Medical Revalidation – Principles and Next Steps

The Report of the Chief Medical Officer for England’s Working Group
Medical revalidation Principles and Next Steps

The report, by an expert working group chaired by Sir Liam Donaldson, sets outs the principles and next steps for implementing revalidation in the United Kingdom. It is based on wide ranging discussions of the proposals in the White Paper, Trust, Assurance & Safety - the Regulation of Health professionals in the 21st Century.
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Foreword

Professor Sir Graeme Catto, Professor Sir Liam Donaldson and Dame Carol Black

The United Kingdom’s medical profession is respected internationally for its high standards of practice and for the professionalism of its members in meeting them. The introduction of revalidation, through which doctors regularly demonstrate their continued commitment to meet those high standards, will further reinforce the trust that patients and public have in their doctors.

This report, by an expert working group chaired by Sir Liam Donaldson, sets out the principles and next steps for implementing revalidation in the United Kingdom. It is based on wide-ranging discussions of the proposals in the Government White Paper, Trust, Assurance and Safety - The Regulation of Health Professionals in the 21st Century.

In shaping the way forward, we have had several key principles in mind. 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;
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- 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.

Doctors are confident that their practice will answer the additional scrutiny that revalidation brings and welcome the opportunity to demonstrate their continuing ability to bring the science and art of medicine to the service of patients. The principles and next steps set out in this report set out a way ahead to ensure that this now takes place and we look forward to working in partnership on this important programme of work.

Professor Sir Graeme Catto  
President  
General Medical Council  
Medical

Professor Sir Liam Donaldson  
Chief Medical Officer  
England

Dame Carol Black  
President  
Academy of  
Royal Colleges
Summary

1. This report follows the work of a group chaired by the Chief Medical Officer for England to set out the approach to implementing a programme of revalidation for all doctors registered in the United Kingdom. The group held a series of five meetings in which the principles and challenges of implementation were discussed, informed by the findings of an independent study of the current state of readiness in the NHS.

2. The concept and underlying principles of revalidation were set out in the Chief Medical Officer for England’s consultation document Good doctors, safer patients and adopted in the United Kingdom Government’s White Paper on professional regulation, Trust Assurance and Safety – The Regulation of Health Professionals in the 21st Century (February 2007).

3. The process of revalidation will involve two strands: relicensing (confirming that doctors practise in accordance with the General Medical Council’s generic standards) and recertification (confirming that doctors on the specialist and GP registers conform with standards appropriate for their specialty of medicine). There are five main challenges to implementation:

   **Logistic:** large numbers of doctors need to be covered by the scheme, which needs to encompass a great diversity of roles and practice settings, including the private sector and doctors working in industry and elsewhere.

   **Methodological:** valid, reliable, proportionate and fair systems need to be designed to set standards and to assess practice against them.

   **Connections:** a large number of systems and organisations examine the quality of healthcare in the NHS and many throw light on doctors’ performance and practice. Where appropriate, effective connections need to be made between them and the system of revalidation and there needs to be a concerted effort to avoid duplication and bureaucracy.

   **Information:** high quality data on clinical outcomes of care are vital to effective assessment of clinical practice. These have been lacking in the past and must be developed more quickly, with an emphasis on accurate and verifiable data.

   **Cultural:** to be valued and valuable to doctors and patients, revalidation must be seen primarily as a mechanism for quality improvement and not merely spotting ‘bad apples’. The involvement of patients and the public will greatly enhance the quality of the process of revalidation and help promote public confidence in the profession itself.
5. The relicensing component of revalidation will rely on annual locally-based appraisal informed by, amongst other evidence, periodic multi-source feedback.

6. Two main points came out of the group’s discussion on appraisal. First, current NHS appraisal is patchy and not fit for relicensing across the country as a whole. Secondly, systems of appraisal reflect the diversity of practice settings and employers of doctors. It would be inappropriate and infeasible to impose a new standardised model of appraisal everywhere.

7. To address this, the system will require that a standardised module of appraisal, agreed by the GMC, should be included in all appraisal systems. The other aspects of appraisal will be a matter for local employers. This standardised module will be derived from the GMC’s Good Medical Practice.

8. The recertification component of revalidation will involve the specification of a clear set of standards formulated by each medical Royal College working in collaboration with Specialist Associations and others. Methodologies for evaluating specialist practice will vary but will need to be rooted in the evidence of doctors’ actual practice and will need to be proportionate to the benefit they bring. They could also, in some circumstances, involve the use of simulators and workstations, building on the most modern training assessment methods, although it will be important to avoid a single high stakes test and to ensure it is part of a wider assessment of practice over the five year period of revalidation.

9. It will be important that there are clear links and overlaps between the form of review of practice in relicensing and that in recertification. It would not make sense for example to examine only the generic aspects of a doctor’s practice for relicensing and ignore their local performance in their specialist role. In order to bind these elements together, and ensure a process that is both fair and efficient, the GMC will need to receive a single recommendation for revalidation that covers both relicensing and recertification.

10. At a local level, the Responsible Officer, usually the medical director or equivalent, will ensure that appraisal is carried out to a good standard; work with doctors to support them in addressing any shortfalls; ensure any concerns or complaints have been addressed; and collate this information to support a recommendation on the revalidation of individual doctors to the GMC. Arrangements are being agreed to ensure that all doctors can relate to an appropriate Responsible Officer whatever environment they are working in.

11. In England, the GMC will be conducting pilots this year to explore and develop the role of the regional GMC Affiliate. The work to design detailed arrangements for delivery will also seek to develop and clarify the respective roles, in England, of the
Care Quality Commission, the GMC Affiliates, Responsible Officers and the Regional Medical Regulation Support Team in providing independent assurance of the quality and consistency of local appraisal and clinical governance systems that underpin revalidation decisions. Scotland will consider the GMC Affiliate role in the light of English piloting.

12. Just as revalidation for the individual doctor will be a process rather than an event, so too will the introduction of the system of revalidation. The roll out of both relicensure and recertification will be incremental, as the capacity and capability of local clinical governance and appraisal systems develops and as the standards and assessment work of individual Royal Colleges is completed. To ensure effective, proportionate and sensitive introduction of these systems, many aspects will be piloted, evaluated and adapted prior to implementation. A preliminary indicative timetable for roll out in England is set out in the document, envisaging the component parts of the system being put in place over the next 18 months to two years, with piloted initiation in early adopter sites, specialties and sectors in late 2009 and 2010, and spread across the country and all specialties gathering pace in subsequent years.
Introduction

The Working Group

1.1 The Medical Revalidation Working Group was one of seven working groups established to take forward the recommendations in the 2007 White Paper, Trust, Assurance and Safety - The Regulation of Health professionals in the 21st Century. The White Paper set out the key principles that will underpin the regulation of health professionals over the next decade.

1.2 The group’s primary objective was to set out the way forward to implement the White Paper’s intention to introduce a new model of revalidation. The group’s members had been invited both as the leaders of key organisations and for their personal practical experience of the issues. The group met five times between July 2007 and February 2008. The meetings were used to discuss and refine the key components of revalidation and to examine and resolve concerns and potential problems in order to identify practical steps that would support the development of an implementation strategy by the key stakeholders. These include the Department of Health in England, the Devolved Administrations, the General Medical Council, the Academy of Medical Royal Colleges, NHS employers, commissioners, the private sector and the BMA.

1.3 The group received papers and presentations on the underlying themes and key issues. Minutes of all five meetings, terms of reference, and group membership are available on the Department of Health’s website at:


1.4 The Department of Health and the General Medical Council jointly commissioned KPMG to undertake a review of the state of readiness of clinical governance and medical appraisal to support the implementation of medical relicensure. They found that the description of both clinical governance and medical appraisal as ‘patchy’ in England and across practice areas was substantially accurate. The necessary foundations, structures and organisational arrangements for clinical governance are, however, in place in virtually all hospital trusts, although primary care arrangements needed strengthening in a number of parts of the country. The profession now regards annual appraisal, with its current formative purpose, positively and at the consultant and general practitioner level, it is widely practised. The intention is that, whatever the current state of readiness for revalidation, the drive to implement will continue to improve clinical governance systems until they are capable of delivering effective appraisal and revalidation.
The Purpose of Revalidation

1.5 The purpose of revalidation is to ensure that licensed doctors remain up to date and continue to be fit to practise. Revalidation has three elements:

- to confirm that licensed doctors practise in accordance with the GMC’s generic standards (relicensure);

- for doctors on the specialist register and GP register, to confirm that they meet the standards appropriate for their specialty (recertification); and

- to identify for further investigation, and remediation, poor practice where local systems are not robust enough to do this or do not exist.

1.6 Revalidation also:

- gives further focus and energy to doctors’ desire to keep up to date and improve their practice, through continuous professional development and reflective practice;

- aims to sustain and enhance public confidence in the profession as a whole by providing periodic assurance that doctors continue to be fit to practise;

- provides a process through which doctors who may fall short of professional standards in some respects can be supported in addressing them;

- acts as a driver for local clinical governance processes to provide the opportunity for a doctor to demonstrate they reach acceptable standards, to allow informed judgements about individual performance;

- identifies the small proportion of professionals who are unable to remedy significant shortfalls in their standards of practice and remove them from the register of doctors;

- lets the voice of patients and colleagues be brought in to reflective practice and the assessment and development of doctors’ practice; and

- is one of several mechanisms for improving the quality and reducing the risks of patient care, all of which must act in concert.
The Shape of Revalidation

1.7 For doctors, the White Paper largely endorsed proposals for revalidation made by the CMO for England in Good doctors, safer patients. 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. We are aware that there are a large number of doctors working in the UK who are not on the specialist or GP register or in substantive training posts. Although they will not be required to recertify from the outset, medical specialties are in the process of developing standards for specialist practice that should be applicable to this group of doctors, enabling their specialist practice to be revalidated in the future. 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.

1.8 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.

1.9 Recertification will be based on standards for specialist practice set by the medical Royal Colleges, working with the Specialty Associations, and approved by the General Medical Council (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.

1.10 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.

1.11 Revalidation will be introduced following a series of pilot exercises to develop the best models for its component elements, and proposals will be adapted in the light of learning from evaluation of those pilots. A joint GMC and Academy of Medical Royal Colleges group has been established to:

- support the development of revalidation processes; and
• consider the practical issues about how the whole process will knit together in a coherent, unbureaucratic and proportionate manner.

1.12 The Department of Health has provided £3.9m in grant funding to the Academy of Medical Royal Colleges for a project to:

• enable the development of standards and tools for re-certification; test these tools and standards against the needs of patients and healthcare providers;

• consult with all relevant stakeholders during the development process; work towards developing the first phase of secure, confidential and user-friendly information technology tools to support the recertification system;

• evaluate the likely cost of installing and administering recertification tools; and

• develop detailed arrangements with the GMC to ensure doctors meet the requirements for remaining on the appropriate part of the medical register.

Challenges

1.13 There are 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.
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- **The cultural challenge** is to allay fears and to create a climate and set of attitudes whereby revalidation is primarily a dynamic 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.

**Appraisal**

2.1 The key challenge for implementation is to agree and deliver a new component of appraisal that provides a valid evidence base for revalidation which doctors understand, accept and value.

2.2 In the NHS, appraisal is patchy geographically and is not fit for the purpose of relicensing across the country as a whole. Current systems of appraisal reflect the diversity of practice settings and employers and commissioners of doctors. It would be inappropriate and not feasible to impose a new standardised model of appraisal everywhere. To address this, the system will require that a standardised module of appraisal, agreed by the GMC, should be included in all appraisal systems. The other aspects of appraisal will be a matter for local employers and those who contract with doctors. This standardised module will be derived from *Good Medical Practice*. Initially the revalidation module will simply ensure that appraisal, together with other evidence, informs a judgement on whether the evidence presented supports revalidation or not over the five years of a revalidation cycle and gives doctors feedback on areas of their practice that may need development.

2.3 The new model will require further detailed discussion with stakeholders about practicalities but the key elements will be:

- a GMC designed and approved *Good Medical Practice* module, used in every appraisal scheme, whatever the setting, if the doctor wishes to retain a license to practice;

- in England, Primary Care Trusts contracts with providers should require their medical staff to undertake appraisal. There is already a requirement in the English Performers List Regulations that General Practitioners will participate in the Primary Care Trusts appraisal system; and

- in England, the Care Quality Commission would require the new system of appraisal to support revalidation as part of its registration requirements.
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2.4 Administrations in Scotland, Wales and Northern Ireland will work with the GMC, the Academy of Medical Royal Colleges and the Department of Health for England to agree appropriate systems that are consistent in outcome across the United Kingdom, whilst reflecting the different processes and systems in different parts of the United Kingdom.

2.5 Annual appraisal as a primary basis for revalidation brings particular value because:

- as an annual process within a five year revalidation cycle, it will provide useful punctuation marks to review progress towards revalidation, with opportunities to remediate any potential issues at an early stage;

- it will help to identify any problems quickly and enable doctors, employers and those who contract with doctors to deal with them effectively locally;

- it will inform both relicensure and recertification, binding the two strands into one process; and

- if carefully agreed and sensitively implemented, it will continue to provide a predominantly formative facility for doctors, with the core module concurrently supporting them to provide the evidence of the fitness to practise required for revalidation.

2.6 The GMC has made good progress on translating Good Medical Practice into a framework against which individual doctor’s practice can be appraised and objectively assessed and has completed a consultation on a framework that will form the foundation for the core appraisal module in all settings in which doctors practise. The appraisal module will include detailed attributes in four key areas:

- knowledge, skills and performance;

- safety and quality;

- communication, partnership and teamwork; and

- maintaining trust.

2.7 The module will set out for each attribute in each area the types of evidence – for example clinical information, clinical audit, Continuing Professional Development, evidence from training or assessment, record keeping, logbooks – which might be drawn on by appraisers to inform judgements about the doctor’s continuing fitness to practise. The Royal Colleges are developing specialty specific versions of Good
Medical Practice that would also inform those elements of appraisal that will support specialist recertification.

2.8 In addition, some members of the working group felt that for each domain, appraisers might indicate whether the doctor was excellent, satisfactory, or in need of improvement and development to ensure future revalidation. Given the level of professional concern in some quarters about a graded assessment of their practice, and a perception amongst some that revalidation is intended as a system to “catch them out”, appraisal will initially simply provide an important component of the evidence to inform a recommendation for revalidation over the five-year cycle. The appraisal module will require that appraisers take a judgement on whether the appraisee has successfully presented the agreed essential evidence required to support revalidation, engaged in the appraisal, and produced a personal development plan relevant to their learning needs – in other words that they are progressing satisfactorily towards revalidation.

2.9 In England, the Department of Health has established the NHS Revalidation Support Team, that was formerly the Clinical Governance Support Team, to provide expert professional leadership for the design and delivery of new appraisal arrangements in England. They will work closely with stakeholders on the piloting, evaluation and implementation of appraisal, and ensure that the professions, employers and commissioners are informed and involved in both design and rollout of the new arrangements. The Revalidation Support Team will also consider the BMA’s proposals on job-planning for secondary care. The team will work closely with the Devolved Administrations to ensure consistency of approach where possible and appropriate.

2.10 The Department of Health will ask the NHS Revalidation Support Team to develop a pilot in England to explore whether a more graded approach to appraisal might strengthen the formative and developmental core of appraisal as an aid to reflective practice. The primary focus of revalidation must be to support doctors to develop their own talents, rather than solely to detect the small proportion of doctors who cause concern. The pilot will explore how a more graded assessment might inform the developmental component of appraisal, shape continuous professional development for the individual and “talent management” in clinical teams and organisations. The BMA and other professional organisations would be fully involved in the design, piloting and independent evaluation of the pilot.

2.11 The next stage is for the four UK Health Departments, the NHS across the UK, the GMC and the professions, in partnership with patients and the public, to discuss with employers and commissioners and agree the process of roll out. The GMC has already published and consulted on the Good Medical Practice module.
In England, the Department of Health has commissioned a small team, from the former Clinical Governance Support Team, to lead the work in partnership with the Devolved Administrations, patients, the profession, the GMC and other key stakeholders. Some of the key issues to be resolved are:

- the extent to which the new model diverges from current arrangements;
- the speed with which it is to be implemented;
- the information requirements;
- managing information about doctors who work in more than one specialty, site, contractor, commissioner or employer;
- the training of appraisers to carry out the new processes consistently and fairly; and
- the support that will need to be in place to enable its delivery.

2.12 The group also noted the concerns from General Practice that a number of PCTs in England had failed to fund appraisal for GPs because of other financial pressures. The group agreed that this would be unsustainable when formal revalidation arrangements were in place, noted that PCTs who failed to support appraisal were failing to meet a contractual requirement and thought it essential that any areas that were still remiss in this respect took urgent steps to ensure appropriate appraisal for GPs.

2.13 The Department of Health in England will be discussing with the GMC, the Colleges, the profession, the British Medical Association, the NHS, NHS Employers and other healthcare providers and commissioners, what support, training and infrastructure will be needed to enable the module to be introduced over time in a way that builds and sustains both professional and public confidence in the new system.

Multi-source feedback (MSF)

2.14 A range of patient and colleague questionnaires, often called “360° feedback”, have been developed by several different organisations and are either in use or are being researched across a number of specialties, sectors and countries. The task now is to

- secure agreement about the principles and criteria that these feedback tools must meet in order to be acceptable for relicensure purposes;
• agree the way such tools are administered;

• consider whether they can encompass the “whole practice” of doctors who work in multiple sites;

• agree how information from MSF will be fed back to individual doctors; and

• discuss whether MSF will be required for every appraisal, or only a proportion of them.

One possibility would be for such feedback only to be used at the beginning and end of a revalidation cycle, unless it raises issues of concern, in which case it might be repeated annually until such concerns are resolved. Many trusts already ensure annual MSF as part of local clinical governance processes.

2.15 The White Paper envisaged that the GMC would have an important role in quality assuring the processes that would lead to recommendations to relicense individual doctors, including the development of 360° multi source feedback tools. The participation of patients in the design of this process will be critical. A strong and clear voice for patients in the evaluation of performance is an essential component of the assurance that patients and the public need about the professionals to whom they entrust themselves. Like the other component of appraisal and revalidation, that voice equally deserves to be underpinned by high quality evidence and the GMC will develop principles and criteria for these tools. They will seek expert advice on this and will consult widely before they are adopted. Although the GMC will wish to establish and approve the overall criteria and principles that any such tool will need to meet, in order to be acceptable for revalidation purposes, they will not approve individual questionnaires.

Licences to Practise

3.1 To enable relicensure, all doctors wishing to practise in the UK will first require a licence to practise. As a first step towards the introduction of revalidation, the GMC will issue licences to all doctors who require one during 2009. All doctors who hold a licence will be required to participate in revalidation. There are currently 240,000 doctors on the register of medical practitioners. It is estimated that about 150,000 of these are in active practice in the United Kingdom. The process of introducing licensing will help the GMC to identify the subset of registered doctors in active practice who will need to undergo revalidation.

3.2 All registered doctors will be entitled to be licensed to practise. Subject to Parliamentary agreement, in 2009 legislation will take effect to ensure that all
licensed doctors have adequate and appropriate indemnity insurance, something that is already a professional requirement. Although the clinical practice of a large number of doctors is covered by their employers, the GMC will ensure that these requirements are in place in advance of the issuing of licences so that doctors can confirm that they have the indemnity insurance cover that is appropriate to their practice.

3.3 The full significance of the new licensing scheme for doctors will not be felt until the process of revalidating doctors’ licences begins. But issuing licences to all those who need one will be the first step towards that goal, and requiring all doctors to have appropriate indemnity insurance in advance will provide further assurance and protection for patients.

3.4 Doctors who are currently registered with the GMC but do not wish to practise in the UK will not need a licence. They will not, however, be able to exercise any of the legal privileges associated with medical practice, such as prescribing or signing death certificates. Doctors who elect to hold registration only, without a licence, will not be subject to the requirements of revalidation as they will not be involved in practising medicine in any capacity in the UK, but they will be unable to exercise the legal privileges associated with medical practice.

3.5 Issuing licences will also provide a clear signal that revalidation is on the way and will help to make doctors aware that they will need to prepare for its introduction. For doctors, this means ensuring that they develop a folder of evidence to support their future revalidation. For NHS employers, contractors and those in the independent sector across all four countries, it means ensuring that systems of local clinical governance, quality assurance and appraisal are sufficiently robust to facilitate doctors’ revalidation by providing a positive affirmation of their fitness to practise.

3.6 For retired doctors, the Department of Health in England has considered carefully arguments that they should retain limited prescribing rights without having to provide evidence to the GMC that they remain fit to practise. Good Medical Practice, based on extensive consultation with the profession, patients and the public is clear that doctors should not prescribe to themselves, their friends or their families. The Government agrees that for public confidence and patient safety, doctors’ prescribing privileges need to be balanced by a responsibility to demonstrate that they are up to date with current practise.

Relicensure

4.1 Doctors will need to renew their licence to practise every five years. Relicensure should be seen as confirmation of fitness to practise based on
information about performance derived from the workplace. The GMC will audit the evidence on which revalidation decisions are based. In England, the Department of Health has consulted on draft licensing requirements for healthcare providers that require that healthcare organisations have in place systems of clinical governance and appraisal that are fit for purpose for revalidation.

4.2 Relicensure will be based on assessments based on judgements against the criteria in a new module of the GMC’s Good Medical Practice. This will be embedded within the annual appraisal schemes of doctors and will draw on a range of evidence brought together through appraisal, including evidence from local clinical governance processes, (including evidence from other sites where doctors practise, to include audits, multi-source feedback, and complaints or concerns about the doctor’s performance

4.3 The quality of the medical register, as a definitive list of doctors who are fit to practise, is directly related to the quality of information about doctors derived from their employers and commissioners. The GMC, as a central regulatory body, cannot directly supervise, inspect and evaluate the work of the 150,000 doctors who are engaged in clinical practice. High quality relicensure depends on good local systems of clinical governance where doctors practise. It is only at local level where there are people who are sufficiently familiar with individual doctors to make well-informed judgements about their work.

4.4 It would be unreasonable for the GMC to seek additional information beyond that needed by employers or commissioners to assure themselves of the quality of care provided by the doctors that they employ, or with whom they contract. So many of the proposals set out in the framework in this document are essentially about strengthening local clinical governance and appraisal systems to ensure that they are fit for purpose for employers, commissioners and others who contract with doctors. The by-product of those enhancements is to provide better evidence and assurance for the integrity of the medical register.

4.5 The arrangements for the respective roles of employers, providers, commissioners, Responsible Officers, Affiliates (in England), local clinical governance committees and other local and regional players in making final submissions to the GMC on recommendations for revalidation will need to be carefully designed and tested to ensure that arrangements are fair, unbureaucratic and robust.

4.6 Legislation will provide for the withdrawal by the GMC of a licence to practise where a doctor does not provide the GMC with information it reasonably asks for in order to determine whether the doctor should be revalidated. Such decisions will be subject to an appeal process.
Recertification

5.1 All doctors wishing to practise in the United Kingdom will be required to renew their licence every five years by undertaking relicensure. In addition, doctors on the GP register or the specialist register and those doctors working in the UK who are not on those registers or in substantive training posts will need to demonstrate that they continue to meet the standards that apply to their medical specialty to achieve recertification.

5.2 The Academy of Medical Royal Colleges, the individual Royal Colleges and specialist societies will have a central role in setting standards for recertification and designing the methods by which doctors will be evaluated against those standards. The GMC have to agree the proposed standards and methods of evaluation because of its responsibility for the integrity of the register. The evidence required for recertification will need to be proportionate to avoid unnecessary costs and bureaucracy.

5.3 The GMC has developed the following principles for use in reviewing and approving the standards and processes of evaluation proposed by the Colleges. These principles have been tested with the Academy and the Colleges:

- recertification must command the confidence of the GMC’s four key interest groups in England, Scotland, Wales and Northern Ireland:
  - patients and the public;
  - the profession;
  - the NHS and other healthcare providers; and
  - the medical Royal Colleges.

- individual Colleges and Faculties, and specialist associations, should consider how doctors could best produce evidence for their specialty;

- Colleges and Faculties working in collaboration with specialist associations, will be responsible for defining the standards appropriate to a specialty, or area of practice, and the methods used to assess them;

- evidence should be drawn from a range of sources and activities;

- appropriate standards, evaluation schemes, arrangements for monitoring and delivery, and quality assurance must be in place before a recertification scheme is approved by the GMC;
• decision making processes and procedures for recertification must be fair, objective, transparent, and free from unfair discrimination;

• doctors will not need to be members of Colleges to undertake recertification;

• as far as practicable, recertification will coincide with relicensure for doctors on the Specialist Register or GP Register and those doctors working in the UK who are not on those registers or in substantive training posts; and

• schemes for recertification must be monitored and the evaluation methods kept under review, amended and updated as appropriate.

Standards for recertification

5.4 It is important that the processes that lead to recertification offer assurance that doctors have appropriate skills and competencies. The standards for remaining on the Specialist Register and the GP Register will be the same as the standards currently required for entry to those registers. It would seem unhelpful however, to achieve this through a broad spectrum test of knowledge and skills. Work will be required to establish what standards are to be expected of a doctor, relating to the context of their work, even within apparently close levels of specialism. There may be circumstances in which the evaluation for recertification will need to be individually designed.

5.5 It is important for fairness of evaluation and manageability of delivery, that the evidence to support recertification is gathered over the whole of the revalidation cycle and is not dependent on one single "big day" of assessment.

5.6 The Academy of Medical Royal Colleges has established a development group, supported by £3.9m grant aid from the Department of Health in England, to work in partnership with the Colleges to design and agree the evaluation methods that will support specialist recertification.

5.7 The roll out proposals will have to consider carefully the respective roles of the Royal Colleges, employers, commissioners Responsible Officers, Affiliates (in England), local clinical governance committees and other local and regional players in signing off recertification recommendations. Whilst some may express disappointment that this report does not seek to specify these detailed processes, it is vital that they are tried and tested and agreed in practice to ensure they are fair, effective, proportionate and robust.
The relationship between relicensure and recertification

5.8 Revalidation is not simply a matter of applying *Good Medical Practice* separated in generic practice terms for relicensure and specialist practice for recertification. Whilst the broad distinction between relicensure as a local process of performance review, and recertification as a College-led process is helpful, there are significant areas of overlap.

5.9 For doctors on the GP register or the specialist register, relicensure and recertification should form intertwined strands of a single process in which there is an evaluation of their actual practice. For this reason, they should not be seen as separate activities in which a doctor whose practice gives rise to serious concerns might fail recertification but retain his licence to practise in other areas.

5.10 Equally, there is a clear need to minimise any burdens associated with revalidation. The process of relicensure and recertification will draw on largely the same evidence. For example, the CPD requirements that a doctor meets in order to comply with the relevant specialty standards for the purposes of recertification might also form part of the evidence requirements for relicensing.

5.11 For a doctor, there will be a single evaluation of whether they should be revalidated. Much of the evidence to support this process must be drawn from the workplace through the Responsible Officer, and informed by the specialty standards and evaluation methods developed by the Colleges. Detailed work is needed on how the roles of the Colleges, the GMC and the responsible officer are brought together within this process, but the Colleges will need to retain a clear accountability for ensuring that any local processes which inform revalidation of specialists and GPs are fair, effective and fit for purpose. The process will vary from specialty to specialty and will need to be piloted carefully, both to ensure fair and effective arrangements for individual doctors, but also to ensure that arrangements in one specialty are not especially onerous or relatively undemanding compared to those of others. The GMC and the Academy have established a steering group to lead this work. It is important however, that decisions are not taken by individuals in isolation or based on informal discussion and agreements. Clear accountability for these important matters must be in place.

5.12 Over time, it is envisaged that the assessment of clinical performance will make much greater use of valid, publicly available outcome data. It is appreciated that much more developmental work is needed to make this possible across all fields of medicine but is a need that will constantly be kept under review.
Continuing Professional Development

6.1 Continuing professional development (CPD) is the process by which individual doctors keep themselves up to date and maintain the highest standard of professional practice. Participation in CPD will be an important means for doctors to demonstrate their continuing fitness to practice. CPD belongs to the individual, but there is a need for the organised collection of evidence of appropriate activity, together with some audit of the adequacy of any individual’s programme. To facilitate these requirements, the Colleges and Faculties of the Academy of Medical Royal Colleges have developed CPD schemes.

6.2 It would be easier for those involved in appraisal and revalidation if variations were confined to what doctors did rather than how they recorded their CPD. This could be achieved by adopting a common framework. Ideally, such a framework should be as simple as possible. As CPD schemes evolve, they will increasingly focus on the outcome of an individual’s programme in terms of its effect on clinical practice.

6.3 It will be desirable to increase the linkage between CPD and appraisal. Appraisal focuses on meeting agreed educational objectives. Monitored systems which define College or Faculty approved educational activities may assist the meeting of those objectives. Presently most College or Faculty schemes are based on acquiring credits. The advantage of this system is that the time devoted to CPD can be measured and recorded. The disadvantage is that it is insensitive to the quality and relevance of the various CPD activities. The more that credits can encompass the value of the learning and not simply the time spent engaged in CPD, the more it will be valued by doctors and the better a measure it will be of their CPD activities.

6.4 Effective CPD schemes are flexible and largely based on self-evaluation. This lets doctors develop what they do in the context of their individual professional practice while providing evidence for external scrutiny. There is no single correct way of doing CPD. The methods chosen will depend on spheres of practice, learning styles and personal preference.

6.5 The principles underpinning CPD schemes therefore need to be as simple as possible while providing a good foundation on which to build an appropriate portfolio unique to the individual doctor.

Responsible Officers

7.1 The concept of the “Responsible Officer” was set out in Good doctors, safer patients and developed further in the White Paper. The Department of Health in
England is publishing a consultation document on Responsible Officers together with this report. In England, the Responsible Officer will be a senior doctor in a healthcare organisation, normally, but not always, the Medical Director, who takes personal responsibility for those aspects of the local clinical governance system which deal with the performance and conduct of doctors. ROs and GMC affiliates should liaise with the Royal Colleges and Faculties.

7.2 In addition, Responsible Officers in England will have responsibility for the local processes relating to:

- the recruitment of medical staff;
- annual appraisal and multi-source feedback;
- monitoring indicators of clinical performance;
- handling complaints and concerns relating to the conduct and performance of individual doctors, and, where appropriate, referring on to the GMC for further action; and:
- collating the information from all these potential sources in order to support a recommendation on revalidation.

7.3 For revalidation, every doctor in the United Kingdom will need to relate to one, and only one, Responsible Officer. In most cases in England this will be the Responsible Officer of their principal employer or, for doctors in primary care, their Primary Care Organisation. The primary legislation however allows for other possibilities, for instance:

- in England, doctors who work purely in private self-employed practice could relate to the Responsible Officer of the primary care organisation in which most of their practice is performed; and

- organisations which employ too few doctors to provide their own Responsible Officer may make arrangements with another healthcare organisation to provide oversight by a suitable senior doctor.

7.4 Revalidation is a continuous five-year process. The Responsible Officer will therefore need systems to review the practice and conduct of all the doctors for whom they are responsible. Where significant concerns are raised, the Responsible Officer will need to ensure that they, or another senior doctor, review the evidence to decide whether there is an issue which could put revalidation at risk and, if so, what remedial or developmental action is needed.
7.5 Provided this has been done, the Responsible Officer’s role in relation to the five-yearly revalidation cycle should consist of a final check that:

- successive appraisals and multi-source feedback support revalidation; and
- any concerns flagged up during the intervening five years have been resolved and any remedial action completed.

The GMC Affiliate

8.1 The White Paper outlined a model of GMC Affiliates in England who would provide a link between national and local workplace regulation. Thinking about the precise role of affiliates has been developed further since publication in the light of comments from the profession, commissioners, employers and the GMC. Initial piloting in England of the Affiliates concept in 2008 will begin to test ideas about the range of activities where they could add value and help to clarify the potential relationship between the Affiliate and local governance systems. In these first pilots in England, the functions of the Affiliates will include:

- providing advice on whether particular issues fall most appropriately to be dealt with by the GMC or by local procedures;
- providing guidance and assistance to Responsible Officers, medical directors and complaints managers;
- facilitating case conferences;
- developing relationships with the Responsible Officers; and
- supporting the work of the Regional Medical Regulation Support Teams.

8.2 Further piloting will help to develop better understanding of the scope for the Affiliates to support Responsible Officers in the context of revalidation in England and for helping to promote consistency of approach in local systems. Affiliates will be one part of locally owned and led Regional Medical Regulation Support Teams that will help to support effective local clinical governance. These teams will bring together the Affiliates and representatives from primary and acute NHS care, the private sector, the National Clinical Assessment Service, the systems regulator, and the Deanery as well as the Responsible Officers.
Risk Based Regulation

9.1 Medical regulation is at its most effective when national and local workplace regulation are individually robust and properly connected. Many of the initiatives discussed in this report, such as the role of regional Affiliates and the establishment of Responsible Officers, are aimed specifically at reinforcing the individual elements of regulation and plugging the gap that has existed between local and national action. The robustness of local systems in the form of local clinical governance and appraisal, whilst improving, is patchy, and the connection between national and workplace regulation remains imperfect.

9.2 Where local systems are strong and capable of supporting good medical practice and identifying emerging signs of poor practice, then the risk for patients will be low and the need for intervention by the national regulator will also be correspondingly low. Conversely, where local systems are weak the national regulator must apply a greater level of scrutiny in order to minimise the regulatory risks. This does not mean that poorly run healthcare organisations can be “let off the hook”

9.3 The GMC must be in a position to act where local systems are weak or absent and the potential for risk to patient safety is at its highest. In part, this is about the GMC using regulatory tools to help identify outlying low performance. Alongside this, there needs to be a better understanding of:

• the factors that may predispose doctors to future serious impairment;
• the indicators of actual serious impairment; and
• the patterns of complaints which point to areas of high risk practice.

9.4 The GMC has commissioned a series of research projects to help it consider these issues. This will not be a quick fix, but over time it will inform more risk based regulatory strategies at national and local level.

Patient Involvement

10.1 Patients should not be seen as passive recipients of healthcare interventions chosen and delivered by health professionals. Patients and carers have a vital role to play in helping to define what counts as good healthcare and good health professionals and in drawing attention to unacceptable standards of care. Increased patient involvement and participation in their healthcare brings:
• increased patient safety;

• more effective management of long-term conditions; and

• better identification of poor performance, especially in communication skills.

10.2 The purpose of revalidation is not only to protect patients and raise standards of care, but also to reassure the public and maintain their confidence in the profession. It is important therefore, that the patient and public voice is strongly heard, both in designing the mechanisms for revalidation and in the actual process of revalidating individual doctors.

10.3 Patients have an important contribution to make on how well a doctor performs in relation to:

• effective communication, including listening, informing and explaining;

• involving patients in treatment decisions;

• care coordination and support for self-care; and

• showing respect for patients and treating them with dignity.

10.4 Well-designed and carefully implemented patient questionnaires are one means of collecting this information. These should form an important component of 360° feedback. Few members of the public understand professional regulation and they tend to assume that current processes are more robust than they actually are. It will be important to develop an effective means of disseminating information to the public about the new procedures. Knowledgeable lay or patient representatives have already been involved in thinking about these issues. It will be important to engage them in helping to design revalidation processes and evaluation to ensure these reflect the patient’s perspective. Equally, doctors will need to be assured that the feedback tools represent a fair and evidence-based means for contributing to their overall revalidation over the five-year cycle.

10.5 Priorities include:

• engaging patients and lay people in developing the detailed plans for revalidation;

• ensuring professional confidence in the use of multi-source feedback in their appraisal and revalidation;
• developing a communications strategy to inform the public about the new developments and ensuring they know who to go to if they have concerns or complaints; and

• reassuring the public that revalidation is only one part of the continuum of clinical governance and performance management and not the only way of identifying poor performance.

Involvement of Employers and those who contract with Doctors

11.1 Good alignment between an employing, contracting or commissioning organisation and its professionals will be important to effective revalidation. Revalidation will not be a tool for weeding out professionals who are perceived to be managerially difficult or uncooperative. That said, revalidation, in helping to reconcile regulatory, clinical governance, patient, employer, contractor and commissioner concerns into an assessment of the work of the doctor, should help to ensure that all are focussed on the common aspiration of safe and effective practice.

11.2 The introduction of revalidation will present many practical challenges to employers, contractors and commissioners in order to secure the benefits that it will bring. In drawing up the detailed proposals, the GMC, the four UK Health Department and the Royal Colleges will need to work closely with commissioners, contractors and employers, both NHS and private sector, to ensure that the pace, nature and depth of the arrangements are manageable. Equally, employers, commissioners, and private hospitals that contract with doctors will need to ensure that they have the capacity in place to enable delivery at a pace that is in keeping with the expectations of the public, patients and the professions.

Incremental Delivery

12.1 A successful system of revalidation will be crucially dependent upon robust, quality assured, local systems capable of delivering two key requirements:

• early detection of, and effective action on, actual and emerging impaired practice. Action should be taken as soon as impairment is suspected and should not be artificially delayed until the doctor’s appraisal, and certainly should not wait until the doctor’s licence to practise is scheduled for revalidation; and

• robust, quality assured, recommendations to support GMC decisions in relation to individual doctors, based on evidence derived, as far as practicable, from day to day practice.
12.2 Early thinking about the roll out of revalidation was that during the first five-year cycle, twenty per cent of licensed doctors would be called for revalidation each year. The order would be randomised, probably using the penultimate digit of doctors’ GMC reference numbers. This randomised approach is easily understood by doctors and is perceived by their representatives to be fair. However, the randomised approach was based on an assumption that local systems within the NHS and other healthcare providers across the UK would be uniformly ready to support revalidation. The KPMG report prepared for the Working Group confirms that key elements, such as effective clinical governance and appraisal capable of delivering a reliable judgement, are not consistently embedded across the UK.

12.3 Implementing revalidation in this way now would risk a high proportion of doctors failing to meet the requirements for revalidation unfairly, because the local systems within which they work are unable to generate the evidence based, ‘positive affirmation’ of their fitness to practise that the White Paper requires. Given the general acceptance of the need to make progress, and the perception that further delay will militate against the strengthening of appraisal and clinical governance, the Working Group has concluded that an incremental roll out offers the most practical way forward. This will mean starting relicensure where local systems of appraisal and clinical governance are well developed and fit for purpose.

12.4 Similarly, the development by the Medical Royal Colleges and Faculties of the standards and evaluation tools necessary to support recertification will take time. They are at different stages of readiness. This points to the need to make early progress where standards and evaluation tools are sufficiently developed. The Working Group has therefore concluded that an incremental approach to the roll out of recertification offers the most practical way forward, beginning where preparations by individual Royal Colleges and Faculties are well advanced.

12.5 A managed, targeted approach might take a number of forms:

- by geographical location;
- by field of practice, by grade;
- by working environment;
- by primary or secondary care;
- country by country; and
• it might involve voluntary participation by institutions or individuals supported by incentives.

12.6 Further analysis will be undertaken of how to translate a managed, targeted approach into practice, taking account of patient safety, fairness, the potential of questionnaires, timeliness and cost effectiveness.

**Consistent Assurance Through Different Routes**

13.1 The GMC, the Department of Health and the Royal Colleges will need to work closely with the Devolved Administrations in the United Kingdom to ensure that different means of delivering evidence to support revalidation deliver consistent assurance within a United Kingdom regulatory framework for medicine in both the public and private sectors.

13.2 Within England, an increasingly devolved system of delivery in the NHS means that, with greater flexibility at the frontline and greater autonomy for Foundation Trusts, the Government will devolve responsibility for many aspects of care to local commissioners and services. For the core basic requirements of healthcare in a national service, of which patient safety is key element, all providers who contract to provide care to NHS patients will be expected to meet core standards as the foundation of their license to operate.

13.3 The assurance of the quality of the professional workforce is central to public confidence and patient safety. Both the Department of Health in England and the General Medical Council will ask healthcare providers to put in place the investment, leadership and management time needed to deliver revalidation. The Department of Health in England will be discussing with the NHS, the private sector, the GMC, the Royal Colleges and others the most appropriate levers to ensure that a balance between professional regulation, national medical contracts, system regulation and local commissioning assures patient safety, public confidence and high professional standards.

13.4 While the NHS is the dominant employer and commissioner of doctors within the United Kingdom, it is not the sole employer or contractor. All four Health Departments and the General Medical Council have shared statutory duties to ensure that all doctors practising in the United Kingdom are fit to practise. There will need to be careful consultation with other employers, commissioners and agencies to ensure appropriate arrangements for, for example:

• the assurance of fitness to practise of locums;
• those working in the private sector;

• doctors working in the pharmaceutical industry;

• academic doctors; and

• doctors in Government and other settings in which the primary function of the role is based on the medical qualification and professionalism of the employee.

Next Steps

14.1 Revalidation represents the biggest change to medical regulation since 1858. The White Paper emphasises the need for careful implementation, based on good evidence and piloting. This report has described how the vision for revalidation set out in the White Paper has been developed and taken forward. It identifies much that has been achieved, but also a number of areas where further detailed work is required before revalidation can be implemented. All stakeholders recognise the need to make progress but the work must be carefully planned and the details rigorously piloted.

14.2 Several approaches to piloting will be needed to:

• test the concepts,

• evaluate the potential impact;

• describe the components and processes, and

• assess the state of readiness of the different sectors and localities.

14.3 Some of this work is already underway:

• the research on questionnaires has provided valuable early information on their validity and reliability;

• work has started to review the readiness of health boards in Wales to support the revalidation process. and

• other options are also being explored with individual Trusts, specialties and sectors.
14.4 The sense of urgency and desire to make progress must be balanced with the need to get it right. This points to a careful, incremental approach that enables all concerned to benefit from early learning and allows the revalidation model to be refined and strengthened as it matures. England, Scotland, Wales and Northern Ireland Administrations will work with the GMC, Royal Colleges, employers, commissioners, patients and other key stakeholders to use the pilots in 2008 and 2009 to achieve this.

14.5 The pilots will include further work on questionnaires and testing the use of the Good Medical Practice documents at [http://www.gmc-uk.org/guidance/good_medical_practice/index.aspx](http://www.gmc-uk.org/guidance/good_medical_practice/index.aspx). The GMC has been working closely with the Department of Health in England, and in consultation with a stakeholder advisory group, to develop a pilot on the role of affiliates and their interface with responsible officers. Details will be announced in the near future.

14.6 Processes must:

- be effective and efficient,
- be fair, open, transparent
- free from discrimination;
- command the confidence of patients, employers, commissioners and the profession; and
- engage with and draw on the expertise of the different stakeholder groups.

**Governance and Project Management**

14.7 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.

14.8 The key participants in the delivery of revalidation are:

- the General Medical Council, which leads the overall programme to ensure the continuing validity of its medical register;
Medical Revalidation – Principles and Next Steps

- the Department of Health in England, which seeks to ensure that the delivery of revalidation is consistent with the policy intentions of the United Kingdom White Paper;

- the Devolved Administrations, who seek to ensure that the delivery of revalidation is consistent with their national policy, structures and processes and who will also adapt appraisal and other arrangements, where necessary, to suit local circumstances;

- the Medical Royal Colleges, who are responsible for developing systems for specialist recertification;

- employers and commissioners, both public and private, who will be important delivery agents by ensuring the introduction of revised appraisal arrangements and Responsible Officers as well as supporting and enabling the provision of evidence for revalidation;

- the BMA, who will be important in assuring that the proposals have the support of individual doctors in the implementation of revalidation;

- patients and the public, to whom the proposals need to make sense and deliver real benefit; and

- doctors themselves, who will be required to provide the evidence needed to support their revalidation.

14.9 In England, the NHS Revalidation Support Team will be a key player in the design and delivery of the new system, focussing on the piloting and introduction of new appraisal arrangements. It will work closely with all stakeholders and identify and help to provide the support needed for sensitive and effective introduction of the new system.

14.10 The key participants intend to work together closely on this project, with shared risk and shared responsibility. Whilst the GMC owns revalidation of its register, the other key participants share the risk and the responsibility for ensuring its successful delivery. Although the final decision on all aspects of revalidation rests with the GMC, all participants have a common interest and common responsibility in supporting the GMC in its work.

14.11 It is proposed that the GMC establish an inclusive Programme Board to oversee the delivery of revalidation, encompassing the four UK administrations, the medical Royal Colleges, employers, commissioners, the BMA, patient representatives and the system regulators for the four countries. The GMC will
appoint an independent chair to assist in drawing in all responsible organisations into an effective team to deliver the programme.

14.12 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 Department of Health in England and the General Medical Council will jointly commission a Project Initiation Document to help to clarify programme processes, aims and objectives from the outset and to ensure clear attribution of roles, responsibilities and expectations to all the key revalidation partners. The GMC will discuss and agree detailed terms of reference and membership for their Board with stakeholders.

**Timetable for England**

15.1 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 timetable for England set out below is indicative and will require further refinement and revision as the detailed delivery arrangements are discussed and agreed. The Department of Health in England would welcome views on the provisional timetable set out below. The GMC will discuss with the Devolved Administrations how this timetable may need to differ in Scotland, Wales and Northern Ireland to reflect their different approaches and needs.

15.2 The key elements required for the implementation of revalidation are:

- a revised system of appraisal;
- a network of Responsible Officers;
- the issuing of licences to practise; and
- standards and assessment and evaluation methods for specialist recertification.

15.3 The table below sets out a provisional timetable for delivery of these components in England.
## Timetable for implementation of revalidation

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**Provisional Timetable for England**

15.4 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.

15.5 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.

15.6 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.

15.7 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.

15.8 The timetable therefore envisages the component parts of the system being put in place of 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.
Conclusion

16.1 The introduction of revalidation, as a significant change, is naturally a source of concern to some, but its benefits to doctors, patients, the public, commissioners and employers are potentially enormous. At governmental and national level it will require close cooperation between the administrations of the England, Scotland, Wales and Northern Ireland and with the GMC, the Academy of Medical Royal Colleges, the profession itself, employers and commissioners. At regional level, it will require close cooperation between local and regional players. At local level, it will require a change in the rigour of appraisal that will be significant and of concern for those who participate in it.

16.2 Revalidation will provide rigorous and evidence based assurance to patients that their positive view of their doctors is firmly based. It will provide more effective support to doctors in reflecting on their practice and developing their talents. It will help a small number of doctors to improve on those areas where they need help to meet the standards of their peers. It will provide the means to secure the investment in audit, appraisal and continuing professional development that doctors themselves seek. It will cement further the trust that the people of the United Kingdom have in the medical profession, and give doctors the ongoing means to sustain that trust. It will contribute to the quest to make health care both safer and higher quality.