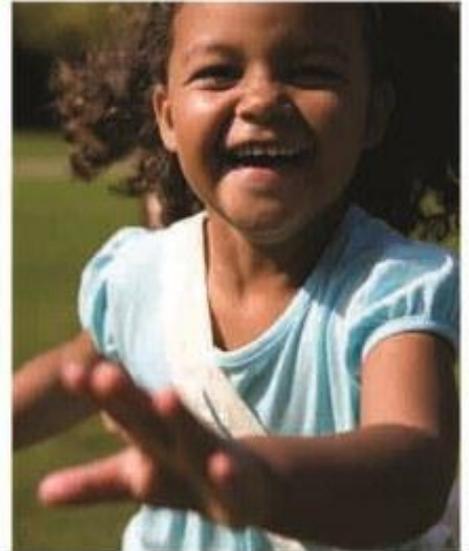


FAQs regarding Medical Revalidation



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FAQs regarding medical revalidation

NHS England frequently asked questions (FAQs) regarding the implementation of the responsible officer regulations including the revalidation of doctors.

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No.	Item Change	Detail of Change
4.1	What is revalidation?	New FAQ
4.2	How will I revalidate?	New FAQ
4.3	When will I revalidate?	New FAQ
4.4	What is my designated body?	New FAQ
4.5	What is a responsible officer?	New FAQ
4.6	Will I need to revalidate?	New FAQ
4.7	I work wholly outside the UK. How will I revalidate?	New FAQ
4.8	I hold a licence but I don't do any clinical practice. How will I revalidate?	New FAQ
4.9	I do not have a prescribed connection to a designated body	New FAQ
4.10	Do I need a specific number of hours or credits to meet the GMC's requirements for revalidation?	New FAQ
4.11	I'm a locum using my own 'umbrella' company. Is my prescribed connection to the organisation that contracts my services through my company?	New FAQ
5.10	When is patient feedback acceptable? And if not acceptable how long should I defer for?	New FAQ
5.11	How do doctors who work in roles where direct patient feedback is impossible, i.e. ICU doctors, forensic pathologists, doctors in managerial only roles, gain their individual doctor/patient feedback from?	New FAQ

5.13	What are the definitions of a completed, incomplete and missed appraisal?	New FAQ
6.2	What are the funding arrangements for remediation?	Updated answer provided
7.2	Where can I find further guidance as to whether my organisation is a designated body?	Updated answer provided
7.5	What should I do if I believe there to be a conflict of interest or appearance of bias between a responsible officer and a doctor with whom they have a prescribed connection?	Updated answer provided
7.6	Can a responsible officer confirm a doctors' GMC registered address to validate that their prescribed connections are correct?	New FAQ
8.1	How will responsible officers (ROs) make decisions on language competency?	Updated answer provided

Prepared by jfisher4@nhs.net

For generic questions on revalidation, please visit:

<http://www.revalidationsupport.nhs.uk/faqs.php> and

http://www.gmc-uk.org/doctors/revalidation/faq_revalidation.asp

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2. General

2.1. Who is the NHS England corporate point of contact for revalidation?

Dr Mike Bewick (Deputy Medical Director, NHS England) is the lead for revalidation in NHS England. The generic contact of the NHS England revalidation programme management office is nhs.cb.revalidation@nhs.net.

A list of NHS England Responsible Officers is also provided on the [NHS England revalidation web-page](#).

A governance chart is provided on the [NHS England revalidation web-page](#)¹

- Following a successful health gateway review®, the role of senior responsible owner for revalidation, passed from the Department of Health to NHS England in October 2013. This means that NHS England will chair the England Revalidation Implementation Board (ERIB) to oversee the implementation and standardisation of revalidation across circa 160,000 doctors and c700 designated bodies in England.
- The responsibilities of the Revalidation Support Team (RST) will be transferred from RST to NHS England throughout 2013/14 and before April 2014. This means that the RST will not exist in 2014/15 and that NHS England will take over their responsibilities in providing support and guidance to all ROs in England.
- From 1 April 2013, NHS England are also responsible as a designated body under the Responsible Officer regulations.

2.2. Does revalidation cover just fitness to practise or does it also include fitness for purpose?

The GMC defines Revalidation as “the process by which licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practise” as doctors. Fitness for purpose describes what employers/commissioners require from the doctors working in a particular post. It is likely to include requirements over and above the requirements to remain a licensed doctor eg experience in a particular area.

2.3. How do I access RO, Case investigator and appraiser training?

Contact [your RO](#) or their team.

¹ <http://www.england.nhs.uk/ourwork/qual-clin-lead/revalidation/>

3. Funding

3.1. What is the £750k of funding to be used for and how is it split?

A budget of £750k has been allocated within running costs for the national and regional posts to support revalidation. These funds should be considered as recurring and positions should be substantively appointed to.

£150k of this is for the National Programme Management Office (PMO) roles:

- Clinical Revalidation Lead – 1x 0.5 whole time equivalent
- Revalidation Project Manager – 1x band 8a
- Revalidation Project Support Officer – 1x band 6

The remaining £600k is allocated evenly to each of the four regions for the regional revalidation team roles:

- Clinical Lead – x1 per region
- Project Manager – 1x band 8a per region
- Administrative Support – 1x band 6 per region

3.2. What is the £1.6m of funding to be used for and how is it split?

£1.6m has been agreed from the direct commissioning budgets to fund revalidation supporting activities including:

- RO networks - calibration, QA and training
- Appraiser networks – calibration, QA and training
- Case investigator networks – calibration, QA and training
- Development of single operating model for responding to concerns
- Development of single operating model for remediation
- National co-ordination and sharing of best practice

£540k of this is allocated to the National Programme Management Office (PMO) for the national support and events with the remaining £1,072k being allocated equally to the regions.

3.3. What happened to the £40/head top slice for regional appraisal support costs referred to Mike Bewick's letter dated 21 February 2013?

This was rescinded in Paul Watson's correspondence to regional finance directors dated 17 March 2013. The funding has subsequently been replaced by the £1.6m detailed above.

4. Doctors

4.1. What is revalidation?

Answer available at http://www.gmc-uk.org/doctors/revalidation/faq_revalidation.asp

4.2. How will I revalidate?

Answer available at http://www.gmc-uk.org/doctors/revalidation/faq_revalidation.asp

4.3. When will I revalidate?

Answer available at http://www.gmc-uk.org/doctors/revalidation/faq_revalidation.asp

4.4. What is my designated body?

Answer available at http://www.gmc-uk.org/doctors/revalidation/faq_revalidation.asp

4.5. What is a responsible officer?

Answer available at http://www.gmc-uk.org/doctors/revalidation/faq_revalidation.asp

4.6. Will I need to revalidate?

Answer available at http://www.gmc-uk.org/doctors/revalidation/faq_revalidation.asp

4.7. I work wholly outside the UK. How will I revalidate?

Answer available at http://www.gmc-uk.org/doctors/revalidation/faq_revalidation.asp

4.8. I hold a licence but I don't do any clinical practice. How will I revalidate?

Answer available at http://www.gmc-uk.org/doctors/revalidation/faq_revalidation.asp

4.9. I do not have a prescribed connection to a designated body

Answer available at http://www.gmc-uk.org/doctors/revalidation/faq_revalidation.asp

4.10. Do I need a specific number of hours or credits to meet the GMC's requirements for revalidation?

Answer available at http://www.gmc-uk.org/doctors/revalidation/faq_revalidation.asp

4.11. I'm a locum using my own 'umbrella' company. Is my prescribed connection to the organisation that contracts my services through my company?

Answer available at http://www.gmc-uk.org/doctors/revalidation/faq_revalidation.asp

5. Appraisers and Appraisals

5.1. What are the funding arrangements for appraisals?

Funding for appraisal and its support was confirmed in [Ian Dalton's letter](#) to Regional Directors and Area Team Directors, dated 7 February 2013, which instructed that existing 2012/13 PCT contracts with local appraisers may be carried over into 2013/14 and that provisions be made within direct commissioning budgets for paying appraisers in 2013/14.

Regions and area teams are responsible to make arrangements such that sufficient resources are available to carry out their responsible officer requirements, including appraisals, in accordance with The Medical Profession (Responsible Officers) (amendment) Regulations, 2013 (RO regulations)².

5.2. Will the engagement arrangements for appraisers change?

A Contract for Medical Appraisers is available for use for those who do not have satisfactory terms and conditions at present. This interim contract will operate up until 31 March 2014. Those with existing and satisfactory arrangements in place should continue with these until further notice.

All government organisations are being expected to hold contracts with a recognised body such as a GP practice, limited company or limited liability partnership, and not with individuals. This has obvious implications for a significant number of appraisers and discussions are therefore underway with commercial colleagues to find a solution that is suitable for appraisers whilst consistent with policy elsewhere in NHS England.

5.3. What are the remuneration arrangements for appraisers?

Information indicated that this varied considerably prior to April 2013, with payments ranging from around £200 to £900 per appraisal, with the bulk of appraisers being paid between £400 and £600. After wide-ranging discussion, including with the BMA, and taking into account the tasks involved in appraisal, the money allocated by NHS England to supporting appraisal, and the need for consistency and fairness, NHS England has set a rate of £500 per appraisal. This rate includes normal appraiser expenses and the requirements for on-going training and supervision of the appraiser. We intend that this rate of payment will be applied throughout NHS England no later than 1 April 2014. Area teams should move towards it by agreement with their appraisers as soon as possible. For details of superannuation payments, where these are payable, please see 4.4.

Whilst in exceptional cases, area teams will have discretion to reimburse travel expenses and time when these are particularly expensive or long, excessive travel should be

² <http://www.legislation.gov.uk/uksi/2013/391/contents/made> and <http://www.legislation.gov.uk/uksi/2010/2841/contents/made>

avoided where possible. Some area teams are successfully minimising excessive travel through means such as agreeing for meetings to take place on NHS estate midway between both parties' base locations, encouraging doctors to travel to the appraiser and occasionally the use of video conferencing.

5.4. What are the superannuation arrangements for appraisers and how should these be managed?

The options are as follows:

1. **Appraisers who are GP partners** (or single-handers) in a practice may be engaged as independent contractors and may opt to have their payment paid through their practice gross of superannuation, rather than through the 'SOLO form' route. The payment, including the 14% employers contributions component, may then either be distributed among the partners of the practice, or re-allocated to the individual appraiser, depending on the partnership agreement. The actual 14% employer contribution element is non-superannuable and is forwarded by the practice to NHS Pensions via the local area team. There does not need to be a service level agreement with the practice, though NHS England should bring to the attention of the practice their duties in relation to proper administration of the superannuation.
2. The above option is not available to a practice based salaried GP because they are not permitted to share in the income (i.e. profits) of a practice. **Appraisers who are salaried GPs** may be engaged as independent contractors and will have their payment paid directly to them as individuals. This method is also available to **appraisers who are partners in a practice who do not wish their payment paid through their practice**. They will then complete the SOLO process, whereby NHS England will retain both their "employer" and "employee" contributions, make payment to the appraiser net of these, and forward the employer and employee payments to NHS Pensions via the local area team.

NHS Pensions have confirmed that to avoid processing a SOLO form for each and every appraisal that is undertaken and appraisal payment that is made, NHS England may agree with the specific GP to pay the appraisal fees on a quarterly basis, in relation to all of the appraisals that are carried out during the relevant period. In this way the number of SOLO forms completed by both parties is reduced and can be batched. It will also ensure that NHS England complies with the requirement to pay the superannuation to NHS Pensions within the required time frame.

3. GPs who are classed as **locums** in NHS Pensions terms, doctors who have left the NHS Pension scheme and appraisers operating through a limited company, are not entitled to treat appraisal income as superannuable within the NHS Pension scheme. They will not therefore receive the 14% employers contribution (and by the

same token will not need to pass the employee contribution to NHS Pensions either).

5.5. Will NHS England pay costs of providing appraisals for all doctors with a prescribed connection to them?

The majority of doctors connected to NHS England will not have to pay for their appraisal. The responsible officer regulations state that a designated body can recharge locum doctors that have a connection to it for the work of the responsible officer (including appraisal). However, NHS England currently does not currently intend to charge for the provision of appraisal for locum general practitioners. NHS England reserves the right to revisit this position depending on individual circumstances, for example, where a locum with a prescribed connection to NHS England undertakes no clinical work within NHS England.

5.6. What is the remuneration for primary care locums?

Payments to primary care locums undergoing appraisal have previously been made in some areas. These facilitated the engagement of these doctors when appraisal was a new process. NHS England is committed to providing appraisal to all doctors with a prescribed connection free of charge. However it is NHS England's view that direct payment to any doctor undergoing appraisal can no longer be supported. It is now every doctors' professional responsibility to undergo appraisal as part of revalidation. In exceptional cases, Area Teams may support individual doctors where particular hardship is demonstrated.

5.7. How much of the appraisal policy do I need to implement?

All of it. NHS England Responsible Officers should move towards the published [medical appraisal policy](#)³ at the earliest opportunity and certainly no later than 1 April 2014.

5.8. Can a GP who is retired from clinical practice continue as an appraiser and if so do they still need to remain on the performers list?

The Performers List is a list of GPs that can provide NHS primary medical services. Appraisal is not a primary medical service. The designated body will need to ensure that appraisers are trained and have the appropriate skills.

5.9. What is the indemnity cover for appraisers?

Risk: It is important to note that the: General Medical Council (GMC) makes the decision to revalidate a doctor; the responsible officer (RO) makes the recommendation; and the

³ <http://www.england.nhs.uk/ourwork/qual-clin-lead/revalidation/>

appraiser carries out the appraisal. Thus in practice it is very unlikely that any criticism of a decision about revalidation (or not to revalidate) could be laid at the feet of an appraiser.

The Medical Defence Union (MDU), the Medical Protection Society (MPS) and the Medical and Dental Defence Union of Scotland (MDDUS) consider that the risk of appraisers being sued because of an appraisal they have conducted to be extremely low.

The greater risk is that if a doctor is disappointed with the outcome of his or her appraisal they may report the appraiser to the GMC. Whilst such cases are unlikely to have serious consequences for the appraiser they would, without doubt, be extremely stressful and the medical defence unions would wish to reassure their members that in such circumstances they should seek their support (see statements below).

Employer Liability: Conducting appraisals should be considered as part of an employee's professional duties (as are the functions of a responsible officer) and thus the members' employing body is vicariously liable for the acts and omissions to act of its employees. NHS organisations have cover for employed staff provided under the NHS Litigation Authority (NHS LA) arrangements or suitable alternative indemnity. Where NHS England contracts out appraisal to an independent contractor, that contractor will be liable in law, either directly as a contracted individual or vicariously as a contracted body undertaking the appraisal through its own employees.

Individual Liability: An appraiser's individual liability arrangements depend on whether they are formally employed in the role or whether they are engaged as independent contractors.

Appraisers who are employed: Should a claim be made against an individual employed by an NHS body (including NHS England), professional indemnity is provided through the NHS LA Liabilities to Third Parties Scheme (LTPS). If a doctor is not revalidated as a result of a recommendation by an employee of NHS England, then we may see the doctor bring a claim against the employee or NHS England directly on the grounds that the appraisal/recommendation was flawed in some way. In either event, LTPS would defend such claims.

Appraisers who are independently contracted: Independent contractors will need to make arrangements for indemnity for claims brought against them and it would be prudent for NHS England to require the contractor to be indemnified contractually, otherwise NHS England could be exposed in the event of a claim against an unindemnified appraiser (note: From October 2013, holding indemnity will be a requirement of registration). This indemnity could be provided by a medical defence organisation (MDO) or a professional indemnity insurer.

The Medical Defence Union (MDU) stated:

- The MDU considers that acting as an appraiser for other GPs is an accepted part of the work of many GP members and therefore GPs who require advice or assistance in respect of their undertaking this role (including an indemnity for negligence claims) can approach the MDU to seek our help in the usual way. There is no specific need for a GP acting as an appraiser (as a minority part of their role within their declared average number of weekly 'sessions') to contact us. We would not expect this small part of a GPs role to have any effect on a member's subscription.
- We understand that some GPs may be working only as appraisers and not providing any other clinical GP services. These GPs may have a licence to practise or they may have no licence but be registered with the GMC. Either way, we would expect GPs in this category to contact the MDU's membership department so that we can ensure they are paying the correct subscription for the work they are doing.
- We would not be in a position to offer the benefits of membership to a medical appraiser who is not on the GMC register as we only offer active membership to registered healthcare professionals.

The Medical Protection Society (MPS) stated:

- MPS considers that undertaking the role of an appraiser is a normal part of the duties of a general practitioner and provided the member is paying a GP subscription rate, no further subscription would be required. Where a GP appraiser is not paying a GP subscription rate for whatever reason, we would be grateful if they could contact our Membership Department to ensure that they are paying an appropriate rate for the work they are undertaking.

The Medical and Dental Defence Union of Scotland (MDDUS) stated:

- We would normally indemnify general practitioners for a wide range of clinical activity which is not directly related to their practice or registered list of patients and this includes work as an appraiser. However, where appraisal work is the only work carried out by a member, they should contact our Membership Department for advice.

5.10. When is patient feedback acceptable? And if not acceptable how long should I defer for?

The GMC have issued guidance on the requirements for patient and colleague feedback and doctors should view this before embarking on these exercises http://www.gmc-uk.org/doctors/revalidation/revalidation_information.asp The RST have also prepared a Briefing on Colleague and Patient Feedback which doctors may find useful <http://www.revalidation.support.nhs.uk/doctors/doctorscolleagueandpatientfeedback.php>.

It is for the RO to be satisfied that the doctor has provided sufficient supporting information to assure a recommendation about the doctor, so if in doubt, a doctor should speak to the RO or their team. In some places, there are agreed mechanisms that a doctor may use to be confident they are meeting the requirements.

On a practical note, doctors should be advised that the mechanics of many patient and colleague feedback surveys take some time to organise, and underestimation the time required is one of the most common reasons for a doctor's revalidation recommendation being deferred. Many doctors find that it is good to allow at least three months to set up, undertake, receive and reflect upon the results of patient and colleague feedback.

5.11. How do doctors who work in roles where direct patient feedback is impossible, i.e. ICU doctors, forensic pathologists, doctors in managerial only roles, gain their individual doctor/patient feedback from?

[GMC Supporting information for appraisal and revalidation, March 2012](#) states 'We recommend that you think broadly about who can give you this sort of feedback. For instance, you might want to collect views from people who are not conventional patients but have a similar role, like families and carers, students, or even suppliers or customers'.

5.12. What does "Agree" mean in output statement of MAG?

An appraiser should indicate "Agree" to an appraisal output statement if they agree with each of the components of that statement. For example, in the first statement they should select "Agree" if:

- An appraisal has taken place
- It reflects the whole of the doctor's scope of work
- It addresses the principles and values set out in Good Medical Practice.

Appraisers should note that ticking "Disagree" does not necessarily cause a problem in terms of the doctor's revalidation recommendation. In fact, there is a greater risk of creating a problem by ticking "Agree" when there is significant room for doubt. An appraiser ticking "Disagree" should indicate in writing which component of the statement they are concerned about and their reasons for this on the appraisal output documentation. They can also indicate what arrangements will be taken to correct the matter prior to the doctors next revalidation date.

The responsible officer can review the "Disagree" statement and the supporting comments and decide whether any additional steps are required to ensure that a positive recommendation can be made when the revalidation date becomes due.

5.13. What are the definitions of a completed, incomplete and missed appraisal?

The definitions from within the Medical Appraisal Policy are:-

Completed medical appraisal:

A completed annual medical appraisal is one where the appraisal meeting has taken place between 9 and 15 months of the date of the last appraisal and the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor within 28 days of the appraisal meeting.

Incomplete appraisal:

An incomplete appraisal is one where the appraisal discussion was not completed or where the personal development plan or appraisal summary have not been signed off within 28 days of the appraisal meeting.

Missed appraisal:

A missed appraisal is one which was due within the appraisal year but not performed or which was performed beyond the 15 month window for completed annual medical appraisal.

5.14. How are the information governance requirements met with regard to the examination of appraisal portfolios by the RO and their team?

When making their decision to recommend for revalidation the responsible officer will normally take into account the appraisal outputs, i.e. the summary of discussion, the new personal development plan, and the appraiser's statements. However, the responsible officer may view any relevant information to assure their recommendation about the doctor's fitness to practise. In the context of appraisal this may on occasion include the completed full appraisal documentation and the doctor's supporting information. It is also worth noting that this applies to all aspects of the doctor's scope of work. The responsible officer or their staff may also need to review appraisal portfolios when undertaking quality assurance processes around appraisal.

Access to appraisal information by administrative support staff and other members of the local revalidation team should be defined in a written local protocol with named personnel and criteria for access.

More guidance on this can be found in the NHS Revalidation Support Team document: Information management for medical revalidation in England, and in the NHS England Medical Appraisal Policy: Annex H Information Governance.

6. Responding to concerns including Remediation

6.1. What are the funding arrangements for responding to concerns?

Costs for case investigation and case management lie where they fall and should be assigned to direct commissioning budgets.

Work is underway to develop a model for the provision of professional support units (PSU) to provide access to an expert shared service to support designated bodies in responding to concerns concerning within their (medical) workforce. An update will be available in Summer 2013.

6.2. What are the funding arrangements for remediation?

Remediation is based upon the following non-negotiable principles arising from the professional, regulatory, contractual and legal obligations;

- i. the responsibility of the individual doctor, flowing from professional and regulatory requirements, to keep themselves up to date and fit to practise;
- ii the responsibility of the NHS provider to meet the quality and continuity aspects of their contract; and
- iii. the responsibility of the RO (in England) to fulfil their legal requirements around investigation, training and work experience where there are concerns about a doctor.

Should the remediation process require a doctor to be placed away from their place of work, the impact on smaller organisations could be significant. Work is therefore underway to agree a case for making transitional funding / loans, to support alignment to the above three principles whilst mitigating organisational risk. **Until this work is completed, costs should be agreed locally on a case by case basis and linked to the local business needs.**

Funding for individual practitioners should be exceptional and based on agreed clinical and service need. The following issues could be considered by area teams in considering suitability for funding. These are suggestions only and should not be considered as formal guidance at this stage until formal policy has been agreed:

- The practitioner should produce a business case detailing the financial impact on the practitioner and on service delivery to explain why the costs of the remedial package cannot be contained within their business or individually without impacting on patient care;
- The remedial package should be supported by an educational action plan with measurable outcomes, including timescales and addressing all areas of concern;
- The performance of the practitioner is likely to improve to an acceptable standard i.e. as part of the formal assessment process, and a clear decision has been made that there is capacity to benefit from a planned remediation package;

- A signed learning agreement must be in place;
- Occupational health assessments would be supported but health care should be provided through NHS commissioned routes.

As a guiding principle and based on historical practice and the consensus of current practice in area teams, it is suggested that a split funding arrangement between the area team and the individual has been the norm.

It is therefore suggested based on this historical practice that areas teams may pay up to 50% of costs up to maximum of £10,000, but that the individual practitioner should pay the first 50% and the total should include all on costs. Salaries, income or drawings will not be paid. Funding would apply to costs arising from conditions or outcome of formal assessment.

In this context, formal assessment is defined as: A formal, structured and methodologically sound process conducted to assess performance across a practitioner's scope of practice, taking into account the concerns raised in order to identify development needs.

7. Prescribed Connections, Designated Bodies, Responsible Officers and Suitable Persons

7.1. When is an organisation a 'Designated Body'?

Some organisations are automatically designated, these are listed in the Schedule Part 1 of the responsible officer regulations⁴. Other organisations (the types are listed in the Schedule Part 2⁵ are designated bodies when they have a prescribed connection with at least one doctor usually through employment or one of a variety of contract arrangements.

7.2. Where can I find further guidance as to whether my organisation is a designated body?

Organisations that believe they may be a designated body (DB) should read the RO regulations⁶ and associated Department of Health guidance⁷ for further information. Contact should also be made with regional revalidation teams to discuss in further detail.

If the DB status remains unknown, legal advice should be requested to identify the applicable clause in the regulations which deems them to be designated.

Once the status as a DB has been confirmed, the board of the DB should formally appoint their RO and inform the applicable higher level RO.

7.3. How do I declare my organisation as a 'Designated Body'?

Contact should be made directly with your regional revalidation team within NHS England – contacts for revalidation leads can be found on the [NHS England revalidation web-page](#) alongside RO contacts. Regional teams can assist in informing the GMC and ensuring your organisation and responsible officer have access to appropriate support and guidance via relevant networks.

⁴ <http://www.legislation.gov.uk/ukxi/2010/2841/schedule/made> and <http://www.legislation.gov.uk/ukxi/2013/391/regulation/5/made>

⁵ <http://www.legislation.gov.uk/ukxi/2010/2841/schedule/made> and <http://www.legislation.gov.uk/ukxi/2013/391/regulation/6/made>

⁶ <http://www.legislation.gov.uk/ukxi/2013/391/contents/made>

⁷ <https://www.gov.uk/government/publications/closing-the-gap-in-medical-regulation-responsible-officer-guidance>

7.4. What should I do if the organisation I think I am connected to does not appoint a responsible officer?

In the first instance you need to confirm that your organisation is designated in the Responsible Officer Regulations. This is best done by asking it. It may have legal advice it is not designated or does not need to appoint a responsible officer. If you still think it is covered by the Regulations you should contact the NHS England region team where the organisation is based providing them with as much information about why the Regulations apply to your organisation.

7.5. What should I do if I believe there to be a conflict of interest or appearance of bias between a responsible officer and a doctor with whom they have a prescribed connection

The responsible officer regulations require each designated body to appoint one responsible officer (except for NHS England which may appoint several). However, where a conflict of interest or appearance of bias exists between the responsible officer and one of the doctors, an alternative responsible officer must be nominated or appointed.

In deciding whether to appoint an alternative responsible officer, designated bodies will need to demonstrate that:

- they have complied with the responsible officer regulations
- doctors have been treated fairly and equitably.

For more information please see the briefing document at http://www.revalidationsupport.nhs.uk/doctors/doctors_conflict_of_interest_or_appearance_of_bias.php.

7.6. Can a responsible officer confirm a doctors' GMC registered address to validate that their prescribed connections are correct?"

Yes, further information can be found within the GMC' s privacy policy which can be found at http://www.gmc-uk.org/privacy_policy.asp#1.

7.7. I can't find my prescribed connection – can I use the 'Suitable Person's' route?

There is a clear set of rules that determines which designated body doctors are connected to. For most doctors, this is quite straightforward because their organisation will be the one in which they spend most or all of their practice. For example, if a doctor is employed wholly by one NHS hospital, their designated body is that organisation.

For some doctors the designated body they are connected to will depend on:

- the number of organisations that they practise in and where they spend most of their practice
- the basis on which they are employed, such as whether they are employed, hold practising privileges or have another type of contract.

They should speak to their employer, if they have one, if they are unsure about their employment status.

The [GMC's online designated body tool](#) can help doctors find the type of organisation that is their designated body. After using the online tool, doctors may find it helpful to check the [GMC's A-Z list of designated bodies](#).

Most doctors have a designated body but some don't.

The [GMC has a supplementary online tool](#) that provides information and advice to doctors who don't have a connection to a designated body. For some doctors the GMC's advice may recommend that they identify a 'suitable person'. This will allow some doctors who do not currently have a connection to engage in local systems and revalidate. The GMC's website has more information for doctors about [how to identify a 'suitable person'](#).

If, after using [the GMC's online designated body tool](#) a doctor believes they don't have a designated body, they should tell the GMC using their GMC Online account.

7.8. I've been asked to be a 'suitable person' – what is this and should I accept

Most licensed doctors have a designated body. However, under the responsible officer regulations which cover the whole of the UK, some doctors do not have a connection.

The GMC can recognise 'suitable persons' to make recommendations about doctors who do not have a responsible officer. This will allow some doctors who do not have a connection to a designated body to engage in local systems and revalidate. The GMC's website has more information about the role of the ['suitable person'](#).

The GMC needs to approve anyone acting as a suitable person, whether or not they are an existing responsible officer. This means that anyone who wants to make revalidation recommendations about doctors who do not have a connection to a designated body must make an application to the GMC. The GMC's website has more information about [applying to be recognised as a suitable person](#).

If no prescribed connection exists, NHS England encourages doctors to obtain one by joining a suitable locum agency, or a designated Faculty⁸, or the Independent Doctors Federation. NHS England Employees thinking of becoming a suitable person should

⁸ Faculty of Pharmaceutical Medicine, Faculty of Occupational Medicine, Faculty of Public Health, Faculty of Homeopathy, Faculty of Medical Leadership & Management, British College of Aesthetic Medicine

discuss the issues with their responsible officer and ensure that they have appropriate indemnity or insurance. NHS England insurance covers employees in their work for NHS England. The suitable person role is not part of their NHS England duties.

7.9. How are zero hours and honorary contracts treated for determining a prescribed connection?

Zero hours and honorary contracts should be considered as any other contract of employment. If the zero hours or honorary contract is the only employment contract, and there is no prior connection, the connection should be to the designated body issuing the contract. If there is more than one employment contract the prescribed connection is to the designated body for which the doctor does the majority of their clinical work (or if they are the same then it is the body closest to the doctor's address registered with the GMC).

8. Language Checks

8.1. How will responsible officers (ROs) make decisions on language competency?

This will be up to individual ROs to determine. In essence, the RO will need to be assured that suitable checks are taking place during the recruitment / contracting process to ensure that English language communication skills are appropriately assessed (in accordance with the responsible officer regulations⁹).

These responsibilities are augmented by the GMC's ability to check the language skills of doctors as part of the licensing process. The GMC currently checks the language skills of doctors who qualified outside of the European Economic Area when they apply for GMC registration, and refuse to grant registration if the doctor cannot communicate in English to a safe level.

From Summer 2014, subject to Parliamentary approval, the GMC will be able to check the English language skills of EEA doctors when concerns about their language capability arise during the registration process. Those who are unable to provide evidence of the necessary knowledge of English may be refused a licence to practise in the UK.

Acceptable Standards:

The GMC accepts a range of evidence from International Medical Graduates (IMGs). Further information can be found on the GMC website: http://www.gmc-uk.org/doctors/registration_applications/language_proficiency.asp

8.2. Do responsible officers have the autonomy to accept other language tests?

Further to the [GMC English language requirements](#), employers should be prepared to accept a range of evidence and tests. For example, the applicant may be a fluent English speaker because they have lived, worked and/or studied in an English-speaking environment. Employers must not systematically test all EEA applicants. For example, making all applicants sit the same test, even though they may be able to demonstrate their competence in other ways, is not permitted.

8.3. How will responsible officers evaluate the level and relevance of English language qualifications awarded in other EU countries?

Decisions by the employer about what evidence it requires to be satisfied about the applicant's English language knowledge must be made on a case by case basis and be proportionate, depending on the work the individual is going to undertake.

8.4. What will happen with doctors already practising in this country if there is concern regarding their level of English - how are ROs expected to respond to this or even judge if there is a concern?

This will be an issue that may come to light through various means including the annual appraisal process where evidence covering the whole scope of a doctor's work is reviewed e.g. feedback from patients and colleagues; complaint letters or involvement in serious untoward incidents which could indicate a communication issue.

Concerns should be identified and any shortfalls rectified in accordance with the policy and procedures for managing concerns about primary care practitioner performance (<http://www.england.nhs.uk/ourwork/qual-clin-lead/revalidation/>). Where a doctor's language competency / communication skills either fail to improve through training or are considered to be a barrier to their fitness to practise, this should be addressed through normal GMC fitness to practise channels.