GMC Affiliate pilots – one in North London, the other in West Yorkshire. The North London pilot covered three Primary Care Trust (PCT) areas (Camden, Enfield and Haringey) and the West Yorkshire pilot covered five PCT areas (Bradford and Airedale Teaching PCT, NHS Calderdale, NHS Wakefield and District, NHS Leeds and NHS Kirklees).

164. Both pilots were based on the model of pairing a medically qualified and a non-medically qualified GMC Affiliate. The aim of the pilots was to establish whether it was possible to bridge the gap between national and local regulation and provide faster, more effective resolution of complaints and concerns about doctors in England.

165. We also wanted to clarify and develop the relationship between medical directors and GMC Affiliates to facilitate discussion about poorly performing doctors and to provide the directors with a more supportive environment. The pilots also explored the potential role of Regional Medical Revalidation Support Teams (RMRSTs) and the data they would need to support their work.

166. The RMRSTs consisted of representatives of medical directors, locum and out-of-hours care agencies, Strategic Health Authority patient safety leads, the Deanery, the Care Quality Commission, the British Medical Association, the National Clinical Assessment Service and complaints managers.

167. We are intending to undertake further piloting in England with the Department of Health (England) in 2010 to test how the GMC Affiliates model might be developed to support the introduction of revalidation. We have also been piloting a separate model in Scotland based on developing closer relationships with local Medical Directors.

Involvement in the GMC decision-making process where concerns are raised

168. At present, where concerns are raised about a doctor's fitness to practise there is direct lay involvement in the GMC's processes for investigating and adjudicating on those concerns. That involvement will continue where concerns arise through revalidation.

169. Following any investigation into a doctor's fitness to practise all decisions on whether to refer a case to one of our Fitness to Practise panels are made by two case examiners, one medical and one non-medical. Similarly, all our Fitness to Practise panels have both medical and non-medical members.

Question 14:

- *Do you agree with our approach to patient and public involvement in revalidation? If not, what other arrangements would you suggest?*

Colleague and Patient Questionnaires

170. Those who work closely with doctors and patients will also be directly involved in the revalidation process by providing feedback on the practice and performance of doctors that they work with and see. This feedback will usually be gathered by asking colleagues and patients to complete questionnaires and provide their views on the doctor's practice and performance. This is also known as multi-source feedback or MSF.

171. MSF from colleagues and patients (where relevant – some doctors do not see patients) represents useful supporting information that will enable doctors to demonstrate that they meet the standards for revalidation. This information is likely to be considered at a doctor's annual appraisal along with other information about a doctor's performance, drawn largely from their practice. The outputs of appraisal and other collated information will subsequently lead to a revalidation recommendation about the doctor to the GMC from the Responsible Officer in their healthcare organisation. See Section 1 of this consultation document.

172. The feedback from colleagues and patients will be obtained through the completion of questionnaires. This will not be organised by the GMC but through the doctor's workplace. This process will need to be robust and independently administered. The following paragraphs look in particular at how the GMC can ensure that any questionnaires that are used for these purposes are of an appropriate standard and that they are administered appropriately by healthcare organisations and others.

173. We do not envisage that doctors will need to submit completed colleague and patient questionnaires at each annual appraisal. Our current view is that doctors should participate in colleague and patient (if appropriate) questionnaires at least once in every five-year cycle.

Draft principles and criteria for Colleague and Patient Questionnaires in revalidation

174. We need to be confident that the information brought to appraisal and revalidation from patient and colleague questionnaires is consistent, objective and gives a clear voice to patients and colleagues about the professional performance of doctors.

175. Having clear principles and criteria that any colleague or patient questionnaires must meet for the purposes of revalidation will help to address some of the concerns that have been voiced about the fairness and reliability of colleague and patient questionnaires.

176. We have identified some key principles which we believe should be used as the basis for evaluating colleague and patient questionnaires. Questionnaires that are used for the purposes of revalidation should:

a. Be piloted on the appropriate population.

b. Demonstrate that they are robust, reliable, valid and generalisable.

c. Have the capacity to identify doctors where further evaluation of practice may be required, particularly in comparison to other doctors that work in the same area of practice.

d. Provide appropriate and useful feedback to doctors that can be integrated into local systems (such as discussions with a supervisor or mentor and through appraisal).

e. Reflect and measure the whole practice of the doctor.

f. Be evaluated and administered independently from the doctor or employer to ensure an objective review of the information.

g. Be feasible.

177. Based on some earlier work completed by the Academy of Medical Royal Colleges, we have developed detailed criteria for patient and colleague questionnaires. These criteria are set out in a document called *GMC Principles, Criteria and Key Indicators for Colleague and Patient Questionnaires in Revalidation*, which can be found in Annex 3. The document sets out the principles and criteria that the GMC will require colleague and patient questionnaires to meet in order to be acceptable for use as one piece of the supporting information that will from the basis of a recommendation to revalidate a doctor.

178. The purpose of *GMC Principles, Criteria and Key Indicators for Colleague and Patient Questionnaires in Revalidation* is to provide:

a. Guidance to organisations developing colleague and patient questionnaires on the requirements those questionnaires will have to meet.

b. Guidance for those introducing and implementing colleague and patient questionnaires.

c. Criteria to evaluate colleague and patient questionnaires for accreditation purposes.

Question 15:

- *Do you agree that GMC Principles, Criteria and Key Indicators for Colleague and Patient Questionnaires in Revalidation are appropriate for evaluating these types of questionnaires for revalidation?*

Question 16:

- *Do you agree that doctors should be required to participate in colleague and patient (where applicable) feedback at least once in each five year cycle?*

Piloting colleague and patient questionnaires

179. We have developed our own colleague and patient questionnaires based on the standards in *Good Medical Practice* and these are currently undergoing extensive research and piloting with hundreds of doctors across a range of different practice settings.

180. Early research by Peninsula Medical School into the validity, reliability and practicality of these questionnaires has been encouraging. The results of the pilot study conducted by Professor John Campbell of Peninsula Medical School were published in the *Quality and Safety in Healthcare Journal* in June 2008.

181. We have now commissioned Professor Campbell to undertake more in-depth testing of the questionnaires across a larger number of doctors in different clinical settings. The work will look at how the questionnaires perform across different kinds of organisations (including primary care trusts and acute settings) and in different areas of the UK. It will also examine the performance of the questionnaires with doctors who may find it more difficult to participate in patient feedback, such as psychiatrists and anaesthetists. We anticipate that the results of this research will be available in early 2011.

182. We do not expect that the colleague and patient questionnaires developed by the GMC will be the only ones that will meet the principles and criteria that we have set and we do not suggest that our questionnaires should be the only mechanism for obtaining patient and colleague feedback. However, any questionnaires that are used as supporting information for revalidation will have to meet the principles and criteria that we have set and be approved for these purposes.

Accrediting Colleague and Patient Questionnaires

183. *The GMC Principles, Criteria and Key Indicators for Colleague and Patient Questionnaires in Revalidation* set out our requirements for helping to ensure that questionnaires are robust and fair. They will not, however, guarantee to employing organisations and individual doctors that these requirements have been met by any particular questionnaire.

184. We are seeking views, therefore, on whether the GMC should be involved in reviewing and accrediting the colleague and patient questionnaires developed by different organisations. We currently do not have the systems in place to do this.

185. GMC accreditation of colleague and patient questionnaires could involve kite marking those questionnaires which have satisfied the GMC principles and criteria set out in this consultation document. This would have the virtue of encouraging good practice and would provide reassurance for both employing organisations and doctors that the questionnaires meet the relevant criteria.

186. Our preferred approach would be to constitute an independent expert group with the remit of evaluating questionnaires against the principles, criteria and key indicators. The cost of maintaining such a group could be offset by charging a fee to those organisations seeking our accreditation or kite mark.

Question 17:

- *Do you think that there should be a mechanism for making sure that colleague and patient questionnaires comply with our criteria for revalidation?*

Section 4 – How and when revalidation will be introduced

This section considers how we ensure that organisations are ready to support revalidation and the process for rolling out revalidation across the UK.

187. The previous sections of this consultation document look at the processes and systems that healthcare organisations will need to have in place for revalidation to be introduced effectively. Revalidation will be built largely on local, workplace-based systems of clinical governance, including an effective form of appraisal. The timing for introducing revalidation across the UK is dependent primarily on when these systems are in place and working effectively.

Introducing revalidation – shared responsibility

188. The successful introduction of revalidation is a shared responsibility involving the GMC, the health departments in England, Northern Ireland, Scotland and Wales, the medical Royal Colleges, the NHS and other employers and the medical profession. More detailed information on the different workstreams for revalidation and the roles and responsibilities of the organisations delivering revalidation can be found on the GMC website.

189. Planning for the introduction of revalidation needs to acknowledge the complexity of modern healthcare, including the different systems and structures in the four UK countries and the range of healthcare providers, including the NHS and the independent sector.

190. There are currently approximately 218,000 doctors who hold full registration and a licence to practise in the UK. Introducing a system of revalidation which will apply to each and every one will be a major challenge for all the organisations involved.

Our proposals for roll-out – a managed and targeted approach

191. Revalidation will be based on the local evaluation of doctors' performance in the organisations where they work. The way in which revalidation is rolled out must take account of the readiness of local systems to support the process.

192. We are therefore proposing to take a phased and incremental approach to the roll-out of revalidation, starting where systems are in place and working effectively. This will have a number of advantages. First, it avoids the risks associated with a 'big bang' implementation across the UK. Second, it enables us to begin where we are confident that the local systems needed to support revalidation are robust. Third, it helps us to learn from piloting the procedures and enables us to work with others to make improvements as we go.

193. The UK Revalidation Programme Board (UKRPB) has been established by the GMC and is responsible for overseeing the practical delivery of medical revalidation across all four countries of the UK in a way that is co-ordinated and consistent. The UKRPB brings together the key interest groups involved in the delivery of revalidation, including the four health departments of the UK, the GMC and professional and employer representation. You can find out more information about the work of the UKRPB on the GMC website.

194. The UKRPB's terms of reference include overseeing the effective delivery of a revalidation implementation plan. This plan has been compiled from information provided by the four health departments of the UK, the GMC

and the Academy of Medical Royal Colleges, and involves an ongoing assessment of when local organisations will be ready to support the introduction of revalidation.

195. The UKRPB has agreed the basic criteria against which such readiness for revalidation would be determined:

a. Responsible Officers appointed.

b. Effective systems of clinical governance established.

c. Effective systems of strengthened appraisal established based on the *Good Medical Practice* Framework for appraisal and assessment (see Section 2 of this consultation document).

d. Specialist standards embedded in local appraisal processes (see Section 2 of this consultation document).

e. Local processes ready to deliver necessary recommendations with appropriate quality assurance.

f. Reliable mechanisms in place to enable doctors to obtain feedback from patients and colleagues (see Section 3 of this consultation document).

196. The health departments in each of the four countries are taking responsibility for ensuring that local processes are ready to support revalidation across all sectors. They are leading on testing and piloting the various elements involved in the process and in assessing whether organisations in their areas have systems in place to support doctors through the process.

197. Those systems do and will exist for a range of purposes that go beyond the revalidation of doctors. By moving to a state of readiness for revalidation, healthcare organisations will not only be indicating that they are, in principle, ready to support the process of revalidation, but that primarily they have developed stronger systems of clinical governance for patient safety and improved healthcare quality.

198. Each of the four countries of the UK has plans to move towards a state of readiness within the next 12-18 months.

199. The GMC will decide and announce when and where the first doctors will be revalidated when it is assured, by the UKRPB, that the local systems on which revalidation will be built are robust. This decision will be made by the GMC once the components of revalidation have been tested and piloted, they are embedded in local organisations, and the GMC has assurance that they are ready to support revalidation.

Question 18:

- *Do you agree that revalidation should be introduced initially in areas and organisations where local systems are developed and sufficiently robust to support the revalidation of their doctors?*

Piloting and early adopters

200. Piloting and testing all of the various elements of revalidation are central to developing proposals for implementation.

201. The four UK countries are committed to careful piloting of all of the key elements of revalidation. The Department of Health (England) is currently working with others on planning and implementing two further phases of piloting:

- **'Pathfinder' pilots** – which will test key aspects of revalidation, including the new strengthened appraisal framework and specialty standards in respect of individual clinicians and the role of the Responsible Officer. Pathfinder pilots have already begun at 10 sites in England involving approximately 3,000 doctors.

- **'Early adopters'** – these will be organisations and sectors which have been through a piloting process and have been assessed as ready to deliver revalidation recommendations for their doctors as soon as the legislation for revalidation has been switched on.

202. Similar pilots are planned in Wales, Scotland and Northern Ireland through 2010 and 2011.

Our proposed approach

203. Detailed proposals for the roll-out of revalidation will need to be developed in each of the four UK countries, taking account of responses to this consultation and ongoing projects and pilots.

204. Our proposed approach is that, where applicable, those organisations involved in early adopter initiatives will be the first to introduce revalidation. Our expectation is that this will begin at some point in 2011 but only once sufficient time has been allowed to enable us and others to understand and learn from the outcomes of the earlier pilots. Revalidation will be rolled out thereafter over the following five years to all registered doctors holding a licence to practise.

205. Our proposals are based on the assumption that revalidation should be implemented when local systems are ready. However, it is possible that there will be healthcare organisations whose clinical governance and appraisal systems are weak and failing to improve. There will also be doctors who work entirely independently for whom the concept of system readiness will not apply. Both these issues need to be addressed.

206. It will not be acceptable for healthcare organisations to argue indefinitely that their systems are not robust enough to support revalidation. We would expect revalidation to be extended to all doctors holding a licence to practise within five years from when revalidation goes live. This may involve setting a deadline by which organisations will be expected to be ready.

Question 19:

- *Do you agree with our proposed approach for the initial roll-out of revalidation? If not, what alternatives do you suggest?*

Question 20:

- *Do you agree that a deadline should be set for organisational readiness for revalidation?*

Further work

207. The proposals outlined in this consultation document have provided an initial picture as to how revalidation will work in practice. We recognise that further work is required to develop the detail of some of the proposals and to understand how revalidation will be implemented throughout the UK.

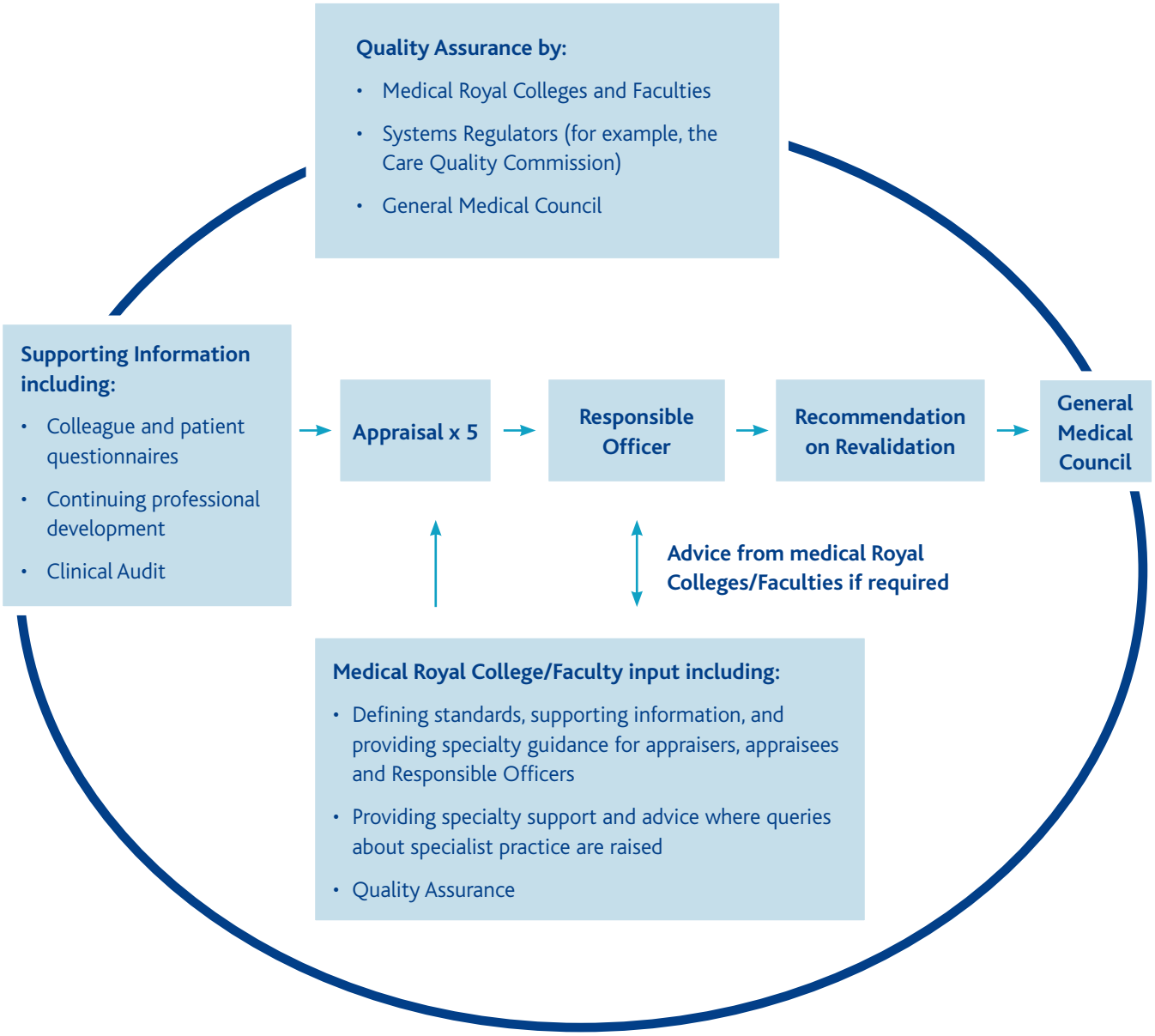
208. We view this consultation as the first step in an ongoing dialogue we need to have with patients, doctors, employers and other interested parties as our work on revalidation continues.

209. All of the organisations responsible for delivering revalidation are undertaking further work on defining the detail around revalidation, including:

- Running a series of pilots and projects both within and outside of the NHS to test different elements of revalidation and the process more broadly.
- Developing IT systems to support appraisal and revalidation.
- Completing a full Impact Assessment on the impact of introducing revalidation which includes consideration of the potential impact on different groups of doctors in different roles and sectors.
- Working with the healthcare systems regulators (for example, the Care Quality Commission in England) to define how we can quality assure local processes that need to be in place to support the revalidation of individual doctors.
- Identifying ways that doctors who might have difficulty linking to a Responsible Officer in a designated organisation will be able to revalidate.

210. Following the completion of this further work we should have a more detailed picture about revalidation and how it will be rolled out for all doctors in the UK. However, even once revalidation begins, it is likely that the process will change and improve as we learn more about which elements work well and identify those areas we can improve to better support the delivery of care for patients.

Appendix A – Process diagram



Appendix B – Glossary of terms, organisations and acronyms

Academy of Medical Royal Colleges (AoMRC)
The Academy's role is to promote, facilitate and where appropriate co-ordinate the work of the medical Royal Colleges and their Faculties for the benefit of patients and healthcare. Website: **www.aomrc.org.uk**

Annual Review of Competence Progression (ARCP)
The Annual Review of Competence Progression is a mechanism of recording the review of a trainee's progression through their training programme. All doctors occupying a Specialty training post are required to undertake a yearly assessment of their progress.

Appraisal and Whole Practice Appraisal
Appraisal is the regular review of a doctor's performance, usually undertaken in the hospital or practice in which the doctor works. Our proposals for revalidation are based on local appraisal systems.

Doctors practising in both the NHS and independent sectors need to undertake whole practice appraisal which will take account of their work in both sectors. The appraisal will usually take place in the sector within which they do the bulk of their work.

British Medical Association (BMA)
The British Medical Association is the professional medical association and trade union for doctors and medical students. Website: **www.bma.org.uk**

Certificate of Completion of Training (CCT)
The Certificate of Completion of Training (CCT) confirms satisfactory completion of an approved programme of training and is one of the certificates which allows entry to the GMC Specialist or GP Registers.

Clinical Governance
Clinical governance has been defined as "a framework through which NHS organisations are accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish." *G Scally and L J Donaldson, 'Clinical governance and the drive for quality improvement in the new NHS in England' BMJ (4 July 1998): 61-65*

Colleague and Patient Questionnaires
Feedback through Colleague and Patient Questionnaires (also known as Multi Source Feedback (MSF)) is one of the elements required for revalidation. It involves doctors obtaining feedback on their performance from patients and colleagues. The feedback will be obtained through the completion of questionnaires. We envisage that doctors will need to do this at least once during each five-year revalidation cycle.

Continuing Professional Development (CPD)
CPD refers to the processes and activities pursued by doctors after the formal completion of training programmes that enable them to maintain and develop their professional practice. Doctors will need to demonstrate evidence of CPD in order to revalidate.

Delivery Boards
Delivery Boards have been established for each of the four UK countries. It is the responsibility of each Delivery Board, led by the department of health in each country, to ensure organisations have systems in place to support revalidation across all forms of healthcare.

Department of Health - England
The work of the Department of Health exists to improve the health and wellbeing of people in England. Specifically it aims to provide:

- Better health and well-being for all: helping people stay healthy and well; empowering people to live independently; and tackling health inequalities.
- Better care for all: the best possible health and social care that offers safe and effective care, when and where people need it; and empowering people in their choices.
- Better value for all: delivering affordable, efficient and sustainable services; contributing to the wider economy and the nation.

More information about the DH (England) can be found on its website at: **http://www.dh.gov.uk/en/index.htm**

Department of Health, Social Services and Public Safety (DHSSPS) – Northern Ireland
The Department of Health, Social Services and Public Safety is one of 11 Northern Ireland Departments created in 1999 as part of the Northern Ireland Executive by the Northern Ireland Act 1998 and the Departments (Northern Ireland) Order 1999.

It is the Department's mission to improve the health and social well-being of the people of Northern Ireland. It endeavours to do so by:

- Leading a major programme of cross-government action to improve the health and well-being of the population and reduce health inequalities. This includes interventions involving health promotion and education to encourage people to adopt activities, behaviours and attitudes which lead to better health and well-being. The aim is a population which is much more engaged in ensuring its own health and well-being.
- Ensuring the provision of appropriate health and social care services, both in clinical settings such as hospitals and GPs' surgeries, and in the community through nursing, social work and other professional services.

More information about the DHSSPS(NI) can be found on its website at: **http://www.dhsspsni.gov.uk**

Department of Health and Social Services - Wales
The work of the Department of Health and Social Care in Wales includes treating disease and addressing the social, economic and environmental influences that affect the health and well being of people in Wales. Specifically it is responsible for:

- Advising the Welsh Assembly Government in setting policies and strategies for health and social care in Wales.
- Contributing to making legislation in the field of health and social care.
- Providing funding for the NHS and other health and social care bodies.
- Managing and supporting the delivery of health and social care services.
- Monitoring and promoting improvements in service delivery.

More information about the DHSS (Wales) can be found on its website at: **http://wales.gov.uk/about/civilservice/departments/dhss**

Follett Principles
The Follett Review reported in September 2001 and made a number of recommendations regarding the appraisal, disciplinary and reporting arrangements for senior clinical academic staff. In regard to appraisal, the report recommended that Universities and NHS bodies should work together to develop a jointly agreed annual appraisal and performance review process based on that for NHS consultants, to meet the needs of both partners. The process should:

- Involve a decision on whether single or joint appraisal is appropriate for every senior NHS and university staff member with academic and clinical duties.
- Ensure joint appraisal for clinical academics holding honorary consultant contracts and for NHS staff undertaking substantial roles in universities.
- Define joint appraisal as two appraisers, one from the university and one from the NHS, working with one appraisee on a single occasion.
- Require a structured input from the other partner where a single appraiser acts.
- Be based on a single set of documents; and start with a joint induction for those who will be jointly appraised.

A full copy of the Follett report is available at: **http://www.academicmedicine.ac.uk/uploads/folletreview.pdf**

General Medical Council
The GMC registers doctors to practise medicine in the UK. Our purpose is to protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine.
Website: **www.gmc-uk.org**

Good Medical Practice
Good Medical Practice is the GMC's core guidance for doctors. It sets out the principles and values on which good practice is founded.

List of Registered Medical Practitioners (LRMP)
Patients and the public can use the List of Registered Medical Practitioners to check details of all the doctors on the GMC's register. It can be accessed through the GMC website.

Medical Royal Colleges and Faculties
Medical Royal Colleges and Faculties are professional bodies responsible for the standards and training of doctors practising in particular fields of medicine. For the purposes of revalidation, they will be responsible for setting the specialty specific standards that doctors practising in that specialty will need to meet.

National Clinical Assessment Service (NCAS)
The National Clinical Assessment Service (NCAS) is a division of the National Patient Safety Agency. Its role is to offer advice, specialist interventions and shared learning to help resolve concerns about a practitioner's performance. Website: **www.ncas.npsa.nhs.uk**

Professional and Linguistic Assessments Board Test (PLAB TEST)
The PLAB test is the main route by which International Medical Graduates (IMGs) demonstrate that they have the necessary skills and knowledge to practise medicine in the UK.

Recertification
Recertification was the second component of revalidation proposed in the White Paper (*Trust, Assurance and Safety*), applying only to those doctors who are on the GMC's specialist register or GP register. The White Paper proposed that these doctors would need to demonstrate, through recertification, that they continue to meet the particular standards that apply to their specialty or area of practice.

This consultation proposes that revalidation should be based on a single set of processes for evaluating doctors' performance in practice, rather than through the separate elements of relicensing and recertification.

Regional Medical Revalidation Support Team (RMRST)
The Regional Medical Revalidation Support Team (RMRST) is a local forum that covers the whole spectrum of healthcare providers and associated bodies and enables a rich discussion of issues on topics such as data available to Medical Directors, policies on alcohol at work and the particular problems posed by specific groups of doctors. These teams have been piloted as a part of the GMC Affiliates pilots in London and Yorkshire and the Humber. Feedback from team members is that they feel it is an extremely valuable forum to exchange information, ideas and policy.

Relicensing
Relicensing was the first element of revalidation proposed in the White Paper by which all licensed doctors will need to demonstrate to the GMC that they are practising in accordance with the generic standards of practice set by the GMC (as described in *Good Medical Practice*).

This consultation proposes that revalidation should constitute a single process.

Remediation
Remediation refers to the use of corrective methods to improve skills and competencies; these will include further training, support, mentoring and guidance for doctors when performance concerns have been identified.

Responsible Officers (ROs)
The post of Responsible Officer (RO) is a new statutory role. In broad terms, the RO will be responsible for the local evaluation of doctors' fitness to practise for the purposes of revalidation, for overseeing the operation of local clinical governance arrangements necessary to support revalidation (except in Scotland where this is a matter for medical directors), and for ensuring appropriate action where there are concerns about doctors' fitness to practise. In particular, ROs will be responsible for the revalidation recommendations made to the GMC regarding the doctors linked to their organisation.

Revalidation
Revalidation is the process by which doctors will have to demonstrate to the GMC that they remain up to date and fit to practise. In the future, all licensed doctors will need to revalidate regularly if they wish to keep their licence to practise. For most doctors, revalidation will take place every five years.

Revalidation Support Team (RST)
The Revalidation Support Team (RST) is a Department of Health-funded body which exists to support the implementation of Revalidation. The main aims of the RST are to:

- Support NHS organisations in the effective provision of revalidation
- Support individual participation in appraisal and revalidation.
- Work with all stakeholders, including the GMC, Colleges, Faculties and other professional bodies, to develop and promote coordinated, consistent, effective and appropriate revalidation arrangements.
- Establish and maintain cooperative links with revalidation systems emerging in the devolved administrations in Scotland, Northern Ireland and Wales, to maintain a consistent approach throughout the UK.

More information about the RST can be found on its website at: **http://www.revalidationsupport.nhs.uk/**

Scottish Government Health Directorates (SGHD)
Scottish Government Health Directorates are a set of directorates of the Scottish Government. They are responsible for NHS Scotland, as well as policies on the development and implementation of health and community care. The Scottish Government Health Department (SEHD) was created in 1999 from the former Scottish Office Health Department (SOHD).

More information about the SGHD can be found on its website at: **http://www.scotland.gov.uk/Topics/Health**

Specialty Standards
Specialty standards have been developed by each of the Medical Royal Colleges and Faculties and will apply to doctors practising within the particular specialty. These are based on the GMC's main guidance for doctors, *Good Medical Practice*.

UK Revalidation Programme Board
The UK Revalidation Programme Board (the UKRPB) is responsible for overseeing the practical delivery of medical revalidation across all four countries of the UK in a way that is co-ordinated and consistent. The UKRPB brings together the key interest groups involved in delivering revalidation across the UK.
Website: **www.gmc-uk.org/revalidation**

Appendix C – Revalidation: Frequently Asked Questions

Please note: there is a longer and more detailed version of Revalidation: Frequently Asked Questions available on the GMC website at http://www.gmc-uk.org/doctors/licensing/faq_revalidation.asp

Questions about methods and evidence for revalidation

Will I have to pass an examination in order to revalidate?

For practising doctors, this is very unlikely. That is because revalidation is about what doctors do in their actual practice. In most cases, an examination would not tell us about this. Some specialties are proposing to use online open book knowledge assessments as part of Continuing Professional Development (CPD) and this would contribute to the supporting information for revalidation, but no one is proposing a formal revalidation examination for practising doctors.

Instead, revalidation will be based on annual appraisal in the workplace. It will require you to show, within the context of your practice, that you are meeting the appropriate professional standards.

I have no medical practice of any kind and therefore cannot draw on evidence of actual practice. How do I revalidate?

If you are not involved in any form of medical practice, there is no need for you to retain a licence to practise. If you do not have a licence, you will not need to revalidate.

However, if you have no medical practice of any kind (either clinical or non-clinical), and still wish to maintain a licence, an objective evaluation such as an examination incorporating a knowledge and skills test may be the only practical way for you to demonstrate you are up to date and fit to practise.

In these circumstances, success in one of the following examinations will enable you to revalidate:

a. The Professional and Linguistic Assessments Board (PLAB) test or any postgraduate qualification currently accepted by the GMC for the purposes of full registration.

b. Successful completion of the knowledge and skills assessments developed for the GMC performance procedures.

Will my employer's existing appraisal process satisfy the requirements for revalidation?

Your annual appraisal will be the main way in which you will demonstrate that you are meeting the standards required for revalidation. We know, however, that the quality of appraisal in different parts of the UK is, at present, patchy. In many cases, employer appraisal systems will need to work more effectively. Work on this is underway. We will not start revalidating doctors until we are confident that appropriate systems are in place. For information on how we propose to roll-out revalidation gradually as systems become robust enough to support it, see Section 4 of this consultation document.

The GMC has developed a *Good Medical Practice* (GMP) Framework for appraisal and assessment which will support the delivery of revalidation. The Framework sets out generic standards of practice which all doctors will need to meet. The Framework has been used by the medical Royal Colleges and Faculties as the basis for the development of specialty-specific standards frameworks for revalidation. The GMP Framework is now being incorporated into strengthened systems of appraisal so that when you come to revalidate you will be able to use your appraisal to demonstrate that you are meeting the required standards. The GMP Framework is provided in Annex 1 and the specialty standards frameworks are available in Annex 2.

Must my appraiser be medically qualified and work in my specialty?

The NHS Revalidation Support Team in England (see glossary) is currently reviewing its guidance on medical appraisal. This states that to improve, challenge and facilitate evaluation the appraiser should be familiar with the role and working environment of the appraisee. For specialists and GPs, this will usually mean that the appraiser is from the same specialty, but not necessarily from the same sub-specialty as the appraisee. Whether or not this is the case, the GMC will require the arrangements to be appropriately quality assured.

I am self-employed, I work wholly outside the NHS and there is no local process through which I can be appraised. How will I be able to access an appraiser and Responsible Officer provided by my College/Faculty?

Some Faculties and independent doctor organisations already provide appraisal facilities for their members who do not have access to local arrangements. To meet the requirements of revalidation, any appraisal service offered by your Faculty, or by another agency, will need to incorporate the *Good Medical Practice* Framework for appraisal and assessment and be appropriately quality assured.

Eligibility to fulfil the Responsible Officer role is not a matter for the GMC. This will be determined by legislation and guidance produced by the health departments in England, Wales, Scotland and Northern Ireland. However, we expect that the legislation will provide for many non-NHS organisations and some Faculties to appoint Responsible Officers. These are likely to include the Faculty of Occupational Medicine, the Faculty of Pharmaceutical Medicine and the Faculty of Public Health on the grounds that doctors in these specialties often work in situations where those employing or contracting their services would be unable to provide a Responsible Officer role to assist in their revalidation.

I keep hearing about multi-source feedback from patients and colleagues as being part of the requirements for revalidation. Will the GMC organise this for me?

Feedback from colleagues and patients (where relevant – some doctors do not see patients) represents useful supporting information that will enable doctors to demonstrate that they meet the standards for revalidation. This information is likely to be considered at a doctor's annual appraisal along with other information about a doctor's performance, drawn largely from their practice. The outputs of appraisal and other collated information will subsequently lead to a revalidation recommendation about the doctor to the GMC from the Responsible Officer in their healthcare organisation. See Section 1 of this consultation document.

Colleague and patient questionnaires and feedback will not be organised by the GMC but through the doctor's workplace.

It will not be mandatory to use GMC questionnaires for obtaining feedback from patients and colleagues. However, it is important that any colleague and patient questionnaires used to support a doctor's revalidation are robust, valid and reliable. We have therefore developed a set of principles and criteria which we think any colleague and patient questionnaires should meet for the purposes of revalidation (see Section 3 of this consultation document).

We also plan to put in place arrangements for accrediting those questionnaires that satisfy the principles and criteria we have set. This will enable doctors, and healthcare organisations purchasing colleague and patient questionnaires, to be confident that they are fit for purpose. More information about the principles and criteria, and about our plans for accrediting colleague and patient questionnaires, is contained in Section 3.

How often do I need to participate in colleague and patient questionnaires for revalidation?

Doctors should participate in colleague and patient (where appropriate) questionnaires at least once in every five-year revalidation cycle. There should also be provision for a doctor to obtain further feedback within that revalidation cycle if concerns are identified in the first colleague and patient questionnaires. We do not envisage that doctors will need to provide information about participation in colleague and patient questionnaires at each annual appraisal.

How many hours Continuing Professional Development (CPD) will I need to complete in order to revalidate?

Continuing Professional Development (CPD) must be tailored to the specific needs and interests of individuals and their practice. It would not be appropriate for revalidation to set prescriptive requirements for all doctors about the number of hours of CPD they must undertake.

However, revalidation does need to provide assurance that doctors are keeping up to date. Evidence of participation in appropriate CPD, as brought to appraisal, is one way of doing this.

In developing the specialty standards for revalidation the medical Royal Colleges and Faculties have described participation in CPD as one of the ways in which doctors will be able to show that they are meeting the required standards. They currently require their members to complete 50 credits of CPD per annum and a total of 250 credits in a five-year revalidation cycle. This applies whether a doctor is full-time or part-time. You may find that participation in College or Faculty CPD schemes is helpful both in keeping up to date and in demonstrating compliance with the standards.

However, we will not require you to be a member of a College or Faculty in order to revalidate. Nor will we require doctors to participate in a College- or Faculty-run CPD scheme. Doctors must be able to show through appraisal that they are keeping up to date. This applies whether they are full-time or part-time. Doctors cannot have less regard to maintaining their competence and performance just because they are not in full-time practice.

Although we do not believe that setting prescriptive requirements for CPD in revalidation is helpful, we have identified some core principles that should guide doctors in their CPD activity. These are set out in Section 2 of this consultation document.

What is the minimum number of clinical sessions that I would need to work in order to revalidate?

Revalidation will not require doctors to undertake a set minimum number of hours or sessions.

Doctors will need to provide information about the full range of their work to show that they are practising to the appropriate standards in their specialty or field of practice.

This information will need to cover the four domains and 12 attributes described in the *Good Medical Practice* Framework for appraisal and assessment (see Annex 1 to this consultation document):

- knowledge, skills and performance
- safety and quality
- communication, partnership and teamwork
- maintaining trust.

Questions about work undertaken overseas

I am on the specialist register and have worked for many years in the UK. I have moved to another country to work, but would like to return to the UK in a few years time. What can I do to maintain my licence to practise?

Unless your overseas employer requires it, there is no need for you to maintain your licence to practise if

you are not practising in the UK. You can voluntarily relinquish your licence and apply for it to be restored when you return to the UK, at no cost. Restoring your licence and your entry in the specialist register will usually be straightforward. It will generally be easier for you to do this than to maintain your licence while working overseas.

If you decide to maintain your licence to practise while you are working abroad, you will need to participate in revalidation. Revalidation is being designed to ensure that doctors practising in the UK are doing so to the appropriate professional standards, and systems (such as strengthened appraisal and colleague and patient questionnaires) are being put in place to support this. Because those systems, or equivalent systems, may not exist in other countries, revalidation will be less straightforward for you. You will still be required to show that you are meeting the same professional standards as doctors practising in the UK, but the information and systems that you use to demonstrate this will obviously be different.

What information you can provide will, to some extent, be determined by the systems and processes in place where you are working. But you will need to look at the standards that the College/Faculty is developing for your specialty and at the examples of supporting information which it recommends as necessary for showing that you are meeting those standards. Those standards are based on the generic *Good Medical Practice* standards set by the GMC that all doctors will need to meet.

For doctors in the UK, systems of annual appraisal will provide confirmation that they are meeting the required standards. Depending on your circumstances overseas, it seems likely that participation in an appraisal system abroad will not always, in and of itself, be sufficient to assure the GMC that you can be revalidated.

You should therefore remain aware of the evidence requirements for NHS appraisal and keep collecting such information in relation to your clinical practice (wherever this may be).

The GMC will also require confirmation of your continued good standing with the medical regulator in the jurisdiction where you are working.

You should also link with a Responsible Officer (see glossary) in the UK. A Responsible Officer will normally be a senior doctor in a UK healthcare organisation, such as the medical director. They will have specific duties relating to the evaluation of doctors' fitness to practise for the purpose of revalidation. They will help to ensure that individual doctors are meeting the requirements for revalidation and will make recommendations to the GMC about whether they should be revalidated.

If your work overseas enables you to maintain a connection with a UK healthcare organisation which will be appointing a Responsible Officer, this is likely to make the revalidation process more straightforward for you. If you are unable to link to a Responsible Officer in the UK the only option is likely to be for the GMC to evaluate the information you provide in support of your revalidation.

Can I be appraised for revalidation while I am overseas?

We would not want to discourage doctors from having appraisals while overseas, including virtual appraisals, as these are likely to be valuable in their own right and aid professional development.

However, unless the appraisal corresponds with those being used in a UK context (incorporating the essential elements of the *Good Medical Practice* Framework for appraisal and assessment, and an evaluation against the relevant specialty standards) and is subject to the same quality assurance processes, it is unlikely to meet the requirements for revalidation.

I am intending to work abroad for a couple of years. If I give up my licence to practise will I need to revalidate or pass a test of some kind in order to regain my licence?

This is highly unlikely. Our aim is to make it easy for doctors who are taking career breaks or moving overseas for a short period to re-enter the workforce once they are ready to resume medical practice in the UK.

However, we will reserve the option to require someone to revalidate at the point of restoring their licence if it has become clear that they are repeatedly relinquishing and then restoring their licence in order to avoid undergoing revalidation.

I work for a UK aid agency. The job entails overseas postings of up to a year at a time, often in places where modern medical facilities do not exist and gathering material such as multi-source feedback is not practicable. The agency expects me to keep my licence during this time. How can I demonstrate that I am meeting the UK standards necessary for revalidation?

Even though you are working abroad for part of the time, you should still be able to draw on information from your practice during the time you are in the UK to support your revalidation. If this does not cover the full five years of your revalidation cycle, we will have the option of deferring your revalidation for a short period (during which you would keep your licence). Alternatively, we will be able to revalidate you on the basis of less than five years' supporting information as long as you demonstrate your performance across the four domains of the *Good Medical Practice* Framework for appraisal and assessment and the specialty standards set by the relevant medical Royal College or Faculty for your specialty.

When I return to the UK, will I need to go through a re-entry programme?

This will not be necessary as a condition of maintaining or restoring your licence, but your employer may require it.

Questions about different types of medical practice

I work in a field that is not connected with a medical Royal College or Faculty. How do I revalidate?

The revalidation model will be the same for doctors working outside the mainstream specialties as for all other doctors. You will need to participate in a system of annual appraisal in your workplace. As part of the appraisal process, you will need to show that you are complying with the standards set out in the *Good Medical Practice* Framework for appraisal and assessment.

You will need to link to a Responsible Officer within the main organisation where you are working. The Responsible Officer will make a recommendation to the GMC regarding your revalidation. If you are not in an organisation with access to a Responsible Officer, you are strongly advised to make other arrangements to access a Responsible Officer. There are likely to be several organisations which will provide Responsible Officer facilities, including the Independent Doctors Federation **(http://www.idf.uk.net**).

I work in an area of medical research in which I do not prescribe or see patients. Will I be able to revalidate given that I do not undertake any clinical work and cannot collect feedback from patients?

Yes. Even though you are not involved in clinical work you will still be able to revalidate.

If you hold a licence to practise your revalidation will be based on the work that you do. Even if you do not see patients, you should still be able to obtain feedback on your work from colleagues and participate in an annual appraisal based on the *Good Medical Practice* Framework for appraisal and assessment.

We are working with the Academy of Medical Royal Colleges and others to develop a series of frameworks that describe the standards which are applicable for doctors in a range of non-clinical roles, and the types of information that they might bring to appraisal to show how they are meeting those standards. We will consult on these later in 2010.

I work in a non-clinical role and do not currently see patients. Will revalidation prevent me from returning to clinical medicine later in my career?

No. Your licence is generic. It will not restrict you to working in a particular specialty or field of practice. You will, however, be bound by the professional obligation in *Good Medical Practice* to recognise and work within the limits of your competence. If you have been out of a specific field of practice for a significant period it is your responsibility to consider what additional support you may need to help you to re-enter that field of practice safely.

I am a retired GP who does sessions in dermatology clinics. How do I revalidate?

Revalidation is based on what doctors do in practice. You will need to show that you are practising in accordance with the relevant specialty standards (in this case, the physician medicine specialty standards) and you will do this through your participation in workplace appraisal.

I am a locum consultant, and not on the specialist register. How do I revalidate?

The requirements for your revalidation will be exactly the same as for your colleagues on the specialist register. However, we recognise that there may be greater challenges for locum doctors, and the range of information you bring to appraisal may be different from other doctors.

As a locum consultant, you will still be required to demonstrate that you are practising to the appropriate standards for the specialty in which you are working. Whether you are on the specialist register or not, the specialty standards that you need to meet will be the same.

This is possible because revalidation for all doctors will be largely rooted in the evidence of their actual practice, and the information you provide will reflect what you do as a doctor. The relevant medical Royal College/Faculty will be able to provide you with guidance on the specialty standards and information requirements in your specialty.

You will also need to link to a Responsible Officer. Proposals for how locum doctors will do this are still being finalised by the four health departments of the UK. In England and Wales the current proposals are that locum agencies should be designated to appoint Responsible Officers for locums in secondary care. In Scotland the link will be with the Responsible Officer for the appropriate Health Board. In Northern Ireland, the link could be with the locum agency or the organisation where the locum doctor delivers most of his or her work.

Locums working in primary care will be on a Performers List and will link to the Responsible Officer in the primary care organisation whose list they are on.

I am a doctor in training. Will I be expected to participate in revalidation? If so, can I use the documentation in my Specialty Training Record as evidence for revalidation?

Yes. Doctors in training will be required to participate in revalidation.

You will be able to use the record of your progress through training for the purposes of your revalidation. There may need to be some enhancement of the Annual Review of Competence Progression (ARCP) process so that it incorporates patient and colleague feedback.

Our intention is that the ARCP process, in conjunction with feedback and sign-off of trainee placements from employers, should provide the vehicle through which trainees would be able to revalidate. In effect, revalidation would be the by-product of your successful progression through training.

Your first revalidation will be either at the point you are awarded a Certificate of Completion of Training (CCT) or five years from the date you are granted full registration, whichever is the sooner.

I am a specialty doctor (SAS grade) who has practised in my specialty for the last 10 years in the UK. I do not have the Fellowship and am not on the specialist register. How will this affect my revalidation?

The revalidation process will also be the same for you as for doctors on the specialist register. You will need to participate in a process of annual appraisal where you will be required to demonstrate that you are practising to the appropriate standards in your specialty. Whether you are on the specialist register or not, the specialty standards that you have to meet will be the same. What may differ is the nature of the information about your practice that you will provide to show you are meeting those standards. Because revalidation for all doctors will be largely rooted in the evidence of their actual practice, the information you provide will reflect what you do as a doctor.

The outputs from the appraisal process will be considered by your Responsible Officer and will contribute to the recommendation to the GMC about whether you should be revalidated.

I work as an academic and a clinician. Will my revalidation have to be based on the same supporting information (content and breadth) as a full-time clinician? What about the evidence from my university appraisal process?

Yes. Revalidation needs to affirm that you are practising in accordance with the standards appropriate for your specialty. You will need to be able to show that you are meeting those standards through the work you do within your specialty.

Appraisal will need to encompass all of the work that you do, including your academic work. But this will not require you to undergo separate revalidation processes for the different elements of your clinical and academic work. You should be able to demonstrate your continuing fitness to practise for the purposes of revalidation through an appraisal process if that process is compliant with the Follett principles.

I am an associate medical director/senior manager in my Trust but I still undertake a limited amount of clinical work. I hope to maintain my clinical role. How should I prepare for revalidation?

Your revalidation will be based on the whole of your medical practice, both clinical and non-clinical.

Although you are only undertaking a limited amount of clinical work, you will need to be able to show that you are meeting the standards appropriate for your specialty across the breadth of the clinical work that you do. The relevant College/Faculty will be able to provide you with guidance on the information you will need to collect to show that you are meeting those specialty standards.

Your annual appraisal will need to cover the non-clinical, as well as the clinical, aspects of your work. Guidance on the strengthened appraisal process that is being developed by the NHS Revalidation Support Team (see glossary) will provide for this.

I am a European national and work in the UK occasionally for a few weeks a year. Will I need to be licensed and participate in revalidation?

Yes, you need to hold a licence to practise. Your licence will be granted when you register with the GMC. If you hold a licence and full registration you will need to revalidate. This applies whether you are established in practice in the UK or, for example, here to provide regular locum services.

There will be a small number of European Economic Area (EEA) doctors who are only granted temporary registration and a licence because they are providing only temporary and occasional services in the UK (usually just a few days or weeks a year). An example might be a visiting academic who is here to demonstrate a particular procedure. Under European Commission law we cannot require this group of doctors to participate in revalidation. However, if the services they are providing cease being temporary and occasional and they become established here in the UK, they will be required to revalidate.

If you are an EEA doctor and are uncertain about your registration and licence status, you should contact the GMC for further advice.

Question about changing specialties

I am on the GP register, but I currently practice in a different medical specialty. What specialty standards should I meet for revalidation? What will happen to my entry on the GP register?

Revalidation is about what doctors do in their actual practice. Doctors on the specialist or GP registers will be required to demonstrate that they are meeting the specialty standards which apply to the actual work that they do.

Although you are on the GP register you will need to show that you are complying with the standards relevant for the specialty you actually practise in. The relevant College/Faculty will be able to provide you with guidance on the specialty standards and information requirements for that specialty. The vehicle for this will be your annual appraisal.

Our intention is that your licence will show the field of practice within which you demonstrated your competence for the purpose of revalidation. This will not affect your entry in the GP register which will remain as a historical record of achievement.

Questions about breaks in service

I have been ill for over a year and have missed both my appraisal and much Continuing Professional Development (CPD) activity during that time. What should I do to revalidate?

If you are on long-term sick leave, there is no need for you to maintain a licence to practise. You can relinquish your licence and apply for it to be restored once you are fit and well. However, before relinquishing your licence you should check with your employer whether there is any contractual need for you to retain it.

Assuming that you are now back at work, the fact that you missed an appraisal and CPD activity while you were on sick leave should not prevent you from revalidating.

In general, the GMC will expect evidence for revalidation to be not more than five years old. If you have no medical practice or CPD to draw on over the last year, account will be taken of information relating to your four years' medical practice prior to that. Your next revalidation date will then be set for four years' time; that is to say, a total of five years from the date of the most recent evidence for your last revalidation.

I took a career break a few years ago and during that time I did not hold a licence. Once I have restored my licence how soon will I need to revalidate and how will I meet the requirements if I don't have five years of work to draw on?

We still have some work to do to finalise exactly how we will approach this situation, but our current thinking is as follows.

Doctors will normally be expected to revalidate every five years. If your career break was of less than five years, you will normally be required to revalidate on the anniversary of your five-year cycle. That will mean that you will have less than five years' work to draw upon for your revalidation. This will not matter as long as you have sufficient information about your practice to show that you are meeting the relevant generic and specialty standards (see Section 2 about methods and supporting information for revalidation). If you have only been back in practice

for a very short time before your revalidation falls due, we might need to defer your revalidation date for a short period to give you the opportunity to generate more information to support your revalidation.

If your career break was longer than five years, your licence will be restored but you will be required to revalidate within two years of returning to practice.

Question about retirement

I am an NHS consultant and have just decided to retire but would like to work part-time for a few years. Do I need to revalidate and how long will it last for?

Yes, even if you are working part-time you will need to participate in revalidation.

The revalidation process will be exactly the same whether you are part-time or full-time. You will need to participate in a process of annual appraisal. You will need to bring to the appraisal process information to show how you are complying with the standards and supporting information requirements set by the relevant College or Faculty across the range of the work that you do. The outputs from the appraisal process will be considered by your Responsible Officer (see glossary). The outputs from your appraisal will contribute to a recommendation to the GMC, normally every five years, about whether you should be revalidated.

Questions about work in the independent sector

I am a doctor working solely in private practice in the UK. How can I revalidate?

The requirements for your revalidation will be the same, regardless of whether you are working in the NHS or in the independent sector.

You will need to participate in a process of annual appraisal within your workplace. As part of that appraisal process, you will need to show that you are complying with the standards and information requirements specified by the College or Faculty for the specialty. For advice about appraisal in the independent sector you might find it helpful to contact the Independent Healthcare Advisory Services (**http://www.independenthealthcare.org.uk**) or the Independent Doctors Federation (**http://www.idf.uk.net**).

You will also need to link to a Responsible Officer within the main organisation in which you are working and who will make a recommendation to the GMC regarding your revalidation. Most large independent sector providers will have their own Responsible Officers.

We recognise that some doctors in private practice do not work in managed organisations that appoint Responsible Officers. However, there are likely to be a small number of other organisations (including the Independent Doctors Federation, the Faculty of Occupational Medicine, the Faculty of Pharmaceutical Medicine and the Faculty of Public Health Medicine) that expect to able to provide Responsible Officer facilities for their members.

I work in both the NHS and the private sector. How will I revalidate?

The arrangements will be the same for you as for other doctors. You will need to participate in annual appraisal in the workplace and show that you are meeting the specific standards relevant to your specialty.

Because your practice spans both the NHS and the independent sector your revalidation will need to take account of your work in both sectors. Your appraisal will take place in the sector where you do the majority of your work.

Work is currently being undertaken through the Independent Healthcare Advisory Services to ensure that doctors with both NHS and independent sector commitments can benefit from whole practice appraisal.

I am not a member of any Royal College or Faculty. How will I revalidate?

Even though you are not a member of a medical Royal College or Faculty you will still be able to revalidate. The College/Faculty will be able to assist you in meeting the requirements for revalidation, for example through Continuing Professional Development (CPD). Some Faculties may also provide appraisal facilities for doctors in their specialty who do not have access to workplace appraisal. Colleges and Faculties may charge non-members a fee for using their facilities.

Questions about doctors who do not revalidate

What will be the consequences for my revalidation if there are concerns about my standard of practice?

We expect that the vast majority of doctors will have no difficulty meeting the standards for revalidation.

Where there are concerns about any aspect of your practice these should be identified early and, where possible, addressed through appraisal and relevant local clinical governance processes. The identification of, and action on, concerns should not wait until you are due to be revalidated.

If, by the time a doctor comes to revalidate, there remain significant concerns about a doctor's fitness to practise which are so serious that the doctor cannot be recommended by the Responsible Officer (see glossary) for revalidation, the doctor would be referred into the GMC's fitness to practise procedures for investigation.

The GMC has a range of powers under its fitness to practise procedures. These include no action (in which case the doctor would be revalidated), a warning, conditions on registration, suspension from the register and erasure from the register.

What happens if I do not provide any information to support my revalidation?

If you wish to keep your licence to practise, you must participate in revalidation. If you do not, you run the risk of having your licence to practise withdrawn.

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