1. **Title of Paper**

Medical Revalidation

2. **Author(s) of Paper**

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3. **Purpose of Paper**

To provide Board members with an update on the implementation of Medical Revalidation across Scotland, with particular reference to the arrangements for the revalidation of Doctors in Training.

4. **Key Issues**

The announcement by the Secretary of State on 19 October 2012 that the implementation of medical revalidation will commence in December this year is a watershed moment for the profession and patients. Revalidation fills a key gap in the current regulatory framework by requiring regular reviews and providing stronger regulatory oversight of doctors’ fitness to practise.

Revalidation will be the General Medical Council’s new way of regulating licensed doctors that aims to give extra confidence to patients that their doctors are up to date and fit to practise. Licensed doctors will have to revalidate, usually every five years, by having regular appraisals that are based on the GMC core guidance for doctors, Good Medical Practice¹. These regular checks on doctors aim to be a world leading system that will help improve the quality of care received by patients. The Secretary of State for Health, Jeremy Hunt, has confirmed that revalidation will start on 3 December 2012. The GMC will begin to revalidate licensed doctors from this date onwards and expects to revalidate the majority of them by March 2016. Only doctors who have a licence to practise will need to revalidate.

The key role in revalidation is that of the ‘responsible officer’ (RO), who will make recommendations to the GMC regarding the revalidation and re-licensure of doctors. For NES, the **medical director** will be the RO, and will be responsible for making recommendations on all 5,700 doctors in training across Scotland – over 30% of the Scottish medical workforce.

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¹ Good Medical Practice ([Link](#))
5. **Educational Implications**

Doctors have a connection to one organisation that will provide them with a regular appraisal and help them with revalidation. This organisation is called their designated body.

Doctors will need to have a regular appraisal based on GMC core guidance for the medical profession, Good Medical Practice. The GMC appraisal framework tells doctors, plus their appraisers and responsible officers, the professional values they need to show they are meeting in their everyday practice. Doctors in training will be assessed through the Annual Review of Competence Progression (ARCP) process they go through instead.

Doctors will need to maintain a portfolio of supporting information drawn from their practice which demonstrates how they are continuing to meet the principles and values set out in Good Medical Practice. Doctors will need to collect some of this information themselves while the rest will need to come from the organisation that is supporting them with revalidation. The GMC has developed supporting information guidance which tells doctors the six types of information they need to collect, including Continuing Professional Development (CPD) and feedback from patients. GMC have also agreed supplementary guidance with the four UK health departments that will help doctors understand how they can meet our requirements in the first revalidation cycle.

A person called a ‘responsible officer’ will make a recommendation to the GMC, usually every five years, that the doctor is up to date and fit to practise, and should be revalidated. The responsible officer will usually be the medical director of the doctor’s designated body. They will make their recommendation based on the doctor’s appraisals over the last five years and other information drawn from their organisation’s clinical governance systems.

The GMC will receive a recommendation about a doctor from their responsible officer and will carry out a series of checks to ensure there are no other concerns about that doctor. If there are no such concerns, the GMC will revalidate the doctor. This will mean that the doctor can continue to hold their licence to practise.

6. **Financial Implications**

Overall, we are well positioned to implement and manage this important statutory process. However, it should be noted that GMC have only produced clarity around their arrangements in mid-August 2012, and the political sign-off for revalidation to go live was only provided in mid-October 2012. For this reason, detailed resource requirements are not yet clear, and will be the subject of a further paper to the executive team in due course. The RO Regulations (Paragraph 14) set out the requirement that “each designated body must provide the responsible officer nominated or appointed for that body with sufficient funds and other resources necessary to enable the officer to discharge their responsibilities for that body under regulations 11 and 13”.

The medical appraisal and deanery teams have been working hard to develop structures to manage this new and high-stakes process, and for the most part, these build on existing and established systems. However, guidance from the GMC leads us to believe that we should now be seeking to establish an ‘office of the responsible officer’ to co-ordinate and support the decision making and administration around this important process, and to ensure that we are in a position to respond rapidly to issues which will arise, both from the regulator and from the doctors whose revalidation recommendations we will be managing. Given that the medical director of NES will be acting as the RO for a very large number of
doctors (probably more than any other RO in the UK), the volume of work will be significant, and we anticipate a need for additional administrative support.

7. **Which NES Strategic Objective(s) does this align to?**

Medical revalidation is a statutory obligation, but one which effectively supports many of our key objectives particularly:

1. We will deliver consistent evidence based excellence in education for improved care
2. We will continue to build coordinated joint working and engagement with our partners
3. We will develop our support for workforce redesign
4. We will support education in partnership that maximises shared knowledge and understanding
5. We will develop flexible, connected and responsive educational infrastructure which covers people, technology and educational content
6. We will support education in partnership that maximises shared knowledge and understanding
7. We will support education in partnership that maximises shared knowledge and understanding
8. We will develop flexible, connected and responsive educational infrastructure which covers people, technology and educational content
9. We will improve the sharing of knowledge across our organisation.

8. **Impact on the Quality Ambitions**

“The revalidation model will give greater public confidence and assurance of the competence of doctors and significant benefits in terms of quality of care and patient experience. Throughout the UK over 4000 doctors have taken part in the testing and piloting to develop a model that delivers for patients, doctors and the organisations where care is delivered.”

Appraisal will be the “corner stone” of medical Revalidation. Performed annually, it is predominantly a reflective interview between a doctor and a trained appraiser informed by available information about the whole range of that doctor’s practice. It is inevitable however that appraisal will in the future involve an element of summative assessment. This is because the appraiser comes to a judgment as to whether the information presented by the doctor is sufficient for revalidation purposes. Further, Appraisal will provide the essential information that will be used by the Responsible Officer to recommend to the GMC that a doctor should have his/her license to practise maintained.

Annual appraisal is also an important component of NHS Scotland’s efforts to deliver against the Healthcare Quality Strategy and to ensure continuous quality improvement. Most doctors already practise to a high standard and it is expected that they will find appraisal a helpful process for both their personal and professional development.

9. **Key Risks and Proposals to Mitigate the Risks**

Revalidation and re-licensure are high stakes decisions for the professional affected, as well as for the patients for whom they care, and the systems within which they practice.

Because of the large numbers of doctors for which NES is the ‘designated body’ and the NES medical director the ‘responsible officer’ under the relevant statute, this is a significant responsibility.

The proposed approach set out in the attached paper has been developed in partnership through the revalidation delivery boards in Scotland and at a UK level, and builds on the already well established processes for monitoring the progress of doctors in training.

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2 Statement by the 4 UK CMOs, October 2012.
3 The Medical Profession (Responsible Officers) Regulations 2010
There will be an opportunity, in due course, to share the principles and processes developed for medical revalidation, with other professional groups.

10. **Equality and Diversity Impact Assessment**

This is a significant and complex new work stream, the details of which have only been confirmed very recently, and the process of undertaking a full EQIA is not yet complete. Given that revalidation is a statutory responsibility, the focus of the EQIA is not on revalidation per-se, but rather on NES’s role in delivering revalidation for Scotland. In this regard, it should be noted that our approach to revalidation in Scotland builds on existing systems and processes.

Our concern is to ensure that we have given due regard to what needs to be done to carry out our statutory remit in a way that works to eliminate discrimination and harassment, advance equality of opportunity and to foster good relations. Due regard in this case means to actively consider any equality implications in decisions and to take relevant and proportionate action to advance those three elements of the Equality Duty. In addition, we are working to identify any equality and diversity related risks arising from this work stream and note any relevant approaches to managing these risks. The following key areas have been identified for consideration under EQIA:

1. NES's responsibilities as the designated body for revalidation for doctors in training. The issue here will be about fair application of the existing and established ARCP system. As the (UK-wide) approach to trainee revalidation builds on existing systems, we are considering whether there is any evidence of discrimination or bias in the existing ARCP. We will also be seeking to review the adequacy of training of ARCP panellists in equality and diversity issues, and the issue of reasonable adjustments which may be required in the process.

2. NES's role in the national appraiser training programmes. We will be seeking to establish that any relevant lessons have been learned from the work already carried out training primary care appraisers. We will also be seeking to explore how we can be confident that our appraiser training supports fair delivery of appraisal and reasonable adjustments where relevant.

3. SOAR -- our role supporting IT systems will involve rollout of an existing system. We will be working to establish the extent to which any accessibility issues been identified in that system.

11. **Communications Plan**

A Communications Plan has been produced and a copy sent to the Head of Communications for information and retention:

Yes [ ] No [X]

At the time of writing, the GMC has not yet confirmed plans for communicating revalidation dates to all doctors, but is expected to do so during the first week of December. A draft communication plan has been prepared and will be finalised and issued once this information is available.

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4 [Dental Revalidation (Link); Nursing revalidation (Link)].
12. **Recommendation(s) for Decision**

The Board is asked to note the proposed arrangements for the implementation of Medical Revalidation.

Nes

*November 2012*

*DSI / WR*
Medical Revalidation

1. Introduction

1.1 Revalidation will be the General Medical Council’s new way of regulating licensed doctors that aims to give extra confidence to patients that their doctors are up to date and fit to practise. Licensed doctors will have to revalidate, usually every five years, by having regular appraisals that are based on the GMC core guidance for doctors, Good Medical Practice. These regular checks on doctors aim to be a world leading system that will help improve the quality of care received by patients. The Secretary of State for Health, Jeremy Hunt, has confirmed that revalidation will start on 3 December 2012. The GMC will begin to revalidate licensed doctors from this date onwards and expects to revalidate the majority of them by March 2016. Only doctors who have a licence to practise will need to revalidate.

1.2 The overall governance arrangements for revalidation in Scotland are set out at Annex 1.

2. Background

2.1 The road to medical revalidation has been prolonged. Increasing public scrutiny of medical professionals culminated in the GMC beginning a consultation process in 2000 (Revalidating Doctors) over how to reassure patients that doctors were sufficiently up to date and performing well in practice. In 2001, GMC Council resolved to ask Government to put in place the required legislative framework for revalidation with NHS appraisal as the vehicle for Revalidation, and in 2003 GMC issued guidance to all doctors, at which stage revalidation was due to begin 2005. This work was critiqued by The Shipman Enquiry, Fifth Report in 2004.

2.2 Further publications followed - Good Doctors, Safer Patients - 2006, Trust, Assurance and Safety – 2007. The Medical Revalidation Working Group was one of seven working groups established to take forward the recommendations in the 2007 White Paper. The White Paper set out the key principles that would underpin the regulation of health professionals over the next decade. This culminated in 2008, in Medical Revalidation – Principles and Next Steps.

2.3 In 2010, the GMC Consulted and in 2011, the UK Government Health Committee published a report on the revalidation of doctors. Later in 2011, the GMC consulted on the Licence to Practise and Revalidation Regulations. Each of the 4 UK nations set up delivery boards, with an overview from a UK board. Although each nation has developed their own implementation plans, medical regulation is not devolved, & it is only recently that the Secretary of State for

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1 Good Medical Practice [Link]
3 A license to Practice and Revalidation, General Medical Council, April 2003.
4 Shipman Inquiry : 5th Report. [Link]
5 Good Doctors, Safer Patients, CMO England, 2006. [Link]
6 Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century [Link]
7 Medical Revalidation – Principles and Next Steps, CMO England, 2008. [Link]
8 Revalidation – The Way Ahead, GMC, 2010. [Link]
9 House of Commons Health Committee : Revalidation of Doctors, 2011 [Link]
10 General Medical Council (Licence to Practise and Revalidation) Regulations, 2011 [Link]
Health in England has signed off the legislation to enact the process, which will become ‘live’ from 3 December 2012\textsuperscript{13}.

3. Revalidation Overview

3.1 Doctors have a connection to one organisation that will provide them with a regular appraisal and help them with revalidation. This organisation is called their designated body.

3.2 Doctors will need to have a regular appraisal based on GMC core guidance for the medical profession, Good Medical Practice. The GMC appraisal framework\textsuperscript{12} tells doctors, plus their appraisers and responsible officers, the professional values they need to show they are meeting in their everyday practice. Doctors in training will be assessed through the Annual Review of Competence Progression (ARCP) process they go through instead.

3.3 Doctors will need to maintain a portfolio of supporting information drawn from their practice which demonstrates how they are continuing to meet the principles and values set out in Good Medical Practice. Doctors will need to collect some of this information themselves while the rest will need to come from the organisation that is supporting them with revalidation. The GMC has developed supporting information guidance\textsuperscript{13} tells doctors the six types of information they need to collect, including Continuing Professional Development (CPD) and feedback from patients. GMC have also agreed supplementary guidance with the four UK health departments that will help doctors understand how they can meet our requirements in the first revalidation cycle.

3.4 A person called a ‘responsible officer’ will make a recommendation to the GMC, usually every five years, that the doctor is up to date and fit to practise, and should be revalidated. The responsible officer will usually be the medical director of the doctor’s designated body. They will make their recommendation based on the doctor’s appraisals over the last five years and other information drawn from their organisation’s clinical governance systems.

3.5 The GMC will receive a recommendation about a doctor from their responsible officer and will carry out a series of checks to ensure there are no other concerns about that doctor. If there are no such concerns, the GMC will revalidate the doctor. This will mean that the doctor can continue to hold their licence to practise.

4. Designated Body

4.1 Most licensed doctors have a connection with one organisation that will provide them with a regular appraisal and help them with revalidation. This organisation is called their designated body. Only UK organisations can be designated bodies, because the legal rules that determine this only cover the UK. A connection with this organisation ensures a doctor is always:

- supported with appraisal and revalidation
- working in an environment that monitors and improves the quality of its services, regardless of how or where they practise in the UK.

\textsuperscript{11} http://www.dh.gov.uk/health/2012/10/revalidation-starts/

\textsuperscript{12} The Good Medical Practice Framework for Revalidation, GMC, 2012. (Link)

\textsuperscript{13} Supporting information for appraisal and revalidation, GMC, 2012. (Link)
4.2 It will be the responsible officer of this designated body that will make a recommendation to the GMC about a doctor, usually every five years, that they are up to date, fit to practise and should be revalidated.

4.3 There is a clear set of rules that determines which organisation is a doctor’s designated body. For most doctors, this is quite straightforward, because their organisation will be the one in which they spend most or all of their practice. In the case of doctors in training in Scotland, the designated body is NHS Education for Scotland. NES will also be the designated body for the small number of trained doctors who spend most or all of their practice employed by NES. In the case of the medical director of NES, the responsible officer will be the Chief Medical Officer.

5. **Responsible Officer**

5.1 The role of the responsible officer (RO) is set out in the regulations (2010)\(^\text{14}\). These set out the duty of the organisation to appoint a responsible officer, the conditions of appointment of the RO, the responsibilities of the RO, and the provision of appropriate resources.

5.2 Under the Medical Profession (Responsible Officers) Regulations 2010, the Responsible Officer is responsible for ensuring systems of appraisal are in place and for making recommendations on the fitness to practise of doctors within an NHS Board. The RO is thus responsible to both his/her NHS Board as Medical Director, and to the GMC in terms of the reserved functions covered by the RO Regulations.

5.3 In order to be a responsible officer:

(a) the person must be a medical practitioner; and

(b) the person must, at the time of appointment, have been a medical practitioner throughout the previous 5 years, and for this purpose “medical practitioner” means a person who was fully registered under the Act.

(c) a responsible officer must continue to be a medical practitioner in order to remain as a responsible officer.

5.4 The responsibilities of the RO are:

(a) to ensure that the designated body carries out regular appraisals on medical practitioners

(b) to establish and implement procedures to investigate concerns about a medical practitioner’s fitness to practise raised by patients or staff of the designated body or arising from any other source;

(c) where appropriate, to refer concerns about the medical practitioner to the General Medical Council;

(d) where a medical practitioner is subject to conditions imposed by, or undertakings agreed with, the General Medical Council, to monitor compliance with those conditions or undertakings;

(e) to make recommendations to the General Medical Council about medical practitioners’ fitness to practise;

(f) to maintain records of practitioners’ fitness to practise evaluations, including appraisals and any other investigations or assessments.

\(^{14}\) The Medical Profession (Responsible Officers) Regulations 2010. [Link]
5.5 Provision of resources to responsible officers - each designated body must provide the responsible officer nominated or appointed for that body with sufficient funds and other resources necessary to enable the officer to discharge their responsibilities for that body under regulations.

5.6 To be ready for revalidation, organisations need to ensure they have:

(a) a responsible officer with the systems in place to support them in their role
(b) an up to date appraisal system that reflects the GMC’s core guidance for doctors, Good Medical Practice, and ensures every licensed doctor is having a regular appraisal
(c) a sufficient number of trained appraisers in post
(d) clinical governance systems that can provide doctors with the supporting information they need for appraisal and revalidation
(e) policies and systems in place for identifying and responding to concerns about doctors
(f) robust links with the other organisations where your doctors may also be working, so information about their practice and any concerns about them can be shared.

5.7 Starting revalidation: The four UK health departments (and the NHS Revalidation Support Team in England) have worked with responsible officers to develop national plans for how revalidation will start in each country. Each country is taking a slightly different approach but has signed up to a set of principles\(^\text{15}\) that will ensure revalidation is implemented in a way that’s fair and consistent for all licensed doctors across the UK.

5.8 Revalidation will start on 3 December 2012. After this the GMC expect to revalidate:

(a) the majority of responsible officers and other medical leaders by March 2013
(b) a fifth of licensed doctors between April 2013 and the end of March 2014
(c) the majority of licensed doctors by the end of March 2016
(d) and all remaining licensed doctors by the end of March 2018.

5.9 Very recently, the GMC has published a guide for responsible officers\(^\text{16}\).

6. Appraisal

6.1 For trained doctors, enhanced appraisal will be key to the process of revalidation, for doctors in training, this requirement will be met by the Annual Review of Competence & Progression (ARCP) process.

6.2 In Scotland, SGHSCD – through the National Appraisal Leads Group – has produced detailed guidance on appraisal for medical revalidation\(^\text{17}\) for non-training grade doctors in secondary care.

6.3 Appraisal will be the “corner stone” of medical Revalidation. Performed annually, it is predominantly a reflective interview between a doctor and a trained appraiser informed by available information about the whole range of that doctor’s practice. It is inevitable however

\(^{15}\) [http://www.gmc-uk.org/implementation_principles_branded_.pdf_48968801.pdf](http://www.gmc-uk.org/implementation_principles_branded_.pdf_48968801.pdf)

\(^{16}\) Making revalidation recommendations: the GMC responsible officer protocol. 2012. [Link](http://www.gmc-uk.org/implementation_principles_branded_.pdf_48968801.pdf)

\(^{17}\) A guide to appraisal for medical revalidation. SGHSCD, 2012. [Link](http://www.gmc-uk.org/implementation_principles_branded_.pdf_48968801.pdf)
that appraisal will in the future involve an element of summative assessment. This is because the appraiser comes to a judgment as to whether the information presented by the doctor is sufficient for revalidation purposes. Further, Appraisal will provide the essential information that will be used by the Responsible Officer to recommend to the GMC that a doctor should have his/her license to practise maintained.

6.4 Annual appraisal is also an important component of NHS Scotland’s efforts to deliver against the Healthcare Quality Strategy and to ensure continuous quality improvement. Most doctors already practise to a high standard and it is expected that they will find appraisal a helpful process for both their personal and professional development.

6.5 For the small minority of doctors who fail to provide sufficient information at appraisal or in whom concerns are raised, annual appraisal will allow action to be taken while the situation is more likely to be remediable. This will be good for both patients and doctors. Guidance on remediation will be issued in due course.

6.6 The National Appraisal Leads Group (NALG) was set up in March 2009 by the Scottish Government Health Directorates with a remit to ensure the implementation of appraisal in NHS Scotland across all career grade doctors in all specialties and NHS Boards (It should be noted that trainee doctors are not appraised by Boards but are under the supervision of the Post Graduate Dean. The Medical Director of NES will be the RO for all trainee doctors in Scotland).

6.7 For governance purposes the NALG reports to the Scottish Government Health and Social Care Directorates via the Revalidation Delivery Board Scotland.

6.8 NES Involvement in appraisal – local systems for trained doctors

It will be necessary for the Responsible Officer to ensure that in each NHS Board a structure is developed to deliver appraisal. For NES, mechanisms are already in place to deliver annual appraisal to the very small number of trained doctors employed by the organisation. Work is currently underway to ensure that these remain fit for purpose following the roll-out of enhanced appraisal for revalidation, and to ensure that there is appropriate linkage with existing systems of performance management and job-planning.
6.9 **NES Involvement in appraisal – systems for doctors in training**

As indicated above, doctors in training will undergo annual review through the existing systems of Annual Review of Competence & Progression. These arrangements are set out in detail below.

6.10 **NES Involvement in Appraisal – appraiser training**

6.10.1 In order that appraisal is delivered to a uniform high standard across the country, all appraisers must undertake the National Appraiser training scheme and any subsequent training.

6.10.2 It has been agreed by The Scottish Government that NES will undertake the training programme for appraisers in secondary care. NES has already trained all appraisers in primary care. This will align training in primary and secondary care; and this training programme is well underway. The necessary complement of appraisers will either have been trained by the end of 2012 when roll-out of revalidation is expected to commence, or scheduled for such training in 2013. For ease of access, NES has arranged to undertake this training on a Regional basis. It is anticipated that approximately 650 appraisers will be required for secondary care appraisal in Scotland. This has been delivered through the medical appraisal team within the NES Medical Directorate\(^\text{18}\).

6.10.3 In addition to the initial training, appraisers may be required to attend ongoing training as appraisal develops.

6.11 **NES Involvement in Appraisal – Supporting IT Systems – SOAR**

6.11.1 NES has provided IT support for the appraisal process for primary care doctors for some time through the Scottish Online Appraisal Resource – SOAR\(^\text{19}\). GP Appraisal is a national scheme, co-ordinated and quality assured on a national level. Since April 2002 it has been a statutory requirement for all General Practitioners to have an annual appraisal. In Scotland the GP Appraisal Scheme is managed at a national level by NHS Education for Scotland’s Appraisal team. The Appraisal team co-ordinate the development and monitoring of the scheme, providing support and guidance for Appraisers, Appraisees and Local Administrative staff. Local Appraisal Advisers (LAAs) are responsible for the development and internal quality assurance of the GP appraisal scheme in Scotland at a local level. Each Health Board has its own Local Appraisal Adviser(s) providing support and guidance. The appraisal criteria are defined by the General Medical Council in Good Medical Practice and further elaborated by the Royal College of General Practitioners and the General Practitioners' Committee in their joint publication Good Medical Practice for General Practitioners.

6.11.2 During 2011/12, the NES Medical Appraisal Team has developed a parallel SOAR system for career grade doctors in secondary care\(^\text{20}\).

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\(^{18}\) NES Medical Appraisal Annual Report 2012. [Link](http://www.scottishappraisal.scot.nhs.uk/)

\(^{19}\) SOAR for Primary care - [http://www.scottishappraisal.scot.nhs.uk/](http://www.scottishappraisal.scot.nhs.uk/)

7. Supporting Information

7.1 Licensed doctors will need to bring a portfolio of supporting information to their appraisal which shows how they are meeting the professional values set out in Good Medical Practice. Appraisers will be interested in what doctors think the supporting information says about their practice and how they plan to develop or modify their practice as a result.

7.2 GMC guidance\(^{21}\) tells doctors the six types of supporting information they need to collect and how often they should collect it. Employers will to need to ensure they have clinical governance systems and other types of support in place that can provide doctors with the information they need.

7.3 There are six types of supporting information that doctors will be expected to provide and discuss at their appraisal at least once in each five year cycle. They are:

(a) Continuing professional development (CPD)
(b) Quality improvement activity
(c) Significant events
(d) Feedback from colleagues
(e) Feedback from patients
(f) Review of complaints and compliments

7.4 The GMC has also produced specific guidance on colleague and patient questionnaires\(^{22}\). The GMC have agreed that one type of information required of all doctors for the purposes of their revalidation is feedback from colleagues. This is also referred to as Multi-Source Feedback (MSF) or 360 degree feedback. All doctors are expected to seek such feedback from colleagues at least once in every 5 year revalidation cycle.

7.5 The feedback should be used formatively:

(a) as a reflective learning and development tool to identify strengths and areas for possible development and improvement in a doctor’s practice, to inform their continuing professional development
(b) as one of several pieces of supporting information, that when considered together, will inform the decision as to whether a doctor should be recommended for revalidation by their responsible officer

7.6 A variety of Colleague Feedback (MSF) tools are available. The GMC have provided a questionnaire\(^{23}\) and a number of Medical Royal Colleges and commercial providers offer questionnaires for this purpose. In September 2011 the Scottish Government Health Department commissioned NHS Education for Scotland (NES) to develop a Colleague Questionnaire that would be suitable for all GPs and Career Grade doctors in Scotland. This questionnaire is available as a web resource and is free to use for doctors registered with the Scottish Online Appraisal Resource (SOAR).

\(^{21}\) Supporting information for appraisal and revalidation. GMC, 2012. (Link)
\(^{22}\) Guidance on colleague and patient questionnaires. GMC, 2012. (Link)
8. Revalidation for Doctors in Training

8.1 The GMC has very recently produced specific information for this group of doctors.

8.2 A doctor in foundation or specialty training, will revalidate in a similar way to other licensed doctors. The ‘responsible officer’ will make a recommendation to the GMC that the doctor is up to date, fit to practise and should be revalidated.

8.3 The responsible officer will be in the ‘designated body’ that is supporting the trainee with revalidation.

(a) For trainees in England, the designated body is the postgraduate deanery. The responsible officer is the postgraduate dean. (The designated body will change when postgraduate deaneries are replaced by local education and training boards in April 2013).

(b) For trainees in Scotland, the designated body is NHS Education for Scotland. The responsible officer is the medical director for NHS Education for Scotland.

(c) For trainees in Wales, the designated body is the Wales Deanery. The responsible officer is the postgraduate dean.

(d) For trainees in Northern Ireland, the designated body is the Northern Ireland Medical and Dental Training Agency (NIMDTA). The responsible officer is the postgraduate dean.

8.4 The medical director of NES, acting as the responsible officer for trainees in Scotland, will base a recommendation on a trainee’s participation in the Annual Review of Competence Progression (ARCP) process or its equivalent the Record of In-Training Assessment (RITA).

8.5 Doctors in training will be generating the supporting information as they meet the requirements of the GMC approved curriculum and training programme. Where a training programme does not require a trainee to routinely collect items of supporting information, trainees are not expected to go beyond the requirements of their training programme to collect this.

8.6 The underlying imperative of re-licensing is that the doctor demonstrates that they are ‘practicing in accordance with the generic standards of practice set by the GMC as described in Good Medical Practice’. All the curricula that trainees follow have to demonstrate the principles of Good Medical Practice and so the argument has been made that by following the curricula and achieving their objectives trainees are practicing in accordance with the appropriate principles.

8.7 Trainees already collect a folder of information either in hard copy or electronically which includes the suggested elements. Many trainees also take part in multisource feedback from colleagues through their college processes. There may need to be an extension in some cases to include feedback from patients. However, current GMC guidance is that formal patient feedback is only required in those specialties which already have it as a curricular requirement – currently only General Practice trainees.

8.8 Educational appraisal should normally include objective setting, review of the job plan, review of evidence of multisource feedback, audit evidence and a discussion of any examples of problems with the doctor’s practice. The educational supervisor needs to produce an annual report which is the primary source of evidence for the Record of In Training Assessment (RITA)

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24 Information for doctors in training. GMC, 2012. (Link)
(legacy SpRs) or Annual Review of Competence Progression (ARCP). It is important that any incidences of problems (formal complaints, SUIs, disciplinary matters etc) encountered by the trainee within a Board or placement setting should be recorded in this report.

8.9 For those trainees who receive anything other than an ARCP1 or RITA C there will need to be a discussion between the senior responsible officer and the training programme director and deanery as to whether the issues identified required that the trainee undertook remedial action before a recommendation for re-licensing or whether the trainee was simply acquiring further experience for example due to missed training opportunities.

8.10 The point at which a trainee revalidates as a doctor in training will depend on how long training lasts:

(a) If training lasts less than five years, the first revalidation will be at the point of eligibility for CCT.
(b) If training lasts longer than five years, trainees will be revalidated five years after they gained full registration with a licence to practise, and again at the point of eligibility for CCT.

8.11 The GMC are working with the responsible officers for trainees to agree the dates that doctors in training will revalidate, and NES has provided GMC with information to allow them to set revalidation submission dates.

8.12 Following completion of training, the postgraduate deanery or NES in Scotland will no longer be the designated body. The designated body will change to the organisation in which the doctor spends most or all of their practice. Doctors will need to tell the GMC when their designated body changes by using GMC Online.

8.13 Differences between Scotland and Other UK nations

8.13.1 Early on in the process of designing appraisal for trainees, it became apparent that anything other than an IT based system to facilitate the process would prove unwieldy and may be prone to difficulties with implementation. The decision of Scottish Government to mandate the NES SOAR (Scottish Online Appraisal Resource) system for all doctors working in Scotland to aid the process of revalidation encouraged us to incorporate a trainee version of the programme into our plans.

8.13.2 SOAR has been used successfully in General Practice for some years now, and NES Medicine have spent some of the last two years developing a trainee module. This means that trainees will have the benefit of using the IT system used by other doctors in Scotland prior to becoming trained doctors. Other advantages include being able to import information from their e-portfolios for the purposes of producing evidence for revalidation, convenience of storage of such evidence, and the ability to maintain a record wherever they work.

8.13.3 A (paper-based) revalidation pilot project has been run in English deaneries over the last few months. This has demonstrated considerable difficulties in gathering the evidence required, along with considerable concerns about additional costs required. Informally, some of the other devolved nations are looking at the Scottish system for all of their doctors, both in training and trained.

8.14 The Process of Trainee Revalidation in Scotland
8.14.1 The fundamental process is based around the ARCP/RITA process, already running in across the four deaneries. The trainee is expected to present to the assessment panels evidence of progression through the programme of training appropriate to their level. This, along with an educational supervisor’s report, forms the current basis of the current system. Most medical training curricula include the provision of multi source feedback on a regular basis, and this, along with the more recent inclusion of medical leadership competencies in curricula, means that those requisite assessments mandated by the GMC are covered in our process.

8.14.2 In addition to the above, we propose that a declaration is made by the trainee – identical to the one made by trained doctors in Scotland. This would cover probity issues and is expected to cover all employments (including peripatetic locum work), and asking for information about complaints, significant incidents and the like. The educational supervisor would have sight of this before the submission of the evidence, and deanery staff (training programme directors, associate deans) would also have access (as they do at present) to any untoward issues prior to the annual assessment process, meaning that important judgements can be made ahead of discussion at the panels.

8.14.3 The decision on progression through training is independent of the revalidation process. It is entirely possible to have delayed or arrested progression in a programme of training without having any concerns on revalidation. The converse is not the case,

8.14.4 Established processes at Deanery level provide an overview of what determines sufficient evidence, the postgraduate medical deans will have effective oversight of the process, and will be in a position to make a recommendation to the responsible officer (in NES’s case, the medical director), who will have the opportunity to review all decisions, and will be responsible ultimately for making a recommendation to the GMC. There are three options at that point:

(a) Recommend for revalidation
(b) Recommend deferral in the case of doctors subject to an on-going process or where more information is required
(c) Refer to GMC as a fitness to practice concern (although such issues will normally be referred at the time of any problems arising). The issue of non-engagement with the process will be dealt with through the deaneries’ normal processes, however may lead to more GMC scrutiny under the new systems.

8.14.5 Our IT based system means that we will be able to incorporate a RAG dashboard in order to track any difficult cases, and will allow easy statistical analysis as well as real time scrutiny of progress.

9. Other issues to note

9.1 Overall, we are well positioned to implement and manage this important legal process. However, it should be noted that GMC have only produced clarity around their arrangements in mid-August 2012, and the medical appraisal and deanery teams have been working hard since to develop structures to manage the process. For this reason, detailed resource requirements are not yet clear, and will be the subject of a further paper to the executive team in due course.

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25 GMC RO Recommendation Statements. 2012. (Link)
9.2 The IT support for some of the process is still in development, with an active tender for further development in progress. The specification for this work includes very tight deadlines for completion of the work to have a trainee interface ready to activate by February/March 2013, when the process requires trainees to engage. The development of a more seamless interface between Pinnacle, SOAR and the various e-portfolios used by trainees will follow, and work on this is ongoing. Until then, the processes will be coordinated through the training departments in the deaneries on a manual basis.

9.3 Sufficient attention to both communications to trainees and educational supervisors will have to take place between now and March to ensure that all are aware of and have registered with SOAR in sufficient time to allow the evidence to be used at ARCP. A strategy group has been established and is coordinating work on websites/mailshots/web training etc. The great benefit of using the same package as all other doctors in Scotland is that it should build familiarity with the software in both groups of doctors who will have to use it.

9.4 The introduction of Approval and Recognition of Trainers by the GMC means that the introduction of revalidation and SOAR gives us an opportunity to verify the names of educational supervisors. This work will be iterative, and has been hampered by the delay in implementation of Pinnacle v3, but will run in parallel with work streams already extant in the directorate.

9.5 The lag in implementing seamless IT solutions for revalidation purposes means that capacity in training departments would not be sufficient at present to manage the total work around revalidation once fully implemented. Fortunately, only small numbers of trainees will revalidate this coming year, and we can target this group as a priority. The bulk of trainees will revalidate in the following three years, by when we should have a better idea of the workforce and resources to support the activity.

Dr Stewart Irvine
Director of Medicine
NES

November 2012

Professor Bill Reid
Postgraduate Dean
South East Scotland Deanery

26 Recognising and approving trainers: the implementation plan. GMC, 2012. (Link)
Annex 1

Governance Arrangements for Medical Revalidation in Scotland (Link)
### REGULATOR
- Set UK-wide policy
- Agree policy for devolved areas
- Interpret reserved policy for Scottish context
- Strategic oversight of implementation
- Provide practical implementation advice to OISG

### GOVERNMENT
- Set standards for re-licensure
- Agree standards for recertification
- Assure quality of national processes
- Ensure delivery of revalidation across all specialties and all 4 Countries
- Agree standards for recertification, subject to GMC agreement
- Assure quality of local processes
- Interpret AoMRC standards for Scottish context
- Communicate Scottish issues to AoMRC
- Communicate AoMRC issues to CPFtP
- Keep Scottish Academy informed
- Implement enhanced appraisal & internal QA
- Harmonise processes
- Share knowledge

### COLLEGES
- NHS Boards
  - QIS
    - EQA of CG
    - EQA of appraisal
  - NES
    - Train appraisers
    - Facilitate appraisal
  - Pilots

### SERVICE
- RDBS
  - Coordinate delivery of revalidation
- AoMRC
  - Set standards for recertification, subject to GMC agreement
  - Assure quality of local processes
  - Interpret AoMRC standards for Scottish context
  - Communicate Scottish issues to AoMRC
  - Communicate AoMRC issues to CPFtP
  - Keep Scottish Academy informed
- SARG
- GMC
- UKRPB
- SGHD
- DH(E)
- OAISG
- CPFtP
- ALG
- RON
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<th>Description</th>
</tr>
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<tr>
<td>GMC</td>
<td>General Medical Council</td>
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<td>UKRPB</td>
<td>UK Revalidation Programme Board</td>
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<td>Scottish Government Health Directorates</td>
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<td>Department of Health (England)</td>
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<td>Overarching Implementation Steering Group</td>
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<td>Cross-Professional Fitness to Practice Group</td>
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Annex 2

Revalidation: Joint CMO Statement – 19 October 2012 (Link)
MEDICAL REVALIDATION

The announcement by the Secretary of State on 19 October 2012 that the implementation of medical revalidation will commence in December this year is a watershed moment for the profession and patients. Revalidation fills a key gap in the current regulatory framework by requiring regular reviews and providing stronger regulatory oversight of doctors’ fitness to practise.

The revalidation model will give greater public confidence and assurance of the competence of doctors and significant benefits in terms of quality of care and patient experience. Throughout the UK over 4000 doctors have taken part in the testing and piloting to develop a model that delivers for patients, doctors and the organisations where care is delivered.

The active participation of the patient groups, Medical Royal Colleges and professional associations has ensured that the vision of a streamlined and proportionate system outlined in the Statement of Intent in October 2012 has been achieved.

All four UK countries have made considerable efforts to ensure they have achieved an acceptable state of readiness, and must now maintain this welcome progress as we move into active implementation. This is a significant and positive milestone for the medical profession, and we encourage all doctors to grasp the opportunities which revalidation offers to demonstrate the principles and values on which good medical practice is founded.

Dr Aileen Keel CBE
Deputy Chief Medical Officer for Scotland

Dr Ruth Hussey
Chief Medical Officer, Welsh Government

Dr Michael McBride
Chief Medical Officer for the Department of Health, Social Services and Public Safety, Northern Ireland

Prof Dame Sally Davies, DBE
Chief Medical Officer for the Department of Health, England
Annex 3

Responsible Officer Regulations (2010) ([Link](#))