REVALIDATION OF DOCTORS IN THE DEFENCE MEDICAL SERVICES AND MINISTRY OF DEFENCE

Introduction

1. Medical revalidation is the process by which all doctors who are licensed with the General Medical Council (GMC) will regularly demonstrate that they are up to date and fit to practise. It will provide assurance that licensed doctors are practising to the appropriate professional standards.

2. There has been extensive consultation on the legislation underpinning the introduction of revalidation for doctors[1], which HQ Surgeon General and the Defence Medical Services (DMS) have been involved in, and it is anticipated that The General Medical Council (Licence to Practise and Revalidation) Regulations will become law in December 2012.

3. All doctors working within the DMS, regardless of the role in which they are employed, are required by the Surgeon General to retain their licence to practise[2] and will, therefore, need to revalidate. In order to enable this, it is essential that all doctors working in the DMS have an annual appraisal.

Aim And Scope

4. This policy leaflet explains how revalidation will be introduced and applies to all doctors working within the DMS and, additionally, to those doctors employed by the MoD who do not work within or for the DMS but who require to maintain their licence to practise.

Overview Of Revalidation

5. Revalidation will be required every 5 years in order to retain a licence to practise and is linked to the completion of annual professional appraisals. The designated Responsible Officer (RO) (see below) will make a recommendation to the GMC for revalidation or otherwise based on appraisals[3] and clinical governance systems[4].

6. The GMC's Good Medical Practice Framework sets out the broad areas which should be covered in medical appraisal and on which recommendations to revalidate doctors will be based. The framework sets out the key principles that are relevant to the whole profession, allowing a standardised approach to all medical appraisals.

7. There is no change to the requirement to appropriately address any concerns about a doctor's practice at the time these are identified[5].

ROLES AND RESPONSIBILITIES

General Medical Council

8. The GMC is responsible for making decisions about the revalidation of doctors, based on recommendations from ROs. It works with the Designated Bodies (DBs) and ROs to:

a. Identify those doctors who have a licence to practise and are therefore required to revalidate.

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[1] Consultation on the GMC (Licence to Practise and Revalidation) Regulations

[2] Any doctors who have voluntarily relinquished their Licence to Practise must therefore take appropriate action to have it reinstated. Guidance is available at GMC (Restoration following Adminstrative Erasure) Regulations Order of Council 2004 and GMC (Restoration following Administrative Erasure) (Amendment) Order of Council 2009.

[3] JSP 950 Lflt 10-2-1: Appraisal of Medical Officers.

[4] JSP 950 Lflt 5-1-4: Healthcare Governance and Assurance in the Defence Medical Services.

[5] JSP 950 Leaflet 5-2-4 Management of Poorly Performing Doctors and Dentists in the Defence Medical Services

b. Confirm which doctors have a prescribed connection with the DBs.

c. Set submission dates for revalidation recommendations.

d. Act to administratively remove Licences to Practice when doctors fail to engage with revalidation.

Designated Bodies

9. The Medical Profession (Responsible Officer) Regulations 2010 regulations specify the organisations or bodies which are DBs and which must appoint or nominate a RO. The MoD, Defence Primary Health Care, the 3 single Services (sS) and the Defence Postgraduate Medical Deanery (DPMD) are all DBs under the provisions of these Regulations.

Responsible Officers.

10. The role of the RO is underpinned by The Medical Profession (Responsible Officer) Regulations 2010 (The Regulations). ROs must be licensed medical practitioners.

11. The RO plays a crucial role in the revalidation process by ensuring that the GMC's standards are met by licensed doctors. The RO is also responsible for ensuring that governance systems and appraisal in their organisation are working and are appropriate for revalidation.

12. The Regulations mandate that the DB must provide the RO with sufficient funds and resources to enable them to fully carry out their role as RO. This includes the allocation of sufficient time, staff and administrative support in order for them to be able to fully discharge their statutory obligations in accordance with The Regulations.

13. ROs will be responsible for the doctors employed by, or contracted to, the DB or organisation, or who have some other prescribed link; for example, through membership. Doctors will link to one RO only.

14. The ROs for the DMS for the purposes of revalidation are as follows:

a. The 3 single Services (sS) Directors of Medical Services (or a doctor nominated by the sS if the Director is not a doctor) for all uniformed doctors (including GDMOs) who are not trainees and for civilian doctors (except locums) within that Service.

b. The Defence Postgraduate Medical Dean for all uniformed doctors in training.

c. Commander Defence Primary Healthcare for all CMPs[6]

15. In addition to these 5 ROs for doctors working in the DMS, there will be an additional RO[7] for doctors employed by the MoD who do not work within the DMS (e.g. SPVA).

16. ROs will evaluate and make recommendations to the GMC about doctors' fitness to practise based on the supporting information that is presented to them. This will be done via a secure system called GMC Connect. The information ROs require to decide what recommendation to make about individual doctors will be collected and collated using the Revalidation Support Team (RST) RO Dashboard[8]. It is hoped, in time, to develop a DMS-specific dashboard.

17. ROs can make one of 3 recommendations to the GMC about the doctors they are responsible for:

a. Make a positive recommendation that the doctor is up to date, fit to practise and

[6] With effect from FOC (April 2014)
[7] HQ SG Head Medical Strategy and Policy.
[8] RST RO Dashboard

should be revalidated (the GMC expects this will be the case for the vast majority of doctors).

b. Request a deferral because they need more time or more information to make a recommendation about a doctor. For example, this might happen if a doctor has taken an extended break from their practise. The Licence to Practise is unaffected by deferral.

c. Notify the GMC that a doctor has failed to engage with appraisal or any other local systems or processes that support revalidation.

18. More information about the role and responsibilities of ROs is contained in the Department of Health (DH) publication The Role of Responsible Officer: Closing the Gap in Medical Regulation-Responsible Officer Guidance and The GMC's Responsible Officer Protocol.

Appraisers

19. The medical appraisal system in which all DMS doctors should already be participating gives an independent, impartial review of current performance and input into each individual's personal development plan, including assisting with the formulation of each year's planned CPD.

20. The completion of appraisal is central to the revalidation process. It is essential, therefore, that sufficient resources (personnel, time, transport and subsistence) are allocated to support it. The employing organisations must ensure that sufficient appraisers are in place to support the needs of their doctors. It is recommended that the ratio of appraisers to doctors should be 1:5 or greater[9].

21. The appraiser, who must have undergone appropriate training[10], should not normally be part of the Officers Joint Appraisal Report (OJAR) or Performance Appraisal Review (PAR) reporting chains.

22. The outcome of the appraisal will be used as the basis for ROs making their recommendations to the GMC about individual doctors[11]. It is therefore essential that the outcome of the appraisal is reported as directed in JSP 950 Lflt 10-2-1: Appraisal of Medical Officers and, for military personnel, DIN 2010DIN 01-184: Medical Personnel - Additional JPA Fields.

23. More information may be found in JSP 950 Lflt 10-2-1: Appraisal of Medical Officers and on the appraisal pages of the GMC website.

REVALIDATION PROCESS

Individual Doctors

24. All doctors must have a GMC Online account in order to manage their registration with the GMC.

25. Every doctor will need to connect to a RO who will make a recommendation to the GMC as to whether a doctor should be revalidated. An algorithm to assist in identifying the correct RO is at Annex A.

26. Individual doctors are responsible for maintaining a portfolio of supporting information to demonstrate the maintenance of their clinical and professional standards and, where applicable, their specialist skills. This provides a basis of evidence that ROs

[9] i.e no more than 5 doctors per appraiser.
[10] There is no requirement for an appraiser to be a doctor, but it is anticipated that most DMS appraisers will be doctors. All appraisers must have completed appropriate training in performing appraisals for the purposes of revalidation.
[11] The RO may also use other information as appropriate.

can use to help assess fitness to practise.

27. In order to have a revalidation recommendation made about them, doctors must:

a. Be participating in an annual appraisal process which has Good Medical Practice as its focus and which covers all aspects of their medical practise. The DMS policy on appraisal for doctors is contained in JSP 950 Lflt 10-2-1 which is being updated to reflect the requirements of revalidation.

b. Have demonstrated, through appraisal, that they have collected and reflected on the following information as outlined in the GMC publication Supporting Information For Appraisal and Revalidation:

i. Continuing professional development.
ii. Quality improvement activity.
iii. Significant events.
iv. Feedback from colleagues } i.e. multi-source
v. Feedback from patients (where applicable) } feedback
vi. Review of complaints and compliments.

28. The Medical Royal Colleges and Faculties have also produced advice about how to meet the requirements, in particular specialties or general practise. However, this is only guidance; it is the requirements mandated by the GMC that are statutory and which must be met.

Revalidation for Doctors in SHC

29. A large number of Armed Forces secondary care doctors work within NHS Trusts throughout the United Kingdom, either as part of a Ministry of Defence Hospital Unit (MDHU) or in isolated posts. Whilst they may be working within an NHS Trust they are deemed to be employed by the military and this may cause confusion regarding their correct designated body and RO affiliations. The Medical Profession (Responsible Officers) Regulations 2010 make special provision for the Armed Forces and direct that their designated body will be their respective Service with ROs allocated for the RN, Army and RAF and the Defence Postgraduate Medical Deanery (for military doctors under training). Whilst these doctors will continue to operate under local Trust arrangements for annual appraisal the record of completion of any appraisal will need to be forwarded to the respective military RO for the purposes of a revalidation.

Revalidation for Doctors in Medical Leadership and Management Posts

30. For an individual who currently holds a licence to practise and is on the GP register or a specialist register but who is not undertaking any clinical practice:

a. They appraise, and therefore revalidate, in the role which they are currently in.

b. As long as they revalidate successfully, they retain their licence to practise, even though there is no clinical component to their appraisal portfolio or revalidation.

c. As long as they revalidate successfully, they also remain on any specialist register which they are on, even though there is no clinical component to their appraisal portfolio or revalidation.

31. Therefore, an individual who has a licence to practise, is on a specialist register but does not do any clinical work will, as long as they revalidate successfully, retain both licence to practice and their listing on specialist register, regardless of how long it is since they have done any clinical work.

However, if they wish to return to clinical practise they will be required to undertake an appropriate return to practise programme[12].

32. The detailed guidance obtained from the GMC about revalidation for doctors in leadership and management posts can be found at Annex B. Additional guidance is being developed in partnership with the Faculty of Medical Leaders and Managers and will be promulgated in due course.

Revalidation for Trainees

33. Trainees, as registered and licensed doctors, will need an annual appraisal. This will take the form of the Annual Review of Competency Progression (ARCP). Mandatory evidence that is required for annual appraisal of all doctors needs to be submitted for the ARCP in order that the ARCP Panel may make a judgement based on the full evidence mandated for appraisal by the GMC. This will be in the form of the portfolio review, Form R. Exit Report and, where required, an Exception Report.

34. Additionally, the Educational Supervisor and Clinical Supervisors will make a statement in their reports detailing any concerns or investigations or the lack thereof.

35. For most trainees, this evidence will be submitted at the time of the annual progression from one training year to the next. For those who have a break in the training programme, for what ever reason (e.g., pregnancy, approved training experiences or career breaks) or who are extended in training, this information still needs to be submitted annually from the point of entering training and then annually from the point of re-engagement with the training programme. This may result in the need for 2 assessments in one year. On award of the final Certificate of Completion of Training, the trainee will be revalidated.

Revalidation for Reservists

36. Registered doctors who are members of the UK Military Reserve Organisations are deemed to work predominantly for their civilian employer and will therefore link to their employing Trust or Primary Care organisation for their Designated Body and RO affiliation. There is, however, a requirement for the DMS to support them in compiling evidence to support their appraisal in order to ensure that all aspects of their practise are covered.

37. It is, however, necessary to take into account the requirements of both appraisal and revalidation during the mobilisation process in order to ensure that these can continue to be met.

38. If the Revalidation Submission date for a Reservist falls within a period during which they are mobilised then there is an onus on the individual doctor to discuss with their RO how this is to be managed, noting the following:

a. The RO can make a recommendation about revalidation of an individual doctor at any point in the 4 months prior to the Revalidation Submission date.

b. The RO can make a request to the GMC to defer the Revalidation Submission date by up to 12 months in order to give time to gather more evidence on which to base their recommendation.

39. There is, therefore, a potential window of 16 months for revalidation which should permit management of revalidation for Reservists without requiring them to change their RO.

40. If any concerns about a Reservist are raised during the period during which they are mobilised then these must be appropriately addressed at the time they are identified and the RO of

[12] JSP 950 Leaflet 4-1-4: Returning to Clinical Practice

their parent sS informed. The sS RO must notify the RO of the individual's DB of any concerns about their practice.

Revalidation for Locums

41. The RO for a locum will normally be the Locum Agency for which they work[13]. There is, however, a requirement for the DMS to support them in compiling evidence to support their appraisal in order to ensure that all aspects of their practise are covered and a responsibility to notify the locum's RO of any concerns about their practise.

Management Of Conflict Of Interest/Appearance Of Bias (CIAB)

42. This may occur between an individual doctor and their RO where:

a. A personal relationship exists between the RO and the doctor (e.g. familial, intimate).

b. A financial or business relationship exists between the RO and the doctor (e.g. co-investors).

c. There is third party involvement in a personal relationship (e.g. affair, relationship breakdown).

d. There is known and long-standing animosity between the RO and the doctor.

e. There is a role conflict (e.g. doctor is part of RO's OJAR reporting chain).

43. Each of the DBs within the MoD is to appoint a senior neutral person (e.g. healthcare governance lead) to whom doctors and the RO can raise these concerns if they occur. If all 3 parties agree that there is a CIAB issue then this should be discussed with the Level 2 RO[14].

a. If the Level 2 RO agrees that there is a CIAB issue, then a second RO should be appointed. For all doctors apart from trainees, this will normally be the Defence Post-Graduate Medical Dean. For the trainees, this will normally be the RO for their parent sS. A formal communication[15] should be made by the DB to the second level RO setting out:

i. The grounds for CIAB.

ii. The alternative arrangements proposed.

The Level 2 RO will formally confirm their agreement.

b. If agreement is not reached with the Level 2 RO, the neutral representative is to write formally to the first level RO, setting out the case for CIAB; the RO should respond formally. This decision is final. The Level 2 RO will be responsible for keeping a record of all decisions.

c. If the doctor, first level RO and neutral representative cannot reach agreement, the doctor or first level RO may approach the second level RO independently to discuss the issues. The second level RO will take a view after discussion with the other parties concerned and then the process in either (a) or (b) above should be followed.

44. If a second RO is appointed, the individual doctor's DB does not change. It is the responsibility of the DB to confirm in writing the responsibilities of the various parties in the new arrangement, including the sharing of information with the second RO. The doctor is responsible for informing their DB when they have been revalidated or if there are any issues that will delay their

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[13] As per Schedule Part 2 Para 20 of The Regulations.

[14] The Level 2 ROs for the MoD/DMS DBs are the NHS (South) and NHS (Midlands and East) Level 2 ROs.

[15] See Annex C for suggested template.

revalidation. The doctor's appraiser has a responsibility to inform both ROs if there is any cause for concern or if a patient safety issue is identified.

Scheduling of Doctors for Revalidation

45. The GMC will normally allocate a revalidation date for doctors at a date 5 years from when they achieve full registration with a licence to practise. The date allocated is the latest date at which the RO can make a recommendation about the doctor. The recommendation can be submitted at any time within the preceding 4 months without reference to the GMC.

46. Doctors in training will have their revalidation date set for five years after the issue of their licence to practise or to coincide with the issuing of their Certificate of Completion of Training, whichever comes sooner.

47. If it is predicted that there will be difficulties making the revalidation date that has been set by the GMC this should, in the first instance, be discussed between the doctor, the appraiser and the RO. There is flexibility within the system for deferring revalidation for up to 12 months, e.g. where the RO requires more evidence to be provided to support their recommendation to the GMC. This must be agreed with the GMC and HQ SG (SO1 Medical Policy)[16] notified.

First Cycle of Revalidation

48. In order to meet the GMC's requirements for revalidation in the first cycle (i.e. Year 1: 01 April 2013 – 31 Mar 2014) doctors must fulfil the following criteria:

a. Be participating in an annual appraisal process which has Good Medical Practice as its focus and which covers all aspects of their practise.

b. Have completed at least one appraisal which has Good Medical Practice as its focus and which has been signed off by both the doctor and their appraiser. This must include appropriate multi-source feedback[17].

c. Have demonstrated, through appraisal, that they have collected and reflected on the information outlined in the GMC publication Supporting Information for Appraisal and Revalidation.

49. More information can be found in Meeting the Requirements for Revalidation in the First Cycle.

OUTCOME OF REVALIDATION

Recommendation for Revalidation Made

50. If the RO makes a recommendation that a doctor should be revalidated and this is accepted by the GMC, the GMC will notify both doctor and RO of this decision and set the doctor's next revalidation submission date (usually 5 years).

51. A recommendation for revalidation from an RO may be rejected by the GMC e.g. if it is made too early. These are returned to the RO, who may seek further guidance from the GMC.

52. If a recommendation is made for a doctor who is undergoing fitness to practise review, then the GMC will conduct a manual review of the recommendation once the review is completed.

[16] This will transfer to the HQ SG Revalidation and Appraisal Support Manager in due course.
[17] The exact nature of this will be determined by the doctor's role.

Deferral Request Made

53. If the RO makes a deferral request and this is accepted by the GMC, a new revalidation submission date will be notified by the GMC to the doctor and their RO. If the request is rejected by the GMC then the original revalidation date must be adhered to.

54. If a deferral request is made for a doctor who is undergoing a fitness to practise investigation, then the doctor's revalidation will be put on hold until the investigation is complete.

Notification of Non-Engagement

55. The RO should only be making a notification of non-engagement following discussion with the doctor, their appraiser and the appropriate GMC Employer Liaison Adviser.

56. Depending on the situation, the GMC may reject the notification, issue a warning letter to the doctor, change their submission date or accept the notification, in which case withdrawal of licence action will be instigated.

Withdrawal of Licence to Practice

57. A doctor can only lose their licence to practice as a result of positive action taken by the GMC i.e. licences do not lapse accidentally.

58. In the case of a doctor missing their submission date or having a notification of non-engagement made about them, the GMC will attempt to get in touch with them (28 day notification of intention to take action to withdraw licence). If the doctor does not respond within 28 days the GMC will issue a notification of withdrawal of licence; if the doctor does not appeal within 28 days of this notification being issued, their licence to practise will be withdrawn[18].

59. If the doctor responds to the GMC's notifications or makes an appeal against the withdrawal of their licence to practice then action to withdraw their licence is halted until the situation is resolved.

60. Once a doctor has had their Licence to Practise withdrawn, their name will also be taken off the GP or Specialist Register and they will not be able to take any of the activities legally restricted to doctors who are licensed[19]. They will therefore not be able to undertake any medical practise which involves any of these activities. The RO will need to ensure that the employer of any doctor who loses their Licence to Practise is made aware that this has happened as the continued employment of that doctor will need to be reviewed. They are also to ensure that HQ SG (SO1 Medical Policy)[20] is notified of any cases where a doctor is having or has had their Licence to Practise withdrawn at the time this occurs.

TIMETABLE FOR INTRODUCTION OF REVALIDATION

61. It is expected that the legislation underpinning the introduction of revalidation will come into force in December 2012.

62. Revalidation will then be introduced as a rolling process, starting in April 2013. The vast majority of doctors should have had a revalidation recommendation made about them by 31 March 2016, although the first 5 year cycle will not be complete until 31 March 2018. A timetable for the introduction of revalidation is at Annex D.

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[18] Under GMC Licence to Practice Regulations Section 5.14.

[19] These include but are not limited to prescribing and signing death and cremation certificates. They will still be registered with the GMC, entitled to call themselves 'Doctor' and may perform acts that are not legally dependent upon their status with the GMC, such as signing passport photographs.

[20] This will transfer to the HQ SG Revalidation and Appraisal Support Manager in due course

63. The GMC will give doctors and their ROs a minimum of 3 months notice as to when their revalidation submission is due. This is the latest date on which the RO can submit their recommendation as to whether a doctor should be revalidated; a submission may be made up to 4 months prior to this date.

REPORTING REQUIREMENTS

64. ROs are to submit an Annual Report on Revalidation and Appraisal to HQ SG (Head Medical Strategy and Policy), using the template at Annex E. These reports are to cover the period 01 Apr – 31 Mar and are to be submitted not later than 31 May.

QUALITY ASSURANCE AND GOVERNANCE OF REVALIDATION

65. Under The Medical Profession (Responsible Officer) Regulations 2010 , ROs are accountable for ensuring that the systems for appraisal, clinical governance and for gathering and retaining other local relevant supporting information are in place and are effective. They are responsible for ensuring that systems are in place to record and collate all the necessary information, including a record of any practise undertaken by the doctor outside of the organisation[21].

IMPLEMENTATION

66. Unless cancelled or otherwise revised, this leaflet will automatically be reviewed after three years. SG will make this policy leaflet publicly available in accordance with the legislation concerning freedom of information. However, this policy leaflet is not to be published on the Internet without the express permission of the author. Where elements of this leaflet become further incorporated into single Service policies and procedures that might affect individuals from minority groups, action addressees are to ensure that the information is made available in a culturally appropriate manner - this includes providing translation where required. In accordance with the Public Sector Equality Duty and the Equality Act 2010, an Equality Analysis has been undertaken in the formulation of this Policy and no detrimental impact is anticipated.

POINT OF CONTACT

67. The point of contact is HQ SG - SO1 Medical Policy.

ANNEXES

A. Revalidation: A Guide to Identifying Your Responsible Officer.

B. Revalidation for Armed Forces Doctors Employed in Non-Clinical Posts.

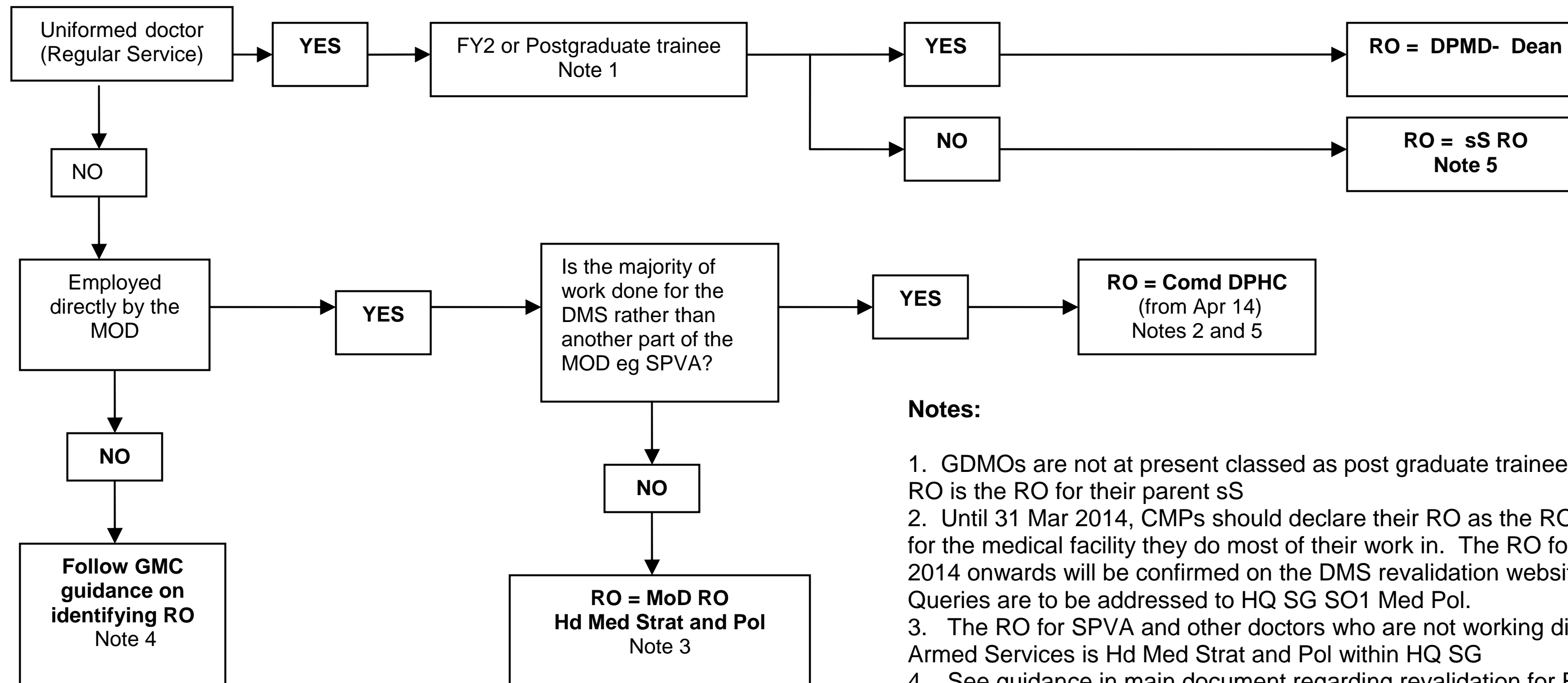
C. Request to Second Level RO for a Second RO to be Appointed due to CIAB.

D. Timetable for Introduction of Revalidation.

E. Annual Report on Revalidation and Appraisal.

[21] Additional guidance is being developed by HQ SG IG and will be included in the review of JSP 950 Lflt 10-2-1

REVALIDATION: A GUIDE TO IDENTIFYING YOUR RESPONSIBLE OFFICER (RO)



Notes:

1. GDMOs are not at present classed as post graduate trainees; at present their RO is the RO for their parent sS
2. Until 31 Mar 2014, CMPs should declare their RO as the RO of the lead Service for the medical facility they do most of their work in. The RO for CMPs from Apr 2014 onwards will be confirmed on the DMS revalidation website by Apr 2013. Queries are to be addressed to HQ SG SO1 Med Pol.
3. The RO for SPVA and other doctors who are not working directly for one of the Armed Services is Hd Med Strat and Pol within HQ SG
4. See guidance in main document regarding revalidation for Reservists.
5. Confirmation as to the arrangements for doctors in NI who are required to be on a Performers' List will be promulgated separately.
6. ROs are listed by appointment in this Policy although on the GMC online website these are listed by name. Names are provided on the DMS Revalidation webpage; as individuals move from these appointments each doctor for whom they are responsible is automatically assigned to the new post holder as RO.

REVALIDATION FOR ARMED FORCES DOCTORS EMPLOYED IN NON-CLINICAL POSTS

1. Specific guidance has been sought from the GMC regarding how revalidation will work for doctors who are employed in wholly non-clinical roles. The GMC response is as follows:

> *All licensed doctors will basically revalidate in the same way - there isn't a specific or separate route to revalidation for medical managers. Whatever the nature or extent of a doctor's professional activities, they will collect supporting information about all their work and bring this information to an annual appraisal. It is on this basis that a recommendation will be made, normally once every five years, about the doctor's revalidation.*
>
> *The GMC is not prescribing specific arrangements for appraisal, as doctors' work and circumstances vary widely. Our only stipulations are that appraisal should conform to our guidance and have Good Medical Practice as its focus. In this connection, I would refer you to our 'Framework for revalidation and appraisal', which can be found at the following webpage:*
>
> *http://www.gmc-uk.org/doctors/revalidation/revalidation_gmp_framework.asp*
>
> *Our guidance is not meant to be overly prescriptive - it will be necessary for doctors to discuss with their appraiser/Responsible Officer how the guidance can be best applied to their situation. This will include deciding exactly what supporting information and appraisal procedures are suitable, taking into account the doctor's work and role.*
>
> *I want to emphasise that revalidation will based on the work a doctor is doing from day to day. This applies equally to doctors whose names are on the GP and Specialist Registers, whether or not they continue to be engaged in those practice areas. As long as they revalidate successfully on the basis of their day to day work, these doctors will not only retain their licence to practise but will also keep their entry in the GP/Specialist Register. It was originally envisaged that revalidation would include an additional component called 'recertification', requiring doctors on those registers to demonstrate that they had kept up to date with their knowledge and skills in the relevant areas. But the revalidation model was subsequently streamlined to focus on doctors' actual practice. This was partly because it was recognised that many doctors move into different and varied areas of practice during the course of their careers (including, of course, medical management).*

2. This can be summarised as follows:

For an individual who currently holds a license to practice and is on the GP register or a specialist register but who is not undertaking any clinical practice:

a. They appraise, and therefore revalidate, in the role which they are currently in.
b. As long as they revalidate successfully, they retain their license to practice, even though there is no clinical component to their appraisal portfolio or revalidation.
c. As long as they revalidate successfully, they also remain on any specialist register which they are on, even though there is no clinical component to their appraisal portfolio or revalidation.

3. So, an individual who has a licence to practise, is on a specialist register but does not do any clinical work will, as long as they revalidate successfully, retain both licence to practice and listing on specialist register, regardless of how long it is since they have done any clinical work.

REQUEST TO SECOND LEVEL RO FOR A SECOND RO TO BE APPOINTED DUE TO CIAB

Name, Organisation and Contact Details of Individual Making Request	
Date Request Submitted	
Name and Contact Details of RO	
Name and Contact Details of Doctor Requiring 2nd RO	
Reason For Requesting 2nd RO	
Proposed Arrangements for 2nd RO	
Decision of 1st RO Level RO with Reason, Signature and Date.	
Confirmation That All Involved Parties Informed (with date)	
Signature of Doctor Requiring 2nd RO and date.	

TIMETABLE FOR INTRODUCTION OF REVALIDATION

DOCTORS WITH A LICENCE TO PRACTICE AS A T DECEMBER 2012

GMC ALLOCATES REVALIDATION SUBMISSION DATES TO DOCTORS
All doctors to have a date issued by end of 2013
Statutory 3 months notice of revalidation submission date

GROUP	WINDOW WITHIN WHICH REVALIDATION SUBMISSION DATE WILL BE ALLOCATED					
Responsible Officers	Q4 12/13					
Doctor Cohort 1 **Doctors who meet readiness criteria now or will during 13/14**	20% and trainees →	Q1 13/14 Q2 13/14 Q3 13/14 Q4 13/14				
Doctor Cohort 2	40% and trainees →	→	YR 14/15			
Doctor Cohort 3	40% and trainees →	→	→	YR 15/16		
Any remaining doctors	Trainees and deferrals →	→	→	→	YR 16/17	
Any remaining doctors	Trainees and deferrals →	→	→	→	→	YR 17/18

ANNEX E TO
JSP 950 Lflt 10-2-2
Dated Oct 12

ANNUAL REPORT ON REVALIDATION AND APPRAISAL			
Period covered by report			
Designated Body and Name(s) of RO(s)			
Name and contact details of individual by whom report compiled			
NUMBERS OF DOCTORS	**PHC**	**SHC**	**OTHER(1)**
Number of doctors with whom there is a prescribed connection at the end of the Reporting Period (31 Mar)			
ANNUAL PROFESSIONAL APPRAISALS			
Number of doctors who are recorded as having completed annual professional appraisal during the reporting period (2)			

REVALIDATION RECOMMENDATIONS	**Recommended to Revalidate**			**Deferral Requested (3)**			**Notice of non-engagement (4)**		
	PHC	SHC	Other	PHC	SHC	Other	PHC	SHC	Other
Number of doctors for whom revalidation submission date has been during this reporting period									
Number of doctors for whom revalidation submissions have been made during the reporting period.(5)									
How many of those for whom a recommendation to revalidate has been made have been revalidated by the GMC? (6)									

DEFERRALS	**PHC**		**SHC**		**OTHER**	
	Military	Civilian	Military	Civilian	Military	Civilian
For those for whom deferral has been requested, how many are predicted to gain a recommendation to revalidate after additional action/remediation?						
For those for whom deferral has been requested, how many are predicted to be unlikely to gain a recommendation to revalidate after additional action/remediation?						

WITHDRAWAL OF LICENCE TO PRACTICE	**PHC**		**SHC**		**OTHER**	
	Military	Civilian	Military	Civilian	Military	Civilian
How many doctors have had, or are in the process of having, their Licence to Practice withdrawn (7)						

NOTES		
1.	List those positions included under ‘other’	
2	List reasons for completion of annual appraisal not being recorded and number of doctors to whom each reason applies	
3.	List reasons for requesting deferral and number of doctors to whom each reason applies	
4.	For each doctor for whom a notification of non-engagement has been made, give outline of action taken to rectify non-engagement, any additional information relating to the decision to make non-engagement notification and specialty of doctor concerned	
5.	Give reasons for any cases where a revalidation submission has been due but has not been made, including remedial action	
6.	For each doctor for whom a recommendation to revalidate has been rejected by the GMC, give the reasons for the rejection and details of remedial action	
7.	For each doctor who has had their licence to practise withdrawn, give outline of subsequent action taken.	
ADDITIONAL COMMENTS		