Royal College of General Practitioners

The RCGP Guide to the Revalidation of General Practitioners

CPD & Revalidation

Version 8.0 | September 2013

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RCGP
Royal College of General Practitioners

The Royal College of General Practitioners was founded in 1952 with this object:
'To encourage, foster and maintain the highest possible standards in general practice and for that purpose to take or join with others in taking steps consistent with the charitable nature of that object which may assist towards the same.'

Among its responsibilities under its Royal Charter the College is entitled to:
'Diffuse information on all matters affecting general practice and issue such publications as may assist the object of the College.'

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Please note: this document is intended as the definitive guide to revalidation for general practitioners. It is continually evolving in the light of policy decisions from the General Medical Council, Departments of Health and the Academy of Medical Royal Colleges. If you wish to refer to it, we strongly recommend that you download the document from the RCGP website where the latest version will be posted.

Contents

Acknowledgements

The RCGP acknowledges the work of the many people who generously allowed their documents to be used to create *The RCGP Guide to the Revalidation of General Practitioners*. It is based on the RCGP's *Revalidation Criteria, Standards and Evidence* and this, in turn, was based on the GMC's *Framework for Appraisal and Assessment*. Other sources used include the GMC's *Good Medical Practice*, *Good Medical Practice for General Practitioners*, *Essential Evidence to Support Appraisal* from the Welsh Deanery, the Leicester 2007 conference statement on *Evidence for Medical Appraisal*, *Appraisal Evidence for Out of Hours GPs* prepared by Dr Peter Berrey for NHS Education Scotland, the NHS Revalidation Support Team's *Enhanced Appraisal Unified Form* and RCGP Scotland's Revalidation Toolkit. The Revalidation Support Team has given valuable advice both to the RCGP and to the wider profession.

Later editions of the Guide were developed in line with the GMC's *Supporting Information for Appraisal and Revalidation* guidance and the Academy of Medical Royal Colleges' *Supporting Information for Appraisal and Revalidation: core guidance framework*. The Revalidation Support Team's *Medical Appraisal Guide* (MAG) should be considered an essential adjunct to this guide.

We would also like to acknowledge the input of the RCGP Specialty Advisers in the development of version 8.0 of the Guide, and that of a number of stakeholders, particularly the BMA General Practitioners Committee (and Sessional GP Subcommittee) and Dr Di Jelley and Dr Paula Wright from the Northern Deanery.

We would also like to thank individual GPs who have contacted us with questions, comments and concerns, and helped develop the Guide around identified information needs.

Revalidation summary

Revalidation is the process by which licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practise. Revalidation aims to give extra confidence to patients that their doctor is being regularly checked by their employer and the General Medical Council (GMC).

Revalidation started in December 2012. By March 2016 it is expected that virtually all licensed doctors will have been revalidated for the first time. In most circumstances, licensed doctors will revalidate at 5-year intervals after their first revalidation.[1]

This section summarises what most GPs need to know for their revalidation.

- You will have been licensed to practise by the GMC. For established doctors these licences were issued in November 2009.
- Most licensed doctors have a connection with one organisation that will provide them with a regular appraisal and help them with revalidation. This organisation is called a 'designated body'. Each designated body has a responsible officer who will make a recommendation about you to the GMC – normally every 5 years after your first revalidation – that you are up to date, fit to practise and should be revalidated.
- If you are on an NHS Performers List, your designated body is the UK primary care organisation (PCO)[2] that manages the list you are on.[3]
- If you are a GP in England working in the NHS, your designated body is NHS England and your responsible officer is based in one of the 27 Area Teams.[4]
- If you are not working in an NHS PCO, you are likely to have a connection to one of a number of non-NHS designated bodies. The GMC provide a list of designated bodies.[5]
- If you are in training in Scotland, your designated body is NHS Education for Scotland. If you are training in Wales or Northern Ireland, your designated body is your postgraduate deanery. If you are training in England your designated body is one of the 13 new Local Education and Training Boards (LETBs) known as, for example, Health Education North West. Your revalidation recommendation will be made by your postgraduate dean based upon your training activities and Annual Review of Competence Progression (ARCP) submissions. You do not need to collect additional supporting information.

1. See www.gmc-uk.org/doctors/revalidation/9611.asp.
2. The acronym PCO is used throughout this document to denote NHS Area Teams in England, NHS Boards in Scotland, Health and Social Trusts in Northern Ireland and NHS Health Boards in Wales.
3. The exception would be if you are on an NHS Performers List but the majority of your practice is with the armed forces, in which case your designated body would be the service that you practise in, either the Army, Royal Air Force or Navy. Similarly, GPs who spend the majority of their time working for the Foreign and Commonwealth Office (FCO) would have a prescribed connection to that organisation.
4. As above, this would not apply if the majority of your practice was with the armed forces or FCO.
5. www.gmc-uk.org/help/list_of_designated_bodies.htm.

- A small number of GPs will not have a connection to a designated body. The GMC can accept recommendations about doctors who do not have a responsible officer from a 'suitable person'.[6] This is somebody who performs the same function as a responsible officer. You should contact the GMC if you believe you fall into this category.
- If you do not know your designated body, you should use the GMC's online help tools in the first instance and contact the GMC if you are still unclear.[7]
- All doctors with a licence to practise are required to participate in revalidation. Doctors who are working wholly outside of the UK should consider relinquishing their licence.[8]
- The GMC will have given you a date for your first revalidation. If you have not received a date, then you need to contact the GMC.
- In order to recommend you for revalidation your responsible officer will need to be satisfied that:
  - you have participated in an annual appraisal process that has covered your full scope of work, and that you and your appraiser have signed off appraisals that have had *Good Medical Practice* as their focus since the start of revalidation in December 2012
  - you have brought to your appraisals appropriate supporting information (see Table 1)
  - there are no unresolved concerns about your performance as a doctor.
- If your appraiser thinks that your eligibility for revalidation is in doubt, he or she should seek advice from your responsible officer so that things can be put right if possible; revalidation is a continuous process, not a high-stakes examination at a fixed point in time.
- When your date for revalidation comes due, your responsible officer can recommend to the GMC that your licence is continued (in other words that you are revalidated); that the decision is deferred; or that it is impossible to make a recommendation because you have not engaged with the process. A responsible officer can notify the GMC that a doctor is not engaging with the revalidation process at any time; he or she does not need to wait until a doctor's recommendation is due.
- The vast majority of doctors will be recommended for revalidation and the GMC (which makes the final decision) will continue your licence; you will then be told when you will need to be revalidated again – usually after a further five years.

All these points are covered in more detail in the rest of this Guide, as is advice for those GPs whose circumstances are not standard.

Key things to do now

Ensure that you have a responsible officer – if not, inform the GMC.[9]

- Ensure that your annual appraisals are conducted properly with *Good Medical Practice* as their focus.
- Use an electronic portfolio or MAG form to collect your supporting information for appraisal and revalidation.
- Record your CPD and PDP objectives and outcomes.
- If you haven't participated in a Patient or Colleague Feedback survey in the past two years, plan to do one.
- Ensure that you are participating in annual quality improvement activity, providing SEAs or individual case reviews each year.
- If you haven't completed a full-cycle clinical audit or quality improvement project since April 2011, plan to do one.

6. See www.gmc-uk.org/doctors/revalidation/9611.asp.
7. www.gmc-uk.org/doctors/revalidation/designated_body_tool.asp.
8. www.gmc-uk.org/FAQ_for_overseas_regulators.pdf_50925072.pdf.
9. www.gmc-uk.org/doctors/revalidation/designated_body_tool_landing_page.asp.

Table 1: Summary of supporting information recommended for appraisals before your revalidation date

Supporting information	*Quantity*
General information	
Personal details	At a minimum, relevant to the period from December 2012
Scope of your work	
Record of annual appraisals	
Personal Development Plans (PDPs)	
Probity declaration	
Health declaration	
Keeping up to date	
Continuing professional development (CPD)	At a minimum, 50 learning credits each year from the start of revalidation in December 2012
Review of your practice	
Annual quality improvement activity, to include significant event audits (SEAs) (or individual case reviews)	At least two quality improvement activities are required each year. These can be SEAs[10] or individual case reviews. The GMC requires ALL significant adverse events to be included in your appraisal portfolio. Must be relevant to scope of work
Clinical audit or quality improvement project	Once per revalidation cycle. Must be relevant to scope of work
Feedback on your practice	
Colleague feedback	One of each in the five years before your revalidation recommendation, and each must be relevant to the scope of your work at the time of revalidation
Patient feedback	After their first revalidation, doctors may consider collecting colleague and patient feedback in the first three years of the cycle to allow time for follow-up questionnaires if issues are identified
Formal complaints	A description of any formal complaints (including complaints that have activated a practice/organisation's complaint procedure) and your response to them in the period since December 2012

10. In the GMC document *Supporting Information for Appraisal and Revalidation*, the term 'Significant Events' refers to critical or serious untoward incidents in a secondary care setting. It is clarified, however, that in general practice 'Significant Event Auditing' is used to describe case reviews (as described in an earlier section of that document) and is used to illustrate events that may not have a serious outcome but highlight issues which could be handled with greater clinical effectiveness and patient safety, and from which lessons could be learnt.

How revalidation will work

Background

The GMC introduced licences to practise in November 2009. All registered doctors were given the opportunity to request a licence to practise; all doctors eligible for registration with the GMC since November 2009 have also been licensed. From its introduction, the GMC licence rather than GMC registration signifies to patients that a doctor has the legal authority to write prescriptions and sign death certificates etc. GPs working in the NHS, either on a permanent or locum basis, will need to be:

- licensed by the GMC
- listed on the GMC's General Practice Register
- included on an NHS Performers List.

Only licensed doctors are subject to revalidation. In common with all doctors, GPs will need to be relicensed periodically. This is being achieved through a process called revalidation, for which GPs provide supporting information that shows that they are keeping up to date and remain fit to practise.

Revalidation is not concerned with the GMC's Specialist or General Practice Registers, only the doctor's licence. This means that GPs who are no longer in active clinical general practice but who are active as doctors (for example those in medical management, occupational health or doing referral surgical procedures) will continue to be on the General Practice Register, but will be revalidated for what they do.

In order for doctors to maintain their licence to practise they are expected to have annual appraisals based on the GMC's core guidance for doctors, *Good Medical Practice*.[11] Revalidation involves a continuing evaluation of doctors' fitness to practise and is based on appraisal and local systems of clinical governance.

The GMC has set out its generic requirements for medical practice and appraisal in three main documents:

- *Good Medical Practice*[12]
- *Good Medical Practice Framework for Appraisal and Revalidation*[13]
- *Supporting Information for Appraisal and Revalidation*[14]

11. www.gmc-uk.org/guidance/good_medical_practice.asp.
12. www.gmc-uk.org/guidance/good_medical_practice.asp.
13. www.gmc-uk.org/doctors/revalidation/revalidation_gmp_framework.asp.
14. www.gmc-uk.org/doctors/revalidation/revalidation_information.asp.

For doctors in England, the GMC guidance should be read in conjunction with the NHS Revalidation Support Team's MAG document, which is designed to help doctors understand what they need to do to prepare for and participate in annual appraisal. Equivalent guidance to MAG exists in the devolved countries of the UK.

The RCGP has the responsibility to support the above documents with specialty specific guidance for GPs and to give advice to responsible officers on the interpretation of our guidance. All Royal Colleges and faculties have agreed a core set of supporting information for revalidation,[15] and GPs are not being asked for any more or any less than other doctors.

Changes in this eighth edition of the RCGP guide to revalidation

The key changes to this version (Version 8.0) of the Guide are as follows.

- Changes to primary care structures in England are reflected, as is the fact that revalidation has commenced.
- We have removed the recommendation that a responsible officer should be able to consider a portfolio for recommendation if a minimum of 200 clinical sessions are documented over the 5-year revalidation period. Instead, we would emphasise that consideration should be made at appraisal as to whether a doctor is up to date and fit to practise in all aspects of his or her work.
- We have removed the concept of standard and non-standard practice, placing emphasis instead on *scope of work*.
- The Review of Practice section has been substantially revised in order to reflect the many forms that quality improvement can take, depending on the working context of the GP.
- We have revised the Feedback on Practice section to give further clarity on the processes for collecting colleague and patient feedback.
- We have referenced a number of new RCGP revalidation web resources, hosted on the RCGP Additional Revalidation Resources web page.[16]

Your position in 2013

All doctors undertaking clinical work in the UK must hold a GMC licence and have a connection to a responsible officer (or 'suitable person'). In addition all those GPs working in the NHS must be on a Performers List and be on the GMC's General Practice Register. Doctors in non-clinical practice may be required to have a licence depending on the employment requirements of their organisation. If you do not have an attachment to a designated body and responsible officer, the GMC will advise you on how to make a connection.

If you are not currently working in the UK but start to do so in the future, you will be attached to either an NHS or other designated body at the time you start working here. If you are not working in the UK, the GMC would recommend that you consider giving up your licence until you return to the UK. You can however choose to remain on the GMC's register, although that does not give you the rights of a doctor such as prescribing. When you wish to return to work as a doctor in the UK, you will need to re-apply to the GMC for your licence to practise – you are entitled to a licence on the basis of your qualifications unless there are unresolved concerns about your practice.[17] Then you will need to become attached to a designated body and responsible officer.

15. www.aomrc.org.uk/revalidation/item/speciality-frameworks-and-speciality-guidance.html.
16. www.rcgp.org.uk/revalidation-and-cpd/revalidation-additional-resources.aspx.
17. www.gmc-uk.org/doctors/registration_applications/relinquish_options.asp.

You should be experiencing an annual appraisal with an appraiser who is trained and approved by the designated body.

The revalidation timetable

The GMC has given all doctors a date for their revalidation. If you have not received your date, contact the GMC as soon as possible. In the first four months (December to March 2013) the responsible officers and other doctors in leadership roles were revalidated. The 'roll out' of revalidation started in April 2013 and the intention is that the vast majority of doctors will be revalidated for the first time by March 2016.

The revalidation process

You need to ensure that each of your annual appraisals covers the requirements for revalidation, and that you are sharing the required supporting information with your appraiser.

Your appraiser is key to your revalidation. Your appraiser reviews your supporting information with you and offers your responsible officer reassurance that your supporting information and your reflection on it are appropriate.

Your responsible officer is required by law to deliver effective annual appraisals, clinical governance and revalidation oversight to the doctors within your designated body. Your responsible officer will need to be continuously satisfied that there are no unresolved concerns about your practice or that if there are any concerns they are being managed appropriately.

The responsible officer should not wait until your revalidation date to act on any concerns; rather any concerns should be addressed as soon as they become apparent. Revalidation is a continuous process to protect the public and promote better practice, not a once in 5 years test.

However, your responsible officer is required to make a revalidation recommendation to the GMC when your revalidation date becomes due. He or she will recommend revalidation if your appraiser and you have signed that your appraisal has been properly conducted and if there are no local unresolved concerns about your performance.

When your responsible officer makes a positive recommendation to the GMC, the GMC will check their files and, provided they have no concerns, they will normally revalidate you. However, it is important to note that the definitive revalidation decision lies with the GMC, not your responsible officer.

Your responsible officer will have two other choices concerning your revalidation. In addition to a positive recommendation, he or she can request a deferral of the recommendation because there is a need for more information (e.g. after a period of sick leave or maternity leave) or the completion of a local performance process. He or she can also notify the GMC that you have failed to engage in the local processes and systems, such as appraisal, which support revalidation. A responsible officer can notify the GMC of a doctor's non-engagement at any point in the revalidation cycle.

How you should collect and store your supporting information for revalidation

Although some GPs still present information to their appraiser on paper, most are now submitting their appraisal information electronically and storing their supporting information in an electronic portfolio or form. There are a number of resources available for GPs to store and

submit their appraisal revalidation, including the RCGP Revalidation ePortfolio,[18] the Revalidation Support Team's MAG Model Appraisal Form and those from other commercial toolkit providers. The RCGP and the British Medical Association (BMA) General Practitioners Committee (GPC) have agreed that GPs should have a choice of the portfolio they use (if they have chosen to use one), as long as the resource used facilitates the storing, submission and receipt of the information required by the GMC for appraisal and revalidation.

Scope of work

Licensed doctors must provide supporting information that covers the full scope of their work. The GMC describes six types of supporting information that doctors are expected to provide and discuss at their appraisal:[19]

- CPD
- quality improvement activity
- significant events
- feedback from colleagues
- feedback from patients
- review of complaints and compliments.

With the exception for patient surveys for those who do not see patients,[20] doctors are expected to provide the information listed above and all portfolios have to reflect the circumstances and context in which a doctor works, including extended roles (described in more detail in the General Information section of this Guide). The requirement to ensure that a doctor is up to date and fit to practise is the same for all doctors and the overall standard must be the same. However, the particular role of the doctor must be taken into account when deciding the precise nature of the supporting information. In all cases supporting information must meet the underlying attributes that each area of supporting information is intended to demonstrate.

General practice is a heterogeneous professional group that includes, among others, GP partners, locums (some highly peripatetic), sessional and employed doctors, GPs in secure environments, out-of-hours GPs (and those working in similar clinical contexts such as in walk-in centres), GPs in the Defence Medical Services, private GPs and GPs who work in very remote or small practices. Additionally, many GPs have portfolio careers, working in a variety of contexts. This Guide seeks to reflect the diverse nature of general practice in later sections that address specific supporting information requirements. Furthermore, the RCGP has developed a selection of Example Portfolios that demonstrate how GPs in a diverse range of roles can show that they are meeting the requirements for revalidation.[21]

Non-clinical GPs

Non-clinical GPs are a small but important group, especially prevalent in NHS management, academic practice and independent healthcare systems. These doctors must be in good standing with the GMC in order to undertake the work they do, but they may not be in active clinical practice for significant periods of time. If the doctor does any clinical work in the NHS he or she will need to meet the Performers List requirements and demonstrate being up to date and fit to practise in his or her clinical role.

18. https://gpeportfolio.rcgp.org.uk/Login.aspx.
19. www.gmc-uk.org/doctors/revalidation/revalidation_information.asp.
20. The GMC recommends that doctors think broadly about what constitutes a 'patient' in their practice. If a doctor does not see patients he or she may consider collecting feedback from other sources, such as families and carers.
21. www.rcgp.org.uk/revalidation-and-cpd/revalidation-additional-resources.aspx.

Non-clinical GPs will submit a portfolio to their responsible officer that demonstrates that they are fit to undertake their non-clinical roles. This will include supporting information in all areas except patient surveys – although the GMC recommends that doctors think broadly about what constitutes a 'patient' in their practice (e.g. a GP educator may seek feedback from trainees or students). This will include evidence of satisfactory annual appraisal, PDPs agreed and reviewed, and evidence that they are keeping up-to-date in their area of practice. They should submit a colleague survey and a description of any cause for concern or formal complaint. They should provide a statement on probity and health, and documentation that meets the requirements of extended practice. For doctors who undertake very limited clinical work, they need to be able to demonstrate that they are up to date and fit to practise in the clinical component of their work with appropriate CPD, quality improvement activity and reflection.

GPs working part time

Part-time GPs need to maintain their skills at the same level as their full-time colleagues. They will normally be expected to submit a full portfolio, with any notes relating to special circumstances that have affected the amount of information collected, such as maternity leave or ill health.

GPs taking a break from UK practice

Doctors who continue to hold a licence to practise while working overseas and outside a UK designated body will need to revalidate if they wish to keep their licence. They will need to remain connected to a UK organisation that will support them in their appraisal and revalidation.[22] In most cases, supporting information for revalidation will need to be collected within the context of the NHS or a UK designated body, such as the Defence Medical Services. However, ultimately the responsible officer will make a decision as to whether supporting information collected outside a UK setting can be relied upon for the purposes of revalidation.

It is recognised that some doctors have roles that will require them to work overseas for some periods in the revalidation cycle. We would advise that such doctors discuss their revalidation with their responsible officer or appraiser. Doctors should, where possible, maintain their CPD while working abroad and keep up to date with evidence-based guidelines etc. in the UK as this will help them on their return.

Doctors who do not undertake any work in the UK might want to consider whether they should relinquish their licence to practise.[23] Such doctors can remain registered without a licence while overseas, and this will indicate that they are in good standing with the GMC. When the doctor plans to return to UK practice he or she can apply for the licence to be restored – the licence is an entitlement based on qualifications provided there are no unresolved concerns. The doctor may, however, be required to be revalidated within, say, two years. It is important that doctors provide the GMC with an up-to-date contact address at all times.

If a returning doctor wishes to be entered on a Performers List and to start working as a GP, the PCO may want evidence that the doctor is suitable. In reality this would normally mean that, after sustained absence from clinical general practice in the UK, a doctor would require an assessment that may indicate the need for a targeted re-entry educational experience before returning to clinical general practice. If a GP has been working in, for example, New Zealand as a GP, his or her re-entry education may be solely to re-familiarise that doctor with the UK health service, such as evidence-based clinical guidelines, pathways and referrals, safeguarding vulnerable people, etc. At present, if a doctor has not been in clinical practice for two years or more, a

22. www.gmc-uk.org/FAQ_for_overseas_regulators.pdf.
23. www.gmc-uk.org/doctors/registration_applications/relinquish_licence.asp.

formal re-entry or returners' scheme is required.

The Committee of General Practice Education Directors (COGPED) recommends a re-entry assessment and a course in an approved setting after a GP has had an absence from UK general practice for a period of two years or more. It is the duty of the doctor to ensure that he or she is safe to return to UK general practice, whether following work overseas or for other reasons, and responsible officers must establish systems to evaluate and support doctors to ensure their safe return to the workplace. NHS England is developing a policy for entry and management of the England Performers List that is expected to introduce a standardised approach to re-entry across England.

There are many doctors who will be absent from UK clinical general practice for periods of two years or less due to pregnancy, illness, career breaks, sabbaticals, working abroad or taking on non-clinical roles. The revalidation process is designed to be flexible and accommodate these circumstances. A responsible officer will consider any portfolio submitted but may make a decision to defer revalidation until he or she feels there is sufficient supporting information. The responsible officer may consider:

- the environment in which the GP has worked and whether the supporting information of clinical governance and annual appraisal from that environment can be relied upon
- the GP's learning credits both over the revalidation period and within each appraisal year
- the supporting information of annual appraisal, annual PDP and PDP review
- the supporting information of feedback from colleagues and patients (patient and colleague surveys)
- any assessment of clinical skills or knowledge
- any outcome from a re-entry programme.

Ultimately the revalidation decision will be taken by the GMC based on the information available to it, including the opinion of the responsible officer.

GP registrars whose licence becomes due for renewal

The introduction of revalidation means that the Postgraduate Dean, as responsible officer, will be in receipt of any relevant information about trainees that reside with their employing organisations(s). Through the use of an enhanced Form R, this information is available to the ARCP panels so that any issues or concerns can be recorded and monitored. The majority of GP trainees will revalidate at the point of Certificate of Completion of Training (CCT) via their final ARCP panel.[24] Full engagement in Workplace-Based Assessment is likely to suffice. In most cases, GPs will revalidate 5 years after CCT. If, however, a doctor takes longer than 5 years to complete training from the point that they are licensed, the Postgraduate Dean would (in most cases) make a recommendation to the GMC prior to the completion of CCT and again at completion of CCT.[25]

Organisational and peer support

One key aspect for peripatetic locums and doctors who work in out-of-hours services or in walk-in centres is the frequent absence of organisational and peer group support. The employers of GPs who work as locums or in out-of-hours services have a responsibility to include all doctors working for them in educational activities. They also need to share their own quality assurance processes with the GPs they employ. An example of this is the audit of telephone consultations that out-of-hours providers should be carrying out. Information from this audit can be used by GPs in their professional development and as a supporting documentation for revalidation.

24. In order to accommodate changes in the CCT date, revalidation occurs approximately 60 days following CCT.
25. www.gmc-uk.org/doctors/revalidation/12383.asp.

The RCGP is supportive of the development of mechanisms to reduce the professional isolation that many of these doctors experience. The models for this that have been identified include the following.

- General practices, federations and out-of-hours organisations that frequently employ GPs on short-term, sessional contracts must recognise their responsibility to all their employees, including these doctors. They should inform and involve the doctor in any significant event or complaint that relates to them; they should facilitate access to the clinical records of patients treated by these doctors for the purposes of clinical audit and quality improvement; and they should support the conduct of patient surveys.
- Professional organisations that support the working lives and professional development of peripatetic locums are becoming more established. The National Association of Sessional GPs (www.nasgp.org.uk/) has developed the 'chambers' model through which contracts, bookings, education and quality assurance are supported collectively by other locum doctors. Other organisations such as the North-East Sessional GP Group (www.nesg.org.uk) act as an information forum in a specific area, advertising local educational events, running educational meetings and providing space for locums and practices to advertise. The GPC's Sessional GP sub-committee (http://bma.org.uk/about-the-bma/how-we-work/negotiating-committees/general-practitioners-committee) considers and reviews all matters affecting salaried and locum GPs, including revalidation, and provides regular updates.
- Educational groups (locum groups, self-directed learning groups, etc.) are also developing. In these, doctors working outside supportive organisations in an area meet to share experience and to learn together. Such educational groups may well be virtual if that works for the participants.

Although there are some circumstances in which such mechanisms are impractical, it is the view of the RCGP that all GPs need to consider how they achieve peer support to prevent professional isolation. For some this is a supporting practice; for others it may be a single-handed doctors' group, a new practitioners group, a chambers or an educational group. Doctors who work in professional isolation miss out on many of the benefits of working in a team. They have fewer opportunities for peer support and to receive informal feedback, and fewer chances to exchange new information, which may make them feel disconnected from the profession and may make them more vulnerable to stress, exhaustion and burn-out. Importantly, the lack of opportunities to discuss day-to-day clinical work results in missed opportunities to 'benchmark' their practice against that of their peers – a key mechanism that operates informally amongst more connected doctors in maintaining standards. This may also lead to them finding it more difficult to identify areas in which they could improve their knowledge and care standards. One potential benefit of revalidation activities may be the encouragement of inter-professional linking and joint learning throughout the revalidation cycle.

Supporting information for revalidation: overview

As described in the GMC's document *Supporting Information for Appraisal and Revalidation* and the Academy's *Supporting Information for Appraisal and Revalidation: guidance for general practitioners*,[26] your supporting information, grouped into four main headings, is as described in Table 1 (see p. 3).

It is important to note that, even in the first cycle of revalidation, the GMC expects responsible officers to be satisfied that supporting information has been seen at appraisal for all areas.

This Guide will now look in detail at what is required for each item of supporting information.

26. www.rcgp.org.uk/revalidation-and-cpd/~/media/Files/Revalidation-and-CPD/Revalidation/Guidance-for-GPs/2-RCGP-Supporting-information-for-appraisal-and-revalidation-for-GPs.ashx.

General information

Providing context to what you do in all areas of your professional practice

Personal details

Your revalidation portfolio should include the following details:

- title and name
- email address
- work address and telephone number
- preferred contact address and telephone number
- primary medical degree and awarding institution
- professional and medical qualifications
- GMC number, registration date, licence date and date of entry onto the General Practice Register
- date of last revalidation (when applicable).

Scope of work

You need to record your professional roles and update your entries annually. This should include:

- all current posts and those within the revalidation period – date started, time commitment, contracting authority or employer (including address); if clinical, whether within an organisation with a quality-assured system for clinical governance;[27] role content/description and performance review/appraisal within this post
- any voluntary roles undertaken in the capacity of a doctor and which requires you to have a licence to practise to carry out the role
- free-text elaboration of any unusual supporting information.

Revalidation is based on what a doctor actually does in practice. In order for appraisers and responsible officers to understand what the GP does, all posts undertaken as a doctor, whether paid or not, must therefore be included. GPs in the Defence Medical Services, for example, need to provide details of their extended responsibilities in clinical areas. These may include pre-hospital emergency medicine, occupational medicine, travel medicine, sports and exercise medicine, public health, environmental health, aviation medicine, diving medicine and military community psychiatry.

For sessional doctors who locum for multiple providers over the revalidation period there is no

27. Organisations with quality-assured systems for clinical governance will include: the NHS; independent providers of primary care such as the Defence Medical Services and the Prison Service; and PCO-endorsed out-of-hours providers.

requirement to specify every one in which they worked. Instead they are expected to give the dates and sessions over which they have been working, practices/organisations in which they have worked regularly or frequently, and to indicate the general nature of the role(s) they have undertaken. For most, the latter will be 'clinical primary care in undifferentiated general practice consultations' but you should also describe other medical roles if appropriate.

This area of recording is also used for two other types of supporting information:
- details of extended practice
- any exceptional circumstances.

Extended practice is:
- an activity that is beyond the scope of GP training and the MRCGP, and that a GP cannot carry out without further training (e.g. surgical services); or
- an activity undertaken within a contract or setting that distinguishes it from standard general practice (such as work as a GP with a Special Interest); or
- an activity offered for a fee outside of care to the registered practice population (teaching, training, research, occupational medicals, medico-legal reports, cosmetic procedures, etc.).

Some GPs will indicate that they have nothing to include in this supporting information area. However, many doctors do have areas of extended practice and they will be required to demonstrate that they are fit for these roles. In essence 'extended roles' are those for which the GP is remunerated on a regular basis. They should not include occasional (less than once a quarter) activity for which an honorarium is paid (such as delivering continuing education to colleagues or writing opinion articles), but should include all clinical activities undertaken for which any payment is made.

There is a group of common activities for which the supporting information should be straightforward:
- teaching of undergraduates – a review of performance statement from the university department
- GP training – a statement from the postgraduate organisation (deanery etc.) including the date and outcome of the last trainer approval
- research (including collaboration in research studies) – a statement from recognised research institution(s) involved and a statement from the Research Governance Team in the local PCO
- appraisers – a record of annual review of their work as an appraiser
- out-of-hours work – a statement from the out-of-hours provider that regular reviews have been satisfactory
- GPs with a Special Interest under contract to a PCO – a statement from their contracting organisation that they have maintained accreditation for the role.

For other non-clinical activities a statement from a responsible organisation will normally suffice.

For clinical activities, you should describe in detail the role and provide supporting information that satisfactorily answers the following three questions:
1. How did you qualify to take on this role? This should include prior experience, education and qualifications.
2. How do you keep up to date in this role? This should include reference to all new and refresher education or development, and refresher education and training undertaken for this role in the

revalidation period, including any learning credits recorded.

3. How can you demonstrate that you are fit to practise in this role? This should include appropriate audits of care delivered, including reference to any information from third-party observation of your work, and sign-off from an appropriate consultant/expert/colleague who knows your work.

This section of the portfolio is also the opportunity for you to explain any unusual aspects of your working life during the revalidation period that may help the appraiser and responsible officer to understand and interpret your supporting information. There will be an opportunity to record anything relevant including:

- prolonged or significant illness
- career breaks including sabbatical or maternity leave
- periods working abroad (including for charities and non-governmental organisations)
- important changes in working circumstances including the dissolution of a partnership or a move to another practice.

This list is not intended to be exhaustive – there may be other circumstances that you may wish to include. This supporting information area is used by appraisers and responsible officers to provide context in evaluating your portfolio.

Annual appraisals

All GPs are expected to take part in regular annual appraisal and they must bring supporting information for their revalidation to their appraisal.

All doctors on an NHS Performers List or working within an organisation with a quality-assured system of clinical governance, including locums, should receive administrative support in undertaking annual appraisals. If you experience significant problems, which are not resolved satisfactorily with your PCO or employer, you should draw this to the attention of your responsible officer at an early point in the revalidation period and include it in your portfolio as exceptional circumstances.

An annual PDP should be derived from participation in each annual appraisal. It should be signed off by you and your appraiser, and should represent the agreed plan for the forthcoming year. The portfolio should contain one PDP for each year in the period of revalidation.

A PDP consists of a number of objectives. There is no minimum or maximum number of objectives. For example, a doctor setting the objective of achieving recognition as a vocational trainer might regard that as a sufficient single objective for a year; most GPs will set themselves between three and five objectives that reflect the breadth of their practice, responsiveness to the health needs of their local population, and their own development needs. All objectives need to be 'SMART' (Specific, Measurable, Achievable, Realistic and Time-bound) although some may, of necessity, be less measurable and time-bound than others.

A valid PDP must contain the following key elements for each objective:

- a statement of the development need
- an explanation of how the development need will be addressed (the action to be taken and the resources required); objectives are more likely to be achieved if consideration is given to several ways of meeting them

- the date by which the objective will be achieved
- the intended outcome(s) from the objective.

For each PDP objective submitted there should be a column recording the outcome of the objective. The entries in this column should be agreed between the appraiser and the GP at the appraisal following the one in which the PDP was agreed.

The entries reviewing the outcome of agreed objectives are likely to reflect the following:

- the fact that the objective has been completed and the extent to which the intended outcome from that objective has been achieved; or
- the fact that the objective has not been completed and an explanation such as:
  - the objective became irrelevant due to changing circumstances in the year
  - the objective became unachievable as the implications became clearer
  - the time for achieving the objective was agreed to be longer than the time to the next appraisal.

It is very important that you reflect on the objective, the development achieved and any reasons for not achieving the objective. This reflection is an important attribute of your fitness to practise.

Over a 5-year period you should not only consider clinical learning and development but also non-clinical competencies, which may include leadership, management or teaching, recognising the importance of all a doctor's roles in the provision of a safe system of health care for patients.

Statements on probity, health and use of health care

You will be asked to verify a standard statement or to provide an alternative statement. The standard statement will cover:

- that there are no issues of probity in your work
- whether you have been suspended, had restrictions placed on your practice or been subject to an investigation since your last appraisal
- whether your designated body or responsible officer has requested you to bring specific information to your appraisal
- that there are no health issues that might affect your ability to deliver safe care to patients (including infections, immunisation status such as against hepatitis B, problems with drugs and alcohol, mental health concerns and other significant diagnoses or problems) – a statement that you have a health condition that is being treated adequately and that your doctor has no concerns should be acceptable
- that you are in a position to receive independent, impartial healthcare advice (for example you are not consulting a family member)[28] and that you access health care appropriately. Unless there is a good reason it is best practice for a GP to be registered in a practice in which he or she does not work
- that you have appropriate and current insurance or indemnity cover for all aspects of your work. You will be asked to provide the name of the organisation providing insurance or indemnity cover and the membership number.

28. Paragraph 30 of the GMC's Good Medical Practice says: 'You should be registered with a general practitioner outside your family.'

Keeping up to date

Maintaining and enhancing the quality of your professional work

All medical royal colleges are using learning credit systems with a minimum of 50 credits in a year and 250 credits in a 5-year cycle to support a positive revalidation decision. However, unlike other college schemes, the RCGP credit system[29] is not purely based on time spent but also reflects the impact of learning.

In essence, 1 hour of education accompanied by a reflective record is 1 learning credit. However, if you can demonstrate to your appraiser that a particular episode of learning was implemented in practice with positive benefit for patients, yourself or the practice, you can claim 2 learning credits for each hour of such education. The RCGP Impact Toolkit includes several examples of ways in which impact can be demonstrated.[30]

Your credits are self-assessed and verified at appraisal. The pattern of credits should, over the revalidation cycle, reflect the working life of the GP. For example, a GP with a special interest in respiratory medicine should have a mixture of general practice and respiratory learning credits.

You will, therefore, be expected to record your educational activity and award yourself credits based upon the hours involved and the impact of the education on yourself, your patients or the service in which you work. 'Educational activity' can include formal courses, lectures, seminars, small group or practice-based learning events, online learning, reading, learning a new skill, mentoring someone, action learning, becoming a trainer, doing individual reflective activity, etc. A reflective log of learning should satisfy an appraiser that each recorded activity was educational. Over a revalidation cycle you will be expected to demonstrate a broad range of general practice education appropriate to the work you do, with at least 50 learning credits being achieved and confirmed by the appraiser each year.

29. www.rcgp.org.uk/revalidation-and-cpd/~/media/Files/Revalidation-and-CPD/Credit-Based-System-for-CPD.ashx.
30. www.rcgp.org.uk/revalidation-and-cpd/revalidation-additional-resources.aspx.

Review of practice

Evaluating and improving the quality of your professional work

The GMC states that quality improvement activities 'could take many forms' depending on the role the doctor undertakes and the work that he or she does. The RCGP has defined SEA/case reviews and clinical audit as the core information to be included under Review of Practice. GPs who do not feel that it would be feasible for them to participate in clinical audit activity should produce alternative evidence of quality improvement and discuss this with their appraiser.[31] Similarly, if it is not feasible for a GP to submit SEAs because of his or her working circumstances, the GP may wish to include individual case reviews that have been discussed with colleagues and demonstrate reflection and learning in his or her portfolio instead. It is important that all GPs record and reflect upon any serious clinical incidents in which they have been involved.

Most GPs are involved with a broad range of quality improvement activities, including case discussions and briefer reviews of clinical and other work, and these should also be submitted. You should submit evidence of quality improvement activity for every appraisal to show that you regularly review your practice and learn from events, concerns, errors, audits, etc.

SEAs/individual case reviews

Significant event auditing (also known as learning event audits, critical incident analysis or significant event analysis) is a routine part of general practice and is based on individual events or case reviews. Significant event auditing, as described here, is referred to by the GMC as case reviews. It is a technique to reflect upon, and learn from, individual cases or events to improve quality of care overall. The expectation is that you provide an analysis of at least two significant events in which you have been directly involved for each appraisal as a demonstration of annual quality improvement activity.[32]

Although a significant event suitable for auditing can be one that demonstrates all levels of care from excellent through to poor, for the purposes of revalidation each of the submitted events must demonstrate, through the analysis, areas for improvement, reflection and the implementation of change. You must *only* submit an analysis of a significant event in which you have been directly involved, where the event was discussed with other colleagues.

For practice-based GPs the expectation would be that the discussion around a significant event would occur within the practice-based team meeting (usually an SEA meeting) with an appropriate

31. The RCGP Quality Improvement Toolkit contains examples of quality improvement activity other than clinical audit (www.rcgp.org.uk/revalidation-and-cpd/revalidation-additional-resources.aspx).
32. RCGP Significant Event Toolkit (www.rcgp.org.uk/revalidation-and-cpd/revalidation-additional-resources.aspx).

selection of other primary care team members present, such that necessary changes can be made within the practice. However, sometimes employed doctors may not have sufficient influence over meetings and their employer to see their significant events discussed in this formal way. For doctors without a fixed practice base the discussion of the significant event in a peer group or learning group allows reflection, learning and planning of changes. For the SEA to be appropriate to your appraisal the changes arising from the discussion should involve yourself, perhaps as the person responsible for implementing the change or as someone who needs to change his or her own practice.

If there is a patient safety concern or event (also known as a serious incident) within your clinical practice, the GMC requires that each event should be included as one of your ten SEAs/case reviews and included in your revalidation portfolio. [The GMC document *Supporting Information for Appraisal and Revalidation* refers to serious incidents as significant events. A subsequent footnote clarifies that this does not refer to SEAs that are, in the GMC parlance, case studies. If you have a serious incident, it should be included as a significant event in your portfolio, but many of your significant events will not be serious incidents.]

A significant event may occur in the period immediately before an appraisal, leaving insufficient time for you to reflect, change and demonstrate that change. In this case, the event can be carried through to the next appraisal and discussed more fully then.

An account of an SEA should not allow patients to be identified and should comprise:

- title of the event
- date of the event
- date the event was discussed and the roles of those present
- a description of the event involving the GP
- what went well?
- what could have been done differently?
- reflections on the event in terms of:
    - knowledge, skills and performance
    - safety and quality
    - communication, partnership and teamwork
    - maintaining trust
- what changes have been agreed:
    - for me personally
    - for the team
- changes carried out and their effect.

Although the clinical governance procedures in out-of-hours and walk-in centres normally require significant events to be discussed with the doctor concerned, locums and out-of-hours doctors often are not notified of any significant events arising from their work, and getting access to the case notes of such patients can be challenging. The responsibilities of those who engage locums (including general practices) to support access for quality assurance must be made clear and included in terms and conditions of employment. Doctors working out of hours should seek opportunities to report and discuss significant events within their organisations so that they can contribute to organisational learning. However, where such processes are not fully established the doctor should seek to take the significant event to an alternative forum for discussion and reflection with peers such as a self-directed learning group or peer group.

If it is impractical for a GP to provide evidence of SEA because of his or her working circumstances, the GP may wish to provide individual case reviews instead. Typically, a case review would be structured using the same headings as an SEA but discussion of the review can take place within a peer group rather than a practice team if more appropriate. Trigger tools are becoming available in which the care of patients with certain high-risk characteristics is reviewed systematically.[33] Evidence from the use of trigger tools can be used for revalidation by doctors for whom significant event auditing is not feasible.

It is important, however, that *all* serious clinical incidents a GP is involved with are recorded and reflected upon.

Clinical audit

All GPs should be familiar with the principles and practice of clinical auditing. If your circumstances allow you to complete a clinical audit, this should be recorded in your revalidation portfolio. This should be a full-cycle clinical audit (initial audit, change implemented, re-audit to demonstrate improvement).

The key attributes of a clinical audit are: the relevance of the topic chosen; the appropriateness of the standards of patient care set; the reflection on current care and the appropriateness of changes planned; the implementation of change for the GP's patients; and the demonstration of change by the GP. There is no expectation that you will actually undertake the data extraction and/or analysis.

Several GPs who work together as a team may undertake a common audit or quality improvement project. If you are doing a clinical audit for your revalidation portfolio, you must have contributed properly to the choice of topic and the standards set and made your involvement explicit in your submission. You must be able to state that the care identified within the first audit and the re-audit reflects the care that you deliver. You must state what changes you instituted and be able to demonstrate the effects of those changes.

A description of a clinical audit should include:

- the title of the audit
- the reason for the choice of topic
- dates of the first data collection and the re-audit
- the criteria to be audited and the standards set, with their justification; the clinical condition to be audited; or the process of care to be audited (all referenced to evidence-based guidelines etc.)
- the results of the first data collection in comparison with the standards set
- a summary of the discussion and changes agreed, including any changes to the agreed standards
- the changes implemented by the GP
- the results of the second data collection in comparison with the standards set
- quality improvement achieved
- reflections on the clinical audit in terms of:
    - knowledge, skills and performance
    - safety and quality
    - communication, partnership and teamwork
    - maintaining trust.

33. www.institute.nhs.uk/safer_care/primary_care_2/introductiontoprimarycaretriggertool.html.

Clinical audits tend to involve *retrospective* data collection and are therefore much easier to undertake when working over time in one organisation and where there is access to the organisation's administration. These advantages do not normally apply to peripatetic locums and out-of-hours doctors. However, there are some clinical audit topics that involve the *prospective* collection of data which may be more suitable for locums and out-of-hours doctors. These include:

- antibiotic prescribing
- investigation and imaging
- prescribing for pain
- referrals and admissions
- cancer diagnosis, e.g. breast/lung/prostate
- depression case handling
- medication reviewing
- hypertension management.

Practice audits

The GMC has accepted that many clinical audits are undertaken by practice teams. These are acceptable provided you have reflected on what that audit means for your own practice and that you indicate your role in the audit process.

Local and national audits

Participation in local or national audit is acceptable as long as the audit itself has been designed to encourage reflection, change and re-audit by individuals. The data must apply to you and you must be able to demonstrate the relevance of the audit to your personal practice. You might, for example, use data from the national diabetic audit and relate this data to your own personal practice. You must indicate your role in the audit process.

Quality and Outcomes Framework audits

If you have a sustained interest in a Quality and Outcomes Framework (QOF) area, agreed with the QOF standards, reflected on one year's QOF audit in that area and put in place changes to your clinical practice that you can document – and then can demonstrate an improvement in that area of QOF – then this should be acceptable to your appraiser and responsible officer. However, simply producing two years' worth of QOF data in which there is an improvement from one year to the next would not be sufficient.

Alternative quality improvement projects

Clinical audit with retrospective data collection is one of a number of established tools for improvement of quality in systems and teams. For doctors with managerial responsibility within their practice this may be the most appropriate form of quality improvement activity to submit as it will demonstrate they are involved in continuously improving the quality of their systems of health care. For some GPs, however – particularly those without a fixed practice base or employed GPs who usually have no managerial role and therefore no or limited organisational influence to bring about change in the behaviour of colleagues – audit in its traditional format may be more challenging and less relevant to the individual's appraisal. Additional challenges that audit presents to locum GPs include limited access to records, a lack of continuity in the place of work and the ability of the GP to influence other team members. The essential elements of audit – reviewing, reflecting and improving – can however be incorporated into other review exercises that support quality improvement in the individual; these are discussed further below.

A quality improvement project can be designed to review and improve systems of care and may include a review of pathways of care experienced by a specific group of patients. A quality improvement project can include defining an area of clinical practice to review and the standards required, then prospectively collecting data, reviewing and evaluating, planning change and followed by a further data collection and review. A description of a quality improvement programme should include:

- the title of the quality improvement programme
- the reason for the choice of topic and statement of the problem
- the process under consideration (process mapping)
- the priorities for improvement and the measurements adopted
- the baseline data collection, analysis and presentation
- baseline data collection, analysis and presentation
- the quality improvement objectives
- the intervention and the maintenance of successful changes
- the quality improvement achieved and reflections on the process in terms of:
    - knowledge, skills and performance
    - safety and quality
    - communication, partnership and teamwork
    - maintaining trust.

It is helpful if you submit supporting information that gives precise information on as many of the above items as possible.

Quality improvement projects (as an alternative to clinical audit) may include:

- a review of your prescribing, e.g. looking at the use of sedatives and hypnotics in a nursing home you look after, or reviewing nephrotoxic drugs in your patients with declining renal function
- looking at the complication rates of minor operations you carry out, performing a risk assessment on the surgery to improve patient safety and reduce complication rates, and detailing how you have addressed each area of risk
- setting up a new service, e.g. a teenage health clinic, a community obesity reduction project, or a new primary care team approach to patients in a community hospital
- looking at and improving patient safety issues such as:
    - the effective monitoring of hazardous drugs, e.g. warfarin, TNF-alpha blockers
    - addressing an area where patient follow-up has been a problem and diagnosis and management have been sub-optimal
    - using a validated trigger tool to identify high-risk patients and prevent harm, e.g. using an NHS Primary Care Trigger Tool to identify and reduce catheter-associated UTI adverse events
- setting up and evaluating a new educational or research initiative, e.g. developing a regional programme of multidisciplinary learning, or being the lead person involved in enabling the practice to become accredited for research
- evaluating the impact and effectiveness of a new policy or practice, e.g. a new system for near-patient testing, or the piloting of nurse triage within the practice
- setting up and piloting a new system of nurse triage within the practice, and evaluating the effectiveness of this
- conducting a case notes review of complex cases with an appropriately skilled and experienced colleague or colleagues in which challenging cases are reviewed, reflection occurs and

improvements identified. A serial case analysis (ten consecutive cases from a randomly chosen consulting session) or a problem-based case series (ten cases with a specific condition) can be used, discussing the process and outcome of each consultation with an appropriately skilled and experienced colleague or colleagues in which reflection occurs and improvements are identified. A case notes review is one way in which GPs who can only influence their own personal practice (not that of their team) may demonstrate quality improvement of the care they personally deliver by reviewing their own practice

- conducting a condition-based review by selecting a clinical area that you feel may merit improvement for which there are good (preferably) evidence-based guidelines and which you see a reasonable number of cases of, e.g. UTIs, depression, COPD, asthma, anxiety
    - o carry out a prospective collection of encounters printing off (anonymised) the consultation and patient summary and meds
    - o once you have collected at least ten, look carefully at how you have managed these in the context of the guidelines you have found and see whether there are any patterns, themes or learning points as to aspects of diagnosis or care that you have omitted or need to improve
    - o identify key changes that you need to make in your personal practice
    - o repeat the exercise.

[The above example is taken from the North-East Sessional GP (NESG) group's guidance on evidence for appraisal for sessional GPs.][34]

- review of referrals – see the Scottish Online Appraisal Resource's (SOAR) Sessional GP Appraisal Toolkit.[35]

Further guidance on quality improvement projects can be found in the RCGP Quality Improvement Toolkit.[36]

34. www.nesg.org.uk/content/Appraisal%20and%20Revalidation.
35. www.scottishappraisal.scot.nhs.uk/scottish-sessional-gp-appraisal-toolkit-(online-forms)/domain-2.aspx.
36. www.rcgp.org.uk/revalidation-and-cpd/revalidation-additional-resources.aspx.

Feedback on practice

How others perceive the quality of your professional work

Feedback from colleague survey

A survey feeding back from colleagues (previously called Multi-Source Feedback or MSF) is a recognised way for a person to gain formative information on how he or she is seen by those with whom he or she works.[37] They are not a 'pass/fail' assessment, but provide an opportunity for a doctor to reflect and, if appropriate, change his or her behaviour. As such, colleague surveys can be used to demonstrate that a GP is both reflecting and improving. You will be expected to provide a colleague survey and discuss this with your appraiser in every revalidation cycle. The survey for your first revalidation can date from up to 5 years before the date of your recommendation as long as it remains relevant to your current scope of work. We recommend that you undertake a colleague survey early in the revalidation cycle to enable time for a follow-up survey if any issues are identified and discussed with an appraiser.

The process

You will need to identify a number of clinical colleagues and other people (nurse, practice manager, practice secretary, receptionist, etc.) with whom you work sufficiently closely to enable informed and representative opinions to be made. If you work in multiple roles you should ask individuals from as many of these roles as possible to provide feedback, accepting that some colleagues may not be able to comment directly on your clinical practice. The selected colleagues, who should represent an appropriate mixture of clinical and non-clinical, will be asked by email – via the survey tool you are using – to complete a questionnaire giving their view on key attributes concerning yourself. Questionnaire providers will state a minimum number of colleagues to ensure reliable feedback. In uncomplicated cases the questionnaire should take 10 to 20 minutes to complete, but it may take longer if reflection and consideration are required. The information colleagues provide will be anonymised and a summary report will be created.

Requirements

It is important that colleague feedback data are:

- anonymised
- not inputted by yourself (as the subject of the feedback exercise)
- collated and analysed independently to ensure an objective review of the information.[38]

Ideally, colleague feedback should use national or group norms for comparison.

37. RCGP Feedback Toolkit (www.rcgp.org.uk/revalidation-and-cpd/revalidation-additional-resources.aspx).
38. We would advise that these functions are not undertaken by a practice manager as he or she is essentially an employee of the practice.

If you feel that you will experience difficulty in meeting the above requirements, you should highlight this to your appraiser.

RCGP-recommended colleague questionnaires

The RCGP reviews colleague survey questionnaires on an ongoing basis and currently considers that the following are suitable for use by GPs for revalidation:

- Sheffield Peer Review Assessment Tool Version 2 (GP-SPRAT)[39]
- Colleague Feedback Evaluation Tool Version 2 (CFET)[40]
- General Medical Council Colleague Questionnaire[41]
- Edgecumbe 360° Colleague Feedback[42]
- 2Q MSF.[43]

The reviews have considered:

- the breadth of coverage by each questionnaire (mapped to the GMC Framework)
- the validation undertaken for each questionnaire.

The companies themselves, value for money or the software tool used for input, collation, analysis and feedback have not been considered in the assessment.[44]

If you have used a colleague feedback questionnaire that is not on this list, it will still be acceptable if it is focused on you, what you do, and the quality of your care for your patients, and if it was conducted objectively and confidentially in line with GMC guidance.

Reflection and implementation of change in practice

The most important aspect of doing colleague surveys is reflecting upon the results and, if appropriate, implementing changes. The result of your survey should be discussed in your annual appraisal, and the revalidation portfolio will need to show supporting information from that discussion. Any agreed actions should be included in that appraisal's PDP and should be reviewed at the next appraisal. You should undertake a colleague survey reasonably early in the revalidation cycle (i.e. in the first three years) to allow time for a follow-up survey later in the cycle if problems are identified.

Colleague feedback for GPs in a variety of working circumstances

Peripatetic locums and out-of-hours doctors may not be well enough known to those they work with for them to form a viable opinion; a survey could be conducted long after they have worked in a particular setting. Some questions in conventional colleague surveys only apply to GPs in a fixed general practice base or locums in chambers. GPs in small, remote practices may have insufficient colleagues.

For some, the problems may not be insurmountable. Colleague surveys designed for peripatetic locums and out-of-hours doctors should be piloted and validated. The results of colleague surveys should compare any group of doctors with their peer groups (as well as GPs in general). A doctor in a professional organisation (chambers etc.) might include colleagues in that organisation for colleague feedback.

39. www.waspsoftware.co.uk/MAP/Volunteer/Login.aspx.
40. www.cfepsurveys.co.uk/OrganisationalAndPersonalDevelopment/PrimaryCare/CFET.
41. www.gmc-uk.org/colleague_questionnaire.pdf_48212261.pdf.
42. www.doctor360.co.uk/.
43. www.tipportfolio.co.uk/example2q.aspx.
44. The list of recommended tools was up to date at the time of publication. For an up-to-date list please see www.rcgp.org.uk/revalidation-and-cpd/supporting-information-for-appraisal-and-revalidation.aspx.

For these doctors, equivalent supporting information could be provided. Doctors may submit an online questionnaire to practices and organisations in which they work to be completed immediately after they work there, accumulating the evidence from these surveys over an extended period of time. A doctor may be observed in practice by a suitably qualified and trained colleague (such as a trained appraiser or vocational trainer) over a period of at least 2 hours, with assessment of his or her team working, communications, note keeping and clinical care. Evidence from out-of-hours clinical governance reviews may include peer review of the performance of individual doctors and can be used by them as supporting information.

Feedback from patients – patient survey

You will be expected to provide a patient survey and discuss this with your appraiser in each revalidation cycle. The survey for your first revalidation can date from up to 5 years before the date of your recommendation as long as it remains relevant to your current scope of work. We recommend that you undertake a patient survey early in the revalidation cycle to enable time for a follow-up survey if any issues are identified and discussed with an appraiser.

The process

GPs commonly arrange for the reception to hand a paper questionnaire to a patient before the consultation. The patient will complete the questionnaire following the consultation and give it to the practice receptionist or another member of staff to input the results into a survey questionnaire tool. Some survey tool providers offer a stamped address envelope to enable the patient to send his or her feedback directly to the survey tool provider for input. This service can be used by GPs without a fixed practice base who may not have administrative support within their place(s) of work. Additionally, some survey tool providers allow a patient's email address to be entered for inclusion on an electronic request for feedback. It is important, however, that GPs do not rely exclusively on email feedback as they are unlikely to capture feedback from a representative range of their patients by doing so.

Survey tool providers will state a minimum number of patients to ensure reliable feedback.

Requirements

It is important that patient feedback data:

- are anonymised
- come from successive patients (or successive patients in more than one place of work)
- are not inputted by yourself (as the subject of the feedback exercise)
- are collated and analysed independently to ensure an objective review of the information.

You will need to seek the views of the patients actually consulting you – practice-based surveys of the registered population will not be acceptable.

Ideally, patient feedback should use national or group norms for comparison.

If you feel that you will experience difficulty in meeting the above requirements, you should highlight this to your appraiser.

RCGP-recommended patient questionnaires

The RCGP reviews patient survey questionnaires on an ongoing basis and currently considers that the following are suitable for use by GPs for revalidation:

- General Medical Council Patient Questionnaire[45]
- Improving Practice Questionnaire (IPQ)[46]
- Edgecumbe 360° Version 2[47]
- Doctors' Interpersonal Skills Questionnaire (DISQ)[48]
- Consultation Satisfaction Questionnaire (CSQ)[49]
- CARE Measure Questionnaire[50]
- General Practice Assessment Questionnaire (GPAQ-R).[51]

The reviews have considered:

- the breadth of coverage by each questionnaire (mapped to the GMC Framework)
- the validation undertaken for each questionnaire.

The companies themselves, value for money or the software tool used for collation, analysis and feedback have not been considered in the assessments.[52]

If you have used a patient feedback tool that is not on this list, it will still be acceptable if it is focused on you, what you do, and the quality of your care for your patients; and if it was conducted objectively and confidentially.

Reflection and implementation of change in practice

The most important aspect of undertaking patient surveys is the reflection upon the results and, if appropriate, implementing changes. The result of each patient survey should be discussed at your annual appraisal, and your revalidation portfolio will need to show supporting information of that discussion. Any agreed actions should be included in that appraisal's PDP and should be reviewed at the next appraisal.

Patient feedback for GPs in a variety of working circumstances

It is recognised that some GPs may find patient surveys more challenging than others. Locums and out-of-hours doctors usually lack a long-term relationship with their patients; locums may be working in practices that are under stress; and they may not be in one setting long enough to recruit a coherent cohort of patients. The results of patient surveys should compare locums and out-of-hours doctors with their peer groups (as well as GPs in general). The patients for a survey conducted by a locum or out-of-hours doctor should be consecutive, over several sessions and in a variety of clinical sessions if necessary. Evidence from out-of-hours clinical governance reviews may include patient views on the performance of individual doctors and can be used by them as supporting information.

45. www.gmc-uk.org/patient_questionnaire.pdf_48210488.pdf.
46. www.cfepsurveys.co.uk/OrganisationalAndPersonalDevelopment/PrimaryCare/IPQ.
47. www.doctor360.co.uk/.
48. www.cfepsurveys.co.uk/OrganisationalAndPersonalDevelopment/PrimaryCare/ISQ.
49. http://csq.org.uk/websurvey/index.php?sid=69411&lang=en.
50. www.caremeasure.org/.
51. www.gpaq.info/GPAQ-R.pdf.
52. The list of recommended tools was up to date at the time of publication. For an up-to-date list please see www.rcgp.org.uk/revalidation-and-cpd/supporting-information-for-appraisal-and-revalidation.aspx.

GPs working in secure environments may find eliciting their patients' views challenging. Benchmarking data against other GPs working in secure environments may be possible in the future. It is important that appraisers and responsible officers are able to understand feedback gained in this context.

The RCGP will ask organisations conducting the analyses of patient surveys to provide peer referencing against GPs as a whole and also an appropriate peer group (partners, salaried, locums, prison doctors, etc.). An additional challenge for GPs without a fixed practice base is the potential lack of administrative support to enter patient data. Whereas colleague feedback is generally provided by email, it cannot be assumed that patients will have access to email and patient feedback provided solely by email risks being unrepresentative. Many survey tool providers offer a freepost stamped addressed envelope that can be attached to the survey and handed to patients by practice staff. The survey provider will input the data, collate it and return it to the GP in the form of a report.

Description of any cause for concern and/or formal complaint, and compliments

Failure to disclose any cause for concern at appraisal is a significant breach of probity. Responsible officers should have in place a mechanism for ensuring that GPs who are currently giving cause for concern should have their appraisal paperwork checked after the appraisal meeting to ensure that the issues have been discussed and the discussions recorded.

Some GPs may have been identified as giving cause for concern during their revalidation period. Any cause for concern[53] should be recorded and reported on in this supporting information area. The key elements of the report, which should not identify patients or other relevant individuals, should be:

- a description of events that resulted in a cause for concern being expressed
- the cause for concern
- the assessment of that cause for concern
- any actions resulting from that assessment
- the outcome of the cause for concern
- reflection by the GP on the experience, including lessons learnt, changes made and implications for the future.

If a serious cause for concern (which, if substantiated, might call into question a doctor's fitness to practise) is unresolved at the time of revalidation, the responsible officer may ask the GMC to defer that doctor's recommendation submission date.

There will be many more GPs who have had a formal complaint or formal complaints initiated or resolved within the revalidation period. A formal complaint is one that activated, or should have activated, the practice complaints procedure, involved the primary care organisation, or involved any other formal health service organisation.

Although many complaints are satisfactorily resolved at an early stage, your revalidation portfolio should include all such complaints.[54] The intention is to look for two points: a pattern of complaints that may suggest systemic issues; and to confirm your appropriate level of response to receiving complaints (reflection, lessons learnt, etc.). The description of such complaints should be sufficient

53. A 'cause for concern' is significant for revalidation purposes if the local responsible officer judges it to be so and is unresolved until the responsible officer is satisfied that there are no continuing issues that would compromise revalidation.
54. RCGP Complaints Toolkit (www.rcgp.org.uk/revalidation-and-cpd/revalidation-additional-resources.aspx).

for the responsible officer to satisfy him or herself regarding these two points and should include:

- a description of the events that resulted in a formal complaint
- the concerns expressed by the complainant
- the assessment of that complaint
- any actions resulting from that assessment
- the outcome of the complaint
- your reflection on the experience, including lessons learnt, changes made and implications for the future.

In this part of their portfolio a GP can also record unsolicited compliments that he or she has received from patients or their carers or relatives.

Other sources of advice

RCGP revalidation helpdesk

revalidation@rcgp.org.uk

RCGP revalidation guidance for GPs web pages

These pages include:

- a comprehensive set of FAQs
- a range of resources relating to:
  - appraisal
  - CPD
  - quality improvement
  - feedback on practice.

www.rcgp.org.uk/revalidation-and-cpd/new-revalidation-guidance-for-gps.aspx

RCGP additional revalidation resources

These include:

- example portfolios
- toolkits
- an easy-to-navigate question and answer (Q&A) bank.

www.rcgp.org.uk/revalidation-and-cpd/revalidation-additional-resources.aspx (non-RCGP members will need to register to access these resources unless they are currently registered with the RCGP)

RCGP Revalidation ePortfolio

An electronic system designed specifically to help GPs collect supporting information for appraisal and revalidation.

https://gpeportfolio.rcgp.org.uk/Login.aspx

RCGP Online Learning Environment (OLE) – revalidation course

The recently published OLE revalidation course contains the following four interactive modules developed by RCGP Specialty Advisers:

- Revalidation – general overview
- Keeping Up To Date

- Review of Practice
- Feedback from Colleagues and Patients.

The RCGP Online Learning Environment (OLE) offers a variety of online courses aimed at practising GPs, including the Essential Knowledge Update (EKU) and the Essential Knowledge Challenge (EKC) programme. Courses are added regularly to reflect the ever-changing needs of GPs.
www.elearning.rcgp.org.uk

e-GP

e-GP is an educational project run by the RCGP and e-Learning for Healthcare. It provides a comprehensive programme of e-learning modules to support GP training and professional development.
www.e-lfh.org.uk/projects/general-practitioners/

Learning credits

Find out more about the RCGP learning credits scheme at:
www.rcgp.org.uk/revalidation-and-cpd/cpd-credits-and-appraisal.aspx

Clinical audit

The RCGP Clinical Innovation and Research Centre (CIRC) has developed valuable guidance on clinical audit.
www.rcgp.org.uk/clinical-and-research/clinical-resources/clinical-audit/audit-guidance.aspx

RCGP courses and events

The RCGP runs many courses, conferences and events across the UK covering a number of clinical and professional topics to support CPD.
www.rcgp.org.uk/courses-and-events.aspx

External guidance and tools

Further guidance and advice can be found at the following sources:
www.gmc-uk.org/doctors/revalidation.asp
www.revalidationsupport.nhs.uk
www.bma.org.uk
www.aomrc.org.uk/revalidation.html

NHS England Medical Appraisal Policy (draft)

www.england.nhs.uk/wp-content/uploads/2013/03/medical-app-policy.pdf

NHS Health Education England – Local Education and Training Boards (LETBs)

http://hee.nhs.uk/about/our-letbs/

Chambers organisations

www.pallantmedical.org.uk

www.nasgp.org.uk/cpd/revalidation

Sessional/out-of-hours GPs

National Association of Sessional GPs
www.nasgp.org.uk/cpd/revalidation/

North East Sessional GP Group
www.nesg.org.uk/

BMA General Practitioners Committee (GPC) Sessional GP subcommittee (see subcommittee downloads)
http://bma.org.uk/about-the-bma/how-we-work/negotiating-committees/general-practitioners-committee

RCGP additional revalidation resources

- **Locum GP Example Portfolio.**
- **Out-of-Hours GP Example Portfolio.**
- **Quality Improvement Toolkit.**

www.rcgp.org.uk/revalidation-and-cpd/revalidation-additional-resources.aspx

Scottish Online Appraisal Resource (SOAR) Sessional GP Appraisal Toolkit

www.scottishappraisal.scot.nhs.uk/scottish-sessional-gp-appraisal-toolkit-(online-forms).aspx

Scottish Online Appraisal Resource (SOAR) Out Of Hours (OOH) GP Appraisal Toolkit

www.scottishappraisal.scot.nhs.uk/scottish-ooh-gp-appraisal-toolkit-(online-forms).aspx

Toolkits

Significant Event Audit Toolkit

www.nrls.npsa.nhs.uk/resources/?entryid45=61500

Glossary

Academy of Medical Royal Colleges (AoMRC)	The organisation that represents the views and interests of all the medical royal colleges and faculties collectively
Appraisal • GP appraisal • annual appraisal	Each GP on an NHS Performers List should he appraised every year (April to March). An appraisal assists the GP to review his or her performance and draw lessons from it
Appraiser	A trained and supported GP who undertakes the appraisal of colleagues
Clinical governance	A framework through which NHS organisations and other designated bodies are accountable for improving quality of services and care, and promoting patient safety
Designated body	An organisation, which most licensed doctors should have a connection with, responsible for supporting doctors through appraisal and revalidation. Each designated body has a responsible officer (see below) who recommends doctors to the GMC to be revalidated
General Practice Register	The register maintained by the GMC of those doctors who have satisfactorily completed vocational training (or equivalent in other countries) and are eligible to work in the NHS as a GP
Learning credit	A unit of education that includes a reflective record to demonstrate learning
Locum chambers	Small groups of freelance GPs performing all their work within a clinical governance framework in small self-governing managed teams
Performers List	NHS England holds a list of doctors able to work in general practice in England and performers lists are held for Scotland, Wales and Northern Ireland
Portfolio	The collective supporting information accumulated for an individual GP's purposes, for appraisal and for revalidation

Primary care organisation	This is a generic term used in this document that covers Area Teams in England, NHS Boards in Scotland, Health and Social Trusts in Northern Ireland and NHS Health Boards in Wales
RCGP	The Royal College of General Practitioners; its remit covers standards, education, research and quality of patient care, but not contractual issues
RCGP Specialty Adviser	A trained and supported person who will provide generic advice to responsible officers and similar stakeholders on complex or unusual revalidation queries
Registers	The GMC maintains three main registers: a Medical Register of doctors in good standing; a Specialist Register for those who have achieved a level of expertise (and who may work as a consultant in the NHS); and the General Practice Register for those who have the expertise to work as a GP
Responsible officer	Every organisation ('designated body') with a quality-assured system of clinical governance is required to appoint a locally based senior doctor as a responsible officer to oversee appraisal, local concerns and revalidation
Revalidation	The periodic confirmation that a doctor remains up to date and fit to practise
Revalidation ePortfolio	An electronic portfolio used for the purposes of appraisal and revalidation
Sessional GPs	Fully qualified GPs such as salaried GPs, GP locums or retainer GPs. Their working arrangements are invariably stipulated in terms of sessions covered rather than contracted-for services
Specialist Register	The register maintained by the GMC of those doctors who have obtained a certificate of completion of specialist training (or equivalent in other countries) and are eligible to work in the NHS as a consultant