

Taking revalidation forward

Improving the process of relicensing for doctors

Sir Keith Pearson's review
of medical revalidation

January 2017

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Acknowledgements

I would like to thank the many people who gave up their time to meet with me to discuss revalidation, and those who provided such insightful written submissions. I am also very grateful for the support provided by the GMC in responding to my many requests for data, information and clarification. Finally, I am indebted to Helen Arrowsmith who has directly supported me throughout the review, and to Sophie Holland and India Silvani-Jones who managed the logistics of the very many meetings I attended across the four countries.

Executive summary

My overall conclusion is that revalidation has settled well and is progressing as expected.

Revalidation was introduced in December 2012. It means that doctors who wish to maintain their licence to practise medicine in the UK must demonstrate on an ongoing basis that they are up to date and fit to practise. Revalidation aims to give assurance that individual doctors are not just qualified, but safe. It also aims to help identify concerns about a doctor's practice at an earlier stage and to raise the quality of care for patients by making sure all licensed doctors engage in continuing professional development and reflective practice.

At the GMC's request, I have reviewed evidence on the impact of revalidation and met with people involved at every level of the process, across all four countries of the UK. My overall conclusion is that revalidation has settled well and is progressing as expected. For that, huge credit must go to the medical profession and those leading revalidation, both locally and nationally. Many, although not all, of those who were sceptical about the merits of revalidation at the outset now recognise it is a valuable means of assuring the public that doctors are keeping themselves up to date and safe to practise.

Revalidation has already delivered significant benefits. Firstly, it has ensured that annual whole practice appraisal is now taking place. Regular, supported reflection upon specified types of information, including feedback from patients and colleagues, is starting to drive changes in doctors' practice. Secondly, evidence shows that revalidation has strengthened clinical governance within healthcare organisations, helping them to identify poorly performing doctors and support them to improve. In time, I am confident that these developments will lead to safer and better care for patients.

I have listened to concerns raised by some doctors that revalidation is unnecessarily burdensome or that appraisal is not benefiting them. I have spoken personally to doctors in order to understand what lies behind these concerns. My conclusion is that the principles of revalidation are sound but more can be done locally to support doctors to meet requirements while maintaining a focus on personal development and improvement.

I have considered how revalidation could become more effective in assuring the public and employers that all licensed doctors are safe to practise. I am concerned that the revalidation process is sometimes less rigorous for doctors who work outside 'managed' environments or who move frequently between jobs. I would also like to see greater public awareness of revalidation and steps taken to make it easier for patients to provide feedback to doctors.

Revalidation is still a new process; it is important that we learn from the first cycle to make it more effective in the next. I do not believe major overhaul is needed. Rather, I have made recommendations to improve some aspects of revalidation, for the benefit of both doctors and patients.

Revalidation is still a new process; it is important that we learn from the first cycle to make it more effective in the next.

For revalidation to achieve its goal of increasing assurance:

- Local healthcare organisations should promote revalidation to their patients, explaining the assurance that it provides and why their feedback matters.
- Mechanisms for capturing feedback on doctors from patients and colleagues should be strengthened.
- The system needs to be more robust for doctors who work outside mainstream clinical practice and those who move around the system, such as locums.
- The GMC should work with others to identify quantifiable, long-term impact measures for revalidation.

For revalidation to secure confidence across the medical profession:

- The GMC should update its guidance on the information doctors need to collect for revalidation to make clear what is sufficient and what is (and is not) mandatory. ROs should avoid placing revalidation requirements on doctors that go beyond what is specified as necessary by the GMC.
- Local healthcare organisations should continue their work to improve and assure the quality and consistency of annual whole practice appraisal.
- The boards of healthcare organisations should offer greater challenge and support to make sure local revalidation processes are efficient, effective and fair.
- Organisations should make it easier for doctors to collect evidence for their appraisal by improving local information systems and support. But doctors also need to approach the process constructively, recognising that revalidation is a legitimate and proportionate assurance mechanism for patients and employers.

Key recommendations

For the GMC, working with others:

Update guidance on the supporting information required for appraisal for revalidation to make clear what is mandatory (and why), what is sufficient, and where flexibility exists. Ensure consistency and compatibility across different sources of guidance.

Identify ways to improve the input of patients into the revalidation process by developing a broader definition of feedback which harnesses technology and makes the process more 'real time' and accessible to patients.

Consider bringing forward the date of first revalidation for newly-licensed doctors.

Set out expectations for board-level engagement in revalidation and provide tools to support this.

Address weaknesses in information sharing in respect of doctors who move between designated bodies.

Continue work with the CQC and NHSE in England to reduce workload and duplication for GPs. Work with relevant organisations in Northern Ireland, Scotland and Wales to identify and respond to any similar issues if they emerge.

Identify a range of measures by which to track the impact of revalidation on patient care and safety over time.

Consider replacing the term 'revalidation' with 'relicensing'.

For healthcare organisations and their boards, supported by others:

Work with local patient groups to publicise and promote processes for ensuring that doctors are up to date and fit to practise.

Continue work to drive up the quality and consistency of appraisal and make sure the process is properly resourced.

Explore ways to make it easier for doctors to pull together and reflect upon supporting information for their appraisal. This might occur through better IT systems or investment in administrative support teams.

Ensure effective processes are in place for quality assurance of local appraisal and revalidation decisions, including provision for doctors to provide feedback and to challenge decisions they feel are unfair.

Avoid using revalidation as a lever to achieve local objectives above and beyond the GMC's revalidation requirements.

Boards should hear regularly about the learning coming from revalidation and how local processes are developing. They should also challenge their organisations as to how revalidation is helping to improve safety and increase assurance for patients.

For the government health departments, advised by the GMC:

Review the RO Regulations with a view to establishing a prescribed connection to a designated body for all doctors who need a licence to practise in the UK.

Review the criteria for prescribed connections for locums on short-term placements.

Throughout this review I have tried to see revalidation through the eyes of a patient. Is medical practice safer? Are patients' views being heard and considered by doctors?

Reasons for my review

1 When the General Medical Council (GMC) launched revalidation in December 2012, its Chief Executive, Niall Dickson, described it as: *“the most significant reform of medical regulation for over 150 years.”* And so it was. We are now four years into revalidation and nearly all licensed doctors have been through the process. So this is an opportune time to take stock of progress.

2 Revalidation is a hugely ambitious programme of work. The responsibility for its delivery is shared across the GMC, the health departments in England, Northern Ireland, Scotland and Wales, the medical royal colleges, employers in both the public and private sectors, and the medical profession as a whole.

3 In March 2016 the GMC asked me to undertake a review of revalidation.* I have been the independent Chair of the [Revalidation Advisory Board](#) (RAB)[†] – a four-country group of external advisers to the GMC – since 2009. I am therefore well placed to provide an insight from a range of perspectives about how revalidation is operating for doctors, Responsible Officers (ROs) and employers and whether the public can be assured that doctors are up to date and fit to practise.

Scope and approach – revalidation through a patient lens

4 Throughout this review I have tried to see revalidation through the eyes of a patient. Is medical practice safer? Are patients' views being heard and considered by doctors? Is revalidation helping to identify the poor practitioner? And am I assured that doctors are keeping up to date and are safe to practise?

5 My approach has been to go back to the beginning of the journey and to look at the expectations set for revalidation at the start. I have tried to understand what has been achieved and to identify what should be changed in the next few years to improve systems and processes and to increase assurance.

Contributors to this review

6 I interviewed a range of doctors (including doctors working in both the NHS* and the independent sector), their professional bodies and their representative organisations, patients and patient organisations, and medical leaders in Northern Ireland, Scotland, Wales and England. I interviewed many supporters of revalidation but I also sought out doctors who were less than enthusiastic and yet to be fully convinced about the merits of revalidation.

* You can find the terms of reference for my review on the GMC's website at www.gmc-uk.org/news/27478.asp

[†] RAB provides external advice to the GMC about how revalidation is working on the ground. It includes representatives from health departments in the four UK countries, the royal colleges, the British Medical Association and individuals speaking on behalf of patients.

* References in this report to the NHS also cover Health and Social Care in Northern Ireland.

7 Everyone I met was generous with their time and I was struck by how keenly they wanted to engage with the review and provide their perspective. This report is their report and I hope I have done justice to their contribution. These are people and organisations involved in developing, implementing and running revalidation on a day-to-day basis as well as those experiencing it. Their commitment to high quality, safe patient care was a golden thread that ran through every interview I carried out. There is a list of all of the people, groups and organisations I spoke with at [Annex A](#).

Documentary evidence informing the review

8 There has been a wealth of information published on revalidation. This report does not provide an overview of all of the literature or research. In summary, I looked at UK-wide research into revalidation and appraisal; [operational data](#) provided by the GMC to RAB (which is made publicly available on the GMC website[†]); reports on how appraisal and clinical governance are working in each country of the UK; UK-wide surveys completed since the introduction of revalidation; and [comments made on the GMC's website](#).

9 I asked the GMC to analyse the key points of each documentary source identified for the review and to collate them for my consideration. Each document was read individually and the main points were summarised and drawn together into themes for me to review. There is a list of references at [Annex B](#).

10 Both the GMC and the Department of Health in England have commissioned academic evaluations of revalidation. Interim reports from the evaluations were published in early 2016.^{*} The RAB has received presentations from both groups of researchers, and I have had the opportunity as part of this review to interview the researchers to better understand the underlying information and messages. I value their academic input and their work is reflected in this report. In particular, I have reviewed in detail the results of the profession-wide survey undertaken by the UMbRELLA consortium in 2015 which reflects the views of more than 26,000 licensed doctors.

11 All four UK countries have undertaken reviews into revalidation and publish progress reports on a regular basis. Healthcare Improvement Scotland produces an annual report for Scotland. In Wales, the Deanery's Revalidation Support Unit also issues an annual report on progress. In Northern Ireland, consideration of revalidation was part of the Regulation and Quality Improvement Authority's (RQIA) review of clinical governance arrangements supporting professional regulation, which is awaiting final publication. I have reviewed all these reports, including receiving a briefing on the RQIA report.

[†] The GMC's operational data is updated on a monthly basis.

^{*} UMbRELLA, [Shaping the future of medical revalidation](#), January 2016; Boyd et al, [Implementing medical revalidation: organisational changes and impacts](#), April 2016.

It is a common misconception that revalidation was devised in response to the Shipman inquiry.

Revalidation – influences and objectives

12 Revalidation was under consideration and development for over a decade before its introduction in December 2012. I do not intend to provide a detailed history of its evolution – others have done this already. However I think there is merit in highlighting the key events that contributed to the journey and influenced the current shape of revalidation. A summary timeline of these events is included at [Annex C](#).

13 No one single event triggered the start of discussions around revalidation. Changing expectations of patients emerged from several high-profile public inquiries into failings in the provision of care. There were calls for more transparency in the governance of the care provided by the NHS and greater accountability – both system and personal – for that care. And it was suggested that there should be some form of regular checks on doctors.

14 It is a common misconception that revalidation was devised in response to the Shipman inquiry. In fact, revalidation had been proposed by the GMC in 1998, before Shipman was even arrested. Its rationale was not to uncover criminality but to fill a gap in the regulatory framework whereby, barring serious concerns being raised, a doctor could practise from registration to retirement without any check on their performance or competency.

Identified failings in healthcare systems

15 A number of public inquiries and medical malpractice cases between 2000 and 2005 called into question the traditional model of medical regulation.* The cumulative effect of these inquiries and cases was that, on behalf of the public, the GMC decided it needed to be proactive in checking that doctors on the register continued to be safe to practise.

16 The Bristol Inquiry was set up in 1998 to investigate the deaths of babies undergoing heart surgery at Bristol Royal Infirmary during the 1980s and 1990s. The inquiry highlighted the fact that there was no means of assessing the quality of care provided by doctors or evaluating their performance. [The final report made over 200 recommendations](#), including recommendations about: strengthening leadership; promoting openness and acknowledging errors; the need for cultural change within the organisation and the wider NHS; creating effective systems within hospitals to ensure that clinical performance is monitored; and the use of appraisal, continuing professional development (CPD) and revalidation to make sure all healthcare professionals remain competent to do their job.

17 Some of the same points were reiterated by Robert Francis QC in the Mid Staffordshire NHS Foundation Trust Public Inquiry. In the [final report](#), published in February 2013, he discussed the use of appraisal to reinforce cultural change, saying: “As a part of this mandatory annual performance appraisal, each clinician and nurse should be required to demonstrate their ongoing commitment, compassion and caring shown towards patients, evidenced by feedback of the appraisee from patients and families, as well as from colleagues and co-workers. This portfolio could be made available to the GMC or the NMC, if requested as part of the revalidation process.”†

* For example, inquiries into children’s heart surgery at Bristol Royal Infirmary, the retention of organs at Alder Hey Children’s Hospital in Liverpool and the cases of Ledward, Ayling, Neale and Kerr/Haslam.

† [Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, February 2013, Executive Summary, paragraph 1.201, page 78](#)

Rising patient expectations

18 It is noteworthy that research carried out in 2006* found that almost half of patients when asked thought that doctors were already subject to regular assessments, with one in five believing that this happened annually. The introduction of revalidation was, therefore, in part, catching up with the public's established expectation.

19 Patient expectations have changed and they continue to change, making the interaction a patient has with a doctor very different from that of only a few years ago. Patients are better informed, increasingly acting as consumers, expecting a dialogue with a doctor, with explanation and discussion about treatment options and risks. They look increasingly to be 'consulted' when it comes to their care.

20 As patients today are informed, involved and empowered, so healthcare professionals need to adapt to hear their voice. Doctors and their leaders, educationalists and health service providers need to keep pace with the shift from the passive compliant patient to the proactive healthcare consumer; the consumer who is motivated to know more about their care and the implications of their treatment package. By way of example, I heard the case of an elderly lady who was spoken to by one of the hospital's most senior consultants during a ward round. He looked at her notes, conferred with colleagues, spoke to his patient about the treatment he planned for her and moved on. Some short time later a doctor in training attended the patients to arrange the medication that had been prescribed. In the intervening period, the patient had taken out her iPad and Googled the medication. "Doctor," she asked, "can you please explain the pharmacology of the drug I'm being prescribed and can we discuss the possible side effects?" Informed patients will become the norm and doctors need to rapidly adapt. Appraisal and revalidation should encourage this adaptation.

21 In Professor Don Berwick's 2013 [report on patient safety in the NHS in England](#), he wrote: "The goal is not for patients and carers to be the passive recipients of increased engagement, but rather to achieve a pervasive culture that welcomes authentic patient partnership – in their own care and in the processes of designing and delivering care. This should include participation in decision-making, goal-setting, care design, quality improvement, and the measuring and monitoring of patient safety. Patients and their carers should be involved in specific actions to improve the safety of the healthcare system and help the NHS to move from asking, 'What's the matter?' to, 'What matters to you?' This will require the system to learn and practice partnering with patients, and to help patients acquire the skills to do so."

* Department of Health (England), [Good doctors, safer patients: A report by the Chief Medical Officer](#), July 2006.

In my interactions with patient representatives for this review, I have heard consistently that patients expect doctors to be subject to some form of ongoing review and professional development.

22 The expectation of patient-centred care has been established in all four countries of the UK. For example, in her 2014/15 annual report, [Realistic Medicine](#), Scotland's Chief Medical Officer wrote: *"Shared decision-making is not a one-way transmission of information about options and risks from the professional to their patient. It is a two-way relational process of helping people to reflect on, and express, their preferences based on their unique circumstances, expectations, beliefs and values. This can be a challenging communication process and individuals will equally need reassurance that their professional has understood them."*

23 In my interactions with patient representatives for this review, I have heard consistently that patients expect doctors to be subject to some form of ongoing review and professional development. And they would like to receive an assurance that this process is taking place in their local hospitals and GP practices.

Changes in the medical profession

24 As patient expectations of healthcare have developed, so have models of care and the attitudes of doctors towards their work. Today's doctors operate in a multi-generational and multi-skilled workforce of healthcare professionals. The motivations and expectations of each generation are different. For example, the newer generation of doctors seeks greater flexibility in working hours and has different expectations of managers and leaders.

25 Anecdotally, I hear that, in comparison to earlier periods, current doctors in training are less likely to complete their training in a single concentrated period, fewer GPs wish to become full-time partners in a practice and locum work is proving increasingly attractive as a means of balancing work and family commitments. Doctors, particularly younger doctors, spoke to me about an aspiration to have a portfolio career where medicine might be only one part of that career.

26 Many doctors are employed by organisations where they are the sole qualified medical practitioner or work in settings such as public health where the main business is not the delivery of clinical care. This presents a different challenge in terms of maintaining core knowledge and professional competency.

27 I make these points because I believe we must be cautious about looking at revalidation just through the lens of today. Regulators are constantly updating their processes to reflect the context in which healthcare is delivered. For example, early in 2017, the GMC plans to begin a public consultation on the introduction of a new Medical Licensing Assessment to create a common threshold for entry on to the UK medical register for both UK and overseas-qualified doctors.

“Revalidation supports doctors in developing and improving their practice throughout their career, by making sure they have the opportunity to reflect regularly on how their practice can be developed, modified or improved. Over time, revalidation will give patients greater confidence that doctors are up to date in the areas in which they practise, and promote improved quality of care for patients by driving improvements in clinical governance.”

GMC, *Guide for doctors: Revalidation and maintaining your licence*

What revalidation set out to achieve

28 The GMC and the chief medical officers of the four UK countries set out their overall objective for revalidation in a joint [Statement of Intent](#) published in October 2010: *“The purpose of revalidation is to assure patients and the public, employers and other healthcare professionals that licensed doctors are up to date and fit to practise.”*

29 Revalidation marks a departure from the traditional method of regulation for doctors. Most professional regulators, including the GMC, regulate by controlling access to a register. Doctors are admitted to the register once they have attained the correct qualifications, training and experience.

30 However, the register only records past qualifications. It is not a contemporary account, and so it offers limited assurance that any particular doctor is as up to date now as they were when they entered the register, or that their practice across the range of their work is safe. Before revalidation, doctors would remain on the register without having to demonstrate their ongoing competence, unless a serious issue was identified about their fitness to practise and they were referred to the GMC.

31 Patients want to be assured that doctors are keeping up to date and are safe to practise. Revalidation was introduced to provide that assurance. All doctors who hold a licence are now subject to continuing evaluation of their practice in their everyday working environment.

32 This means that holding a licence to practise has extra significance – it means that anyone holding a licence should now be engaged in revalidation and working within a governance framework that regularly checks to make sure they are up to date, fit to practise and that there are no outstanding concerns.

How revalidation works

The medical register and the licence to practise

33 Registration with the GMC demonstrates a doctor has the necessary qualifications and is in good standing. However, holding a licence to practise is what allows doctors to undertake medical practice in the UK. Any doctor wishing to practise medicine in the UK must be both registered and licensed with the GMC – irrespective of whether they practise in the NHS or privately, part time or full time, or are self-employed.

34 As of 30 September 2016, 273,146 doctors held full registration with the GMC. Of those, 229,992 held a licence to practise and were therefore subject to revalidation. The remaining 43,154 were unlicensed: they may be working overseas, retired or employed in a non-clinical role.

Outline of the revalidation model

35 Revalidation is based on a doctor's whole scope of practice across all the settings in which they work. For most doctors, the evaluation of that practice takes place in the environment in which the doctor works and is part of the wider clinical governance system within an organisation.

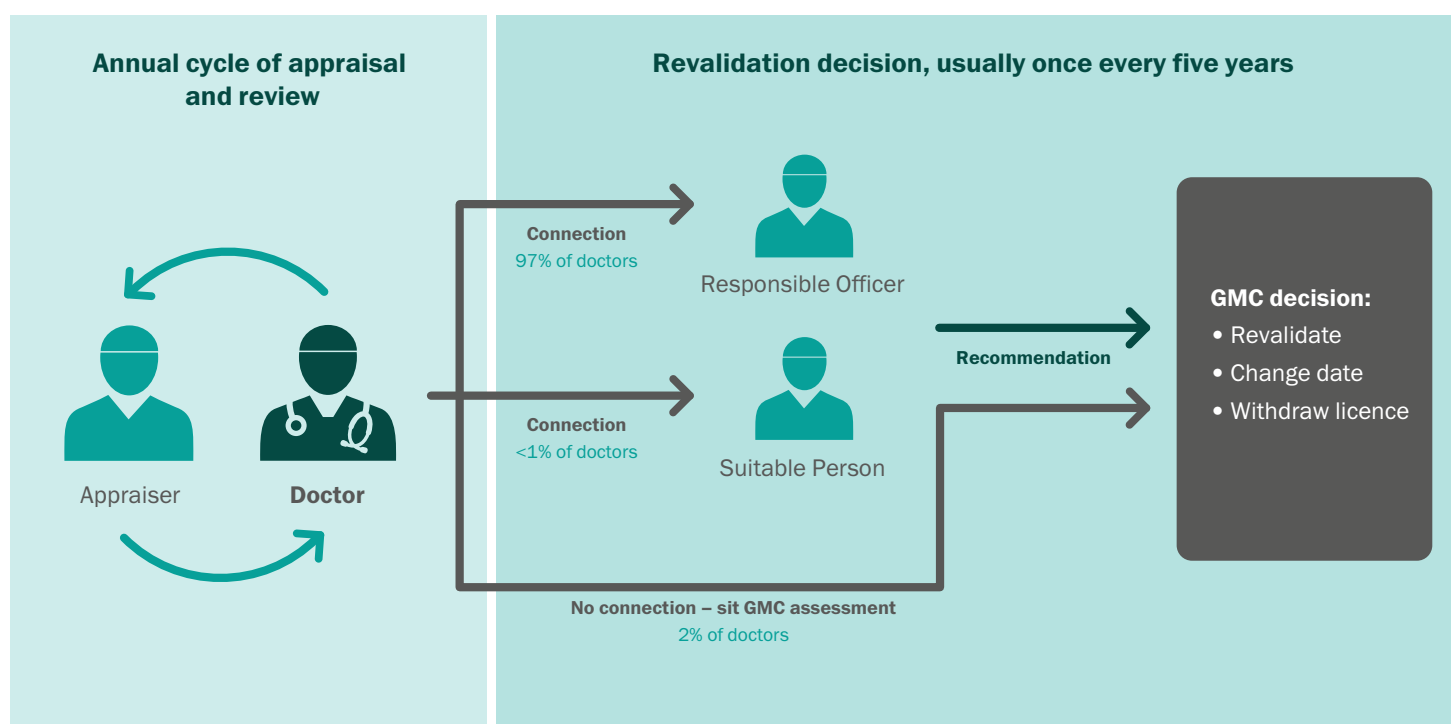
36 Revalidation is not a point-in-time assessment or merely a demonstration of training and development activities undertaken.

37 All doctors are required to have an annual appraisal that covers the whole of their practice [figure 1]. The GMC has described the [supporting information](#) that doctors are required to bring to their whole practice appraisals to demonstrate that they are meeting the standards in the GMC's core guidance for doctors – [Good medical practice](#). Most of the supporting information is generated in the doctor's day-to-day practice or is available within their workplace. Doctors need to reflect on and identify learning from continuing professional development, feedback from colleagues and patients, any complaints or compliments made about them, any significant events they were involved in, and quality improvement activities [figure 2].

38 The vast majority of doctors have a prescribed connection to a designated body set out in the RO Regulations.* These regulations established arrangements for ROs to be appointed by each designated body (healthcare organisations and certain other bodies), with responsibilities relating to the evaluation of the fitness to practise of doctors who work in the body. When a doctor moves to work in a different body, their prescribed connection will change.

* The "RO Regulations" referred to in this report are *The Medical Profession (Responsible Officers) Regulations 2010 (as amended)* and *The Medical Profession (Responsible Officers) Regulations (Northern Ireland) 2010*. The regulations came into force in October 2010 for Northern Ireland and January 2011 for the rest of the UK.

Figure 1 - Revalidation model



Doctor	Responsible for their own revalidation, including demonstrating that they are reflecting on information from their practice, learning and making improvements.
Appraiser	Responsible for providing the doctor with a whole practice appraisal.
Responsible officer (RO)	Usually a senior doctor within a healthcare organisation – often the medical director. The role is set out in statute and includes making sure systems are in place to evaluate doctors' practice on an ongoing basis. This includes establishing appraisal processes and procedures to investigate and refer fitness to practise concerns to the GMC. The RO makes recommendations to the GMC about each doctor's revalidation. They usually sit on the executive board of the organisation.
Designated body	This is the organisation that provides a healthcare service. They range in size from large NHS trusts and private hospitals to smaller independent healthcare providers. They must appoint and resource an RO.
GMC	The professional regulator of doctors, which is responsible for setting the national framework for revalidation and for making revalidation decisions about individual doctors.
Suitable person (SP)	A licensed doctor approved by the GMC as suitable to make a recommendation to the GMC about the revalidation of a doctor who does not have an RO.

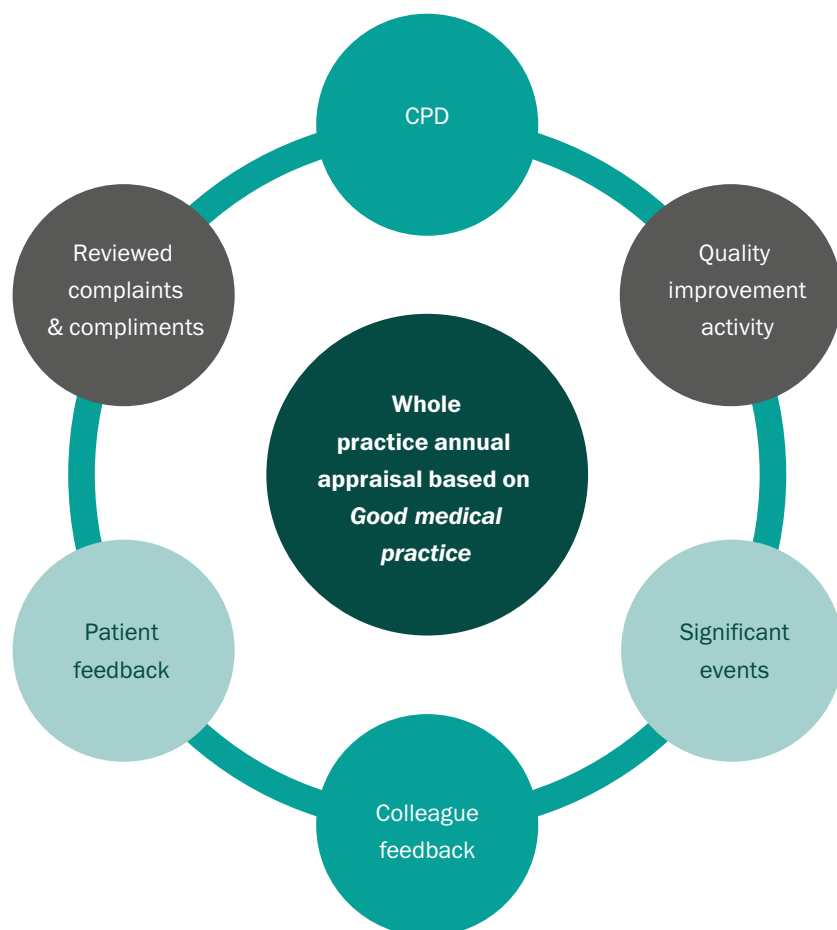
39 Generally once every five years, a doctor's RO will make a recommendation to the GMC to confirm that the doctor has been engaging in revalidation and there are no outstanding concerns about the doctor's practice. Alternatively, the RO may recommend deferring the doctor's revalidation date (for example, to give them more time to collect the necessary evidence) or inform the GMC that a doctor is not participating in revalidation by sending a non-engagement recommendation. In the latter case, if it is clear that the doctor is not sufficiently engaging with revalidation, the GMC can withdraw their licence to practise. This means that, although the doctor remains registered with the GMC, they can no longer practise in the UK.

40 If an RO has concerns about a doctor's fitness to practise (as distinct from concerns about their engagement with revalidation) which they cannot resolve locally, they may refer them into the GMC's fitness to practise processes. This occurs separately from the revalidation process. Where the GMC decides to investigate, the doctor's revalidation is placed on hold.

41 Where a doctor does not have a prescribed connection under the RO Regulations, the GMC may approve a Suitable Person (SP) to make recommendations about that doctor's revalidation. 1,002 doctors were connected to SPs approved by the GMC as at 30 September 2016.

42 There are a small number of licensed doctors (4,366 on 30 September 2016) who do not have an RO or an SP. Doctors who do not have an RO or SP are still required to revalidate. These doctors are typically working on an occasional basis, outside clinical environments or are based overseas: the majority do not require their licence to practise. The process for them involves providing evidence directly to the GMC on an annual basis, showing that they have had an annual whole practice appraisal and providing statements from organisations to which they provide medical services confirming that there are no fitness to practise concerns. They must also take part in an assessment to demonstrate their medical knowledge once in every cycle.

Figure 2 - Supporting information for revalidation



Four domains of *Good medical practice*

- Knowledge, skills and performance
- Safety and quality
- Communication, partnership and teamwork
- Maintaining trust

Concerns about fitness to practise must be raised with GMC as and when they arise

As the regulator, the GMC has set a strong clear national framework for revalidation, but the revalidation process is owned and resourced at a local level by organisations and employers.

My view on the purpose of revalidation

43 Revalidation is a safety and quality system aimed at assuring the public that doctors are up to date and fit to practise in the UK, whilst also reinforcing the professional standing of a doctor. It is underpinned by evidence and robust processes and procedures.

- **The public must have confidence that the overall system of regulation of doctors is right.**

We often draw the analogy with airline pilots. As passengers, we don't ask to see the pilot's credentials, but we are confident that the airlines and regulators have passenger safety at the core of their systems of governance. Similarly, the public want to know that medical practice is safe; that their views are being heard by doctors and that doctors are keeping themselves up to date and fit to practise; we need to assure them that this is happening. It is evident that the public expect such a system to be in place, but are largely unaware that revalidation exists. It is clear from the evidence I have seen that we have not done enough to take the public with us on this journey, and I will discuss this further later in the report.

- **Revalidation is part of a wider quality assurance framework across healthcare.** As the regulator, the GMC has set a strong clear national framework for revalidation, but the revalidation process is owned and resourced at a local level by organisations and employers. Revalidation is therefore, part of a local clinical governance framework. It is also designed to strengthen that framework.

- **Doctors, as professionals, should buy in to revalidation as a demonstration of their professionalism.** Revalidation puts in place a framework where doctors can demonstrate their professional standing and, therefore, their professionalism. It requires organisations to support them in identifying learning – through an agreed personal development plan (PDP) – and making changes, where necessary, to improve their practice. Revalidation should underpin the standing of doctors in the minds of patients and provide further evidence that we have very good doctors working in the UK.

- **Revalidation will identify concerns that might lead to poor performance.** Robust whole practice appraisal, and the triangulation of information about a doctor's practice through revalidation, will help to identify areas for improvement in a doctor's practice. Identifying and dealing with these (generally minor) concerns through appraisal will make sure the concerns don't escalate and help reduce the likelihood of harm to patients.

44 I also want to be clear on what revalidation does not do.

- **Revalidation does not exist solely to identify poor performance.** Revalidation does have a vital role to play in helping to identify concerns about a doctor's practice at an early stage, before they escalate. It can and should deal with poor behaviour and performance. However, contrary to a commonly repeated myth, it was never intended to 'catch another Shipman'. Shipman was a serial killer responsible for the deaths of more than 200 people. He was also a family GP. Much has been said about whether he would have been caught earlier if revalidation had been in place. It is impossible to say for certain, but my view is that the array of governance changes put in place since Shipman, including those established as part of revalidation,

makes it much more likely that his behaviour would have been detected earlier. Alongside revalidation, these include: changes to the death certification process and coroners system; safer management of controlled drugs; closer monitoring of prescribing data, mortality rates and unexpected deaths; guidance for police officers carrying out investigations into unexpected death or serious harm of patients following medical treatment; improved approaches to investigating complaints and concerns; and inspections of GP practices. Moreover, [Good medical practice](#) places an obligation on doctors to report concerns about colleagues who may not be fit to practise and may be putting patients at risk.

- **Revalidation is not a complaints process.** Revalidation is not another route for patients to make complaints about a doctor. However, complaints are an important source of information for doctors to use to identify improvements to their practice. When a complaint is made, it goes into the complaints system of the organisation. It is also captured as evidence in the review of the doctor's performance in their whole practice appraisal every year. Some organisations publish all of the complaints they receive on their website and explain how they dealt with them.
- **Revalidation is not the whole system of assurance.** It is one, but only one, important part of a system of assurance in a safety critical industry. There are many processes involved in delivering safe and effective patient care, and numerous organisations responsible for setting standards, monitoring and quality assuring various aspects of healthcare provision in the UK.

How the report is set out

45 In the remainder of this report I set out my findings in three sections.

- The impact of revalidation – what I have heard and seen.
- Taking revalidation forward – what I think can be improved and my recommendations for the future.
- Closing thoughts – my key messages and what I would like to happen next.

Revalidation means that all licensed doctors must demonstrate they are up to date and fit to practise

46 When reporting on the impact of revalidation, I am conscious that the implementation of revalidation has been a joint enterprise by the GMC, health administrations in the four UK countries, local designated bodies and others. Therefore, the successes I identify, and the areas for development I recommend, apply to a wide range of stakeholders and should not be seen as purely a matter for the GMC. I say this because the GMC may not always be best placed to make the changes required.

Doctors are meeting the requirements of revalidation

47 The population of the UK medical register changes constantly as new doctors join and others leave, either to retire or practise elsewhere. Some doctors have been practising in the UK for over 50 years; others for just a few weeks. The introduction of revalidation means every doctor who wants to maintain their licence – regardless of their field of work – must regularly demonstrate they are reflecting on how to improve their practice and taking steps to keep their knowledge and skills up to date.

48 I receive regular updates on the operational data held by the GMC about revalidation through the Revalidation Advisory Board (RAB). For this review I asked the GMC to tell me how many doctors had a revalidation decision by 30 September 2016. Up-to-date [operational data](#) is available on the GMC's website.

49 There have been 160,735 decisions to revalidate a doctor and 37,653 decisions to defer. Almost half of all deferrals to date have been for doctors in training, purely to align their revalidation date with the date they are expected to complete their training.* For non-trainees, the vast majority of deferral decisions were made because the RO felt the doctor needed more time to collect their evidence. I would expect to see fewer such deferrals during the second cycle of revalidation, as doctors and their organisations are more familiar with the requirements of the process. A very small percentage of deferral recommendations (4%) were made because the doctor was subject to an ongoing local human resources or disciplinary process, the outcome of which was deemed by the RO to be material to their evaluation of the doctor's fitness to practise.

50 The GMC has so far approved 499 recommendations of non-engagement made by ROs. When the GMC agrees with an RO that a doctor is not engaging sufficiently with revalidation requirements, they issue the doctor with formal notice that the GMC is minded to withdraw their licence. If the doctor does not take corrective action within a specified period, their licence is withdrawn.

* Doctors in training must participate in revalidation. Where their training lasts less than five years, trainees revalidate at the point of eligibility for their Certificate of Completion of Training (CCT). If their training lasts longer than five years, trainees will revalidate after five years, and again at the point of eligibility for their CCT. This means that trainee revalidation dates sometimes need to be adjusted or deferred.

There are several hundred privileges that are restricted by law to licensed doctors.

The licence to practise must be actively maintained

51 In 2009, in preparation for the introduction of revalidation, all doctors registered with the GMC were issued with a licence to practise, unless they told the GMC they did not want one. There are several hundred privileges that are restricted by law to licensed doctors. Notable amongst these are the ability to prescribe controlled drugs; to hold the appointment of physician, surgeon or medical officer in any public institution; to work as a GP in the NHS; to gain practising privileges in an independent hospital; to sign death certificates; to undertake duties for which approval under section 12 of the *Mental Health Act* is required; and to assess the suitability of individuals to perform certain activities (for example, to drive a heavy goods vehicle or join the police service). These are significant rights which require a level of continuing competency. Revalidation is the mechanism that testifies to that competency.

52 It was always anticipated that many of the doctors who were on the GMC register in 2009 would not require a licence for a variety of reasons; some would be wholly retired, some would be approaching retirement and some would not be living in the UK. This assumption was found to be correct. Of around 228,700 doctors who were subject to revalidation when it was introduced in December 2012, 42,904 no longer have a licence to practise in the UK. During those same years, 50,504 doctors joined the GMC register for the first time.

53 It is clear that revalidation has encouraged doctors to reflect on their need for a UK licence to practise and whether they want to go through the robust processes that are in place for keeping their licence. This has clear benefits for patient safety, as it ensures the licence to practise in the UK is proactively maintained rather than existing indefinitely upon payment of a fee. Doctors can no longer continue to treat patients and prescribe medicines in the UK just on the basis of having met the criteria for initial registration and licensing.

54 From a doctor's point of view, there is the flexibility to remain registered with the GMC – showing they are in good standing in the UK – but to give up their licence temporarily in order to take a career break or work overseas.

55 ROs have told me that revalidation has encouraged doctors to consider their current registration and licensing status. For example, I am aware of cases where doctors have decided to give up their licence, either temporarily or permanently, following a discussion with their appraiser. I have also heard that doctors are having conversations with their RO when retirement is approaching and deciding to stop clinical work or to reduce the scope of their practice, based on whether they will have sufficient supporting information for their revalidation. From a patient safety perspective, I believe this is a good thing.

The RO Regulations do not provide a prescribed connection for every doctor who is working in the UK. In my view, that is an assurance weakness that must be addressed by the UK health departments.

56 Where a doctor does not engage with revalidation and will not relinquish their licence voluntarily, the GMC can withdraw it, but it must seek representations from the doctor before doing so. It is important to note that withdrawing a licence does not mean the doctor has been found to be unfit to practise; it means they are not taking part in revalidation. Since revalidation began, the GMC has withdrawn 3,314 licences from doctors who were not engaging with the process. I am content, having looked at the process, that the GMC does not take lightly the decision to withdraw a doctor's licence to practise, but it is necessary in circumstances where the GMC – and thereby the public – cannot be assured that a doctor is up to date and fit to practise.

57 The decision to withdraw a doctor's licence can be appealed and the appeal panel is independent of the GMC. Up to the 30 September 2016, there have been 49 appeals heard by a panel. Only one such appeal has been successful. I believe this confirms that the principles underlying licence withdrawal are fair and robust.

But I hear concerns that the process is not equally robust for all doctors

58 The vast majority of doctors have a prescribed connection to a designated body under the RO Regulations. The model of prescribed connections set out in the Regulations is based, as far as possible, on the local systems of support and management that exist for doctors in the workplace. For this reason, most licensed doctors have a prescribed connection to an organisation that employs them or contracts their services.

59 But the RO Regulations do not provide a prescribed connection for every doctor who is working in the UK. In my view, that is an assurance weakness that must be addressed by the UK health departments. It is also a source of frustration for those doctors who find themselves without a connection and yet needing a licence.

60 Doctors without a connection are most likely to be working as independent practitioners, in a part-time capacity or in some form of advisory or managerial role. But many are not working in the UK at all. When a doctor informs the GMC that they have no prescribed connection, they must indicate the broad nature and location of their practice. I have asked the GMC to summarise this information and they tell me that, of 4,366 licensed doctors without a connection to an RO or SP on 30 September 2016:

- **747 say they are practising in the UK in a role involving patient contact.** This includes doctors who run their own private clinics providing advice, treatment or surgery, and doctors who do ad hoc locum work.
- **1,470 say they are based in the UK but not treating patients.** This group includes medico-legal advisers, royal college examiners, retired doctors and those currently on a career break.

- **2,149 say they are working wholly overseas.** The vast majority of these doctors do not require their UK licence because they are not practising in the UK. Some of these doctors wish to retain their licence because they, or their employer, mistakenly believe it is required as evidence of good standing in the UK. I also understand that some doctors who practise entirely overseas want to retain the ability to return to the UK to work, on a sessional basis, often at short notice.

61 I heard from some doctors without a connection that revalidation is problematic. Those based overseas can struggle to find an appraiser who meets the GMC's requirements,* and those without recent medical practice find it difficult to gather all the necessary supporting information to revalidate. This raises the question why many of these doctors feel the need to hold a UK licence to practise when their practice is not in the UK. Although the legislation and licence restoration processes have been designed so that it is straightforward for doctors to relinquish their licence to practise then restore it when they return to practise in the UK, many prefer to keep it. GPs who give up their licence will be removed from the Performers Lists† and I have heard it can be difficult to get back on a List at short notice. I believe the solution to this problem lies within the licensing and Performers List processes, not in changes to revalidation requirements.

62 I understand the problems experienced by doctors without a connection but do not believe there is a case to relax the standards of revalidation. My concern is that doctors without a connection are sometimes falling outside the most exacting standards of revalidation. They are required to have an annual appraisal in the same way as any other doctor, but there is limited assurance around the quality of those appraisals (although I understand that the GMC is currently looking at this issue). And there is no obvious mechanism for identifying and dealing with low level concerns in respect of doctors without an RO or SP. I consider it hard to explain why a doctor practising in the UK who has any role in the provision of care to patients should not have their revalidation overseen by an RO or SP. I believe the GMC and UK health departments should explore ways to bring doctors without a connection into the mainstream of revalidation.

* Amongst other requirements, appraisers carrying appraisals for doctors without a connection must themselves hold a prescribed connection to, and carry out appraisals for, a designated body or suitable person. The full criteria can be found in the [GMC's revalidation guide for doctors](#).

† All GPs providing NHS services are required to be on the performers list for the country in which they practise.

63 In addition, I heard concerns from many sources about the rigour of appraisal and revalidation processes for doctors working as locums, especially on a short-term basis. Specifically, I heard the following.

- **It is not always clear which organisation should be responsible for the appraisal and revalidation of secondary care locums.*** I heard that the RO Regulations can be difficult to interpret in respect of prescribed connections for locum doctors on short-term contracts, especially if the locum works for multiple agencies.
- **GMC data shows that locums have their revalidation deferred more than any other doctor group apart from trainees.** For example, in 2015, locum agencies had a 36% deferral rate, compared to an average rate of 16% for other types of (non-trainee) designated bodies. It is not yet fully understood why this is the case. It may relate to difficulties experienced by locums in gathering all the necessary evidence for appraisal, administrative failings inside some locum agencies, or problems with the performance of some locum doctors. I would like the GMC to look at this in more detail.
- **Not all locum agencies are properly fulfilling their responsibilities towards doctors.** Some locum agencies are identified as designated bodies, but not all.† Many locum agencies and their ROs have introduced strong clinical governance arrangements in the wake of revalidation. But I heard that others are not supporting their doctors well to keep up to date with revalidation. This can mean that a locum doctor arrives for a temporary placement in an NHS organisation and is immediately due for appraisal or revalidation. This is mainly an issue in England at the moment but could become a problem elsewhere in the future and needs addressing.
- **Appraisers and ROs do not always have access to information and evidence covering the whole of a locum doctor's practice.** I was concerned to hear that information relevant to a locum doctor's revalidation – including details about potential performance issues – is not always transferred when they move between work locations. This appears to be partly a problem of systems. But I also heard that the healthcare bodies in which locum doctors are placed are sometimes unwilling to provide frank feedback to the supplying agency (the locum doctor's RO) on the performance of those doctors. For example, I heard that if a locum doctor's performance falls below the standard expected by the healthcare organisation, sometimes they simply say, "Please don't send this doctor again," or they argue that access to information is restricted by commercial considerations.

64 It is important to recognise that, because of revalidation, assurance processes around doctors without a connection and those working as locums are very much stronger than they used to be. However, for patients and doctors to have confidence in the revalidation process and systems, it is essential we can demonstrate that all appraisals and recommendations for revalidation have a consistency underpinned by evidence. There are areas of the assurance system that are still comparatively weak. These need to be addressed and I return to them in the next chapter.

* GP locums in England have a prescribed connection to NHS England, while those in Wales, Scotland and Northern Ireland connect to the local health board. The prescribed connection for secondary care locums depends on which agency they work for, where they are based in the UK and, if they work for more than one agency, where they did most work over the preceding 12 months. Some locums are directly employed, such as long term placements or maternity cover, and therefore have a connection with the employer.

† As of 30 September 2016, there were 86 locum agencies acting as designated bodies, with a total of 8,517 doctors connected to them. All but four of these agencies are in England. Agencies vary in size from as small as one to over 1,500 doctors.

Revalidation underpins the professional standing of doctors

Revalidation is a national framework but it commands ownership and confidence at the local level

One RO told me:
 “Once upon a time you were a doctor for life once qualified. Society now requires those in authority to continuously offer themselves to be held to account for their competence and actions.”

65 Many of the people I spoke with believe that revalidation has enhanced doctors’ accountability to their patients and underpinned their professional standing. One RO told me: *“Once upon a time you were a doctor for life once qualified. Society now requires those in authority to continuously offer themselves to be held to account for their competence and actions.”*

66 A group of GP appraisers in Northern Ireland told me: *“We have moved from governance being something that you have to do to something that doctors really want to do.”* A hospital consultant and appraiser I met said: *“I don’t have evidence that revalidation has improved patient safety, but it has led to doctors ‘on the fringes’ becoming more engaged in training and development.”*

67 The GMC sets the overall framework and requirements for revalidation but ROs and employers have embraced their role. Credit is due in no small part to the chief medical officers, deaneries, medical directors and senior medical and non-medical staff in organisations across the UK for the leadership they have shown. One of the strongest messages I have picked up during my conversations with medical leaders is that revalidation, whilst being a requirement of the national regulator, now feels as though it belongs to them. This is especially impressive since revalidation has been delivered against a backdrop of enormous change and demands.

68 During my review I heard many times that revalidation has benefits for doctors in reassuring them about the safety and the quality of their practice. The Chief Medical Officer for Scotland shared with me one GP’s experience of revalidation: *“I’ve been practising in my office under the radar for 30 years; you’ve allowed me to realise I’m doing the right things.”* Around 44% of doctors responding to a survey funded by the GMC and undertaken by the UK Medical Revalidation Evaluation coLLaboration (UMbRELLA) consortium* agreed that revalidation allows doctors to show they are up to date and fit to practise. 26% had no opinion on that statement and 29% disagreed. This demonstrates real progress but shows there is still a long way to go.

69 In summary, revalidation underpins the high standard of medical practice in the UK by providing tangible, individualised and regular evidence to this effect. This is not to say that medical practice was deficient before revalidation was introduced – on the contrary, it adds to an already well evidenced body of knowledge about the standard of medical practice in the UK.

* The UMbRELLA interim report of January 2016 sets out the findings from the survey. 156,610 doctors were invited to complete the survey and 26,171 responded, giving a response rate of 16.7%.

Doctors have told me they value the feedback they obtain from patients and colleagues as part of their revalidation and they are using it to identify potential changes to their practice.

There is evidence of more reflective practice as a result of revalidation

70 The ability to reflect regularly on one's practice and experience, and to learn from it, is a core aspect of professionalism. That is true of any profession, but is especially pertinent to doctors given the trust placed in them by patients and the critical decisions they must take on a daily basis. Reflection sits at the pinnacle of professional practice where a doctor is prepared to hear the voice of their patients and their colleagues and is willing to adjust their practice accordingly.

71 Reflection does not come naturally to all doctors. But I have heard that the introduction of whole practice annual appraisal is encouraging more doctors to reflect on their practice and to discuss this reflection with their appraiser. One consultant surgeon in independent practice told me that: *"The very fact of having to explain my practice and aspirations to my appraiser was helpful in requiring me to analyse what was going on in an objective way."* This sentiment was echoed in feedback from lead appraisers in Scotland, who told me that: *"Doctors are more reflective now. The majority of professionals are keen to do a good job and just need the support to do it. They are now getting recognition for their constant learning – they appreciate that."*

72 Some 42% of doctors responding to the UMbRELLA survey stated that they had made changes to their practice, behaviour or learning activities as a result of their most recent appraisal. Of the 58% who had not made changes, the most common reasons offered were that nothing had been identified which required that a change be made or that they were reflecting on an ongoing basis. One doctor wrote: *"My last three appraisals have been excellent and have helped me to reflect on the overall direction of my career. As a result I have made some major changes. I am grateful to have had the chance to have a one-to-one with three very different professional colleagues and have learned a lot from having these appraisals."*

73 Some organisations are actively supporting doctors to improve the frequency and quality of their reflection. The Wales Deanery has produced online support materials including templates and examples to guide doctors' reflection.* In England, NHS Employers has run workshops on reflective practice for SAS doctors, and made the more general observation that: *"Better appraisal was being blocked by poor reflective learning. There are now trusts with [improved] learning programmes and these are having an impact."* The GMC's [Regional Liaison Service](#)† and its offices in Northern Ireland, Scotland and Wales also run training sessions for doctors which focus on reflecting for revalidation.

74 Doctors have told me they value the feedback they obtain from patients and colleagues as part of their revalidation and they are using it to identify potential changes to their practice. Doctors responding to the UMbRELLA survey rated patient feedback the most useful type of supporting information. But doctors (and patients) also raise questions and challenges about the effectiveness of current feedback mechanisms: I address those later in this report.

* See the Wales Deanery's website at <http://gocpd.walesdeanery.org/index.php/reflective-practice>.

† The GMC's Regional Liaison Service provides interactive sessions for doctors and medical students aimed at helping them to better understand GMC guidance around professionalism, revalidation and fitness to practise.

75 I heard that feedback from colleagues has helped doctors to realise that they can be perceived as being unapproachable or intimidating, or has identified ways they could improve their time management or communication skills (even if they are already good). Respondents to the UMbRELLA survey listed learning points such as: *“I will use written information along with verbal information when explaining a complex diagnosis”* and *“More patient involvement in medical decision making.”* The overwhelming majority of feedback is positive and this in itself can be beneficial: *“Seeing positive comments from patients and colleagues can be really welcome when you’re up to your eyes in work.”*

76 It is probably too early to conclude that more widespread reflection has improved care for patients – although I have heard anecdotal evidence for this. But it stands to reason that reflective thought influences practice; and it is reasonable to assume that reflective thinking among doctors is becoming more embedded with the universal requirement for annual appraisal. One lead appraiser told me that, in her view: *“patient care is already safer as a result of the focus that revalidation places on professional standards, probity, personal health and doctors’ duty of care.”* She also quoted the personal experience of doctors who had felt empowered by revalidation to raise concerns about adverse impacts of colleagues’ health or behaviour on their ability to care for patients.

But the process feels burdensome and ineffective to some doctors

77 It is clear from the UMbRELLA interim report, and from feedback received by the GMC that I have reviewed, that not all doctors have a positive view on revalidation. For example, 37% of those responding to the UMbRELLA survey do not believe that revalidation will improve the standards of doctors’ practice; and 43% do not agree that it has led to an improvement in patient safety. In this review I have sought to understand the reasons that lie behind negative perceptions of revalidation and what can be done to address these.

78 The doctors I met for this review recognised that, as professionals, they should not expect to practise without demonstrating to their patients and themselves that they remain competent and safe. However, many doctors have concerns about the practicalities of the process. These centre in particular on the cost-benefit balance: the time they spend on activities related to revalidation versus the benefits they perceive for themselves and for patients.

- Some doctors feel the time they spend preparing for their annual appraisal and gathering supporting information is excessive.
- Many doctors feel that the addition of revalidation requirements to their pre-existing appraisal process has diminished the value of appraisal as a tool for personal development. Of doctors responding to the UMbRELLA survey, 30% felt that revalidation has had a negative impact on the appraisal process. Slightly more (32%) felt the impact of revalidation had been positive, while 37% said the impact was neither positive nor negative.

It is my belief that the vast majority of doctors fully accept the principles of accountability and assurance that are central to revalidation. But many do have reasonable concerns about the efficacy of the process.

- Doctors working in primary care in England have identified duplication between the information they must prepare for their appraisal and that required when their GP practice is inspected by the Care Quality Commission (CQC).
- There is sometimes disagreement or confusion between a doctor and their RO or appraiser about what is sufficient evidence for revalidation.
- Doctors without a connection to a designated body are dissatisfied with the cost and difficulty of meeting revalidation requirements without support from an employer. I am told that retired doctors and those who work overseas make up the majority of complainants to the GMC in relation to revalidation.*

79 I was concerned to hear from doctors and their representative bodies that some doctors have relinquished their licence purely because they do not want to meet the requirements of revalidation. This seems to relate in particular to doctors who are in the later stages of their careers. Several doctors have left [comments](#) to this effect on the GMC website. A typical example is: *“Appraisal is a waste of time. The NHS is losing huge numbers of older doctors like me who would previously have been happy to carry on working part time, but now can’t be bothered to revalidate. The CPD requirements alone mean that, as part-timers, we would have to spend unrealistic amounts of time and money attending courses just to put ticks in the right boxes, without any proven benefit to our patients.”*

80 In my view, some of the negative comments made by doctors about revalidation betray a lack of understanding about the purpose of the process and whom it is for. There may be some doctors who feel it is an unreasonable condition of their licence that they must show that they remain up to date and fit to practise on an ongoing basis, but I doubt that view would be shared by many patients.

81 It is my belief that the vast majority of doctors fully accept the principles of accountability and assurance that are central to revalidation. But many do have reasonable concerns about the efficacy of the process. At a time of significant workload pressures in the health service, some doctors mention revalidation as one of the reasons why they are considering early retirement.[†] Organisations need to be alert to the concerns of doctors who wish to continue their career but require additional support and encouragement to undertake annual appraisal and to prepare for revalidation.

82 In reviewing comments from doctors about revalidation, it is striking how many of them relate not to the whole system of revalidation but to their personal experience of appraisal. One doctor I met told me: *“When people say revalidation is a waste of time, what they mean is they have found their appraisal process has not been constructive.”* This is an important distinction. I return to the question of the quality and consistency of appraisal in the next section and address with recommendations in chapter 3.

* Between December 2012 and September 2016, 924 doctors registered a complaint with the GMC about revalidation.

† See, for example, [research carried out by Dale et al among GPs in the West Midlands](#).

83 I suspect that some negative perceptions of appraisal and revalidation have arisen, quite naturally, because the system is new. Many doctors in the UK would not have experienced a formal, whole practice appraisal prior to the introduction of revalidation. There is already anecdotal evidence that the process feels less arduous for those approaching their second revalidation, especially where doctors are properly supported to meet requirements. A lead appraiser in one NHS trust told me: *“Many who were hostile to the idea of revalidation at the start were, by the end of the process, appreciative of it with quite a lot sending thanks in writing to the Revalidation Support Team for their assistance.”*

84 During my review I heard suggestions that – to reduce burdens on doctors – appraisal should take place every other year or even once every five years. But I also heard calls to make the process more demanding – for example, by replacing every fifth appraisal with a test of knowledge or by requiring additional, specialty-specific evidence. My view is that revalidation was built on the concept of annual whole practice appraisal and it is still a very young process. It would be unwise to deviate from the current approach of annual appraisal or to ‘water down’ the standard of assurance.

85 While there is not a case for lowering the standard of revalidation, I believe there is a case for examining the mechanisms, processes and systems for delivering it. We should look to extract greater efficiencies by reducing the time burden on doctors and ROs and the cost burden for healthcare bodies. I want to keep all the benefits of revalidation but reduce the costs for organisations and doctors. I recognise doctors’ concerns about administrative burdens and, in the next chapter, I set out ways these could be reduced without compromising assurance to employers and the public.

Revalidation has embedded annual whole practice appraisal

Annual whole practice appraisal is now embedded across the UK and across all doctor groups. This is a direct result of the introduction of revalidation.

Revalidation has significantly increased appraisal rates

86 Annual whole practice appraisal is the foundation of revalidation. It is the mechanism by which licensed doctors regularly demonstrate that they have discussed and reflected on their whole practice having collected supporting information to assist their reflection. Revalidation has meant that annual appraisal is now prevalent and is underpinned by increasingly robust and structured local processes.

87 For some groups of doctors, GPs in particular, appraisal was already well developed before revalidation came along. But for others the approach was irregular and unstructured. One recently-retired trust chairman told me: *“Before revalidation, proper appraisal was rare; it was just a cup of coffee and a chat now and then. Revalidation has changed that.”*

88 Throughout the course of my review I have repeatedly heard that revalidation has been the catalyst for increases in appraisal rates across all settings. 90% of respondents to the UMBRELLA survey stated that they had had a medical appraisal at some point in their career, of which 95% had done so within the previous 12 months. Despite appraisal being a contractual requirement in the NHS for many years,^{*} annual appraisal rates in England in 2010 were just 36% for SAS[†] doctors, 64% for consultants and 79% for GPs. Annual whole practice appraisal is now embedded across the UK and across all doctor groups. This is a direct result of the introduction of revalidation.

89 Appraisal rates have risen steeply in all four countries of the UK since the introduction of revalidation.

- In Wales, 82% of doctors had an appraisal in 2015/16, compared with just 53% in 2012/13.
- In Scotland, 92% of doctors had an appraisal in 2015/16, compared with 87% in 2012/13.
- In England, around 88% of doctors employed by the NHS had an appraisal during 2015/16.
- For trusts in Northern Ireland, appraisal rates for 2013/14 and 2014/15 ranged from 71% to 100%.[‡]

It is generally accepted that appraisal rates can never reach 100% as, in any one year, there will be a group of licensed doctors who are new to the UK or are absent from work, for example, on sick or maternity leave.

90 I heard that the impact of revalidation on the likelihood of receiving an appraisal has been particularly marked on doctors who are not consultants or GPs. This group were often overlooked for appraisal in the past. NHS Employers told me that SAS doctors now feel more empowered to ask for – and more entitled to have – a high quality annual appraisal.

^{*} The date on which appraisal was added to NHS contracts varies across the UK and for different roles but, for most doctors, annual appraisal has been a requirement since the early 2000s.

[†] Specialty, associate specialist and staff grade (SAS) doctors are those who are not employed in a training role or as consultants.

[‡] Data provided by NHS England, Wales Deanery, HIS in Scotland and RQIA in Northern Ireland.

91 The embedding of appraisal is valuable in itself. For example, the British Medical Association (BMA) told me that structured annual appraisal prevents a doctor's skills becoming so out of date that they become subject to formal competency procedures without being given the opportunity to put things right. I also heard examples from appraisers where the process had helped doctors to recognise the need, and take corrective action, to keep up to date across the whole scope of their practice, not just their main role. That said, as I noted earlier in relation to locum doctors, I have concerns that not every appraisal is yet a genuinely whole practice appraisal.

But the quality and consistency of appraisal varies

92 ROs and appraisers tell me that revalidation has driven improvements in local appraisal systems. Where no appraisal systems existed, revalidation led to their introduction, and where existing systems required improvement, revalidation has incentivised developments. In research undertaken for the Department of Health in England, but covering the whole of the UK, [Boyd et al](#) report that 85% of ROs responding to their survey said their organisation's appraisal systems had changed as a result of the introduction of revalidation. I commend both NHS and independent sector organisations for the effort they have put into improving local systems.

93 But I also heard concerns from doctors about the quality of their appraisal experience. The BMA told me: *"Appraisal feels like an industry or an inspection against a checklist, rather than an opportunity to reflect. Doctors are more focused on collecting reflections than the quality of the actual reflection."* One doctor responding to the UMBRELLA survey wrote: *"My appraisal was not helpful. The appraiser was stressed about her own workload issues and her energies were focused on dealing with the system rather than any content to the appraisal."*

94 It is inevitable that not everyone will have the same experience of appraisal. But it concerns me that some doctors report very negative experiences or identify revalidation as having an adverse impact on the quality of appraisal. I return to this issue in the next chapter.

95 I have also heard that, despite the [guidance issued by the GMC setting out supporting information needed for appraisal](#),* there can be differences in the evidence required. One senior doctor told me: *"Variation exists. Some people are expected to bring complex data and performance comparisons and to reflect on how they've changed. Others just bring information on what they've done."* And I heard numerous concerns from doctors about being asked to complete activities above and beyond what is specified in the GMC's guidance – for example, undertaking a specific number of clinical audits or gathering patient or colleague feedback more frequently than once per cycle. I address the issue of revalidation evidence requirements in the next chapter.

* The GMC's guidance on supporting information for appraisal and revalidation was published in March 2012. It sets out six types of supporting information that doctors are expected to provide and discuss at appraisal at least once in each five year cycle: continuing professional development; quality improvement activity; significant events; feedback from colleagues; feedback from patients; and complaints and compliments. This guidance is currently under review by the GMC and a revised version is expected by the end of 2017.

96 I believe that both doctors and the public would expect to see some form of quality assurance process around appraisal and revalidation. During my review, I was pleased to see that this is beginning to emerge in many areas. For example, the Wales Deanery told me that they examine a percentage of appraisal summaries each year and have begun quality assuring revalidation processes in two pilot areas. But this type of process is not yet universal. We need to be able to demonstrate that appraisals are of high quality and capable of underpinning consistent revalidation recommendations in all cases. In its document, [A Framework of Quality Assurance for Responsible Officers and Revalidation](#), NHS England states: “ROs will want to demonstrate that their own decision-making, and also that of appraisers and case investigators, is robust and consistent, not only at the individual level and internally within the designated body, but also that they are in alignment with the decision-making of peers in other organisations, from all sectors, across the country.”

Revalidation – and the wider role of the RO – has strengthened local clinical governance

97 The RO is central to the revalidation process. Among other things, ROs are responsible for making sure appraisal systems are in place, making revalidation recommendations to the GMC and establishing procedures to investigate concerns about doctors’ fitness to practise. Alongside the GMC, ROs have delivered revalidation. They are committed and have dealt with challenges and implementation problems. And now they are driving forward efforts to improve quality and consistency in revalidation processes.

Revalidation is helping to identify poor performance

98 I discussed earlier how revalidation has driven improvements in appraisal rates and helped ensure appraisal covers the whole of a doctor’s practice. ROs and appraisers told me that this is beginning to have a real impact on their ability to identify doctors who may present fitness to practise concerns. [Boyd et al](#) asked ROs across the UK to comment on the impact of revalidation on clinical practice. Their report concluded: “Depending on how wide a definition of clinical practice is used, then roughly between 15% and 40% of survey respondents indicated positive impacts of revalidation on clinical practice.”

99 One in ten appraisers who responded to the UMbRELLA survey said they had formally escalated a concern about at least one of their appraisees, while 23% had identified a concern that they did not need to escalate as it could be dealt with at the appraisal. The concerns most frequently cited by appraisers as requiring escalation were a lack of reflective practice (identified as a factor in 45% of escalated cases), poor relationships with colleagues (29%) and clinical knowledge and skills not being up to date (26%). It is not known whether the total number of

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concerns being raised is higher than prior to revalidation, but it is reasonable to assume that the extension of appraisal to all doctors has increased the likelihood of difficulties being identified.

100 ROs told me that the requirement to gather and reflect upon evidence about their practice has resulted in some poorer performing doctors leaving the profession. One RO told me: *“Revalidation has forced medical directors to take an interest in the full scope of practice of their doctors and that is a benefit.”* Another said: *“In short, there are fewer bolt holes for doctors with unaddressed concerns to disappear into.”*

101 Anecdotal evidence from ROs about the impact of revalidation on poorer performing doctors is supported by GMC data which shows that, up to 30 September 2016, 1,413 doctors had their revalidation deferred due to an ongoing local process, of whom 94 (6.6%) subsequently relinquished their licence or had it withdrawn by the GMC.

102 Certainly, revalidation has stimulated improvements to local assurance systems for doctors. One RO described revalidation to me as: *“an extra string to the governance bow.”* [Boyd et al](#) concluded that revalidation is helping to formalise the various systems that exist within organisations for managing medical performance, stating that: *“Some types of change were mentioned quite frequently in relation to many or all of the performance management systems: increased formalisation; greater doctor engagement and participation; improved record keeping and monitoring; better alignment between appraisal and other systems; greater doctor awareness of the importance of that aspect of performance; and increased robustness and quality of the system.”* All in all this represents a significant and positive culture change for organisations and their relationships with their doctors.

103 For example, in relation to significant events or serious untoward incidents, the report concludes that revalidation was: *“generally felt to have brought about formalisation and made existing systems more robust and rigorous or to have forced organisations that had no systems in place to implement them.”* This view was supported by the ROs that I spoke to. One said: *“I believe that patients are safer now because there is increased visibility of serious incidents and near misses.”* And one representative of a royal college told me that: *“Organisations and their boards are becoming more accountable for their systems of appraisal and clinical governance.”*

104 There is also evidence that revalidation is encouraging ROs to share information about doctors when they move between organisations. This is beneficial, especially where an individual may require support to address low level concerns. However, ROs tell me there is not yet a consistent approach to sharing information (taking appropriate account of data protection considerations) and difficulties can arise where a doctor joins them following a period without a connection to a designated body.

ROs are better supported to manage concerns locally

105 A key part of the RO role is in managing concerns about doctors' fitness to practise. Revalidation provides a mechanism for identifying and acting upon concerns before they reach a level that needs GMC attention. During the course of my review, I have heard that revalidation has clarified local responsibilities and given organisations the confidence to address concerns about doctors locally where appropriate. One civil servant told me: *"ROs are now inclined to be more courageous in dealing with difficult doctors. Revalidation has helped by making clear the local responsibilities rather than just referring to the GMC. It has enhanced local capability and clarified how to get things done."*

106 Almost half of designated bodies responding to the survey undertaken by [Boyd et al](#) reported that they had improved their systems in relation to doctors causing concern since the implementation of revalidation. One RO said: *"It is more formalised and we have a remediation policy with more support."* I have also heard that revalidation provides a vehicle to discuss lower level concerns in a supportive but challenging environment. The Welsh NHS Confederation told me that they believe organisations in Wales are developing a more open culture around raising concerns.

107 As part of its support provided to doctors and ROs, the GMC has introduced the [Employer Liaison Service](#) (ELS).^{*} The ELS told me that each year their Employer Liaison Advisers (ELAs) attend more than 1,300 face to face meetings with ROs. These meetings provide an opportunity for ROs to raise any concerns they have about the fitness to practise of their doctors and to obtain advice on GMC investigation thresholds. In addition, ROs frequently contact ELAs by telephone and email for ad hoc advice and support when concerns emerge. The majority of ELA advice is to support ongoing local investigation and management of concerns, taking into account any patient safety risks. ELAs also contribute to around 40 RO network meetings across the UK each year which often include anonymised case discussions from ROs to share experiences and good practice around the management of concerns.

108 I have repeatedly heard that ROs and healthcare organisations value the advice and support provided by the ELS. For example, NHS Employers told me that the GMC ELA role has been 'a revelation' and helps to deliver consistency in the process. [Boyd et al](#) also note the success of the ELS, saying that: *"Over 93% of respondents [to the survey] had contacted ELS advisers, and over 70% of these had found this very useful,"* and that: *"The attitude to the ELAs' role in this regard was overwhelmingly positive, and often ROs cited the ELAs as helping to make the process of dealing with doctors causing concern more 'robust' at a local level. One RO went so far as to suggest that it had changed their entire working relationship with the GMC."*

109 I met with a group of NHS England medical directors who told me that, in their view, the RO role has had a beneficial impact, even where appraisal is weak or the doctor does not give it their full commitment: *"The existence, and statutory duties, of the RO means that poor performers will*

^{*} The Employer Liaison Service aims to facilitate closer working between the GMC and healthcare organisations, focusing on matters related to fitness to practise and revalidation.

There is a widely held view that boards need to become more engaged in the process – not just in monitoring compliance but looking to capture learning from the process to improve standards.

be identified sooner than they would have previously.” In its report, [The early benefits and impact of medical revalidation: report on research findings in year one](#), the NHS Revalidation Support Team noted: “An important distinction is that appraisal offers the opportunity for doctors to self-identify concerns while clinical governance enables concerns to be identified by others.” One regional medical director told me that: “We have lifted the floor of what is acceptable, and that is significant.”

But organisations are not making the most of revalidation information

110 The published research I have reviewed for this report suggests that local clinical governance systems are seen as paramount for the successful implementation of revalidation. There is anecdotal evidence to suggest that revalidation has been more successfully implemented where boards* and ROs provide strong local leadership, and where sufficient local resources are provided to support implementation. This makes sense. I have personally seen many excellent examples of organisations working to improve their appraisal and revalidation processes and to support their doctors to meet requirements.

111 However, a number of interviewees told me that revalidation is not yet having the degree of impact that it could on local clinical governance. In particular, there is a widely held view that boards need to become more engaged in the process – not just in monitoring compliance but looking to capture learning from the process to improve standards. I heard the view that: “Some organisations have started drilling down and learning from revalidation, but not many. Most still focus on the percentages.” I believe there is considerable potential for boards to better use revalidation to drive improvement in their organisations and I explain how in the next chapter.

112 Some doctors are sceptical as to the value of the Personal Development Plan (PDP) created during appraisal. One consultant surgeon told me: “There seems to be no connection between the agreed PDP and line managers who can make it happen.” This was an isolated view but I heard little evidence in my review that organisations are consistently taking note of the PDP requirements emerging from appraisal and ensuring the necessary resources are being deployed to make sure plans are being delivered. It seems likely that this omission would have a negative impact on doctors’ attitude to the process.

And some ROs face pressures in their role

113 On average, each RO has 367 connected doctors for whom they must make a revalidation recommendation, generally once every five years. But the actual number of doctors connected to a designated body ranges from just one to over 6,000. 44% of ROs are responsible for fewer than 50 doctors; 39% are responsible for between 51 and 500 doctors; and the rest are responsible for more than 500 doctors. [Boyd et al](#) have questioned whether smaller designated bodies have the resources and capabilities to deliver revalidation effectively. I have also heard concerns that ROs with a very large number of connected doctors may struggle to manage their workload.

* When I refer in this report to boards, I mean the team of executive and non-executive directors who oversee the organisation.

I believe that revalidation outcomes to date confirm the high standards of practice that exist in the UK medical profession. In the rare cases where doctors' performance or behaviour does not meet accepted standards, I am satisfied there are now stronger processes in place to identify and tackle this.

* www.iamra.com/resources/Pictures/IAMRAStatementonContinuedCompetency.pdf

114 I believe that the focus should be less on the size of the designated body and more on the conditions necessary for good governance and organisational efficiency. I am aware that the UMbRELLA consortium and the universities of Manchester, York and Plymouth are undertaking further research in this area. It would be wise to await their findings before proposing changes to structures or responsibilities. However, I would like the GMC to consider whether it needs to do more to support ROs (especially new ROs), either alongside others or on its own. The RAB could be asked to consider possible changes and to advise the GMC, particularly in respect of proportionality and balance.

115 Through my meetings with doctors, I have become aware of a perception that the revalidation process is sometimes being used to achieve goals for which it was not intended – for example, to require doctors to meet local health system objectives that are unrelated to fitness to practise – or in a way that is not fair to all doctors. Although this is a complex area, I feel such concerns need to be addressed. I return to the question of how best to ensure transparency and fairness in decision making in the next chapter.

Medical regulation is better fulfilling public expectations

The public have long expected doctors to be subject to regular checks on their fitness to practise – and now they are

116 I explained at the start of this report that patients and the public rightly assume that a system is in place to confirm that doctors continue to practise safely and to the necessary standards. They also expect doctors to be supported to learn and improve. One patient told me: *“I would expect there to be a process of continuing development for any professional.”*

117 Revalidation is now in place and forms a core element of the systems that provide assurance to patients about the safety and quality of their medical care. I have heard and seen enough to be confident that the process is operating largely as it should. I believe that revalidation outcomes to date confirm the high standards of practice that exist in the UK medical profession. In the rare cases where doctors' performance or behaviour does not meet accepted standards, I am satisfied there are now stronger processes in place to identify and tackle this.

118 The GMC and medical professionals in the UK have led the world in developing a model to assess the continuing competency of doctors. Revalidation now exists for nurses in the UK and is being developed in other professions and jurisdictions. At its 2016 conference, the International Association of Medical Regulatory Authorities (IAMRA) approved a set of principles encouraging medical regulators across the world to develop systems that are designed to improve the quality of medical practice by promoting, encouraging or requiring career-long learning for all practising doctors.*

But we need to strengthen patient input and better measure outcomes

119 There is more work to be done to demonstrate how revalidation is improving patient care and safety. In my view, this has two elements. Firstly, we must make revalidation more visible to the public. And, secondly, we need to find simple ways to measure its impact.

120 Patients play a vital role in revalidation by providing feedback on the doctors who care for them. Doctors responding to the UMbRELLA survey said that patient feedback was the most helpful type of supporting information in terms of reflecting on their practice, but it was also the most difficult to obtain. During my review I have heard concerns about the way in which patient feedback is collected and used in revalidation – that the mechanisms are inflexible, that the sample is too small or not representative, and that patients feel unable to provide open views for fear of being identified. I will expand on these issues in the next chapter.

121 Two thirds of patient and public involvement representatives surveyed for the UMbRELLA interim report (11 out of 17) felt that patients were unaware of revalidation or did not understand its aims and purpose. My experience of talking to patient representatives for this review confirms that position.

122 There are some who argue that it is not essential for the public to know how revalidation works, merely that it exists. But I am not entirely convinced by that position. One patient representative challenged me directly by stating: *“If we are saying the system is robust, we need to be able to evidence that. We need publicly accessible information to give confidence that doctors must meet certain standards and that feedback from patients is acted upon.”* In the next chapter I set out my vision for increasing public awareness of revalidation and the assurance that it provides.

123 Finally, although I recognise the challenges involved, I believe there is more that can be done to quantify the impact of revalidation. There is emerging evidence of impact from the evaluations commissioned by the GMC and the Department of Health in England. My review has highlighted many benefits for doctors, employers and patients, but much of the evidence is anecdotal at this stage. It would be helpful – both in terms of raising public assurance and increasing support for the process across the profession – if some simple measures of impact could be agreed and monitored over time.

3 Taking revalidation forward

“Revalidation is successfully in place and we can now work to improve it. We are at the ‘acceptance stage’ and the next step is to strengthen ownership by the profession and engagement with the public.”

Royal college representative

124 My review found widespread consensus that revalidation has been implemented successfully and it is progressing in line with expectations. But it is still a very new process. It will take time for the impact of revalidation to be recognised by patients as a means by which they can feel assured that doctors are up to date and fit to practise. The impact on the medical profession is already significant; much of this impact is positive, but there are areas of disquiet among doctors that need to be addressed by those with responsibility for revalidation locally and nationally.

125 Very few people suggested to me that revalidation should be radically overhauled. People want to see evolution rather than revolution; I think that is the right approach. As a revalidation lead at one royal college told me: *“Revalidation is successfully in place and we can now work to improve it. We are at the ‘acceptance stage’ and the next step is to strengthen ownership by the profession and engagement with the public.”*

126 In this chapter I give a flavour of the ideas I have heard for improving revalidation. My report does not mandate what change should take place or prescribe detailed solutions. I recommend areas for development, with a view to increasing the impact of revalidation over the next five years, and I identify who should play a part in those developments.

Organisations should work with the GMC to increase public awareness of the assurance provided by revalidation

127 I have described revalidation as primarily a system for assuring the public that all doctors working in the UK are up to date and fit to practise. My review has confirmed the findings of research carried out by and for the GMC – that patients and the public are not generally aware of revalidation. In my view this is a missed opportunity as it means patients are not conscious of the increased assurance revalidation provides.

What patients and the public expect from medical regulation

128 The chief executive of one patient group commented: *“I think patients must feel that there is some means by which the GMC is checking that doctors are practising well, but I do not think there is any clarity about the types of feedback and the way that patients and the public can be involved.”*

129 One medical director told me about some of the conversations he has had with relatives following a serious incident resulting in harm to a patient. His experience was that patients most want to hear that there are systems in place to prevent the same thing happening again. He told me that, when he explains to them how revalidation works and the evidence that feeds into it, they do feel reassured.

“We need to give patients the confidence that we have a governance and assurance system that works.”

Royal college representative

130 I heard differing views as to how much detail the public needs in order to feel assured and sufficiently involved. Some of the people I spoke with felt that revalidation information for individual doctors should be made publicly available in their workplaces and online. Others felt that it would be sufficient for healthcare organisations to display information about the arrangements for regulating local doctors and healthcare services (of which revalidation is one part) and to confirm that their doctors participate in these arrangements.

131 I have tried to reflect the views of the profession, employers and system leaders and have attempted to synthesise the few opinions voiced by patient groups about how revalidation might be made more relevant to patients and the public. My conclusion is that the public don't need to see the 'wiring' of revalidation, but they should have confidence that the system that is in place is a robust and well-governed assurance process. And they should have access to the system so they can test that robustness for themselves. By way of example, designated bodies could, and in my view should, invite their patient groups to look at how revalidation works locally; where levels of local assurance need attention and where patient involvement could be strengthened. Patient groups could also be invited to provide an assurance statement annually.

132 Patients should understand that revalidation is one component of a wider set of processes designed to protect them and improve the quality of care. This would include – for example – knowing that any patient who is unhappy with their experience can make a complaint and, as well as receiving a response from the healthcare provider, that complaint will go into a doctor's portfolio for appraisal and revalidation. Equally, they should be able to see how compliments about a doctor's care are dealt with and should see the process that underpins the handling of serious incidents in which a doctor is involved and how this is reflected upon in appraisal and revalidation.

Increasing public confidence in revalidation processes

133 I am aware that many organisations already provide opportunities for patients and lay representatives* to contribute to local regulatory processes. For example, the Southern region of NHS England has six appointed lay representatives who are involved in the appointment of appraisers and in visits to service providers to quality assure local revalidation processes. Both Scotland and Wales include lay representatives in their revalidation review arrangements. This is to be encouraged. Such representatives provide a degree of independent scrutiny and challenge of the revalidation process.

134 I would like to see all healthcare organisations set out more clearly and publicly their local assurance arrangements, including the role played by appraisal and revalidation. I would also like to see local patient representatives invited to review periodically how those arrangements are working in practice, thereby gaining confidence on behalf of the wider public that local

* Lay representatives are drawn from the non-medical community but do not represent any specific patient group.

In my view, it would not be disproportionate to ask newly-licensed doctors to revalidate for the first time within two years of commencing their UK practice.

governance is robust. This will provide external validation of the revalidation process. Local patient representative groups will need support and guidance from both national patient organisations and local healthcare providers in order to fulfil this role effectively.

Recommendation

- 1.** Healthcare organisations, with advice from the GMC and national partners, should work with local patient groups to publicise and promote their processes for ensuring that doctors are up to date and fit to practise, including the requirement for periodic relicensing.

135 Although I would argue for greater public access to the revalidation governance and assurance process, I am not suggesting that the public should play any direct role in the appraisal or in the revalidation recommendation. The outcome I seek is to increase public awareness and confidence in local regulatory processes that underpin and deliver the national revalidation system. I believe it should be a local decision as to how best to approach this, led by health departments in the four countries. But it would be useful for the GMC to set out some high level expectations and advice, perhaps through an update of the existing revalidation governance handbook.*

136 During my review I heard that doctors who are new to UK practice, regardless of whether they qualified in the UK or overseas, are sometimes surprised by the demands of revalidation. They may, for example, lack experience of undertaking structured reflection on their practice. Although these doctors have an annual appraisal, they currently have up to five years to cover the full requirements of revalidation, including reflecting upon patient and colleague feedback. In my view, it would not be disproportionate to ask newly-licensed doctors to revalidate for the first time within two years of commencing their UK practice. For doctors completing UK foundation training, this would form a logical and straightforward transition. For doctors joining from overseas, I believe an earlier first revalidation would be a helpful discipline and would contribute positively to public assurance.

Recommendation

- 2.** The GMC should consider setting an earlier revalidation date for newly-licensed doctors so that they receive their first revalidation within two years of commencing practice in the UK.

137 At the end of the previous chapter I suggested that it would be helpful to agree some high-level quantifiable impact measures for revalidation over the next cycle. In addition to helping to reassure the public, they would be of interest both to doctors and to those who fund appraisal and revalidation. The GMC should work with local and national organisations, and in particular with patient representative bodies, to identify what measures might be appropriate and at what level data should be gathered and reported.

* [Effective governance to support medical revalidation: a handbook for boards and governing bodies.](#)

Recommendation

3. The GMC should work with stakeholders to identify a range of measures by which to track the impact of revalidation on patient care and safety over time.

138 A final point on terminology. In conversation with patient organisations I heard the view that the term ‘medical revalidation’ is simply not understood. To be clear, patients feel that the term does not convey the degree of importance attributed to the process. They felt that the patient feedback provided as part of a doctor’s revalidation would be seen in a quite different light if the patient knew that this was part of a doctor being allowed to continue their practice in the UK. I asked those I met what they would prefer the process to be called and I heard that the term ‘relicensing’ would be more meaningful and more impactful. Irrespective of whether the name can be changed in legislation, I would like to see more accessible language used when communicating with patients and the public about revalidation.

Recommendation

4. The GMC and others should begin using the term ‘relicensing’ in place of ‘revalidation’, in order to increase understanding of the significance of the process for both patients and doctors.

We need to improve mechanisms for patient and colleague feedback

139 In the introductory chapter I spoke about patients’ growing expectations of their doctors. In a report such as this it is difficult to truly represent the views of patients; when you have spoken to one patient – you have heard one view! However, I have heard enough from my interaction with patients and their representatives to be assured that there is an appetite among patients for greater involvement in the design and delivery of their care. This principle is supported by recent national initiatives such as the Shared Decision Making Collaborative: a group of organisations in England, including Healthwatch, NICE and Health Education England, who have pledged to support the wider health and care system to embed shared decision making into routine practice.

140 In looking to the next five years for revalidation, I believe that the aspiration of patients to move away from being ‘passive recipients’ of healthcare needs to be underpinned by a revalidation system that reflects the enhanced expectations patients have for their interactions with doctors.

141 The patient representatives I met for this review asked some pertinent questions about the role of patients in revalidation. How easy is it for patients to contribute to revalidation? How do we explain how the process works, including what happens if a doctor ‘fails’ revalidation? How do we reassure patients that giving feedback is a positive (and anonymous) step that will not adversely affect their future care?

142 While revalidation is not the main mechanism by which patients provide feedback on their care, it does provide a means for each individual doctor to reflect on feedback from patients about their own practice and – in combination with other information – to learn and improve as a result. Many doctors were already doing this before revalidation; but now the approach is more structured and consistent.

The challenge of obtaining high quality, representative feedback from patients

143 Most of the people I spoke with agreed that patient feedback is one of the most important elements of revalidation. A profession-wide survey by UMbRELLA found that a majority of the 26,000 responding doctors felt that patient feedback was the most useful type of supporting information to help them reflect on their practice.

144 But patients and their representatives tell me that the current mechanisms for gathering patient feedback for revalidation are not ideal. At least once in every five year revalidation cycle, each doctor must arrange for questionnaires to be distributed to their patients (or other recipients of their services) and they must demonstrate to their appraiser that they have reflected on the results. The most commonly identified problems with this approach are listed below.

- Patients are not given sufficient information about the purpose of the questionnaires, what sort of issues they should comment upon, and how their feedback will be used. For example, many are not aware that providing constructive, critical feedback about an individual doctor will be balanced with information from other sources during revalidation, and that is not the same as making a complaint.
- Patients are deterred from giving honest feedback by fears that it will not be anonymised and that critical comments may impact on the future care they receive. This is exacerbated by the ‘official’ appearance of the written questionnaire.
- Contributors to UMbRELLA’s Patient and Public Involvement Forum were critical of the standard GMC questionnaire. They felt that some questions required them to express views beyond their expertise (for example, to indicate how good the doctor was at “assessing your medical condition”) and that the questionnaire allowed insufficient space for free text comments.
- Patients, especially younger people, would like the opportunity to provide feedback online or via social media. Others, especially those who are not confident in reading or writing English, would like to be able to provide feedback verbally.

Employers and medical leaders told me: “We need to be more sophisticated around the expectation for patient feedback” and “We need a wider definition of what is meaningful feedback.”

- Patient and lay representatives express concern that, due to conscious or unconscious bias, questionnaire respondents may not be truly representative of the range of patients seen by a doctor or cover the whole scope of their practice.

145 Doctors themselves have also identified shortcomings. I heard the following comments from doctors.

- The feedback is overwhelmingly positive, so there is not much chance to identify areas for learning or development (although positive feedback was still appreciated for providing reassurance and boosting confidence).
- Patients sometimes struggle to distinguish between problems with the system – for example, delays in getting access to treatment – and actions relating to the individual doctor.
- Collecting feedback once in a cycle (often covering just a single day’s practice) does not provide sufficient, representative views for reflection. But it was felt by some that to collect it more often might be too costly or burdensome.
- Appraisers were felt to place too much focus on the volume of patient feedback obtained, as opposed to the quality of a doctor’s reflection and learning.
- Although revalidation is about an individual doctor, much medical care is delivered in teams and it can seem artificial (and out of step with the principle of shared care) to ask patients to identify a specific doctor from within what might be a multi-disciplinary team.

146 Some doctors find it difficult to obtain feedback on their practice. Overall, 33% of respondents to the UMbRELLA survey said they found it either difficult or very difficult to collect patient feedback; a figure rising to 55% for those working in anaesthetics and intensive care, 50% for psychiatrists and 45% for doctors in emergency medicine. Doctors working in roles that do not involve patient contact also report difficulties, although GMC guidance does make clear that feedback can also be sought from other service users such as carers, students, customers or suppliers.*

Developing a more sophisticated approach to patient feedback

147 Employers and medical leaders told me: “We need to be more sophisticated around the expectation for patient feedback” and “We need a wider definition of what is meaningful feedback.” I agree with these views. I would like the patient input to revalidation to be more representative of a doctor’s whole practice and made easier for patients to provide.

148 While statistically valid, I am not convinced that a set of questionnaires – usually numbering around 40 or 50 and often collected on a single day in each five year cycle – provides sufficient quality and breadth of information to enable a doctor to reflect properly on their interaction with patients. I recognise that many doctors receive feedback through other means

* The GMC has published advice and case studies to help doctors in non-conventional roles to collect feedback – see www.gmc-uk.org/doctors/revalidation/colleague_patient_feedback.asp

(for example, patient participation groups in GP practices) and some will be reflecting upon such feedback on an ongoing basis. But others may not have that opportunity, either because they do not seek feedback or because it is difficult for patients to provide it.

149 I am interested in the concept of 'real time' feedback; feedback that could take place following any or all interactions a patient has with a doctor. A number of people have suggested we need to move beyond the concept of a single feedback exercise at a particular period of time and towards a continuous approach to seeking and reflecting on feedback. Patients have said that this would be more convenient and would make the process less daunting for them. One system regulator told me that real time feedback would fit well with their approach to inspection of healthcare providers.

150 But we need to explore the practicality of this approach before pursuing changes. Is a 'real time' approach feasible and manageable for revalidation purposes? How much of the responsibility for enabling patients to provide feedback should lie with individual doctors and how much with their organisations? How do we ensure feedback is open to all patients, including those whose condition may mean they require an advocate to ensure their voice is heard? Should real-time feedback replace the current questionnaires or supplement them? Does it matter if doctors use different approaches and the results cannot be directly compared?

151 I am also interested in making better use of technology to collect feedback. I have heard about organisations that have simple but effective feedback technology available for all patients in the waiting room. This might range from a touch screen in which the patient is asked a single question and can respond across a range of answers, to an iPad with multiple questions. I also heard a very creative suggestion that doctors could choose to have a Quick Response Code on their name badge which patients could scan with their mobile phone and then provide feedback via an app.

152 Although there are many ideas for alternative approaches to feedback, it is clear that they come with their own challenges and potential drawbacks. I am also aware that significant investment has been made in systems designed for the current approach. I do not want to recommend any specific changes to patient feedback mechanisms or questionnaires until they are tried and tested, and shown to be superior to existing methods without being excessively burdensome for doctors or patients.

153 I am aware that the Academy of Medical Royal Colleges is currently funding a review of patient feedback by the Royal College of Physicians. I look forward to seeing the findings of this review and hope the Academy will work with the GMC, patient groups, employers and regulators to identify changes that make it easier for patients to provide useful and productive feedback into the revalidation of doctors.

One RO told me that “the requirement to undertake colleague feedback helps deal with those doctors who drift incrementally towards the margins of good medical practice.”

Recommendation

5. The GMC should work with others to identify ways to improve patient input to the revalidation process. In particular it should develop a broader definition of feedback which harnesses technology and makes the process more ‘real time’ and accessible to patients.

Maximising the impact of colleague feedback

154 Colleague feedback, which forms one of the required types of supporting information for appraisal, was a lively topic in many of my interviews.* Most doctors, ROs and appraisers spoke positively about colleague feedback and its importance in the revalidation process. One RO told me that: “the requirement to undertake colleague feedback helps deal with those doctors who drift incrementally towards the margins of good medical practice.” But I also heard concerns that feedback from colleagues sometimes lacks the necessary objectivity, honesty and candour. For example, I heard from the Care Quality Commission that colleague feedback does not consistently identify doctors, whether in a hospital department or GP practice, whose behaviours are ‘disruptive’ and affect the cohesion of the department or practice. I was told by doctors that “we all know who these doctors are,” but no one confronts the issue. It seems to me that this could translate into the quality and safety of care provided to patients.

155 Doctors have a professional obligation to ‘speak up’ when they have concerns about a colleague. Around 15% of appraisers who responded to the UMbRELLA survey said they have heard a doctor raise concerns about a colleague during appraisal; but we do not know whether those same doctors had also given candid feedback to the colleague concerned as part of the revalidation process. At present, some organisations allow doctors to choose which of their colleagues are approached to complete feedback questionnaires, while others have the choice made for them. I believe it would be helpful to review different approaches and determine which works best, drawing upon learning from other sectors.

156 I also heard that, when feedback does include critical comments, it is important that the appraiser is able to manage the discussion with the doctor sensitively. One royal college revalidation lead told me: “We have found that colleague feedback works better when the appraiser approves or recommends which colleagues are sampled rather than the doctor selecting their ‘friends’. Also, it is only useful if the quality of the appraiser/appraisal is good and there is appropriate reflection at appraisal and good communication with clinical leads or the medical director if appropriate.”

* The GMC requires doctors to seek feedback from colleagues and to review and act upon that feedback as appropriate. Feedback will usually be collected using standard questionnaires that comply with GMC guidance. Doctors should seek feedback from a range of colleagues, including non-medical co-workers (including other health professionals, managers and administrators) and medical colleagues (including trainees and juniors).

Boards should provide greater support and challenge

“Revalidation is an incredibly powerful tool. I don’t think boards are aware of what they’ve got.”

Medical director

157 I explained earlier how organisations have strengthened their systems of appraisal and overall clinical governance processes and become more accountable for those systems. I have also heard that revalidation has encouraged designated bodies to triangulate a range of information that didn’t exist before – for example linking serious incidents involving a particular doctor or team to feedback from patients and colleagues about that doctor. These are important developments, but there is scope to get much more from the revalidation process and the information generated by it.

How organisations could benefit further from revalidation

158 It is understandable that, during the first cycle of revalidation, ROs and organisations have focused on establishing local processes to deliver revalidation and monitoring levels of compliance, such as appraisal rates. They have brought doctors into managed appraisal processes and helped make sure revalidation recommendations are made on time. 95% of organisations responding to the survey undertaken by [Boyd et al](#) said that they reported on appraisal to the governing body at least annually.

159 ROs in England are asked by NHS England to present an annual report on revalidation to their board or equivalent management team. I am aware that some ROs go beyond this to provide more frequent or broad-ranging information. I have also heard that some organisations involve non-executive directors in appraisal and revalidation processes, thereby giving enhanced oversight. I would like to see organisations extracting greater value from the investment they have made in local revalidation processes and challenging how governance processes could be improved.

160 System regulators tell me that high-performing healthcare organisations tend to have inquiring boards that offer both challenge and support across the span of their responsibility. I believe revalidation is a new and important tool that can provide assurance to boards (particularly non-executives) that the care provided to patients is safe and the doctors providing this care are up to date and fit to practise. The [Higgs Report](#) says: “Non-executive directors need to be sound in judgement and to have an inquiring mind. They should question intelligently, debate constructively, challenge rigorously and decide dispassionately. And they should listen sensitively to the views of others, inside and outside the board.”

Suggested questions for boards and other governing bodies

161 I heard a number of suggestions for questions that boards could be asking of their organisations in relation to revalidation. I also have some suggestions of my own based on the experience of conducting this review.

- How are local appraisal and revalidation processes contributing to improving patient care and safety?
- How can we make the revalidation process less administratively burdensome for our doctors and reduce the workload of preparing for appraisal?

- What does appraisal tell us about education and training requirements for our organisation?
- Are we confident that doctors are giving honest and open feedback on their colleagues and that, where difficult issues are raised, they are being addressed? If not, how can we create an environment where this happens?
- How can we make local processes for doctors to gather feedback from patients easier and more representative? Should we be looking at using 'real-time' feedback in appraisal?
- Are we assured that, when our RO is considering the revalidation of a doctor, they have had access to all the relevant information from the doctor's work in other locations or previous posts?
- Are we confident that all revalidation recommendations are fair, based on all the relevant evidence and have been discussed with the doctors concerned?
- Are we learning from good practice in other organisations?

Recommendation

6. ROs should report regularly to their board on the learning coming from revalidation and how local processes are developing. Boards should challenge their ROs as to how they are learning from best practice and how revalidation is helping to improve safety and quality.

162 There are already networks of ROs and appraisers where good practice is shared. I would like to see all designated bodies brought into such networks so that those organisations or settings with less mature systems can learn what works and what the benefits are. Higher-level ROs (the ROs of ROs) could usefully give a lead on this. GP appraisers in Northern Ireland told me: *"The learning that you get as an appraiser you take back to your practice but we have not managed to get a process about how we capture that."*

163 The GMC and system regulators can do more to encourage and support local healthcare organisations and boards in maximising the benefits of revalidation. Organisations in the four countries jointly published a [governance handbook for revalidation](#) in March 2013. This document set out core elements of local governance needed to support revalidation but it does not reflect the learning we now have from the first cycle of the process and would benefit from greater ambition in places. I suggest it should now be updated and widely promoted to healthcare providers.

Recommendation

7. The GMC should work with others to update its governance handbook for revalidation and set out expectations for board-level engagement in revalidation and provide tools to support improvement.

We need to be clear what evidence is (and is not) relevant for revalidation

Some doctors raised concerns with me about the transparency and consistency of their local revalidation processes.

164 I have already welcomed the way in which government health departments and individual organisations have taken ownership of revalidation. I believe it is right that revalidation should be locally owned and managed as part of an organisation's wider governance and assurance processes, within an overarching framework set by the GMC. However, it is important that the overall purpose of revalidation as a UK-wide standard of assurance is maintained and that doctors have confidence that local decision-making is fair and consistent.

165 The doctors I met for this review told me that revalidation is a significant event in their professional life; it means they can continue to hold their licence and practise in the UK. I heard that to be revalidated feels like an achievement; that it is affirming and reinforces the professional standing of a doctor. But, if problems arise, it can also be a source of great anxiety. Some doctors raised concerns with me about the transparency and consistency of their local revalidation processes. Their concerns covered two broad issues.

- It is suggested that some appraisers or ROs are asking doctors to provide information or complete tasks, as a condition of revalidation, that are above and beyond GMC requirements.
- Doctors can sometimes perceive they have been treated unfairly when their RO makes a deferral recommendation to the GMC and there is no process by which they can challenge this.

I address each of these concerns below.

Clarifying mandatory requirements for revalidation

166 Individual doctors, their representative organisations and royal colleges have all raised concerns with me about employers adding requirements for appraisal or revalidation that go beyond those specified by the GMC. To be clear, I heard that some ROs are refusing to sign off a revalidation recommendation unless a doctor 'delivers on' a local 'priority'. I have been given examples of doctors being asked to carry out specific numbers or types of clinical audits; attend generic training courses; use specific templates or obtain fixed numbers of CPD points before they can be revalidated. These are not requirements for revalidation.

167 I have given careful thought to this issue. I want to make a clear distinction between the requirements of local appraisal processes – which are rightly a matter for individual organisations – and the strictly defined decision-making process leading to a revalidation recommendation. While revalidation is utterly dependent on good annual whole practice appraisal, the appraisal process generates benefits for the doctor and their organisation above and beyond the making of a revalidation recommendation. Organisations should, therefore, feel able to develop their approach to appraisal in a way that is efficient and effective for them.

168 It is not, of course, unreasonable for an employer to require job-related training. And some of this training will relate directly to a doctor's fitness and safety to practise – for example, I heard the example of a paediatrician who had been mandated to attend safeguarding training before the RO would make their revalidation recommendation. That makes sense. However, I

“The problem is the inappropriate implementation of requirements without flexibility to account for complexity. ROs and appraisers are taking the GMC vision and twisting it or creating myths.”

Royal college representative

am less convinced that failure to undertake a clinical audit on a locally-specified topic should adversely affect a doctor's revalidation. Where doctors are being asked to carry out activities that go beyond the GMC's guidance, I would suggest that local processes other than revalidation ought to be used to secure compliance. At the very least these local requirements add an unnecessary burden; at worst they damage doctors' confidence in how revalidation contributes to increasing patient safety and demonstrating their professionalism.

169 I would like to see those who provide guidance for doctors on supporting information for revalidation – mainly the GMC and royal colleges – review that guidance in the light of experience of revalidation to date. With advice from ROs, appraisers and doctors, the GMC should look to distinguish more clearly between mandatory requirements and areas where there is scope for flexibility. And the colleges should make sure their guidance is complementary, providing specialty-specific examples but not creating new requirements. For example, the GMC requires doctors to undertake and evidence some form of quality improvement activity; but the doctor and their appraiser can decide what level and type of activity is appropriate. It would also be useful to provide more case studies and examples to help doctors and appraisers to understand the rationale for the mandatory requirements and how best to use the flexibility available.

170 I am aware that the GMC is already undertaking a review of its [supporting information guidance](#), looking at how requirements can be made clearer and more accessible. This review includes wide discussion with key revalidation partners and revised guidance is expected to be available by the end of 2017.

Recommendation

- 8.** The GMC should continue its work with partners to update guidance on the supporting information required for appraisal for revalidation to make clear what is mandatory (and why), what is sufficient, and where flexibility exists. They should also ensure consistency and compatibility across different sources of guidance.

Ensuring fair decision making

171 Most doctors are revalidated without difficulty. However, around 13% of recommendations made by ROs are to defer revalidation (excluding doctors in training from the data). This can occur because the doctor is involved in an ongoing local disciplinary process or, more commonly, because the RO decides the doctor needs more time to prepare all the necessary evidence. Deferral is described by the GMC as a 'neutral act', meaning that there is no implication that the doctor concerned is unfit to practise. Rather, they have not yet gathered all the supporting information needed for revalidation or the RO is awaiting information from other sources.

Given the significance of revalidation to a doctor's career, I believe it is important that processes are in place locally to assure the fairness of those judgements.

* 65% of ROs who responded to the survey undertaken by Boyd et al were also the medical director of their designated body. A further 7% were an associate or deputy medical director.

172 For this review, I approached a wide range of doctor representative groups to seek views on their experience of revalidation. In addition to the BMA, I invited input from groups representing black and minority ethnic (BME), women, lesbian, gay, bisexual and transgender (LGBT), and unwell doctors. In my meeting with the GMC's BME Doctors Forum I heard concerns that revalidation processes are sometimes being used to discriminate against BME doctors. Their perception, illustrated by specific examples, is that BME doctors are sometimes being recommended for deferral for reasons that are spurious or have not been applied equally to other doctors. They feel that, although deferral should be neutral, it is rarely delivered, experienced or perceived as such.

173 ROs must consider a wide array of evidence before deciding on their recommendation for a doctor's revalidation. Inevitably, there will be occasions when a doctor does not agree with their RO's judgement. Given the significance of revalidation to a doctor's career, I believe it is important that processes are in place locally to assure the fairness of those judgements. I am aware that some doctors question whether there is an inherent conflict of interest if the RO is also the medical director in an organisation.* Speaking personally, I do not believe the two roles are incompatible and I believe there is a strong argument for the RO to be a board-level position. What matters most is that organisations should have the leadership, culture and governance arrangements needed to operate fair and effective revalidation systems. However, it would be helpful if the ongoing evaluation of revalidation could explore the strengths and weaknesses of differing local approaches to the RO role.

174 As I touched on in the previous section, I would like to see boards take a more active role in overseeing the processes that support and deliver revalidation. They should be asking whether local quality assurance processes around appraisal and revalidation give sufficient consideration to questions of fairness. I have considered, but do not wish to recommend, enhanced GMC oversight of local decision making. It is for employers to make sure revalidation recommendations are made fairly. But I would be disappointed if employers did not establish robust local processes to enable doctors to challenge decisions they feel are unfair. I would also like the GMC to look in more detail at its data on deferrals and seek to understand why deferral rates vary across organisations or groups of doctors.

Recommendations

- 9.** ROs should make sure that the revalidation process for individual doctors is not used to achieve local objectives that are not part of the requirements specified by the GMC.
- 10.** Boards of healthcare organisations should make sure that effective processes are in place for quality assurance of local appraisal and revalidation decisions, including provision for doctors to provide feedback and to challenge decisions they feel are unfair.

Appraisal can be challenging as well as supportive

“Appraisal is the framework that allows doctors to get better.”

Senior RO, NHS England

175 Annual whole practice appraisal is at the core of revalidation and is the main mechanism by which revalidation will deliver benefits for patients and doctors. Appraisal is not a construct of the GMC or of revalidation. But, as I have described earlier, one of the most significant impacts of revalidation has been to embed whole practice appraisal as an annual requirement for all doctors.

176 Many doctors are having good appraisals and reporting that the process helps them to reflect on their practice and make improvements. Most of the people I spoke with were very positive about appraisal. But I have also heard criticisms that revalidation has made appraisal a less productive experience for doctors.

Understanding negative attitudes to appraisal and revalidation

177 As I stated earlier, on closer inspection, many of the negative comments made by doctors about revalidation actually relate to their experience of appraisal. In their submission to my review, the UMbRELLA team provided information about the concerns most commonly expressed by respondents to their 2015 survey of the medical profession. I have also received direct comments from a number of doctors. The most common criticisms of the impact of revalidation on appraisal are below.

- **Revalidation has reduced the quality of my appraisal.** The UMbRELLA research suggested that the more standardised format and delivery of appraisal caused a ‘loss of ownership’ of the appraisal process and has focused it on judgement at the expense of learning. This comment arises especially in primary care where appraisal was more established prior to the introduction of revalidation.
- **Appraisal is just a ‘tick box exercise’.** Some doctors have said that the introduction of revalidation has made their appraisal discussions too focused on compliance with evidence requirements at the expense of reflection on learning.
- **Preparing for appraisal eats into my personal time and the time I have available for patients.** The UMbRELLA survey suggested that some doctors are spending more time on appraisal and associated activities since revalidation was introduced. Many doctors question the benefits of this extra investment of time and energy.
- **My appraiser does not know me or my practice.** Some doctors question whether a doctor from outside their field of practice is in a position to help them to reflect and learn.

178 In my view some, but not all, criticisms of current approaches to appraisal are warranted. It is clear from comments I have reviewed on the GMC’s website that some doctors simply don’t think appraisal should apply to them. Here are three examples.

- *“We know we have to have revalidation to satisfy our paymasters. Our patients already love us.”*
- *“The whole exercise was, for me, a headache. In some NHS institutions it may be beneficial but I fail to see how.”*

An evidenced process of reflection and appraisal, drawing on experience and learning to identify personal development goals, is a given in almost every profession. It is the minimum the public should expect of doctors.

- *“When I got revalidated, it inspired me to retire; I informed colleagues that I’d be leaving the day after my next appraisal fell overdue. And I did, after enjoying a year free from ‘reflecting’ to order.”*

179 I have also heard that doctors dislike filling in forms or having to document their reflection. I’m not sympathetic to those objections. An evidenced process of reflection and appraisal, drawing on experience and learning to identify personal development goals, is a given in almost every profession. It is the minimum the public should expect of doctors.

180 I do not subscribe to the view that it is impossible for an appraisal to satisfy both summative and formative goals. The positive experience of many doctors serves to dispel that myth. In other words, appraisal can provide evidence for a revalidation recommendation *and* support a doctor’s learning and development. Nor have I seen evidence that appraisal cannot work if both parties do not share the same clinical background. But I do believe that success requires both a skilled appraiser and a well-prepared appraisee. Placing a regulatory framework on top of an appraisal process that was previously wholly developmental (or did not exist at all) has clearly presented challenges.

181 I would like doctors to see revalidation as a positive tool that they can use, with support from an appraiser, to make themselves better doctors. I expect some of the challenges of the first cycle to reduce as doctors and appraisers become more familiar with and confident around the new processes. But the experience of the first cycle suggests organisations need to take proactive steps to make sure the formative benefits of appraisal are retained, while also providing an assurance mechanism for patients and the public. These steps could include setting out expectations more clearly, ensuring appraisers have sufficient time for their allocated tasks, and strengthening quality monitoring.

Appraisal quality depends on both doctors and their appraisers

182 I asked some of the doctors I met to tell me, in pithy terms, what makes a good appraisal. The responses I received capture the importance of both the skill of the appraiser and the willingness of the appraisee to meaningfully reflect.

- *“Good appraisal is a formative supportive process, carried out by skilled appraisers, to enable the personal and professional development of the individual doctor.”*
- *“In a good appraisal, I benefit from the facilitation of an expert peer appraiser who can help me to stop and reflect critically on my scope of work.”*
- *“A good appraisal is one that doesn’t place a huge additional administrative burden on a doctor and which is seen by them as their annual opportunity to review their practice and consider their plan/goals for the coming year.”*
- *“In a good appraisal, by considering what has gone well, and what could have gone better, over the time since my last appraisal, and what challenges I can see ahead, I can plan for how to make changes that make a real difference to improve the care that I can provide.”*

183 The GMC has set expectations for what doctors need to do for their appraisal and appraisers need to check that these requirements are met. In some sense, that could be construed as ‘box ticking’. But doctors have a responsibility here too. One senior doctor told me: *“If you take a tick-box mentality, it will become a tick-box exercise.”*

184 It concerns me if some doctors are having appraisal meetings consisting entirely of checking compliance with the rules. If the doctor has prepared properly and submitted their portfolio of evidence ahead of time, there should be plenty of time available for a flexible and informative discussion about the doctor’s practice. By the same token, appraisers need to have the confidence to challenge appraisees. Having focused, challenging conversations can be difficult, but it is these conversations that really have impact and can be where the ‘reflection’ really begins.

185 I heard from, and read about, doctors who have been negative about appraisal and revalidation, but after having an appraisal with a good appraiser, have found it a valuable and affirming experience. One doctor wrote: *“I might have had negative comments to make about appraisal and revalidation two or three years ago. But I’ve changed my mind, or maybe my mind has been changed by the process! We’ve got to do it; it’s a bit of a hassle but it’s not that difficult if you put your mind to it. My last appraisal was a completely positive experience, has given me direction and has pointed me in the right direction for another revalidation when I’m even more elderly.”*

186 The RCGP has published helpful [guidance for GPs](#), emphasising the need for a proportionate approach.* It states: *“All doctors should have to meet the same standards to revalidate, no matter what their scope of work, and revalidation should not detract from patient care. You must not allow the effort involved in producing your documentation to become disproportionate by attempting to document every example of your reflective practice. Appraisal is a valuable opportunity for facilitated reflection and learning, sharing and celebrating successes and examples of good practice, and planning for the future. It is important that you and your appraiser keep a supportive and developmental focus on quality maintenance and improvement through your personal and professional development without a major increase in workload.”*

* The RCGP has also produced a ‘[Mythbuster](#)’ document, to address common misunderstandings about appraisal and revalidation.

Improving the skills and confidence of appraisers

187 Appraisers need the experience and confidence to allow the necessary level of flexibility in their appraisals. They should be able to exercise their judgement about whether the doctor has met the requirements, but not limit the appraisal discussion to checking off requirements. They need to talk about reflection and improvement, and provide a ‘proportionate’ challenge to the doctor.

I have been very impressed by the leadership shown by appraisers locally. They have created networks to share good practice and improve consistency.

188 Many organisations have invested heavily in training and development for their appraisers and I applaud this level of commitment. As we enter the second cycle, this commitment needs to continue and to reflect the learning from the process so far. My review of the published literature tells me that, despite some ongoing challenges around resourcing and training for appraisers, revalidation has positively impacted on appraisers and their role by increasing the importance and visibility of appraisers and appraisal.

189 I have heard suggestions of specific areas for appraiser development. The BMA told me: *“Appraisers need better training on how to use and interpret data. GP appraisers are better at this than hospital ones. You need to focus on the important stuff and make sure it is not just an exercise in collecting diplomas or training courses. We need to make that clear to appraisers to prevent it becoming a tick box exercise and make sure there is a robust and respected link between the information held about our work and our appraisal. Otherwise appraisal occurs in a vacuum and feels like going through the motions. Fixing this would make the process more real for practitioners and also raise public confidence.”*

190 Organisations also need to value their appraisers more, providing sufficient protected time for them to prepare. I would like to see greater acknowledgement (particularly from boards) about the crucial work appraisers do in the revalidation process. Appraisers and appraisal should be seen as one of the mechanisms through which the board gains assurance. I am also persuaded by the argument that, in order to maintain and develop their skills, appraisers need to do a minimum number of appraisals each year.

Developing and sharing good practice

191 I have been very impressed by the leadership shown by appraisers locally. They have created networks to share good practice and improve consistency. The Wales Deanery examines a percentage of appraisal summaries each year. In Scotland, lead appraisers do performance reviews of appraisal. Appraisers in Northern Ireland undertake a similar exercise. NHS England has published [quality assurance guidance for appraisal](#) and I understand that an appraisal network is well established at national and regional levels, with some designated bodies also running their own meetings.

192 There is ongoing debate around the selection of appraisers. Should a doctor choose their appraiser or have one allocated? Does the appraiser’s background matter? The Medical Appraisal and Revalidation System (MARS) online appraisal system used in Wales prevents a doctor choosing the same appraiser more than twice in five years. In Scotland, on the other hand, doctors cannot select their own appraiser. There is emerging opinion that a mixed approach to matching appraisers with appraisees could be beneficial, and I share this view. Following a quality assurance exercise, the Wales Deanery recommended that secondary care doctors have at least one appraisal by an appraiser who is outside their field of practice/specialty.

193 It is probably still too soon to understand fully the anatomy of successful appraisal. I am conscious of the fact that the long-term evaluation of revalidation being carried out by the UMbRELLA consortium has a work stream focused on appraisal. Alongside other research, this work should help us to gain a better understanding of what works. In the meantime, I believe the priority for healthcare organisations should be to raise the quality of appraisal locally, so that it has increasing value in the eyes of doctors and contributes reliably to assurance for patients.

Recommendation

- 11.** Healthcare organisations should continue work to drive up the quality and consistency of appraisal, learning from feedback and acknowledged good practice. They should also make sure the time set aside for appraisal adequately reflects its importance to revalidation outcomes.

We can reduce burdens for doctors

194 Revalidation attests the fitness to practise of individual doctors. It is therefore right that each doctor is responsible for drawing together and presenting the required evidence. But I believe healthcare organisations also have a responsibility to make the process as efficient and effective for doctors as possible.

195 One senior doctor told me: *“Doctors perceive the need for revalidation: no-one says get rid of it. But doctors complain about burden of paperwork; not just the quantity of paperwork but whether it is the right paperwork. Will it flush out the people who are not practising as the GMC would like? Will it reduce harm?”* I have argued earlier that revalidation is not just about early identification of poor performers. But clearly it is problematic if doctors feel that the burdens of the process outweigh the benefits.

196 Doctors told me about the frustrations they experience in preparing for appraisal and revalidation.

- **Difficulty accessing personalised information on activity and outcomes.** Other than consultants, most hospital doctors do not have their work recorded under their name, so they struggle to identify evidence through their employer’s treatment and patient care records systems. This also affects locums and SAS doctors. The [*BMA’s Charters for Staff and Associate Specialty Doctors for each of the four UK countries*](#) emphasise that, where appropriate or applicable, patients and work activity should be coded under an SAS doctor’s name.

I believe all the supporting information that the GMC specifies for appraisal has a valuable purpose. It is the ease of collecting this information that needs attention.

- **Time wasted in extracting information from a variety of different work-based systems.**

I heard that it can take considerable time for some doctors to identify and extract the information required for their appraisal portfolio from multiple IT systems covering quality outcomes, complaints, serious events, patient feedback etc. As one appraiser told me: *"We're asking doctors to work in three or four different systems to extract the data they need for appraisal."*

- **Insufficient allowance in contracted hours for reflection and development.** For most doctors, preparation for appraisal and revalidation is undertaken in their own time. One royal college representative told me: *"Everyone has the best of intentions but doctors also have the day job."*

- **The amount of time needed to prepare for the appraisal discussion.** Respondents to the UMbRELLA survey indicated that, on average, they spent 14.5 hours in direct preparation for their most recent appraisal, including collating and completing paperwork and attendance at the appraisal meeting itself. Some spent much longer. This time is on top of ongoing learning and development activity.

197 When considering whether the demands of revalidation are proportionate, I want to make a clear distinction between personal and organisational development activity (which was, or should have been, occurring at a similar level prior to revalidation) and the extra administration involved in collating the specific supporting information required by the GMC for revalidation.

198 I believe all the supporting information that the GMC specifies for appraisal has a valuable purpose. It is the ease of collecting this information that needs attention. I recognise that there will always be an element of local variation and personal choice in the amount of time a person spends putting together a portfolio of evidence. One doctor told me: *"It depends on your personality and your appraiser. Some people collect reams of information, whereas I just do what I need to do."* I also think it likely that doctors will find the process progressively easier and quicker as they experience it for a second and third time.

199 But there remains scope for organisations to better support their doctors by providing, or enhancing, the systems or advice available to support appraisal and revalidation. The GMC has itself made assumptions about the quality of local information systems: *"Revalidation is concerned with how doctors perform in practice. Therefore workplace systems of clinical governance and appraisal need to be sufficiently mature to enable doctors to collect the information they need for their revalidation and for that data to be properly evaluated in the workplace."**

* GMC, *Revalidation impact report*, submitted to RAB June 2015.

Better use of technology

200 Technology is part of the solution. I would like to see doctors being easily able to access all relevant clinical governance data from across the organisation. They should be able to download into their portfolios any relevant complaints and compliments, colleague and patient feedback and patient care and treatment data. I believe doctors should be able to record reflections in real time straight into their portfolios. I want organisations to consider the value of smart data transfer technology inside their organisations and the inter-operability of appraisal and revalidation systems within and between the four country systems; supporting doctors to assure patients (and themselves).

201 I have heard some good examples of how organisations have set up systems to make information sharing throughout the organisation easier. One doctor told me how she helped set up a bespoke system that allowed doctors to access information from different parts of the healthcare provider and drop them into their e-portfolio. It also allowed doctors to request information such as complaints and compliments directly from the complaints department.

202 At the UK level, the four countries have taken different approaches to information systems for appraisal and revalidation. Scotland and Wales developed whole-country systems prior to the introduction of revalidation and a single system for collecting multi-source feedback. These systems were seen as critical to the smooth rollout of revalidation in those countries by the system leaders and doctors alike. In England, a range of different commercial and in-house systems are in use, although I am aware that NHS England is now rolling out a national system that is similar to those used in Scotland and Wales.

203 I do not believe that technology can solve all the challenges presented by the first cycle of revalidation and am wary of recommending major investment to change existing systems or develop new ones. But it does appear that frustration with information systems is a major source of grievance in relation to appraisal and revalidation. I would suggest that future developments should address two broad objectives.

- **Ensuring revalidation considers the whole of a doctor's scope of practice.** Systems should help appraisers and ROs to access easily all the information needed to make a revalidation recommendation about a doctor. In particular, there is scope to increase the inter-operability of systems within and between UK countries to make sure revalidation decisions for doctors who work in multiple locations (including locums) are robust and based on evidence covering the doctor's whole scope of practice.
- **Reducing burdens for doctors and appraisers.** Where possible, systems supporting appraisal should be designed to increase the ease and speed with which doctors can collate their evidence. The e-portfolio systems used by postgraduate doctors in training seem to have the support of these doctors and might be a model to build upon.

I would like to think that in five to ten years' time there will be an online lifelong learning system that doctors across the UK can access throughout their career.

204 The GMC has developed a CPD app. It allows doctors to make a record of their learning or reflections 'on the go' on a mobile phone or tablet. It recognises that there are opportunities for learning every day and that doctors don't always have time to note them down. I would like the GMC to consider whether any value would be added by extending their CPD app to cover some of the other supporting information categories. This might help doctors who do not work in standard employment settings.

205 I would like to think that in five to ten years' time there will be an online lifelong learning system that doctors across the UK can access throughout their career. This is already starting to happen in Scotland. It would reflect their learning from medical school through to retirement and would help to develop doctors more effectively. It would talk to other systems, facilitate the sharing of information between employers, and help to bring locum and other more isolated doctors into a shared environment. This is my ambition.

Administrative support and advice

206 Technology is not the only way to support doctors. And it may not always be the most effective way of solving the problems identified. One senior RO told me: *"I would rather put the resource into the quality of the appraisal than a new IT system."*

207 I have seen organisations that have dedicated teams who help doctors to collate their supporting information in advance of appraisal. Some also provide (optional) templates and tools to support reflection. This is something that doctors value. I heard that one designated body in the independent sector collates a data pack of all complaints, incidents, outcomes, prescribing information, audit results and other governance information for their doctors each year and sends it to them in advance of their appraisals. The majority of their doctors have their prescribed connection to another larger designated body, but they are supporting the doctors to discuss their work in the independent sector at their appraisal.

208 I recognise the varying size and complexity of healthcare settings and would not wish to be prescriptive. But I recommend that organisations consider whether a local support function for revalidation would be a worthwhile investment in terms of the time freed up for doctors to concentrate on their clinical duties. The ELS tell me that a number of ROs have drawn attention to a lack of local HR support and resources and the challenge this can present to delivering their role effectively.

Recommendation

12. Healthcare organisations should explore ways to make it easier for their doctors to pull together and reflect upon supporting information for their appraisal. This might occur through better IT systems or investment in administrative support teams.

The addition of revalidation to existing processes of medical regulation places an obligation on those involved in assurance to share intelligence with others.

Reducing duplication in the regulatory system

209 I heard from the English GPs I met during my review that some of the information they need to gather for appraisal and revalidation duplicates what is requested by the CQC inspection process. I understand this particularly affects GPs in small practices. In England, the GMC, CQC and NHS England have recently published a [*joint statement of intent around reducing regulatory burdens on general practice*](#). This is a promising development, for which I commend those involved. But I heard there is more work to be done to reduce burdens in practice.

210 The addition of revalidation to existing processes of medical regulation places an obligation on those involved in assurance to share intelligence with others. For example, I would expect system regulators to use information coming out of revalidation to inform their judgements around the quality and impact of clinical governance in the organisations they inspect. One doctor told me: *“CQC do not look at the quality of revalidation processes generally, which is a missed opportunity. Also, their questionnaire only asks about audit rather than the broader spectrum of quality improvement activity.”*

211 In addition, the CQC told me that they would expect to see greater coherence between their inspection scores for hospital and GP services and the revalidation status of the doctors who work in those services. This is a complex issue because the scope of inspection differs significantly from that of revalidation. However, I believe there would be merit in the GMC, CQC and NHS England exploring whether further changes are needed to better join up regulatory systems. This work might also uncover issues that would be of relevance to systems in Scotland, Wales and Northern Ireland.

Recommendation

- 13.** The GMC should continue its work with the CQC and NHSE in England to reduce workload and duplication for GPs, and work with relevant organisations in Northern Ireland, Scotland and Wales to identify and respond to any similar issues if they emerge.

Revalidation processes must be equally robust for all doctors

212 I believe that, for the vast majority of doctors, revalidation processes are rigorous and effective; they provide good assurance that doctors are up to date and fit to practise. But it has become apparent to me that there are some weaker points in the system. To put it simply, I do not have the confidence, at this point, to say to patients that every doctor is subject to the same high standard of whole practice appraisal or that ROs always have sight of all relevant information about a doctor's fitness to practise. I should, however, qualify this by saying that patients should draw considerable confidence from the fact that all doctors are now in a managed system of governance with whole practice appraisal taking place annually and revalidation leading to a doctor being relicensed every five years.

We need to strengthen assurance around locum doctors

213 It is increasingly common for doctors to work as locums, for lifestyle or other reasons. That is not a problem in itself – most of these doctors are good doctors, and many healthcare providers rely on them and speak highly of the contribution they make. However, I am hearing that the increasing mobility of the healthcare workforce is putting strain on assurance systems, including revalidation. One lead appraiser told me: *“Locum doctors are generally perceived to be a greater risk for a variety of reasons, many of which are systemic rather than related to the individual practitioner. A ‘perfect storm’ of risk occurs where a short-term locum doctor from a poorly organised agency is given an urgent short-term placement in an organisation with poor governance procedures.”*

214 In England, when the NHS or other public sector healthcare providers need temporary or fixed term cover they can secure medical services through a locum agency which appears on the [Crown Commercial Service \(CCS\) Framework Agreement list](#). An agency on the Framework list is able to supply locum doctors from its own pool or can rely on doctors sourced from pre-approved sub-contracting locum agencies. Under the RO Regulations, an agency that supplies medical locums under the Framework Agreement to NHS bodies and the wider public sector is deemed to be the designated body for doctors contracting with it.

215 I have some concerns about the current position for revalidation of locums.

- There is some confusion as to where prescribed connections lie for secondary care locums in England, especially where the doctor is employed by a sub-contracted agency. This situation appears to be caused by a lack of clarity in both the RO Regulations and the CCS Framework Agreement.
- I heard that not all locum agencies are properly fulfilling their responsibilities as designated bodies in terms of ensuring that locum doctors are up to date with appraisal and supporting them to collect and reflect upon the evidence required.
- Deferral rates for locum doctors are higher than for any other group. It has been suggested to me that one reason for this is the difficulty experienced by ROs in accessing all the information they need to make revalidation recommendations for locum doctors.

The public has the right to expect that governance arrangements are of the same high standard, regardless of the size or type of organisation that is responsible for a locum doctor's revalidation.

216 I regard the lack of clarity around revalidation arrangements for locums as unacceptable. The public has the right to expect that governance arrangements are of the same high standard, regardless of the size or type of organisation that is responsible for a locum doctor's revalidation; public protection and the rules of good governance are paramount. Recognising these overriding priorities, there needs to be certainty about the identity of the organisations that exercise the statutory responsibilities of being a designated body – particularly bearing in mind that it falls to the Secretary of State for Health (following consultation with the Scottish or Welsh Ministers or Monitor, as appropriate) to nominate an RO for any designated body that fails to appoint an RO themselves. And those bodies that are designated bodies by virtue of the RO Regulations need to be clear about their responsibilities.

217 I would like the Departments of Health in England (in consultation with Scotland and Wales) and Northern Ireland to look again at the provisions in the RO Regulations for connecting locum doctors to a designated body to make sure that locum doctors have a clear connection to an organisation that is accountable and has robust clinical governance systems. I also want to see the responsibilities that locum agencies are required to undertake under the RO Regulations (and the consequences of failing to do meet them) being made clearer – preferably through terms within the Framework Agreement/Contract.

218 I am also concerned about the potential for information about a locum's revalidation and appraisal history to be lost when a doctor moves between provider organisations and roles. My starting point – and one that I am sure the public would share and expect – is that, when a doctor moves between designated bodies, and between postings, information pertaining to their revalidation should move with them. So there needs to be a clear obligation to share information on an appropriate basis where this is relevant to a doctor's revalidation.

219 As I mentioned when discussing fairness in decision making, I would like the GMC to undertake further analysis to identify the reasons behind higher deferral rates for some designated bodies and to share that information. Boards and healthcare providers can use the data to improve the efficiency and effectiveness of the delivery of high quality healthcare in their organisation.

Improving information sharing across designated bodies

220 Earlier in the report, I explained my concerns that locum doctors (and their ROs) are not always receiving proper feedback on their performance, including details of any concerns. This is not acceptable from a patient safety perspective and does not afford the doctor the opportunity to understand how to strengthen and improve his or her practice, to reflect and make the necessary changes. Locum agencies need to work with hospital trusts and other receiving organisations to share information relating to the revalidation of these doctors. And ROs should be cognisant of their own duty, applying to all doctors, to raise any concerns about colleagues at an appropriate level (in the case of locums, this would be their employing or contracting authority).

“Are there ways the system could better support doctors without a designated body? They are getting a raw deal and are probably the doctors who need revalidation most.”

Faculty revalidation lead

221 I have heard that ROs of locum agencies and membership organisations (who do not directly employ the doctors who are connected to them) are not always able to obtain information about concerns and any subsequent investigations involving their doctors. These ROs are often reliant on the employer/contractor to notify them when there has been a concern and to undertake the investigation. The GMC's ELS tells me that ROs have noted several examples where this has not happened and they have only become aware of the concern because the doctor has told them. This represents a significant weakness in a system that is intended to provide assurance to patients and it must be addressed.

222 ROs making revalidation recommendations need to be confident that they are seeing all of the doctor's practice. This requires organisations, including agencies, to share information. The issues around locum doctors and doctors working away from their designated body present a strong case for my earlier suggestion to improve the inter-operability of systems around appraisal and revalidation.

Recommendation

- 14.** The GMC should work with health departments and ROs to address weaknesses in information sharing in respect of doctors who move between designated bodies.

All doctors working in the UK should have an RO

223 Throughout the development of revalidation, it was known that there would be doctors who did not have an obvious designated body to oversee and support their revalidation. However, when the RO Regulations were drawn up, it was not anticipated quite how many doctors would lack a prescribed connection and yet want to keep their licence. I understand from the GMC that, while the number of licensed doctors without a connection is falling, there are still around 4,360 doctors in this position, of whom 750 are currently engaged in clinical work with patients in the UK. As I have already said, from a patient safety perspective, that cannot be right.

224 I have heard a range of opinions about doctors who have no connection, from the need to offer more support and flexibility to these doctors to the heightened risk presented by doctors working in environments without established clinical governance. One faculty revalidation lead asked me: *“Are there ways the system could better support doctors without a designated body? They are getting a raw deal and are probably the doctors who need revalidation most.”*

225 The GMC explored a range of mechanisms that it could use to revalidate doctors without connections. These options were limited in critical ways by the legislation. For example, the GMC has no power to require a doctor to give up their licence if they are no longer practising in the UK. And it has no power to enforce a connection to an SP, even if the doctor meets the criteria for connecting to that SP. Finally, there is no provision for any authority to force a particular organisation to accept its obligation to be a designated body under the RO Regulations and to appoint an RO.

226 The SP route has allowed over 1,000 doctors to connect to an SP to support their revalidation. There may be disappointment in some quarters that more individuals and organisations have not stepped forward to become an SP, but I would not support calls for the GMC to lower its standards. It must be right that potential SPs are required to demonstrate that they can deliver the high standards of clinical governance expected.

227 The current revalidation process for doctors without an RO or SP who wish to retain their licence has two aspects: they must provide a return to the GMC each year with appraisal details and statements that there are no known fitness to practise concerns from organisations to which they provide medical services; and, where the GMC decides that it is reasonable, they must sit a written test of knowledge once every five years. I do not consider those to be unreasonable requirements. But I do recognise that they may not reflect the doctor's exact scope of current practice to the same degree as the RO/SP model for revalidation.

228 I want to recognise the progress that the GMC has made in developing assurance arrangements in respect of doctors without a prescribed connection. However, I am not confident that current revalidation arrangements for unconnected doctors provide the same level of assurance to patients as those for a doctor subject to clinical governance via an RO. I believe there should be an expectation that more robust measures will be put in place during the next cycle of revalidation.

229 In thinking about how to tackle this issue, I am conscious that the cohort of doctors without a connection is very diverse and also that it is constantly changing. It includes the following groups:

- Doctors who definitely require a licence to practise in the UK for their current work, but who are unable or unwilling to connect to a designated body or SP.
- Doctors who do not require their licence at the present time but expect to need it in the near future. This includes those who are temporarily overseas (including some working for charities), on a career break, or suffering from ill health. I have heard that some UK employers give preference to doctors holding a current licence when shortlisting for posts. If true, this is of dubious legality.
- Doctors who are unsure whether a licence is needed for their current work. This includes those undertaking medico-legal work that does not involve direct patient contact and some doctors working in managerial or civil service roles.
- Doctors who are working permanently and wholly overseas and therefore do not require their UK licence to practise (but, by law, are entitled to keep it).
- Doctors who are not undertaking any formal medical practice but wish to keep their licence, perhaps because they advise or prescribe on an occasional basis.

230 The diversity of doctors without connections makes it very challenging to arrive at an approach to revalidation that appears fair and proportionate to those doctors whilst also delivering the level of assurance that the public has a right to expect. Certainly, no-one I met was able to suggest an immediate solution that would meet my expectations – on behalf of the public – that every doctor holding a licence and, therefore, capable of practising in the UK is subject to the same high standards of appraisal and revalidation.

231 I believe the solution lies partly in legislative change and partly in the provision of better advice to doctors and employers. Firstly, I would like the Departments of Health in England (in consultation with Scottish and Welsh Ministers) and Northern Ireland, in discussion with the GMC, to review the RO Regulations with a view to establishing a prescribed connection to a designated body for all doctors who need a licence to practise. The current situation – whereby a doctor may be required by statute to hold a licence (for example, those acting as crematoria referees or approved under section 12 of the *Mental Health Act*) and yet not have a prescribed connection under the RO Regulations – is not sustainable.

232 Secondly, I would like organisations that use the services of doctors in the UK to accept that they should be making sure that those doctors are subject to robust clinical governance, including annual whole practice appraisal, and are properly supported with their revalidation. This could be achieved either by appointing an RO or ensuring that the doctor makes a connection elsewhere. At the very least, bodies that commission medical services should reflect upon whether they require the doctor to hold a licence to practise (as opposed to registration alone) for that role and be clear about the reasons why. The GMC could assist by providing clearer guidance on the roles that do and do not require a licence and indicating where explicit legal advice might be needed.

Recommendation

- 15.** The Departments of Health, in consultation with the GMC, should review the RO Regulations with a view to establishing a prescribed connection to a designated body for all doctors who need a licence to practise in the UK. They should also review the criteria for prescribed connections for locums on short-term placements.

My key messages for those involved in revalidation

Revalidation, alongside and underpinning other clinical governance and regulatory systems in the four countries of the UK, places the safety of patients as central to its purpose.

For patients and the public

233 Most patients who have an interaction with a doctor in the UK do so through the NHS. The opening paragraph of the [NHS Constitution for England](#) reminds us that: “*The NHS belongs to the people.*” It goes on to say: “*It is there to improve our health and wellbeing, supporting us to keep mentally and physically well, to get better when we are ill and, when we cannot fully recover, to stay as well as we can to the end of our lives. It works at the limits of science – bringing the highest levels of human knowledge and skill to save lives and improve health. It touches our lives at times of basic human need, when care and compassion are what matter most.*”

234 Most, if not all, doctors will have given witness to the *Hippocratic Oath*, possibly the most famous text in western medicine. A line from that text reads: “*And I will use treatments for the benefit of the ill in accordance with my ability and my judgment...*” I am assured that, since the introduction of medical revalidation, licensed doctors can now evidence that they continue to be up to date and fit to practise as a doctor in the UK. I am further assured that all doctors holding a licence to practise in the UK are now in a managed system of governance that requires them to undertake an annual whole practice appraisal and to be revalidated (relicensed) once every five years. Revalidation, alongside and underpinning other clinical governance and regulatory systems in the four countries of the UK, places the safety of patients as central to its purpose. Patients and the public should be assured that many of the recommendations I have set out in this review seek to further strengthen patient safety. But I want you, as patients, to be assured too. I make recommendations that patients through patient representative bodies should be able to validate this most important of all reassurance systems. I also want your experiences of the interaction you have with doctors to play a bigger role in their reflection and learning and I recommend ways that this can be achieved.

235 I want to make it easier for you to give feedback on your doctor. Currently, a doctor may obtain and reflect on patient views only once in each revalidation cycle. While this feedback will be valuable, I would like to shift the balance towards making it easier for you, as patients, to feedback on any interaction you have with a doctor. Real-time feedback should over time become commonplace. Bodies that represent the views of patients and the boards of healthcare organisations should consider how you, as patients, can inform the discussions about how this might best be achieved.

For doctors

236 I started this review believing that revalidation existed primarily to assure patients that doctors were current in their practice and fit to practise. I still believe that, but have developed a greater appreciation of the benefits of the process to healthcare organisations and to doctors themselves. I believe that revalidation underpins and evidences the professional standing of a doctor. Richard Horton, editor of the *Lancet* and prime author of a [report on medical professionalism from a working party of the Royal College of Physicians](#), wrote: “*Professionalism is medicine’s most precious commodity.*”*

* Horton, [Medicine: the prosperity of virtue](#), *The Lancet*, Vol. 366, No. 9502, p1985–1987, 10 December 2005.

237 I hear and share doctors' concerns about the cost and administrative demands of the appraisal and revalidation process. I am asking healthcare organisations, the GMC and system regulators to look at practical ways they can reduce the time and effort needed to prepare for appraisal. I am also asking organisations to continue work to improve the quality of appraisal and to make sure they have processes in place to assure the fairness of local revalidation processes. However, I do not want to recommend lowering the evidence requirements or the standard of assurance that revalidation provides to patients.

238 For doctors without a connection, I recognise the difficulties and anxieties you have faced in meeting revalidation requirements. In my view, the system needs to change; recognising that, provided you need a licence, you should be better supported. But I will not sanction a lesser standard of revalidation for licensed doctors who work only occasionally or have a very limited scope of practice. That wouldn't be right for patients. I believe it would be best if every doctor who needs a UK licence to practise had a connection to an RO. While I understand this will require legislative change, I still believe this should be seen as a realisable ambition.

For ROs and boards of healthcare organisations

239 This report recognises that you have played a critically important role in the successful delivery of revalidation. I also believe that ROs and their organisations are in a good position to know how processes can be improved and, indeed, have already begun to do this.

240 I would like to see continued progress in increasing the quality of appraisal, so that every doctor can benefit from a supportive yet challenging appraisal. I would also like you to look at ways you can reduce the administrative demands on doctors. I believe this will help doctors to buy in to the process. In addition, you should seek to raise public awareness of revalidation. I would like you to invite patient representative bodies to look at this important system of governance and offer advice about how, locally, patients could be further reassured about their doctors' fitness to practise. This could be achieved by working with local patient bodies, for example the Scottish Health Council, the Community Health Councils in Wales, Healthwatch in England and the Patient and Client Council for Northern Ireland.

241 This report contains a number of messages for boards. The fact that every doctor in your healthcare organisation is supported, by you, to be appraised annually, and to reflect on colleague and patient feedback is a strong message to patients and the public that you take this aspect of your clinical governance responsibility seriously. Demonstrating that these same doctors are evidencing that they are also up to date and fit to practise through the revalidation and relicensing process is reassuring and confidence building for patients. Discussing appraisal rates and the outcomes and learning from revalidation at board meetings underpins that commitment. Giving every patient the supported opportunity to feedback on their interaction with your doctors supports the new approach to revalidation that I recommend in this review.

I would like to see the GMC supporting local healthcare organisations in promoting awareness of revalidation and strengthening their governance arrangements; and working with system regulators to reduce duplication.

For the GMC

242 I want to acknowledge the significant role that the GMC has played in the successful implementation of revalidation. From my perspective as Chairman of RAB, the GMC has provided clear and professional leadership to the planning and introduction of revalidation. It has led on the principles and key requirements, while being willing to step back and allow local processes to take shape.

243 Annual whole practice appraisal and revalidation are now embedded throughout the four countries and increasingly seen by doctors as part of the norm of being a doctor. To have achieved this degree of operationalisation and broad acceptance of revalidation in barely four years is remarkable and worthy of recognition in this review. The GMC will continue to be seen to lead revalidation into and through the second cycle. I urge the GMC Council to carefully review the recommendations in this report and to seize the opportunities they provide to increase assurance to patients that doctors are up to date and fit to practise.

244 The GMC will also need to hear the voice of those doctors that find revalidation to be more difficult, more time consuming and perhaps more arduous than it should be. They should work with royal colleges and others to clarify guidance on appraisal. And they should use the data gathered on revalidation to investigate concerns around deferral rates and to consider some high-level impact measures.

245 I would like to see the GMC supporting local healthcare organisations in promoting awareness of revalidation and strengthening their governance arrangements; and working with system regulators to reduce duplication. I have also raised in this review that patients and the public struggle with the term 'revalidation' but instantly connect with 'licensing' and the concept of 'relicensing'. Now may be the time for the GMC to revisit this terminology. And I have suggested that consideration be given to an earlier revalidation date for doctors completing UK foundation training and those from overseas who are new to UK practice.

246 Finally, I have encouraged the GMC and national governments to take another look at the RO Regulations with a view to strengthening oversight of locums and doctors who work outside managed environments. Legislation is not the only possible avenue for increasing assurance in relation to these doctors, but I believe the overall revalidation system would be considerably strengthened if all doctors who practise in the UK were to be given a prescribed connection to a designated body.

What I would like to happen next

247 This report was commissioned by the GMC and delivered to their Council. However, by no means all my recommendations are addressed to the GMC. This reflects the fact revalidation is, to a large degree, owned and operated by designated bodies and ROs. GMC leadership and support is vital, but many of the actions I suggest will need to be taken at a local level.

248 When responding to my report, I have asked the GMC to consider how it will co-ordinate and monitor the activity needed to implement my recommendations. I have further suggested that this should include a review of the role, membership and functions of the current Revalidation Advisory Board, which I chair.

249 I believe my recommendations are pragmatic and can be largely delivered within the next five years. In particular, I would expect to see early action to strengthen revalidation processes for locum doctors, remove unnecessary burdens for doctors and increase public understanding of the purpose and impact of revalidation.

Annex A – List of people I met

Organisation	Representatives
Academy of Medical Royal Colleges, England	Professor Dame Sue Bailey, Chairman Mr Alastair Henderson, Chief Executive Professor Graham Layer, Academy's CPD Lead Dr Andrew Long, Academy's Remediation Lead Dr Ian Starke, Chair of the Academy Revalidation and Professional Development Committee and Chair of the Patient Feedback Group
Association of Independent Healthcare Operators	Lene Gurney, Practice and Policy Advisor Dr David Mitchell, Responsible Officer for the Hospital of St John and St Elizabeth
BME Doctors Forum, GMC	Professor Iqbal Singh, Chair of Forum Dr Babatunde Gbolade, President, Medical Association of Nigerians Across Great Britain (MANSAG) Dr Alam Khan, Pakistani Medical Association Dr Ramesh Mehta, President, British Association of Physicians of Indian Origin (BAPIO) Professor Iqbal Memon Dr Murthy Motupali Dr Anthea Mowat, Chair of the BMA representative body, and the BMA's equality, diversity and inclusion advisory group Dr Umesh Prabhu Dr Gurpreet Singh
British Medical Association	Dr Peter Bennie, BMA Chairman, Scotland Dr Sara Hunt, Deputy Chairman, BMA Welsh Consultants Committee Dr Mark Porter, BMA Chair, England Mark Hope, Senior Policy Advisor
Care Quality Commission	Professor Ted Baker, Deputy Chief Inspector of Hospitals David Behan, Chief Executive Professor Steve Field, Chief Inspector of General Practice Peter Wyman, Chairman
Department of Health, England	Dr Nick Clarke, Deputy Director, Professional Standards Branch and Workforce Division Professor Dame Sally Davies, Chief Medical Officer
Faculty of Public Health	Dr John Woodhouse, Responsible Officer

Faculty of Pharmaceutical Medicine	Sam Hutchinson, Revalidation Manager
Faculty of Sport and Exercise Medicine	Yvonne Gilbert, Executive Manager
Health and Social Care in Northern Ireland	Bob Magill, Business Partner Medical & Dental Workforce, South Eastern Trust Dr Charlie Martyn, Medical Director, South Eastern Trust Dr Moya McAleavy, Medical Adviser, Health and Social Care Board Helen Rogers, Revalidation Manager
Health Education England	Dr Julia Whiteman, Postgraduate Dean
Health Foundation	Gavin Larnar, Policy Associate
Healthcare Improvement Scotland	Leslie Marr, Senior Programme Manager Steven Wilson, Programme Manager
Healthcare Inspectorate Wales	Kate Chamberlain, Chief Executive Alison Kedward, Clinical Director
Independent Doctors Federation	Mr Ian Mackay
Individual doctors speaking in a personal capacity	Dr Dean Marshall Dr Anthea Mowat Dr Daniel Redfern Baroness Finlay of Llandaff
Alliance Manchester Business School	Professor Kieran Walshe, Professor of Health Policy and Management
NHS Education for Scotland	Niall Cameron, National Appraiser Advisor
NHS Employers	Bill McMillan, Assistant Director, Medical Pay and Workforce Sarah Parsons, Medical Workforce Manager

NHS England	Dr Maurice Conlon, National Appraisal Lead Professor Sir Bruce Keogh, National Medical Director Dr Andy Mitchell, Regional Medical Director (London) Dr Mike Prentice, Regional Medical Director (North) Dr Nigel Acheson, Regional Medical Director (South) Attended meeting of senior medical directors
NHS Lothian	Dr Rosie Dixon, Appraisal lead for primary care Dr Eddie Doyle, Appraisal lead for secondary care
NHS Wales	Dr Paul Buss, Medical Director, Aneurin Bevan University Health Board
Northern Ireland Government	Dr Paddy Woods, Deputy Chief Medical Officer
Northern Ireland Medical and Dental Training Agency	Professor Keith Gardiner, Chief Executive & Postgraduate Dean GP Appraisers: Dr John Adams, Dr Fiona Allen, Dr Ivor Cairns, Dr Tracey Cruickshanks, Dr Richard Ferguson, Dr Claire Loughrey
Regulation and Quality Improvement Authority, Northern Ireland	Dr David Stewart, Chairman Dr Gareth Lewis, Clinical Leadership Fellow Dr Lyndsey Thompson, Clinical Fellow
Royal College of Anaesthetists	Chris Kennedy, CPD and Revalidation Co-ordinator
Royal College of General Practitioners	Dr Susi Caesar, Medical Director for Revalidation
Royal College of Paediatrics and Child Health	Dr Carol Roberts, Officer for Continuing Professional Development & Revalidation
Royal College of Pathologists	Professor Peter Furness, Director of Professional Standards
Royal College of Psychiatrists	Dr Wendy Burn, College Dean Julian Ryder, Revalidation and Workforce Manager

Royal College of Physicians, London	James Hill-Wheatley, Head of Revalidation and CPD Dr Gerrard Philips, Vice-President for Education and Training Dr Myra Stern, Federation Medical Director, Revalidation and CPD
Royal College of Physicians, Edinburgh	Professor Derek Bell, President Sushee Dunn, Programme Manager
Royal College of Physicians, Ireland	Professor Hilary Hoey, Director of Professional Competence, Senior Fellow and Censor
Royal College of Surgeons, London	Professor Clare Marx, President
Royal College of Surgeons, Edinburgh	Duncan McArthur, Director of Professional Activities
Scottish Association of Medical Directors	Professor Andrew Russell, Medical Director, NHS Tayside
Scottish Government	Dr Catherine Calderwood, Chief Medical Officer Professor Ian Finlay, Senior Medical Director Shirley Rogers, Workforce Director
University of Plymouth	Dr Julian Archer, Director of the Collaboration for the Advancement of Medical Education Research & Assessment (CAMERA) Dr Samantha Regan De Bere, Deputy Director of the Collaboration for the Advancement of Medical Education Research and Assessment (CAMERA)
Wales Deanery	Dr Chris Price, Deputy Director of General Practice, Revalidation Support Unit Katie Laugharne, (former) Organisational Lead of Revalidation Support Unit Katie Leighton, Deputy Organisational Lead Revalidation Support Unit
Welsh Government	Professor Chris Jones, Deputy Chief Medical Officer Geraldine Buckley, Revalidation Policy Manager
Welsh NHS Confederation	Vanessa Young, Director Andrew Davies, Policy and Development Manager

Representing patient views	<p>James Austin, Macmillan Cancer Support</p> <p>Sir Donald Irvine</p> <p>Clare Jenkins, Community Health Councils in Wales</p> <p>Christine Johnstone, Scottish Health Council</p> <p>Eddie Lynch and John Mackell, Office of the Commissioner for Older People for Northern Ireland</p> <p>Sol Mead, Independent lay representative</p> <p>Andrew McCulloch and Bridget Hopwood, Picker Group</p> <p>Neil Walbran, Healthwatch Manchester</p> <p>Patricia Wilkie, National Association for Patient Participation</p> <p>Dr Rose McCullough, Robin McHugh, Karen Mooney and Jill Brennan (members of the RCGP PIP group)</p>
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Annex C – Revalidation timeline

