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RCGP Guide to the Revalidation of General Practitioners



Royal College of
General Practitioners

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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 to become the definitive guide to Revalidation for
general practitioners. It is continually evolving in the light of future policy decisions from
the General Medical Council, Departments of Health and the Academy of Medical Royal
Colleges. If you wish to refer to it, we strongly recommend that you download the
document from the RCGP website ([www.rcgp.org.uk/revalidation/
revalidation_guide.aspx](http://www.rcgp.org.uk/revalidation/revalidation_guide.aspx)) where the latest version will be posted.*

Contents

Background	1
Section 1: details of the supporting evidence required for the Revalidation of GPs	5
Supporting information area 1: statement of professional roles and other basic details	7
Supporting information area 2: statement of exceptional circumstances	9
Supporting information area 3: evidence of active and effective participation in annual appraisals	10
Supporting information area 4: a Personal Development Plan from each annual appraisal	11
Supporting information area 5: a review of the Personal Development Plan from each annual appraisal	12
Supporting information area 6: learning credits in each year of the revalidation period and in the revalidation period overall	13
Supporting information area 7: Multi-Source Feedback from colleagues	15
Supporting information area 8: feedback from patients	17
Supporting information area 9: description of any cause for concern and/or formal complaint	19
Supporting information area 10: Significant Event Audits	21
Supporting information area 11: Clinical Audits	23
Supporting information area 12: statement on probity and health	26
Supporting information area 13: additional evidence for areas of extended practice	27
Section 2: supporting information required in the introductory phase of Revalidation of GPs	29
Submitting supporting information in the first year (April 2011 to March 2012)	29
Submitting supporting information in the second year (2012/13)	30
Submitting supporting information in the third year (2013/14)	30
Submitting supporting information in the fourth year (2014/15)	31
Submitting supporting information in the fifth year (2015/16)	32
Submitting supporting information in the sixth year (2016/17) onwards	32
Section 3: supporting information required for the Revalidation of GPs whose experience is not standard	34
Guidance in considering non-standard portfolios	34
Minimum standards for considering a portfolio	35

Alternative supporting information in a revalidation portfolio	35
GPs returning to general practice or wishing to be revalidated without an acceptable minimum portfolio	36
Vocational registrars	36
Non-clinical GPs	36
Portfolios for Revalidation for GPs	37
Partial portfolios during the transition	38
Section 4: processes of Revalidation of GPs	40
Submission of the supporting information	40
Assessment of supporting information for Revalidation	41
GMC affiliates	42
Quality assurance	42
Section 5: derivation of the supporting information for the Revalidation of GPs	43
The map of the RCGP's criteria, standards and evidence to the GMC's Revalidation Framework	43
Glossary	51

Background

Please note that the text in this document sets out the current view of the Royal College of General Practitioners (RCGP). As our thinking evolves, including through comments on this document and the results of pilots, new versions of this document will be posted on the website (www.rcgp.org.uk/_revalidation/revalidation_guide.aspx). In particular, later versions will take account of policy statements from the General Medical Council (GMC), Departments of Health and the Academy of Medical Royal Colleges (AoMRC).

The GMC introduced licences to practise in November 2009. All registered doctors were given the opportunity to request a licence to practise. 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. General practitioners (GPs) working in the NHS, either on a permanent or locum basis, will need to be both licensed and listed on the GMC's General Practice Register.

Only licensed doctors will be subject to Revalidation. In common with all vocationally trained doctors, GPs will need to be relicensed and recertified (the latter for the General Practice Register) periodically. These two outcomes will be achieved through one process – Revalidation – in which GPs will need to provide supporting information which shows that they keep up to date and remain fit to practise.

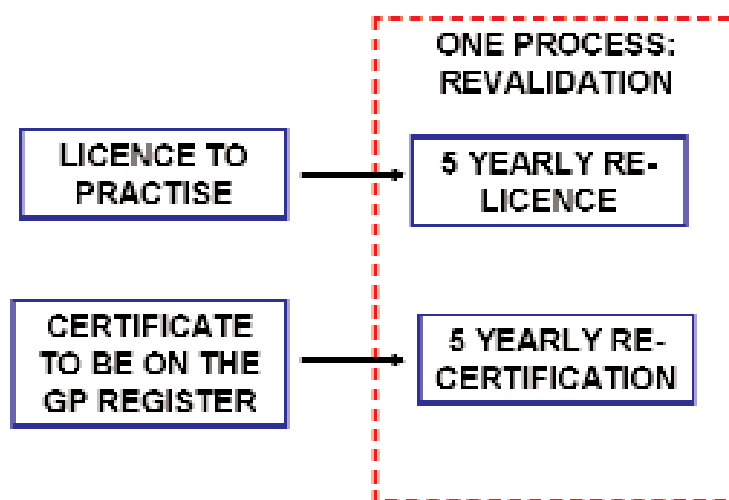


Figure 1: The revalidation process

The RCGP has the responsibility, on behalf of all GPs, to propose the standards and methods for the Revalidation of GPs. However, the GMC must approve the standards and methods before they are introduced. **The RCGP has submitted the proposals in this guide to the GMC, which has approved the supporting information described here for use in the NHS Pathfinder pilots. The RCGP will refine its proposals in the light of evidence from pilots and will seek GMC approval for any significant changes.**

The first practical step towards defining the standards for Revalidation was the publication by the GMC of a *Working Framework for Appraisal and Assessment*¹ based on *Good Medical Practice*. The criteria for the Revalidation of all doctors are based on this document. Next, in 2008, the RCGP published its revision of *Good Medical Practice for General Practitioners*,² which set out the expectations to be held of an exemplary and an unacceptable GP.

The RCGP consulted on the types of supporting information that could reasonably be expected from GPs in both the NHS and independent sectors. Comments received on the *Revalidation for General Practitioners: a consultation document*³ have informed this guide.

In April 2009 the RCGP published the first edition of this *Guide to the Revalidation of General Practitioners*, and a second edition in August 2009. The RCGP received over 150 responses via the website to the first and second editions, almost all generally supportive but suggesting refinements. These comments and suggestions, as well as developing policy, have informed the changes to the guide for this, the third edition. The key changes to this third edition are given in the box below.

The key changes between the second and third editions of this *Guide to the Revalidation of General Practitioners*

- The RCGP has adopted throughout this guide the convention used by others of using the term 'supporting information' in place of 'evidence' for revalidation.
- The timelines have been adjusted to reflect the fact that the Early Adopters (in which the first doctors will revalidate) will now start in the year 2011/12, and not earlier.
- The possibility of submitting a quality improvement project in place of the second clinical audit has been included.
- There is a new reference to the revalidation of GPs in training, although the details concerning this are still not clear.
- The definition of what activities are included in Supporting Information Area 13 (extended practice) has been refined.
- We have emphasised the discretion that will be required by Responsible Officers in assessing supporting information for Revalidation.
- A simplification of the continuing professional development learning credits system in supporting information area 6.

Note: the key changes to this version are **marked in red**.

1 www.gmc-uk.org/about/reform/gmp_framework.asp.

2 RCGP and GPC. *Good Medical Practice for General Practitioners* (second edn) London: RCGP, 2008, www.rcgp.org.uk/PDF/GMP_web.pdf.

3 www.rcgp.org.uk/practising_as_a_gp/revalidation.aspx.

The RCGP commenced piloting in 2009 and will continue to do so in 2010 in preparation for the anticipated commencement of Revalidation. The evidence from those pilots will help to shape the Revalidation process and will inform revisions of this guide. In particular, the RCGP recognises that there is still uncertainty around the roles and responsibilities of Responsible Officers, the concept of assessors and the local groups, the RCGP National Adjudication Panel, and the quality assurance of Revalidation decisions. There are other areas where future policy may require changes to this guide.

The most important unresolved debate concerns the resources required for Revalidation to be effective. PCOs will need resources to ensure that annual appraisals and clinical governance are improved; and they will need to recruit, train and support their Responsible Officers. GPs themselves will require time to gather supporting information and maintain their portfolios. There will be costs for the RCGP.

Support, for some general practitioners who give cause for concern may involve substantial expense. In the RCGP's view, the roles in remediation can be summarised as follows:

The individual GP has responsibility for:	<ul style="list-style-type: none"> ● Seeking support where it is recognised that he or she is encountering difficulties ● Engaging honestly in appraisal and the revalidation processes ● Engaging positively in any remedial process ● Identifying his or her own health problems and seeking treatment
The PCO has responsibility for:	<ul style="list-style-type: none"> ● Ensuring there is a local system involving representation from the Local Medical Committee to respond to concerns regarding a doctor's performance (these may vary from county to county) ● Liaising with the local Postgraduate Director of General Practice Education to seek support, including the development of an appropriate educational plan and assessment ● Ensuring systems are appropriately supported and resourced ● Ensuring there are high-quality Occupational Health Services available ● Supporting doctors with health problems in a confidential manner
The deanery has responsibility for:	<ul style="list-style-type: none"> ● Provision of educational expertise to support the remedial process, including assessment and development of an educational plan
The College has responsibility for:	<ul style="list-style-type: none"> ● Quality assurance of appraisal and revalidation processes enabling early identification and support for doctors in difficulty ● Quality assurance processes ensuring that PCOs have robust and properly resourced Remediation processes in place ● Supporting deaneries and PCOs by provision of a number of assessment tools that can be utilised in Remediation ● Pastoral support for RCGP members through the College faculty networks ● Signposting doctors with health problems to appropriate support where possible

The RCGP has convened a remediation working group with representation from all key stakeholders and has written a report. It will be working with others, especially the British Medical Association, to identify the resources required for remediation.

The RCGP will need to have further discussions with the GMC and the Departments of Health in England, Scotland, Wales and Northern Ireland about how these ideas might operate in practice. Piloting on the ground with thorough evaluation and economic analysis will help to shape the final agreed system.

The RCGP is also developing an ePortfolio for Revalidation that will enable GPs to store all the information required for Revalidation

To prepare for its roles, the RCGP has been working closely with the GMC, the General Practitioners Committee (GPC) of the British Medical Association, the AoMRC, the Departments of Health, the Revalidation Support Team in England, and major independent providers of primary care, such as the Defence Medical Services (DMS). This document takes into account the views of all these valued partners.

This document sets out for all interested parties – GPs; other doctors; the NHS; other colleges, faculties and specialist associations; regulators; independent healthcare providers; and, most importantly, the public – the RCGP’s current proposals for the supporting evidence required for the Revalidation of GPs. Although this document has been discussed with key stakeholders, several aspects are dependent on future policy decisions by others. This guide will, therefore, evolve into the definitive source of advice for GPs preparing their supporting information for Revalidation, appraisers and their advisers, assessors and Responsible Officers.

These proposals are intended to be fit for the purpose of demonstrating that GPs are up to date and fit to practise; that they are proportionate, feasible and cost-effective.

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 *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.⁴ The Revalidation Support Team’s documents, *Assuring the Quality of Medical Appraisal for Revalidation* (AQMAR) and *Strengthening Medical Appraisal* (both available on the website, www.revalidationsupport.nhs.uk) are highly recommended further reading.

⁴ www.revalidationsupport.nhs.uk/.

Section I

Details of the supporting evidence required for the Revalidation of GPs

This section looks at each type of supporting evidence that will be expected in a GP's Revalidation Portfolio. It offers advice on how GPs, including principals, sessional doctors, General Practitioners with a Special Interest (GPwSIs), emergency care doctors, GPs in independent practice and those in hierarchical organisations such as the Defence Medical Services, will meet the requirements for Revalidation. It also gives guidance to those who will assess GPs' Revalidation Portfolios.

In addition to the supporting information provided by the GP in the Revalidation Portfolio, the Responsible Officer in the Primary Care Organisation will have access to any relevant clinical governance and performance evidence relevant to that GP. The Responsible Officer will take all the evidence available into account when making a Revalidation recommendation.

The Framework for evidence for Revalidation has been published by the GMC (and is given in Section 5 of this document). Each GP will need to provide supporting information against all of the 12 GMC attributes. When placing such information in the Revalidation Portfolio, the GP and his or her appraiser will agree which of these 12 attributes are covered by that evidence, building an overall picture against all GMC attributes.

For the purposes of this document, the Revalidation period is taken to start officially on 1 April 2011. Of course, the start date is very much dependent on external decisions, and some key infrastructural changes will need to be in place right across the UK before Revalidation can begin. This will include the appointment of Responsible Officers in every PCO and Local Health Board, and the roll out of an enhanced system of appraisal based on the *Good Medical Practice Framework for Appraisal and Assessment*.

We are working on a timetable that would see the first GPs revalidating in 2011, so it is important that GPs begin putting together a portfolio of supporting information from April 2009 (if they have not been doing so already). Of course, the required supporting information for the year April 2009 to March 2010 will be limited to that required for annual appraisal, so should be achievable by any GP. A GP will not be penalised for not providing supporting information for the period prior to 1 April 2009 but the vast majority will have supporting information from earlier appraisals that they will wish to include in their Revalidation Portfolio.

Although it will be possible to complete a paper portfolio for Revalidation, the clear preference will be for all GPs to complete an electronic toolkit or portfolio for each appraisal, which will build into a Revalidation ePortfolio covering the whole of the Revalidation period. Supporting information entered in the NHS Toolkit and the Wales Deanery portfolio will be usable for Revalidation.

Sessional doctors and GPs in remote or small practices

Revalidation must be fair and equitable. This means that we will strive to make Revalidation feasible and proportionate for all GPs. While the standards expected of all doctors must be the same, there will need to be flexibility concerning the supporting information required that takes the GP's individual circumstances into account. The RCGP is working with representatives of such doctors and is undertaking pilot projects (including one in the North East dedicated to these GPs) before putting its proposals to the GMC.

The number of sessional doctors in British general practice is significant. Many will find no extra problems in gathering supporting information (as described in this guide) for their Revalidation Portfolio. However, peripatetic locums and sessional doctors working in unsupportive practices may experience difficulties. Some of these difficulties are also likely to be experienced by GPs in small and remote practices.

Undertaking Multi-Source Feedback from colleagues may be complicated if there are insufficient colleagues who know your practice. This may happen if you are a locum who does very few sessions in any single practice or, for example, if you work with your spouse in a small island practice. The scope of these problems will become clearer in the pilots. However, we have already said that a questionnaire undertaken by a peripatetic locum at the end of locum sessions and accumulated over time will be regarded as sufficient supporting information for a colleague survey. We will be looking for other equivalents for those few doctors who experience similar difficulties.

The other key areas of potential difficulties relate to supporting information of Significant Event Audits and Clinical Audits. Those doctors who do not have a supportive practice team will benefit from establishing other peer groups to offer support. The 'chambers' model for locums is an example. Undertaking the reflection required for Significant Event Auditing is often best with the involvement of other members of a practice. However, it is certainly possible for this to be undertaken with other such colleagues. The RCGP is collecting topics used effectively for Clinical Auditing by locum doctors and those in small, remote practices. **It is also lobbying for all locums to always use their own identity when logging into clinical computer systems and issuing prescriptions.**

What GPs need to do now

GPs should ensure that they have their annual appraisals, and use an electronic toolkit to record their supporting information, including their Personal Development Plans (PDPs). They should consider recording their Significant Event Audits or Clinical Audits. They should deal with any complaints properly, recording their reflections.

The learning credits system is still being refined. At present you should record all your education, including the hours spent, in preparation for the introduction of learning credits.

There is no need to undertake colleague surveys or patient surveys yet – when the approved surveys are ready for use the profession will be notified.

Supporting information area 1

Statement of professional roles and other basic details

Advice for GPs

The statement of professional roles will need to be entered into the Revalidation ePortfolio⁵ at the first appraisal, and then updated annually. The Revalidation ePortfolio will indicate what other details are required within this section for Revalidation, such as:

- title and name
- email address
- work address and telephone number
- preferred contact address and telephone number
- primary medical degree and awarding institution
- medical qualifications
- GMC number, registration date, licence date and date of entry onto the General Practice Register
- date of last Revalidation (if applicable)
- all current posts and those within the revalidation period – date started, time commitment, employer (including address); if clinical, whether within an organisation with a quality-assured system for clinical governance;⁶ role content/description and performance review/appraisal within this post
- any voluntary roles undertaken in the capacity of a doctor
- free-text elaboration of any unusual supporting information.

The GMC states Revalidation will be based on what a doctor actually does in practice. In order for appraisers, Responsible Officers and assessors to understand what the GP actually does, all posts undertaken as a doctor, whether paid or not, must therefore be included. The electronic portfolio will provide a format in which to record all roles. The details required will be the basics described above. GPs with extended roles, such as GPwSIs, GPs working in community hospitals, those involved in undergraduate, postgraduate or other teaching roles, or researchers, will be expected to include these roles here, and also provide fuller details in supporting information area 13.

GPs in the DMS will need to provide details of their extended responsibilities in clinical areas. These may include pre-hospital emergency medicine (e.g. BASICS), occupational medicine, travel medicine, sports and exercise medicine, public health, environmental health, aviation medicine, diving medicine and military community psychiatry.

For sessional doctors who locum for multiple providers over the revalidation period there 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 on more than one occasion, 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

⁵ A Revalidation ePortfolio, approved by the RCGP, will contain appraisal evidence, building into a revalidation portfolio. If a GP can justify it, in exceptional cases a paper-based portfolio will be accepted.

⁶ 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.

practice consultations' but they should also describe other medical roles if appropriate.

Advice for appraisers, Responsible Officers and assessors

This section of the portfolio is key to understanding the GP's background and the context and content of his or her working life over the period of Revalidation. Provided the section is fully completed, and there are no concerns about the honesty or truthfulness of the content of the submission, assessment of this section should be straightforward.

Supporting information area 2

Statement of exceptional circumstances

Advice for GPs

This section of the portfolio is the opportunity for the GP to explain any unusual aspects of his or her working life during the revalidation period that may help the appraiser, Responsible Officer and assessor to understand the supporting information. Although most GPs will tick a box to indicate a nil return in this supporting information area, a free-text box will offer 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 break-up of a partnership or a move to another practice.

This list is not intended to be exhaustive – there may be other circumstances that a GP may wish to include. This supporting information area will be used by appraisers, Responsible Officers and assessors to provide context in evaluating the GP's portfolio.

Advice for appraisers, Responsible Officers and assessors

Any portfolio of supporting information must meet the requirements for Revalidation, including the minimum criteria specified in Section 3 of this guide. The contents of the statement of exceptional circumstances are not included in the portfolio to bypass the standards for Revalidation, but to assist the appraisers, Responsible Officers and assessors in interpreting the supporting information presented to them. For example, there may be a year in which there is no evidence of a satisfactory appraisal. If it is clear that the GP was working abroad or was on maternity leave at that time, the absence of supporting information concerning that appraisal can be accepted.

The content of the statement of exceptional circumstances requires interpretation. The appraisers, Responsible Officers and assessors will need to be satisfied that any stated exceptional circumstances are indeed legitimately exceptional. If, after discussion with the Responsible Officer, there is doubt, the portfolio should be referred to the RCGP's National Adjudication Panel where consistent national standards can be applied. As experience of Revalidation increases it is expected that fuller guidance based on case experience will be developed for appraisers, Responsible Officers and assessors by the College.

Supporting information area 3

Evidence of active and effective participation in annual appraisals

Advice for GPs

All GPs in clinical practice are expected to take part in regular annual appraisal. In the early years of Revalidation the supporting information of active and effective participation in annual appraisal will relate to the period from 1 April 2009 (see Section 2 of this guide). Almost all Revalidation Portfolios will contain supporting information automatically derived from the annual appraisal Revalidation ePortfolio, accumulated year-on-year as the appraiser signs off each annual appraisal.

The minimum number of annual appraisals required for Revalidation is set out in Section 3 of this guide. It is anticipated, however, that almost all revalidation folders will contain a complete series of satisfactory annual appraisals.

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 any doctors experience significant problems, which are not resolved satisfactorily with their PCO or employer, they must draw this to the attention of the RCGP at an early point in the revalidation period and also list it under supporting information area 2 (exceptional circumstances).

Advice for appraisers, Responsible Officers and assessors

For most GPs, the assessment of this supporting information area should be simply a case of checking that five appraisals have been signed off by a trained and approved appraiser within an organisation with a quality-assured system of clinical governance (see note above). If any annual appraisals are not certified, there should be an acceptable explanation in supporting information area 2 (exceptional circumstances) and the minimum criteria must be met (Section 3).

If an annual appraisal has been undertaken but the appraiser was unable to sign off the GP's participation as active and effective, an explanation should be given that should include a statement from the clinical governance team where the doctor is based. One unsatisfactory appraisal may be acceptable if an investigation was undertaken, the reason was clearly established, Remediation was prescribed and the doctor responded appropriately. If there are any significant doubts, or there has been more than one unsatisfactory annual appraisal, the portfolio should be referred to the RCGP's National Adjudication Panel, where consistent national standards can be applied. As Revalidation is a rolling programme (not an isolated event in the final year of the revalidation cycle), it is not necessary to wait until the last year before such action is taken.

Supporting information area 4

A Personal Development Plan from each annual appraisal

Advice for GPs

An annual PDP should be derived from participation in each annual appraisal. It should be signed off by the appraiser and the GP, and should represent the agreed plan for the forthcoming year. The portfolio should contain one PDP for each year in the period from 1 April 2009 (see Section 2 of this guide).

Usually a GP's PDP will be recorded as part of the Revalidation ePortfolio for each annual appraisal and will be transferred into that GP's Revalidation Portfolio automatically.

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' (see below) 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 of the goal.

Advice for appraisers, Responsible Officers and assessors

In assessing a GP's PDP, the appraiser, Responsible Officer and assessor will need to be satisfied that all the PDPs submitted in a revalidation period, when taken together, represent an appropriate spread of learning areas as to reflect the statement of that doctor's practice in Supporting information area 1.

Some goals in a PDP are, inevitably, rather unspecific, but all of the recorded goals in the PDP should be 'SMART' (with some permitted to be less rigorous on the 'M' and the 'T'):

- **Specific** – described in such a way that the appraiser, Responsible Officer and assessor can understand what the goal was and what it was intended to achieve
- **Measurable** – specifying how the GP and the appraiser will know if it has been achieved
- **Achievable** – the goal should be realistic given the GP's position and resources available
- **Relevant** – the goal must be relevant to the needs of the GP, and the goals overall should be relevant to the clinical work undertaken by the GP
- **Time-bounded** – there must be a specified time by which the goal will be achieved.

The appraiser, Responsible Officer and assessor will only accept the GP's PDP if they show an overall commitment to personal development using appropriate goals. If there is significant doubt on the appropriateness of the submitted PDPs for Revalidation, the portfolio should be referred to the RCGP's National Adjudication Panel, where consistent national standards can be applied.

Supporting information area 5

A review of the Personal Development Plan from each annual appraisal

Advice for GPs

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 the GP reflects on the goal, the development achieved and any reasons for not achieving the goal. This reflection is an important attribute of a GP's fitness to practise.

Over a 5-year period the GP should not only consider clinical learning and development but also the competencies around leadership and management, recognising the importance of all doctors' role in a safe system of health care for patients (www.institute.nhs.uk/medicallleadership).

Advice for appraisers, Responsible Officers and assessors

In assessing the comments on the goals set in the previously agreed PDP, the appraiser, Responsible Officer and assessor should recognise that not all goals can always be met. However, SMART goals have a greater chance of achievement and low levels of achievement of goals may reflect the quality of PDP writing (supporting information area 4). As a rule of thumb, at least two-thirds of agreed PDP goals should be successfully achieved.

Normally goals, whether met or not, should show supporting information of reflection on the personal development achieved and, if appropriate, the reasons for non-achievement. If there is significant doubt about reflection or the level of achievement of goals is low, the portfolio should be referred to the RCGP's National Adjudication Panel, where consistent national standards can be applied.

Supporting information area 6

Learning credits in each year of the revalidation period and in the revalidation period overall

Advice for GPs

The RCGP has developed a continuing professional development learning credits system to ensure that every GP:

- updates and applies his or her knowledge and skills
- promotes patient confidence
- ultimately improves patient care.

The learning credits scheme is designed to be appropriate and available to all practising GPs, throughout the UK.

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

In essence 1 hour of education is one learning credit. However, if that education leads to changes for patients, the doctor or the practice, the GP can claim two learning credits for each hour of such education.

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.*

All GPs will, therefore, be expected to record their educational activity and award themselves credits based upon the hours involved and the impact of the education on themselves, their patients or the service in which they work.

Over a revalidation cycle a GP will be expected to demonstrate a broad range of general practice education, with at least 50 learning credits being achieved and confirmed by the appraiser each year.

Advice for appraisers, Responsible Officers and assessors

The appraiser should verify, as part of the appraisal discussion, that the credits claimed by the doctor being appraised are reasonable. *There should be no controversy over low-impact education – the credits are the hours spent on the education. For education with a claimed impact, the appraiser will need to be satisfied that the supporting information submitted by the GP supports his or her claim for extra credits.* The appraiser will have examined the appraisal Form 3 evidence and will have the opportunity to discuss in further depth any aspects of the credits claimed that need clarification. In the large majority of appraisals, it is expected that the appraiser will be satisfied and 'sign off' the GP's learning credits.

There are three scenarios that should lead to further discussion:

- the appraiser feels that overall the doctor has claimed too many credits
- the appraiser feels that overall the doctor has claimed too few credits. The pilot of learning credits demonstrated that almost all GPs undertake far more than 50 hours of education per year and that this standard should be routinely achieved
- the appraiser feels that the numbers of credits claimed for individual items bear little relation to their impact.

The Responsible Officer and assessor will need to rely on the appraiser's 'sign off' to be satisfied that either an appropriate number of credits has been assigned by the GP or the GP's PDP reflects the need to improve the number or attribution of credits. If an appraiser is unable to 'sign off' a GP's claimed learning credits, the local Responsible Officer and the RCGP should be notified.

While the number of credits claimed should normally be at least 50 in each year, there may be exceptional circumstances that need to be taken into account. These may include the GP's statement in supporting information area 2. If a GP does not achieve the 50 credits in a year and the PDP demonstrates that appropriate action is agreed to correct the shortfall in the next year, that will normally be regarded as acceptable. Repetitive or consistent failure to achieve the 50 credits per year will not normally be acceptable.

If in significant doubt about the learning credits claimed by a GP, the appraiser should refer the portfolio to the RCGP's National Adjudication Panel, where consistent national standards can be applied.

Supporting information area 7

Multi-Source Feedback from colleagues

Advice for GPs

Multi-source feedback from colleagues (MSF) is a recognised way for a person to gain formative information on how they are seen by those with whom they work. Their 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, MSF can be used to demonstrate that a GP is both reflecting and improving.

For MSF from colleagues the GP will need to identify a number of GP colleagues and other people (nurse, practice manager, practice secretary, receptionist, etc.) with whom he or she works sufficiently closely to enable informed and representative opinions to be made. The selected colleagues will be asked to complete an online questionnaire giving their view on key attributes of the GP. 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 commissioned a review of MSF instruments and will recommend which ones are appropriate for use in Revalidation. At present only the GMC's MSF instrument meets RCGP requirements. Although it will be permissible to scan in the results of an MSF and attach that file to the Revalidation Portfolio, it is expected that, in time, the results of MSFs will be automatically inserted into the GP's Revalidation ePortfolio.

When Revalidation is fully established, each GP will be required to submit supporting information from two MSFs, one undertaken in the first 2 years of the 5-year revalidation period and one in the last 2 years. The transitional requirements are described in Section 2.

It is recognised that some attributes appropriate to principals in general practice (for example management and team leadership) are not appropriate for some doctors, such as those undertaking locum work. An MSF for sessional doctors is being developed and will be one of the options available for use in Revalidation. Furthermore, if specific groups experience issues bespoke to their organisations, for example conducting MSF in hierarchical systems such as the DMS, the RCGP will work with these partners to facilitate a satisfactory solution. The RCGP will ask organisations conducting MSF to provide peer referencing against GPs as a whole, and also an appropriate peer group (principals, salaried, locums, prison doctors, etc.).

It may be the case that peripatetic locums and/or doctors working out of hours will experience serious difficulties in undertaking conventional MSF. If the GP can show justification, the alternative of submitting the results of approved questionnaires completed by employing organisations (practices or out-of-hours providers) following episodes of service will be acceptable.

The most important aspect of doing MSFs is reflecting upon the results and, if appropriate, implementing changes. The result of each MSF should be discussed at 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.

Advice for appraisers, Responsible Officers and assessors

The first requirement that appraisers, Responsible Officers and assessors will look for is the presence of the required number of MSFs in the GP's Revalidation Portfolio. The appraiser, Responsible Officer and assessor will then look for supporting information that any issues arising from the result of each MSF have been identified, reflected on and appropriate goals set. Lastly, if there is more than one MSF in the portfolio, the appraiser, Responsible Officer and assessor will look for supporting information that, if any areas for improvement were identified in the first, there is evidence of appropriate change in the second, or reflection as to why this is not the case.

Provided the appraiser, Responsible Officer and assessor are satisfied that there is a positive answer to the three issues above, the actual outcome from the MSF will only be of importance if the result is significantly poor compared with an appropriate peer group, or if there is other supporting information that raises the possibility of concerns. The College will issue more specific advice on this matter as the evidence base develops.

If in significant doubt about the results from, or GP's response to, an MSF or MSFs, the Revalidation ePortfolio should be referred to the RCGP's National Adjudication Panel, where consistent national standards can be applied.

Supporting information area 8

Feedback from patients

Advice for GPs

The Revalidation Portfolio will, in time, contain the results of patient surveys. Section 2 of this guide describes when these will be expected in the introductory phases of Revalidation. Once Revalidation is fully established, the portfolio should include the results of two patient surveys, one undertaken in the first 2 years of the 5-year revalidation period and one in the last 2 years.

If the first patient survey demonstrates a highly satisfactory level of patient views, the RCGP proposes that the doctor will be able to choose to submit supporting information of a review of consulting skills instead of a second patient survey. Such a review might include a properly conducted analysis of videotaped consultations or peer observation by a suitably trained and approved colleague.

The RCGP has commissioned a review of patient surveys and will recommend which ones are appropriate for use in Revalidation. They will need to seek the views of the patients *actually consulting* the GP – practice-based surveys of the registered population will not be acceptable. Although it will be permissible to scan in the results of a patient survey and attach that file to the revalidation portfolio, it is expected in time that the results of approved patient surveys will be automatically inserted into the GP's Revalidation ePortfolio.

It is recognised that some GPs, for example those working in the Prison Service, will find eliciting their patients' views challenging. We understand that most secure environments have a 'Prison Involvement (or Participation) Group' and a survey of these patients, along with findings from the relevant healthcare questions in the Measuring Quality of Prison Life (MQPL) survey, should suffice. The method of administering a questionnaire, with a freepost envelope, should be suitable for sessional GPs. 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, etc.).

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 annual appraisal, and the 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.

In addition the GP may wish to include positive feedback received from patients, such as unsolicited letters, in this area of supporting information.

Advice for appraisers, Responsible Officers and assessors

The first requirement that appraisers, Responsible Officers and assessors will look for is the presence of the required number of patient surveys in the GP's revalidation portfolio. The appraiser, Responsible Officer and assessor will then look for supporting information that any issues arising from the result of each patient survey have been identified and appropriate goals set. Lastly, if there is more than one patient survey in the portfolio, the appraiser, Responsible Officer and

assessor will look for supporting information that, if any areas for improvement were identified in the first, there is supporting information of some improvement in the second, or reflection as to why this is not the case.

Provided the appraiser, Responsible Officer and assessor is satisfied that there is a positive answer to those three issues the actual outcome from the patient survey will only be of importance if the result is significantly poor compared with an appropriate peer group, or if there is other supporting information that raises the possibility of concerns. The College will issue more specific advice on this matter as the evidence base develops.

If in significant doubt about the results from, or the GP's response to, a patient survey or patient surveys, the portfolio should be referred to the RCGP's National Adjudication Panel, where consistent national standards can be applied.

Supporting information area 9

Description of any cause for concern and/or formal complaint

Advice for GPs

Some GPs may have been identified as being a 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. deanery) or the National Clinical Assessment Service (NCAS) might have assessed the GP. There may have been a referral to the GMC. Any cause for concern⁸ 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, a Revalidation Portfolio cannot be considered. Neither the local group nor the RCGP centrally will be able to make a recommendation to the GMC. The GMC will, therefore, be asked to consider the GP's portfolio and decide how it wishes to handle that doctor's 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 PCO, or involved any other formal health service organisation.

Although many such complaints are satisfactorily resolved at an early stage, a GP's Revalidation Portfolio should include all such complaints. **The intention is not to rake over old events, but to look for two points: a pattern of complaints that may suggest systemic issues; and to confirm the doctor's appropriate level of response to receiving complaints (reflection, lessons learnt, etc.).** The description of such complaints should be sufficient for the appraisers, Responsible Officers and assessors to satisfy themselves regarding these two points, and should include:

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

There will be a standard form within the Revalidation ePortfolio to record such information.

⁷ 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.

Some locum doctors may not be made aware of complaints concerning their care, but they should be notified by the practice or PCO of all formal complaints. Some may find it more difficult to fully report the outcome of such complaints if the practice or PCO does not communicate the outcome to them. The locum should use organisations such as the British Medical Association, the National Association of Sessional General Practitioners and the RCGP in a timely fashion if necessary to ensure an adequately completed portfolio.

Advice for appraisers, Responsible Officers and assessors

A cause for concern will need to be resolved through local or national systems before an application for Revalidation can be considered within the RCGP processes. If there has been a cause for concern during the revalidation period, the Responsible Officer will submit a statement to be included in the revalidation portfolio.

All the statements on complaints should be known to the local clinical governance team. Additionally the appraiser, Responsible Officer and assessor must consider two aspects. The first is the pattern of events described in this supporting information area that may show a concern that has not been detected by local processes, especially when considering the supporting information within the portfolio as a whole. The second aspect is to look for supporting information of the key attribute of reflection and improvement. For the latter, the two important aspects are the process of handling the complaint and the GP's response to the complaint.

If the appraiser, Responsible Officer or assessor has significant doubt about the supporting information provided by the accounts of cause for concern and/or complaints, including the accuracy of the accounts and/or the GP's response to them, the portfolio should be referred to the RCGP's National Adjudication Panel, where consistent national standards can be applied.

Supporting information area 10

Significant Event Audits

Advice for GPs

Significant Event Auditing 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, a GP's Revalidation Portfolio will be expected to contain an analysis of at least five significant events. These can be from any time during the revalidation period. There is no requirement for 'one per year'. However, an appraiser will be concerned if a developing portfolio contains no such analyses by the beginning of the fourth year of the revalidation period; 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. A GP must only submit an analysis of a significant event in which he or she has been directly involved either clinically or in terms of responsibility for the system of care used, where the event was discussed in a team meeting (usually a Significant Event Audit meeting) by the GP with an appropriate selection of other primary care team members present, and where the changes involve him or herself, perhaps as the person responsible for implementing the change.

An account of a Significant Event Audit should not allow patients to be identified and should comprise:

- title of the event
- date of the event
- date the event was discussed and the roles of those present
- description of the event involving the GP
- what went well?
- what could have been done better?
- 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 Revalidation ePortfolio will have a standard form in which to record these fields.

Significant Event Audits need to be discussed and are much easier to conduct within primary care teams. Single-handed GPs and independent locums may therefore experience difficulties in conducting Significant Event Audits. They should try to discuss the event in a multidisciplinary meeting in the practice in which the event occurred. If that is not possible, they may join a group

of similar GPs who can, together, discuss each other's significant events. Experience shows that there are solutions to these potential problems for such GPs.

Advice for appraisers, Responsible Officers and assessors

The appraiser, Responsible Officer and assessor will need to be satisfied that at least the minimum number of significant events have been analysed and reported, and that they meet the qualifying criteria. Beyond that, the key attributes of a satisfactory Significant Event Audit are reflection and appropriate action undertaken.

If the appraiser, Responsible Officer or assessor has major doubt about the Significant Event Audits provided, either in terms of quantity or their quality, the portfolio should be referred to the RCGP's National Adjudication Panel, where consistent national standards can be applied.

Supporting information area | I

Clinical Audits

Advice for GPs

All GPs should be familiar with the principles and practice of Clinical Auditing. **When Revalidation is fully established, a GP's Revalidation Portfolio will be expected to contain information to demonstrate that he or she has taken part in clinical audit activity.** This will normally be two full-cycle (initial audit, change implemented, re-audit to demonstrate improvement) Clinical Audits during the revalidation period. One Clinical Audit should be undertaken in years one, two or three, and one Clinical Audit in years three, four or five. Section 2 of this guide describes the transitional arrangements during the introduction of Revalidation. However, the RCGP will be exploring other methods of Clinical Audit and may, in time, recommend a range of acceptable types of local, regional and national audit supporting information.

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 the GP will actually undertake the data extraction and/or analysis, and there will be no recognition of the workload in this supporting information area.**

Several GPs who work together as a team may undertake a common audit. If this Clinical Audit is to be put into a GP's Revalidation Portfolio, that GP must have contributed properly to the choice of topic and the standards set. The GP must be able to identify his or her own care, or the care for which he or she is personally responsible, within the first audit and the re-audit. The GP must state what changes he or she 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 standards set and their justification (reference 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 Revalidation ePortfolio will have a standard form in which to record these fields.

If a GP has included one conventional clinical audit in his or her supporting information, the RCGP believes that the GP should be able, if he or she wishes and he or she has the expertise, to include a quality improvement project (QIP) as the second audit. A description of a QIP should include:

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

Locums will have less infrastructure/practice support than practice-based GPs to facilitate Clinical Audits. Practices will be encouraged to facilitate access to clinical records for audits by locums, and the Department of Health will be encouraged to ensure that all prescribing is identified to the prescribing doctor. Guidance on audit topics suitable for sessional doctors, especially locums, will be drawn up, and a list of suggested topics may include:

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

It is intended that a website will be developed, in collaboration with the RCGP, where worked examples of audits suitable for sessional doctors can be accessed.

Advice for appraisers, Responsible Officers and assessors

The appraiser, Responsible Officer and assessor will need to be satisfied that the required minimum number of Clinical Audits has been submitted, and that it meets the key attributes of a satisfactory Clinical Audit. These attributes are:

- the topic(s) chosen for the Clinical Audit(s). Given the GP's clinical roles (supporting information area 1), are the topics appropriate?
- the audit reflects the care undertaken by the individual practitioner
- the standards of care set for the GP's patients. **Are these based on a recognised evidence base and are they appropriate, or are they reflecting local or national priorities?**
- reflection on current care. Has the GP reflected on the findings of the first data collection and

reached appropriate conclusions?

- the changes planned after the first data collection. Has the GP decided on appropriate changes?
- the implementation of change. Has the GP acted to improve care for his or her patients?

If the standards set in an audit are appropriate and challenging, and the initial audit demonstrates exemplary care, then in these exceptional circumstances the GP may be justified in not undertaking the second data collection.

If the appraiser, Responsible Officer or assessor has significant doubt about the Clinical Audits provided, either in terms of their quantity or quality, the portfolio should be referred to the RCGP's National Adjudication Panel, where consistent national standards can be applied.

Supporting information area 12

Statement on probity and health

Advice for GPs

The GP will be asked to verify a standard statement or to provide an alternative statement. The standard statement should be very similar for all doctors. This standard statement will cover:

- there are no issues of probity in the GP's work
- there are no health issues that might affect the GP's 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)
- the GP is in a position to receive independent, impartial healthcare advice (for example is not consulting a family member)⁸ and that he or she accesses that health care appropriately. Unless there is a good reason (such as working on a military base in the DMS or geography) 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)
- **the GP has appropriate and current insurance or indemnity cover for all aspects of his or her work.**

In the latter case, the GP will be asked to provide the name of the organisation providing insurance or indemnity cover and the membership number.

Advice for appraisers, Responsible Officers and assessors

The appraiser, Responsible Officer and assessor will need to be satisfied that this supporting information area has been completed and that the statement is compatible with other supporting information available in the revalidation portfolio (especially any cause for concern or complaint recorded).

If the appraiser, Responsible Officer or assessor has significant doubt about the statements on probity or health provided, the portfolio should be referred to the RCGP's National Adjudication Panel, where consistent national standards can be applied.

⁸ 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.'

Supporting information area 13

Additional evidence for areas of extended practice

Advice for GPs

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
- undertaken within a contract or setting that distinguishes it from standard general practice (such as work as a GPwSI)
- 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 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 visit
- 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 statement from the employing PCO
- out-of-hours work – a statement from the out-of-hours provider
- GPwSIs under contract to a PCO – a statement from their contracting organisation that they have been accredited for the role.

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

For clinical activities, including GPwSIs not in contract with a PCO, the GP should describe in detail the role (in supporting information area 1) and provide in this section of the portfolio 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 education and refreshment undertaken for this role in the revalidation period, including any learning credits recorded in supporting information area 6.
- 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 audits in supporting information

areas 10 and 11, supporting information from third-party observation of your work, and sign-off from an appropriate consultant/expert/colleague who knows your work.

Advice for appraisers, Responsible Officers and assessors

The appraiser, Responsible Officer and assessor will need to be satisfied that the GP's extended roles are appropriate and safe.

Section 2

Supporting information required in the introductory phase of Revalidation of GPs

Provided all the necessary elements can be put in place, it is expected that the first GPs to be revalidated will submit their supporting information in 2011/12. Clearly these doctors cannot be expected to submit a full 5-year revalidation folder. This section sets out what supporting information they, and those in subsequent years, will be expected to submit and is summarised in Table 2 (p. 30). The detailed description of the supporting information is given in Section 1 of this guide.

It should be noted that the description here is the minimum supporting information required and no GP will be penalised for submitting the minimum. However, most GPs will have supporting information from previous years that they will wish to submit to produce as full a Revalidation Portfolio as they can. They will have, for example, a series of successful appraisals, some audits and significant events that they may wish to submit. All supporting information submitted in a Revalidation Portfolio will be assessed for Revalidation.

Submitting supporting information in the first year (April 2011 to March 2012)

In the first year of the introduction of Revalidation, the RCGP intends to work in a limited number of PCOs that have good-quality clinical governance systems, a track record of effective annual appraisals and an appointed Responsible Officer. The GPs will be volunteers and will be expected to submit a portfolio of supporting information that contains, as a minimum:

- a description of all the professional roles undertaken by the GP
- a statement of any exceptional circumstances
- supporting information of active and effective participation in two annual appraisals in 2009/10 and 2010/11
- PDPs agreed with the appraiser in appraisals in 2009/10 and 2010/11
- a review of the PDP agreed in the 2009/10 appraisal, with reflection on whether educational needs identified have been met, or reasons as to why they have not been or only partially met
- either self-accreditation of a minimum of 50 learning credits in 2010/11 or a description of all CPD experienced in 2010/11 with reflection on the effects, discussed and agreed at annual appraisal
- a description of any cause for concern raised about the GP and a review of any formal complaint in which the doctor has been directly involved in 2009/10 or 2010/11
- a minimum of one Significant Event Audit involving the GP that demonstrates reflection and

change, with supporting information of discussion in appraisal

- statements of probity, health and use of health care; evidence of appropriate insurance or indemnity cover
- additional supporting information for those GPs with extended roles.

Submitting supporting information in the second year (2012/13)

In the second year of the introduction of Revalidation, the GP will be expected to submit a portfolio of supporting information that contains, as a minimum:

- a description of all the professional roles undertaken by the GP
- a statement of any exceptional circumstances
- supporting information of active and effective participation in three annual appraisals (2009/10, 2010/11 and 2011/12)
- PDPs agreed with the appraiser in the 2009/10, 2010/11, and 2011/12 appraisals
- reviews of the PDPs agreed in the 2009/10 and 2010/11 appraisals, with reflection on whether educational needs identified have been met, or reasons as to why they have not been or only partially met
- self-accreditation of a minimum of 100 learning credits, at least 50 learning credits in each year 2010/11 and 2011/12, discussed and agreed at annual appraisal
- results of either one MSF from colleagues or one patient survey of his or her consultations and care, with supporting information of reflection and discussion in appraisal
- a description of any cause for concern raised about the GP and a review of any formal complaint in which the doctor has been directly involved in 2009/10, 2010/11 or 2011/12
- a minimum of two Significant Event Audits involving the GP that demonstrate reflection and change, with supporting information of discussion in appraisal
- an audit of the care delivered by the GP in at least one significant clinical area of his or her practice, with standards, re-audit and supporting information of both appropriate improvement, compliance with best-practice guidelines and discussion in appraisal
- statements of probity, health and use of health care; evidence of appropriate insurance or indemnity cover
- additional evidence for those GPs with extended roles.

Submitting supporting information in the third year (2013/14)

In the third year of the introduction of Revalidation, the GP will be expected to submit a portfolio of supporting information that contains, as a minimum:

- a description of all the professional roles undertaken by the GP
- a statement of any exceptional circumstances
- supporting information of active and effective participation in a cycle of four annual appraisals (2009/10, 2010/11, 2011/12 and 2012/13)
- PDPs agreed with the appraiser in 2009/10, 2010/11, 2011/12, and 2012/13 appraisals
- three reviews of the PDPs agreed in the 2009/10, 2010/11 and 2011/12 appraisals, with reflection on whether educational needs identified have been met, or reasons as to why they have not been or only partially been met
- self-accreditation of a minimum of 150 learning credits, at least 50 credits in each of 2010/11, 2011/12 and 2012/13, discussed and agreed at annual appraisal

- results of at least one MSF from colleagues, with supporting information of reflection and discussion in appraisal
- results of at least one patient survey of the GP's consultations and care, with supporting information of reflection and discussion in appraisal
- a description of any cause for concern raised about the GP and a review of any formal complaint in which the doctor has been directly involved in 2009/10, 2010/11, 2011/12 and 2012/13
- a minimum of three Significant Event Audits involving the GP that demonstrate reflection and change, with supporting information of discussion in appraisal
- audit of the care delivered by the GP in at least one significant clinical area of his or her practice, with standards, re-audit and supporting information of both appropriate improvement, compliance with best-practice guidelines and discussion in appraisal
- statements of probity, health and use of health care; evidence of appropriate insurance or indemnity cover
- additional supporting information for those GPs with extended roles.

Submitting supporting information in the fourth year (2014/15)

In the fourth year of the introduction of Revalidation the GP will be expected to submit a portfolio of supporting information that contains, as a minimum:

- a description of all the professional roles undertaken by the GP
- a statement of any exceptional circumstances
- supporting information of active and effective participation in a cycle of five annual appraisals (2009/10, 2010/11, 2011/12, 2012/13 and 2013/14)
- PDPs agreed with the appraiser in 2009/10, 2010/11, 2011/12, 2012/13 and 2013/14 appraisals
- four reviews of the PDPs agreed in the 2009/10, 2010/11, 2011/12 and 2012/13 appraisals, with reflection on whether educational needs identified have been met, or reasons as to why they have not been or only partially met
- self-accreditation of a minimum of 200 learning credits, at least 50 credits in each of 2010/11, 2011/12, 2012/13 and 2013/14, discussed and agreed at annual appraisal
- results of at least one MSF from colleagues, with supporting information of reflection and discussion in appraisal
- results of at least two patient surveys of the GP's consultations and care, with supporting information of reflection, appropriate change and discussion in appraisal
- a description of any cause for concern raised about the GP and a review of any formal complaint in which the doctor has been directly involved in 2009/10, 2010/11, 2011/12, 2012/13 and 2013/14
- a minimum of four Significant Event Audits involving the GP that demonstrate reflection and change, with supporting information of discussion in appraisal
- audit of the care delivered by the GP in at least two significant clinical areas of his or her practice, with standards, re-audit and supporting information of both appropriate improvement, compliance with best-practice guidelines and discussion in appraisal
- statements of probity, health and use of health care; evidence of appropriate insurance or indemnity cover
- additional supporting information for those GPs with extended roles.

Submitting supporting information in the fifth year (2015/16)

In the fifth year of the introduction of Revalidation, the GP will be expected to submit a portfolio of supporting information that includes, as a minimum:

- a description of all the professional roles undertaken by the GP
- a statement of any exceptional circumstances
- supporting information of active and effective participation in a cycle of five annual appraisals over the five-year revalidation cycle (2010/11, 2011/12, 2012/13, 2013/14 and 2014/15)
- PDPs agreed with the appraiser in appraisals in each of five years 2010/11, 2011/12, 2012/13, 2013/14 and 2014/15
- five reviews of PDPs (agreed in appraisals in 2009/10, 2010/11, 2011/12, 2012/13 and 2013/14), with reflection on whether educational needs identified have been met, or reasons as to why they have not been or only partially met
- self-accreditation of a minimum of 250 learning credits, at least 50 credits in each of 2010/11, 2011/12, 2012/13, 2013/14 and 2014/15, discussed and agreed at annual appraisal
- results of at least two MSFs from colleagues, with supporting information of reflection, appropriate change and discussion in appraisal
- results of at least two patient surveys of the GP's consultations and care during the revalidation cycle, with supporting information of reflection, appropriate change and discussion in appraisal
- a description of any cause for concern raised about the GP in the previous 5 years and a review of any formal complaint in the previous 5 years in which the doctor has been directly involved
- a minimum of five Significant Event Audits involving the GP that demonstrate reflection and change, with supporting information of discussion in appraisal
- audits of the care delivered by the GP in at least two significant clinical areas of his or her practice, with standards, re-audit and supporting information of both appropriate improvement, compliance with best-practice guidelines and discussion in appraisal
- statements of probity, health and use of health care; evidence of appropriate insurance or indemnity cover
- additional supporting information for those GPs with extended roles.

Submitting supporting information in the sixth year (2016/17) onwards

In the sixth year of the introduction of Revalidation, the GP will be expected to submit a full portfolio of supporting information as described in Section 1 of this guide.

Table 2: The supporting information required for Revalidation, year by year, during the introductory period

Evidence	Year 1 (2011/12)	Year 2 (2012/13)	Year 3 (2013/14)	Year 4 (2014/15)	Year 5 (2015/16)
Description of roles	✓	✓	✓	✓	✓
Exceptional circumstances	✓	✓	✓	✓	✓
Supporting information of appraisals	Two	Three	Four	Five	Five
PDPs	Two	Three	Four	Five	Five
Reviews of PDPs	One	Two	Three	Four	Five
Learning credits	50 or CPD	100	150	200	250
MSFs from colleagues		Either one MSF or one patient survey	One	One	Two
Patient surveys			One	Two	Two
Review of complaints since 2009/10	✓	✓	✓	✓	✓
Significant Event Audits	One	Two	Three	Four	Five
Conventional audits		One	One	Two	Two
Statement of probity and health	✓	✓	✓	✓	✓

Section 3

Supporting information required for the Revalidation of GPs whose experience is not standard

This section of the document describes possible ways in which supporting information might be submitted by those who would find a standard portfolio of supporting information for Revalidation impractical. This group encompasses: those in clinical general practice who may find elements of a standard portfolio difficult to accumulate; those who were not in work for all years in the 5-year revalidation cycle or who are on extended career breaks; **vocational registrars whose licence becomes due for renewal**; and those whose only or predominant work as a doctor is not as a clinical GP. The latter group includes a small number of GPs in NHS management, educational management, political roles, health informatics, academia or staff appointments within the DMS.

Guidance in considering non-standard portfolios

In considering whether to recommend a doctor for recertification for the General Practice Register, it is suggested that appraisers, Responsible Officers, assessors and the RCGP's National Adjudication Panel will take into account the following guidance:

- if, at Revalidation, a GP has not been in clinical practice at all during the revalidation period, the RCGP will not normally recommend that doctor for recertification to the General Practice Register. During the introductory phase of Revalidation, a GP may submit supporting information of clinical activity prior to the revalidation period but within 5 years. In some such cases the RCGP may recommend that the GMC revalidates the GP; sometimes, however, the RCGP will refer such cases to the GMC for its decision on eligibility
- if, at Revalidation, a GP has been in clinical practice during the revalidation period the appraiser, Responsible Officer, assessor and the RCGP's National Adjudication Panel will wish to consider the following:
 - 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 (MSF) and patients (patient surveys)
 - any assessment of clinical skills or knowledge
 - any outcome from a re-entry programme.

The RCGP will normally expect supporting information that the GP satisfies the requirements for recertification for each year in which the GP was substantially clinically active, within the minimum requirements described below.

Of course, the RCGP is aware that a small but significant number of doctors on the General Practice Register are no longer active in terms of clinical practice but play a significant role in the primary care context as medical directors. Many of these medical directors are likely to be appointed as Responsible Officers and to have a significant role in the Revalidation of GPs within their local setting. We are aware that many of these doctors are concerned at the possibility that the process of recertification might lead to the loss of their entry on the General Practice Register, which, in many areas, is a requirement for a medical director post in primary care. This is also true of full-time medical directors in secondary care who are on the Specialist Register.

We are working with the GMC, the Departments of Health and others to ensure that the processes we develop for Revalidation do not discourage GPs from taking leadership roles in a primary care context that we believe is crucial to enhancing the quality of care in general practice. The GMC is currently considering proposals on how the registers that they hold can best reflect a doctor's medical qualifications as well as an individual's current practice.

Minimum standards for considering a portfolio

When Revalidation is fully established over a 5-year cycle the minimum supporting information that a Responsible Officer, or the RCGP's National Adjudication Panel, 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 3 of the 5 years in the revalidation cycle
- demonstration of 50 learning credits in each of at least 3 of the 5 years in the revalidation cycle
- **documentation of at least 200 clinical half-day sessions (equivalent to 1 day a week over a period of at least 2 years) in the 5 years in the revalidation cycle, 100 of which should be in the 2 years prior to Revalidation. A half-day would normally last 4 hours and include at least 2 and a 1/2 hours of face-to-face clinical contact.**

The GP's Responsible Officer, assessors and the RCGP's National Adjudication Panel will need to be satisfied that the supporting information is sufficient to demonstrate that the doctor is up to date and fit to practise at the time of Revalidation.

It should be noted that the Committee of General Practice Education Directors (COGPED) recommend a re-entry course in an approved setting after a GP has had an absence of a period of 2 years with no learning credits or appraisal during that time.

Alternative supporting information in a Revalidation Portfolio

The RCGP will be recommending to the GMC that there is some choice available to GPs who are eligible for consideration for Revalidation, but who can justify a claim that the collection of a standard portfolio is unreasonably onerous.

In particular, those who wish to undertake and pass an approved knowledge assessment in their fifth year might not be required to submit supporting information of 250 learning credits.

A GP providing supporting information of passing an approved Clinical Skills Assessment within the previous year might be able to justify not submitting Significant Event Audits or Clinical Audits. The option of submitting evidence through knowledge or Clinical Skills Assessments should be used under exceptional circumstances and must be justified on the basis of the doctor's very unusual circumstances. The GP should, therefore, discuss this option with the RCGP's National Adjudication Panel before considering its use. We regard knowledge and Clinical Skills Assessments as a 'last resort' that should only be used by active GPs in rare circumstances. Most will submit a portfolio containing sufficient supporting information for Revalidation.

It should be noted that there will be no alternative to participation in appraisals and clinical governance.

GPs returning to general practice or wishing to be revalidated without an acceptable minimum portfolio

If a GP is on the GMC General Practice Register but does not meet the minimum criteria set out in this guide, then he or she should undertake and achieve satisfactory outcomes from a re-entry programme. Normally this will include the demonstration of his or her fitness to practise through passing an approved knowledge assessment and an approved Clinical Skills Assessment.

The same will apply to GPs who were previously on the General Practice Register but who are not currently certificated. The GMC will need to consider the arrangements whereby such a doctor can be licensed or certificated to allow him or her to participate in a re-entry programme, but a mechanism such as conditional certification will be required.

Vocational registrars

Many younger GPs will pass the MRCGP within 5 years of full registration. Passing the MRCGP is their certification for the General Practice Register of the GMC and can be regarded as their first revalidation. They will then need to be revalidated every 5 years throughout their professional lives.

There are, however, exceptions to this scenario. For some doctors their training for general practice will take them longer than the standard 4 years from full registration. This will include those who have taken time out for sabbaticals, maternity leave or illness. It includes also some doctors who have changed career intentions and are undergoing training for general practice at 5 years from full registration or from their last revalidation.

The aim is that doctors in training should be able to record their progress through training for the purposes of their revalidation. Vocational registrars will not have to meet a separate set of requirements to be relicensed. The most significant uncertainty is related to the identity of the Responsible Officer for such doctors.

Non-clinical GPs

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 DMS. 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. The RCGP recom-

mends that they should submit supporting information for Revalidation under the principles in this document. If they have not been in active clinical practice in the 5 years of the revalidation cycle or have not met the minimum criteria agreed by the RCGP, they will not normally be recommended for recertification.

The GMC will consider whether they are eligible for relicensure, as a licence may be all they require to undertake their non-clinical role. GPs who are relicensed, but not recertified, will still need to relate to a Responsible Officer and if relicensed would need to undergo re-entry before restarting clinical practice. However, the GMC is considering a range of options whereby the General Practice Register can show that a doctor was on the register and is eligible to return to the register (through due process), but is currently in a non-clinical role.

Portfolios for Revalidation for GPs

The RCGP will want to consider each portfolio of supporting information submitted by a GP for recertification on its merits. There will be four main types of portfolios of supporting information, as summarised in Table 3 (p. 34):

Standard portfolio

The expectation is that the vast majority of GPs will submit a standard portfolio of supporting information to be assessed in a standard way.

Non-standard portfolio

Some GPs will find a standard portfolio challenging and may opt to use success in an approved knowledge assessment to replace supporting information of learning credits and/or success in an approved Clinical Skills Assessment to replace supporting information of significant event and conventional audits.

Partial portfolio

If a GP has not been in active clinical practice for all of the 5 years in the revalidation cycle, he or she can submit supporting information that meets the minimum requirement for clinical activity in the 5 years and that he or she has kept up to date and been appraised in at least 3 of the past 5 years.

Re-entry portfolio

If a GP cannot meet the requirements for a partial portfolio, he or she will need to provide supporting information of successful re-entry to clinical general practice, success in an approved knowledge assessment and success in an approved Clinical Skills Assessment.

Table 3: Evidence for portfolios

<i>Evidence</i>	<i>Standard portfolio</i>	<i>Non-standard portfolio</i>	<i>Partial portfolio</i>	<i>Re-entry portfolio</i>
Description of roles	✓	✓	✓	✓
Exceptional circumstances	✓	✓	✓	✓
Supporting information of five appraisals	✓	✓	At least three	
Five PDPs	✓	✓	At least three	
Four reviews of PDPs	✓	✓	At least two	
250 learning credits	✓		At least 150	
Two MSFs from colleagues	✓	✓	Either one or two	
Two patient surveys	✓	✓	Either one or two	
Review of complaints	✓	✓	✓	
Five Significant Event Audits	✓		One for each year in practice in the five	
Two conventional audits	✓		Either one or two	
Statement of probity and health	✓	✓	✓	✓
Approved knowledge assessment		✓		✓
Approved Clinical Skills Assessment		✓		✓
Satisfactory completion of re-entry programme				✓

Partial portfolios during the transition

It is expected that GPs will submit partial portfolios in the first two years (2011/12 and 2012/13).

In 2013/14 a partial portfolio should contain: supporting information of satisfactory appraisal, PDP agreement and PDP review in 2 of the 3 years; at least 50 learning credits in each of 2 of the 3 years; and at least 100 half-days of clinical activity. In other respects the portfolio should be standard (as described in Section 2).

In 2014/15 a partial portfolio should contain: supporting information of satisfactory appraisal,

PDP agreement and PDP review in at least 2 of the 4 years; at least 50 learning credits in each of 2 of the 4 years; and at least 150 half-days of clinical activity. In other respects the portfolio should be standard (as described in Section 2).

In 2015/16 a partial portfolio should contain: supporting information of satisfactory appraisal, PDP agreement and PDP review in 3 of the 5 years; at least 50 learning credits in each of 3 of the 5 years; and at least 200 half-days of clinical activity. In other respects the portfolio should be standard (as described in Section 2).

Section 4

Processes of Revalidation of GPs

This section of the document describes submission of portfolios, their assessment, the recommendation to the GMC, the handling of portfolios that need national review and quality assurance methods.

The whole of the RCGP's proposals for Revalidation, as described in this Guide, must be approved by the GMC. This section, in particular, must both be approved by the GMC and be coherent with the proposals from other colleges.

In addition, in the interests of giving early and authoritative guidance to GPs concerning revalidation, this guide may appear inflexible. This is not intended. It is very important that we recognise the very different circumstances in which some GPs work and the special difficulties they may face. The Responsible Officer must, therefore, exercise judgement within the framework given in this guide. It is our intention that doctors who can demonstrate that they are up to date and fit to practise should be revalidated with the minimum of inconvenience.

Submission of the supporting information

Each GP will be expected to submit a portfolio of supporting information for Revalidation. After the transition period, this will normally be every 5 years. It is expected that most GPs will gather a Revalidation ePortfolio for their annual appraisals and Revalidation. They will submit the relevant parts of that electronic portfolio for their Revalidation.

One function of 'strengthened appraisal' (appraisal fit for Revalidation) is for the appraiser to assess the GP's supporting information being gathered for Revalidation. The appraiser will be asked to check that the quantity of supporting information is appropriate for that point in the revalidation cycle, and that the gathered supporting information, as far as the appraiser can assess, is of appropriate quality for Revalidation. If there are correctable shortfalls these should be included in the GP's PDP with a view to the developing supporting information being appropriate by the next appraisal. This means that the appraiser will need access to the supporting information identified for submission in Revalidation, including all PDPs, in the revalidation period.

The GP's revalidation portfolio of supporting information will be considered alongside supporting information from other local sources including clinical governance data. Such data will be shared with the GP, who will have an opportunity to reflect on it.

All doctors must be able to relate to an appropriate Responsible Officer in whatever environment they are working in. The Department of Health (in its recent consultation) suggests that

each Primary Care Trust or Health Board will have a single Responsible Officer, who will be a 'senior doctor with personal responsibility for evaluating the conduct and performance of doctors and making recommendations on their fitness to practice as part of Revalidation'.⁹ Accordingly, it is intended that a Responsible Officer will usually be the medical director or equivalent who, at local level, will:

- ensure that appraisal is carried out to a good standard
- support doctors in addressing any shortfalls
- ensure any concerns/complaints are addressed
- collate information to support a recommendation on the Revalidation to individual doctors to the GMC
- **make the revalidation recommendation to the GMC.**

Assessment of supporting information for Revalidation

This section is one that is especially liable to change as policies for assessing Revalidation Portfolios become clearer. However, this text sets out the RCGP's current view.

When a portfolio of supporting information is submitted it will initially be sifted by the local Responsible Officer or his or her staff. This assessment will also be informed by the supporting information from annual appraisals and clinical governance processes. **All the supporting information available to the Responsible Officer will be considered together. Patterns of supporting information that fit together to build an overall picture ('triangulation') will be sought. The supporting information as a whole will be initially assessed into three broad categories:**

- appears satisfactory
- needs discussion
- substantial issues are raised.

In every PCO there will be a group consisting of the Responsible Officer, an RCGP external assessor and a lay assessor. **[If the Responsible Officer is not on the General Practice Register, the RCGP argues that the Responsible Officer will need to consider appointing an appropriate GP as his or her adviser and to attend the meeting.]** All three will need appropriate and adequate training and resourcing. The trio will allocate their time appropriately, sampling satisfactory portfolios and assessing fully other portfolios.

The three members of the local group will use this guide to inform their assessment of a portfolio. This guide will be developed as experience of assessing portfolios grows and may be supplemented by special guidance for unusual portfolios. The Responsible Officer will notify the GMC of the names of those GPs that the local group is able to recommend for Revalidation. The notification will be copied to the RCGP so that a sample of anonymised approved portfolios can be quality assured.

There may be circumstances where a deferment is appropriate. This might be where performance procedures are incomplete, where there is a minor fault with an otherwise satisfactory portfolio, where a new complaint has arisen, where, for example, MSF has not been completed on time by the organisation, or when a doctor moves to a new area.

Where the local trio are unable to recommend Revalidation to the GMC, the portfolio will be shared centrally with the RCGP's National Adjudication Panel. The precise processes by which the

⁹ Defined within DH Consultation on Responsible Officers: For more information, see: www.dh.gov.uk/en/Consultations/Liveconsultations/DH_086443.

decision will then be moderated have yet to be decided. **At this stage the National Adjudication Board may recommend either that the RO recommends the doctor for revalidation, or that the recommendation be withheld so that the doctor’s case can be considered further by the GMC.**

A doctor can only be removed from the General Practice Register or lose his or her licence to practise on the decision of the GMC after due process. If a GP wishes to appeal against the local revalidation process or decision he or she will be able to appeal to the GMC.

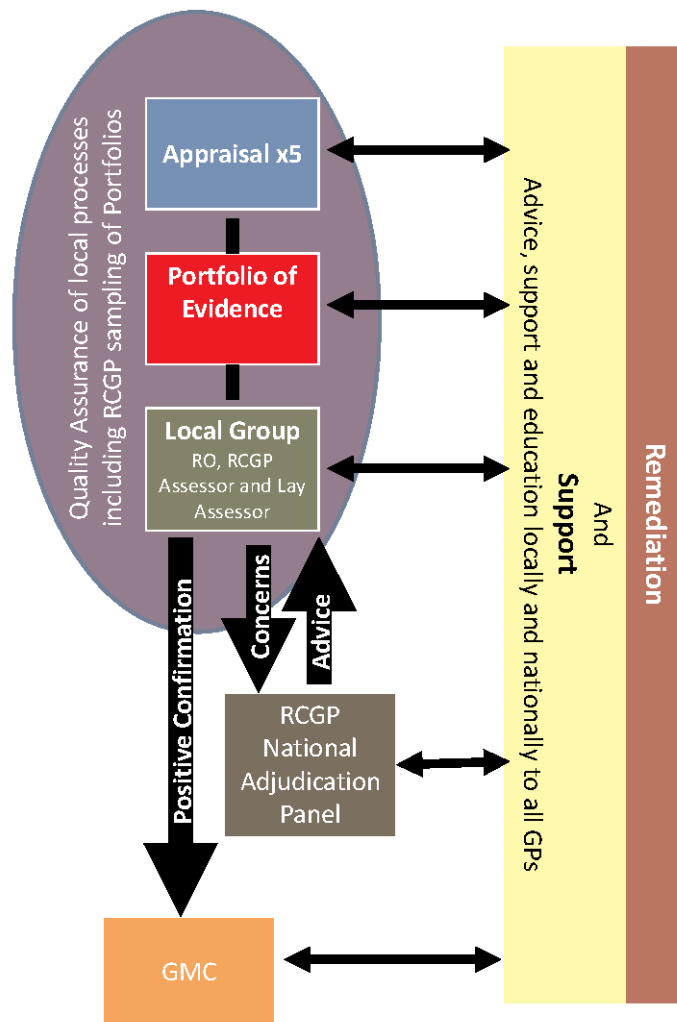


Figure 2: Quality assurance of local processes

GMC affiliates

The GMC is currently conducting pilots to develop the role of the regional GMC affiliate. It is proposed that GMC affiliates should offer guidance on standards and quality assurance for Responsible Officers, and provide independent assurance of the quality and consistency of local appraisal and clinical governance systems that underpin revalidation decisions.

Quality assurance

The RCGP has a key role in quality assurance of the assessment process. **To do this, the RCGP will need to oversee the training and processes of the RCGP and lay assessors**, be assured that local systems are effective, review all portfolios where a local recommendation cannot be made, and review an anonymised sample of recommended portfolios. The RCGP will need to satisfy the GMC that the process of Revalidation is as fair, equitable and objective as possible.

Section 5

Derivation of the supporting information for the Revalidation of GPs

The RCGP has published in other documents the criteria, standards and evidence for the Revalidation of GPs, including the mapping to the GMC's Framework. Since this Guide is intended to develop into the definitive source of information on Revalidation for GPs, the table is included here for completeness.

The map of the RCGP's criteria, standards and evidence to the GMC's Revalidation Framework

<i>GMC attribute</i>	<i>GMC standards</i>	<i>RCGP criterion and standards</i>	<i>RCGP supporting information and evaluation</i>
<i>Domain 1: knowledge, skills and performance</i>			
Maintain your professional performance	<p><i>Generic:</i> Maintain knowledge of the law and other regulation relevant to practice (13) Keep knowledge and skills up to date (12) Follow appropriate national research governance guidelines (71c) Develop and maintain the skills, attitudes and practice of a competent teacher (16)</p> <p><i>Clinical:</i> Undertake regular and systematic audit of your practice and the practice of the team in which you work (14c, 41d)</p>	<p><i>Criterion:</i> A GP must maintain his or her knowledge and skills, and keep up to date <i>Standards: Good Medical Practice for General Practitioners</i> (second edn) (RCGP and GPC. London: RCGP, 2008),¹⁰ Section 2: Maintaining good medical practice, pp. 19 to 21</p> <p><i>Criterion:</i> A GP who teaches, appraises or researches must do so properly, ethically and fairly</p>	<p>Self-accreditation of a minimum of 250 learning credits over the 5-year revalidation cycle, normally at least 50 credits each year, discussed and agreed at annual appraisal Results of relevant questions in at least two MSF surveys from colleagues, with evidence of reflection, appropriate change and discussion in appraisal</p> <p>Evaluations of teaching and appraisals by students and appraisees</p>

GMC attribute	GMC standards	RCGP criterion and standards	RCGP supporting information and evaluation
		<p>Standards: <i>Good Medical Practice for General Practitioners</i> (second edn), Section 3: Teaching and training, appraising and assessing, pp. 23 to 25 And <i>Good Medical Practice for General Practitioners</i> (second edn), Section 6: Probity, pp. 45 to 52 (particularly Research on pp. 49 and 50)</p>	<p>Results of relevant questions in at least two MSF surveys from colleagues, with evidence of reflection, appropriate change and discussion in appraisal Research governance sign-off</p>
<p>Apply knowledge and experience to practice</p>	<p><i>Generic:</i> Manage colleagues effectively (42)</p> <p><i>Clinical:</i> Adequately assess the patient's conditions (2a) Provide or arrange advice, investigations or treatment where necessary (2b) Prescribe drugs or treatment, including repeat prescriptions, safely and appropriately (3b) Provide effective treatments based on the best available evidence (3c) Take steps to alleviate pain and distress whether or not a cure may be possible (3d) Consult colleagues, or refer patients to colleagues, when this is in the patient's best interests (2c, 3a, 3i, 54, 55) Support patients in caring for themselves (21e)</p>	<p><i>Criterion:</i> A GP must have the appropriate clinical and communication skills, and apply those skills for the doctor–patient partnership, including support for self-care <i>Standards: Good Medical Practice for General Practitioners</i> (second edn), Section 1: Good clinical care, pp. 5 to 17 And <i>Good Medical Practice for General Practitioners</i> (second edn), Section 4: Relationships with patients, pp. 27 to 34</p>	<p>Results of at least two patient surveys of his or her consultations and care during the revalidation cycle, with evidence of reflection, appropriate change and discussion in appraisal Results of relevant questions in at least two MSF surveys from colleagues, with evidence of reflection, appropriate change and discussion in appraisal A review of all formal complaints directly involving the GP, with description of the circumstances, lessons learnt and appropriate actions taken, and evidence of discussion in appraisal</p>

<i>GMC attribute</i>	<i>GMC standards</i>	<i>RCGP criterion and standards</i>	<i>RCGP supporting information and evaluation</i>
Keep clear, accurate and legible records	<p><i>Generic:</i> Make records at the same time as the events you are recording or as soon as possible afterwards (3g)</p> <p><i>Clinical:</i> Record clinical findings, decisions, information given to patients, drugs prescribed or other information or treatment (3f)</p>	<p><i>Criterion:</i> A GP must keep good records <i>Standards: Good Medical Practice for General Practitioners</i> (second edn), Section 1: Good clinical care, pp. 5 to 18 (particularly pp. 9 and 10)</p>	Results of relevant questions in at least two MSF surveys from colleagues, with evidence of reflection, appropriate change and discussion in appraisal
<i>Domain 2: safety and quality</i>			
Put into effect systems to protect patients and improve care	<p><i>Generic:</i> Recognise and work within the limits of your competence (3a) Take part in quality assurance and quality improvement systems (14d) Respond constructively to the outcome of audit, appraisals and performance reviews (14e) Provide only honest, justifiable and accurate comments when giving references for, or writing appraisals or other reports about, colleagues (18, 19) Make sure that all staff for whom you are responsible, including locums and students, are properly supervised (17) Ensure systems are in place for colleagues to raise concerns about risks to patients (45)</p>	<p><i>Criterion:</i> A GP must demonstrate commitment to reflective practice, quality assurance and improvement; and that the standards of care and patient safety achieved are appropriate <i>Standards: Good Medical Practice for General Practitioners</i> (second edn), Section 2: Maintaining good medical practice, pp. 19 to 21</p>	Evidence of active and effective participation in a cycle of five annual appraisals over the 5-year recertification cycle A PDP for each year agreed in appraisal A review of the previous year's PDP with reflection on whether educational needs identified have been met and agreed in appraisal A minimum of five Significant Event Audits involving the GP that demonstrate reflection and change, with evidence of discussion in appraisal A review of any concerns raised and all formal complaints directly involving the GP, with description of the circumstances, lessons learnt and appropriate actions taken, and evidence of discussion in appraisal

<i>GMC attribute</i>	<i>GMC standards</i>	<i>RCGP criterion and standards</i>	<i>RCGP supporting information and evaluation</i>
	<p><i>Clinical:</i> Provide information for confidential inquiries and adverse event reporting (14g) Report suspected adverse drug reactions (14h) Co-operate with legitimate requests for information from organisations monitoring public health (14i) Ensure arrangements are made for the continuing care of the patient where necessary (40, 48)</p>		Audits of the care delivered by the GP in at least two significant clinical areas of his or her practice, with standards, re-audit and evidence of both appropriate improvement, compliance with best-practice guidelines and discussion in appraisal
Respond to risks to safety	<p><i>Generic:</i> Take action where there is evidence that a colleague's conduct, performance or health may be putting patients at risk (43, 44)</p> <p><i>Clinical:</i> Report risks in the healthcare environment to his or her employing or contracting bodies (6) Safeguard and protect the health and wellbeing of vulnerable people, including children and the elderly, and those with learning disabilities (26, 28)</p>	<p><i>Criterion:</i> A GP must be suitably trained, skilled and insured or indemnified for the roles he or she undertakes</p> <p><i>Standards:</i> <i>Good Medical Practice for General Practitioners</i> (second edn), Section 1: Good clinical care, pp. 5 to 18 (particularly pp. 6 to 8)</p>	Evidence and supporting statements for his or her training, standards of care and competence in any extended clinical role (such as GPwSI) performed Results of relevant questions in at least two MSF surveys from colleagues, with evidence of reflection, appropriate change and discussion in appraisal Evidence of appropriate insurance or indemnity cover
Protect patients and colleagues from any risk posed by your health	<p><i>Generic:</i> Make arrangements for accessing independent medical advice when necessary (77)</p> <p><i>Clinical:</i> Be immunised against common serious communicable diseases where vaccines are available (78)</p>	<p><i>Criterion:</i> A GP's fitness to practise must not be compromised by health issues</p> <p><i>Standards:</i> <i>Good Medical Practice for General Practitioners</i> (second edn), Section 7: Health, pp. 53 and 54</p>	Statement of health and use of health care, including registration with a GP in another practice Results of relevant questions in at least two MSF surveys from colleagues, with evidence of reflection, appropriate change and discussion in appraisal

GMC attribute	GMC standards	RCGP criterion and standards	RCGP supporting information and evaluation
<i>Domain 3: communication, partnership and teamwork</i>			
Communicate effectively	<p><i>Generic:</i> Ensure any published information about your services is factual and verifiable (60, 61) Communicate effectively with colleagues within and outside the team (41b)</p> <p><i>Clinical:</i> Listen to patients (22a, 27a) Give patients the information they need in order to make decisions about their care in a way they can understand (22b, 27) Respond to patients' questions (22c, 27b) Keep patients informed about the progress of their care (22c) Explain to patients when something has gone wrong (30) Treat those close to the patient politely and offer support in caring for the patient (29) Pass on information to colleagues involved in, or taking over, your patients' care (40, 51–3)</p>	<p><i>Criterion:</i> A GP must communicate with and relate appropriately to colleagues <i>Standards:</i> <i>Good Medical Practice for General Practitioners</i> (second edn), Section 3: Teaching and training, appraising and assessing, pp. 23 to 25 And <i>Good Medical Practice for General Practitioners</i> (second edn), Section 5: Working with colleagues, pp. 35 to 43</p>	Results of relevant questions in at least two MSF surveys from colleagues, with evidence of reflection, appropriate change and discussion in appraisal
Work constructively with colleagues and delegate effectively	<p><i>Generic:</i> Treat colleagues fairly and with respect (46) Support colleagues who have problems with performance, conduct or health (41d)</p>	<p><i>Criterion:</i> A GP must ensure that all staff, including locums and students, are properly trained and supervised</p>	Results of relevant questions in at least two MSF surveys from colleagues, with evidence of reflection, appropriate change and discussion in appraisal

GMC attribute	GMC standards	RCGP criterion and standards	RCGP supporting information and evaluation
	<p><i>Clinical:</i> Ensure colleagues to whom you delegate care have appropriate qualifications, experience, knowledge and skills (54, 55)</p>	<p><i>Standards: Good Medical Practice for General Practitioners</i> (second edn), Section 3: Teaching and training, appraising and assessing, pp. 23 to 25 And <i>Good Medical Practice for General Practitioners</i> (second edn), Section 5: Working with colleagues, pp. 35 to 43</p>	
<p>Establish and maintain partnership with patients</p>	<p><i>Clinical:</i> Encourage patients to take an interest in their health and take action to improve and maintain it (4, 21f) Be satisfied that you have consent or other valid authority before you undertake any examination or investigation, provide treatment or involve patients in teaching or research (36)</p>	<p><i>Criterion:</i> A GP must have the appropriate clinical and communication skills, and apply those skills for the doctor–patient partnership, including support for self-care <i>Standards: Good Medical Practice for General Practitioners</i> (second edn), Section 1: Good clinical care, pp. 5 to 17 And <i>Good Medical Practice for General Practitioners</i> (second edn), Section 4: Relationships with patients, pp. 27 to 34</p>	<p>Results of at least two patient surveys of his or her consultations and care during the revalidation cycle, with evidence of reflection, appropriate change and discussion in appraisal Results of relevant questions in at least two MSF surveys from colleagues, with evidence of reflection, appropriate change and discussion in appraisal A review of all formal complaints directly involving the GP, with description of the circumstances, lessons learnt and appropriate actions taken, and evidence of discussion in appraisal</p>

GMC attribute	GMC standards	RCGP criterion and standards	RCGP supporting information and evaluation
<i>Domain 4: maintaining trust</i>			
Show respect for patients	<p><i>Clinical:</i> Be polite, considerate and honest, and respect patients' dignity and privacy (21a, b, d) Treat each patient fairly and as an individual (38–9, 21c) Implement and comply with systems to protect patient confidentiality (37)</p>	<p><i>Criterion:</i> A GP must have the appropriate clinical and communication skills, and apply those skills for the doctor–patient partnership, including support for self-care <i>Standards:</i> <i>Good Medical Practice for General Practitioners</i> (second edn), Section 1: Good clinical care, pp. 5 to 17 And <i>Good Medical Practice for General Practitioners</i> (second edn), Section 4: Relationships with patients, pp. 27 to 34</p>	Results of at least two patient surveys of his or her consultations and care during the revalidation cycle, with evidence of reflection, appropriate change and discussion in appraisal Results of relevant questions in at least two MSF surveys from colleagues, with evidence of reflection, appropriate change and discussion in appraisal A review of all formal complaints directly involving the GP, with description of the circumstances, lessons learnt and appropriate actions taken, and evidence of discussion in appraisal
Treat patients and colleagues fairly and without discrimination	<p><i>Generic:</i> Be honest and objective when appraising or assessing colleagues and when writing references (18–19)</p> <p><i>Clinical:</i> Provide care on the basis of the patient's needs and the likely effect of treatment (7–10) Respond promptly and fully to complaints (31)</p>	<p><i>Criterion:</i> A GP must have the appropriate clinical and communication skills, and apply those skills for the doctor–patient partnership, including support for self-care <i>Standards:</i> <i>Good Medical Practice for General Practitioners</i> (second edn), Section 1: Good clinical care, pp. 5 to 17 And <i>Good Medical Practice for General Practitioners</i> (second edn), Section 4: Relationships with patients, pp. 27 to 34</p>	Results of at least two patient surveys of their consultations and care during the revalidation cycle, with evidence of reflection, appropriate change and discussion in appraisal

GMC attribute	GMC standards	RCGP criterion and standards	RCGP supporting information and evaluation
			<p>Results of relevant questions in at least two MSF surveys from colleagues, with evidence of reflection, appropriate change and discussion in appraisal</p> <p>A review of all formal complaints directly involving the GP, with description of the circumstances, lessons learnt and appropriate actions taken, and evidence of discussion in appraisal</p>
<p>Act with honesty and integrity</p>	<p><i>Generic:</i> Be honest in any formal statement or report, whether written or oral, making clear the limits of your knowledge or competence (63–5, 67–8)</p> <p>Be honest in undertaking research and reporting research results (71b)</p> <p><i>Clinical:</i> Ensure you have adequate indemnity or insurance cover for your practice (34)</p> <p>Inform patients about any fees and charges (72a)</p>	<p><i>Criterion:</i> A GP must act with probity and honesty</p> <p><i>Standards:</i> <i>Good Medical Practice for General Practitioners</i> (second edn), Section 6: Probity, pp. 45 to 52</p>	<p>Statement of probity</p> <p>Results of relevant questions in at least two MSF surveys from colleagues, with evidence of reflection, appropriate change and discussion in appraisal</p>

Glossary

Academy of Medical Royal Colleges (AoMRC)	The organisation that represents the views and interests of all the medical royal colleges and faculties collectively
Appraisal <ul style="list-style-type: none"> ● GP appraisal ● annual appraisal 	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
Appraisee	The GP being appraised
Appraiser	A trained and supported GP who undertakes the appraisal of colleagues
Assessor	A trained and supported person who will assess portfolios of supporting information submitted for Revalidation. There will be four types of assessor: <ul style="list-style-type: none"> ● the Responsible Officer in the PCO ● an RCGP assessor from outside the immediate area ● a lay assessor ● assessors in the National Adjudication Panel (see below)
Clinical governance	A framework through which NHS organisations are accountable for improving quality of services and care, and promoting patient safety
Revalidation ePortfolio	An electronic portfolio used for the purposes of appraisal and Revalidation
General Practice Register	The register maintained by the GMC of those doctors who have satisfactorily completed vocational training (or equivalent in other countries) and are eligible to work in the NHS as a GP
Learning credit	A unit of education that reflects the impact on patient care and the challenge involved
National Adjudication Panel (the RCGP's)	A group of trained clinical and non-clinical assessors who will act as a national reference group for ensuring equitable and fair application of national standards to revalidation portfolios
Performers List	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 and every GP must be on a Performers List

Portfolio	The collective supporting information accumulated for an individual GP's purposes, for appraisal and for Revalidation
Primary Care Organisation (PCO)	This is a generic term that covers Primary Care Trusts in England and Health Boards in Scotland, Wales and Northern Ireland
Recertification	The periodic reconfirmation of a doctor's position on either the Specialist or the General Practice Register held by the GMC; forms the second element of Revalidation
Registers	The GMC maintains three main registers: a Medical Register of doctors in good standing; a Specialist Register for those who have achieved a level of expertise (and who may work as a consultant in the NHS); and the General Practice Register for those who have the expertise to work as a GP
Relicensure	The periodic renewal of the licence (required by a doctor undertaking any clinical roles) issued by the GMC; forms one element of Revalidation
Responsible Officer	Every organisation 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
Revalidation	The periodic confirmation that a doctor remains up to date and fit to practise. It includes the requirements for relicensure and recertification
Royal College of General Practitioners (RCGP)	The royal college that relates to general practice; its remit covers education, research and 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
Specialist Register	The register maintained by the GMC of those doctors who have obtained a certificate of completion of specialist training (or equivalent in other countries) and are eligible to work in the NHS as a consultant