

Revalidation

Project Initiation Document

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1 INTRODUCTION

1.1 Purpose of this Document

The purpose of this document is to define the scope, approach and controls of the **Revalidation Project** and to set an information baseline for all Revalidation Programme Board members, members of project teams that feed into the overall programme of work and key stakeholders. Specifically, the document should enable the reader to understand the reasons why the project is being undertaken, the scope and deliverables of the project, the approach that will be taken, the resources that will be required and the timeframes.

The document is structured as follows:

- Project Definition
- Governance Structure
- Communication and Engagement Strategy
- Project Controls
- Business Case
- Critical Success Factors
- Project Governance and Project Management
- Key Assumptions
- Timescales

1.2 Project Background

Revalidation is the process by which doctors will, in future, demonstrate to the GMC on a regular basis that they remain up to date and fit to practise.

Revalidation has three elements:

- To confirm that licensed doctors practise in accordance with the GMC's generic standards.
- To confirm that doctors on the GMC's specialist register or GP register continue to meet the standards appropriate for their specialty.
- As a backstop to identify for further investigation and remediation where appropriate doctors whose practice is impaired or may be impaired.

The GMC began to develop proposals for revalidation in 1998. This work was put on hold at the beginning of 2005 when the Government launched parallel reviews of both medical and non-medical regulation.

Following those reviews, the Government's February 2007 White Paper, [Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century](#), sets out its proposals for the reform of healthcare regulation. The proposals were wide-ranging and covered many different aspects of regulation, including revalidation.

The White Paper built upon the revalidation plans that the GMC had been developing prior to 2005. This was followed by the report of an expert working group, chaired by Sir Liam Donaldson, which set out the principles and next steps for implementing revalidation in the United Kingdom. (Medical Revalidation: Principles and Next Steps).

In shaping the way forward for the programme of work on revalidation, the expert group identified several key principles. These are that revalidation in the United Kingdom:

- 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, focussed 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 evidence 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.

The Government White Paper and the report of the Medical Revalidation Working Group confirmed that revalidation will be a single process with two potential outcomes: relicensing for all doctors and, for those doctors on the GP register or the specialist register, relicensing plus specialist recertification.

Annual appraisal will be a key vehicle by which it will be confirmed that a doctor is progressing satisfactorily and that any issues of concern are being managed effectively.

Relicensing will rely primarily on information derived from a revised and strengthened form of annual appraisal, which will usually include, amongst other things, evidence from periodic multi-source feedback from patients, peers and colleagues.

Recertification will be based on standards for specialist practice set by the medical Royal Colleges, working with the Specialty Associations, and approved by the GMC. The evidence that doctors are meeting those standards will need to be drawn, primarily, from their actual practice. The Medical Royal Colleges will design methods of evaluation that are fair, effective and fit for purpose.

The symmetry between evidence needed for, and the processes leading to, relicensing and recertification will be such that the GMC will receive a single recommendation covering both these elements of revalidation. The information assembled for relicensing cannot be purely about generic aspects of practice since the way a doctor conducts their specialist practice at local level will be relevant to their overall performance competence and conduct. Similarly, doctors' generic skills and performance will be relevant to judgements about their specialist roles.

The Medical Revalidation report identified five key challenges which successful implementation must address effectively:

- **The logistical challenge** is to ensure that the system of revalidation can deal with about 150,000 doctors who are actively practising in the UK and phase their revalidation cycles in a way that is manageable for individual doctors, employers and commissioners. The system will also have to identify and keep in view the hard to reach groups of doctors and those who move 'in and out' of the system.

- **The methodological challenge** is to design and implement valid, reliable, proportionate and fair systems through which standards are selected, agreed and assessed.
- **The connecting challenge** is to make effective and appropriate links between other systems of organisational quality assurance, service accreditation, patient safety and quality improvement.
- **The information challenge** is, over time, to develop and make routinely available data on outcomes and processes of care that can facilitate objective assessment of performance of individuals, teams and organisations and place the contribution of each in proper context.
- **The cultural challenge** is to allay fears and to create a climate and set of attitudes whereby revalidation is primarily a dynamic process to support doctors in improving the quality of their practice and is viewed in this way by all constituents (the health professionals, patients and managers). Embedding patient experience, participation and voice throughout the process of revalidation will be vital to this.

The report identified a number of key organisations across the UK that would be crucial to the implementation of revalidation:

- The GMC
- Academy of Medical Royal Colleges and the medical Royal Colleges and Faculties
- The Department of Health (England) and the devolved administrations
- Systems' regulators and quality bodies in each of the four countries (Healthcare Commission and Care Quality Commission (once established), Health Inspectorate Wales, Regulation and Quality Improvement Authority in Northern Ireland, Quality Improvement Scotland and the Care Commission in Scotland)
- Employers and Commissioners in the NHS and independent sector
- NHS Revalidation Support Team
- BMA
- Doctors themselves
- Patients and the Public

The report also helped to identify the key elements required for the successful implementation of revalidation:

- Legislative Framework;
- Licences to practise;
- Generic standards and a framework for appraisal and assessment based on *Good Medical Practice*;
- Validated tools for multi-source feedback and a set of principles and criteria that any tool used for these purposes would need to meet;

- A revised system of appraisal;
- A network of Responsible Officers;
- A network of GMC affiliates;
- Standards and assessment/evaluation methods for GP and specialist recertification;
- Quality assurance arrangements
- A process for periodic delivery of a single recommendation to the GMC
- Processes for revalidating those in non-clinical practice
- A system for remediation and rehabilitation for those doctors who fall short of the required standards and
- IT solution

1.3 Legislative Framework

Much of the primary legislation that will be needed to support revalidation is already in place. Many of the necessary amendments to the Medical Act 1983 have already been approved by Parliament (the Medical Act 1983 (Amendment) Order 2002 and the Medical Act 1983 (Amendment and Miscellaneous Amendments Order 2006). A further Section 60 Order that will make further amendments to the Medical Act, including enabling the GMC to introduce licences to practises, was made in December 2008 and came into effect in January 2009.

The Health and Social Care Act was approved by Parliament in July 2008. The Act deals with a range of issues and includes provisions for the creation of a network of 'responsible officers' within local healthcare organisations who will have specific powers in relation to the delivery of revalidation processes at a local level, including making recommendations to the GMC on revalidation.

Further secondary legislation will be required, including rules and regulations on licensing and responsible officers.

2 PROJECT DEFINITION

2.1 Objectives

The Revalidation Project will have the following aims

- To enhance and develop local systems of appraisal and clinical governance across all sectors and settings and across all four countries of the UK
- To drive the professional development and standards of practice of doctors and give further focus and energy to doctors' desire to keep up to date and improve their practice through continuous professional development and reflective practice
- To provide regular assurance to colleagues, patients and the public that licensed doctors are up to date and fit to practise
- To identify, at an earlier point, those doctors whose practice falls short of the required standards and who require remediation and rehabilitation
- To let the voice of patients and colleagues be brought in to reflective practice and the assessment/development of doctors' practice and to improve the quality and reduce the risks of patient care
- To ensure that all organisations involved in healthcare delivery, professional regulation, medical education and quality assurance are working in concert in the process with interrelated standards and processes and a common aim

2.2 Scope

Revalidation arrangements will apply to all doctors on the GMC register who hold a licence to practise. There are currently approximately 240,000 on the GMC's list of registered medical practitioners. We estimate that there are approximately 150,000 doctors in active practice in the UK at any one time.

All doctors with a licence to practise will need to revalidate, regardless of the nature of their practice. This means that there will need to be processes in place to revalidate licensed doctors who work in areas outside standard clinical practice such as the pharmaceutical industry, civil and public service, medical management, the tribunal service, education and academia etc.

The arrangements will need to involve all those who employ or contract with licensed doctors across all four countries of the UK and in all sectors.

2.3 Constraints and Exclusions

The revalidation process will only apply to doctors who are licensed to practise with the GMC. Once licensing is introduced, all of the powers and privileges that currently attach to registration (e.g. the right to prescribe, the right to hold a post as a doctor in the NHS) will transfer to the licence to practise. Doctors may choose to maintain registration only with the GMC but this will simply become a historical record of a registrant's medical qualification. Doctors who maintain registration only will not be required to revalidate.

Similarly, doctors who provide a service to UK patients but do not hold a licence to practise with the GMC (and are not UK based practitioners) will not (and cannot) be required to revalidate. Telemedicine, and teleradiology in particular, are becoming increasingly common as is the provision of a variety of forms of medical services via the internet. In recent years the NHS has introduced new medical technologies in the ever increasing demand for the supply of, for example, diagnostic services.

The GMC cannot legally require doctors who practise overseas to register with a UK regulator or take a licence to practice. It is, of course, in the best interests of patients that doctors based outside the UK who are delivering telemedicine services to patients based in the UK are regulated to UK standards. Those who are commissioning such services should ensure that specialists are appropriately qualified and regulated and have demonstrated via their regulator or through other means that they are up to date and fit to practise. However, if a doctor does not have a licence to practise in the UK then he, or she, cannot be subject to revalidation.

2.4 Summary of Approach

The overall programme of work will be split into a number of work projects, with specific deliverables assigned to each.

As the programme of work progresses, the UK Revalidation Programme Board will agree the detailed deliverables/project plans for each of the individual work project. These will be presented by the individual project manager at relevant Programme Board meetings. The first meeting of the Revalidation Programme Board will consider the overall revalidation project plan. This plan is being developed and populated from the details of the individual work projects.

2.4.1 High level deliverables

The following high-level deliverables have been identified against each of the work projects:

Project	High level deliverables	Lead Organisation and Project Manager
<p>Project 1</p> <p>The Legislative Framework</p> <p>The primary and secondary legislation that needs to be in place, including subsidiary statutory rules and regulations</p>	<ul style="list-style-type: none"> • Medical Act (Amendment) Order 2008 • Responsible Officer regulations • Licence to Practise regulations 	<ul style="list-style-type: none"> • Department of Health (England) • Nick Clarke (Head of Social Care and Regulation)
<p>Project 2</p> <p>Introduction of the Licence to Practise</p>	<ul style="list-style-type: none"> • The introduction of the licence to practise • Every doctor in the UK has a licence to practise • A two-tier approach to registration with the GMC 	<ul style="list-style-type: none"> • GMC • Ben Jones (Assistant Director, Registration)
<p>Project 3</p> <p>Develop standards and a framework for appraisal and assessment based on <i>Good Medical Practice</i></p>	<ul style="list-style-type: none"> • Produce a framework based on generic standards in <i>Good Medical Practice</i> • Agree the evidence/supporting information that all doctors need to bring to appraisal to demonstrate that they meet those standards 	<ul style="list-style-type: none"> • GMC • Jane O' Brien (Assistant Director, Standards)
Project	High level deliverables	Lead Organisation

		and Project Manager
<p>Project 4</p> <p>Multi-source feedback</p> <p>Validated MSF tools and agreed principles and criteria that must apply to any patient and colleague questionnaires used in the revalidation process</p>	<ul style="list-style-type: none"> Well-researched and validated patient and colleague questionnaires based on the generic standards in <i>Good Medical Practice</i> Agreed principles and criteria that apply to any patient and colleague questionnaires used in the revalidation process 	<ul style="list-style-type: none"> GMC Una Lane (Assistant Director, Revalidation)
<p>Project 5</p> <p>Revised system of appraisal</p> <p>Deliver a revised system of appraisal for all licensed doctors with a standard module based on the <i>Good Medical Practice</i> framework</p>	<ul style="list-style-type: none"> Revised system of appraisal in place for all licensed doctors All licensed doctors in all sectors across four countries of the UK have an annual appraisal with a standard module based on the <i>Good Medical Practice</i> framework 	<ul style="list-style-type: none"> Department of Health (England) Devolved Administrations Gavin Larner (Director of Professional Regulation) DA Leads
<p>Project 6</p> <p>Responsible Officers</p> <p>Creating a network of responsible officers</p>	<ul style="list-style-type: none"> A medically qualified responsible officer in post in all healthcare organisations across the UK All licensed doctors linked to a responsible officer <p>Establishment of Regional Medical Regulation Support Teams</p>	<ul style="list-style-type: none"> Department of Health (England) Devolved Administrations Gavin Larner (Director of Professional Regulation) DA Leads
Project	High level deliverables	Lead Organisation

		and Project Manager
<p>Project 7</p> <p>GMC Affiliates</p> <p>The establishment of a network of GMC affiliates</p>	<ul style="list-style-type: none"> The establishment of a network of medical and non-medical GMC affiliates at SHA level in England and at country level in Wales, Scotland and Northern Ireland 	<ul style="list-style-type: none"> GMC Anna Rowland (Assistant Director SFPD)
<p>Project 8</p> <p>Recertification</p> <p>Develop standards and assessment or evaluation methods for doctors on the GP and specialist registers</p>	<ul style="list-style-type: none"> Clear standards and guidance on the supporting information that doctors will need to demonstrate that they meet the standards set by the medical Royal Colleges Evaluation methods for those who are not in clinical practice but wish to remain on the GP or specialist registers 	<ul style="list-style-type: none"> Academy of Medical Royal Colleges Kirstyn Shaw (Revalidation Project Lead)
<p>Project 9</p> <p>Quality assurance arrangements</p> <p>QA, auditing and sampling process to ensure that the processes are working effectively and revalidation recommendations are consistent across specialties and sectors</p>	<ul style="list-style-type: none"> Clear standards established for all aspects of the process, including appraisal and clinical governance systems Systems in place for auditing the process Systems in place for sampling the underlying information that supports a revalidation recommendation 	<ul style="list-style-type: none"> GMC Una Lane (Assistant Director, Revalidation)
Project	High level deliverables	Lead Organisation and Project Manager

<p>Project 10</p> <p>A process for periodic delivery of a single recommendation to the GMC</p>	<ul style="list-style-type: none"> • An agreed process for local sign-off of a recommendation to revalidation • An agreed process for dealing with those individuals who do not receive local sign-off either because of a lack of information or because of serious concerns about their practice 	<ul style="list-style-type: none"> • GMC • Una Lane (Assistant Director, Revalidation)
<p>Project 12</p> <p>A system for remediation and rehabilitation for those doctors who fall short of the required standards</p>	<ul style="list-style-type: none"> • Processes and local support mechanisms in place for retraining and remediation where necessary 	<ul style="list-style-type: none"> • Department of Health (England) • Devolved Administrations • Gavin Lerner (Director of Professional Regulation) • DA Leads
<p>Project 13</p> <p>IT solution</p>	<ul style="list-style-type: none"> • Standardised electronically accessible appraisal documentation and e-portfolios 	<ul style="list-style-type: none"> • Revalidation Support Team • Devolved Administrations

3 GOVERNANCE STRUCTURE

3.1 Roles and Responsibilities

3.1.1 UK Revalidation Programme Board

The scale, complexity and significant cultural change inherent in the introduction of medical revalidation means it will require robust governance and project management arrangements to deliver revalidation successfully. Recent reports on the delivery of Modernising Medical Careers have pointed to a number of shortfalls in the governance, design and delivery of policy which need to be explicitly addressed at the outset of the programme to deliver revalidation.

Medical Revalidation: Principles and Next Steps charged the GMC with establishing a UK wide Revalidation Programme Board (RPB). The RPB will take responsibility for overseeing the delivery of revalidation and will have representatives of all key stakeholders in the process. The GMC has appointed a Chairman (Sir Michael Pitt) to assist in drawing all responsible organisations into an effective team to deliver the programme. The Programme Board will be accountable to the GMC and will report progress to the GMC on a regular basis.

The Board will be transparent in its proceedings to enable productive debate and constructive challenge to emerging proposals. Early tasks for the Board will be to agree robust programme and project management and reporting arrangements for revalidation and to ensure an effective communications strategy so that the profession, the public and other key stakeholders are able to engage with the work of the Board

The Programme Board will be established with the following membership:

Programme Board Membership
Chair
GMC representatives (one medical and one non-medical member of Council)
Department of Health (England) representative
Scottish Government representative
Welsh Assembly Government representative
Northern Ireland Assembly representative
BMA representative
Patient and Public Representative (x 2)
Employer/Commissioner representative (x3) including one from the independent sector
Non-clinical practice representative
Academy of Medical Royal Colleges (x 2) including one representative from the Royal College of GPs

The Programme Board will be a high level board that will need to agree the common elements that must exist in all processes that lead to revalidation regardless of sector or geographical location. It will convene at least quarterly and its primary role will be to make key decisions on direction of travel and to review progress towards implementation in each of the four countries. It will agree the Project Initiation Document and high level project plan and timetable for delivery at its first meeting. It will review progress against the high level project plan and timetable at each of its meetings following reports from the Delivery Boards and Executive Project Board (see below)

Terms of reference will need to be drawn up and agreed by the Programme Board at its first meeting.

Each of the four countries in turn will need to establish a Delivery Board (or group). That Board will be led by the Department of Health in England and by the Devolved Administrations in Northern Ireland, Scotland and Wales. It should consist of all of the key players in each of the four countries and take responsibility for delivering the changes that are needed in the service to support revalidation. Each of the delivery boards should report progress on implementation to the National Programme Board

PRINCE2 methodology for project management also requires the establishment of an executive project board. The Project Board should manage the project by exception through reports and communication from the Project Managers. The Project Board should convene on a monthly basis and its primary role is to make key decisions and supply resources to the project. Other specific responsibilities include:

- Promoting and maintaining focus on the desired project outcome
- Re-evaluating the priority of issues after impact analysis
- Providing resources
- Ensuring that the solution will meet user needs within the constraint of the Business Case
- Providing project assurance from an end-user perspective)

3.2 Status Reports

A quarterly project status report will be prepared in advance of the quarterly Programme Board meetings. The status report will contain the following headings:

- Summary of Progress (since the last report)
- Activities for Next Period
- Milestones
- Key Issues
- Key Risks

4 COMMUNICATION AND ENGAGEMENT

The project will have a significant impact on a number of key interested parties including employers/commissioners, doctors, medical Royal Colleges, the BMA and patients/public. It is therefore vitally important to the success of the project that communication and engagement activities are appropriately planned from the outset of the project and documented in a communications and engagement plan.

4.1 Interested Parties

The following interested parties have been identified:

Programme Board Members
Delivery Board Members
GMC
BMA
Department of Health (England)
Devolved Administrations
Employers and Commissioners
NHS Confederation
NHS Employers
Revalidation Support Team
Healthcare Commission (Care Quality Commission)
Health Inspectorate Wales
Regulation and Quality Improvement Authority
NHS Quality Improvement Scotland
Care Commission (Scotland)
Academies of Medical Royal Colleges (north and South of the border)
Medical Royal Colleges, faculties and specialist societies (north and south of the border)
Independent Healthcare Advisory Service
National Patient Safety Agency
Patient Groups
Doctors
Patients and the Public

4.2 Communication and Engagement Plan

Individual groups/organisations involved in the project will have different information requirements during the course of the project.

5 PROJECT CONTROLS

The project controls to be used for this project are as follows:

5.1 Issue Management Process

An issue can be defined as a situation, problem or question arising during the project implementation which cannot be efficiently or effectively resolved within the management of the individual project work streams. Left unresolved, an issue will impede or prohibit project-related progress by delaying or suspending a task. Issues should be considered as “something that requires a decision”.

5.1.1 Issue Resolution

The individual project lead will regularly review the Issues Log for the work stream for which he or she is responsible. As new issues are added, the project lead will attempt to resolve the issue directly, with the support of project members. At this stage, the project lead may need to clarify newly raised issues with the originator to ensure that the issue is clearly defined and understood.

Once each issue has been resolved, the project lead will update the Issues Log, identifying the resolution as well as the date the issue was resolved. Additionally, the project lead may update the individual project plan in accordance with the specific resolution.

5.1.2 Action Plan for Resolution

In order to address a particular issue, it may be appropriate to define an action plan which can be used to realise a suitable resolution. This action plan will be defined and maintained in the Issues Log.

5.1.3 Escalation Process

The majority of issues should be resolvable within the project team for the individual projects. However, if the project team is unable to provide a resolution to a particular issue, then the issue will be escalated to the executive Project Board (for the whole programme of work) to provide direction and an action plan for resolution. If necessary, the issue should be escalated to the national UK Revalidation Programme Board for resolution.

Further information and / or analysis may be required in order that the Programme Board can provide a resolution.

5.1.4 Issue Log

Each project work stream will have an individual Issues Log which will be owned by the project lead. Issues that cannot be resolved within the individual project work streams will be included in the issues log for the overall programme of work for discussion and resolution at executive project board level or Programme Board level. The issues log for the overall programme of work will be the central repository where the details and status of all issues will be maintained. The Log will form part of the quarterly project status reports to the UK Revalidation Programme Board.

5.2 Risk Management Process

Risks are uncertainties, liabilities, vulnerabilities or threats that may cause the project to deviate from the defined plan or its deliverables. As part of the risk management process only 'manageable' and 'specific' risks should be identified.

5.2.1 Risk Assessment

The project leads for the individual project work streams will regularly review the risk log for their individual projects to ensure that project risks are being appropriately managed. Key risks from each of the projects will form the risks log for the overall programme of work and will be communicated to the Programme Board on a regular basis for assessment.

The objectives of these reviews will be to:

- Identify and validate new risks
- Identify mitigating plans for managing newly identified risks
- Review the risk owner, impact and probability classifications
- Review and monitor the previously identified mitigation plans
- Ensure that the identified risks are being effectively managed

After a risk review has been performed, the executive Project Board will update the Risk Log, communicate any newly mitigated actions, and update the project plan as necessary in line with the defined mitigating plan(s).

Risks may be escalated into an issue if it is anticipated that an appropriate mitigating plan cannot be identified. When this occurs, a project issue will be raised, and the Risk Log updated to reflect the change of status. The issue will then be managed through the defined Issue Management process.

5.2.2 High Level Risks

The following high level risks have been identified through an initial assessment:

- The scope of the project is not fully defined due to uncertainty around the mandate.
- Appropriate senior involvement from all key stakeholders is not provided.
- The cost and duration of the project exceeds budgetary / timescale expectations.
- Key interest groups are not involved / updated on the progress of the project.
- The project is adversely impacted (cost, schedule, deliverables) due to the unavailability of project resources.
- Further changes to legislation may impact on the project cost and schedule.
- Reputational damage may be caused if project controls around confidentiality and information integrity are not followed appropriately.

5.2.3 Mitigation Planning

For the majority of risks, it will be appropriate to define a risk mitigation plan which can be implemented to minimise the impact of the risk on the project, to remove the risk altogether, or to put contingency in place for situations where the risk cannot be avoided.

The mitigation plan for each risk will be defined and maintained in the Risk Log. Each mitigation plan may be made up of many mitigation actions and each of these actions will also be defined and monitored in the Risk Log.

5.2.4 Risk Log

The risk log will be the central repository where the details and status of all risks will be maintained. The Log will form part of the quarterly status reports to the Programme Board.

6 BUSINESS CASE

The business case for this project is set out in the following documents:-

Good Doctors, Safer Patients: Proposals to strengthen the system to approve and assure the performance of doctors and to protect the safety of patients

GMC's Proposals on Healthcare Professional Regulation (November 2006)

Trust, Assurance, Safety: The Regulation of Healthcare Professionals in the 21st century

Medical Revalidation: Principles and Next Steps

7 CRITICAL SUCCESS FACTORS

The following factors will be critical to the successful delivery of the Revalidation Project:

7.1 Project Governance and Project Management

- Active senior executive engagement and support from each of the key stakeholders identified in paragraph 4.1
- Strong project management /adequate project resources.
- Agreed defined measurable deliverables.
- Clear tracking mechanisms to monitor and report progress.
- Effective document management.

7.2 Communication and Engagement

- Clear communication at the outset of the project (both in terms of the mandate for undertaking the project and the involvement requirements from the various interested parties).
- Regular updates for key interested groups to be provided to the Programme Board

8 KEY ASSUMPTIONS

The following key assumptions have been identified:

- The Medical Act 1983 (as amended) and the relevant provisions in the Health and Social Care Bill will provide the legal framework for the new process.
- Key interest groups will support the project mandate and participate in Programme Board and Delivery Board meetings.
- The Project Leads assigned to the individual work stream projects will be available for the duration of the project or will be replaced as appropriate
- The Revalidation Programme Board will be available to provide guidance and input when required.
- The individual Project Leads will act as the main point of contact in each organisation and will provide access to the necessary information / personnel.
- Information will be shared across the individual work stream projects as required
- The deliverables of each work stream will be signed-off by the Programme Board.
- Resources will be provided to the project as and when required. A detailed resource plan will be developed to support each project work stream.

9 TIMESCALES

There is a consensus between the GMC, the Government, the Colleges and the profession itself, that while there should be no further delay in the implementation of revalidation, the pace of delivery should be incremental as different elements of the programme are piloted and evaluated and as the capacity of employers, commissioners, and national organisations is put in place.

The following timescales and timetable for England were described in the Medical Revalidation Working Group report:

'For appraisal, it is currently envisaged that there would be a three month design phase, a three months consultation phase and a three months piloting and testing phase, which would be followed with a 12 to 18 month implementation of the new appraisal arrangements. This would see implementation of new appraisal arrangements beginning in the second half of 2009 and completing roll out by the end of 2010. The 360° appraisal tools would also be in place by this time. The GMC will be consulting on principles to guide delivery of the 360 approach later in 2008.

Licences to practise will be issued in 2009, enabling relicensure pilots to commence in those parts of the country that have commenced revised appraisal in the second half of 2009, although the nature of this piloting will need to be discussed and considered carefully if it is to be based on a single episode of revised appraisal.

Recertification standards and methods will be developed over a period of 12 to 18 months, but different specialties are likely to be ready at different times and some will require more careful piloting. It is envisaged that some specialties will wish to become early adopters of specialist recertification and will wish to participate in full revalidation piloting which combines relicensure and recertification in 2010.

Subject to Parliamentary scrutiny, the legislative framework for Responsible Officers will be enacted by July or August of 2008, followed by consultation on detailed regulations and guidance. Time will be needed to ensure effective training, support and recruitment, but the new system should be in place by the end of 2009 to enable effective delivery of appraisal and relicensure. In England, pilots on GMC Affiliates and their interface with Responsible Officers will start later this year, with a similar recruitment and lead-in timetable to that of Responsible Officers.

The timetable therefore envisages the component parts of the system being in place over the next 18 months to two years; a careful and piloted initiation of revalidation in early adopter sites, early adopter specialties and early adopter sectors of healthcare in late 2009 and 2010, with spread across the country gather pace in subsequent years. In order to avoid drift, or areas of particular concern being without appropriate assurance arrangements for

some time, the Department of Health in England will seek to agree a date by which all practising doctors in England are participating in revalidation. This will need to be informed by piloting and evaluation to ensure it is both realistic and sufficiently demanding to sustain momentum.'

The following timetable for England appeared in the Medical Revalidation Working Group report. This will require refinement and revision as the detailed delivery arrangements are discussed and agreed. A much more detailed high level project plan with milestones and timelines will need to be prepared and presented to the national Programme Board at its first meeting. This high level plan will be populated from each of the individual work stream projects.

Timetable for England

		Jul 08	Oct 08	Jan 09	April 09	Jul 09	Oct 09	Jan 10	April 10	July 10	Oct 10
Appraisal											
	Design										
	Consultation										
	360 tools										
	Piloting										
	Implementation										
LTP											
Recertification											
	Standards										
	Methods										
	Piloting										
Responsible officers											
	Legislation										
	Pilots										
GMC Affiliates											
	Pilots										
	Training										
	Implementation										