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June 2012

The RCGP Guide
to the Revalidation 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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The RCGP acknowledges the work of many other people who have generously allowed their documents to be used to populate this guide. It is based on the RCGP’s *Criteria, Standards and Evidence for Revalidation* and these, in turn, were 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 Essential Evidence for Appraisal, Appraisal Evidence for Sessional Doctors* prepared by Dr Peter Berrey for NHS Education for Scotland, the Revalidation Support Team’s *Enhanced Appraisal Unified Form* and the *RCGP Scotland Revalidation Toolkit*. The Revalidation Support Team has given valuable advice both to the RCGP and to the wider profession. The Revalidation Support Team has developed *Medical Appraisal Guidance*, which should be considered an essential adjunct to this guide.
Provided that the Secretary of State for Health activates the legislation in the autumn of 2012, revalidation of doctors will start in December 2012. In the first four months, responsible officers (the medical leaders who will recommend other doctors for revalidation) in each organisation will be revalidated. Then from April 2013 the roll-out of revalidation will start. By March 2016 it is expected that virtually all doctors will have been revalidated.

This section summarises what most general practitioners (GPs) need to know for their revalidation.

- You will have been licensed to practise by the General Medical Council (GMC). For established doctors these licences were issued in November 2009.

- If you are on an NHS Performers List you will be allocated to the responsible officer for that list, and this responsible officer will be the one to recommend you to the GMC for revalidation.1

- If you are not working in an NHS primary care organisation (PCO), the GMC will have written to you asking you what organisation, if any, you work in. If you are currently not working in the UK and do not do so before your date for revalidation becomes due, your licence to practise will not be continued. You will need to apply for renewal on your return.

- From December 2012, you should learn in which year you will be revalidated.

- 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 covers all of your medical practice, and that you and your appraiser have signed off at least one appraisal which has Good Medical Practice as its focus
  - you have brought to your appraisals appropriate supporting information (see below)
  - there are no unresolved concerns about your performance as a doctor.

Although you may have full supporting information from the five years before your revalidation, there will be minimum supporting information that you will need to have taken to your last appraisal(s) (see Table 1).

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1. A GP on a PCO’s Performers List will be assigned to the responsible officer of that PCO. If a GP is not on a Performers List, the GP will be under the responsible officer for the organisation for which they do most of their work.
Table 1: Summary of the minimum supporting information required for at least the last appraisal before your revalidation date

<table>
<thead>
<tr>
<th>Supporting information</th>
<th>Quantity</th>
</tr>
</thead>
<tbody>
<tr>
<td>General information</td>
<td></td>
</tr>
<tr>
<td>Personal details</td>
<td>At a minimum, relevant to the 12-month period prior to your last appraisal before your revalidation date</td>
</tr>
<tr>
<td>Scope of your work</td>
<td></td>
</tr>
<tr>
<td>Record of annual appraisals</td>
<td></td>
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<tr>
<td>Personal Development Plans</td>
<td></td>
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<tr>
<td>Probity declaration</td>
<td></td>
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<tr>
<td>Health declaration</td>
<td></td>
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<tr>
<td>Keeping up to date</td>
<td></td>
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<tr>
<td>Continuing professional development (CPD)</td>
<td>At a minimum, 50 learning credits(^2) in the 12-month period prior to your last appraisal before your revalidation date</td>
</tr>
<tr>
<td>Review of your practice</td>
<td></td>
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<tr>
<td>Quality improvement activity, to include:</td>
<td></td>
</tr>
<tr>
<td>Significant event audits</td>
<td>At least two for the 12-month period prior to your last appraisal before your revalidation date; any serious incident must be included</td>
</tr>
<tr>
<td>Clinical audit</td>
<td>Evidence of regular participation in quality improvement activity relevant to your scope of work and discussed at your last appraisal before your revalidation recommendation</td>
</tr>
<tr>
<td>Feedback on your practice</td>
<td></td>
</tr>
<tr>
<td>Colleague feedback(^3)</td>
<td></td>
</tr>
<tr>
<td>Patient feedback</td>
<td>One of each in the five years before your revalidation recommendation; each must be relevant to the scope of your practice at the time of revalidation</td>
</tr>
<tr>
<td>Formal complaints</td>
<td>A description of any formal complaint and your response to it in the 12-month period prior to your last appraisal before your revalidation date</td>
</tr>
</tbody>
</table>

- If your appraiser or your responsible officer think that your eligibility for revalidation is in doubt, they should inform you straight away so you can put things right if possible; revalidation is a continuous process, not a high-stakes examination at a fixed point in time.

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2. A learning credit is one hour of CPD; if you can demonstrate that the CPD has had an impact on your patient care, you can double the credit(s) for that CPD.
3. In the first cycle you may not have used a feedback tool that fully meets the GMC criteria; however, if it is focused on you, your practice and your quality of care, and it was gathered objectively and confidentially, then it should be acceptable.
• 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.

• 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.

Five key things to do now!

• Ensure that you have a responsible officer – if not, inform the GMC.4

• Ensure that your annual appraisals are properly conducted.

• Register with and use a revalidation e-portfolio or equivalent for your appraisals.

• If you haven’t done a patient or colleague feedback survey in the past three years, plan to do them.

• If you haven’t done a full cycle clinical audit in the past three years, plan to do one.

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.

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 will be subject to revalidation. In common with all doctors, GPs will need to be relicensed periodically. This will be achieved through a process called revalidation, for which GPs will need to provide supporting information that shows that they keep 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, working abroad 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 will be expected to have at least one appraisal per year that is based on the GMC’s core guidance for doctors, *Good Medical Practice*. Revalidation will involve a continuing evaluation of doctors’ fitness to practise and will be based on local systems of appraisal and clinical governance.

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

- *Good Medical Practice*
- *Good Medical Practice Framework for Appraisal and Revalidation*
- *Supporting Information for Appraisal and Revalidation*

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The RCGP has the responsibility to support the above three documents with specific specialty 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, and GPs are not being asked for any more or any less than other doctors.

**Changes in this seventh edition of the RCGP guide to revalidation**

There has been no significant change to the supporting information required of a GP in this edition of the guide. However, revalidation policy and implementation is becoming clearer, so the following key changes have been made:

- a summary is included at the start of this guide
- the timetable is clearer
- the way in which revalidation will be rolled out has been fleshed out.

We have also simplified the text to make it more accessible and, therefore we hope, more useful.

**Your position in 2012**

All GPs working in the UK must hold a GMC licence and be on the GMC’s General Practice Register. In addition, all those GPs working in the NHS must be on a Performers List. During 2012 you will be notified to which organisation (designated body in the jargon), and therefore which responsible officer, you are accountable for your revalidation. If you are currently working professionally in the UK, but not in the NHS, you will have been asked to which designated body you are attached. If you don’t have an attachment to a designated body, the GMC will advise you how to become attached.

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, and therefore have no designated body and responsible officer, your licence to practise will be not be continued when your revalidation becomes due. 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 reapply 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. Then you will need to become attached to a designated body and responsible officer.

You should be experiencing an annual appraisal with a trained and conscientious peer. The information that you are already bringing to your appraisal should be similar to the supporting information required for revalidation. For most GPs the extra information required for revalidation, if any, will be minimal.

**The revalidation timetable**

Each UK country is preparing for revalidation. Provided that each country is ready to start revalidation in late 2012 and provided that the business case for revalidation is acceptable, the Secretary of State for Health is expected to activate the legislation for revalidation in the autumn of 2012.

Soon afterwards, you should learn in which year you will be revalidated. In the first four months (December to March 2013) the responsible officers (there are more than 700 of them) in England
(and probably the other countries) will themselves be revalidated. From April 2013 the roll-out of revalidation will start with the intention of the vast majority of doctors being revalidated by March 2016 – a three-year period.

**Once revalidation starts**

From the start of revalidation you will want 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 five 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 its files and, provided there are no concerns, revalidation will normally occur. 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.

**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. Supporting information can be stored in an electronic toolkit, or stored electronically and then uploaded to the new Medical Appraisal Guide form.

The RCGP has developed an e-portfolio for revalidation that will enable GPs to store all the information required for revalidation. The RCGP Revalidation ePortfolio is an important learning and professional development tool, and will offer the facility for information transfer from the RCGP Trainee e-portfolio from summer 2012. The Revalidation e-portfolio already enables transfer from other RCGP online products, such as the Online Learning Environment (OLE) courses,
Essential Knowledge Updates and Challenge Programme, and the Personal Education Planning (PEP) tool. The Revalidation e-portfolio was launched in December 2010 – with full appraisal functionality – and is available as a free membership service to College members. From April 2012 there has been a charge for non-members. From the summer of 2012, PCOs will be able to use its lead appraiser management function to quality assure the appraisal process. Other enhancements to support the ‘end to end’ revalidation process will be developed in due course, including a responsible officer and GMC ‘view’. For further details see www.rcgp.org.uk/revalidation_eportfolio_home.aspx.

General practitioners in non-standard practice

Revalidation applies to all doctors and all doctors must provide all elements of supporting information (with the exception of patient surveys for those who do not see patients). However, some GPs have non-standard careers that must be taken into account when deciding the precise nature of their supporting information. This group includes:

1. Those in clinical general practice who may find elements of a standard portfolio difficult to accumulate; this includes doctors whose main or only work is as:
   - peripatetic locums
   - out-of-hours doctors (and those working in similar clinical contexts such as in walk-in centres)
   - GPs in remote or very small practices
   - GPs in the Defence Medical Services or the Foreign and Commonwealth Office
   - GPs working in secure environments

2. Those who were not in work for all years in the five-year revalidation cycle or who are on extended career breaks, including those working overseas

3. GP registrars whose licence becomes due for renewal

4. Those whose only or predominant work as a doctor is not clinical, but is in NHS management, educational management, political roles, health informatics, academia or staff appointments within the Defence Medical Services.

1. GPs in ‘non-standard’ roles

GPs who work part-time, as retainers, salaried GPs or long-term locums, with a fixed practice base, would not normally be considered to be non-standard. 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 standard portfolio, with notes relating to any special circumstances that have affected the amount of information collected, such as maternity leave or ill health, being recorded in their revalidation portfolio. GPs working in private practice only should also be able to provide a standard portfolio. When a doctor proposes to provide an equivalent portfolio of supporting information he or she must be able to justify that choice and the appraiser must agree with that justification. Ultimately the decision must be acceptable to the responsible officer – if doubts are raised at appraisal, this should be discussed promptly with the responsible officer.

Standard and equivalent portfolios share many elements. All portfolios have to reflect the working life and context in which a doctor works. The requirement to ensure that a doctor is up to date and fit to practise is the same for all doctors. The overall standard must be the same. However, it has to be recognised that the standard supporting information described in this guide cannot be applied universally. Therefore this guide includes advice for those unable to provide a standard portfolio.
If the working life of a GP justifies an equivalent portfolio of supporting information and the rationale is accepted by that doctor’s appraiser, the portfolio should indicate this fact as exceptional circumstances. The portfolio should be processed through revalidation just like any other portfolio.

The alternative methodology for accumulating supporting information in an equivalent portfolio must still meet the underlying attributes that each area of supporting information is intended to demonstrate. For example, clinical audits are included in the standard portfolio to demonstrate that the GP sets him or herself appropriate criteria and standards; reflects on the care he or she delivers; and improves his or her care when necessary. These attributes must also be demonstrated satisfactorily in the supporting information in an equivalent portfolio using an approved alternative to clinical audit if appropriate to do so.

An equivalent portfolio is intended to reflect and to be more appropriate to the working environment of the doctor concerned.

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. One solution is the development of mechanisms to reduce the professional isolation that many of these doctors experience. The models for this that have been identified include:

- 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 doctors 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 Locum Group (www.nelg.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 subcommittee (http://bma.org.uk/about-the-bma/how-we-work/negotiating-committees/general-practitioners-committee) is also able to offer valuable support.

- 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 to receive or offer peer support and have 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. 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.

2. GPs who take a break from practice in the UK

Doctors who continue to hold a licence to practise while working overseas will need to revalidate if they wish to keep their licence. They will need to connect to a UK organisation that will support them in their appraisal and revalidation. 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, it is recognised the 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 who do not undertake any work in the UK might want to consider whether they should relinquish their licence to practise. Such doctors can remain registered without a licence while overseas, and this will indicate that they are in good standing with the GMC. When doctors plan to return to UK practice, they can apply for their licence to be restored – the licence is an entitlement based on qualifications provided there are no unresolved concerns. The licence may stipulate that the doctor needs to be revalidated in, say, two years and it may be conditional on the doctor working in a managed environment (which is likely to mean the NHS) for the initial period.

The Department of Health (England) is currently consulting on changes to the responsible officer regulations, which will include the designation of more bodies in the UK. The GMC is looking at how it can provide flexibility for doctors who do not have a link to a managed environment in the UK.

If such a 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 will normally mean that, after sustained absence from clinical general practice in the United Kingdom, a doctor will 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 British health service, such as clinical guidelines, pathways and referrals, safeguarding vulnerable people, etc. If a doctor has not been clinically active for years, a formal re-entry or returners’ scheme will probably be indicated.

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.

However, there are many doctors who will be absent from British 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. For such doctors, the RCGP recommends that there has to be a minimum content to a portfolio if it is to be considered in the routine manner by a responsible officer.

When revalidation is fully established over a five-year cycle the RCGP proposes that the minimum supporting information that a responsible officer will normally need before a GP’s portfolio can be considered for revalidation will be:

- active participation in approved appraisal with a PDP agreed and a review of a previous PDP
in at least three of the five years in the revalidation cycle

- demonstration of 50 learning credits in each of at least three of the five years in the revalidation cycle

- documentation of at least 200 clinical half-day sessions (equivalent to one day a week over a period of at least two years) in the five years in the revalidation cycle (of which 100 should be undertaken in the two years prior to revalidation).\(^8\) A half-day would normally last four hours and include at least 2.5 hours of face-to-face clinical contact and be conducted in an approved environment within the UK. The sessions will be undertaken as a generalist and require the doctor to be on the GMC’s GP Register but can be within a range of settings.

A responsible officer will consider any portfolio submitted but if a doctor thinks that he or she may not be able to meet these minimum criteria, the implications should be discussed with the responsible officer at an early point in the revalidation cycle. In advising the doctor and deciding if his or her portfolio of supporting information is appropriate for revalidation the responsible officer will also want to 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 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.

3. GP registrars whose licence becomes due for renewal

The introduction of revalidation will mean that the Postgraduate Dean, as responsible officer, will be in receipt of any relevant information about trainees that currently reside with his or her employing organisations(s). Through the use of an enhanced Form R, this information will be available to the Annual Review of Competence Progression (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. Full engagement in Workplace-Based Assessment is likely to suffice. In most cases, GPs will revalidate five years after CCT. If, however, a doctor takes longer than five 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.

4. GPs who only do non-clinical work

Non-clinical GPs are a small but important group, especially prevalent in the upper echelons of independent healthcare systems with quality-assured clinical governance, such as the Defence Medical Services. 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.

These doctors will submit a portfolio to their responsible officer that demonstrates that they are fit to undertake their non-clinical roles and this will include supporting information in all areas.

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8. This is the RCGP recommended minimum requirement for a responsible officer to be able to consider a standard portfolio of supporting information for revalidation. It is not a minimum clinical requirement for other purposes.
except patient surveys. This will include evidence of satisfactory annual appraisal, PDPs agreed and reviewed, and that they are keeping up to date in their area. 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. To undertake clinical work, the RCGP recommends that such doctors undertake a minimum of 200 clinical sessions within the five-year revalidation cycle if they intend to submit a standard portfolio of supporting information for revalidation.
Overview

As described in the GMC’s *Supporting Information for Appraisal and Revalidation* and the Academy’s Guidance on Supporting Information for the Revalidation of General Practitioners, your supporting information is grouped into four main headings (see Table 2).

*Table 2: Summary of the supporting information required for revalidation*

<table>
<thead>
<tr>
<th>Generic heading</th>
<th>Supporting information</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>General information</td>
<td>Personal details</td>
<td>At every appraisal</td>
</tr>
<tr>
<td></td>
<td>Scope of practice including extended practice (clinical and non-clinical)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Contextual details</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Participation in annual appraisal, PDP and review of PDP</td>
<td></td>
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<tr>
<td></td>
<td>Statements of probity and health</td>
<td></td>
</tr>
<tr>
<td>Keeping up to date</td>
<td>Learning credits</td>
<td>At least 50 per year</td>
</tr>
<tr>
<td>Review of practice</td>
<td>Quality improvement activity – to include:</td>
<td>An average of two significant events at each appraisal</td>
</tr>
<tr>
<td></td>
<td>Significant event audits</td>
<td>At least one full-cycle clinical audit in each revalidation cycle</td>
</tr>
<tr>
<td></td>
<td>Clinical audit</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other activities such as case discussion, review of referrals, review of record keeping</td>
<td></td>
</tr>
<tr>
<td></td>
<td>small quality improvement activities that are not full-cycle audits may also be included in this section</td>
<td></td>
</tr>
<tr>
<td>Feedback on practice</td>
<td>Colleague survey</td>
<td>At least one colleague and one patient survey in the five years before revalidation</td>
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<tr>
<td></td>
<td>Patient survey</td>
<td>A review of all formal complaints</td>
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<tr>
<td></td>
<td>Review of complaints</td>
<td></td>
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<tr>
<td></td>
<td>Compliments</td>
<td></td>
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</tbody>
</table>

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. If you are chosen for revalidation in 2013–14 you will need to bring to your last appraisal before revalidation supporting information from the year preceding that appraisal:

- your personal details
- description of the scope of your work
- your PDP from the previous year, and you need to agree a PDP for the next year
- signed statements of health and probity
- your CPD activity, which must show 50 credits in the previous year
- two significant event audits
- a full-cycle clinical audit from the previous five years
- a colleague feedback from the previous five years
- a patient feedback from the previous five years
- a description and review of any formal complaints in the previous year.

The GMC recognises that you may not have used colleague feedback or patient feedback tools that meet its criteria. They will accept such tools if they are focused on you, your practice and your quality of care; and if the data were gathered objectively and confidentially.

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.

If you are revalidated in 2014–15 or 2015–16, you will be required to have presented the same supporting information as described above at least at the appraisal before your revalidation.

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

This is similar to the basic information you provide for your appraisals now. Your revalidation e-portfolio will indicate what details are required for revalidation, including:

- 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 your practice

You will need to record your professional roles into a revalidation e-portfolio at the first appraisal, and then update your entry 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; role content/description and performance review/appraisal within this post
- any voluntary roles undertaken in the capacity of a doctor and which require you to have a licence to practise to carry out the role
- free-text elaboration of any unusual supporting information.

The GMC says revalidation will be based on what a doctor actually does in practice. In order for appraisers and responsible officers to understand what the GP actually does, all posts undertaken as a doctor, whether paid or not, must therefore be included. GPs in the Defence Medical Services will 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.

10. A revalidation e-portfolio will contain appraisal evidence, building into a revalidation portfolio. If a GP can justify it, a paper-based portfolio will be accepted in exceptional cases.
11. 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.
For sessional doctors who locum for multiple providers over the revalidation period there will be no requirement to specify every one in which they worked. Instead they will be expected to give the dates over which they have been consistently 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)
- 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 [GPwSI])
- 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
- vocational 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 work as an appraiser
- out-of-hours work – a statement from the out-of-hours provider that regular reviews have been satisfactory
- GPwSIs under contract to a PCO – a statement from the contracting organisation that he or she has maintained accreditation for the role.

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

For clinical activities, including GPwSIs not in contract with a PCO, 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 will be used by appraisers, advisers 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 to their last appraisal (as a minimum) before their revalidation the supporting information for their revalidation.

All doctors on the Performers List of a PCO 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 the 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 Personal Development Plan (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 goals. There is no minimum or maximum number of goals. For example, a doctor setting the goal of achieving recognition as a vocational trainer might regard that as a sufficient single goal for a year; most GPs will set themselves between three and five goals that reflect the breadth of their practice, responsiveness to the health needs of their local population, and their own development needs. All goals 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 goal:

- 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)
- the date by which the goal will be achieved
- the intended outcome from the goal.

For each PDP submitted, other than in the year immediately preceding submission for revalidation, there should be a column recording the outcome of the goal. 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 goals are likely to reflect the following:

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

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

Over a five-year period you should not only consider clinical learning and development but also the competencies around leadership and management, recognising the importance of all a doctor’s roles in the provision of a safe system of health care for patients (www.institute.nhs.uk/assessment_tool/general/medical_leadership_competency_framework_-_homepage.html).

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
- 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 which is being treated adequately and that your doctor has no concerns should be acceptable
- you are in a position to receive independent, impartial healthcare advice (for example you are not consulting a family member) 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 (or, in the case of a locum, rarely works)
- 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.

12. Paragraph 77 of the GMC’s Good Medical Practice says: ‘You should be registered with a general practitioner outside your family to ensure that you have access to independent and objective medical care. You should not treat yourself.’
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 five-year cycle to support a positive revalidation decision. However, unlike other college schemes, the RCGP credit system is not purely based on time spent but also reflects the impact of learning.

In essence, one hour of education accompanied by a reflective record is one 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 two learning credits for each hour of such education.

Your credits are self-assessed and verified at appraisal. The pattern of credits should, over the years, reflect the working life of the GP. For example, a GPwSI 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.
The RCGP has defined the significant event audit and clinical audit as the core information to be included under Review of Practice. However, a broader range of activities can be submitted including case discussions and briefer reviews of clinical and other work if SEA or clinical audit information is not appropriate given your circumstances. You should bring evidence of quality improvement activity to every appraisal to show that you regularly review your practice and learn from events, concerns, errors, audits, etc.

Significant event audits

Significant event auditing (also known as learning event audits, action learning, critical incident analysis or significant event analysis) is an increasingly routine part of general practice. It is a technique to reflect on, and learn from, individual cases to improve quality of care overall. When revalidation is fully established, your revalidation portfolio will be expected to contain an analysis of an average of at least two significant events for each appraisal since revalidation started. These can be from any time during the revalidation period. There is no requirement for ‘two per year’. However, an appraiser will be concerned if a developing portfolio contains no such analyses; it is good practice to report significant events from throughout the revalidation period.

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 in a team meeting (usually a significant event audit meeting) with an appropriate selection of other primary care team members present, and where the changes involve yourself, perhaps as the person responsible for implementing the change.

If there is a patient safety concern or event (also known as a serious incident) within your clinical practice, that event should be included as one of your ten significant event audits 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 significant event audits 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 a significant event audit should not allow patients to be identified and should comprise:

- the title of the event
- the date of the event
- the 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.

The RCGP Revalidation ePortfolio has a standard form in which to record these fields.

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.

Although a significant event should ideally be discussed with the clinical team involved, it will be acceptable for a locum or out-of-hours doctor to discuss and reflect with a peer group (for example chambers or educational group), demonstrating the improvements in care. The doctor can use 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. Trigger tools are becoming available in which the care of patients with certain high-risk characteristics is reviewed systematically.13 Evidence from the use of trigger tools can be used for revalidation by doctors for whom significant event auditing is not feasible.

Clinical audit

All GPs should be familiar with the principles and practice of clinical auditing. Your revalidation portfolio will be expected to contain information to demonstrate that you have taken part in audit activity. This will normally be at least one full-cycle (initial audit, change implemented, re-audit to demonstrate improvement) clinical audit during the revalidation period.

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. If this clinical audit is to be put into your revalidation portfolio, you must have contributed properly to the choice of topic and the standards set. You must be able to state that the care identified within the first audit and the re-audit reflects the care that they 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 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.

The RCGP Revalidation ePortfolio has a standard form in which to record these fields.

Clinical audits are 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 locums and out-of-hours doctors. There are some clinical audit topics that can be successfully reviewed by locums and out-of-hours doctors including:
- 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.
A locum or out-of-hours doctor may undertake an ‘action audit’ in which the care of presenting cases of a defined nature is continually reviewed against preset criteria and standards with continuous reflection and improvement recorded. One example might be keeping a log of all referrals and patients causing concern, then following up the patient on return to the practice or clinic, and learning lessons from the outcomes. Such a doctor may undertake a random case analysis, in which clinical decision making, record keeping and standards of care in twenty consecutive consultations are reviewed, using a standardised format with an appropriately skilled and experienced colleague or colleagues. Reflection occurs and improvements are agreed upon and demonstrated. The Scottish Online Appraisal resource (www.scottishappraisal.scot.nhs.uk/) provides detailed guidance on how locums can approach clinical audit, with worked examples.

The RCGP believes that GPs should be able, if they wish and they have the expertise, to include a quality improvement project as their audit. 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 description of a quality improvement programme should include the:

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

How others perceive the quality of your professional work

Feedback from colleague survey
A survey feeding back from colleagues (previously called Multisource 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. The value for doctors, including GPs, is being demonstrated in daily experience and in pilots throughout the UK. 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.

For feedback from colleagues (MSF) you will need to identify a number of GP 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 can ask individuals from any of these roles 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 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 RCGP has to date commissioned three reviews of colleague survey instruments and currently considers that the following are suitable for use by GPs for revalidation:
- Sheffield Peer Review Assessment Tool Version 2 (GP-SPRAT), www1.waspsoftware.co.uk/MAP/Volunteer/Login.aspx
- General Medical Council Colleague Questionnaire, www.gmc-uk.org/colleague_questionnaire.pdf
- EDGECUMBE 360° Colleague Feedback, www.doctor360.co.uk/
- 2Q MSF, www.tipporfolio.co.uk/example2q.aspx.

However, if you have used a colleague 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. This will normally mean that the data is externally collated and the feedback uses national or group norms for comparison.
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.

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 at any point in time may be conducted long after they worked in a particular setting. Some questions in conventional colleague surveys only apply to principals in general practice. GPs in small, remote practices may have an insufficient number of colleagues.

For some, the problems may not be insurmountable. Colleague surveys designed for locums and out-of-hours doctors should be piloted and validated. The results of colleague surveys should compare locums and out-of-hours 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.

For these doctors, equivalent supporting information should 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. Doctors 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 two hours, with assessment of their 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

When your revalidation becomes due, your portfolio should include the results of a patient survey undertaken in the previous five years. The RCGP has to date commissioned three reviews of patient surveys and currently considers that the following are suitable for use by GPs as supporting information for revalidation:

- General Medical Council Patient Questionnaire, www.gmc-uk.org/patient_questionnaire.pdf
- Improving Practice Questionnaire (IPQ), www.cfepsurveys.co.uk/products/general-practice/improving-practice.aspx
- EDGECUMBE 360° Version 2, www.doctor360.co.uk/
- Doctors’ Interpersonal Skills Questionnaire (DISQ), www.cfepsurveys.co.uk/products/general-practice/interpersonal-skills.aspx

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.

You will need to seek the views of the patients actually consulting you – practice-based surveys of the registered population will not be acceptable. Questionnaire providers will state a minimum
number of patients to ensure reliable feedback. The method of administering a questionnaire, with a freepost envelope, should be suitable for sessional GPs.

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 folder 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.

It is recognised that some GPs will 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 (or randomly selected if the survey is ongoing), but can be recruited from a series of clinical settings 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.

GPs working in secure environments may find eliciting their patients’ views challenging. 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 (principals, salaried, locums, prison doctors, etc.). Surveys should comply with the GMC guidance. 14

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

Some GPs may have been identified as giving cause for concern during their revalidation period. The PCO may have investigated the GP for possible or proven under-performance. The local postgraduate education organisation (e.g. deanship) or the National Clinical Assessment Service (NCAS) might have assessed the GP. There may have been a referral to the GMC. Any cause for concern15 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.

15. 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.
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. 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 for the responsible officer to satisfy him or herself regarding these two points. The description should include:

- 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 the RCGP Revalidation ePortfolio GPs can also record unsolicited compliments that they have received from patients or their carers or relatives.
Appendix: other sources of advice

RCGP tools and guidance

Revalidation FAQs
A comprehensive set of frequently asked questions and answers covering a variety of revalidation topics.
www.rcgp.org.uk/_revalidation/revalidation_-_faq.aspx

RCGP Revalidation e-portfolio
An electronic system designed specifically to help GPs collect supporting information for revalidation.
www.rcgp.org.uk/revalidation_eportfolio_home.aspx

Online Learning Environment
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. The OLE also hosts a range of other courses that are added regularly to reflect the ever-changing needs of GPs.
www.elearning.rcgp.org.uk

e-GP
e-GP is an ambitious 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/egp/more_info.html

Learning credits
Find out more about the RCGP learning credits scheme at:
www.rcgp.org.uk/professional_development/continuing_professional_devt/cpd_credits_scheme.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/circ/evidence__effectiveness/audit.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
- individual postgraduate deaneries
- www.pallantmedical.org.uk
- ‘Appraisal Evidence for Sessional Doctors’ from peterberrey@hotmail.com
- www.scottishappraisal.scot.nhs.uk/toolkit.aspx
- Significant Event Audit Toolkit at www.nrls.npsa.nhs.uk/resources/?entryid45=61500
- www.nasgp.org.uk/cpd/revalidation
- www.northerndeanery.nhs.uk/NorthernDeanery/primary-care/continuing-practice/appraisal
## Glossary

<table>
<thead>
<tr>
<th>Academy of Medical Royal Colleges (AoMRC)</th>
<th>The organisation that represents the views and interests of all the medical royal colleges and faculties collectively</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appraisal</td>
<td>Each GP on the Performers List of a PCO should be appraised every year (April to March). An appraisal assists the GP to review his or her performance and draw lessons from it</td>
</tr>
<tr>
<td>• GP appraisal</td>
<td>• annual appraisal</td>
</tr>
<tr>
<td>Adviser</td>
<td>A trained and supported person who will advise responsible officers and the RCGP on portfolios of supporting information being prepared or submitted for revalidation. There will be two types of adviser:</td>
</tr>
<tr>
<td>• an RCGP adviser from outside the immediate area</td>
<td>• a lay adviser</td>
</tr>
<tr>
<td>Appraisee</td>
<td>The GP being appraised</td>
</tr>
<tr>
<td>Appraiser</td>
<td>A trained and supported GP who undertakes the appraisal of colleagues</td>
</tr>
<tr>
<td>Clinical governance</td>
<td>A framework through which NHS organisations are accountable for improving quality of services and care, and promoting patient safety</td>
</tr>
<tr>
<td>Designated body</td>
<td>An organisation, with which most licensed doctors will have a connection, responsible for supporting doctors through appraisal and revalidation. Each designated body will have a responsible officer (see below) who will recommend doctors to the GMC to be revalidated</td>
</tr>
<tr>
<td>General Practice Register</td>
<td>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</td>
</tr>
<tr>
<td>Learning credit</td>
<td>A unit of education that reflects the impact on patient care and the challenge involved</td>
</tr>
<tr>
<td>Performers List</td>
<td>Each PCO holds a list of doctors able to work in general practice in the area; a GP can only be on one Performers List(^\text{16}) and every GP must be on a Performers List</td>
</tr>
</tbody>
</table>

\(^{16}\) In most circumstances a GP on a PCO’s Performers List will be assigned to the responsible officer of that PCO. Rarely, however, a GP may undertake more work for another designated body and will be under that body’s responsible officer.
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td><strong>Portfolio</strong></td>
<td>The collective supporting information accumulated for an individual GP’s purposes, for appraisal and for revalidation</td>
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<tr>
<td><strong>Primary care organisation</strong></td>
<td>This is a generic term that covers Primary Care Trusts, Clinical Commissioning Groups and Clusters in England, and Health Boards in Scotland, Wales and Northern Ireland</td>
</tr>
<tr>
<td><strong>Registers</strong></td>
<td>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</td>
</tr>
<tr>
<td><strong>Responsible officer</strong></td>
<td>Every organisation (‘designated body’) with a quality-assured system of clinical governance will be required to appoint a locally based senior doctor as a responsible officer to oversee appraisal, local concerns and revalidation</td>
</tr>
<tr>
<td><strong>Revalidation</strong></td>
<td>The periodic confirmation that a doctor remains up to date and fit to practise</td>
</tr>
<tr>
<td><strong>Revalidation e-portfolio</strong></td>
<td>An electronic portfolio used for the purposes of appraisal and revalidation</td>
</tr>
<tr>
<td><strong>Royal College of General Practitioners (RCGP)</strong></td>
<td>The RCGP’s remit covers education, research and patient care, but not contractual issues</td>
</tr>
<tr>
<td><strong>Sessional GPs</strong></td>
<td>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</td>
</tr>
<tr>
<td><strong>Specialist Register</strong></td>
<td>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</td>
</tr>
</tbody>
</table>