



**Revalidation:
The way ahead**

Response to our revalidation consultation

**General
Medical
Council**

Regulating doctors
Ensuring good medical practice

Contents

Foreword	4
Executive summary	6
Background and overview	10
Section 1 – How revalidation will work	14
Section 2 – What doctors, employers and contractors of doctors' services will need to do	26
Section 3 – Patient and public involvement in revalidation	34
Section 4 – How and when revalidation will be introduced	40
Next steps	44
Appendix A – Glossary of terms, organisations and acronyms	46
Appendix B – List of the organisations that responded to the consultation	51
Appendix C – List of consultation engagement events	54

A detailed analysis of responses on a question by question basis is published in a separate document at Annex 1.

Foreword

We were enormously encouraged by the way in which so many doctors, employers, patients and members of the public responded so constructively to our consultation on revalidation.

We received nearly a thousand formal responses to our consultation and heard the views of many more people at a series of events that we held across the UK. These events gave us the opportunity to talk about the proposals with more than 4,000 doctors, to listen to their views and comments and, in some cases, discuss their concerns about how revalidation will work in practice. We are very grateful for the insight that they provided.

The vast majority of those who responded to our consultation told us that they supported our overall approach. It is also apparent from the thoughtful reactions we received that there is more work to be done if we are to ensure that revalidation works in practice.

The message we heard consistently was that it must be straightforward and proportionate and must not place excessive burdens on doctors or employers. We are committed to reviewing the proposals in the light of the responses and we are determined that revalidation should add value for both patients and doctors and must be workable in the pressured and busy environments in which most doctors work. It must not be a bureaucratic

and costly exercise that diverts doctors and employers away from the safety, care and treatment of patients.

Much has been said about the future of revalidation in recent months. I want you to know that delivering revalidation remains our number one priority. The UK Government has demonstrated its clear commitment to revalidation by agreeing to press ahead with the appointment of Responsible Officers, who will oversee the revalidation process for every licensed doctor. We will also continue to work with the Department of Health in England to ensure that we can embed the process within a revised structure for the delivery of primary care services.

Revalidation has been a long time coming – some would say too long. However, we are now moving into the implementation phase and we are looking forward to working with Responsible Officers and our other key partners to make revalidation a reality.

In my foreword to the consultation document in March I indicated that this was the 'start of a

process'; that we would need further input from the medical profession and others to ensure we got revalidation right. The consultation has shown that there is support for and interest in revalidation, and the challenge for us now is to build upon that. We will continue to engage with all those who will be affected to develop a system that not only works for doctors, employers and patients, but also commands their confidence.

Professor Sir Peter Rubin
Chair, General Medical Council



Executive summary

The General Medical Council undertook a consultation on its plans and proposals for revalidation between 1 March and 4 June 2010. This document reports on the outcome of that consultation. A detailed analysis of responses on a question by question basis is published in a separate document at Annex 1.

1. We received over 940 written responses to the consultation. Of these, around 700 were from individuals (mostly doctors) while the remainder were submitted on behalf of organisations or, in a few cases, groups of doctors. We received responses from representatives of all of our key interest groups across the four UK countries.
2. A statistical analysis of the responses we received shows that there were high levels of support for many of the proposals set out in the consultation.
3. In many cases, however, support for particular proposals needs to be considered alongside the more detailed feedback we received. Some verbatim comments are recorded in the analysis of responses in Sections 1 to 4 (pages 14 to 43) of this report. The full question by question analysis of responses contained in Annex 1 captures many more of the individual comments, concerns and suggestions that we received.
4. In addition to comments on particular consultation questions, many of the respondents also made general observations about revalidation, appraisal, clinical governance and Responsible Officers. A review of these comments indicated that, while many individual doctors and organisations may support or accept the introduction of revalidation, there are still concerns about how it will work in practice and when it should be introduced.
5. There were five key themes which emerged from the responses to the consultation. These were:
Theme 1 – Ensuring that revalidation is as streamlined, straightforward and proportionate as possible
6. A common concern was that some of the proposals in our consultation may be too complicated and aspirational. Respondents commented that the model for revalidation must be proportionate and realistic and must minimise the amount of time doctors have to spend away from patients.
7. These concerns relate, in particular, to the collection and collation of supporting information and seeking colleague and patient feedback. Many respondents questioned whether some of the supporting information suggested in the specialty and general practice frameworks was readily available.
8. It is clear from the responses that many individual doctors and many organisations, including employers, are concerned that some aspects of the proposals are potentially too complicated and onerous. We will be working with our key revalidation partners to review how the proposals and some of the components of revalidation can be streamlined.

Theme 2 – Ensuring the revalidation model is flexible

9. We received many responses from doctors in non-mainstream roles, raising concerns about how revalidation will work for them. These include locum doctors and sessional GPs, doctors working in the independent sector and doctors with portfolio careers.
10. Many respondents commented on the need to ensure that revalidation is flexible so that it will work for doctors in non-clinical and other non-mainstream roles. Respondents also commented on the difficulties that these doctors may face in accessing supporting information or obtaining colleague and patient feedback.
11. We understand the importance of ensuring that revalidation is sufficiently flexible to work for all licensed doctors. We have already carried out a scoping exercise to try to better understand the range of non-mainstream practice in which doctors engage and the particular issues that doctors may face in these specific areas. We will continue to work with our revalidation partners and to engage with non-mainstream doctors, their employers and representative organisations so that we can understand their particular concerns and try to ensure that we can deliver a system that is sufficiently flexible.

Theme 3 – Concerns about the potential costs of revalidation

12. Concerns about the potential costs of revalidation were raised both in the responses to the consultation and at a number of the engagement events. There were particular concerns about the costs of embedding local systems of clinical governance to support appraisal and the administration of colleague and patient questionnaires.

13. Some of the concerns about the potential costs of revalidation are closely linked with concerns about what are perceived to be some of the complexities of the proposals. We will be working with our revalidation partners to deliver a system that is proportionate, streamlined and cost effective. Proposals for revalidation are largely based on local systems of appraisal and clinical governance, which should already exist to support the professional development of doctors, and assure and improve the quality of care provided to patients.

Theme 4 – The need for further detail

14. Many respondents commented on the need for more detail about our proposals, including specific information on how they will be implemented in practice. In particular, respondents sought more detail about the process around the Responsible Officer recommendation to the GMC and the relationship between revalidation and the GMC's fitness to practise procedures. Respondents also sought more detail about the criteria we would apply to determine whether organisations are ready for revalidation.
15. As we take forward the various workstreams around revalidation, we will map out the processes in far more detail. We will need to work closely with our revalidation partners in taking much of this work forward.
16. We will continue to engage closely with doctors, employers and other key interests as we plan for implementation.

Theme 5 – The need for further testing and evaluation

17. Another theme apparent in many responses was the importance of sufficient testing before revalidation is introduced. Many respondents commented that it was vital to evaluate the current pilots before revalidation is rolled out. Respondents also commented that it would be important to further test some of the elements of revalidation, including the specialty supporting information.
18. The additional year of testing in England, announced by the Secretary of State for Health, provides an opportunity to gather further information about the practicalities, costs and benefits of the process. This will enable the Department of Health (England) to widen the scope of current testing to evaluate if the model is feasible and applicable for doctors working across different environments and with varied work patterns. In outlining the scope of any additional testing it will be vital to take into consideration the learning and evaluation of the previous and current pilots.

Looking forward

19. After reviewing the consultation feedback, it is clear that further work is required to refine a number of the proposals so that, together with our revalidation partners, we can deliver a model that is practical and proportionate and that has the confidence of the profession and employers, as well as patients and the public. The common themes that have emerged from our analysis will provide a useful starting point for further work with our revalidation partners.
20. In this report, we outline how we intend to take on board the feedback we have received. Specifically, we intend to do the following.

Streamline the process

- Work with the medical Royal Colleges and Faculties to review and streamline their specialty and general practice frameworks. The Colleges and Faculties will also work on consistent guidance that will help doctors across all specialties to demonstrate their practice using a range of supporting information, and clearly identify what information is 'expected' and what information is 'optional'.
- Refine the GMC framework for appraisal based on *Good Medical Practice (GMP)* to make it more flexible and ensure it covers all types of medical practice.
- Work with our delivery partners to ensure that all components of revalidation are integrated into a single process.

Make the process more flexible

- Develop proposals for how revalidation will work for doctors in non-clinical and non-mainstream roles.
- Continue to talk and listen to non-mainstream doctors and their organisations so that we can better understand the way they practise and the challenges they face.

Add more detail to our proposals

- Define how the medical register will show the field of medical practice that has provided the basis for a doctor's revalidation while continuing to recognise that many doctors practise across more than one discipline.
- Describe how doctors working in non-mainstream and non-clinical roles will revalidate.
- Explore options around quality assurance, including the potential involvement of systems regulators and a possible GMC programme of sampling and auditing.

Learn what works best for doctors and employers

- Examine the challenges that Responsible Officers may face in making recommendations in some circumstances. This will help us see where we might helpfully provide appraisers and Responsible Officers with guidance and information.
- Learn how our *GMP* Framework can be integrated successfully into appraisal. Many pilots are already showing a good degree of support for the use of the Framework as the basis for appraisal and revalidation.
- Understand how specialty practice can be best reflected in appraisal and revalidation and the appropriate supporting information to demonstrate this.
- Conduct a large-scale literature review looking at clinical governance and appraisal, clinical audit, patient and public involvement in the delivery of healthcare and the evaluation of health professionals' practice.
- Learn from the experiences and research of international and industry experts, holding an international symposium in early December 2010.

Start to plan for implementation

- Work with our partners to map out the process, timelines and key milestones for implementation including agreement on a start date.
- Work with our partners to develop medical appraisal and review the clinical governance systems that will need to be fit for purpose. As part of this, we will work with our partners to embed the *GMP* Framework into appraisal systems and develop guidance for employers to help them to do this.

- Develop mechanisms to identify and publicise good and best practice amongst healthcare organisations and Responsible Officers. We will also consider how we can support Responsible Officers to manage concerns about the practice of individual doctors early and effectively.
- Review our principles and criteria for colleague and patient questionnaires which will help organisations that are planning to develop, purchase or administer questionnaires.
- Develop and refine our proposals for assessing the readiness of organisations. This will include defining a series of key criteria and indicators for readiness.

Conclusion

21. The successful introduction of revalidation is a shared responsibility involving the GMC, the health departments in England, Northern Ireland, Scotland and Wales, the medical Royal Colleges, the Revalidation Support Team (RST) working with the NHS and other employers in England, and the medical profession. Looking ahead, this group of interested organisations and individuals will continue to work together to develop, test and implement a system of revalidation throughout the UK that is feasible, flexible, proportionate and cost effective.

Background and overview

This section provides an overview of our consultation and how we engaged with doctors, employers, patients and the public in the process. It also provides a high-level analysis of the responses that we received.

About revalidation

22. The way in which doctors are regulated is changing. Together with our key partners we have developed proposals for a new process to assure patients and the public, employers and other healthcare practitioners that licensed doctors are up to date and practising to the appropriate professional standards. The process is called revalidation. In future, all licensed doctors will need to revalidate regularly if they wish to keep their licence to practise.
23. Through local systems of clinical governance, effective appraisal and revalidation, the profession, employers and the GMC will be able to provide further assurance to patients and the public that doctors working in the UK are fit to practise.
24. Revalidation should provide a focus for doctors' efforts to maintain and improve their practice; facilitate the organisations in which doctors work to support them in keeping their practice up to date; and encourage patients and the public to provide feedback about the medical care they receive from doctors.

25. In the consultation document, we suggested that revalidation should be based, wherever possible, on existing activities, in particular appraisal and clinical governance, rather than new activities devised for the GMC's purposes. This approach would ensure that doctors engage in and support the process and should minimise additional costs and the time doctors have to spend away from patients.

Overview of the consultation

26. On 1 March 2010 we launched a consultation on the plans and proposals for revalidation. The consultation document was divided into four sections:
 - How revalidation will work
 - What doctors, employers and contractors of doctors' services will need to do
 - Patient and public involvement in revalidation
 - How and when revalidation will be introduced.

27. The purpose of the consultation was to obtain feedback on the plans and proposals for revalidation that had been developed by all key partners to date.
28. We sent details of the consultation to several thousand organisations. In addition, many of our revalidation partners, including the medical Royal Colleges, sent details of the consultation to their members or posted links to the consultation on their websites.
29. Interested parties were able to respond to the consultation in a number of ways: online through our consultation website, by email or by submitting a hard copy response.
30. We developed a number of resources to encourage participation in the consultation, including a toolkit and a series of consultation guides. The toolkit was designed to assist groups of doctors and employers to hold local sessions to discuss revalidation and contribute to the consultation.
31. During the consultation 14,500 people visited the consultation pages of our website and we distributed around 6,000 hard copies of the consultation document.

Communication and engagement

32. The consultation was supported by an extensive communication and engagement programme. Through the programme we aimed to:
 - raise awareness of revalidation and the consultation among target groups across the four UK countries
 - ensure that the consultation was accessible to all key interest groups
 - enhance the understanding of revalidation among doctors, employers and other key interests
 - ensure that our process for developing policy is based on openness, transparency and engagement
 - consolidate and strengthen our relationships with organisations that have an interest in revalidation and other regulatory reforms.
33. Our engagement programme enabled us to meet with a wide range of individuals and organisations. During the consultation we attended around 130 events, including conferences, presentations, workshops and meetings with individual organisations. We estimate that around 4,600 people attended these events.
34. We were able to discuss the proposals with doctors at all levels of the profession and in a wide range of sectors. We attended events involving doctors in a range of roles, including consultants, general practitioners, locums, trainees, medical students and staff and associate specialist doctors. We also met with a range of employers, medical directors, HR directors and locum agencies.

35. The engagement programme also enabled us to meet with both doctors and patients from a number of minority groups. We attended a number of events for black and minority ethnic doctors and met with representatives of doctors of specific religious faiths and also gay and lesbian doctors.
36. We held a number of public and patient focused events. We held two day-long events (in Leeds and London) in collaboration with National Voices, a coalition of over 200 health and social care organisations that aims to give a voice to patients and their carers. In Scotland, we held a series of patient and public workshops, involving a number of groups including those with hearing impairment, people with learning disabilities, minority ethnic carers and young people.
37. Feedback from those attending engagement events is included in the overall analysis and is reflected in this report and Annex 1.
38. We produced a special revalidation edition of *GMCtoday*, our newsletter for all doctors on the medical register. We broadcasted a series of revalidation podcasts aimed at patients and the public, doctors and employers.
39. A list of the consultation engagement events is included in Appendix C.

Analysis of responses

40. This section includes the profile of respondents to the consultation. It sets the context for the analysis of particular questions. The sections that follow this chapter set out the responses to individual questions. Many of the very detailed comments made in response to a number of the consultation questions cannot be captured in this report, but they will be invaluable in helping us take forward a number of the workstreams arising out of the consultation.
41. A more detailed question by question analysis of responses is contained in Annex 1, which is available as a separate document.

Overview of responses

42. We were delighted by the high levels of interest in the consultation, reflected in the numbers who attended the engagement events and the responses to the consultation.
43. We received over 940 written responses to the consultation. Of these, around 700 were from individuals (mostly doctors), while the remainder were submitted on behalf of organisations or, in a few cases, groups of doctors. We received a range of responses from all of our main key interest groups across the four UK countries (see Figure 1).

Figure 1: Breakdown of respondents by GMC key interest group

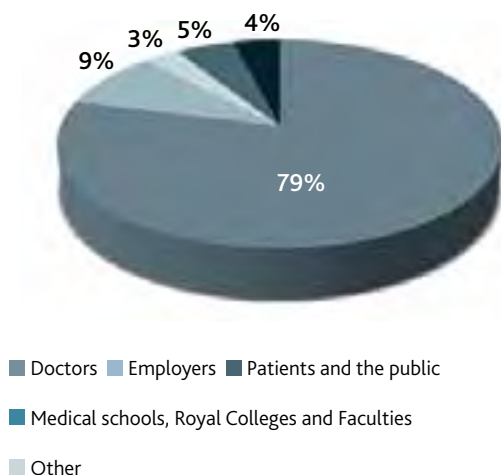
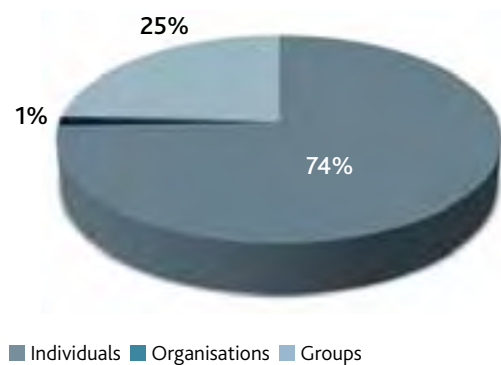


Figure 2: Breakdown of responses from individuals, groups and organisations



General comments on revalidation

- 44. The consultation was about how revalidation would work in practice and not about whether revalidation should happen. A minority of responses nonetheless expressed their underlying opposition to the concept of revalidation.
- 45. Looking at the responses as a whole, there is widespread support for revalidation and for many of our proposals. It is apparent in many of the responses, however, that while there is considerable support, we need to further refine the proposals for revalidation, in particular to take on board some of the underlying key issues and themes in the responses.
- 46. The executive summary outlined the key issues and themes arising from the feedback to the consultation. These were:
 - the need to ensure that revalidation is as streamlined, straightforward and proportionate as possible
 - the need to ensure that revalidation is flexible
 - concerns about the potential costs of revalidation
 - the need for further detail about how revalidation will work in practice
 - the importance of further testing and evaluation.

Section 1 – How revalidation will work

Section 1 of the consultation document contained eight questions which asked for views on proposals for how the revalidation process will work and how revalidation decisions will be made. The model is based on a continuing evaluation of a doctor's practice in the workplace.

A single process

47. Previous proposals divided revalidation into two elements – relicensing and recertification. Relicensing would apply to all doctors with a licence to practise, while doctors on the Specialist or GP Registers would also need to recertify. In our consultation we proposed a single process model.

What we asked

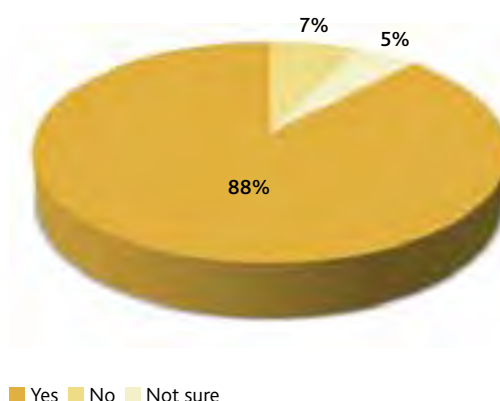
Question 1:

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

What you told us

48. Eighty eight percent of respondents agreed with the move to a single process model (see Figure 3). Many respondents suggested that this would be simpler, clearer and easier to deliver. Respondents also commented that there were no particular benefits in splitting revalidation into two separate processes.

Figure 3: Responses to Question 1



49. The minority who disagreed with our proposed approach, or who had reservations, expressed concern that a single process will not have proper regard to doctors' specialist areas of practice.

50. A selection of the comments we received is below.

'From a patient/public perspective a single set of processes is much clearer. Relicensing and recertification appeared too complex for a lay person to understand.'

Member of the public

'A single revalidation process does, we believe, more accurately reflect the nature of medical practice. It should allow the development of a process which realistically evaluates overall performance rather than artificially differentiating between that which is core to being a doctor and that which reflects the specialist aspects of an individual's practice.'

Newcastle upon Tyne Hospitals NHS Foundation Trust

'It is important to separate general professional standards as covered in licensing from specialist certification standards. While it is simpler to perform these together as one process of revalidation they are separate issues. One may find clinicians perfectly "professional" but not up to scratch in a particular specialty, which would not preclude them from working in other areas.'

NHS Lincolnshire

Our response

51. The proposed move to a single process was based on a number of considerations, not least our desire to make revalidation more streamlined and straightforward. We also believe that a single process called revalidation will enable more consistency across all types of practice and will be widely applicable to all doctors. In addition, a single process will enable further simplification of the proposals, for example by defining one set of standards for all doctors for appraisal and revalidation, while still recognising and reflecting the different types of supporting information that doctors gather to demonstrate their different types of specialised practice in a range of settings. A single process will also allow us to retain the integrity of the Specialist and GP Registers as a historical record of specialist qualification.

52. We will therefore revise our guidance, policies and other documentation to reflect the shift to a single process. We will continue to work with our delivery partners to ensure that all components of revalidation are integrated into a single process delivered through clinical governance and appraisal. In addition, we will continue to discuss with appropriate organisations how the revalidation model will apply to those doctors who work in non-clinical and non-mainstream practice.

A continuing evaluation of doctors' performance in the workplace

53. Question 2 concerned one of the underlying principles of our proposals that revalidation should be based on an ongoing evaluation of what doctors do in practice, rather than a point-in-time assessment.

What we asked

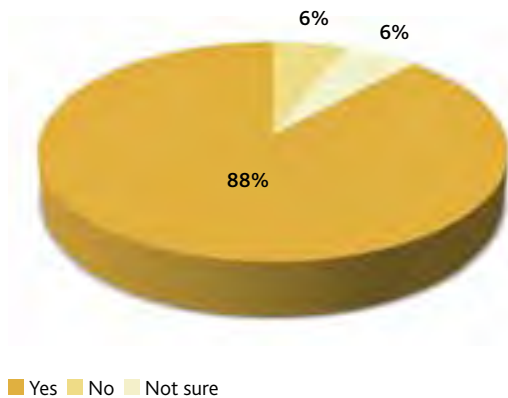
Question 2:

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

What you told us

54. Eighty eight percent of respondents agreed with the proposed approach (see Figure 4).
55. A consistent theme was that this approach ensured a more appropriate, effective and meaningful means of evaluating doctors' performance, than a point-in-time assessment.

Figure 4: Responses to question 2



- 56.** Respondents also commented that revalidation should build upon existing systems, rather than require the implementation of additional ones.
- 57.** However, many respondents commented on the importance of ensuring that the systems which will support revalidation, in particular appraisal and clinical governance, are sufficiently robust and fit for purpose.
- 58.** Many respondents also expressed concerns about how the proposed model might impact on doctors and their employing or contracting organisations. A recurring message was that, while a system based on continuing evaluation is appropriate, there must be a consistent approach and that the local processes and systems which feed into revalidation must not become onerous or disproportionate.
- 59.** There were particular concerns about the amount of information that doctors might be expected to bring to appraisal. Many individual doctors expressed concern that the current proposals were unrealistic and disproportionate. Respondents referred, in particular, to the challenges that locum doctors, sessional GPs and other non-mainstream groups of doctors might face in accessing and collecting supporting information.

60. A minority of respondents expressed a preference for an alternative approach to revalidation, primarily periodic assessments. Those who advocated this approach argued that it provided a more objective and reliable method.

61. A selection of the comments we received is below.

'The systems that are being put in place through annual appraisal, provision of responsible officers and the supporting evidence from the Royal Colleges will underpin the revalidation process.'

Nursing and Midwifery Council

'This is likely to be a far better reflection of their practice than a quinquennial assessment and will also encourage higher standards throughout the doctor's working life rather than peaks and troughs relating to the revalidation cycle.'

NHS East of England

'The proposals for the gathering and evaluation of information are cumbersome, costly and time wasting. They need to be simplified considerably. They propose a number of mandatory processes which are unproven, unnecessary and expensive in terms of time and resources.'

Doctor

Our response

62. We remain committed to the principle that revalidation should be based on an evaluation of doctors' actual performance in the workplace, and welcome respondents' strong support for this principle. Such an approach enables revalidation to be directly relevant to what a doctor does on a day to day basis and makes it applicable to all types of medical practice. Significantly, this approach will also reinforce and promote the importance of having robust clinical governance systems within healthcare organisations.

- 63. We will continue to work with our delivery partners, including employers, to develop medical appraisal and to identify the clinical governance systems and processes that will need to be fit for purpose for revalidation.
- 64. Feedback on this question has also made it clear that we need to further develop the proposals and policies on how revalidation will work for doctors working in non-clinical and non-mainstream roles and also for doctors working overseas.

Instances when a Responsible Officer is unable to make a positive recommendation

- 65. The Responsible Officer will make a recommendation to the GMC about a doctor's revalidation, normally every five years, based on the doctor's annual appraisals. In the majority of cases, they will make a recommendation that a doctor should be revalidated. We suggested that there are likely to be three scenarios in which the Responsible Officer cannot make a positive recommendation.
 - **Scenario A:** The doctor has not been in active practice and has not engaged with any appraisal process or with his or her Responsible Officer. We proposed that, in these circumstances, the doctor will need to take an alternative route to revalidation or have their licence to practise withdrawn.
 - **Scenario B:** There are gaps in the supporting information provided by the doctor. We proposed that the GMC, based on the recommendation of the Responsible Officer, may decide to defer revalidation to enable the doctor to collect the necessary information.

- **Scenario C:** There are concerns about the doctor's fitness to practise. We suggested that it was essential that concerns about a doctor should be identified and addressed as early as possible, with the most serious being referred to the GMC. If the concerns are still ongoing at the point of revalidation, revalidation should be deferred until local, National Clinical Assessment Service (NCAS) or GMC procedures have been concluded.

What we asked

Question 3:

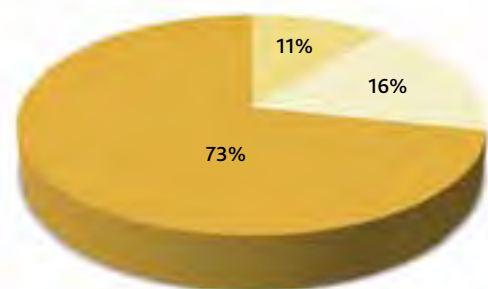
Do you agree with the proposals for dealing with the most common situations where a Responsible Officer may not be in a position to make a positive recommendation?

What you told us

- 66. Between 70-76% of respondents indicated their support for our proposed approach for each of these situations (see Figure 5). However, this question generated very detailed additional comments.

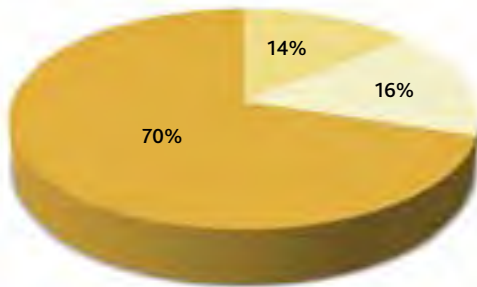
Figure 5: Responses to question 3

Scenario A



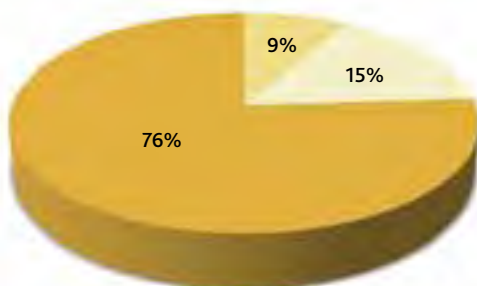
■ Yes ■ No ■ Not sure

Scenario B



■ Yes ■ No ■ Not sure

Scenario C



■ Yes ■ No ■ Not sure

- 67.** Many respondents indicated that they needed more detailed information about the processes and timescales, particularly around the relationship between the revalidation recommendation and our fitness to practise procedures.
- 68.** Many respondents sought clarification on the implications of a decision to defer revalidation on a doctor's ability to continue practising. Respondents also made the point that, in some cases, there may be legitimate reasons why a doctor has not been able to provide all the supporting information. Some respondents expressed concern that deferral could leave a doctor in limbo.

69. Many respondents agreed that any concerns about a doctor should be addressed as and when they arise and not normally at the point of revalidation.

70. Many of the responses to this question focused on concerns about the role of Responsible Officers. The most frequent concern was that Responsible Officers are perceived to have a conflict of interest. A number of respondents expressed concern that there are not sufficient safeguards in place as a check on Responsible Officer powers.

71. Other points about Responsible Officers made repeatedly in responses included:

- a. the importance of ensuring that Responsible Officers are properly selected and adequately trained to carry out the role
- b. the need for quality assurance of Responsible Officer recommendations
- c. the importance of ensuring that Responsible Officers are accountable
- d. the need for provisions for an alternative Responsible Officer in particular circumstances and mechanisms for dealing with conflicts of interest
- e. the need for Responsible Officers to access specialist advice, for example from a medical Royal College or Faculty
- f. the importance of clear guidance on the thresholds for referral to the GMC
- g. the importance of learning from pilots and testing
- h. the need for clarity about Responsible Officer arrangements for particular groups of doctors, such as locums or doctors working independently.

72. A selection of the comments we received is below.

'There will have to be robust mechanisms in place to protect doctors as well as ensure that they are fit to practise. Doctors should be given sufficient opportunities to address deficiencies if these are identified before their licences are withdrawn. It needs to be made clear what the process will be when concerns around a doctor's practice are raised and what the relevant College response will be to help that doctor in the revalidation process.'

College of Emergency Medicine

'We agree that actions on concerns about practice should not wait until a doctor is due to be revalidated and instead should be addressed through the appraisal process, and, if needs be, through the GMC's fitness to practise process. We would like to emphasise that effective and robust mechanisms must be in place to allow for the sharing of information so that the revalidation and fitness to practise processes are able to work effectively.'

POhWER, an independent advocacy organisation

'What is the status for doctors who have deferred revalidation and for doctors under investigation? Will patients be aware that the doctor's revalidation is in question? There needs to be clarity between, for example, deferred revalidation with no known concerns but insufficient evidence to support revalidation, and deferred revalidation, concerns being investigated.'

Royal College of Psychiatrists

'In short, we do not believe that the proposed role for ROs provides enough safeguards for a robust procedure when the ability of a doctor to revalidate and to remain licensed to practise is at stake. Our main concerns relate particularly but not exclusively to robustness and fairness (or otherwise) of the procedures to investigate concerns, and the potential for conflicts of interest between ROs and doctors for whom they are responsible.'

Medical Defence Union

Our response

73. We recognise that there is a clear need for the GMC to try to reduce ambiguity around these issues and to provide more detailed proposals on the nature of the revalidation recommendation, the implications of deferring revalidation, the impact of deferment on the licence to practise and the link between revalidation and the GMC's fitness to practise procedures. For the avoidance of doubt, we want to make it clear that any decision to defer has no impact on a doctor's licence to practise. The doctor remains entitled to practise during this period and would remain so unless and until the GMC made a decision to withdraw the licence (where the doctor has not been in active practice and has failed to engage with appraisal and his/her Responsible Officer) or to remove or restrict the doctor's right to practise as a result of action under the GMC's fitness to practise procedures.
74. We will therefore review our proposals in the light of respondents' comments in order to clarify our intentions and the way the different processes will work in practice in different situations. The evaluation of the pathfinder pilots will help to identify areas where Responsible Officers are having difficulty in terms of forming a recommendation and where we might need to provide further guidance and information.
75. Although the consultation was not about Responsible Officers, we recognise that a lot of the feedback we received to this question outlined a range of concerns which respondents had about the nature, function and potential conflict of interest of this role.
76. Since our consultation, the draft Responsible Officer Regulations were laid before Parliament on 26 July 2010 and are due to come into effect in England, Wales and Scotland in January 2011. The Northern Ireland Assembly has passed corresponding legislation that will require every designated organisation in Northern Ireland to appoint a Responsible Officer by 1 October 2010.

77. Although some of the concerns raised with us may have been addressed through the Department of Health's (England) response to its earlier consultation on Responsible Officer regulations and guidance, we will discuss this feedback with the four health departments for their further consideration.
78. We will also consider how we can best support medical directors and future Responsible Officers to manage concerns about the practice of individual doctors early and effectively. The GMC is involved in further piloting of the potential role of GMC Affiliates in supporting the introduction of revalidation. The pathfinder pilots in Yorkshire & Humber and the West Midlands are both currently testing the role of the Affiliates and their relationships with the likely Responsible Officers in each region.

The involvement of Colleges and Faculties in revalidation recommendations

79. Question 4 of the consultation considered the role of medical Royal Colleges and Faculties in revalidation. In particular, it considered the involvement of Colleges and Faculties in the recommendation made by Responsible Officers and also set out a number of other ways in which they could make a contribution to the process.

What we asked

Question 4:

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

Question 5:

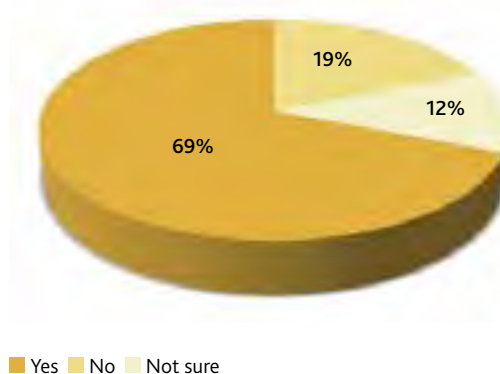
If so, what do you think their role should involve? Please tick one or more of the following options:

- a. Setting standards and defining specialty information
- b. Advice and guidance for appraisers
- c. Advice and guidance for Responsible Officers
- d. Audit and quality assurance of the recommendation process
- e. Other

What you told us

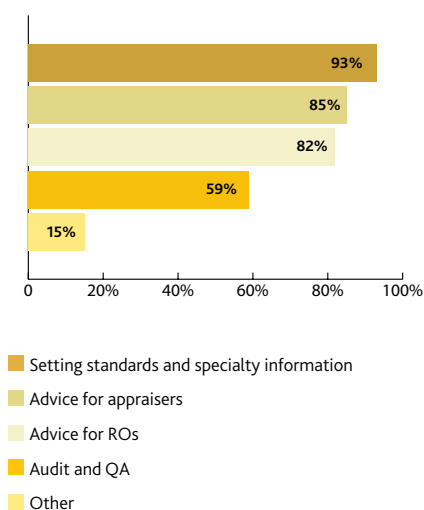
80. The majority of respondents agreed that the Colleges and Faculties should not be directly involved in the recommendations made by the Responsible Officer to the GMC (see Figure 6).

Figure 6: Responses to question 4



81. Ninety three percent of respondents agreed that the Colleges and Faculties should be involved in setting standards and defining specialty information. Eighty five percent agreed they should be involved in providing advice and guidance for appraisers, while 82% agreed that they should provide advice and guidance for Responsible Officers. Finally, 59% agreed that they should be involved in the audit and quality assurance of the recommendation process (see Figure 7 below).

Figure 7: Responses to Question 5



82. While many respondents agreed that the Colleges and Faculties should have an important role in setting standards and defining specialty information, some respondents commented that this should not rest with the Colleges and Faculties alone.

83. Similarly, while many respondents agreed that they should also have a role in providing advice both to appraisers and Responsible Officers, some respondents commented that this should not preclude other parties from also providing advice.

84. There were a number of different views on whether Colleges and Faculties should also have a role in the quality assurance of the recommendation process. A number of responses suggested that the GMC should be primarily responsible for the quality assurance of the process and that it should decide whether input from the Colleges and Faculties was required.

85. A selection of the comments we received is below.

'It also should not be exclusively for Colleges and Faculties to contribute to standards, but specialist societies, which usually having a wider membership, should be equally contributing to the development process.'

Doctor

'Advice and guidance for appraisers, advice and guidance for Responsible Officers and audit and quality assurance of the recommendation process should be the responsibility of GMC as they are responsible for the revalidation process.'

Skills for Health

'[The College is] in a strong position to provide training and guidance for appraisers, particularly in the area of how to interpret the implementation of specialty standards and how to make appropriate judgements... The Royal College of Psychiatrists would see a role in training appraisers and Responsible Officers by establishing a quality assured training programme for appraisers.'

Royal College of Psychiatrists

Our response

86. We remain firmly of the view that medical Royal Colleges and Faculties should not be directly involved in the individual revalidation recommendations made to the GMC by Responsible Officers, and welcome the endorsement of this position by the vast majority of respondents.

- 87. However, like many respondents, we continue to recognise that medical Royal Colleges and Faculties have a key role to play in the revalidation process, particularly in defining the types of supporting information and providing specialty guidance to Responsible Officers.
- 88. We will continue to work with the medical Royal Colleges and Faculties in defining their role in the revalidation process and ensuring full integration with the work being done by other revalidation delivery partners. We agree that, in setting standards and preparing guidance, Colleges should properly collaborate and engage with their members and associated specialty societies, and that such guidance should be restricted to specialty-related matters.
- 89. We recognise that there are a number of different views about College and Faculty involvement in the quality assurance of revalidation, but agree with those who were opposed to the Colleges taking on the lead responsibility for such quality assurance. We therefore intend to review and develop a number of possible options around quality assurance, including the potential involvement of the systems regulators in providing a degree of organisational level assurance, and a possible GMC programme of sampling and audit. As part of this further work we will continue to discuss with the Colleges and Faculties their possible role in the wider quality assurance of revalidation.
- 90. We accept and recognise that Colleges and Faculties may be able to provide a range of other services to support and assist those involved in revalidation. We will therefore pass on the various suggestions made by respondents to the Colleges and Faculties for their consideration.

Doctors in training roles

- 91. Question 6 concerned how revalidation will work for trainees. We suggested that trainees are already among the most closely regulated group of doctors and that revalidation should not create additional burdens for trainees which would add little value. We proposed, therefore, that the Annual Review of Competence Progression (ARCP) process, suitably enhanced, should provide the vehicle through which trainees would be able to revalidate.

What we asked

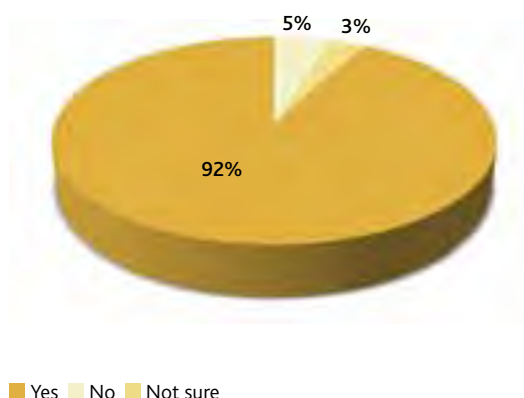
Question 6:

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

What you told us

- 92. Ninety two percent of respondents agreed with our approach (see Figure 8). Many of those agreed that there are already adequate systems in place and that doctors in training are already under sufficient scrutiny.

Figure 8: Responses to question 6



93. A number of those who agreed with the recommendation commented on the importance of enhancing the Annual Review of Competence Progression (ARCP) process and suggested a number of improvements.
94. A selection of comments received is set out below.

'A huge amount of time and effort already goes into exams, all the work based assessments, ARCP and progress for improving our CVs for jobs. I do not think any additional assessment is necessary and would definitely be a negative thing if introduced.'

Doctor

'The different purposes of the two exercises (ARCP and revalidation) need to be very clearly understood before going forward, as the ARCP process is not an appraisal in itself, but a review of evidence. Is revalidation a review or an assessment of the doctor? There also needs to be clarity about what is included in the "enhanced" ARCP process. There would, in our view, need to be input from the medical director or their delegated nominee about aspects of performance in the work place in order to emphasise the importance of attitude and behaviours in the workplace.'

London Deanery

'We fully agree that revalidation should not create additional burdens for trainees, particularly given the recruitment problems in Wales. The proposal that the Annual Review of Competence Progression (ARCP) should be suitably enhanced to ensure its robustness for revalidation is a sound one. Completion of this process along with the view of local clinical governance leads and local medical director leads that there are no issues of concern should allow trainees to revalidate.'

Welsh NHS Confederation

Our response

95. We remain firmly of the view that doctors in postgraduate training, all of whom will hold a licence to practise, should be required to revalidate. We also believe that the ARCP process should provide the mechanism through which such trainees would be able to revalidate.

We will therefore work with the postgraduate deaneries and the medical Royal Colleges and Faculties to consider any enhancements to the ARCP process required to support revalidation and to refine our proposals accordingly.

Revalidation of doctors with no medical practice

96. Question 7 proposed an alternative route for revalidating those doctors with no current medical practice who wish to retain a licence to practise. As these doctors do not have any medical practice of any kind, they will not be able to draw upon supporting information from their practice in order to revalidate. We proposed that this group of doctors might be able to revalidate through passing the Professional and Linguistic Assessments Board (PLAB) test or a similar test or successful completion of knowledge and skills assessments developed for the GMC's fitness to practise procedures.

What we asked

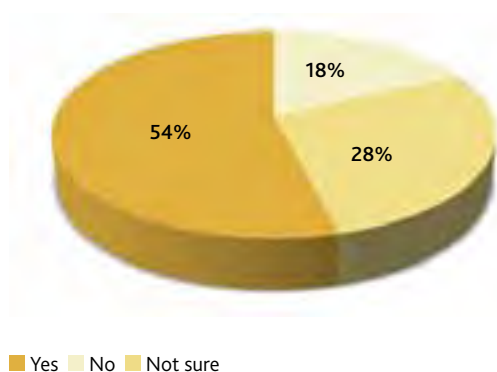
Question 7:

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

What you told us

97. There was less support for this question than for many of the others with only 54% of respondents agreeing with our proposals (see Figure 9). A number of respondents questioned whether it was appropriate for doctors with no current practice to retain a licence. Some respondents questioned whether it was appropriate to provide an alternative exam-based route for revalidation as they felt it would not provide sufficient assurance if the doctors concerned returned to practice.

Figure 9: Responses to question 7



98. A selection of comments received is below.

'Yes, provided that this proxy for an assessment of practice is monitored such that if the doctor takes up medical practice, they are then required to revalidate accordingly.'

Royal College of Radiologists

'Doctors with no medical practice of any kind at the time of revalidation should be encouraged to rescind their licence to practise, although they might wish to continue to hold GMC registration... Should their personal situation change, then GMC processes should allow for re-application and assessment for a licence to practise.'

NHS Employers

Our response

99. Our position remains that licensed doctors with no medical practice of any kind should not hold a licence to practise and therefore should not need to revalidate every five years. In our view such doctors should relinquish their licence on the understanding that, should they at any stage return to medical practice, they would be granted the required licence to practise by the GMC. At that point, they would again be subject to all of the requirements of revalidation, including linking to a Responsible Officer and undertaking annual appraisals. These doctors will be expected to revalidate within two years of returning to medical practice.

100. We accept, however, that there may be a small number of licensed doctors with no medical practice of any kind who wish to (or are required by their employer to) hold or retain a licence to practise. In these cases, we continue to believe that alternative arrangements need to be made to enable such doctors to revalidate every five years. Given the apparent misunderstanding of the GMC's intentions in respect of such doctors, we will revise our proposals for dealing with such doctors so as to remove any ambiguity, to better define what we mean by 'no medical practice', and to reflect the feedback we have received.

101. We also acknowledge that further work needs to be carried out on the revalidation of doctors working in non-clinical fields (for example academia, medical management). We are therefore currently working with non-clinical doctors and organisations that represent them to look at how revalidation should work for them.

The List of Registered Medical Practitioners

102. The consultation set out proposals to make the List of Registered Medical Practitioners (LRMP) a more accurate statement of a doctor's current practice, by showing in broad terms, the field of medical practice in which the doctor revalidated, alongside information about the doctor's entry on the GP or Specialist Register.

What we asked

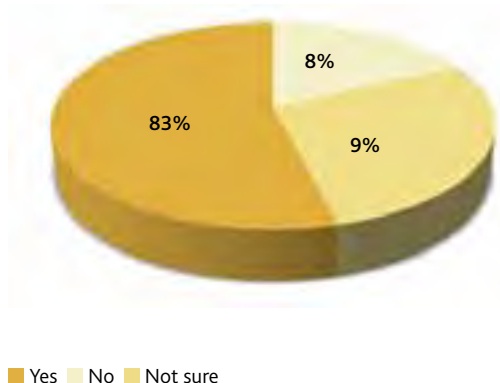
Question 8:

Do you agree that the List of Registered Medical Practitioners should indicate the field of practice on the basis of which a doctor has secured revalidation?

What you told us

103. Eighty three percent of respondents, including a number of public and patient organisations, agreed with the proposals (see Figure 10). Many respondents suggested that the inclusion of this additional information would make the LRMP a more complete and up-to-date source of information for patients and the public, doctors and employers. A number of doctors who responded welcomed the proposal, suggesting that it would give recognition to the specialist practice of many Staff Grade and Associate Specialist doctors who are not currently on the Specialist Register.

Figure 10: Responses to question 8



104. It is clear from responses to this question that a considerable amount of further work will be required to identify the kind of information and degree of detail that might be recorded on the LRMP. Many respondents questioned what kind of information we might include. Respondents also highlighted the challenge of providing meaningful information about, for example, doctors with complex portfolio careers or doctors in very narrow sub-specialties.

105. A proportion of respondents expressed reservations about our proposals. Some questioned whether the additional information would be meaningful to the public.

106. Respondents also commented that it was important to be clear that revalidation in a particular field is not the same as specialist registration. There was some concern that members of the public might interpret a record of a doctor being revalidated in a particular field as being equivalent to a specialist qualification.

107. A selection of comments received is below.

'Given that the person is being revalidated on the basis of what they do in the workplace, it would be misleading to not supply that information.'

Doctor

'It is helpful for the List of Registered Practitioners to indicate their field of practice. This will aid recruitment and provide more transparent information for patients and the public.'

NHS London

'It is one thing to suggest some identification of the field of practice but this should not be seen as the same as specialty registration without the current rigour being applied to check suitability.'

Doctor

Our response

108. We are pleased with the high level of support for this proposal. We will therefore develop more detailed proposals on how the medical register will show the field of medical practice that has provided the basis for a doctor's revalidation, while recognising that many doctors practise across more than one discipline. We will also take into account the concerns expressed by some respondents as well as the helpful suggestions for additional information made by others.

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

Section 2 of our consultation set out the proposals for the standards that doctors would need to meet to revalidate and the supporting information that they would need to provide. It also described the key role that local systems of appraisal and clinical governance would play in the proposed revalidation model.

The Good Medical Practice Framework for appraisal

109. The *Good Medical Practice* (GMP) Framework for appraisal was developed to outline the standards for appraisal on which revalidation recommendations would be based. It was created to support an effective and standardised approach to appraisal.

What we asked

Question 9:

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

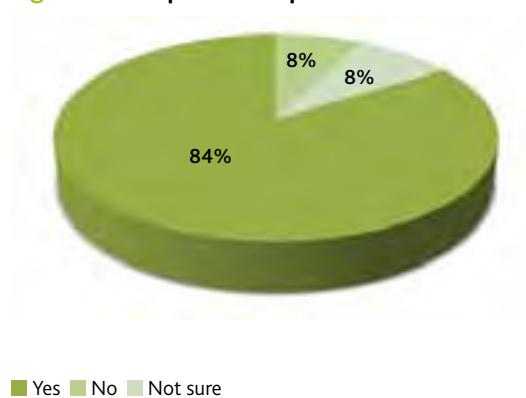
Question 10:

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

What you told us

110. A majority of respondents endorsed the use of the *GMP* Framework as an appropriate basis for appraisal (see Figure 11).

Figure 11 : Responses to question 9



- 111.** Comments on the *GMP* Framework covered a number of key themes, including:
- a. the need for simplicity and proportionality
 - b. the importance of a flexible approach that will accommodate doctors in a range of roles
 - c. the need for clarity
 - d. concerns about the feasibility of collecting supporting information.

- 112.** Respondents commented positively on the consistency that the Framework would provide for appraisal. Some respondents commented that further piloting was required to provide assurance about the effectiveness of the Framework.
- 113.** Although there was a high level of support for the GMP Framework, respondents raised a number of concerns about the application of the Framework and the challenges of collecting supporting information for appraisal.
- 114.** Some respondents suggested that the Framework needed further refining, for example to provide more focus on knowledge and competence. A number of respondents suggested that the Framework should make clear which standards are mandatory and which are discretionary, and that there should be an explicit statement that doctors will not be able to produce supporting information for each standard.
- 115.** Respondents commented that a flexible approach would be required when applying the Framework in a range of non-mainstream roles.
- 116.** A common theme in responses was the importance of a simple and proportionate approach. A number of respondents were concerned that the 12 attributes in the Framework are currently over-complicated.
- 117.** Many respondents commented on the challenges of producing supporting information. A common concern was the challenge that many doctors, in particular locums, self-employed and other independent sector doctors, as well as doctors in other non-mainstream roles, are likely to face in collecting supporting information for appraisal.

- 118.** A selection of comments is below.

'The use of the GMP Framework will hopefully drive forward a move to consistency of approach to revalidation between and within organisations and specialties. This is vital. If the process of revalidation is to gain the acceptance of the medical profession as a whole, there is a need for it to be seen as fair and equitable and for there to be similar outcomes based on similar supporting information regardless of where revalidation takes place.'

Newcastle upon Tyne Hospitals NHS Foundation Trust

'Recent feedback from doctors who participated in secondary care pilots indicated that further guidance on the GMP Framework would be helpful. The overall response to the Framework was positive and most doctors felt the Framework reflected all areas of their practice.'

Department of Health, Social Services and Public Safety
(Northern Ireland)

'While NHS Lothian believes that the GMP Framework is a good starting point, the results of the pilot appraisal project should be widely published and assessed to ensure that this framework is fit for purpose.'

NHS Lothian

'I agree with the principles of revalidation and the use of the GMP Framework but I think this needs to be done in a meaningful way without being so over-burdensome that it impacts on the doctor's ability to effectively do their job given the significant time constraints they already have.'

Doctor

Our response

- 119.** The GMC is pleased with the high level of support for the *GMP* Framework as the basis for appraisal and revalidation. *Good Medical Practice* is our flagship document for standards of practice for all doctors and, as such, we recognise that the *GMP* Framework must be applicable to all doctors and all types of medical practice.
- 120.** We agree with the comments on the importance of piloting and further scrutiny to ensure the effectiveness of the Framework as an appraisal tool. A series of pilots testing the *GMP* Framework have been completed in England, Northern Ireland, Scotland and Wales. Evaluation of these pilots is showing a good degree of support for using the standards from *Good Medical Practice* as the basis for appraisal and revalidation.
- 121.** The GMC is supporting further testing of the *GMP* Framework through the pathfinder pilots and other pilots in Wales and Scotland. The evaluation of these pilots will provide further information on how the standards can be integrated into appraisal. We will continue to work with our delivery partners to embed these standards into medical appraisal.
- 122.** Following the comments, we are reviewing the *GMP* Framework in order to present the standards in a more succinct and less repetitive way, as well as providing further clarification.

Specialty and General Practice Frameworks

- 123.** The *GMP* Framework for appraisal was used as the basis for the development by the medical Royal Colleges and Faculties of specialty frameworks and supporting information requirements for revalidation.

What we asked

Question 11:

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

Question 12:

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

What you told us

124. The majority of responses to these questions focused on the content and application of the general practice and specialty frameworks, rather than the general approach to the development of the standards and supporting information (see Figure 12).

125. Sixty nine percent of respondents indicated that they thought the overall approach to the development of standards and supporting information was reasonable. However, there were lower levels of support for the supporting information set out in the specialty frameworks. While 64% of respondents thought that the information in the frameworks was meaningful, only 46% indicated that they thought it was practicable and only 45% indicated that they thought it was proportionate (see Figure 13 below).

Figure 12: Responses to question 11

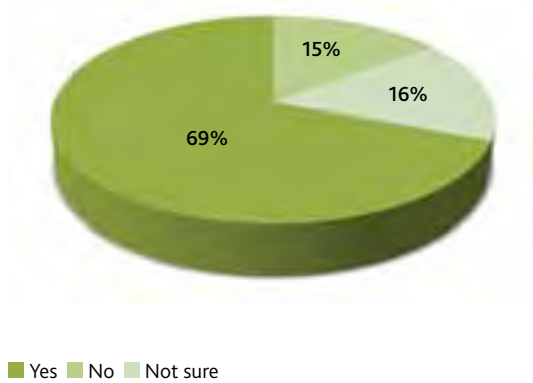
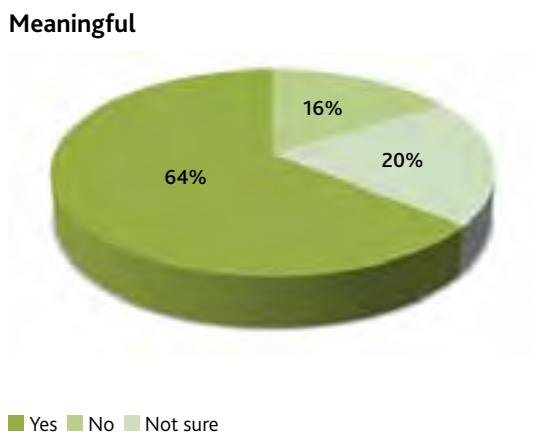
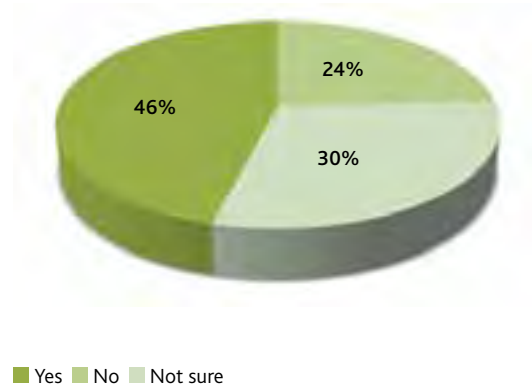


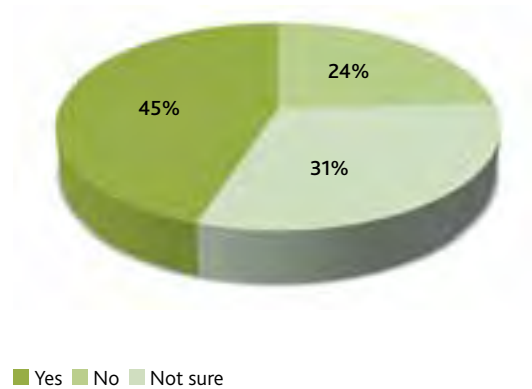
Figure 13: Responses to question 12



Practicable



Proportionate



126. Some respondents suggested that the frameworks would be useful to both appraisers and Responsible Officers. However, it was suggested that they should be treated as guidance about what is reasonable, rather than rulebooks.

127. The main concerns about the frameworks were around:

- a.** the need to simplify the frameworks and to ensure that their application is practicable, proportionate and achievable. Many respondents commented that it was important that the frameworks do not cause undue additional work for both individual doctors and employing or contracting organisations. Respondents suggested that the frameworks needed to be streamlined in order to ensure that the process is fair and practicable. A number of respondents suggested that a flexible approach was needed to take account of doctors' particular sub-specialties and places of work
- b.** the desirability of defining core information and minimum standards in the frameworks
- c.** the need for greater consistency between the frameworks, for example by standardising requirements in core areas of practice
- d.** the challenges that locum doctors, sessional GPs, doctors with portfolio careers and doctors in other non-mainstream roles are likely to have in applying the frameworks.

128. A number of respondents commented that, wherever possible, the approach should be to incorporate information already being collected in routine work. Respondents also commented that it would be important to highlight organisational responsibility in assisting doctors to access supporting information.

129. Finally, respondents commented that the pathfinder and college pilots would produce useful information on the collection of information by particular groups of doctors.

130. A selection of comments received is below.

'The RCPCH agrees that the approach is reasonable. However, only through extensive piloting will doctors, Colleges and Faculties be reassured that the supporting information and standards are practicable and reasonable.'

Royal College of Paediatrics and Child Health

'The consultation document explains how the specialty standards for each college have been evaluated against the following criteria: consistency, confidence, fairness, objectivity, transparency, fairness from unfair discrimination, practicality, proportionality and robustness. Given our concerns with the specialty standards and the fact that we have stated that college standards must be equitable, fair and proportionate, we would welcome further information on how each of the standards has been assessed.'

British Medical Association

'No – the specialty standards produced by many Royal Colleges are aspirational and unrealistic with some verging on being too complex and bureaucratic. They need to be simplified and reflect the real world. There is inconsistency in both the type and level of evidence each college requires to re-accredit doctors.'

NHS East of England

'We would have thought the emphasis must be on greater consistency of requirements between specialties, possibly by standardisation of requirements in core areas of practice and moving even towards a more unified framework for a number of related specialties.'

Medical Defence Union

Our response

- 131.** We recognise the importance of consistency across the specialties. The standards contained in each specialty framework were drawn from the *GMP* Framework, and are based on the GMC's core guidance *Good Medical Practice*. The variation across the specialties was mainly around the types of supporting information each specialty identified for appraisal and revalidation. This is because some specialties are in a more advanced position than others in collecting data about their practice. If data about a doctor's practice and performance already exists, it should be discussed in appraisal and revalidation. Although sources of supporting information across the specialties are likely to differ to a certain extent, we agree that they need to be as consistent and equitable as possible.
- 132.** The GMC agrees that the specialty frameworks need to be streamlined to make them more straightforward, proportionate and realistic. We also agree that the focus should be on identifying information that can be readily collected using existing systems, with the understanding that, as systems become more developed, the type and range of supporting information available may change.
- 133.** The medical Royal Colleges and Faculties have expressed a willingness to review and streamline their specialty frameworks in collaboration with the GMC. The Colleges and Faculties are working together to develop consistent guidance on how doctors in each specialty can demonstrate their practice using a range of supporting information, including identifying types of information they consider 'expected' and what is additional or optional.

134. We agree with the importance of testing the frameworks through piloting. The current secondary care pilot in Wales and the pathfinder pilots in England will provide more information and learning about how these frameworks work in practice. We are also working with groups of doctors and employers to ensure that the *GMP* Framework, standards and guidance are relevant to those doctors whose practice is not closely associated with a medical Royal College or Faculty.

Continuing professional development

135. The final question of Section 2 considered the role of continuing professional development (CPD) in our model for revalidation. In particular, we sought comments on a number of core principles, which are described in detail in our consultation document (paragraph 150).

What we asked

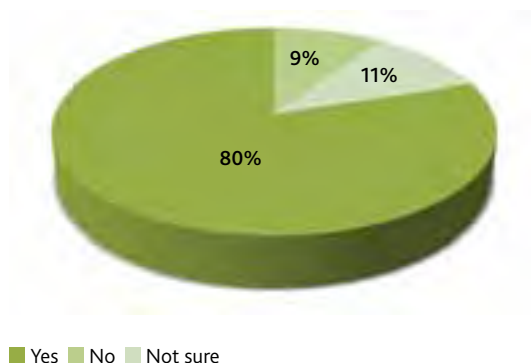
Question 13:

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

What you told us

136. Eighty percent of respondents agreed that the principles are appropriate criteria to guide doctors' CPD activities for revalidation (see Figure 14).

Figure 14: Responses to question 13



■ Yes ■ No ■ Not sure

137. A number of respondents welcomed the development of the principles, suggesting that they will help provide focus to the planning of CPD for revalidation. Respondents commented that it was important that the principles should be applied flexibly and that we should not be overly prescriptive.

138. One concern was that the proposed principles could be made more robust. Some respondents suggested that there should be more emphasis on the independent assessment of learning needs to ensure that it is relevant to the doctor's job.

139. There were also different views on the issue of participation in College and Faculty schemes. A number of respondents welcomed the principle that doctors would not be required to participate in College or Faculty-led schemes. However, some respondents expressed concern that CPD may lack rigour unless linked to a College or Faculty scheme.

140. A number of educational bodies expressed concern that the proposed principles had been developed without sufficiently involving other revalidation partners. Some responses suggested that the principles need to be more closely aligned to College CPD systems.

141. A selection of comments received is below.

'We are delighted to see this set of principles. A needs based approach, apposite to all clinical and non-clinical roles undertaken by a doctor is the ideal. Needs assessment may never be perfect but some tailoring of learning has to occur in an era of technical demand and information overload.'

The National Association of Primary Care Educators

'CPD needs to demonstrate active learning either through technical skills courses or by feedback of some description such as given by the many online systems. Going to courses does not make a good, better or safer doctor.'

Doctor

'We are concerned about how organisations will adequately fund their doctors' CPD given the current financial climate affecting the public sector. Funding will be required to enable doctors to participate in CPD activities by appropriate allocation of time from their individual job plans where identifiable SPA (Supporting Professional Activities) time is not already provided for this activity.'

Royal College of Anaesthetists

Our response

142. We are pleased with the high level of support for the proposed principles for CPD. The GMC has already committed to reviewing its role in CPD and the comments on our proposed principles will help to inform the direction of that review. As part of the review we will revise and update our CPD guidance and address concerns raised in the responses.

143. Many Colleges and Faculties are currently reviewing their CPD systems to incorporate more reflection and outcomes. The Academy of Medical Royal Colleges Directors of CPD Group continues to look at how Colleges and Faculties will support doctors in demonstrating the requirements of revalidation through CPD.

Section 3 – Patient and public involvement in revalidation

Section 3 of the consultation considered the ways in which patients and the public could be involved in revalidation. Question 14 considered, in broad terms, the possible involvement of patients and the public in revalidation. Questions 15 to 17 looked more specifically at the use of colleague and patient questionnaires.

The proposed approach to patient and public involvement in revalidation

144. Question 14 suggested three potential ways in which patients and the public could be involved in revalidation:

Option A: providing feedback through questionnaires.

Option B: involvement in Responsible Officers' recommendations and quality assurance.

Option C: involvement in the GMC decision-making process when concerns are raised about a doctor's practice.

What we asked

Question 14:

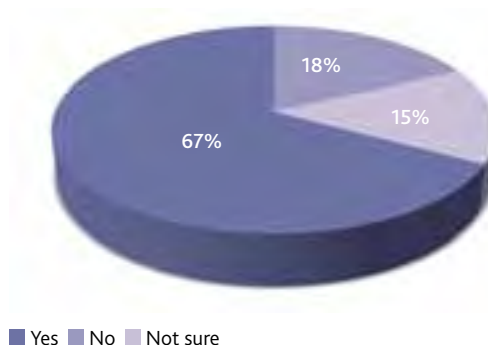
Do you agree with our approach to patient and public involvement in revalidation? If not, what other arrangements would you suggest?

What you told us

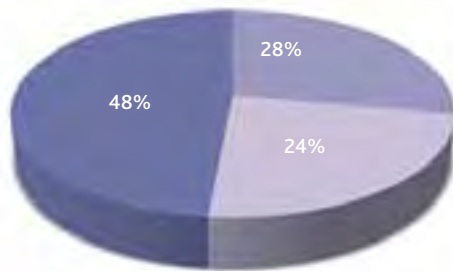
- 145.** Many of the organisations that responded, particularly those with a public and patient focus, underlined the importance of patient and public involvement, both in revalidation and in other regulatory developments. Responses referred to lay contribution in developing the current proposals, for example through College lay advisory groups.
- 146.** Some respondents commented on the challenges of making patient and public involvement meaningful.
- 147.** A proportion of respondents were more sceptical about the benefit of patient and public involvement in revalidation.
- 148.** Of the three possible routes for patient and public involvement outlined above, there were fairly good levels of support for Option A (67%) and Option C (66%) (see Figure 15).

Figure 15: Responses to question 14

Option A: involvement through questionnaire feedback

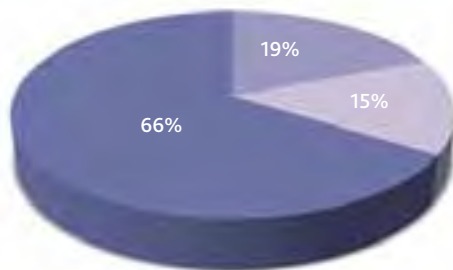


Option B: involvement in the RO's recommendation and QA



■ Yes ■ No ■ Not sure

Option C: involvement in the GMC decision-making process



■ Yes ■ No ■ Not sure

- 149.** Although there was support for patient and public involvement through the use of questionnaires, some respondents questioned whether patient feedback would provide objective information about a doctor's practice.
- 150.** There was less support for Option B, involvement in the Responsible Officer's recommendation and quality assurance (49%). Some respondents questioned whether patients and the public would have the necessary skills to play a meaningful role.
- 151.** A selection of comments is below.

'We welcome the GMC's approach to involving the public in the revalidation process and when raising concerns locally. The involvement of the public in questionnaire feedback on a doctor's performance is a major step in ensuring public trust in the 21st century.'

Nursing and Midwifery Council

'The implementation of revalidation provides a real opportunity to introduce greater lay involvement at local level and to boost public confidence that doctors are assessed on a systematic basis. The GMC Affiliates' pilots have demonstrated the benefits of GMC Affiliates engaging with medical directors together with Regional Medical Regulation Support Teams.'

NHS Birmingham East and North

'Overall, Picker Institute Europe agrees with the GMC's proposals regarding the mechanisms for patient and public involvement in revalidation. We have very considerable concerns, however, about how the GMC's proposals characterise the role and value of patient feedback within revalidation. The patient experience is a core dimension of quality in health and should be positioned as a core dimension of doctors' competence and performance. We do not see this reflected in the GMC's approach. Further, we do not consider the proposals to be consistent with a near-future in which patients and public will have – and will increasingly expect to have – access to useful, useable and continually updated information about health care quality, including information about individual doctors' performance. Picker Institute Europe emphatically disagrees with the GMC's stated position that patient and public involvement in revalidation is one way of inspiring confidence in the way that revalidation will work.'

Picker Institute Europe

Our response

- 152.** One of the aims of revalidation is to provide greater assurance to patients and the public that doctors are practising medicine to an acceptable standard. We agree that patient and public involvement is critical to ensuring confidence in revalidation. However, we acknowledge that there are challenges in ensuring that patient and public involvement is meaningful and robust. Patient and public involvement is expected, and will be included in revalidation.

- 153.** Patient feedback, gathered through asking patients to complete questionnaires, is one of a range of types of supporting information that doctors will collect to demonstrate their practice at appraisal. However, there is no suggestion that a doctor would not be revalidated if they received some poor patient feedback when the majority of supporting information suggests that the doctor's practice is of an appropriate standard. We acknowledge doctors' concerns about the robustness of questionnaires and agree that there needs to be an evidence-based approach to questionnaires. We have explored these topics as part of our response to questions 15, 16 and 17.
- 154.** The proposed legislation is clear that the Responsible Officer is solely responsible for making the revalidation recommendation. The GMC will continue to consider whether there is a role for patients and the public in the quality assurance and GMC decision-making processes.
- 155.** The GMC has commissioned a literature review to look at the evidence base for patient and public engagement. We are also undertaking further work to explore alternative types of patient and public engagement. We are continuing to pilot GMC Affiliates who may prove a useful way of adding lay involvement into local clinical governance and revalidation.

The use of colleague and patient questionnaires in revalidation

- 156.** The three questions about the use of colleague and patient questionnaires as part of revalidation generated many comments. It is clear from the responses that many individual doctors continue to have concerns. Common concerns relate both to the difficulty of obtaining objective feedback and to the potential costs and time demands.

- 157.** In the consultation we suggested that we need to develop clear principles and criteria that any colleague and patient questionnaires need to meet for revalidation; these would help address some of the concerns voiced about the fairness and reliability of questionnaires.

What we asked

Question 15:

Do you agree that GMC principles, criteria and key indicators for colleague and patient questionnaires in revalidation are appropriate for evaluating these types of questionnaires for revalidation?

Question 16:

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

Question 17:

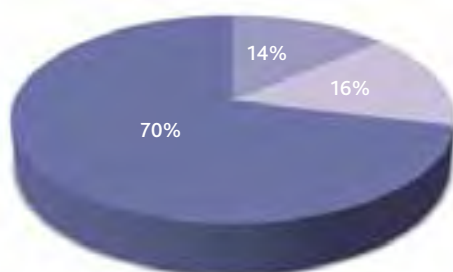
Do you think that there should be a mechanism for making sure that colleague and patient questionnaires comply with our criteria for revalidation?

What you told us

158. Seventy percent of respondents agreed that the principles and criteria were appropriate for the evaluation of colleague questionnaires while 62% agreed that they were appropriate for evaluating patient questionnaires (see Figure 16).

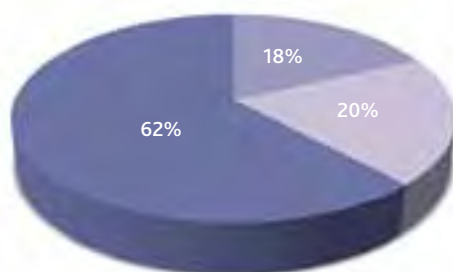
Figure 16: Responses to question 15

Colleague questionnaires



■ Yes ■ No ■ Not sure

Patient questionnaires



■ Yes ■ No ■ Not sure

159. Some respondents expressed concern that it would be extremely challenging for questionnaires to meet all of the criteria. Respondents also expressed concern about the costs. Another concern was that the criteria might inhibit the in-house development of questionnaires and would only benefit commercial organisations.

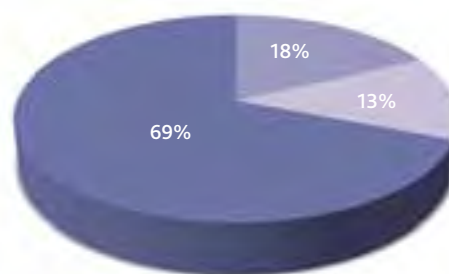
160. A number of respondents commented on the importance of piloting, to ensure that the principles can be tested.

161. Respondents also raised a range of concerns about the use of colleague and patient questionnaires. Concerns related, in particular, to the possibility of bias, lack of consistency and discrimination.

162. As with a number of the other questions, respondents queried the implications for doctors in non-mainstream roles.

163. We also proposed in the consultation document that doctors should be required to participate in colleague and patient (where applicable) feedback at least once in every five year revalidation cycle. Sixty nine percent of respondents agreed with this proposal (see Figure 17).

Figure 17: Responses to question 16



■ Yes ■ No ■ Not sure

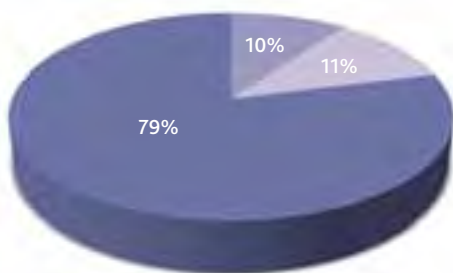
164. A large proportion of respondents agreed that this approach was appropriate and proportionate. Some respondents commented on the cost implications of more frequent participation.

165. However, a proportion of respondents questioned whether once every five years was sufficiently frequent. There were a number of suggestions for how regular participation might be.

166. The final question on colleague and patient feedback concerned whether there needs to be a mechanism in place for accrediting questionnaires. Seventy nine percent of respondents agreed that there should be a mechanism for accrediting questionnaires (see Figure 18).

Figure 18: Responses to question 17

Colleague questionnaires



■ Yes ■ No ■ Not sure

167. Respondents commented that accreditation would provide external validity and reliability and would help to ensure consistency. Respondents emphasised that any process should be simple and inexpensive.

168. A minority of respondents disagreed with the proposed approach. Respondents raised concerns about the potential of additional bureaucracy and the burdens on organisations. Some respondents, while agreeing with the criteria, questioned whether the GMC needed to carry out any accreditation. Some respondents also suggested that a more flexible and locally based approach to accrediting questionnaires should be adopted.

169. A selection of comments received is below.

'There is no mention of the principles that should underpin how feedback is to be delivered to individual doctors. Multi-source feedback is potentially damaging to an individual's self-esteem, confidence and mental health.'

London Deanery

'a) Has there been patient/lay input into the design/structure of the questionnaire? b) Is the questionnaire patient friendly? c) Does the questionnaire ask the right questions? d) Is there need for guidance/clarification which would help patients deal with/understand the questions? e) What are the different medical settings within which the questionnaire will be used? f) Was the use of qualitative questionnaires the only way of collecting patients' views? Have other quantitative approaches been fully examined?'

Royal College of Radiologists Clinical Oncology Patients' Liaison Group

'We have concerns at the use of multi source feedback – this is a particularly difficult tool to obtain useful results from in the rural setting, where GPs may be interacting with only a very limited group of other doctors. The workload in trying to get adequate numbers of patient responses will also be proportionately higher in small rural and remote practices.'

Remote Practitioners' Association of Scotland

'The IDF does not agree that colleague and patient feedback should only be undertaken once every five years. This may be appropriate for some doctors but for those in the private sector without practising privileges to a private hospital we believe that a minimum of two MSFs should be completed in the five year revalidation cycle, as this is one of the few ways in which reliable and validated information relating to their practice can be obtained.'

Independent Doctors Federation

'The GMC would need to be satisfied that the questionnaires and the whole process of administering and interpreting them are fair and consistent and that no doctor is disadvantaged. This would extend not just to the design and content of the forms, but should also cover training for those who administer, collate and analyse the forms and for Responsible Officers who rely upon the information they provide.'

Medical Defence Union

Our response

- 170.** The GMC acknowledges the range of concerns raised about the use of colleague and patient feedback as a source of supporting information for appraisal and revalidation. However, we remain committed to including patient and colleague feedback as part of the supporting information for revalidation based on questionnaires that meet clear and robust criteria.
- 171.** The GMC intends colleague and patient feedback to be a developmental tool to help doctors to reflect on their performance. We are not proposing to use the feedback as a screening tool, although there is evidence that patient and colleague questionnaires can help to identify outliers in particular areas of practice.
- 172.** We agree that the use of colleague and patient feedback in revalidation must be backed up by evidence of the benefits. We have commissioned a literature review to look at the evidence base for colleague and patient questionnaires. Furthermore, the GMC has developed draft questionnaires and has commissioned in-depth piloting and research of those questionnaires across a range of settings. We anticipate receiving the results of this research early in 2011. Further evaluation of colleague and patient feedback is planned through the next stage of testing in England.
- 173.** The principles, criteria and key indicators are intended to set best practice and ensure all questionnaires used in revalidation are of an acceptable standard. They also aim to serve as a guide for organisations looking to develop or purchase a questionnaire. We will review the principles, criteria and key indicators in light of the feedback we have received. We will also work on developing an accreditation mechanism for evaluating whether colleague and patient questionnaires are compliant with our principles, criteria and key indicators.
- 174.** Some aspects of the administration of colleague and patient questionnaires were raised in responses, such as the number of respondents required. These aspects of administration are particular to specific questionnaires and should be piloted and evaluated during the development of any questionnaire.
- 175.** The GMC agrees that participation in colleague and patient feedback once every five year revalidation cycle is reasonable and appropriate, and balances the concerns around the time or cost involved in the process. The Department of Health's cost-benefit analysis will include information on the resource implications of seeking feedback from colleagues and patients in this way. We intend to provide guidance on the administration of colleague and patient questionnaires and will address comments raised in the consultation, particularly in relation to the timing of participation in the revalidation cycle and either repeating the process or reflecting on the feedback to demonstrate improvement.
- 176.** The GMC agrees with the importance of a robust yet flexible system. We are not planning to provide a central system of colleague and patient feedback for all doctors. However, we are intending to provide GMC questionnaires for free on our website for those doctors and organisations who want to use them. Those questionnaires would need to be administered independently. We will continue to identify options for ensuring the quality of questionnaires used in revalidation.

Section 4 – How and when revalidation will be introduced

The final section of the consultation considered how we will ensure that organisations are ready to support revalidation and the process for rolling out revalidation across the UK.

- 177. As revalidation will be built largely on local, workplace-based systems of clinical governance, including appraisal, the timing for introducing revalidation across the UK is dependent on these systems being in place and working effectively.
- 178. We proposed taking a phased and incremental approach to the roll-out of revalidation, starting where systems are in place and working effectively. We suggested in the consultation that roll-out might potentially begin some time in 2011 and should continue over the following five years.

What we asked

Question 18:

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

Question 19:

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

What you told us

- 179. The majority of respondents agreed with both of these proposals: 77% of respondents agreed that revalidation should be introduced initially in areas and organisations where local systems are developed and sufficiently robust to support the revalidation of their doctors; 69% agreed with the proposed approach for the initial roll-out (see Figures 19 and 20).

Figure 19: Responses to question 18

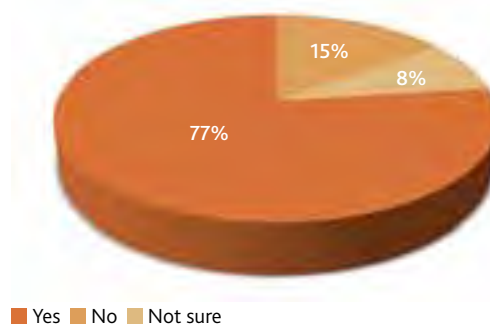
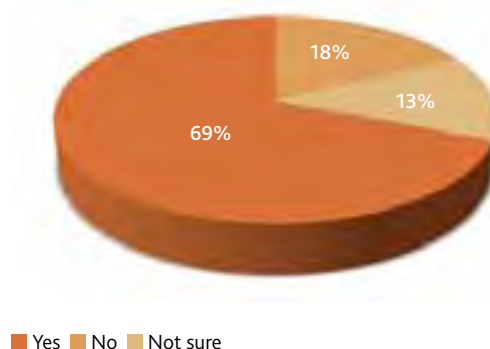


Figure 20: Responses to question 19



- 180. Many of the respondents agreed that the proposed approach was sensible. A number of organisations indicated that they would be willing to take part in piloting or early roll-out.

- 181.** A number of respondents suggested that greater clarity was needed about how readiness might be determined. Respondents also commented that it would be important to develop a clear timetable and milestones for readiness, as well as a strategy for dealing with those organisations that are failing to make sufficient preparations. Respondents suggested a number of specific mechanisms to encourage readiness.
- 182.** Respondents also commented that the proposed approach carried a number of risks and that it would be important not to lose sight of those organisations which do not have appropriate systems in place.
- 183.** A recurring comment in responses to these questions was the importance of adequate piloting and of sharing lessons from the pilots, before revalidation is rolled out. Some respondents questioned whether our proposed approach allowed sufficient time to review and learn from the pilots.
- 184.** A proportion of respondents had reservations about our approach, suggesting that it did not comply with a risk-based approach to regulation. Some respondents were concerned that by beginning with those organisations with systems in place we would not be focusing sufficiently on those organisations or individuals which potentially pose a greater risk to patient safety.
- 185.** A minority of respondents preferred a 'big bang' approach. Those who supported this approach suggested that the proposed approach risked being unfair to doctors working in less developed systems and might create a two tier system.
- 186.** Respondents commented that we should develop proposals for a formal assessment of readiness that is fair and consistent to all parties; this would require robust, measurable and unambiguous criteria in order to assess when organisations are ready.
- 187.** Several respondents commented on the importance of an iterative approach to implementing revalidation.
- 188.** While many respondents agreed that roll-out should begin with organisations involved in pilot schemes, some also commented that we should also look beyond those schemes for other suitable organisations.
- Our response**
- 189.** We remain firmly committed to the introduction of revalidation. The large number of responses we have received to the consultation has not revealed any reason to change this position or any fundamental reason to abandon revalidation. The introduction of revalidation therefore remains a reality and we will continue to take this work forward as quickly as possible.
- 190.** We also remain of the view that revalidation should be introduced and rolled out incrementally, and that there should not be a 'big bang' approach. Different regions and different organisations will be ready at different times and it makes no sense to wait for the slowest to be ready before its introduction. In any event, revalidation will evolve as it is implemented, and over time, in response to ongoing evaluation, quality assurance and a more established evidence base, all of which support a phased introduction.
- 191.** The passing of Responsible Officer regulations in Northern Ireland and laying of the regulations for the remainder of the UK is a clear commitment from the health departments to the implementation of revalidation.
- 192.** We welcome the Secretary of State for Health's decision to extend the period of testing in England by a further year, as this will provide additional time to develop further the proposals and test more extensively elements of the process. This is also in line with much of the feedback we have received from others through the consultation.
- 193.** The extension will also provide employers with additional time to ensure that they have appropriate systems in place to support their doctors in revalidation. This too will be an evolving process as employers strengthen their systems following evaluation and feedback.

- 194.** The current pilots in all four UK countries are an important part of the implementation process and will gather a range of valuable information on costs and benefits, and the current status of clinical governance systems within healthcare organisations, as well as feedback on how the appraisal framework works in practice. Those doctors participating in current pilots should be reassured that their involvement is essential to testing elements of revalidation and for identifying areas for further development.
- 195.** We will continue to work with our revalidation partners through the four country delivery boards and the overarching UK Revalidation Programme Board on implementation and to further develop and refine proposals around readiness. This work will include defining a process for assessing readiness together with the appropriate key criteria and indicators to be used.
- 196.** Some initial baseline data on organisational readiness has already been collected or is in the process of being collected in each of the four countries. In Northern Ireland, for example, the Regulation and Quality Improvement Authority (RQIA) has just completed a readiness assessment of secondary care. Similarly, in England, the Revalidation Support Team will ask NHS healthcare organisations to undertake a second round of readiness assessment in order to measure developments in healthcare organisations over the last 18 months and to identify areas where work is still required. The Department of Health (England) will also be initiating further testing of certain aspects of revalidation in England, including in non-NHS and non-mainstream environments.
- 197.** The Department of Health (England) will continue to collect relevant information on the resource implications associated with the implementation of revalidation, including the likely costs for employers in developing systems that support it. Such information will be set against the benefits to be gained through the introduction of revalidation in a formal impact assessment which will be considered by Ministers.

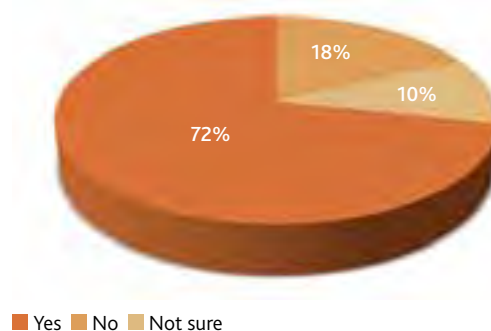
Question 20:

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

What you told us

- 198.** Seventy two percent of respondents agreed that a deadline should be set for organisational readiness for revalidation. Many responses, both from individual doctors and from organisations, suggested that a deadline was necessary to encourage organisations to take the necessary steps to prepare for revalidation. Respondents also suggested that a deadline would encourage individual doctors to engage with appraisal.

Figure 21: Question 20



- 199.** A number of respondents suggested that a deadline of five years after initial roll-out was too long a period and that organisations should be required to implement revalidation sooner.
- 200.** Respondents reiterated the point that a deadline on its own was probably not sufficient; planning for the implementation of revalidation would require a series of clear steps to check progress, together with clearly defined responsibilities.
- 201.** A number of organisations commented that it was important that a phased approach should not penalise individual doctors; individual doctors should not be affected because the organisations for which they work are not ready.

202. A minority of respondents questioned the value of a deadline and commented that it was more important to get revalidation right than to set a deadline.

203. A selection of comments received is below.

'It makes sense to take a phased, incremental approach to roll-out, starting in those organisations where the local systems are deemed sufficiently developed and robust enough to support it.'

Parliamentary and Health Service Ombudsman

'Agree but systems need to be checked and the proposed technique for measuring readiness must be disclosed ASAP and ultimate deadlines must be imposed to ensure that momentum is maintained.'

NHS North East

'It is accepted that areas where local systems are sufficiently developed and robust to support the revalidation of doctors would provide an opportune starting point for the process. However, given that these areas will already be subject to an evaluation "process" and able to offer some quality control on the profession, this is considered an easy option. It appears more important to pursue development in areas where there is no process in place or being undertaken.'

Board of Community Health Councils in Wales

'The system clearly needs to be piloted because not all problems or questions can be foreseen. A less rigorous standard should be expected of Guinea pigs because procedures etc are likely to be redefined and made more equitable as a result of their trial experience.'

Doctor

'What is clear is that trusts are anxious to have a published high-level timetable which sets out key milestones so that they can measure their "state of readiness" more closely than hitherto, and not end up rushing at the last minute to meet target dates.'

NHS Employers

'A deadline for having the systems in place would help with prioritising allocation of resources, but detail from pilots about minimum requirements would be helpful to drive the process.'

Doctor

'In order to ensure all doctors are able to revalidate five years from the starting date, it will be necessary for organisations to demonstrate their readiness three years from this date. This will allow a year for any final remedial action and then a final year for live recommendations based on appraisal and clinical governance systems of the appropriate standard.'

Revalidation Support Team

Our response

204. There are two significant dates to consider.

The first is the date when the enabling primary legislation underpinning the introduction of revalidation will be 'switched on' and revalidation will begin. The second is the date by which all organisations need to be ready to submit revalidation recommendations to the GMC.

205. We will work with partners to map out the process, timelines and key milestones (including preparation time) for implementation, including the identification of a start date. This map will need to retain a degree of flexibility to take into account the learning from the pilots, once completed and evaluated, as well as the conclusions from the Department of Health in England's impact assessment.

206. We take the view that healthcare organisations should be encouraged to begin as soon as possible to develop and strengthen their clinical governance systems where necessary and to embed appraisal systems for all of the doctors they employ or with whom they contract.

207. In developing the proposed approach to quality assuring the revalidation process, we intend to develop mechanisms to identify and publicise good and best practice amongst healthcare organisations and Responsible Officers. This will ensure that any lessons to be learned or improvements to be made can be shared with all concerned in a timely and effective manner.

Next steps

This section outlines the next steps for our revalidation proposals and plans for implementation, now that the consultation is over.

208. The Secretary of State for Health has made a public statement emphasising his commitment to revalidation. Revalidation remains the number one priority for the GMC. All of our key revalidation partners are committed to the delivery of a process, based on robust local systems that supports high quality care in the organisations and practices in which that care is delivered.

209. The many constructive responses to the consultation will help us shape the proposals for revalidation and the plans for implementation. The majority of responses support many of the proposals in our consultation; there is no overriding message that we need to discard the main features of the proposed model for revalidation.

210. However, as a result of the feedback, it is clear that further work is required to refine a number of the proposals, so that we can deliver a model that is practical and proportionate and that has the confidence of the profession and employers, as well as patients and the public. The common themes that have emerged from our analysis of responses will provide a useful starting point for further discussions with our revalidation partners and for planning for the next phase of development.

211. In this report we have outlined a number of ways that we will take on board the feedback we have received to the consultation, including reviewing our policies, developing guidance and further testing. Specifically, we stated that we will do the following.

Streamline the process

- Work with the medical Royal Colleges and Faculties to review and streamline their specialty and general practice frameworks. The Colleges and Faculties will also work on consistent guidance that will help doctors across all specialties to demonstrate their practice using a range of supporting information, and clearly identify what information is 'expected' and what information is 'optional'.
- Refine the GMC framework for appraisal based on *Good Medical Practice* to make it more flexible and ensure it covers all types of medical practice.
- Work with our delivery partners to ensure that all components of revalidation are integrated into a single process.

Make the process more flexible

- Develop proposals for how revalidation will work for doctors in non-clinical and non-mainstream roles.
- Continue to talk and listen to non-mainstream doctors and their organisations so that we can better understand the way they practise and the challenges they face.

Add more detail to the proposals

- Define how the medical register will show the field of medical practice that has provided the basis for a doctor's revalidation, whilst recognising that many doctors practise across more than one discipline.
- Describe how doctors working in non-mainstream and non-clinical roles will revalidate.
- Explore possible options around quality assurance, including the potential involvement of systems regulators and a possible GMC programme of sampling and audit.

Learn what works best for doctors and employers

- Examine the challenges that Responsible Officers may face in making recommendations in some circumstances. This will help us see where we might helpfully provide appraisers and Responsible Officers with guidance and information.
- Learn how our *GMP* Framework can be integrated successfully into appraisal. Many pilots are already showing a good degree of support for the use of the Framework as the basis for appraisal and revalidation.
- Understand how specialty practice can be best reflected in appraisal and revalidation and the appropriate supporting information to demonstrate this.
- Conduct a large-scale literature review looking at clinical governance and appraisal, clinical audit, patient and public involvement in the delivery of healthcare and the evaluation of health professionals' practice.
- Learn from the experiences and research of international and industry experts, holding an international symposium in early December 2010.

Start to plan for implementation

- Work with our partners to map out the process, timelines and key milestones for implementation, including agreement on a start date.
- Work with our partners to strengthen medical appraisal and review the clinical governance systems that will need to be fit for purpose for revalidation. As part of this, we will work with our partners to embed the *GMP* Framework into appraisal systems.
- Develop mechanisms to identify and publicise good and best practice amongst healthcare organisations and Responsible Officers. We will also consider how best we can support Responsible Officers to manage concerns about the practice of individual doctors early and effectively.
- Review our principles and criteria for colleague and patient questionnaires, which will help organisations that are planning to develop, purchase or administer questionnaires.
- Develop and refine the proposals for assessing the readiness of organisations. This will include defining a series of key criteria and indicators for readiness.

Conclusion

212. The successful introduction of revalidation is a shared responsibility involving the GMC, the Health Departments in England, Northern Ireland, Scotland and Wales, the medical Royal Colleges, the Revalidation Support Team working with the NHS and other employers in England, and the medical profession. Looking ahead, this group of interested organisations and individuals will continue to work together to develop, test and implement a system of revalidation throughout the UK that is feasible, flexible, proportionate and cost effective.

Appendix A – Glossary of terms, organisations and acronyms

Academy of Medical Royal Colleges (AoMRC)	The Academy's role is to promote, facilitate and where appropriate co-ordinate the work of the medical Royal Colleges and their Faculties for the benefit of patients and healthcare. Website: www.aomrc.org.uk
Annual Review of Competence Progression (ARCP)	The Annual Review of Competence Progression is a mechanism of recording the review of a trainee's progression through their training programme. All doctors occupying a specialty training post are required to undertake a yearly assessment of their progress.
Appraisal and Whole Practice Appraisal	<p>Appraisal is the regular review of a doctor's performance, usually undertaken in the hospital or practice in which the doctor works. Our proposals for revalidation are based on local appraisal systems.</p> <p>Doctors practising in both the NHS and independent sectors need to undertake whole practice appraisal which will take account of their work in both sectors. The appraisal will usually take place in the sector within which they do the bulk of their work.</p>
British Medical Association (BMA)	The British Medical Association is the professional medical association and trade union for doctors and medical students. Website: www.bma.org.uk
Certificate of Completion of Training (CCT)	The Certificate of Completion of Training (CCT) confirms satisfactory completion of an approved programme of training and is one of the certificates which allows entry to the GMC Specialist or GP Registers.
Clinical governance	<p>Clinical governance has been defined as 'a framework through which NHS organisations are accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish'.</p> <p>G Scally and L J Donaldson, <i>'Clinical governance and the drive for quality improvement in the new NHS in England'</i> <i>BMJ</i> (4 July 1998): 61-65</p>
Colleague and patient questionnaires	Feedback through colleague and patient questionnaires (also known as multi source feedback (MSF)) is one of the elements required for revalidation. It involves doctors obtaining feedback on their performance from patients and colleagues. The feedback will be obtained through the completion of questionnaires. We envisage that doctors will need to do this at least once during each five-year revalidation cycle.
Continuing professional development (CPD)	CPD refers to the processes and activities pursued by doctors after the formal completion of training programmes that enable them to maintain and develop their professional practice. Doctors will need to demonstrate evidence of CPD in order to revalidate.

Delivery boards	Delivery boards have been established for each of the four UK countries. It is the responsibility of each delivery board, led by the health departments in each country, to ensure organisations have systems in place to support revalidation across all forms of healthcare.
Delivery partners	Delivery partners refers to all the organisations we will work with in order to deliver revalidation, including the four health departments.
Department of Health (England)	<p>The work of the Department of Health exists to improve the health and wellbeing of people in England. Specifically it aims to provide:</p> <ul style="list-style-type: none"> ● better health and wellbeing for all: helping people stay healthy and well; empowering people to live independently; and tackling health inequalities ● better care for all: the best possible health and social care that offers safe and effective care, when and where people need it; and empowering people in their choices ● better value for all: delivering affordable, efficient and sustainable services; contributing to the wider economy and the nation. <p>More information about the DH (England) can be found on its website at: www.dh.gov.uk</p>
Department of Health and Social Services (Wales)	<p>The work of the Department of Health and Social Services in Wales includes treating disease and addressing the social, economic and environmental influences that affect the health and well being of people in Wales. Specifically it is responsible for:</p> <ul style="list-style-type: none"> ● advising the Welsh Assembly Government in setting policies and strategies for health and social care in Wales ● contributing to making legislation in the field of health and social care ● providing funding for the NHS and other health and social care bodies ● managing and supporting the delivery of health and social care services ● monitoring and promoting improvements in service delivery. <p>More information about the DHSS (Wales) can be found on its website at: www.wales.gov.uk/about/civilservice/departments/dhss</p>

Department of Health, Social Services and Public Safety (DHSSPS) (Northern Ireland)

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

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

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

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

General Medical Council (GMC)

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

Good Medical Practice

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

List of Registered Medical Practitioners (LRMP)

Patients and the public can use the List of Registered Medical Practitioners to check details of all the doctors on the GMC's register. It can be accessed through the GMC website. Website: www.gmc-uk.org

Medical Royal Colleges and Faculties

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

National Clinical Assessment Service (NCAS)

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

Professional and Linguistic Assessments Board Test (PLAB test)

The PLAB test is the main route by which international medical graduates (IMGs) demonstrate that they have the necessary skills and knowledge to practise medicine in the UK.

<p>Recertification</p>	<p>Recertification was the second component of revalidation proposed in the White Paper (Trust, Assurance and Safety), applying only to those doctors who are on the GMC’s Specialist Register or GP Register. The White Paper proposed that these doctors would need to demonstrate, through recertification, that they continue to meet the particular standards that apply to their specialty or area of practice.</p> <p>Our consultation paper proposed that revalidation should be based on a single set of processes for evaluating doctors’ performance in practice, rather than through the separate elements of relicensing and recertification.</p>
<p>Regional Medical Revalidation Support Team (RMRST)</p>	<p>The Regional Medical Revalidation Support Team (RMRST) is a local forum that covers the whole spectrum of healthcare providers and associated bodies and enables a rich discussion of issues on topics such as data available to medical directors, policies on alcohol at work and the particular problems posed by specific groups of doctors. These teams have been piloted as a part of the GMC Affiliates pilots in London and Yorkshire and the Humber. Feedback from team members is that they feel it is an extremely valuable forum to exchange information, ideas and policy.</p>
<p>Relicensing</p>	<p>Relicensing was the first element of revalidation proposed in the White Paper by which all licensed doctors will need to demonstrate to the GMC that they are practising in accordance with the generic standards of practice set by the GMC (as described in <i>Good Medical Practice</i>). Our consultation proposed that revalidation should constitute a single process.</p>
<p>Remediation</p>	<p>Remediation refers to the use of corrective methods to improve skills and competences; these will include further training, support, mentoring and guidance for doctors when performance concerns have been identified.</p>
<p>Responsible Officers (ROs)</p>	<p>The post of Responsible Officer (RO) is a new statutory role. In broad terms, the RO will be responsible for the local evaluation of doctors’ fitness to practise for the purposes of revalidation, for overseeing the operation of local clinical governance arrangements necessary to support revalidation (except in Scotland where this is a matter for medical directors), and for ensuring appropriate action where there are concerns about doctors’ fitness to practise. In particular, ROs will be responsible for the revalidation recommendations made to the GMC regarding the doctors linked to their organisation.</p>
<p>Revalidation</p>	<p>Revalidation is the process by which doctors will have to demonstrate to the GMC that they remain up to date and fit to practise. In the future, all licensed doctors will need to revalidate regularly, if they wish to keep their licence to practise. For most doctors, revalidation will take place every five years.</p>

Revalidation Support Team (RST)

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

- support NHS organisations in the effective provision of revalidation
- support individual participation in appraisal and revalidation.

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

Scottish Government Health Directorates (SGHD)

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

More information about the SGHD can be found on its website at:
www.scotland.gov.uk/topics/health

UK Revalidation Programme Board

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

Appendix B – List of the organisations that responded to the consultation



Revalidation:
The way ahead

360Clinical
Academy of Medical Royal Colleges
Academy of Medical Royal Colleges and Faculties in Scotland
Academy of Medical Royal Colleges Directors of CPD
Academy of Medical Sciences
Academy of Royal Colleges in Wales
Academy Trainee Doctors Group
Action against Medical Accidents (AvMA)
Action for Sick Children
Age UK
Anaesthetists in Management
Association for Paediatric Palliative Medicine
Association for Palliative Medicine of Great Britain
Association of Aviation Medical Examiners
Association of British Clinical Diabetologists
Association of British Neurologists
Association of UK University Hospitals
Association of Upper Gastrointestinal Surgeons
Avon and Wiltshire Partnership NHS Trust
Barts and The London SMD QMUL
Belfast Health and Social Care Trust
Blue Ribbon for the Awareness of ME
BMA Retired Members Forum
Board of Community Health Councils in Wales
Brighton and Hove City PCT
Bristol University
British Association for Community Child Health
British Association of Aesthetic Plastic Surgeons
British Association of Urological Surgeons
British Geriatrics Society
British Homeopathic Medical Association
British Medical Association
British Orthopaedic Association
British Pharmacological Society
British Society for Rheumatology
British Thoracic Society
Bro Taf LMC
Bromley Local Medical Committee
BUPA
Cambian Group
Cambridgeshire and Peterborough NHS Foundation
Trust
Cambridgeshire LMC
Care Quality Commission
Central and North West London NHS Foundation Trust
CFEP UK Surveys
Cheshire LMC
Christian Medical Fellowship
City and Hackney PCT Appraisers
College of Emergency Medicine
COPMED and NHS Education Scotland
Council for Healthcare Regulatory Excellence
Cygnet
David Lewis Centre
Department of Health Social Services & Public Safety
Dorset Primary Care Trust
Dr ME Glaze and Partners
East Cheshire NHS Trust
ENT UK
EoE PCT Network
Faculty of Forensic and Legal Medicine
Faculty of Homeopathy
Faculty of Occupational Medicine
Faculty of Pharmaceutical Medicine
Faculty of Public Health
Federation of Independent Practitioner Organisations
Five Boroughs NHS Partnership
Gay and Lesbian Association of Doctors and Dentists
General Dental Council
General Healthcare Group
General Teaching Council Scotland
Glasgow LMC
Glasgow University Medical School
GlaxoSmithKline
Gloucestershire Hospitals NHS Foundation Trust
Group of Anaesthetists in Training Committee
Health Professions Council
Health Protection Agency
Health and Safety Executive
Heart of England NHS Foundation Trust
Help the Hospices
Higher Education Academy, Newcastle University

Hoole Road Surgery
 Hospital Consultants and Specialists Association
 Hypermobility Syndrome Association
 Independent Doctors Federation
 Independent Healthcare Advisory Services
 Indian Medical Association UK
 Iodem Health Ltd
 Kent LMC
 Lancashire and Cumbria Consortium of LMCs
 Leeds Partnerships NHS Foundation Trust
 Leeds Teaching Hospitals
 Lewisham PCT
 Liverpool LMC
 Locum Doctors Association
 London Deanery
 London Deanery CPD Unit
 Manchester LMC
 Medacs Healthcare SVS PLC
 Medical and Dental Defence Union of Scotland
 Medical Defence Union
 Medical Insurance Advisory Bureau
 Medical Protection Society
 Medical Schools Council
 Medical Women's Federation
 Medicines and Healthcare products Regulatory Agency (MHRA)
 Medway Trust
 Mencap
 Mental Health Foundation
 Mental Welfare Commission for Scotland
 Merton Surgery
 Ministry of Defence
 National Appraisal Leads Group (Scotland)
 National Association of Primary Care Educators
 National Clinical Assessment Service
 National Information Governance Board for Health and Social Care
 National Voices
 Newcastle upon Tyne Hospitals NHS Foundation Trust
 NHS Bedfordshire
 NHS Birmingham East and North
 NHS Cambridgeshire
 NHS Coventry
 NHS Derby City
 NHS Derbyshire County
 NHS East of England
 NHS East of England Multiprofessional Deanery
 NHS Eastern and Coastal Kent PCT
 NHS Employers
 NHS Greater Glasgow and Clyde Health Board
 NHS Hertfordshire
 NHS Institute for Innovation and Improvement
 NHS Lincolnshire
 NHS London
 NHS Lothian
 NHS Manchester
 NHS National Services Scotland
 NHS North East
 NHS North of Tyne
 NHS Nottinghamshire County
 NHS Quality Improvement Scotland
 NHS Revalidation Support Team
 NHS Salford
 NHS Somerset
 NHS South Central
 NHS Wiltshire
 NHS Worcestershire
 NHS24
 North East Lincolnshire Care Trust Plus
 North Glasgow Community and Health Partnership
 North Tees and Hartlepool NHS Foundation Trust
 Northumbria Health Care NHS Foundation Trust
 Nottingham Healthcare and Derbyshire Mental Health Trust Revalidation Pilot Steering Group
 Nursing and Midwifery Council
 Offender Health, Department of Health
 Parkinsons UK
 Parliamentary and Health Service Ombudsman
 Patient and Client Council
 Peninsula Medical School
 Pfizer
 Picker Institute Europe
 POhWER
 Primary Care and Older Peoples Services Directorate,

Western HSC Trust
Psychiatric Medical Advisory Committee of NHS
Grampian
Public Health Agency
Queens Hospital Burton Hospital NHS Foundation Trust
Ramsay Healthcare UK
Remote Practitioners Association of Scotland
Royal College of Anaesthetists
Royal College of General Practitioners
Royal College of General Practitioners Rural Forum
Royal College of Obstetricians and Gynaecologists
Royal College of Ophthalmologists
Royal College of Paediatrics and Child Health
Royal College of Pathologists
Royal College of Pathologists Lay Advisory Committee
Royal College of Physicians, London
Royal College of Physicians of Edinburgh
Royal College of Physicians of London Patient and
Carer Involvement Steering Group
Royal College of Psychiatrists
Royal College of Psychiatrists Scottish Division
Royal College of Radiologists
Royal College of Radiologists Clinical Oncology
Patients' Liaison Group
Royal College of Surgeons of Edinburgh
Royal College of Surgeons of England
Royal College of Surgeons of England Patient Liaison
Group
Royal Society of Medicine
RSI Action
Scottish Commission for the Regulation of Care
Scottish Government Health Directorates
National Appraisal Leads Group (Scotland) (NALG)
SEPT
Sheffield LMC
Skills for Health
Society for Cardiothoracic Surgery in Great Britain
and Ireland
Society of Biology
Society of Clinical Psychiatrists
South Tees Hospitals
Southern Health and Social Care Trust
Spire Healthcare
St Andrew's Healthcare
Standard Life Healthcare
Sue Ryder Care
Tavistock and Portman NHS Foundation Trust
The BMJ Group
The British Pain Society
The Independent Sector Responsible Officer
Committee
The Patients Association
The Portland Hospital for Women and Children
The Regulation and Quality Improvement Authority
The Rotherham NHS Foundation Trust
The Royal Orthopaedic Hospital NHS Trust
The University of Nottingham
ThreeSixty is us Ltd
Thyroid Patient Advocacy UK
Trade Association of British Insurers
UK Civil Aviation Authority
Universities and Colleges Employers Association
(UCEA)
University College London Medical School
University Hospitals Birmingham
University Hospitals Coventry and Warwickshire NHS
University of Leicester Medical School
University of Sheffield School of Medicine
University of Southampton
Unnamed Hong Kong clinic
Velindre NHS Trust
Wales Deanery
Warwick Medical School
Weldmar Hospicecare Trust
Wellcome Trust
Welsh Assembly Government
Welsh NHS Confederation
West London Mental Health Trust

Appendix C – List of consultation engagement events

Organisation	Interest Group	Country
Wales Medical Academic Group	Doctors (academic)	Wales
Revalidation Consultation Launch – England	All stakeholders	England
Chairs of Wales Specialty Training Schools	Doctors (academic)	Wales
Revalidation Consultation Launch – Scotland	All stakeholders	Scotland
North West Wales Consultants Committee	Doctors (secondary care)	Wales
London Deanery Pathfinder Launch Event	Doctors	England
Scottish Government Health Directorates	Doctors	Scotland
Northern HSC Trust	Doctors	Northern Ireland
Revalidation Consultation Launch – Northern Ireland	All stakeholders	Northern Ireland
BMA Scotland Committee Chairs Conference	Doctors	Scotland
Sinn Fein Ard Fheis	Political representatives	Republic of Ireland
Revalidation Consultation Launch – Wales	All stakeholders	Wales
BAMM/Healthcare Events	Doctors (GPs)	England
Romney Street Group		England
DHSSPS Primary Care Revalidation Roadshow Meeting	Doctors (GPs)	Northern Ireland
Scottish National General Practitioner Revalidation Steering Group (SNGPRSG) and National General Practitioners Appraisal Group (NGPAG)	Primary care	Scotland
Houses of Parliament	Political representatives	England
Meeting with Deputy CMO Wales and Medical Director NHS Wales	Assembly Government	Wales
Meeting with Chief Executive Healthcare Inspectorate Wales	Regulators	Wales

Organisation	Interest Group	Country
Meeting with Secretary BMA Wales	Representative Body	Wales
GP and Appraisal Unit, Dept of Wales Postgraduate Education for General Practice, Cardiff University	Doctors (GPs) and administrators	Wales
BMA Scotland Local Medical Committees (LMC) Conference	Doctors (GPs)	Scotland
BMA SAS Doctors Committee	Doctors (SAS)	England
Royal College of Obstetricians and Gynaecologists	Doctors	England
Royal College of Surgeons	Doctors (SAS)	England
Maidstone and Tunbridge Wells NHS Trust	Doctors (SAS)	England
Scottish Regulatory Forum	Regulators	Scotland
BAMM/Healthcare Events Conference	Medical directors	England
Tayside LMC	Doctors (GPs)	Scotland
Medical & Dental Defence Union in Scotland (MDDUS)	Doctors	England
Scottish Government Health Directorates (Edinburgh)	Doctors	Scotland
GP and Appraisal Unit, Dept of Wales Postgraduate Education for General Practice, Cardiff University	Doctors (GPs) and administrators	Wales
BAMM/Healthcare Events Conference	Medical directors	England
Meeting with DHSSPS	Civil service	Northern Ireland
General Dental Council	Regulator	England
Scottish Government Health Directorates (Glasgow)	Doctors	Scotland
Princess of Wales Hospital Bridgend	Doctors (SAS)	Wales
BMA Regional Committee	Doctors	England
National Clinical Assessment Service (NCAS) Annual Conference	Chief executives, medical directors, non-executive directors of NHS organisations, HR directors and consultants	England
Department of Health – England	Medical directors (SHA level)	England
IHAS/GMC Revalidation Group	Medical directors (independent sector)	England
Recruitment and Employment Confederation	Employers (locum agencies)	England

Organisation	Interest Group	Country
British Medical Association (BMA) Medical Students Conference	Doctors (students)	England
Yorkshire SAS Committee	Doctors (SAS)	England
Wales Medical Academic Group	Doctors (academic)	Wales
DH, Locum Agencies and Revalidation	Employers (locum agencies)	England
Medical Defence Union (MDU) MLA Network	Doctors	England
Directors of CPD	Doctors	All UK
Academy of Medical Royal Colleges	Doctors	All UK
Interdepartmental Clinical Governance Committee	Doctors (civil service)	England
NHS Employers Wales Unit – Wales Employment Practice Group	Employers (NHS) – Deputy HR Directors and HR staff	Wales
Prince Phillip Hospital Llanelli	Doctors (secondary care)	Wales
Community Health Councils – Andrea Matthews	Patients and the public	Wales
BMA Wales - Revalidation SubCommittee	Doctors	Wales
University Hospital Wales, Cardiff	Doctors (secondary care)	Wales
Nottingham University Hospital NHS Trust	Doctors (trainees)	England
British Medical Association (BMA) National Conference of GPs to be	Doctors (GPs)	England
British International Doctors England Association (BIDA)	Doctors (BME)	Scotland
Ysbyty Gwynedd Bangor	Doctors (secondary care)	Wales
Ysbyty Glan Clwyd, Bodelwyddan	Doctors (secondary care)	Wales
Kimnel Manor Hotel, Abergele	Doctors (primary care)	Wales
Department of Health, Social Services and Public Safety, NIMDTA, BMA (NI), RCGP (NI)	Doctors (GPs)	Northern Ireland
Dundee LMC (BMA)	Doctors (GPs)	Scotland
Crosshouse Hospital,	Doctors	Scotland
Betsi Cadwaladr Local Health Board	Employers and Doctors (secondary care)	Wales
NHS Employers Policy Board	Employers (NHS)	England

Organisation	Interest Group	Country
Wrexham Maelor Hospital	Doctors (secondary care)	Wales
NI Delivery Board	Doctors and Civil Servants	Northern Ireland
British Medical Association (BMA) Private Practice Committee Conference	Doctors (private practice)	England
GPC Wales	Doctors (primary care)	Wales
Royal College of Obstetrics and Gynaecologists Clinical Directors Forum	Doctors	England
GLADD	Doctors (gay and lesbian)	England
National Voices	Patients and the public	England
Yorkshire and Humber Employers Group	Employers (NHS)	England
Department of Health, Social Services and Public Safety, NIMDTA, BMA (NI), RCGP (NI)	Doctors (GPs)	Northern Ireland
BUPA	Doctors	England
Stirling Royal Infirmary	Doctors (GPs and secondary care)	Scotland
Western General Hospital	Doctors (trainees)	Scotland
Lothian LMC	Doctors (GPs)	Scotland
BME Doctors Forum (GMC)	Doctors (BME)	England
Annual Conference of British Orthopaedic Specialist Association	Doctors (SAS)	England
Deaf Connections	Patients and the public	Scotland
MECOPP Minority Ethnic Carers	Patients and the public	Scotland
People First – Learning Disability Self Advocacy	Patients and the public	Scotland
HYPPE – Borders Youth Group	Patients and the public	Scotland
Royal Society of Medicine	Doctors	England
Department of Health, Social Services and Public Safety, NIMDTA, BMA (NI), RCGP (NI)	Doctors (GPs)	Northern Ireland
Patient and Client Council NI	Patients and the public	Northern Ireland
Department of Health, Social Services and Public Safety, NIMDTA, BMA (NI), RCGP (NI)	Doctors (GPs)	Northern Ireland
Multiple stakeholders	Doctors, employers, patients and the public	Northern Ireland

Organisation	Interest Group	Country
British Association of Medical Managers (BAMM) – Medical Director Responsible Officer Discussion Group	Medical directors	England
Golden Jubilee	Patients and the Public (learning disability group)	Scotland
Welsh Assembly Government – DCMO Medical Directors Forum	Medical directors (NHS)	Wales
British Medical Association (BMA) Junior Doctors	Doctors (trainees)	England
British Medical Association (BMA) Medical Managers Committee	Medical directors	England
Department of Health, Social Services and Public Safety, NIMDTA, BMA (NI), RCGP (NI)	Doctors (GPs)	Northern Ireland
HSC Trust Medical Directors	Doctors	Northern Ireland
Scottish Academy Revalidation Group	Royal Colleges	Scotland
Scottish Revalidation Conference	Doctors	Scotland
Royal College of Anaesthetists	Doctors	England
St Johns Ambulance	Doctors	England
Medical Women's Federation	Doctors (female doctors)	England
BMA Conference of Medical Academic Representatives (COMAR)	Doctors (clinical academics)	England
Leicester Pathfinder Pilot Information Event	Doctors	England
RC Psych Scottish Division	Doctors	Scotland
Combined Divisional Hospital Meeting, Ayr Hospital	Doctors	Scotland
NHS Forth Valley Consultants Away Day at Inchyra Grange Hotel	Doctors	Scotland
S Dumfries & Galloway Royal Infirmary	Doctors	Scotland
Independent Healthcare Advisory Services (IHAS)	Employers (Independent Sector)	England
North Middlesex Hospital	Doctors	England
Ayr Hospital	Doctors (GPs and secondary care)	Scotland
NI Delivery Board	Doctors and civil servants	Northern Ireland
NHS Employers – Medical Workforce Forum	Employers (NHS)	England

Organisation	Interest Group	Country
Patient Experience Conference Kings Fund	Patients and the public	England
British International Doctors' Association (BIDA)	Doctors	England
Queen Margaret Hospital, Dunfermline	Doctors	Scotland
National Voices	Patients and the public	England
Leicester Pathfinder Pilot Information Event	Doctors	England
British Association of Physicians of Indian Origin (BAPIO)	Doctors (BME)	England
Stobhill Hospital	Doctors	Scotland
Wishaw General Hospital	Doctors	Scotland
BMA Armed Forces Committee Conference	Doctors (military)	England
Faculty of Pharmaceutical Medicines National Trainees Meeting	Doctors (trainees)	England
Belfast HSC Trust Workshop	Doctors	Northern Ireland
RCGP Rural Doctors Steering Group	Doctors	England
UK Systems Regulators Revalidation Group	Regulators	All UK
Cumbria Health On Call	Doctors	England
British Association of Medical Managers – Primary Care Medical Directors Joint RCGP Group	Medical directors (primary care)	England
Belfast Health and Social Care Trust – Medical Leadership Forum	Doctors (secondary care)	Northern Ireland
Southern HSCT Revalidation Seminar (TBC)	Doctors	Northern Ireland
Betsi Cadwalader UHB	Doctors (secondary care)	Wales
Revalidation and Faculty of Sexual and Reproductive Health	Doctors	England
Western HSCT Revalidation Seminar	Doctors	Northern Ireland
Stratheden Hospital	Doctors	Scotland
BMA Consultants Committee Conference Display Stand		England
Raigmore Hospital, NHS Highland	Doctors	Scotland
Medical Protection Society	Doctors	England



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