Name of Document	**Revalidation**
Category	Standard Operating Procedure (SOP) - Trainee Management
Purpose	This document is one of a suite of Standard Operations Procedures to support the management of doctors in training across England. This SOP is aligned to the principles of 'A Reference Guide for Postgraduate Specialty Training in the UK' (The Gold Guide). This SOP does not apply to Foundation and Dentistry trainees who are managed under separate Guides ('The Foundation Programme Reference Guide' and 'A Guide to Postgraduate Dental Specialty Training in the UK'). Within the SOP, whenever reference is made to the Postgraduate Dean, it refers to the Dean / Responsible Officer or their nominated representative who will be responsible for managing the process on their behalf. This SOP is intended to be a guide to encourage consistency of practice across England. Due to the complex nature of Postgraduate Medical Training, there will be occasions where local PG Deans will apply their discretion in enacting this SOP to take account of individual circumstances and varying local structures (e.g. Lead Employer). This suite of SOPs will be screened against relevant Equality and Diversity documentation.
Authorised by	Health Education England Deans (HEEDs)
Date Authorised	27/06/2017
Next Review Date	SOP to be reviewed in line with any future Gold Guide revisions, or every 12 months, whichever comes first
Document Author	HEEDs

Version	**Date**	**Author**	**Notes** Reason for Change, what has changed, etc
1	27/06/2017	HEED	Document signed off at HEED

Related Documents

Gold Guide Version 6 https://www.copmed.org.uk/publications/the-gold-guide

Standard Operating Procedure – ARCP
Standard Operating Procedure - OOP

https://healtheducationengland-my.sharepoint.com/personal/kate_evans_hee_nhs_uk/_layouts/15/guestaccess.aspx?folderid=1b9902b00f7bf44e59842fcb28c1ef8ea&authkey=AU58_M0I3fn0qrhKz8ykeQk

Introduction

Revalidation is the General Medical Council's (GMC) way of regulating licensed doctors that will give extra confidence to patients that their doctors are up to date and fit to practise. Revalidation is the process by which all licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practise in their chosen field and continues to meet the professional standards set by the GMC and the specialist standards set by the medical Royal Colleges and Faculties. Licensed doctors have to revalidate usually every five years, by having annual appraisal based on the core guidance for doctors, Good Medical Practice.

This document aims to provide an overarching SOP for HEE.

The GMC has stated that the ARCP process, in combination with evidence obtained from clinical governance systems, is the mechanism by which doctors in training will revalidate. Therefore, the annual ARCP is considered as the appraisal for the purposes of trainee revalidation. The majority of this information is already included in the training curricula which are approved by the GMC. Where this may not be the case, for example patient feedback, there is no requirement to obtain this at this stage. The HEE ARCP SOP should therefore be used.

The responsibility for ensuring that a doctor engages with the statutory processes for revalidation in order to continue to hold their licence to practise sits with the doctor themselves, whatever the career grade or stage.

Where information is required from local education providers' (LEPs) clinical governance systems, i.e. involvement in significant events and complaints/compliments received, the Conference of Postgraduate Medical Deans of the United Kingdom (COPMeD) Revalidation Steering Group have worked with the Revalidation Support Team, GMC and Department of Health to develop a streamlined, proportionate and pragmatic approach to capture this information in a confidential manner. As such, wherever possible existing documentation has been adapted.

1. Documentation considered as part of annual appraisal and revalidation:

- Clinical/Educational Supervisor report - *Clinical/Educational Supervisor completes*
- Form R Part B-*Trainee completes***
- ARCP outcome form - *ARCP panel chair completes*
- Information from 'live flow' logs where available

** Every doctor is responsible for ensuring that they are appraised annually on their full scope of practice. For trainees it is their personal responsibility to complete the Form R Part B to the best of their ability, capturing the necessary information to cover their full scope of practice since their last appraisal / ARCP, within the timeframe given - failure to do so may necessitate notification to the GMC by the RO of the trainee's failure to engage in the revalidation process. An ARCP outcome 5 is to be awarded for either the non-return of, or the late submission outside of the two week deadline of the Form R Part B before the ARCP panel. It is important that the declaration on the Form R Part B includes involvement in any complaints/investigations in any organisation with which the trainee has undertaken a role as a licenced doctor (voluntary or paid) in the previous year and a contact name/address in the event that the Responsible Officer needs to seek further information.

The Revalidation process for trainees is aimed at ensuring that employers, LEPs, and educational/clinical supervisors have a process to share information when needed, so that trainees can be best supported in their revalidation process. However, to be effective this information must be discussed with the individual or with clinical/educational supervisor(s) at review meetings, with reflection undertaken as required.

2. Legal Responsibilities

i. The Medical Profession (Responsible Officers) Regulations 2010 created a new statutory role in UK healthcare; the Responsible Officer (RO). The main duties of the RO are;

- To make recommendations to the GMC via GMC Connect as to whether a doctor should be revalidated (this relates to doctors with a prescribed connection to the designated body).
- To ensure that the Designated Body's systems of clinical governance and appraisal are sufficiently robust to support revalidation.
- Every Postgraduate Dean, as the RO (Responsible Officer) is therefore required to put into place systems to support revalidation, and has a duty, under the statutory instrument, to ensure that these systems are sufficiently robust.

ii. It is essential that throughout the education and employment process there is clear, concise documentation to support decisions made and actions taken.

iii. The RO should be made aware of all investigations carried out by the employer.

iv. The following steps describe what will enable the Responsible Officer and Designated Body to meet the statutory requirements:

- To ensure that the Designated Body carries out regular ARCPs on medical practitioners,
- Management of investigated incidents and concerns
- The Postgraduate Dean's Revalidation Team will maintain a confidential database of involvement in investigated incidents/complaints.
- All incidents will be notified to the Revalidation Team by local education providers, copied to the trainee (where this is not possible the Postgraduate Dean should be alerted by the LEP and will attempt to contact the trainee on behalf of the LEP).
- For serious untoward incidents that are deemed to have patient safety issues or risk to the trainee these must be reported to the Responsible Officer immediately.

v. It is the Postgraduate Dean's responsibility to ensure that there is educational support provided to any trainee facing an investigation. Support should also be provided by the employer as appropriate.

vi. The Revalidation Team will maintain confidential records relating to potential fitness to practice concerns to facilitate the revalidation process across the 5 year cycle, including; trainee involvement in complaints/significant incidents and records of investigations. This information will be held on a restricted access secure database which is securely protected.

vii. The Revalidation Team will answer all queries generated from the GMC using the revalidation database as source data.

viii. All concerns regarding the meaning of fitness to practise should be assessed against the GMC's meaning of fitness to practise.

3. Out of Programme (OOP) and statutory leave and revalidation

SOPs should be referred to with respect to the management of OOP. For doctors in training who are absent due to sickness or maternity or who temporarily leave the training programme for an approved research or training post, the revalidation date and prescribed connection will remain the same. To enable the Responsible Officer to make a recommendation, to ensure consistency across the programme, the following submission will be required;

- The OOP annual return form. This will include a Clinical/Educational supervisor declaration indicating whether the supervisor is aware of trainee involvement in any conduct, capability,

or serious untoward incidents/significant event investigation or named in any complaint and whether this has been resolved satisfactorily with no unresolved concerns about a trainee's fitness to practice or conduct.

- The trainee must complete an annual Form R Part B including a self-declaration of any significant events, compliments or complaints arising from any work across their full scope of practise.
- There is no absolute GMC requirement for doctors undertaking OOP out with the UK to maintain a license to practice. In terms of revalidation the RO will upon granting approval for OOP agree that the relevant Designated Body will remain the prescribed link for revalidation, however the above documentation must be received.
- Reference should be made to the RO protocol for managing OOP deferrals.

4. Revalidation Standard Operating Procedures

4.1. Responsibilities of the Postgraduate Dean's Revalidation Team

4.1.1. GMC Connect responsibilities:

a. Ensure all trainees provide their most recent ARCP / appraisal outcome information or an equivalent self-declaration statement to enable the RO to be sighted on any unresolved concerns.
b. Monitor and update Connected Doctors list on GMC Connect on a regular basis with removal of leavers and addition of new starters
c. Ensure all trainees approaching CCT are on the 'Under Notice' list on GMC Connect
d. Delegated authority for processing revalidation submissions and adherence the COPMeD deferral policy.
e. The RO / PGD should be informed of any trainees who has an ongoing unresolved concern that calls into question their fitness to practise identified at ARCP (whether they have received a satisfactory or unsatisfactory ARCP outcome),
f. Removing trainees from GMC Connect after award of ARCP outcome 4 –the Revalidation Team and RO to address where the individual is at present in the revalidation cycle and if they are due for revalidation (i.e. in the 4 month period of notice from the GMC) - if it is felt we can make a revalidation recommendation then the trainee's revalidation recommendation would be processed prior to disconnection from GMC Connect. The trainee is to be told they will be disconnected and advised of the need to establish a link to a new RO depending on what they did next.

4.1.2. Management of Live Flow notifications:

a. The Revalidation Team will log all received Incident notification forms. The forms will be shared with the RO and recorded on the revalidation database as appropriate. For serious untoward incidents that are deemed to have patient safety issues or risk to the trainee, these must be reported to the RO immediately. Please see the COPMeD guidance for managing a cause for concern.

4.1.3. Providing information to ARCP panels:

a. Only open incidents or those closed within the last ARCP cycle should be fed in.
b. Following the ARCP panel, if there has been a revalidation concern noted by the panel, this should be discussed with the RO and logged accordingly.
c. If no Form R Part B has been received in advance of the ARCP panel, the ARCP admin team should provide guidance in terms of whether there are any concerns with respect to the trainee. Please see COPMeD agreed actions on incomplete or missing Form R Part B.

4.1.4. Management of incidents on revalidation database:

a. Revalidation team to meet with the RO on a regular basis to review significant incidents and complaints.
b. Revalidation team to regularly review all open incident cases.

4.1.5. Sharing of investigation information with Postgraduate Schools and Employer:

a. The fact that a trainee is undergoing an investigation will be shared with clinician overseeing the relevant programme e.g. relevant Head of school/ senior manager to enable the provision of educational support. If not already known, all cases will also be shared as soon as possible after receipt, with the employer to enable employment support to be provided to the trainee, if necessary. This is particularly important for areas where there is a LET arrangement.

4.1.6. Quality management / audit of revalidation processes:

a. The Revalidation Team will conduct quality management and self-audit activities to assess the functioning of key processes relating to revalidation on a regular basis. Areas to be addressed will include the following:

- Revalidation information presented to ARCP panels
- Statistics of trainees declaring incidents
- Statistics of trainees declaring full scope of practice
- Completion of Form R Part Bs
- Any instances of when an ARCP did not take place
- Participation of any HEE national work as required

b. The Revalidation Team will contribute to HEE's national Quality Assurance Report and Annual Revalidation Reports.

4.1.7. Responding to GMC queries:

a. The Revalidation Team will log the GMC letter and create a new record on the revalidation database.
b. An information request will be sent to the relevant Postgraduate School and the incidents database will be checked for any previously reported information relating to the individual.
c. Once the response is received from the School, the Revalidation Team will write a response letter (from the RO) and send this to the GMC.
d. For GMC information requests pertaining to Trainers/TPDs, the request for further information will be issued to the relevant School who will then approach the appropriate contact (HoS or TPD – to maintain confidentiality). Information will be requested in relation to their educational role only.

4.1.8. GMC restrictions/conditions/suspensions against practice:

a. Upon receipt of the GMC circular advising that a medical practitioner is subject to conditions imposed or undertakings, the Revalidation Team will check whether this contains trainee names linked to the RO, update the revalidation database with any relevant information and then send this to the related postgraduate school and employer as necessary.

4.1.9. Revalidation pre-employment checks:

a. When a request is received for a revalidation reference i.e. the last ARCP outcome, the request should be referred to the trainee to provide the necessary information.
b. If additional information needs to be shared relating to fitness to practice, then an RO to RO communication (conversation or written) should be set up with the trainee's new RO.

4.1.10. Fitness to Practice referrals to the GMC:

a. All trainee fitness to practice referrals should be sent from the RO to the GMC.

4.1.10 Making a revalidation recommendation for a doctor in postgraduate training

a) When a doctor in postgraduate training is due a revalidation recommendation their PGD should base their decision on the most recent ARCP / appraisal, any current governance information they hold about that trainee in relation to any unresolved fitness to practise concerns and, when it is more than 15 months since the last ARCP, a statement of good standing covering full scope of practice from the trainee.
b) Wherever possible the RO should ensure that they have the necessary governance information available to enable a recommendation to revalidate.
c) A decision to recommend deferral of revalidation on grounds of insufficient information when there is no ARCP / appraisal / self-declaration providing the necessary full scope of practice information the period of deferral should normally be limited to 2 months after it is anticipated that the information will be available.
d) When the decision to defer is based simply on a change of CCT date and otherwise all the necessary governance information is in place, the deferral should only happen if the anticipated CCT date is within 12 months of the current revalidation date and it is less than 5 years since the issue / re-affirmation of the doctor's licence to practise i.e. a revalidation recommendation. The deferral period should be to align with the anticipated CCT date.
e) When the decision is to defer because the trainee is part of an on-going process that calls into question their fitness to practise, the RO should ensure that the trainee has access to any necessary support and remediation, consider seeking the advice and support of their GMC ELA, satisfy themselves that there are no risks to patient safety and consider in parallel any action necessary in relation to the trainee's NTN and training progression. The period of deferral should be in accordance with the anticipated resolution date for the process(es) underway.

4.2 Responsibilities of the Postgraduate Dean's ARCP Admin Team

a. To forward ARCP documentation to the trainee, minimum of 6 weeks prior to panel, including the Form R Part B (this is to be completed as a minimum annually, and should be issued every time an outcome is awarded – with the exception of an outcome 5 follow up ARCP).
b. Include statement to trainee advising it is their individual responsibility to ensure this is returned a minimum of 2 weeks prior to panel, failure to do so may mean award of outcome 5 at ARCP, revalidation non-engagement notification forwarded to GMC and failure to revalidate.
c. Chase Form R Part B. If this has not been received post-panel, a review of the portfolio/ARCP outcome form should be arranged to determine whether there are any overall causes for concern. Advise the RO if there is a concern, Revalidation team will then discuss with RO and share with the employer if appropriate.
d. Check if there are unresolved investigated incidents/complaints declared. If so, forward copy of Form R Part B to the RO or nominated deputy for cross-referencing against revalidation database.
e. Obtain from Revalidation details of any known incidents for each trainee at panel
f. Following ARCP, if the ARCP panel chair has indicated there is cause for concern/unresolved investigation or complaints, share a copy of outcome form to Revalidation Team.
g. If additional employment declared within full scope of practice, forward copy of Form R Part B to Revalidation Team who will share a copy of it with the relevant School and Employer.
h. Trainee CCT date changes – PGMDE admin to share with the Revalidation team when a CCT date has been changed.

4.3. Responsibilities of the Trainee Doctor

a. Trainee must ensure they are connected to the correct Designated Body for revalidation on the GMC Connect website for the duration of their training.
b. Provide their most recent ARCP appraisal information when they commence their programme supported by a self-declaration of no on-going concerns if necessary eg more than 15 months since their last ARCP / appraisal.
c. Engage in ARCP process.
d. ARCP admin will send Form R Part B to trainee a minimum of 6 weeks before ARCP panel sits, with checklist of required documentation.
e. Trainee completes the Form R Part B across their full scope of practice in accordance with COPMeD guidance to the best of their knowledge and discusses involvement in investigated incidents/complaints with the Educational Supervisor regarding full scope of practice.
f. Trainee MUST return the Form R Part B a minimum of 2 weeks prior to ARCP panel. Failure to do so may necessitate notification to the GMC by the RO of the failure to engage

4.4 Responsibilities of the Clinical/Educational Supervisor

a. Refer to LEP and local policy and procedures for clinical/educational supervision
b. Discuss educational progress with trainee.
c. Ask trainee if they are aware if they have been involved in any investigated incidents, or have been subject to complaint (s) in full scope of practice.
d. Ask trainee if they are being adequately supported during any investigation.
e. Document discussion.
f. Complete revalidation question on clinical/educational supervisor report.

4.5. Responsibilities of the Local Education Provider (LEP)

a. Advise Revalidation team of trainee involvement in investigated significant incidents/concerns using the Incident Notification Form via the Live Flow reporting process.
b. Advise the Revalidation team of the outcome of any investigation(s).

4.6. Responsibilities of the ARCP Panel

a. Review Form R Part B.
b. Review Clinical/Educational Supervisor report and ePortfolio as appropriate.
c. Review information submitted from the Revalidation team.
d. Panels should address any serious incidents/complaints/investigations and cross-check with trainees' self-declarations on Form R Part B to see if the trainee has declared. The ARCP Panel and relevant School should then pursue any discrepancies with the trainee where required and highlight to the Revalidation Team if relevant.
e. ARCP panel then should note on the ARCP outcome form if there is a discrepancy between incidents declared by the trainee and those reported by the Revalidation team and state if there are any outstanding concerns.
f. The ARCP outcome form should then be sent to the Revalidation team (via ARCP admin) if the panel note any unresolved concerns.