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Appraisal and Revalidation

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All these articles are situated on the BMJ Careers website (careers.bmj.com) and are under the Careers Centre tab.
Countdown to revalidation

After years of delays revalidation is set to be introduced at the end of this year. Helen Jaques looks at the road map to implementation and the possible stumbling blocks.

Most doctors in the United Kingdom do not have to prove their fitness to practise at any time in their career except the point at which they join the medical register. Professionals in other high risk industries, with aviation being the most frequently cited, are expected to prove on a regular basis that their performance, knowledge, and skills are up to date. Many members of the public assume that the same applies to doctors. In the wake of the Shipman inquiry, a government white paper concluded that more needed to be done to assure the quality of doctors’ practice. It recommended that doctors prove their fitness to practise every five years, and thus the concept of revalidation was born.

Timeline to introduction

Revalidation requires doctors to complete an appraisal each year, including providing supporting information to show how they are meeting the professional values set out by the GMC, and then every five years to seek multisource feedback from colleagues and patients. Organisations that employ or contract medical practitioners—“designated bodies” in revalidation parlance—have been asked to assess and improve their clinical governance structures ahead of revalidation to ensure that doctors undergo effective annual appraisals and can get hold of the supporting information they need.

The results of the 2010-11 organisational readiness self assessment (ORSA) in England and Wales, published in October last year, and the interim readiness assessments up to 31 December 2011 show good progress towards implementation of revalidation, says Anita Donley, medical director for the NHS Revalidation Support Team, which is in charge of delivering revalidation in England. As at 31 December 2011 three quarters (77%) of doctors were linked to a designated body that was either ready or expected to be ready by December 2012. Two thirds (62%) of designated bodies had appropriate appraisal policies in place—up from 52% in the 2010-11 ORSA—and 70% of organisations were confident that they had enough trained appraisers.

Over this summer the national delivery boards of each of the four nations of the UK will review the state of readiness in their country and will in September submit an assessment of whether they are prepared for revalidation to begin in late 2012. The same month the UK Revalidation Programme Board will form a UK-wide collective recommendation that it will present to the General Medical Council’s governing council, which will subsequently make a recommendation to the health secretary for England, Andrew Lansley, as to whether the legislation for revalidation should go ahead (figure 1).

Donley says that the Revalidation Programme Board is confident that revalidation will be launched this year as planned. “The time is now; it’s not about waiting again, it’s too important—to wait any longer would be wrong,” she said. Peter Rubin, chairman of the General Medical Council (GMC), is similarly certain that revalidation will be implemented in 2012. “We’re more conscious than anybody that this has been a very long journey, but we’re very confident that this is going to go ahead,” he said. “The public expects it to happen.”

Presuming that this all runs without a hitch, the first doctors to be revalidated at the end of 2012 will be the (senior) level 2 “responsible officers,” such as the chiefs of the strategic health authority clusters. (Responsible officers are senior doctors, in many cases medical directors of designated bodies, who are in charge of recommending whether doctors should be revalidated and for ensuring that appraisal systems are up to scratch.) The next doctors through the gates will be level 1 responsible officers in place at designated bodies. By April 2013 all responsible officers will be expected to start making recommendations for revalidation, with around 20% of doctors expected to be revalidated by April 2014. The vast majority of doctors will have been revalidated by the end of March 2016.

Exactly which doctors will be first up for revalidation next year varies across the UK, although the GMC hopes to inform this first cohort of their revalidation date in December. In England, for example, responsible officers will randomly select a sample of doctors or will select according to locally determined criteria, such as doctors with management or leadership roles or doctors who comply with the...
minimum requirements for the currency and relevance of supporting information (or a combination of both approaches). Scotland will be randomly nominating doctors for revalidation on the basis of their GMC registration numbers, with doctors who have either 4 or 6 as the penultimate digit of their GMC registration number being the first to be revalidated.

Issues to be resolved
Organisations such as the BMA are concerned that several details in the plans may need to be fixed before revalidation can be introduced.[5] In a letter to the Department of Health and the GMC, the association warned about outstanding problems with the supporting information required for revalidation, not least the multisource feedback process that doctors are expected to use to seek feedback from patients and colleagues; the time and resources needed to complete revalidation; and the provision for remediation.

Requirements for supporting information
To prepare for revalidation doctors need to bring to their annual appraisals supporting information to show how they are meeting the professional values set out in the GMC’s guidance Good Medical Practice. Doctors will need to bring six types of supporting information at least once in each five year revalidation cycle:

• Evidence of continuing professional development
• Evidence of quality improvement activity
• Data on significant events
• Feedback from colleagues
• Feedback from patients, and
• A review of complaints and compliments.

To provide some of these types of evidence doctors will need to draw information out of their employers’ clinical governance systems. The BMA is concerned, however, that many clinical governance systems are not up to this task and that doctors might themselves have to dig up this supporting information. The GMC has emphasised, though, that doctors won’t be prevented from being revalidated if their employer fails to provide this supporting information.[6] “We know there are concerns about what sort of information can be made available to doctors in terms of the current technology,” said Rubin. “Some of the more complicated clinical outcome measures will not be widely available, and it would clearly be unreasonable to expect doctors to bring something that is simply not available at their organisation.”

Doctors themselves should kick up a fuss if they find that their organisation isn’t providing the data they need for their supporting information, advises Donley. “What doctors should be doing really is engaging with the information available to them—and with sources that are difficult to access they should be making a fuss about it and drawing the attention of the designated body to the fact that it is difficult to get hold of information,” she said.

The BMA is also concerned about how feedback from patients and colleagues will be collected. The GMC has recommended that doctors seek feedback from up to 43 consecutive patients (minimum 34) and 20 colleagues (minimum 15) to complete revalidation.[7] The BMA’s General Practitioners Committee has called this an “enormous paper chasing exercise” that could eat into time for clinical care.

Rubin emphasises, however, that doctors need only collect multisource feedback once every five years. He acknowledges that collecting feedback and ensuring anonymity of responses may be difficult in some environments, such as for locums and in rural areas, but has said that the GMC will take a “pragmatic” approach. “We’re not going to be rigid about this,” he says. “We know that doctors work in all sorts of different environments, so the last thing we want to do is insist on a one size fits all approach.”

Time and resourcing
Gathering all this information, as well as the actual appraisal process itself, is likely to be time consuming. Pathfinder pilots of revalidation among more than 3000 doctors in England found that doctors spent between 12 and 18 hours collating and summarising information for their appraisal, an additional 4–10 hours on top of their current preparation for appraisal.[8]

The Academy of Medical Royal Colleges has recommended that hospital consultants need 1.5 supporting professional activity (SPA) sessions a week to do all the activities required for appraisal, which the BMA says could prove a problem given the erosion of SPAs by many employers, NHS trusts, and health boards.[9] “It is also currently unclear whether GPs will be provided with the extra resources and therefore time that they will need to complete the process,” the association has said.

The framework to be used for appraisal has been simplified since the pilots were completed, said Donley, making the process simpler and, hopefully, less time consuming. “Strengthened medical appraisal, which was a process that pre-dated the current process, was exhaustively mapped to each attribute of Good Medical Practice, but [applying this framework] was felt by doctors and others to be onerous,” she said. “The guidance and requirements now refer to the four domains of the Good Medical Practice framework rather than an exhaustive mapping to each attribute within each domain.” Even if it is assumed that doctors will need to spend an extra four or five hours on their appraisal, this time will be spread over a whole year, adds Rubin (box 1). “If you do this work as you’re going along and record things as you’re going along it does make life so much easier.”

Remediation
Logic suggests that if all doctors are subjected to greater scrutiny as a result of revalidation, more will be identified as needing to improve their practice. However, the results of the 2010–11 O RSA indicated that remediation of doctors identified by the appraisal and revalidation process as struggling might be a problem. Although most designated bodies (83.2%) had a process for investigating concerns about a doctor’s practice, only a third (30.2%) had a policy in place for re-skilling, rehabilitation, remediation, and targeted support. The BMA has said that it is “still far from clear” how remediation will work in practice and who will be responsible for its delivery and funding.

Revalidation has really “shone a light” on the adequacy, consistency, and fairness of remediation for doctors and on the preparedness of the health sector to deal with issues affecting doctors’ fitness to practise, said Donley. She pointed out that the NHS Revalidation Support Team has recently published guidance on remediation that identifies and signposts good practice and refers to processes, ways of categorising risk, and ways of providing the generic support functions needed for remediation (box 2).[10] “What the guidance suggests is having a consistent, fair, and equitable process across England that identifies the generic functions that would need to be provided to an assured level to provide that,” she said.
Box 1 What you need to do to prepare

If a doctor is engaged in appraisal and is part of a good clinical governance system, he or she should be meeting most of the requirements for revalidation already, says Anita Donley, medical director for the NHS Revalidation Support Team. “Responsible doctors should constantly be in a process of examining the safety and quality of their practice, their own fitness to practise, and the safety and quality of the care that they provide to patients,” she said. “That in a sense is not something that is peculiar to the process of individual appraisal and revalidation: it’s part of a professional and ethical responsibility, it’s something about being a doctor.”

Doctors can do a few things to prepare, though, not least looking at the GMC’s website to see what is required for revalidation and thinking about how they can obtain that information in their own working environment, says Peter Rubin, the GMC’s chairman. It’s also important to plan ahead over the whole five year revalidation cycle and not leave things to the last minute. “With planning and spreading the work over a period of time, the whole thing becomes very manageable,” said Rubin. “If you’re not using an e-portfolio, start using one, because it makes it so much easier to keep everything up to date and show what you’ve done that year in terms of things like CME [continuing medical education], rather than scrambling around in the few weeks before your appraisal wondering where the bits of paper are.”

Donley recommends that doctors take into account all areas of their practice, not just the clinical areas, when preparing for appraisal and revalidation. “I will be submitting to my annual appraisal reflections on the whole of my scope of practice, which will include activities like medical management and leadership as well as my practice as an acute physician in Plymouth Hospital NHS Trust,” she pointed out.

The final countdown

The GMC acknowledges that there may be some teething troubles when revalidation is implemented, and it is avoiding a “big bang” introduction so that organisations have the slack to identify and resolve problems early on. “We at the GMC really, really want this to work well and run smoothly and for it not to be a bureaucratic burden on doctors who are already working very hard,” said Rubin. “Inevitably there will be unexpected challenges, but I think five years from now people will be wondering what all the fuss was about. It will be accepted as a part of normal working life, and people will get on with it.”

The GMC knows that most doctors in this country are very good, he added. “[Revalidation] is about enabling good doctors to enhance their practice [and] to reflect on their practice and improve further,” he said. “I would encourage doctors to view revalidation in that spirit.”

Competing interests: None declared.

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Box 2 Important guidance for doctors from the General Medical Council’s website

The Good Medical Practice framework for appraisal and revalidation—

Supporting information for appraisal and revalidation—

Guidance on colleague and patient questionnaires—
http://bit.ly/MQJwEn


A responsible officer

One of the few parts of revalidation to be confirmed so far is the role of the responsible officer. Caroline White finds out what one does

David Geddes is taking his enhanced duties as a responsible officer in his stride. The enabling legislation for this new role came into force only this January for three of the four UK countries, a few months behind Northern Ireland. But Dr Geddes has been testing out the job for the best part of a year at one of the 10 sites in England selected to pilot revalidation – the five yearly quality assurance scheme for doctors.

The post is pivotal to revalidation, which is due to come on stream in late 2012. It is responsible officers who will ensure that the arrangements for appraisal – the cornerstone of the process – are in place and effective. And it is they who will make recommendations to the General Medical Council (GMC) as to the continued fitness, or otherwise, of a doctor to practise.

Dr Geddes is the responsible officer for NHS Yorkshire and York, a large primary care trust with 910 general practitioners (GPs) on the performers list and 45 GP appraisers. In line with the government’s intentions for the seniority and experience likely to be required for the job, Dr Geddes is a medical director, as well as being director of primary care at the trust.

He explains, “A lot of the RO’s role is currently about setting and ensuring that appraisal processes are more fully integrated into the governance of the primary care trust, and many of those responsibilities are already rested with me as medical director, so when the board meeting was held to decide who would be best placed to take on the [pilot] role, I was appointed.”

Typical day

A typical day is divided between reviewing the effectiveness of systems and processes for revalidation, which includes the consistency of GP appraisers, and looking at concerns about potential and actual performance of GPs. This uses “soft information,” such as patients’ complaints and issues raised by professional colleagues, which is then “triangulated” to see if any patterns emerge.

Although much of the job spec is familiar, the responsible officer’s role requires a different approach, says Dr Geddes. “The focus of the medical director’s role is to look at, and monitor, poor performance. The RO’s role represents the opposite side of the coin, because it’s looking for positive evidence that a doctor is fit to be revalidated,” he explains.

Nevertheless, he is aware that not everyone may view the role positively—at least not just yet. “Cheering is not the way everyone may view the role positively—at least not just yet. “Cheering is not the way most people are going to greet an RO,” he suggests. But he believes that responsible officers need to convey the message that revalidation is not about punishment but about affirming good practice and improving on it.

“Doctors shouldn’t have to go through hoops to revalidate. And if they do, the system has got it wrong,” he emphasises. “Let’s face it, all of us at some stage find work more difficult or find it harder to keep focused, so in a way it’s about supporting clinicians through that. There’s no benefit to a trust ‘catching out’ a doctor who’s giving cause for concern, when it’s too late to provide remediation.”

He adds: “It’s easy to get bogged down in revalidation as being about underperforming doctors, but there are systems already in place to manage that.” But for the small number of those found wanting, responsible officers will ultimately have to decide whether local and regional remediation or referral to the GMC is required.

That’s why so much of Dr Geddes’s time is spent building consistency, he says, both in terms of the appraisal process itself and the triggers for remediation or referral to the GMC. “It’s hugely important to get consistency across the country, otherwise it will undermine confidence in the profession,” he emphasises, adding that the process could also be vulnerable to legal challenge if it isn’t robust.

“The first doctor who is not put forward for revalidation is bound to contest it and challenge it legally, so the systems we put in place now have to be as watertight as possible, and we need to iron out any quality concerns and be clear about the support we provide,” he says.

Training programme

The NHS Revalidation Support Team and the National Clinical Assessment Service have organised a training programme for responsible officers, covering the roles and responsibilities of the job; how to set up an appraisal and clinical governance system; and how to put in place systems to deal with doctors’ conduct and health issues.

Dr Geddes is also part of one of several regional networks of responsible officers. These have been set up to share learning and expertise among the pilots but are likely to continue. “The network needs to be wide because there are a lot of challenging issues around integration between primary and secondary care and how information gets fed across the two,” he says.

But in England the uncertainties of an NHS in flux are provoking some additional anxiety – for everyone. “We’re in an uncertain world in terms of the health bill. And it’s still not at all clear how the performers list will be managed in future and how revalidation will be shaped within primary care.”

The current thinking is that there will be a national performers list rather than local lists held by primary care trusts, with a major role for the NHS Commissioning Board. But how that will be linked to commissioning consortiums is still a bit of a mystery, he says, although there has been talk of some intermediate tier above commissioning consortiums. “That’s a big unknown for ROs, and one of their main tasks is working with that ambiguity.”

Connecting doctors with responsible officers

A House of Commons health select committee report wanted to know where responsible officers would sit in the new NHS landscape, because the routes of access to them for primary care doctors and doctors in training are set to change under current proposals.

In its response to the report the government gave an undertaking to consult on the matter this spring, and a Department of Health spokesperson told

careers.bmj.com
“Subject to the outcome of the ‘listening exercise’ [launched on 6 April], the department is considering the future arrangements for connecting doctors in primary care and those in training to a responsible officer.”

But whatever the outcome of all the feedback in shaping future direction, Dr Geddes believes that responsible officers have a crucial role in preserving good governance systems.

“They need to ensure that processes and systems are maintained and strengthened rather than lost, so primary care trusts can hand these over to their new organisational homes. And they need to be fit for purpose,” he says, “otherwise they will fragment, and it will take a long time to build up credibility. That’s a big challenge for ROS in primary care.”

He is in no doubt that the January recruits have a lot of work ahead of them. “I don’t think people see revalidation as a tangible concept yet,” he suggests, adding that the extent to which appraisal is integrated into governance structures varies from trust to trust and from doctor to doctor.

And all trusts will have some “hard to fit” doctors who are far less well supported by the available governance structures; so making it harder for them to provide the documentary proof needed for structured appraisal, Dr Geddes says. He lists GP locums; people working in the independent sector or in community settings, such as obesity clinics; and small organisations not aligned to NHS trusts.

“The principles are the same, no matter what setting a doctor works in. It’s their responsibility to demonstrate that they are up to date and fit to practise, but it will be harder for some because they don’t work in managed environments,” acknowledges Martin Shelly, programme director of operational readiness at the Revalidation Support Team.

The team has been working with locum and independent sector doctors to see how this might be managed more effectively. “There’s no obligation on locum organisations to give their doctors direct feedback in the form of an exit report, and we are trying to encourage them to do that if doctors work for them for more than a week; that should be standard practice.”

Other anomalies need to be worked through as well, he says. Under the enabling regulations, every “designated body” must appoint and fund a responsible officer, and every doctor must have one. But, as Mr Shelly points out, some healthcare organisations are so small they might not realise they are, in fact, a designated body, or they could have five or 10 doctors in their employ who also work for several other designated bodies.

At the moment no formal evaluation of the role of responsible officer is planned, although there will be “quality assurance of the role, the way recommendations are made, and the systems the RO relies on,” affirms Mr Shelly. It is not clear who will take on that task, but the GMC, the Care Quality Commission, Monitor, and the royal colleges are all likely contenders, he says.

A Department of Health spokesperson confirmed that it was exploring options for the development of an annual programme of sampling and audit of responsible officer recommendations.

Even when the system is running smoothly, the responsible officer role is unlikely to diminish, Dr Geddes believes. Certainly the cost, estimated by the health department at nearly £27m for the first year of implementation and just over £22m for subsequent years for England, Wales, and Scotland, would seem to bear this out.

GPs starting out on the revalidation trail will have plenty to do, says Dr Geddes, pointing out, “It’s easy to forget that doctors joining the performers lists will have a lot of things to adjust to and will need a lot of support.”

And the old hands will create different demands. “Doctors are complex, and they work in a complex world, with many of them having a portfolio career. And that creates lots of challenges for responsible officers to ensure that they have a really full picture of all those elements.”

Caroline White, BMJ

Publication date: 07 May 2011
My first appraisal

Nonye Agomo talks you through her first GP appraisal and passes on tips for others in her position

Preparing for my first general practitioner (GP) appraisal was a surprisingly nerve racking experience. I thought that with all the hoops I had to jump through while training as a GP, this new appraisal (the new compulsory qualification before qualifying as a GP) era—case based discussions, consultation observations, directly observed procedures, 360 degree multisource feedback, and patient satisfaction questionnaires—would be a Godsend as I hadn’t really felt it before, but somehow this one was different. It was new and it was going to be my first appraisal as a fully fledged independent practitioner.

I got a letter from the primary care trust to advise me of their chosen appraiser and to give me enough time to make any objections. As I had none, the appraiser duly contacted me by email to make an appointment for a mutually convenient time to have the meeting. I chose one of the farthest available dates to put off the evil day as much as possible because I was not looking forward to it.

My excellent and thorough trainers had used to being appraised, yet somehow this was different. It was new and it was a Godsend as I hadn’t really felt it before and I had decided to put off form 5 because it wasn’t compulsory), I got a pleasant surprise.

My appraiser, who had offered to speak to my appraiser, so I had some idea of what it was like, but now, actually being allowed to go on the national appraisal toolkit website (not a privilege of registrars) and fill it in was a pleasant surprise. She asked me if this was my first appraisal, and when I told her it was, she said “I thought so, there’ve been a number of new people about, so I thought I’d better ring and see if you need some advice.”

I could hardly believe my ears—this was a Godsend as I hadn’t really felt it appropriate to trouble anyone with my uncertainties or my “stupid” questions, but still didn’t really know where to start, so guidance for the mammoth task was really welcome. It’s good to know this sort of advice is available.

The appraiser simplified the process (boxes 2 and 3), dealt with my fears, and encouraged me; she also advised me to save my work regularly. Two weeks before the arranged date I emailed her to let her know that I had submitted the form. At this point, I was not allowed to go back and make any alterations.

Contact with my appraiser

While trying rather unsuccessfully as usual to make much progress on form 3 (forms 1 and 2 on personal data and workplace information had already been done weeks before and I had decided to put off form 5 because it wasn’t compulsory), I got a pleasant surprise.

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Box 1 The appraisal toolkit

Trainee general practitioners, especially those in their final year, should ask their trainers to print off a paper copy of the toolkit so they can familiarise themselves with all the forms, particularly the domains on form 3 (the main form), namely good clinical care, maintaining good medical practice, relationship with patients, working with colleagues, teaching and training, probity, health, research, and management activity.

Further information can be found on the appraisal toolkit website (www.appraisals.nhs.uk), and from Paula Wright’s toolkit for sessional GPs on the North East Locum group’s website (http://bit.ly/difbMV).

The Department of Health recently stopped funding the toolkit, but individual doctors can still continue to use it by subscribing online.

Box 2: Useful starter and general advice

Process

• Do not be afraid. An appraisal is not done to judge you, but is an opportunity to celebrate your year’s work, to reflect on what went well and what went less well, to think how you would like your skills to grow, and to think how to enhance your performance (and this should be holistic; for example, work-life balance, health)

• The process should help you draw up a personal development plan that is meaningful to you in your work context and that will have a real impact on patient care

• Having an annual appraisal is essential to stay on the performers list

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• The process should help you draw up a personal development plan that is meaningful to you in your work context and that will have a real impact on patient care

• Having an annual appraisal is essential to stay on the performers list
The appraiser may ask you if you are currently under investigation, and it will help you to construct your personal development plan if you focus on the problem in hand, for example, communication.

The appraisal is confidential unless the appraiser has concerns about patient safety as per General Medical Council guidance, and they should tell you this.

Collecting evidence

Collect your evidence all year round. Do this in a dedicated folder on your desktop, or in a dedicated paper folder. This approach makes things easier when preparation time comes round.

Aim to collect evidence for each of the categories.

Less is more when it comes to evidence—don’t send in every piece of paper you can find because your appraiser has to read them; what they want to see is evidence of reflection, change in behaviour as a result, and any impact this may have on patient care.

Structure

- If using the NHS toolkit, complete forms 1, 2, and 3 and sign them off. The online helpdesk is responsive and helpful if you have a problem. If your main workplace has changed in the past year, don’t forget to change form 1.
- If using the NHS toolkit, remember to save your work regularly (every 15 minutes or lose it).
- You need to bring your previous personal development plan to your appraisal. Be prepared to discuss whether you achieved your aims and whether your plans changed mid-year. Your previous form 4 would be useful to bring, especially if you have a new appraiser.
- If you have been on extended leave for illness or maternity, plan to have your appraisal soon after your return to plan your catch up and future learning. Make sure your employer provides a re-induction and helps you to reflect on your learning needs.

Box 3 Suggestions for completing domains of form 3

Apart from using the free text option in each section, one approach to completing the domains of form 3 would be to use the structured templates on the website (denoted by *). They ask the right questions, encourage reflection, and seek out impact on patient care. Helpful data to include are:

**Good clinical care**
- One data collection exercise or audit*; for example, a log of referrals and outcomes.
- Reflection on data about your prescribing practice (supplied to you regularly by the primary care trust as part of multimedia and information systems) or notes on a meeting with colleagues about your prescribing.
- Significant event review*.
- Structured case review*.

**Maintaining good medical practice**
- Keep a record of learning activities since your last appraisal, and keep evidence of your participation where possible—keep a log and write a few bullet points after each event on new learning, on how you will implement it in practice, and on the impact this will have on patient care.
- Reflect on your choice of learning activities; for example, how did you find your blind spots?

**D-day**

D-day, and I couldn’t have had a worse start. Despite the fact that I chose the date, time, and venue, I arrived late and flustered. I prepared myself for a cold reception, but my appraiser was very understanding and had even sent a text message to reassure me. She explained the process, emphasising the confidentiality of our discussion, with a disclaimer that any “serious concerns” would need to be reported to the relevant bodies, such as the General Medical Council.

At the end of three hours, with a five minute tea break, we had gone through a year’s journey in brief, with suggestions and comments on how things could be done differently, and commendation on certain aspects of my work and life. It was nice to get a pat on the back.

As a GP it’s not often one gets direct feedback, and for me it was useful to have an experienced GP cast an eye on what I was doing and help with suggestions where needed. My appraiser also promised to call me midway to my next appraisal to see how I was faring with the objectives we agreed on in my personal development plan (form 4).

A few days after, she had written up the summary of our discussion and signed the personal development plan. When I was satisfied with the content I also signed it off online and informed my appraiser (form 4 and your personal development plan get sent to the primary care trust).

The meeting was useful and motivating and so I decided to write about my experience to help others. Appraisals are here to stay so we might as well make the most of them, and although appraisers are not mentors, they have their place in keeping us on the right professional track and perhaps even giving us plaudits along the way.

With thanks to Dr Rebecca Viney for her general help and for her help with the information in the boxes.

Competing interests: None declared.

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Publication date: 10 November 2010
Improving workplace based assessments

Bill Burr and colleagues outline their 12 month pilot of a new system for workplace based assessments, starting this month.

A major pilot is starting this month to test a range of new workplace based assessments for core medical trainees and higher specialty trainees. Workplace based assessments were originally intended as formative educational assessment tools to provide structured feedback and to aid the development of trainees, but in practice they are often not used for this purpose and instead are sometimes used summatively (that is, to inform the assessment of trainees at their annual review of competence progression (ARCP)). Trainees and supervisors say that there are too many mandatory assessments; for example, between August 2008 and August 2009 foundation trainees at 24 of the 25 UK foundation schools did a total of 249,564 clinical assessments and 193,338.

Improving workplace based assessments

The use of assessments of performance (Aops) will be examined. These are summative assessments—that is, assessments of learning—and will be few in number but will count towards progression and will be considered by the ARCP panels.

• Aops will sample from a set of “key competencies” within each specialty curriculum.

• The tick box appearance of the current workplace based assessment forms has been replaced with free text boxes that we hope will encourage more feedback from supervisors.

• A more robust system for sign off of practical procedures has been developed. For potentially life threatening procedures, trainees will now require sign off by two different consultants.

• A system to capture the opinions of several clinical supervisors has been developed that will feed into the end of placement educational supervisor’s report and be available to ARCP panels. We hope that having access to the opinions of several supervisors will enable educational supervisors to form balanced judgments of trainees’ performance on the basis of observation and evidence of performance in the workplace and engagement in the educational process. Such an approach should help prevent any one person having undue influence over a doctor’s progression.

Controversial aspects

There are two particularly controversial aspects of the new system. The first is that we believe that the formative nature of SLEs can be sustained only by insisting that they be absolutely confidential to the trainee and his or her educational and clinical supervisors. In particular, the outcomes of SLEs will not be available to ARCP panels. This means that it will not be possible to sign off multiple curriculum competencies through the SLE system, as has become the practice in many...
physician specialties, so we will also be emphasising the place of sampling from key competencies to assess trainees’ performance.

The second controversial aspect concerns the AoPs, whose use in training and assessment has been proposed by the General Medical Council. As mentioned, these are summative, will count for progression, and will be trainer led. We have an open mind as to what their eventual role will be. They may not be suitable for all specialties and all years and could ultimately have a role in supporting the assessment of trainees whose progress is causing concern.

Evaluation
Evaluation will be carried out throughout the pilot. Quantitative and qualitative data will be collected from questionnaires to trainees, clinical and educational supervisors, and training programme directors, with a focus on feasibility and acceptability. Focus groups will also be convened to provide feedback, and data will be gathered from e-portfolios.

In the longer term, the impact of this new approach on the numbers and outcomes of assessments, the quality of feedback, and overall educational outcomes will be assessed. Depending on the pilot’s outcomes, the intention will be to roll out the new system for all Joint Royal Colleges of Physicians Training Board specialties in August 2013. An interim report on progress will be produced in April 2013.

In making and piloting these changes to the workplace based assessment system, we hope that we will have dealt successfully with the major criticisms of workplace based assessments while preserving the important educational benefits that followed their introduction.

Further information
For more information about the Joint Royal Colleges of Physicians Training Board and the workplace based assessment pilot please visit www.jrcptb.org.uk/assessment. If you have a question about the pilot please email wpbaqueries@jrcptb.org.uk.

Competing interests: None declared.


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Publication date: 31 July 2012
Most organisations in England are ready for revalidation

Most doctors in England have the organisational backup they need to begin revalidation from the end of this year—the scheduled start date—concludes the latest report from the NHS Revalidation Support Team.

But the appraisal rate across the country is still patchy, particularly for consultants and for staff, specialty, and associate specialist (SAS) doctors, says the report, which will inform the health secretary Andrew Lansley’s decision on whether to give the go ahead for revalidation.

The support team’s second Organisational Readiness Self-Assessment report captures the state of readiness for revalidation of organisations that employ or contract with doctors (designated bodies).

This year, 654 designated bodies completed the self assessment, equating to a 95% response rate overall.

The report shows that substantial progress has been made over the past year. As of 31 March 2012, 82% of doctors covered by the survey were linked to organisations that are ready to support them with revalidation, the responses show.

Virtually all doctors covered by this exercise now have a responsible officer, and almost 98% have a responsible officer who has had appropriate training. As of 31 March 2011 98% of responding designated bodies had appointed a responsible officer but only half (51%) of these individuals had undertaken training.

The appraisal rate has improved for the various types of doctor, with 90% of GPs appraised in the year ending March 2011. Although appraisal rates for consultants and SAS doctors have improved, they remain lower than for GPs, at 74% and 54%, respectively.

At least 85% of doctors are now covered by designated bodies that have enough trained medical appraisers and that operate an appraisal policy that complies with the requirements of revalidation. But only half (58%) of doctors are covered by designated bodies that have a policy for re-skilling, rehabilitation, remediation, and targeted support.

Martin Shelly, director of implementation at the support team, said that all the key indicators measured had shown improvement since the last report.

But he added, “A number of areas still need to be strengthened, and we now have a very clear line of sight on what remains to be done. In particular, the appraisal rates for hospital consultants and SAS doctors are still lower than we would like, and these will require special attention this year.”

The report also states that locum agencies “remain significant outliers in terms of engagement and whilst there are reasons to explain this, a significant improvement is required.”

Dean Royles, director of the NHS Employers organisation, said he was “delighted” with the progress that employers have made to get ready for revalidation.

But he admitted that some groups of doctors had “historically had lower numbers being appraised compared to others.” NHS Employers will be setting up a range of activities in the coming months to help these doctors engage with the process, including webinars and regional workshops, he promised.

Every designated body has been asked to produce an action plan to ensure that their systems would be ready by the scheduled start date of revalidation in December.

The General Medical Council’s chief executive, Niall Dickson, said that the report backed the planned implementation date for December this year. “It is another significant milestone, and we expect to see similar reports from Scotland, Wales, and Northern Ireland over the next month, which will give patients and all those involved the confidence that revalidation can get under way,” he said.


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Publication date: 18 August 2012
GMC to notify doctors of revalidation dates from December 2012

The General Medical Council has confirmed that from December doctors will begin to receive letters notifying them of their date for revalidation. It is expected that all 230,000 licensed doctors in the United Kingdom will have their dates confirmed by the end of March 2013.

Doctors will be given a minimum of six months warning of their first revalidation date, with the first dates scheduled for April 2013.

Trainee doctors will be given a slightly longer window, with revalidation dates running until December 2017. Doctors who register with the GMC after December will be automatically set a revalidation date five years from the date they become fully licensed and registered.

The GMC’s chief executive, Niall Dickson, said, “Subject to the secretary of state’s decision to switch on the legislation, from the end of this year we will begin to tell each doctor the date when he or she will be expected to revalidate.”

Provided that the legislation is passed, this will kick off a cycle of doctors having to revalidate every five years. Revalidation will assess how each doctor is meeting professional standards set out in the GMC’s guidance Good Medical Practice.

The GMC’s ambition is that 20% of doctors will be revalidated within the first year of revalidation being introduced; however, dates for revalidation are to stretch over a three year period until March 2016.

The first 20% of doctors to be revalidated in Scotland and Northern Ireland will have their revalidation dates picked at random on the basis of the penultimate digit of their GMC registration number.¹

In England responsible officers will randomly select a representative sample of doctors to go first for revalidation or will select the first doctors according to locally determined criteria, such as doctors with management or leadership roles (or a combination of both approaches).

Una Lane, the GMC’s director of continued practice and revalidation, said, “We are not just inventing these dates [for revalidation] ourselves. Many doctors will already know their dates before December, as they may have been involved with their responsible officer locally to determine whether that is an appropriate date for them. For some, [the letter] may be the first they hear about this date.”

However, Lane said that the dates are not necessarily set in stone: “Of course, there may be some flexibility with revalidation dates for doctors in that their circumstances might change—they may take a career break or maternity leave,” she said.

Read more about the countdown to revalidation in BMJ Careers: http://careers.bmj.com/careers/advice/view-article.html?id=20007663.


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Publication date: 25 July 2012
New guidance will ease revalidation process for doctors, says academy

Doctors in the United Kingdom are being provided with final guidance to help them prepare supporting information for their annual appraisals under the new revalidation scheme.

Fourteen specialty guidance frameworks were published on 28 June by the Academy of Medical Royal Colleges and its member colleges and faculties.

Neil Douglas, chairman of the academy, said that the guidance was consistent with the General Medical Council’s own supporting information guidance and was welcomed by the GMC.

He said that it would be “key to making the process of appraisal and revalidation more straightforward and consistent for all doctors, irrespective of their medical specialty.”

Revalidation, which is due to begin at the end of this year,[1] aims to ensure that licensed doctors continue to be fit to practise on the basis of a local evaluation of their performance through the appraisal process.

It requires doctors to complete an appraisal each year, including providing supporting information to show how they are meeting the professional values set out by the GMC. Then every five years doctors need to seek multisource feedback from colleagues and patients.

The Academy of Medical Royal Colleges has coordinated work on the final guidance to ensure “commonality in appraisal for revalidation” regardless of specialty.

The 14 specialty guidance frameworks give the specialty context for the supporting information required.

The Royal College of Physicians of London has developed guidance with the Royal College of Physicians of Edinburgh and the Royal College of Physicians and Surgeons of Glasgow. It describes the types of supporting information required across many areas of physicians’ practice.

Doctors are required to bring six types of supporting information to their appraisal at least once in a five year revalidation cycle: evidence of continuing professional development, quality improvement activity, data on significant events, feedback from colleagues, feedback from patients, and a review of complaints and compliments.

Ian Starke, medical director for revalidation for the Royal College of Physicians of London, said that the guidance would help physicians make a “smooth transition” to the new revalidation system.

He said, “All physicians want to demonstrate that they are providing a safe and high quality service to patients and the public, and we fully support them in this endeavour.

“Extensive consultation and piloting mean that the guidance, tools, and resources will meet the needs of physicians across the UK.”

Doctors are being urged to provide supporting information that is relevant to their area of work and to refer to guidance from their relevant college or faculty.

The GMC says that revalidation will help to improve the care that patients receive by identifying problems in some doctors’ practice earlier and by encouraging self reflection.

The UK revalidation programme is expected to be rolled out over the next few years.

The GMC has already set out its generic requirements for medical practice and appraisal. The Academy of Medical Royal Colleges says that doctors should also have regard for any guidance that the employing or contracting organisation may provide on local policies.


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Matthew Limb
London

Publication date: 28 June 2012
Doctors must seek feedback from more than 50 people for revalidation

Doctors will have to seek feedback from up to 45 consecutive patients (minimum 34) and 20 colleagues (minimum 15) on their clinical and professional skills at least once every five years to complete revalidation.

The General Medical Council has developed recommended questionnaires for patients and colleagues that are designed to support doctors in seeking multisource feedback to provide supporting information for revalidation.

The paper based patient questionnaire, which should be administered by reception staff or other clinical staff rather than the doctor in question, asks patients about the doctor’s consultation skills and probity and whether they have confidence in the doctor’s ability to provide care.

The online colleague questionnaire, which ideally should be administered to 10 medical and 10 non-medical colleagues, asks respondents to rate the doctor in 18 questions on clinical skills; communication and organisational skills; probity; and health. Staff are also asked to recommend whether the doctor they are rating is fit to practise medicine.

Doctors will be required to review the responses from the patient and colleague questionnaires and to identify areas for future improvement. Doctors will also have to rate their own skills in a similar questionnaire and compare their responses with the feedback from colleagues and patients.

If the questionnaires raise any serious concerns about a doctor’s fitness to practise, the GMC recommends that these concerns should be pursued through the usual processes in the workplace.

The vast majority of doctors will receive “overwhelmingly positive” feedback from the questionnaires, but the responses will also identify things that they can learn and provide insights into their practice, said Niall Dickson, the chief executive of the GMC.

“We regard this as the start of a process. Medical practice relies on trust between doctors and their patients, and between healthcare professionals—their views matter, and I am sure that over time more ways will be found to gather them.”

The GMC’s questionnaires are designed to reflect the values and principles in Good Medical Practice and have been piloted among 1450 doctors, 44,000 patients, and 21,000 colleagues. Once revalidation begins, the United Kingdom will be the first nation in the world to require every doctor to obtain feedback from their patients and colleagues in this way.

All doctors must seek feedback to support revalidation, but using the questionnaires developed by the GMC is not mandatory. Doctors and employers who choose to use another feedback tool must ensure that it meets the GMC’s criteria.

Helen Jaques, news reporter, BMJ Careers
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Publication date: 05 April 2012
GMC issues guidance on information for revalidation

The General Medical Council has published advice on what supporting information doctors need to provide for appraisals, in a move to make revalidation simpler and more straightforward.

The guidance also emphasises the responsibility of employers to make supporting information available to doctors, after a recent BMA survey showed that two thirds of GPs and consultants were not able to get hold of enough data on performance from their trust to support their appraisals (BMJ Careers 26 Mar, http://careers.bmj.com/careers/advice/view-article.html?id=20002344).

“The objectives are to enable doctors to go through this process without it feeling like it is some great burden and to ensure that it is providing something useful for them,” said Niall Dickson, the GMC’s chief executive. “We believe this is a proportionate means by which we can introduce revalidation without overburdening the system but at the same time introducing something that is useful and is not just a tick box exercise.”

Supporting Information for Appraisal and Revalidation outlines six types of information required from doctors to show that they are keeping up to date, developing their practice, and reflecting on feedback. Each type of information will need to be discussed in at least one appraisal during the five year revalidation cycle.

In addition to basic personal information and details of the scope of their work, all doctors—regardless of their specialty or branch of practice—will need to provide evidence of continuing professional development, quality improvement activities (such as a clinical audit, case reviews, or a review of clinical outcomes), any significant events that could or did lead to harm of one or more patients, feedback from colleagues, feedback from patients, and complaints and compliments.

“Probity and health will also be discussed. "This is an attempt to outline broad areas that should be covered without going down to the minutiae of exactly how the appraisal will be carried out," said Mr Dickson.

The time consuming process of mapping supporting information to the relevant areas of Good Medical Practice has been dropped. Instead, reflection and discussion of the six types of supporting information at appraisal should be sufficient to show that a doctor is meeting the 12 professional attributes required in the Good Medical Practice Framework for Appraisal and Revalidation.

In addition, employers are being asked to make sure that all doctors can access the data they need to provide supporting information about their practice.

Although the new guidance applies to doctors in all specialties, there is some room for appraisals to vary on the basis of the doctor’s professional roles and development needs. Organisations and institutions will be responsible for ensuring the quality of appraisals, although the GMC may randomly sample institutions to ensure that standards are uniform across the United Kingdom and will receive feedback from doctors about the process.

The Good Medical Practice Framework for Appraisal and Revalidation and Supporting Information for Appraisal and Revalidation are at www.gmc-uk.org/doctors/revalidation/revalidation_plans_and_proposals.asp.

Helen Jaques, news reporter, BMJ Careers hjaques@bmj.com

Publication date: 09 April 2011
Doctors urged to identify designated organisation in advance of revalidation

The General Medical Council has launched a campaign to encourage doctors to identify which organisation will be revalidating them. The “Make your connection” campaign will first target doctors who do not have a prescribed link to a designated body under the responsible officer regulations and subsequently ask doctors for which the GMC has identified a designated body to confirm their connection.

The GMC is seeking to identify the designated body and responsible officer for each registered doctor so it knows which organisation will be submitting the doctor’s recommendation on revalidation.

A total of 719 designated bodies exist in the UK at present, which include NHS trusts, independent sector providers, the Independent Doctors’ Federation, postgraduate deaneries, and locum agencies. Every designated body has a responsible officer who will make a recommendation to the GMC every five years on whether a doctor is up to date, fit to practise, and should be revalidated.

For most doctors, the organisation in which they spend most or all of their practice is most likely to be the organisation that will provide them with their regular appraisal and will therefore help them revalidate.

The GMC has identified the designated body for more than 120 000 doctors by using NHS employment and performers list data. Designated bodies for the 50 000 doctors in training will be identified during the GMC’s national training survey.

The remaining 54 000 doctors—16 000 of whose addresses on the medical register are not in the UK—will be asked to work out and submit information on their designated body by using case studies and a decision making tool supplied by the GMC.

Helen Jaques, news reporter, BMJ Careers hjjaques@bmj.com
Publication date: 20 April 2012

GMC spells out revalidation deferral rules

Doctors who don’t have enough information to support their revalidation could be granted up to 12 further months to supply it, the General Medical Council (GMC) has confirmed, but only one such deferral within each revalidation cycle is likely to be permitted.

New guidance, published last week by the GMC, sets out how responsible officers need to go about making revalidation recommendations and what the regulator expects of them.

Responsible officers will have only three options available when a doctor’s revalidation falls due, which, once submitted to the GMC, can’t be withdrawn.

Recommendations will be based on whether a doctor has participated fully in all the processes required for revalidation, including appraisals or assessments or both, any local requirements, and whether any fitness to practise concerns have arisen.

Information from previous periods of work within the current cycle—including voluntary, private practice, and locum posts—will also be included.

The first two options open to a responsible officer will be to make a recommendation to revalidate or to request deferral of the revalidation date because of insufficient supporting information.

The circumstances in which deferral requests are likely to apply include doctors on sabbatical or career breaks, long term sick leave, or on maternity leave, as well as those in the midst of disciplinary hearings or investigations where the outcome won’t be known before the revalidation due date.

“At present ROs [responsible officers] will only be able to request a deferral for up to 12 months. However, we understand that there will be circumstances where an RO needs additional time in which to make an informed recommendation,” said a GMC spokeswoman.

“In these circumstances, we would expect an RO to contact the GMC to discuss the case in question,” she added.

Currently, responsible officers will be able to make only one deferral per doctor, per revalidation cycle. If the responsible officer felt a further deferral was necessary, this would have to be discussed with the GMC, she said.

The third option for responsible officers is to advise the GMC that the doctor has not engaged in the revalidation process—notification of “non-engagement.”

This will trigger administrative procedures to withdraw a doctor’s licence to practise, although the individual will have 28 days in which to appeal once notified of the GMC’s intention.

The GMC has said that it will monitor the responsible officer revalidation practice and feedback any particular patterns that begin to emerge, but the GMC spokeswoman cautioned that it would be a while before sufficient data were available to do this.

“Interpreting ‘outliers’ will be complex and not just about absolute numbers,” she said.

Niall Dickson, chief executive of the GMC, promised that the guidance would be reviewed once revalidation had been introduced, to make sure that it remained practical and up to date.

“Over time, revalidation will not only provide greater assurance to patients about the competence of their doctors, it has the potential to enhance patient safety and improve the quality of medical care in the UK,” he said.

Health secretary Andrew Lansley is expected to give the go ahead to revalidation in the next few weeks, with the first doctors expected to revalidate from December.

The full guidance, Making revalidation recommendations: responsible officer protocol, is available online at: www.gmc-uk.org/static/documents/content/Responsible_Officer_Protocol.pdf.

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Publication date: 30 August 2012
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Overseas Doctors
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General work issues

Workers web page (rights and responsibilities/accidents/whistle blowing)
www.hse.gov.uk/workers