

Revalidation

Licence and revalidation

Revalidation concerns the continuing licence to practise. It is connected to annual appraisal, but the two should never be treated as names for the same event. The doctor gathers information and engages in professional review. The appraiser conducts and records the annual discussion. The responsible officer, or an approved suitable person where applicable, considers the wider evidence and makes a recommendation. The GMC makes the decision. Understanding that chain removes much of the mystery surrounding the process and helps the doctor direct a question to the person who can answer it.

The usual pattern is a recommendation around every five years, informed by annual whole-practice appraisal and governance information. The actual submission date is the one notified by the GMC; it can change. Revalidation demonstrates continued fitness for licensed practice rather than awarding an employment grade, specialist registration or competence in a newly proposed procedure. A favourable decision therefore does not establish that a doctor meets every requirement of a Specialist vacancy. Those decisions require the relevant capability and appointment evidence described later in this handbook. ^[66]

Begin with the licence because career changes can alter the assumptions underneath it. A doctor may move from a full clinical post to a mixture of teaching, leadership and occasional clinical work. The smaller clinical component does not make professional obligations disappear. Conversely, someone who stops work requiring a UK licence may consider retaining registration without the licence, with appropriate advice about the activities still intended. The choice should follow a description of the future work. It should not be made simply because a revalidation date has become inconvenient.

A useful personal record contains the GMC number, current registration and licence status, recognised connection, submission date and the contact responsible for local revalidation administration. This need not be a complex spreadsheet. Its purpose is to ensure that an employer change, inaccessible email account or misunderstood date does not become a professional problem through administrative neglect. Check that GMC communications reach an address you monitor independently of a single

temporary workplace. Record any confirmed change rather than relying on a conversation remembered differently months later.

The process is sometimes described as a final portfolio inspection. That image is misleading because it encourages the doctor to concentrate all effort near the submission date. Reliable assurance develops through ordinary professional systems: appropriate review of work, timely handling of concerns, annual discussion and follow-through on learning. If those systems reveal a difficulty, action belongs at the time it arises. Revalidation is not designed to store concerns for a five-year reckoning. A doctor who understands this can distribute preparation sensibly and seek help while there is time to resolve a gap.

Nor is revalidation a universal examination of everything a doctor could ever be asked to do. The declared scope matters. If the role expands, the doctor and organisation need suitable development, support and assurance for that expansion. An existing licence remains necessary but does not replace local credentialling, supervision or assessment where these are required. Michael's successful revalidation, for example, would not authorise a clinical activity he has not maintained. The organisation still needs to understand the proposed work and the evidence relevant to it.

This chapter follows the process from connection to decision, including what happens when circumstances disrupt the expected sequence. Its aim is practical confidence, not a guarantee of an outcome. The reader should be able to explain who makes the recommendation, what information is still needed and which next action lies within their control. When a formal notice or disputed decision appears, that same organised account will help a defence organisation, representative or legal adviser provide focused advice instead of first reconstructing an uncertain history.

Use the same terminology when discussing progress with colleagues. Saying that the appraisal is complete, the recommendation is pending or the GMC decision has arrived conveys a specific stage. Saying simply that revalidation is 'sorted' may conceal an important outstanding step.

Designated body and prescribed connection

A designated body is an organisation identified within the responsible-officer framework. Its responsible officer has defined duties relating to the doctors connected to it. The prescribed connection follows the applicable regulations; it is not an arrangement chosen for convenience. The GMC protocol makes clear that doctors cannot select whichever responsible officer they prefer and responsible officers cannot simply decline a connection established by the rules. Northern Ireland has its own

responsible-officer regulations, alongside the framework applying in England, Scotland and Wales. ^[67]

For many SAS doctors, the substantive employer provides an obvious starting point. It should still be confirmed rather than inferred from a job title. Multiple employers, agency work, changing contracts, practice outside the NHS or a period between posts can make the answer less straightforward. The GMC's online connection tool asks about the doctor's circumstances and directs the user towards the relevant route. Work through the actual questions with current information; an answer based on the previous year's main job may no longer fit. ^[9]

Do not replace the tool or regulations with a rough rule such as 'whichever employer pays most'. Some employment relationships have particular significance in the connection hierarchy, and the relevant facts may include the type of organisation and the contractual relationship. The safe practical approach is to assemble those facts, use the official route and obtain clarification where the result is unclear. This is not excessive bureaucracy. Choosing the wrong connection can leave the right organisation unaware of its responsibility while the doctor assumes that arrangements are already in place.

Aisha, the composite Specialty Doctor, provides a simple example. She starts a substantive NHS appointment and is told at induction that the medical director is the responsible officer. She still needs to confirm the designated body recorded in GMC Online, register with the appropriate appraisal arrangements and identify the local contact. These are related but separate actions. Having a portfolio login does not prove that the connection has been recorded. Receiving an appraisal date does not prove that the responsible officer has information about work she undertook before joining.

Michael's mixed career creates a different question. He has a main NHS appointment and external professional roles. Whole-practice appraisal requires information about all relevant roles, but that does not ordinarily mean appointing a separate responsible officer for each. The connected responsible officer needs a sufficiently complete view, including information from other organisations. Michael should therefore identify external governance contacts and explain his scope to the appraisal and revalidation team. Multiple sources of evidence are compatible with a single prescribed connection; the evidence should follow the work rather than multiply recommendations.

If no designated-body connection can be identified, do not assume that revalidation is optional or that a personally selected senior colleague can

simply sign it off. The GMC provides routes involving an approved suitable person and arrangements for doctors without either a responsible officer or suitable person. Doctors in the latter position have additional direct requirements, including an annual return and, when requested, a revalidation assessment. The current annual-return form is a distinct GMC process, not the same as an employer appraisal declaration. Obtain specific instructions from the GMC before committing to a privately supplied appraisal package.

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A connection problem should be described in a short factual enquiry. List the organisations, contractual relationships, dates, current medical activities and the result of using the connection tool. Ask who will confirm the prescribed connection and what should happen while clarification is pending. Avoid sending a large unstructured portfolio when the missing information is contractual. Keep the response with the personal revalidation record and update GMC Online as instructed. If employment changes before the issue is resolved, tell the contact rather than allowing the original enquiry to proceed on outdated facts.

Relationships also matter. A conflict involving the responsible officer may require formal arrangements, but it does not give the doctor a general right to move the connection elsewhere. Raise the specific concern through the designated body's process and seek independent advice if necessary. A disagreement about a management decision, an appraisal summary or a whistleblowing issue needs accurate description. The remedy depends on the nature of the conflict and the applicable framework. A new connection should never be treated as a way to leave relevant governance information behind.

The reader's connection finder is therefore a sequence of evidence-based questions. What licensed work am I doing? Which organisations employ or contract with me? What does the official connection route indicate? Does GMC Online show the confirmed position? Who arranges appraisal and receives whole-practice information? What must change when the work changes? Once those questions are answered, the doctor can concentrate on the substance of revalidation rather than repeatedly trying to solve uncertainty through informal reassurance.

Keep the confirmation date beside the answer, so that later changes trigger review rather than unnoticed drift.

Information used for recommendation

The responsible officer's recommendation draws on more than the doctor's preferred account of the year. The GMC requires consideration of appraisal

participation, supporting information and reflection across the whole practice, and relevant clinical and corporate governance information. Applicable conditions or undertakings and relevant local processes also matter. A recommendation to revalidate means that the responsible officer can make the required declaration on the available information; the appraiser does not make that declaration merely by completing an annual summary. ^[69]

This wider view explains why a completed appraisal may be followed by a request for further information. The request does not necessarily imply that the appraisal was defective or the doctor is under suspicion. A role may not yet have a governance statement, a previous organisation may not have transferred records, or the responsible officer may need confirmation of an action discussed in the summary. Ask what question the requested item answers. A precise response is more useful than resending every attachment from the appraisal portfolio.

Keep the history intelligible. Record appraisal dates, periods covered, final outputs and any approved interruptions. Note when formal patient and colleague feedback were collected and discussed, and identify the relevant quality improvement activity. These are not boxes to complete in isolation: Chapter 10 explains the learning each category should support. The revalidation overview simply enables the responsible-officer team and doctor to see where the cycle's information sits. It should point to the source records without copying confidential content into a second uncontrolled archive.

Governance information needs context. A complaint that was investigated and resolved should not be described as an unresolved allegation. Equally, a doctor's personal belief that a complaint is unfounded does not establish its formal outcome. Where there is an ongoing process, identify who owns it, what stage it has reached and when information is expected. A neutral chronology helps the responsible officer understand the position without being asked to decide disputed facts from a selective narrative. The doctor can still challenge an error through the proper route.

Consider Michael's external teaching role. His appraisal reflection may explain what he changed in response to participant feedback, while the host organisation separately confirms whether it holds relevant governance concerns. Those records do different work. The positive evaluation cannot substitute for the governance statement, and a statement that there are no recorded concerns cannot demonstrate educational improvement. Together they provide a more complete picture. The same principle applies to

occasional private work, honorary activity and professional roles undertaken for another employer.

Evidence quality is often improved by identifying its owner. An appraisal summary is an agreed record of a discussion; a feedback report comes from a particular collection method; an employer statement has a defined period and scope. Label these accurately. If a document is provisional, say so. If the doctor has written a personal explanation, do not present it as an independent finding. This discipline is especially valuable when several organisations use different terminology for similar records. Clear provenance reduces the risk that an impressive-looking document is asked to answer a question it cannot answer.

The practical readiness review therefore asks whether the information is complete enough, coherent and available to the right person. Does it cover all relevant roles? Are important dates consistent? Are unfinished actions visible? Has reflection been discussed rather than merely uploaded? Are organisational delays being managed? The doctor need not reproduce the responsible officer's evaluation, but should know where a gap exists. Early identification turns an apparently last-minute regulatory problem into a defined administrative or professional task with an owner and a realistic timetable.

If a requested record seems disproportionate or confidential material is involved, ask for the purpose, minimum necessary content and approved transfer route. Seek advice where appropriate. Cooperation does not require indiscriminate disclosure, and a concern about disclosure should be explained promptly rather than expressed through silence. The aim is to provide information that can legitimately support the decision while preserving accuracy, confidentiality and a clear record of how the request was addressed.

When the item is supplied, ask whether it resolves the stated gap. This closes the communication loop and prevents both parties assuming that the other has identified a further problem. Record any remaining question separately with its owner.

Revalidate defer and non engagement

The GMC protocol identifies three recommendation types: revalidate, defer and non-engagement. The distinction is substantive. A recommendation to revalidate states that the relevant requirements are met on the information available. Deferral concerns an engaged doctor for whom additional time or information is reasonably needed. Non-engagement concerns failure to participate sufficiently without a reasonable explanation after appropriate

opportunities and processes. None should be translated casually into 'pass', 'fail' and 'warning'. Those labels obscure who makes the decision and what the doctor needs to do next. ^[70]

Where the recommendation is to revalidate, the doctor should retain the resulting GMC communication and note the next notified date. A favourable appraisal summary or an administrator's expectation is not the final GMC decision. Continue ordinary professional maintenance while the process completes. There is no need to manufacture additional evidence simply because the date is approaching, but any material change or request should be addressed. Once the decision arrives, update the personal record and continue the annual routine rather than treating revalidation as permission to stop collecting information until the next cycle.

Deferral changes the submission date; it is not a sanction or a finding of impaired fitness to practise, and does not itself affect the licence. ^[66] The GMC permits it for an engaged doctor when information is incomplete or a relevant local governance process needs to conclude. Reasonable circumstances include parental leave, sickness, a break in practice or delayed records. Not every break requires deferral if sufficient information exists. The responsible officer must identify what is needed and a realistic plan. Recommendations can be submitted in the 120 days before the submission date, for a proposed period of 120 to 365 days. ^[71]

The useful response to proposed deferral is therefore a set of practical questions. What precise information is missing? Why is it necessary? Who can provide it? What must the doctor do, and by when? Which part depends on an organisation? How will progress be reviewed? A vague assurance that there will be 'more time' is insufficient. The revised timetable should lead to an informed recommendation. Deferral should not leave the doctor guessing whether to repeat an appraisal, collect another survey or wait for an investigation that someone else controls.

Suppose Aisha's previous employer has not transferred a required governance record. She has completed appraisal, engaged with requests and provided the information she holds. A plan might identify the transferring office, the request already made, the expected response and a review date. This is quite different from Aisha declining to disclose a role or repeatedly ignoring requests. The missing document looks similar on a checklist, but the circumstances and response are different. A sound process examines that difference rather than treating every absence as non-compliance.

Non-engagement can put the licence at risk. The GMC criteria require insufficient participation despite support and opportunity, no reasonable grounds or appropriate deferral basis, and exhaustion of reasonable local

attempts to resolve matters. A recommendation starts a regulatory process rather than removing the licence immediately. The current protocol gives the doctor 28 days to respond to the GMC's risk notification; a subsequent withdrawal decision carries a 28-day appeal period. A timely appeal prevents removal until the appeal outcome. The actual notice and qualified advice should govern the response, because deadlines are consequential. ^[72]

If such a notice arrives, act immediately. Preserve the letter, establish the response deadline and contact the defence organisation or appropriate adviser. Assemble a chronology of invitations, responses, technical failures, health-related communications, agreed adjustments and material already submitted. Distinguish a reasonable explanation from a general expression of distress. If the doctor can now provide missing information, say what it is and when it will be supplied. Challenging an inaccurate allegation of non-engagement and engaging with the outstanding process can proceed together.

Silence is particularly damaging because it prevents the relevant people from understanding circumstances that may be reasonable. A doctor overwhelmed by illness or an employment dispute may need help with communication; that need should be raised through an appropriate representative or support route. Conversely, repeated promises without action may not resolve the problem. The plan needs a credible next step and a date. Do not assume that an appeal against an unrelated employment decision suspends revalidation obligations or changes the GMC deadline unless the GMC confirms the position.

Repeated deferral also needs careful handling. It is not an unlimited holding arrangement. If the agreed information remains unavailable, the reason and revised proposal need early discussion with the responsible-officer team. A doctor should show the actions taken and identify what remains outside personal control. Further deferral requires exceptional circumstances and early discussion between the responsible officer and GMC employer liaison adviser. An unresolved organisational delay, a new exceptional circumstance and continued failure to engage are different situations. None can be inferred reliably from elapsed time alone. ^[71]

Whatever the proposed recommendation, ask for an intelligible explanation and retain the final communication. The most useful personal summary states the current position, the decision-maker, the outstanding action and the next date. That short record is more protective than a comforting label. It allows the doctor to tell an employer or adviser accurately what has happened, without describing deferral as disciplinary

failure or treating an initial recommendation as a decision already made by the regulator.

A doctor concerned about the reputational meaning of deferral can ask how it will be recorded locally and who needs to know. The explanation should match the actual reason. An administrative information delay should not be described through language suggesting a finding about clinical performance that nobody has made.

Career breaks health absence and missing appraisal

An interrupted working year does not fit neatly into a routine annual timetable. The GMC's overarching supporting-information guidance explicitly recognises clear and reasonable circumstances preventing annual appraisal. These should be discussed and agreed with the responsible officer or suitable person. Approved missed appraisals do not have to be retrospectively caught up, and five completed appraisals are not an invariable prerequisite for revalidation. The question is whether the available whole-practice information and engagement support the recommendation, not whether every calendar year contains an identical administrative event. ^[58]

Consider a separate composite doctor, Nadia, a Specialty Doctor in Wales returning after parental leave. Her submission date falls several months after return, and her appraisal history includes an approved interruption. She worries that she must arrange two appraisals quickly to replace the missed year. Her first task is to obtain the written record of the approved absence and discuss readiness with the revalidation team. The appropriate outcome depends on the information already available and what remains needed. It cannot be determined by adding the number of meetings alone.

Nadia prepares a chronology of work, leave and return. It identifies the last appraisal, the period covered, earlier feedback and quality improvement, and the date on which her current responsibilities resumed. She also records any change in scope or support on return. This allows a focused conversation. Does existing feedback remain appropriate within the cycle? Is there sufficient current information? Does a particular category need further work? If additional time is justified, the plan should name the missing item rather than instruct her vaguely to 'build up the portfolio'.

Sickness absence requires the same distinction between professional evidence and personal medical detail. The revalidation team needs enough information to understand the interruption and necessary arrangements, using appropriate confidential channels. It does not follow that detailed

treatment records belong in appraisal attachments. A supported return may involve occupational-health advice, altered duties and a period of supervision or updating. Describe the effect on the professional role and the relevant plan. Chapter 10 explains how health and development can be discussed without making illness a proxy for professional failure.

A career break abroad raises an additional issue. UK revalidation normally relies on information from UK practice. The GMC allows a responsible officer or suitable person to consider overseas information if satisfied that it provides the required assurance, but maintaining a licence on wholly or substantially overseas evidence is exceptional. Discuss intended overseas practice before departure, including whether a UK licence is required for the proposed work. Do not assume that an overseas employer's annual assessment automatically substitutes for UK requirements.^[73]

For any planned break, establish what will happen to the connection, appraisal arrangements and access to records. Obtain final outputs through authorised routes before an account closes. Agree how the organisation will contact the doctor, whether any appraisal is expected during the period and when the plan will be reviewed. If the return date changes, notify the relevant team. A short contemporaneous agreement is much easier to use than reconstructing whether a manager's reassuring comment was intended as formal approval for a missed appraisal.

Missing appraisal without an agreed interruption is a different problem and needs prompt explanation. The doctor should identify why the meeting did not occur, what attempts were made and how it can now be addressed. A cancelled appraiser appointment, unresolved allocation problem and refusal to participate are not equivalent circumstances. Present the evidence without exaggeration. If responsibility is shared, describe both the organisational failure and the action the doctor took. The goal is to restore a workable process, while preserving an accurate account if a later judgement depends on it.

After return, choose development according to the actual work and time away. A familiar post may have changed systems, personnel or pathways. Extensive previous experience does not remove the need for reorientation, but neither does a break erase established capability. The readiness discussion should identify what needs updating and how it will be supported. Revalidation then sits within a coherent return plan, alongside safe duties, appraisal and wellbeing, instead of appearing as an isolated deadline imposed on a doctor still trying to understand the changed service.

Moving organisation or nation

Moving employer creates two related tasks: establish the new connection and transfer enough professional information for continuity. A new contract, a new appraisal platform and a new responsible officer may take effect through different administrative steps. None should be assumed complete merely because employment has begun. The doctor should confirm the leaving and joining dates, identify both revalidation teams and check the resulting position in GMC Online. The submission date does not simply restart because a career move feels like a new beginning.

The GMC protocol expects responsible officers to consider the whole practice and arrange access to information from relevant organisations. Its information-sharing principles support continuity across systems. For the doctor, the practical implication is to facilitate an accurate transfer, identify missing material and provide the receiving team with a clear account of the work. An organisational transfer should include relevant concerns and their status as well as favourable appraisal outputs. Changing employer is not a method of resetting the professional record.^[74]

Before departure, ask which documents will transfer directly and which the doctor should retain or supply. Commonly useful records include final appraisal summaries, PDPs, relevant feedback outputs and confirmation of appraisal interruptions or other agreed arrangements. Governance information may travel between authorised organisational contacts rather than through the doctor personally. Respect that distinction. Do not export patient records or investigation files into a private account to ensure that 'everything is saved'. Retention and transfer must use the appropriate information-governance arrangements.

Aisha's move from one NHS employer to another illustrates the timing problem. Her last appraisal covered a period ending before the move, while the next is due after she joins. The receiving organisation needs to understand both periods. She prepares a scope chronology and provides the final summary through the approved process. If her previous portfolio is no longer accessible, she contacts its administration team rather than trying to recreate an appraiser's report from memory. Her own explanatory note remains labelled as such and does not impersonate an official output.

Cross-border moves add delivery differences without changing the fact that the GMC regulates the licence. Wales uses MARS for medical appraisal, and Scotland uses SOAR. England and Northern Ireland require the receiving organisation's operational arrangements to be confirmed. The Department of Health Northern Ireland publishes its revalidation framework and responsible-officer material; this should not be replaced by assuming an

English local policy applies. The doctor needs a transfer plan that distinguishes regulatory continuity from the practical work of entering a different appraisal system. [19][17][18]

Close to a submission date, notify the receiving team early. Ask who will make the recommendation, what information is available and whether any transfer delay affects readiness. An employer move does not itself prove that deferral is needed, and it does not justify promising revalidation before the responsible officer has reviewed the record. A short joint clarification between the organisations may resolve the uncertainty. Keep the doctor-facing outcome in writing, particularly if an appraisal date or information deadline changes as a result.

The handover should also capture unfinished professional actions. If an improvement project continues after the doctor leaves, record the contribution completed and who owns later evaluation. If a complaint remains open, identify the responsible organisation and contact route. If a PDP objective depends on experience unavailable in the new post, revise it transparently at the appropriate review. Continuity does not mean carrying every old objective unchanged into a different job. It means preserving the history and making deliberate decisions about what remains relevant.

After arrival, check the transfer rather than assuming that a sent email equals completion. Has the new team received the final outputs? Can it identify the prior period and any interruption? Is the connection correct? Does the next appraisal cover the intended scope? Are external roles still declared? This final reconciliation often takes little time when planned early. It prevents the first warning of an incomplete transfer arriving shortly before a recommendation is due, when the former contact may have moved and access to old systems may be harder to restore.

Retain the receiving team's acknowledgement with the transfer checklist. It provides a clear starting point if information is later reported missing or a different period of practice needs clarification.

When concerns overlap

Revalidation can coincide with a complaint, employer investigation or GMC fitness-to-practise process, but it does not replace those procedures. A recommendation should not be used to introduce concerns that ought to be raised through the appropriate route. The GMC distinguishes an ongoing local governance process relevant to recommendation from its own fitness-to-practise investigation; the latter has separate handling arrangements. Doctors who retain a licence should continue engaging with revalidation as

far as possible, including complying with applicable conditions or undertakings.^[75]

The first practical task is to draw a chronology with separate columns or clearly labelled entries for each process. Record the employer review, any regulator communication, appraisal dates and revalidation requests. Identify the decision-maker and deadline for each. A letter from an employer's investigator may require a factual response, while the appraisal asks for reflection and the responsible officer seeks the status of the investigation. These are related subjects, but submitting the same narrative everywhere can create confusion and unnecessary disclosure.

Seek advice early about formal statements. A defence organisation can help distinguish factual evidence, reflection and a response to an allegation. An employment representative may be needed for contractual or disciplinary issues. Explain to each adviser which other processes are running. The doctor's account should remain consistent in its facts, but the purpose and appropriate content of each document may differ. Do not turn an appraisal note into an unsupported admission merely because the doctor wishes to demonstrate insight, or use a defensive legal narrative as the entire account of learning.

An unresolved allegation should retain its correct status. Suppose a complaint concerns communication during a difficult service episode. The doctor may already have identified a useful improvement while disputing part of the factual account. Both can be stated. Learning does not require invention of a finding that has not been made. Equally, the absence of a final finding does not prevent reasonable action to improve practice or reduce risk. A careful record separates what is alleged, what is established, what has changed and what awaits determination.

Public-interest concerns require particular care if the doctor is also being described as non-engaging. Preserve the chronology and seek independent advice about the appropriate route. The GMC protocol requires responsible officers to involve their employer liaison adviser in specified circumstances involving public-interest concerns and proposed deferral or non-engagement. The doctor should neither assume that raising a concern removes ordinary revalidation duties nor accept an unexplained conflation of whistleblowing, employment disagreement and professional non-participation. These are different questions requiring evidence.^[67]

The safest personal method is active, documented engagement within appropriate advice. Respond to requests, clarify uncertainty, ask for reasonable support and maintain the relevant professional activities. If a restriction or health circumstance limits what can be done, explain it

promptly through the correct channel. Keep the next action visible for each process. Chapter 13 develops the handling of formal concerns in greater depth; here the essential point is that a difficult parallel process should be managed explicitly rather than allowed to make the revalidation record incomprehensible.

Support should include the person as well as the paperwork. A trusted colleague can help organise a chronology or identify a missed communication, while professional advisers address the formal issues. Agree what assistance is useful and preserve confidentiality; informal support should not become an uncontrolled circulation of sensitive documents.

Personal readiness timeline

A readiness timeline should make preparation routine while accommodating the actual GMC date. At the beginning of a cycle, confirm the connection and record the decision and new submission date. Review the scope and plan activities that need lead time, particularly formal feedback and substantial improvement work. At each annual appraisal, examine learning, update declarations and identify what remains outstanding across the cycle. The timetable is a working aid, not a claim that every doctor must follow an identical five-year sequence.

During the early and middle years, test whether evidence collection represents the work. A new clinical role, external appointment or change in patient population may require a different feedback approach. A project may finish earlier than expected or fail to produce usable evaluation. Adjust the plan while there is time. Schedule periodic brief reviews of the evidence map, rather than a large annual attempt to remember everything. The purpose is to preserve learning and identify dependencies, not to turn every ordinary working day into a documentation exercise.

As the final year approaches, ask the local team what readiness review it undertakes and when it needs information. Reconcile appraisal history, formal feedback, quality improvement, scope and governance records. Check that important material has been discussed where required, not merely collected. If a gap remains, define it precisely and agree the action. Do not wait for the last appraisal to discover that an external organisation needs several months to provide a statement or that a feedback exercise requires an accessible alternative method.

Near the submission date, keep communication simple. Confirm that the responsible-officer team knows about any material change and can obtain the information it has requested. Record the expected next step without

treating an anticipated recommendation as a completed decision. If deferral is proposed, keep the action plan and monitor its dependencies. If a formal warning or adverse notice arrives, use its actual deadline and obtain advice immediately. A personal diary entry should support, never replace, reading the regulator's communication.

A practical final check uses three short headings in a private working note: complete, awaiting another person, and action for me. Put only genuinely outstanding items under the last two. Add dates and remove items when resolved, retaining the underlying records elsewhere. This keeps preparation manageable during busy clinical periods. It also makes a request for help specific: the doctor can identify the blocked item and required decision instead of reporting only a general feeling that the whole process is becoming unmanageable.

After the GMC decision, retain the notification and update the timeline. Review what made the process easy or difficult. Perhaps external roles need better governance contacts, the annual scope map needs a fixed review date or a change of email caused avoidable delay. Improve that small part of the system. The purpose of readiness is not to create a second career in administration. It is to keep professional work, evidence and the relevant decision-makers connected well enough that the doctor can explain the position accurately at any point.