



Royal College of  
General Practitioners

# Royal College of General Practitioners: RCGP Guide to supporting information for appraisal and revalidation (2016)

Dr Susi Caesar  
Medical Director for Revalidation  
Royal College of General Practitioners  
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With many thanks for the input and valuable contributions from patient and lay representatives and a wide range of internal and external stakeholders

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 supporting information for general practitioners. It is continually evolving in the light of policy decisions from the General Medical Council, Department 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.

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# Introduction

Successful revalidation is based on the demonstration that your normal way of working is safe and up-to-date. This is achieved by sharing, and discussing during the appraisal process, a relatively small number of examples of reflective practice that meet the General Medical Council (GMC) requirements across six types of supporting information. In addition, the responsible officer (RO) must be satisfied that there are no outstanding concerns about your practice arising from clinical governance information, or any other source.

Since the introduction of revalidation, there has been recognition that the effort involved should be reasonable and proportionate. Feedback from the 2015 RCGP revalidation survey, and other sources, suggests that inconsistencies in interpretation have led, in some cases, to the GMC requirements and RCGP guidance being applied in ways that are more onerous than intended. The inconsistencies must be removed so that the administrative burden is decreased.

All doctors should have to meet the same standards to revalidate, no matter what their scope of work, and revalidation should not detract from patient care. You must not allow the effort involved in producing your documentation to become disproportionate by attempting to document every example of your reflective practice. Appraisal is a valuable opportunity for facilitated reflection and learning, sharing and celebrating successes and examples of good practice, and planning for the future. It is important that you and your appraiser keep a supportive and developmental focus on quality maintenance and improvement through your personal and professional development without a major increase in workload.

Almost all GPs will have completed their first cycle of revalidation by the end of March 2016. From 1 April 2016 onwards, the RCGP guidance needs to be clearer and simpler to avoid inconsistencies in interpretation and an unnecessary burden on GPs. This new document provides specialty specific detail on revised RCGP recommendations to enable you to fulfil the GMC requirements for supporting information while protecting your time for patient care.

# Headlines

The RCGP recommend that, as a GP, you maintain a focus on the quality rather than the quantity of supporting information in your appraisal and revalidation portfolio by demonstrating:

- an appropriate level of detail in describing your scope of work
- reflection on the probity and health statements and the domains of *Good Medical Practice* (GMC, 2013)
- annual reflection on continuing professional development (CPD) learning activities across a balanced programme appropriate to your scope of work
  - If you undertake the full range of general medical services in undifferentiated primary care (normal general practice), the RCGP recommend that you demonstrate at least 50 CPD credits per annum on average, irrespective of the number of sessions you work. If you no longer provide the full range of general practice services, or have exceptional circumstances to declare, you may sometimes do less, provided there is appropriate explanation and reflection within your appraisal portfolio, which is discussed with your appraiser and agreed with your responsible officer
  - one CPD credit = one hour of learning activity demonstrated by a reflective note on lessons learned and any changes made
  - each learning activity only needs one reflective note even if it lasts several hours
  - when a learning activity consolidates what you know, but you learn nothing new, your reflective note should say so, and the time taken should be credited
  - all your learning activities, including learning arising from Quality Improvement Activities, Significant Events, Feedback from colleagues and patients and Complaints, as well as personal reading and professional conversations, are eligible for CPD credits providing that you document them appropriately with reflection
  - once you have demonstrated 50 CPD credits, there is no need to obsessively document or write reflective notes on every learning activity you undertake (prioritising reflection on your key learning from the past year is recommended)
  - the 'one size fits all' doubling of CPD credits for demonstrating the impact of your learning on your practice is being phased out, and being replaced by the recommendation that you record accurately the CPD credits for time spent on additional learning activities involved in demonstrating impact
  - in order to avoid professional isolation, it is recommended that over the five year cycle, you should provide evidence of some learning activities taking place with colleagues outside your normal place of work

- annual reflection on ongoing review of your work across your whole scope of work
  - the RCGP recommend that you include representative quality improvement activities (QIA) every year to demonstrate how you review the quality of your work and reflect on the standard of care you provide
  - you should provide a balance of different types of QIA over the five year cycle, including reflection on your personal outcome data, where available, and examples of initiatives that have led to quality improvements in practice
  - it is important that your quality improvement activities review whether changes you make have made a difference to quality of practice
- reflection on the analysis and review with colleagues of all significant events (SE) in which you have been personally named or involved and in which serious harm could have, or did, come to patients, as and when they arise
  - it is appropriate for you to make a declaration that there have not been any such significant events if you have not been personally named or involved in one
  - normal GP significant event analysis (SEA) should be included as a form of quality improvement activity, unless the event reaches the GMC threshold of harm
- reflection on feedback from colleagues using a feedback tool compliant with the GMC requirements at least once in every five year cycle
  - it is important to ensure that there are appropriate respondents from across your whole scope of work, over the five year cycle, whether they are all included in your one formal GMC compliant feedback, or whether you seek and reflect on feedback separately for a specific role (e.g. an appraiser seeking feedback from appraisees)
- reflection on feedback from patients using a feedback tool compliant with the GMC requirements at least once in every five year cycle
  - it is important to ensure that you choose, from the ever increasing range of feedback tools, a GMC compliant tool that is appropriate for your scope of work and accessible to the whole range of respondents / patients
- reflection on other sources of feedback from patients, whether formal or informal, including compliments, where appropriate, on an annual basis
- reflection on all complaints in which you have been personally named or involved, as and when they arise
  - it is appropriate for you to make a declaration that there have not been any complaints if you have not been personally named or involved in one
- reflection on anything else you have been specifically asked to bring to the appraisal
  - if your responsible officer has asked you to bring specific information to the appraisal, such as routine clinical governance information provided by your organisation, or the outcomes of an investigation or complaint, then you must do so, so that you can share your reflections on it with your appraiser, and your appraiser can record it in the summary of the appraisal.

# Context

The GMC has issued *Good Medical Practice: a Framework for Appraisal and Revalidation* (GMC, 2012a) and *Supporting Information for Appraisal and Revalidation* (GMC, 2012b) as well as *Continuing Professional Development: Guidance for all doctors* (GMC, 2012c). These key documents outline the broad areas that need to be covered in a medical appraisal for revalidation and describe six types of supporting information required by the GMC for a positive revalidation recommendation:

- continuing professional development (CPD)
- quality improvement activities (QIA)
- significant events (SE)
- feedback from colleagues
- feedback from patients
- review of complaints and compliments.

The GMC requirements are necessarily broad enough to fit every doctor, no matter what area, sector or scope of work.

Additional generic guidance has been developed by the Academy of Medical Royal Colleges (AoMRC), including *Supporting Information for Appraisal and Revalidation: Core Guidance Framework* (AoMRC, 2013) and *Appraisal for Revalidation: A Guide to the Process* (AoMRC, 2014).

Generic GMC requirements and AoMRC guidance have been interpreted by the RCGP, in a specialty-specific context, for all GPs, irrespective of their scope of work, in this document. This arises from the need to remove inconsistencies in the interpretation of earlier guidance and to keep proportionate the amount of documentation required to successfully revalidate. Each section is structured to highlight the GMC requirement (in shaded boxes), followed by the AoMRC guidance (in outlined boxes) and finally the RCGP specialty specific recommendation(s) (in black). It provides additional detail for GPs on providing the specific supporting information required in each of the six GMC categories, scope of work and reflection on probity and health.

GPs should also understand the process of annual medical appraisal for revalidation as defined for GPs in England in the Revalidation Support Team's *Medical Appraisal Guide*, for GPs in Scotland in NHS Scotland's *A Guide to Appraisal for Medical Revalidation*, for GPs in Wales in the Wales Deanery's *All Wales Medical Appraisal Policy* and for GPs in Northern Ireland in documentation provided by the Northern Ireland Medical and Dental Training Agency.

# Reflection

The GMC say: “In discussing your supporting information, your appraiser will be interested in what you did with the information and your reflections on that information, not simply that you collected it and maintained it in a portfolio. Your appraiser will want to know what you think the supporting information says about your practice and how you intend to develop or modify your practice as a result of that reflection. For example, how you responded to a significant event and any changes to your work as a result, rather than the number of significant events that occurred.” (GMC, 2012b, p.2)

The GMC requirements, AoMRC guidance and RCGP recommendations, all highlight the importance of reflection on supporting information, not just the capture of raw data in a portfolio. Reflective practice is central to the annual appraisal process because the quality of your medical practice is maintained and improved by thinking through what you have learned and what you will do differently as a result. There are two stages to reflection in appraisal: firstly, your thoughts about your supporting information, captured in your reflective notes in your portfolio and, secondly, the facilitated reflection with the appraiser during the appraisal discussion, when your individual reflection may be put into context and developed into plans for the future.

Because reflection is so important for appraisal and revalidation, and yet the word itself means different things to different people, and there are many different models of reflection, there has been a lot of anxiety about how to document reflection appropriately without allowing the recording of it to become disproportionate.

Doctors are trained to think about what they do all the time, and to have the insight to acknowledge when they feel that there are potential gaps in their knowledge or skills, or that something could have gone better, and to take steps to address those needs. For doctors, professionalism means engaging in a continuous process of self-assessment and personal and professional development. Often this process is so ingrained in the reflective practitioner, that it is hard to bring their thoughts and reflections to the level of conscious awareness to write them down and this is one of the reasons why the documentation associated with appraisal has been perceived, in some cases, as burdensome, especially if it is not applied in a proportionate way.

The emphasis in *Good Medical Practice* (GMC, 2013) is on practising as a reflective professional, not on documenting reflection obsessively, especially if the documentation detracts from time spent with patients, colleagues, friends or family.

The RCGP recommend that you should provide a relatively small number of representative, high quality documented examples of your reflective practice in your supporting information for appraisal and revalidation, not to try to document your reflection every time something new is learned or looked up or discussed. Before including an additional piece of supporting information in the portfolio, you should ask yourself what it adds to what is already there.

# Description of professional roles

The GMC describe: "Scope of Work. This will include the organisations and locations where you have undertaken work as a doctor. You will also need to provide a comprehensive description of the scope and nature of your practice". (GMC, 2012b, p3)

The AoMRC, 2014, recommend that: "The doctor should record the scope and nature of all of their professional work carried out to ensure that the appraiser and the responsible officer understand the doctor's work and practice. This should include all roles and positions for which a licence to practise is required, and should include work for voluntary organisations, work in private or independent practice and managerial, educational, research and academic roles.

Types of work may be categorised into:

- clinical commitments
- educational roles, including academic and research
- managerial and leadership roles
- any other roles.

Although the supporting information brought to appraisal for revalidation should cover the whole scope of a doctor's practice, this coverage does not have to take place every year of the five year cycle. It is permissible for a doctor to concentrate on specific areas of practice each year, and then to discuss with their appraiser how and when the remaining areas will be covered during the five-year cycle."

As a GP, you need to clarify your scope of work, because you are required to provide supporting information to demonstrate the quality of your work against the standards in *Good Medical Practice* (GMC, 2013) for the scope of work that you actually do, not what you historically qualified for.

Any separate role which requires a licence to practise, paid or unpaid, for a different organisation, employer, or as an individual, needs to be included so that the responsible officer (RO) knows where to seek assurance that you are fit to practise. It is best practice to include the contact details, where applicable, for each organisation or employer, to facilitate the transfer of information to the RO, and to be aware of the clinical governance arrangements in place. The RO may request confirmation,

from each part of your scope of work outside the designated body, that there are no outstanding clinical governance issues, concerns or investigations, or request an up-to-date status report on any progress made, before making your revalidation recommendation.

In those circumstances where you have had a separate internal in-post review or 'appraisal' for a specific part of your scope of work, it is normal to include the outputs from this review, and your reflection on those, where appropriate, as 'additional supporting information' in your main annual medical appraisal for revalidation.

Where you have several different responsibilities within the same part of your scope of work, such as the various lead responsibilities that a GP partner might take on for the practice, it is appropriate and reasonable to reflect on these elements of your 'job description' with your appraiser, but they do not need to be declared as separate "scopes of work". They do not require separate supporting information, or clinical governance review, because they are not provided for a different organisation, or independently. In determining the level of detail that is appropriate in declaring scope of work, you may find it helpful to consider whether the RO will need to have separate contact details to determine that the clinical governance arrangements are robust. Reflection on appropriate supporting information over the five year cycle needs to take place at the level of separate posts for different employers, or independently, not every responsibility that you may have.

Over the five year revalidation cycle, you do need to reflect on how you keep up-to-date, review what you do and what feedback you have had, as well as declaring all GMC level Significant Events and Complaints, for every post that forms a separate part of your scope of work.

# Probity and health

## Probity

The GMC requirements are expressed as follows: “Probity is at the heart of medical professionalism. Probity means being honest and trustworthy and acting with integrity. Probity is covered in paragraphs 65-80 of *Good Medical Practice*.” (GMC, 2012b, p3)

The AoMRC, 2014, recommend that: “The doctor should provide a statement indicating compliance with the requirements on probity set out in *Good Medical Practice* (GMC, 2013). This may take various forms depending on the appraisal portfolio that the doctor is using, but it should be clear that the doctor has considered all elements of the probity requirements of the GMC’s guidelines before making the statement.

On occasion, there may be ongoing investigations or disciplinary matters where progress towards resolution should be reviewed at appraisal. Appraisal is not the place where these matters should be resolved, but they should be acknowledged in a probity declaration”.

As well as signing the probity statement, and acknowledging where there is an ongoing investigation or disciplinary matter, the RCGP recommend that you reflect on the potential probity challenges raised in *Good Medical Practice* with your appraiser. This may include whether you have adequate and appropriate indemnity cover across the full scope of your work, any possible conflicts of interest between roles, business interests, etc.

## Health

The GMC requirements are laid out in *Good Medical Practice*: “Protect patients and colleagues from any risk posed by your health”. Paragraphs 28-30 (GMC, 2013)

The AoMRC, 2014, recommend that: “A declaration that the doctor has considered and complied with these requirements should be viewed and agreed by the appraiser”.

As well as signing the health statement, the RCGP recommends that you should reflect on your responsibility to be appropriately immunised, registered with a GP outside your own family and to protect patients from any risks posed by your health. If you have a health condition that could impact on patient care, it is best practice to reflect on any reasonable adjustments that you may have made to ensure that patient safety is not compromised.

# Continuing professional development (CPD)

“Every doctor is required to demonstrate how they keep up-to-date across their whole scope of work”. (GMC)

“The doctor should be participating in Continuing Professional Development (CPD) activity that covers the whole scope of his/her professional practice. It is not expected that CPD will be undertaken in every area of professional work every year, but the doctor should ensure all aspects are supported adequately over the five year cycle.

There should be a balance of learning methods and experiences. Evidence of CPD taking place with colleagues outside the normal place of employment is extremely important, particularly for those doctors working within a small group and isolated in their day to day work...

Achievement of at least 50 credits per year of the revalidation cycle...is recommended by all Colleges and Faculties as being the minimum time likely to be required in order to remain up-to-date in a doctor's specialty.

It is important to remember, however, that 50 hours of activity does not guarantee that all educational needs have been met. Emphasis should be placed on the quality of the CPD activities rather than simply on the number of hours spent...

As part of the supporting information, the doctor should provide reflection on what has been learned from CPD, and how this has influenced practice. The process of reflection will allow the consideration of CPD activity to focus on learning outcomes, rather than on a consideration of time spent.” (AoMRC, 2014)

- If you provide the full range of general medical services in undifferentiated primary care, the RCGP recommend that you demonstrate engagement with at least 50 CPD credits, on average, per twelve months of work, irrespective of the number of sessions worked. If this has not been possible, for any reason, you should provide a detailed reflective note, which includes an explanation, analysis of the implications and future plans to redress the balance (if appropriate), discussed with your appraiser, and agreed with your responsible officer.
- One credit = one hour of learning activity demonstrated by a reflective note on the lessons learned and any changes made.

- If you no longer provide the full range of general medical services in undifferentiated primary care, it may be appropriate for you to provide less than the recommended 50 CPD credits per year, provided that a detailed explanation and justification is reflected on during the appraisal, documented by your appraiser and agreed with your responsible officer.
- For periods of work that are more or less than twelve months, such as when your appraisal month has changed, or there has been a significant period of time out of work, such as maternity or sick leave, the RCGP recommends that you should demonstrate a number of CPD credits proportionate to the time you have spent in work, and provide an explanation that has been reflected on during the appraisal, as above.
- Keeping a structured learning log to capture CPD credits (including date, title, time taken, key lessons learned and reflection on impact on practice or any changes made as a result of learning) is recommended.
- There is no need for you to scan, or provide, copies of certificates for appraisal and revalidation where learning has been demonstrated through an appropriate reflective note (although it may be best practice to keep certificates for statutory and mandatory training defined by an employing organisation, so that you could provide them on demand).
- The former provision for GPs to 'double' their CPD credits by demonstrating impact led, in some cases, to disputes over credits rather than focus on demonstrating impact. This will be phased out, such that 'impact credits' of this type are no longer included after 31 March 2016. This will bring the guidance for GPs in line with other medical specialties by the second cycle of revalidation. The importance of demonstrating impact will be enhanced by the new definition of a CPD credit and the opportunity to claim for all learning activities associated with demonstrating impact.
- You are encouraged to reflect on any impact that your learning (from any CPD, QIA, Significant Events (SEs), feedback, complaints or compliments) has had on your practice and to include it in the CPD log as separate learning activity, allocating accurately the time taken, using the same definition:
 

One credit = One hour of learning activity demonstrated by a reflective note on the lessons learned and any changes made.

This gives you an appropriate way to demonstrate the time spent and the impact of the learning, which is more flexible and proportionate than the previous 'doubling' of CPD credits for demonstrating impact.
- It is best practice to document a balance of learning methods and experiences over the five year cycle.
- It is best practice to note any participation in CPD with colleagues outside your normal place of employment over the five year cycle.

Remember: "Emphasis should be placed on the quality of the CPD activities rather than simply on the number of hours spent". (AoMRC, 2014)

# Quality improvement activities (QIA)

“Every doctor is required to demonstrate how they review the quality of their work across their whole scope of work”. (GMC)

“For the purposes of revalidation, the doctor will have to demonstrate that they regularly participate in activities that review and evaluate the quality of their work. These should be systematic and relevant to their work and should include an element of evaluation and planned future action. Where possible, these activities should be able to demonstrate an outcome or change.

The GMC states that the following areas should be considered in relation to quality improvement activities:

- Have you participated actively in the selected quality improvement processes?
- Do the selected processes reflect key elements of your professional work?
- Have you evaluated and reflected on the result of the quality improvement activity?
- Have you taken appropriate action in the form of practice change, service development or other activities in order to respond to the findings?
- Have you undertaken, or planned to undertake, a review of the changes made?” (AoMRC, 2014)

- All doctors must demonstrate an ability to review and learn from their medical practice, particularly from significant events and patient care.
- The RCGP recommends that you should demonstrate the ability to review and learn from your medical practice by reflecting on representative quality improvement activities (QIA) relevant to your clinical work every year, with a spread of QIAs across all of your scope of work over a five year cycle.
- Previously the RCGP recommended reflection on two significant event analyses and/or case reviews every year and one quality improvement project, such as a clinical audit, or service redesign, in the five year cycle. Experience has shown that, although this is still appropriate for some, for many GPs it is too restrictive, and a far wider range of ways to review and improve the quality of your practice may be appropriate. This is in recognition that some forms of quality improvement activity may be difficult to achieve in certain circumstances, such as truly

peripatetic locum work, and that there is a growing understanding of the variety and breadth of excellent quality improvement activities presented by GPs.

- Going forward, you are advised to choose representative quality improvement activities, appropriate to your scope of work and circumstances, that reflect how you review and improve the quality of your practice every year.
- QIA may take many forms, including, but not restricted to: large scale national audit, formal audit, review of personal outcome data, small scale data searches, information collection and analysis (Search and Do activities), plan/do/study/act (PDSA) cycles, significant event analysis (SEA) and reflective case reviews, as well as the outcomes of reflection on your formal patient and colleague feedback survey results, Significant Events and Complaints.
- You are advised to choose the best examples of your routine primary care significant event analysis to include as quality improvement activities to demonstrate how you review and learn from significant events, but all significant events, in which you have been personally named or involved, that reach the GMC defined level of harm, must be included in Significant Events (see Significant Events below).
- For some parts of your scope of work, particularly relating to specific clinical skills such as minor surgery, joint injections, cervical smears and IUCD/IUS insertions (where applicable) it may be possible and appropriate to maintain a log of personal outcome data and reflect on the outcomes.
- If you are in a role where there is organisational, regional or national outcome data provided, it is best practice to demonstrate how you reflect on your personal involvement and response to the information provided about your performance.
- You do not need to have undertaken data collection personally but your reflection should describe your personal involvement in the activity and what you have learned about your own performance in relation to current standards of good practice, including what changes you plan to make as a result, or how you will maintain high standards of performance.
- No fixed number of QIA is being recommended, as some will be very brief interventions, and others will be very significant projects. The RCGP recommend that you keep in mind the principle of providing documentation that is reasonable and proportionate and does not detract from patient care, while ensuring that your QIA cover the whole of your scope of work over the five year cycle and demonstrate clearly how you review and improve the quality of your practice every year. If in doubt, discuss your plans for the coming year with your appraiser and use your professional judgement about what is appropriate.
- In earlier RCGP recommendations, counting CPD credits for the time spent on QIA was discouraged, but experience has shown that all learning activities can appropriately be included as continuing professional development, providing the CPD credits are demonstrated through reflection using the usual formula:

One credit = one hour of learning activity demonstrated by a reflective note on the lessons learned and any changes made.

# Significant events (SEs)

The GMC say: “A significant event (also known as an untoward or critical incident) is any unintended or unexpected event, which could or did lead to harm of one or more patients. This includes incidents which did not cause harm but could have done, or where the event should have been prevented.” (GMC, 2012b, p.9)

“... discuss Significant Events involving you at appraisal with a particular emphasis on those that have led to a specific change in practice or demonstrate learning’ (GMC, 2012b)” (AoMRC, 2014)

Experience has shown that there is some confusion about what should be included as Significant Events in the appraisal and revalidation portfolio.

- The GMC definition of Significant Events (SEs) includes critical incidents, significant untoward incidents and/or serious incidents requiring investigation. By definition, these are serious events where significant harm could have, or did, come to a patient or patients.
- The GMC consider the type of significant event analysis (SEA) routinely undertaken in primary care to be a quality improvement activity (QIA). You should include general practice significant event analysis as a form of QIA, except where the event crosses the threshold of significant harm described above.
- All GMC level SEs in which you have been personally named or involved must be declared, and the reflections on them and actions agreed as a result must be provided in this section of supporting information and reflected on during your annual appraisal.
- All GMC level SEs should be written up on a standardised pro forma, formally analysed to ensure that the root causes are understood and changes are made to protect patients, and discussed with colleagues to maximise and share learning according to GMC requirements.
- If you have not been personally named, or involved, in a GMC level SE during the year, you should sign a statement to confirm there were none.
- It is best practice to demonstrate that you are aware of how SEs are captured in the organisations within which you work, across the whole of your scope of work. You should know how to report any SEs that you become aware of and how to ensure, as far as possible, that you find out if you have been named, or involved, in any.

- All relevant data included in the appraisal and revalidation portfolio should be anonymised to remove any third party identifiable information. For this reason, although the reflective note should always form part of your portfolio, specific supporting information relating to SEs in which you have been named, or involved, may sometimes appropriately be submitted separately or reviewed in paper format, which your appraiser should then reference in the appraisal summary.

# Feedback from colleagues and patients

“Every doctor is required to demonstrate how they reflect on feedback about the quality of their work across their whole scope of work”. (GMC, 2012b)

“Feedback from colleagues and patients should be obtained using a validated questionnaire that meets the standards set by the GMC (GMC, 2013). The key principles are that acceptable questionnaires must:

- be consistent with the principles, values and responsibilities set out in the GMC’s core guidance, *Good Medical Practice*
- be piloted on the appropriate population, and demonstrate that they are reliable and valid
- reflect and measure the doctor’s whole practice
- be evaluated and administered independently from the doctor and their appraiser to ensure an objective review of the information
- provide appropriate and useful information that can be used in discussions with a supervisor or mentor, or through appraisal
- help the doctor to reflect on their practice and identify opportunities for professional development and improvement.” (AoMRC, 2014)

- Like all doctors, you must reflect on feedback relating to the whole of your scope of work over the five year cycle.
- Like all doctors, you must complete a minimum of one formal colleague feedback exercise and one formal patient feedback exercise, each compliant with the GMC requirements, over the five year cycle.
- As the number of appropriate tools increases, the RCGP no longer recommends any tools in particular. Instead, you are advised to choose a suitable tool that meets all the GMC requirements, is appropriate to the scope of work about which you are seeking feedback, and accessible to the whole spectrum of respondents.
- If you have made significant changes as a result of feedback, it is best practice to repeat the feedback exercise to facilitate reflection on the impact of the change, and so you may choose to complete the formal colleague and patient feedback in the first three years of the revalidation cycle to allow time for this.

- Your colleague feedback over the five year cycle must cover your whole scope of work, so you may choose to include colleagues from all the different parts of your scope of work within your one formal GMC compliant colleague feedback exercise.
- Alternatively, you may choose to limit the GMC compliant colleague feedback exercise to colleagues from your clinical roles and to seek and reflect on colleague feedback about other areas of your scope of work separately, using more specific tools.
- If you seek feedback from specific non-clinical parts of your scope of work separately, it does not need to fulfil all the GMC requirements. For example, you may reflect on non-anonymised feedback, or have fewer respondents e.g. feedback from colleagues about a leadership role, or from trainees or appraisees.
- Although the GMC require only one formal GMC compliant patient feedback exercise in a five year cycle, patient groups have expressed the view that, for most GPs, who see many patients every day, this is inadequate and does not allow patients sufficient voice. All sources of feedback from patients, both formal and informal, are important triggers for reflection. In addition to the formal GMC compliant patient survey, done once in the five year cycle, the RCGP now recommends that you reflect on some of the many other sources of feedback from your patients, including compliments, annually at your appraisal.
- You should include a reflective note, rather than original material, in the electronic portfolio, due to the difficulties with anonymising data, and keep any original cards or letters, if you wish, securely in a paper portfolio.
- In exceptional situations, you may have difficulties in undertaking your five yearly formal colleague feedback exercise and/or your five yearly formal patient feedback exercise in a way that fulfils all the GMC requirements. In such cases, you will need to provide a detailed reflective note explaining the circumstances. It would be best practice to agree that the proposed process for seeking feedback is appropriate for revalidation with your appraiser and your responsible officer before undertaking it.

Remember: “One of the principles of revalidation is that patient feedback should be at the heart of doctors’ professional development.” (GMC, 2012b, p.10)

# Review of complaints and compliments

## Complaints

“A complaint is a formal expression of dissatisfaction or grievance. It can be about an individual doctor, the team or about the care of patients where a doctor could be expected to have had influence or responsibility. Complaints should be seen as another type of feedback, allowing doctors and organisations to review and further develop their practice and to make patient-centred improvements.” (GMC, 2012b, p.12)

“As a matter of probity, doctors should include all complaints... The doctor should document any change in their own practice that they have made, or that they have ensured in members of their team.” (AoMRC, 2014)

- All organisations where doctors work should have appropriate complaints procedures, which should include all doctors who work in that organisation, including locums.
- You should be aware of the complaints procedures for all the organisations in which you work and be kept fully informed of all formal complaints in which you are named.
- You should include reflection on all formal complaints in which you have been named, or involved, in your appraisal every year, although if the complaint is not yet resolved your reflection may be incomplete.
- Your reflections should consider how the complaint arose, your response and any further actions taken, or to be taken (and the results of those changes once available).
- You may not be personally named, or involved, in any complaints during the year, in which case you should sign a statement to confirm there were none.
- If a complaint in which you have been named goes on over several years, you do not need to reflect on it in detail at every appraisal if no significant progress has been made, but you should acknowledge that there is an ongoing complaint every year in your annual declaration, and include reflection about it at least once in every revalidation cycle.
- All relevant data included in the appraisal and revalidation portfolio should be anonymised to remove any third party identifiable information. For this reason, although the reflection on the complaint should form part of your portfolio, specific supporting information relating to complaints may sometimes appropriately be submitted separately or reviewed in paper format, which your appraiser should then reference in your appraisal summary.

## Compliments

“Compliments should also be presented at appraisal as they, too, provide a source of learning and reinforcement.

Complaints and compliments should be summarised and anonymised before they are included in the portfolio of supporting information.” (AoMRC, 2014)

- You may choose to reflect on any compliments you have received annually as part of your reflection on patient (and /or colleague) feedback.
- You should include a reflective note, rather than original material, in the electronic portfolio, due to the difficulties with anonymising data, and keep any original cards or letters, if you wish, securely in a paper portfolio. Such original data, if shared, can be referenced in the appraisal summary to preserve the anonymity of the sender without defacing the source material.

# Additional information

## **Other 'appraisals'**

If you have a portfolio career, you may have a separate performance review or 'appraisal' for some specific post(s) in your scope of work, in addition to your main medical appraisal for revalidation. It is good practice to include the outputs of such meetings as additional supporting information in your appraisal and revalidation portfolio so that your appraiser knows that that role has been reviewed and your reflection on the outcomes can be discussed.

## **Supporting information required by the responsible officer**

The responsible officer may be aware of some clinical governance information, such as outcome data, or the results of an investigation or complaint, and request that you bring the information to your annual appraisal so that your reflection on it can be shared with your appraiser. It is important that your appraiser records whether any such information was included and the outcomes of any discussion that took place in the summary of your appraisal.

# Summary of changes

- The description “scope of work” is clarified to ensure that you are providing an appropriate level of detail for the responsible officer to be assured that all parts of your scope of work have appropriate supporting information and reflection over the five year cycle and the contact details for the clinical governance review of any parts of the scope of work outside your designated body are shared.
- The probity and health statements are reviewed to ensure that you reflect on the implications of the requirements in *Good Medical Practice* (GMC, 2013) for your own practice.
- The requirement to demonstrate appropriate continuing professional development (CPD) to keep up-to-date for each part of your scope of work over the five year cycle is clarified.
- The definition of a CPD credit is clarified:
  - One credit = one hour of learning activity demonstrated by a reflective note on the lessons learned and any changes made.
  - (It is appropriate to treat each learning activity as a whole, e.g. a whole day event will only require one reflective note, and if time is spent on a learning event but nothing new is learned, the time spent can still be claimed by an appropriate reflective note.)
- The process for GPs to claim additional credits for demonstrating “impact” by doubling their credits for time spent is being phased out. Where additional learning takes place in delivering changes as a result of lessons learned (demonstrating impact) following an initial learning activity, it is more flexible and proportionate to demonstrate this as a separate learning event with its own reflective note.
- There is no need to provide documentary evidence of reflection on all your learning. Quality not quantity is emphasised. You should be selective and provide high quality examples of reflection on your most significant learning.
- The recommendation that you should review your personal practice every year through a variety of quality improvement activities, ensuring that you cover the whole scope of your work over the five year cycle, is clarified.
- The wide variety of types of quality improvement activities that are acceptable to demonstrate the regular review of practice – particularly for sessional GPs and those working in relative isolation – is emphasised so that it will be better understood.
- The GMC definition of Significant Events (SEs) is clarified. Many GPs will not have been personally named or involved in any SEs needing declaration in any given year and the learning opportunities that GPs call significant event analysis should be considered a normal part of review of practice and included in quality improvement activities.
- The GMC requirement that you seek formal feedback about your practice using appropriate tools for your scope of work, that are accessible to the respondents and fully compliant with all the GMC requirements once in the five year cycle from colleagues and once in the five year cycle from patients is re-emphasised.

- If you wish to seek feedback from colleagues in the separate non-clinical parts of your scope of work separately so that it is easy to interpret in context, this does not need to be GMC compliant, particularly in terms of anonymity or respondent numbers, as you only need to complete a formal colleague feedback survey compliant with all the GMC requirements once in the five year cycle.
- There is a new recommendation that GPs, who see many patients, and have many sources of patient feedback, reflect during appraisal on feedback received from patients every year. This does not need to be GMC compliant, as you only need to complete a formal patient satisfaction survey compliant with all the GMC requirements once in the five year cycle. You are not expected to undertake additional formal feedback surveys, but you are advised to reflect on the variety of sources of feedback already available to you, including informal comments and compliments.
- Where exceptional circumstances dictate that any of the GMC requirements or RCGP recommendations cannot reasonably be met, then you must include a detailed reflective note containing an explanation, analysis of the implications and the response agreed with your appraiser and your responsible officer.

# GLOSSARY

Term	Definition
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 should be appraised every year. An appraisal assists the GP to review his or her performance and reflect on the lessons learned and any changes already made, or to be made, as a result. It allows the GP to demonstrate the quality of his or her practice.
Appraiser	A trained and supported peer 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 defined as having a statutory responsibility for providing structures for annual medical appraisals for all doctors with whom it has prescribed connection. Each designated body has a responsible officer (see below) who makes revalidation recommendations to the GMC about the doctors with whom they have a prescribed connection.
CPD credit	A one-hour unit of education that includes a reflective record to demonstrate the lessons learned and any changes made as a result of learning.
Performers List	A list of doctors eligible to work in general practice in the NHS. There are separate national performers lists for England, Scotland, Wales and Northern Ireland.
Responsible officer	Every organisation ('designated body') is required to appoint a senior doctor, as the responsible officer, who is responsible for the quality assurance of appraisal and clinical governance and making revalidation recommendations to the GMC.
Revalidation portfolio	The collective supporting information accumulated by an individual GP for the purposes of providing supporting information for appraisal and revalidation.
Revalidation	The periodic confirmation that a doctor remains up-to-date and fit to practise. A positive revalidation recommendation results in the GMC renewing a doctor's licence to practise.
RCGP	The Royal College of General Practitioners; its remit covers standards, education research and quality of patient care, but not contractual issues.
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.

# References

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