General Medical Council

Taking revalidation forward

Working with others to improve revalidation

November 2018

Contents

Foreword from the Chair of the Revalidation Oversight Group

In 2016, we commissioned Sir Keith Pearson to undertake an independent review of revalidation. The report that followed, *Taking revalidation forward*, provided valuable insight into how appraisal and revalidation were working in practice.

Sir Keith made a number of recommendations that gave us – and all those involved in revalidation – an opportunity to reflect on how revalidation was working on the ground. It challenged us to consider how our processes and systems could be refined and improved. As with so much that is geared towards improvement in care, the findings reinforced our view that we need the support of organisations across the UK to make appraisal and revalidation work effectively.

Doctors and health services across the UK are working under a level of pressure never seen before. Our role as a regulator, along with employers and educators, is not to add to that burden. It's to create an environment where lifelong learning can flourish, where doctors are supported to deliver high quality safe care, for all their patients. That means protecting the time needed for doctors to reflect and learn, without making time-heavy demands on the way they do so. It means giving those responsible for appraisal and revalidation the tools they need to identify improvements and support consistent practice. It means involving patients more in local processes so that revalidation matters to them and to the doctors who care for them. In short, it means making sure that revalidation is something doctors recognise as a benefit to their practice, not an imposition to be managed.

Although this programme of work has concluded, this doesn't mark an end to our aspiration to continually improve and develop revalidation. Along with our partners, as we've outlined in this report, we have committed to delivering further initiatives both next year and in the future.

On a personal note, one of the achievements of this programme has been the collaboration with such a wide range of partners. We could not have delivered this programme of work without the commitment and dedication of everyone involved. I'm incredibly grateful to the members of the four country Revalidation Oversight Group for their thoughtful contributions and guidance throughout the whole programme.

Finally, I want to thank Sir Keith for his continued commitment and support as we worked to deliver his recommendations. He has remained a valued critical friend and a champion of revalidation's objectives. The continued implementation of his practical recommendations will help make the revalidation experience more valuable for everyone involved.

Charlie Massey

GMC Chief Executive and Chair of the Revalidation Oversight Group

Improvements for doctors

When we set out on this journey to take forward the recommendations from Sir Keith Pearson's review of revalidation we, and our partners, wanted to maximise how revalidation contributes to reflective practice, professional development and safer, high quality patient care.

Our guidance plays a vital role in shaping the way doctors collect supporting information and reflect on their practice for their appraisal. We wanted to make changes that help doctors do this effectively and focus on what is important – making positive changes to their practice.

The research undertaken by UMbRELLA highlighted the challenges that some doctors face in meeting our revalidation requirements, such as collecting supporting information. Sir Keith identified opportunities for us to work with partners to improve how revalidation works for doctors to support their practice. That's why we made improving the appraisal experience and reducing burdens for doctors our top priority.

We also wanted to improve support for doctors who do not have a prescribed connection for revalidation, and work with others to look at options for regulatory change to increase the numbers of doctors with a connection to a designated body. For doctors who work in multiple locations, we wanted to clarify what information can be shared about them and when, making systems more consistent and fair.

We collaborated with doctors, appraisers, responsible officers (ROs), suitable persons and healthcare organisations across the UK to make sure the changes we made reflected the views of those who participate in and deliver revalidation on the ground.

We know these changes will take time to take effect, but we hope they will help make revalidation a more constructive and supportive experience for doctors.

Doctors

We wanted to

- Make the requirements for revalidation clearer and support professional development in appraisal.
- Improve revalidation guidance and advice.
- Help doctors find the information they need online.
- Review revalidation connections for doctors.
- Review the impact of revalidation on independent doctors.
- Increase reassurance for doctors who raise public interest concerns (also known as whistleblowing).
- Provide practical advice for doctors deciding if they need to hold a licence to practise.
- Provide better support to doctors without a connection to a designated body, those who work in multiple locations including locum doctors and to doctors in training.

Making the requirements for revalidation clearer and supporting professional development in appraisal

Doctors and others told us that our supporting information guidance could be clearer and better highlight how appraisal can support reflection and professional development. Some doctors reported that they felt the time they were spending collecting supporting information was excessive, and some were confused about the difference between the GMC's requirements and those of their employer or royal college.

We spoke to a wide range of interested groups to understand the issues further and redrafted the guidance to try and address these issues. We've made a number of changes to help remove unnecessary burdens from the appraisal process:

- We introduced new overarching principles for all supporting information, including 'quality not quantity' and 'proportionality' in the evidence that doctors should collect. We want doctors to collect and reflect on evidence that generates meaningful discussion at their appraisal and supports their development – not to document activity for the sake of it.

- New summary boxes at the beginning of each section of the guidance provide a snapshot of our requirements, clarifying what doctors must do and where there is flexibility.

- We've made the distinction between GMC requirements and local requirements clearer and emphasised that failure to meet local requirements – eg completion of health and safety training – shouldn't influence the revalidation recommendation made about a doctor.

- The guidance explains that the GMC doesn't ask doctors to use any specific appraisal portfolio tools or systems but employers or ROs might.

> *"The balance seems right and I think the emphasis on utilising reflection as a way of demonstrating engagement with the process is an important message from this guidance – **Appraiser***

We tested the revised guidance with doctors, appraisers, ROs and others, to make some final improvements before publication. The guidance is now available in two formats on our website, in mobile and tablet friendly chapters and pdf. We hope that doctors find the new guidance provides greater clarity about what they need to do, and helps reduce burdens by supporting them to find the right balance between collecting information and reflecting on their practice.

The Academy of Medical Royal Colleges has published its own revised supporting information guidance framework in line with our updates. The Academy is now working with royal colleges and faculties to look at updates to specialty guidance documents.

The reflective practitioner guidance was published, which we developed together with the Academy of Medical Royal Colleges, the Conference of Postgraduate Medical Deans and the Medical Schools Council. It supports medical students, doctors in training and doctors engaging in revalidation on how to reflect as part of their practice. We spoke to doctors in training, medical students, trainers, appraisers and educators across all four countries of the UK. They asked us to recognise the value of reflecting with peers and colleagues, and to reinforce that the benefits of reflection are learning and action rather than describing the incident. We hope this guidance will help doctors to reflect, and by doing so, support them to demonstrate insight, learn and identify opportunities to improve patient safety.

The Royal College of General Practitioners, ROs, sessional doctor representatives and the British Medical Association have worked together to look at GPs doing low volumes of clinical work. A new 'low volume of clinical work structured reflective template' has been introduced for doctors to use as supporting information in their appraisal. It gives GPs who

work less than 40 clinical sessions a year a way to demonstrate that appropriate safeguards are in place for them to practice safely and give confidence that they are providing a good quality of care.

Improving revalidation guidance and advice

Along with the supporting information guidance, we've also updated our Guidance for doctors: requirements for revalidation and maintaining your licence to include summary checklists of all key points which we hope makes it more accessible and easier to use. It should now be clearer for doctors to see what they need to do to revalidate, how ROs make recommendations and how we make decisions.

We worked with a wide range of doctors to create 'revalidation top tips', which provide practical, bespoke guides for doctors. These are for specific groups of doctors – for example, those who are new to UK practice, working as short-term locums or finishing supervised training.

We have also created five new additional patient feedback case studies to help doctors collect and reflect on patient feedback. They provide practical advice and show how doctors in similar situations collected feedback successfully. These case studies should help doctors who find it more difficult to get feedback from their patients.

NHS England have also created new supporting material for ROs including a presentation, information sheet and a one-page appraisal preparation guide, customised for all doctors and GPs. These bring an important focus on the development of the doctor. The materials have been shared with all ROs in England. These are accessible on the NHS England's Sharepoint site.

Helping doctors find the information they need online

In early 2018 we launched a brand new website. This gave us a great opportunity to look at how we could improve all the information we publish about revalidation – from how easy it is to find, to how we present it and the tools we use to make our advice easier to understand. We now have step by step guides that explain the revalidation process for different groups of doctors. We created a video that explains how revalidation works and we have updated our online tool to help doctors find their prescribed connection to a designated body.

Reviewing revalidation connections to designated bodies for doctors

Designated bodies are organisations that employ or contract doctors. They range from large NHS trusts, private hospitals and membership organisations, to smaller independent healthcare providers and locum agencies. They must appoint an RO who has a duty to provide support to their doctors for their appraisal and revalidation and make recommendations about their continued fitness to practise. This link between a doctor and a designated body is called a prescribed connection and it is defined in the Responsible Officer Regulations.

The Department of Health and Social Care (DHSC) have reviewed these regulations to identify potential changes that would make prescribed connections more meaningful and cover all doctors who need to maintain a licence and revalidate. The GMC and NHS England have made suggestions for changes using the knowledge and experience built up since revalidation was introduced. DHSC have been given permission to amend the regulations, with a view to consulting on potential changes during 2019. The statutory guidance that supports the regulations will also be revised once the changes have been agreed. This will reference the role of the designated body and provide more detail about prescribed connections. Ownership of this guidance will also be discussed as part this work.

The impact of revalidation on independent doctors

As part of this programme of work, the Independent Doctors Federation (IDF) audited the impact of revalidation on independent doctors. Over a 12 month period, the appraisals of 500 doctors connected to the organisation were reviewed. These doctors are often self-employed, work alone or in small groups, and undertake a wide variety of work. The final report has been published on the IDF website.

> *“There are many learning points for myself and my colleagues, and it has changed my perspective –* ***Appraisee***
> *(in response to the percentage of significant events declared at appraisal)*

Fairness for doctors who raise public interest concerns (also known as whistleblowing)

We were already aware that some doctors felt that raising concerns locally had the potential to impact on their revalidation. We wanted to address this by introducing greater safeguards to make sure whistleblowers are treated fairly and that revalidation recommendations are made appropriately. ROs have a duty to inform us about doctors who are not engaging in appraisal and wider clinical governance locally. When this happens, we now ask doctors to tell us if they have raised a public interest concern and if they feel it prevented them from meeting our requirements for revalidation. We also ask ROs to speak to their GMC employer liaison adviser before making non-engagement recommendations or consecutive deferrals for doctors.

Practical advice for doctors deciding if they need to hold a licence to practise

As well as focusing on revalidation information, we've also provided more advice to guide doctors on whether they need to hold a licence to practise and participate in revalidation. We reviewed enquiries and complaints we received on this issue over the last few years to better understand doctors' concerns. We used this insight to create the licensing resource hub. It includes advice on the most common enquiries we receive together with case studies. We also have a discussion checklist for doctors and employing organisations to support their conversations about whether a doctor needs a licence for the work they do.

Supporting doctors without a connection to a designated body

There are a small number of doctors who need a licence for the work they do, but don't have a prescribed connection to an organisation that can support them with their revalidation. A 'suitable person' or SP is a licensed doctor we have approved to make a revalidation recommendation about some of those doctors who don't have a prescribed connection. As well as general improvements to our online connection tool, we've added specific advice and signposting for doctors to help them identify their SP so they can be supported with their revalidation.

We have also updated our advice for doctors without a prescribed connection or SP. Our guidance is now clearer on what they need to do to complete their annual return, and how to take the revalidation assessment if they need to. We contact these doctors at key stages during their revalidation cycle to understand their circumstances and offer tailored advice to address any concerns or queries they might have. Our staff have also received training so they can better support doctors to identify potential connections.

In addition, we've reviewed our suitable person scheme to make sure it continues to provide a high level of assurance. The review found that the process is robust, works well

and is helping doctors without a prescribed connection to engage in revalidation. We now plan to improve the support we offer SPs and develop an approach to quality assure the scheme.

Supporting doctors who work in multiple locations including locum doctors

We worked with partner organisations across all four countries to create UK-wide principles for sharing information. These principles should reassure doctors that appraisal documentation is confidential and that they should not be expected to share their appraisal portfolios on a routine basis. The principles also provide clarity about what doctors should tell their RO and what information an RO can share about them.

Our jointly published guidance *the reflective practitioner* emphasises the importance of anonymising reflective notes wherever possible. It also makes it clear that we do not ask a doctor to provide their reflective notes in order to investigate a concern about them. We hope this will support doctors to include their reflections and learning as they move between different roles and locations.

We gathered intelligence from our employer liaison service to identify the kinds of issues doctors who work in multiple locations face with revalidation. We used this information to create a checklist summarising the responsibilities of designated bodies in relation to revalidation. This checklist emphasises that local systems should be put in place to support locums and others who work in more than one location.

NHS England have published guidance for locums and doctors in short-term placements along with accompanying guidance for supporting organisations engaging with locums and doctors in short-term placements. Recognising that these doctors are a valuable part of the workforce, the guidance aims to highlight ways they can be supported to enhance their work experience and provide safe care.

Supporting doctors in training

Health Education England has updated its annual process for reviewing doctors in postgraduate training, known as the Annual Review of Competency Progression or ARCP. The information in the ARCP about revalidation has been clarified. The revalidation requirements are now highlighted to raise awareness among doctors in training and frameworks have been put in place to improve consistency.

We've improved the revalidation information on our website for doctors in training and we now provide advice on how their revalidation date is determined, what to do if they're taking a break from training and what happens when they complete their training. We're

also signposting better to other organisations that can support them, such as the Conference of Postgraduate Medical Deans' website.

We now also have separate sections in our supporting information guidance and protocol for making revalidation recommendations specifically for doctors in training. And our information sharing principles explain what information doctors working in UK training programmes should share with their RO, which includes any locum roles.

We hope that collectively these changes will support doctors throughout their revalidation cycle, help to minimise the burdens they feel and allow them to focus on learning from their reflective practice.

Improvements for patients

Sir Keith identified that revalidation is a mechanism for demonstrating that all licensed doctors are up to date and fit to practise. He challenged us to consider how it could become more effective in providing that assurance to patients. He also asked us to look at ways that we and healthcare organisations could increase public and patient awareness of revalidation, and make it easier for patients to provide feedback to doctors.

We worked with patients, lay representatives and healthcare organisations from across the UK to help us understand how we can raise awareness and increase patient and lay involvement in local governance systems that support revalidation.

We wanted to

- Help patients to understand revalidation and how we check that doctors are giving good care.
- Increase lay and patient involvement in providing assurance on the revalidation processes in place at the organisations where doctors work.
- Review our requirements for how doctors get feedback from their patients to increase the impact it has on their practice.

Helping patients to understand revalidation

We worked with patients and the public to create an explanation about revalidation called, 'how do we check doctors are giving good care?' With the help of focus groups, we made the explanation easy to understand and included the information patients told us they wanted to know. Before publishing it, we asked a patient participation group, provided by the National Association for Patient Participation, for feedback on the content and language to make sure we had it right. Ninety eight percent of the group said that they understood what revalidation was after reading the explanation. Our explanation can be used by any healthcare organisation to explain revalidation in their own materials for patients and the public. We have promoted it through our newsletter for patients and social media channels. We will continue to identify opportunities to use the new explanation to help more patients understand revalidation.

> *The explanation is clear, easily understandable and user-friendly* – ***Volunteer***

Increasing lay and patient involvement in revalidation

The Academy of Medical Royal Colleges commissioned the Royal College of Physicians to report on the current challenges relating to the collection, analysis and use of patient feedback for revalidation. The report, improving patient feedback for doctors, was published on 13 April 2018, and has a number of key recommendations and options for improvement. The Academy Revalidation and Professional Development Committee (ARPDC) are now considering how to take forward the next stage of this work.

The AOMRC also published a report in December 2017 on lay involvement in revalidation activities. The report shares examples of patient and public involvement in revalidation and the important contribution this makes. A survey is now underway to identify new examples and seek views on both the benefits and challenges to lay involvement.

We developed extra case studies to give doctors advice on how to collect feedback from patients where it might be more challenging to do so. For example, from patients who are too young or too unwell to respond. The case studies show how doctors could collect feedback in ways that reduce stress for the patient. They should also help to address some of the barriers patients may face when asked to give feedback about their doctor.

We have also published case studies that show how some organisations have involved lay people in their local clinical governance processes. And following feedback from the lay representatives on the Revalidation Oversight Group, we have a page on our website dedicated to involving patients in revalidation. We hope these encourage other organisations to think about how they can involve lay people in their local appraisal and governance processes.

We recognise the important role that patients and the public can play in revalidation – helping to increase local accountability and patient confidence. We have developed a best practice measure to track whether designated bodies have lay representatives involved in their governance processes that underpin revalidation. System leads across the UK can use this to understand where lay representatives are influencing governance processes in designated bodies. ROs can use this measure to help them introduce lay involvement in their designated bodies.

Reviewing our patient feedback requirements for revalidation

We have started to review our requirements for patient feedback for revalidation. So far, we've engaged with key stakeholders to help us understand how we could make it easier for patients to provide feedback about their doctors, and make that feedback more meaningful for doctors. We've heard that more flexibility in how feedback is collected would be welcome so all patients can respond, and that more frequent reflection on feedback from patients would be useful for doctors. We'll be consulting on our requirements in spring 2019.

Improvements for responsible officers, suitable persons and healthcare providers

ROs and SPs play a key role in managing the systems that support revalidation. Making sure they have the best possible guidance and support is essential to making sure local governance processes are working effectively, and revalidation recommendations are made fairly and consistently.

Sir Keith recognised the need to engage boards more in how governance processes that support revalidation are working in their organisations. He felt setting expectations for boards and providing them with tools to help drive improvements could help do this.

We wanted to

- Improve governance and oversight.
- Ensure fairness for doctors who raise public interest concerns.
- Improve guidance for ROs and SPs to make it more comprehensive and easier to find.
- Encourage patient and lay involvement in revalidation processes by promoting ways to embed lay representatives in designated bodies and explain revalidation to patients.

Improving governance and oversight

Our handbook on effective clinical governance for the medical profession provides a helpful guide for developing robust and effective clinical governance systems in designated bodies and other healthcare organisations. We worked with stakeholders to review and update the handbook to capture learning and best practice from healthcare organisations. We have expanded the handbook so it covers the whole RO role. This includes appraisal, responding to concerns and pre-employment checks. Following RO feedback, we have also developed a self-assessment tool to help organisations review their governance arrangements.

We are working with other signatories of the handbook to increase its impact. We have sent the handbook to all NHS chairs and chief executives. We are working with the healthcare system regulators and improvement agencies to promote the handbook across the four countries of the UK. We continue to engage with ROs through a number of networks to support its use in their designated bodies.

> *The document is well laid out and an easy 'high-level' read. I think it will be helpful to organisations as a guide and in places as a check-list against which to ensure engagement and standards –* ***Educational body***

The new information sharing principles should also help support the development of consistent practice across the UK healthcare system. This straightforward guidance should help ROs make decisions about whether to share information and when and give them confidence in doing so. The principles highlight the importance of sharing information where there is a patient safety concern and to maintain public confidence. They also address the issue of balancing the interests of doctors and patients to make sure information is shared legitimately and confidentially. Importantly, they provide support for ROs to make sure that appraisal and revalidation takes account of information covering a doctor's whole scope of practice. If ROs need further advice on applying these principles they can contact their GMC employer liaison adviser.

> *The guidance is easy to read and understand. ROs will be clear about how to apply this as a minimum expectation in order to safeguard patient safety and public confidence –* ***Consultant***

In spring 2018, NHS England circulated their Skipton house expert group statement on locum and short terms doctors in secondary care. This statement was created by an expert group on the use of locum doctors across the healthcare system. It includes a statement of principles, responsibilities and potential enablers to improve governance and patient safety in this area.

Our employer liaison service helped us to identify the kinds of issues designated bodies and doctors face with revalidation where doctors work in multiple locations or frequently change their designated body. We've created a simple checklist for ROs and a checklist for designated bodies summarising their main responsibilities.

We worked with partners to establish a framework and accompanying 'best practice' measures to make sure we can continue to understand how revalidation is working in practise and whether it is achieving its aim. The framework sets out ways of tracking whether revalidation activities are happening and what the impacts are. ROs can use these measures to understand whether aspects of revalidation are working as expected in their designated bodies. In the long term, we hope this will help us understand where we can improve revalidation.

The Wales Revalidation Support Unit has started a programme of revalidation quality review visits on behalf of the Chief Medical Officer to understand how well revalidation processes are working. Each designated body in Wales will be visited over a two year period with an emphasis on supporting development, promoting consistency and sharing best practice.

Assuring decision making for doctors who have raised public interest concerns

We reviewed the report from Sir Anthony Hooper into the handling of cases involving whistleblowers, and worked with colleagues to identify issues that ROs face when making recommendations where a doctor has raised a public interest concern. As a result, we now ask ROs and SPs to speak to their employer liaison adviser as early as possible to make sure they are supported when they make their recommendation for doctors who have raised a concern. They must also confirm that the concern raised has not had any bearing on the revalidation recommendation they make to us. This also allows us to consider whether the public interest concerns affected the doctor's ability to engage in revalidation when we are making decisions, including whether to revalidate a doctor, defer their revalidation or accept that the doctor hasn't been engaging in the process.

Improving guidance for responsible officers and suitable persons

The new responsible officer hub on our website brings together all the information that ROs need for their role in one place. It includes information about registration, revalidation and dealing with concerns about a doctor, along with links to GMC Connect and our data and reports.

We now have a section on our website for SPs with information they need for each step of revalidation. We have also expanded the connection tool to signpost doctors to a specific SP who might be able to support them with their revalidation. We hope this will help doctors who should be supported by an SP to make a connection to them sooner and more easily.

Through engaging with ROs and SPs, we have made improvements to our protocol for making revalidation recommendations. In particular, we have clarified our advice around overseas evidence, local appraisal requirements and for doctors in training. We've also introduced some new infographics and removed the unnecessary jargon. We tested the new protocol with ROs and SPs and received positive feedback, so we hope it provides better support for those making revalidation recommendations.

NHS England has also created and shared a one-page appraisal preparation guide, customised for all doctors and GPs, with ROs. Further supporting material including a presentation and information sheet has also been provided to support a subtle shift in the process-based focus of appraisals to one where the development of the doctor is emphasised. They plan to use RO and appraiser networks to share these more widely.

Encouraging patient and lay involvement in revalidation

Organisations can use our ready-made narrative to explain revalidation to their patients and encourage them to give feedback about their doctors. We worked with patient representatives and other members of the public to create the narrative. Organisations can be reassured that it includes information that patients want to know and explains it in language that is easy to understand.

We worked with two hospital trusts to create case studies showing how they involve lay representatives in their local appraisal and governance processes. We spoke to staff employed by the organisations and the lay representatives to understand the impact from both sides. These case studies promote the benefits of involving patients in local governance systems that support revalidation and show how the approach can be flexible to meet the needs of organisations. They also offer practical advice on how to implement the approaches. We have promoted patient involvement in revalidation in our email bulletin to all ROs and a blog by Dr Jose Mathew. Throughout 2019, our employer liaison advisers will use these new materials to highlight the benefits of patient involvement in revalidation to designated bodies and ROs.

The future of revalidation

We believe that revalidation is fundamental to supporting doctors' professional development. We want doctors to have a positive experience from their annual appraisal, and gain useful insight from their reflective practice. This programme has brought a wide range of improvements, delivered not only by us but by our partners too. We acknowledge that these improvements will take time to bed in. But we hope they will improve the revalidation experience for doctors.

We also hope that this programme of improvements will bring greater assurance to patients that their doctor is providing high quality care and this, in turn, should help drive public confidence. We want the patient voice to be heard. Patients should play a bigger role in the ways that organisations assure themselves their doctors are providing good care.

Revalidation would not happen without the hard work and commitment from all those involved in delivering it – ROs, SPs, appraisers and revalidation support staff. Our revised suite of guidance should give greater support to them in the work that they do – which can be challenging at times – and help them to help doctors focus on what's important.

But our work doesn't stop here. We and our partners have a number of initiatives to deliver in the future.

Improvements for the future

In 2019 we'll launch our consultation about revalidation requirements for patient feedback. We want the feedback doctors get from their patients to be more valuable and help them improve the care they provide. We'll be launching our formal consultation on changes to our requirements in spring 2019. The four UK governments are also working on different models for involving patients and public in revalidation.

We know that some groups of doctors are more likely to have their revalidation deferred, but we don't fully understand the reasons why. So we have developed new categories to describe the reasons for recommendations where a doctor's revalidation is being deferred. We are planning to start collecting this information in March 2019.

We continue to work with our partners to develop more ways to help designated bodies to track aspects of revalidation. We are committed to using our data and intelligence to share best practice where things are working well and to change any parts of the process that can be improved.

4 The future

We commissioned the Wessex Appraisal Service to undertake a pilot to audit appraisals of doctors who don't have a connection. We wanted to understand how we could improve the revalidation experience for these doctors and how we can best assure ourselves and others of the quality of their appraisals. We're now working to address the recommendations made in their Report on pilot of further assurance on appraisals for doctors without a connection.

In early 2019, NHS Employers will update its guidance on the appointment and employment of NHS locum doctors. This guidance safeguards the quality of patient care by setting the standards for appointing and assessing NHS locum doctors.

The Royal College of General Practitioners is looking at how GPs who have a unique or limited scope of practice can demonstrate that they remain safe. As well as how GPs, and doctors in general, should be supported to gain valuable experience abroad and return back to UK practice without unnecessary hurdles or delays.

The Welsh Government has established a new special health authority within NHS Wales. This was recommended by independent reviews into health professional education and workforce development in Wales. The Health Education and Improvement Wales (HEIW) was established on 1 October 2018 and now sits alongside health boards and trusts. HEIW will play a key role in educating, training, developing, and shaping the healthcare workforce. This will provide significant opportunities for collaborative work to support ongoing improvements for patients, doctors, ROs and healthcare providers.

The Revalidation Support Unit will continue to promote patient and public awareness of revalidation on behalf of the Welsh Government. And, will publish a dedicated patient and public section on the Revalidation Wales website at the end of 2018.

The views of doctors, patients, ROs and many others mentioned in this report laid the foundation for these improvements. We and our partners are committed to making sure their views will continue to shape revalidation in the future.

Annex A – Acknowledgements

This programme of work would not have been possible without the support of and contributions from all the organisations and people who committed to delivering the recommendations from *Taking revalidation forward*. We're grateful to Sir Keith Pearson for his continued support and involvement in delivering his recommendations. And we'd like to thank everyone involved for sharing their knowledge and experience, and for their hard work and dedication.

Revalidation Oversight Group members

Organisation	Representative
Academy of Medical Royal Colleges, England	Yvonne Livesey, Revalidation and Professional Development Manager Dr Ian Starke, Chair of the Academy Revalidation and Professional Development Committee and Chair of the Patient Feedback Group
British Medical Association	Mark Hope, Senior Policy Advisor Dr Chaand Nagpaul, BMA Chair, England
Care Quality Commission	Professor Nigel Sparrow, Senior National GP Advisor
Department of Health, England	Robert Duff, Senior Policy and Legislation Manager
General Medical Council	Helen Arrowsmith, Programme Manager Clare Barton, Assistant Director Judith Chrystie, Assistant Director Una Lane, Director of Registration and Revalidation Charlie Massey, Chief Executive
Healthcare Improvement Scotland	Sharon Ballie, Programme Manager Leslie Marr, Senior Programme Manager
Healthcare Inspectorate Wales	Jane Dale, Clinical Director
Health Education England	Dr Peter Hockey, Postgraduate Dean – Wessex Dr Julia Whiteman, Postgraduate Dean
Independent Doctors Federation	Mr Ian Mackay, Responsible Officer
NHS Education Scotland	Professor Stewart Irvine, Director of Medicine Professor Clare McKenzie, Postgraduate Dean Professor William Reid, Dean of Postgraduate Medicine

Annexes

NHS Employers	Sean King, Senior Business Manager
NHS England	Cathy Hassell, Head of Professional Standards Dr Mike Prentice, Regional Medical Director (North)
NHS Improvement	Dr Simon Bennett, Director of Business and Operations - Medical Directorate
Northern Ireland Government	Dr Paddy Woods, Deputy Chief Medical Officer
Northern Ireland Medical and Dental Training Agency	Professor Keith Gardiner, Chief Executive & Postgraduate Dean
Nursing & Midwifery Council	Sara Kovach-Clarke, Head of Regulatory Development
Regulation and Quality Improvement Authority, Northern Ireland	Dr Lourda Geoghegan, Medical Director and Quality Improvement Lead
Representing patient views	Sol Mead, Independent lay representative Stephen Barasi, Independent lay representative
Royal College of General Practitioners	Dr Susi Caesar, Medical Director for Revalidation
Scottish Government	Professor Ian Finlay, Senior Medical Director Val Millie, Health Workforce and Strategic Change Sally White, Health Workforce and Strategic Change
Wales Deanery	Professor Malcolm Lewis, Director Postgraduate Education for General Practice Julie Nallon, Organisational Lead, Revalidation Support Unit
Welsh Government	Professor Chris Jones, Deputy Chief Medical Officer

Annexes

Contributors to Revalidation Oversight Group working groups

Organisation	Representative
Healthwatch	Brighton and Hove
Mencap	Sarah Coleman, Policy Officer
National Association for Patient Participation	Group of 100
NHS England	Claire Brown, Senior Revalidation Manager Dr Maurice Conlon, Clinical Advisor Ros Crowder, Deputy Director (Revalidation)
Plymouth University	Sam Regan De Bere, Lecturer in Medical Humanities
Representing patient views	Rea Mattocks, Independent lay representative
Royal College of Physicians London	James Hill-Wheatley, Head of Revalidation and CPD Dr Nick Lewis-Barned, Consultant Physician, Patient Feedback Project Clinical Lead Don Liu, Education Research Fellow
Wales Deanery	Katie Leighton, RSU Deputy Organisational Lead

Annex B – What is revalidation

Every licensed doctor who practises medicine must revalidate at least once every five years. Revalidation shows doctors are keeping their knowledge up to date and are fit to practise. It supports doctors to develop their practice, drives improvements in clinical governance and gives patients confidence that their doctor is giving a good level of care.

How does revalidation work?

Revalidation is based on annual whole practice appraisals. Doctors must collect evidence and examples of their work to understand what they're doing well and how they can improve. Doctors collect and reflect on:

- feedback from their patients and from people they work with
- compliments and complaints they've received
- information about what they've learnt if something has gone wrong
- evidence of activities they've undertaken to improve the quality of their practice.

Every year, doctors review and discuss their work with a specially trained doctor (called an appraiser) to identify strengths and areas of development. They agree a plan for how the doctor can improve and build on what they do well during the next year.

How do doctors revalidate?

Doctors with a connection

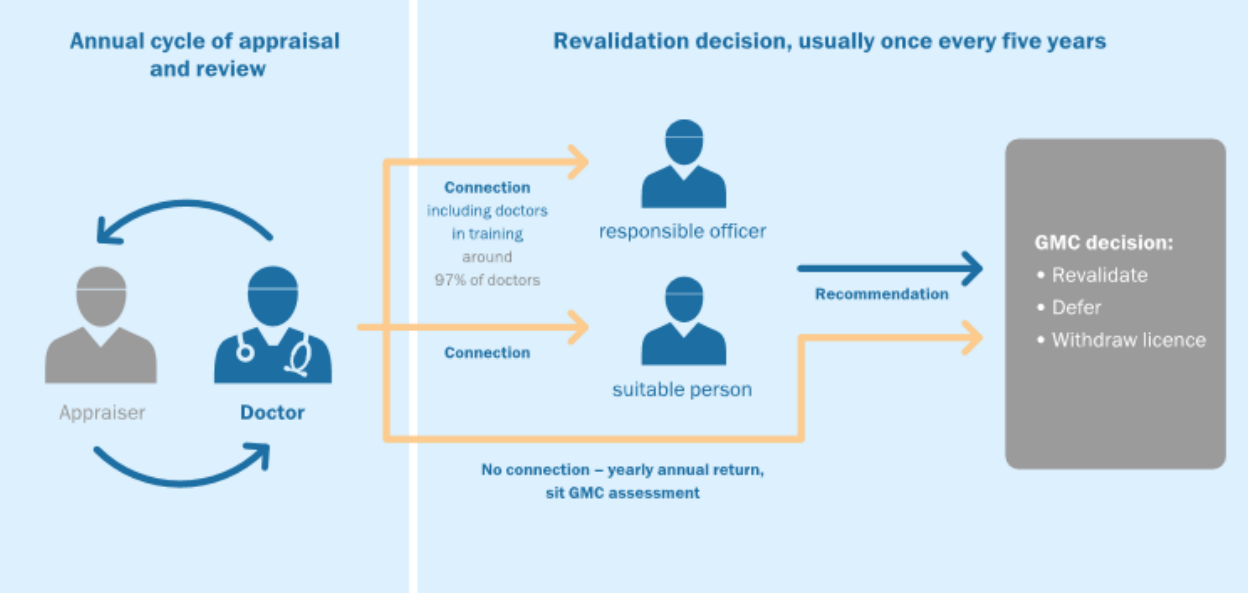
Most doctors have a connection to a designated body (usually the organisation where they work) and revalidate through a recommendation from their responsible officer or suitable person. The recommendation is based on the outputs from their appraisals and clinical governance information. We make a revalidation decision based on this recommendation and other information available to us.

Doctors without a connection

Doctors without a connection to a responsible officer or suitable person revalidate through a process of annual returns submitted to us and a five-yearly assessment. We make a revalidation decision based on the outcomes of these activities and their annual appraisals.

Doctors in training

Doctors in training revalidate by meeting the requirements of their UK training programme. We make a revalidation decision based on a recommendation from the responsible officer of their training body.



You find out more about revalidation by watching our video or reading our explanation for patients and members of the public.

Annex C – Glossary

Term	Definition
Annual return	Allows doctors without a connection to provide us with evidence of their engagement with revalidation and their fitness to practise.
Appraiser	Responsible for facilitating a whole practice appraisal with the doctor.
Clinical governance	A systematic approach to maintaining and improving the quality of patient care.
Designated body (DB)	For most doctors the organisation in which they undertake most or all of their practice. They range from large NHS trusts, private hospitals and membership organisations, to smaller independent healthcare providers and locum agencies. They must appoint and resource a responsible officer.
Employer liaison service	A team of staff at the GMC who support medical leaders in all sectors, including the NHS and independent providers.
Licence to practise	Doctors who practise medicine in the UK need to hold a licence to practise along with the correct type of registration for the work that they do. It is the licence to practise which allows them to carry out certain activities such as prescribing medicines and treating patients. Doctors who hold a licence must take part in revalidation.
Local systems	Healthcare provider organisations should put in place systems that consistently promote and protect the interests of patients and service users. For example, this includes creating an environment in which doctors can meet their professional obligations and sharing information and intelligence across the places where doctors work.
Prescribed connection	Most licensed doctors are supported with their appraisal and revalidation through a prescribed connection to a designated body. Within that organisation, a responsible officer oversees the process of revalidation and makes recommendations to us about whether we should revalidate a doctor. For most doctors their designated body is the organisation in which they undertake most or all of their practice and their responsible officer is a senior doctor within that organisation.

Annexes

Public interest concern	The term public interest concern is used to refer to instances where a doctor has raised concerns in the public interest, usually relating to patient safety, rather than for personal reasons (this is also sometimes referred to as 'whistleblowing'). This type of concern is distinct from a grievance or private complaint, for example a dispute about the employee's own employment position that has no public interest element.
Responsible officer (RO)	Usually a senior doctor within a healthcare organisation – often a medical director. The role is set out in statute and includes making sure systems are in place to evaluate doctors' practice on an ongoing basis. This includes making sure their doctors are regularly appraised and there are processes to investigate and refer any fitness to practise concerns to the GMC. They make recommendations to the GMC about each doctor's revalidation. They usually sit on the executive board of the organisation.
Responsible officer regulations	The RO role was introduced in the UK by the Medical Profession (Responsible Officers) Regulations 2010 and the Medical Profession (Responsible Officers) (Northern Ireland) Regulations 2010. The RO Regulations that apply to England, Scotland and Wales were made by the Department of Health (England). The RO Regulations (Northern Ireland) were made by the Department of Health, Social Services and Public Safety.
Revalidation assessment	Allows doctors without a connection to show they meet the required standard for revalidation, in the absence of formal clinical governance arrangements.
Suitable person (SP)	A licensed doctor approved by the GMC as suitable to make a recommendation about the revalidation of a doctor who does not have a responsible officer.

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Taking revalidation forward

Working with others to improve revalidation

Written by the GMC on behalf of the Revalidation Oversight Group

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