



Royal College of
General Practitioners

RCGP Guide to the Revalidation of General Practitioners

Version 4.0 | June 2010



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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.*

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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.

An important aspect of the GMC's consultation is that revalidation will not now be concerned with the Specialist or General Practice Registers (previously called recertification). It will now just concern the licence, which will describe what the doctor does, and therefore for what he or she was revalidated. This means that GPs who are no longer in active clinical general practice but who are active as doctors (for example those in medical management, occupational health, working abroad or doing referral surgical procedures) will continue to be on the General Practice Register, but their licence will show that they were not in clinical general practice at the time of revalidation.

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*, a second in August 2009 and a third in January 2010. 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 changes to the Guide. The key changes to this fourth edition are given in the box below.

The key changes between the third and fourth editions of this Guide

- The RCGP has replaced the terms 'lay assessor' and 'RCGP assessor' with 'lay adviser' and 'RCGP adviser' to emphasise the fact that they will not make recommendations to the GMC.
- The Guide has been updated to demonstrate that revalidation will be concerned with the licence rather than the Specialist or General Practice Registers.
- The paragraphs on remediation and support for doctors in difficulty have been updated.
- Section 3, 'Supporting information required for the revalidation of GPs whose experience is not standard', has been significantly expanded and retitled 'Supporting information required for the revalidation of GPs in special groups'.
- Section 3 adopts the term 'equivalent portfolios' and explores the needs of special groups of GPs in more detail, including peripatetic locums, out-of-hours doctors and GPs who work in secure environments. A table has been added to highlight areas of supporting information that may be difficult for particular groups to collect and to provide alternative methodologies.
- A section on trainees has been included in Section 3.

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

The RCGP commenced a number of revalidation-related pilots in 2009 and is continuing 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. The RCGP pilots involve: a trial of GPs completing portfolios of evidence; a pilot focused on sessional doctors and GPs in small practices; pilots in the Defence Medical Services and in secure environments; and an exploration of the training and support needed to introduce specialty standards. We have completed a pilot of Learning Credits and have an ongoing pilot of the RCGP revalidation portfolio.

The Revalidation Support Team (England) has started the Pathfinder pilots, which pilot all aspects of revalidation in ten health communities in England. The RCGP is actively working with these pilots and is leading input from the AoMRC in two sites.

In particular, the RCGP recognises that there is still uncertainty around: the roles and responsibilities of responsible officers; the concept of advisers and the local groups; the RCGP National

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.

Advisory Panel; and the quality assurance of revalidation decisions. There are other areas where future policy may require changes to later editions of this Guide.

The most important unresolved debate concerns the resources required for revalidation to be effective. Primary Care Organisations (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 in delivering, for example, an ePortfolio for its members and quality assurance of revalidation decisions concerning GPs.

Support for a small minority of GPs who give cause for concern may involve substantial cost; the Department of Health (England) is leading work to establish how these costs will be met, and by whom. In the RCGP's view, roles in targeted support, including remediation, can be summarised on Table 1.

Table 1: Summary of roles in targeted support

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 processes ● Identifying his or her own health problems and seeking treatment ● Identifying possible health problems in professional colleagues and encouraging them to seek assistance
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 support processes in place ● Supporting deaneries and PCOs by providing assessment tools that can be utilised in remediation ● Pastoral support for RCGP members through the College mechanisms including faculty networks ● Signposting doctors with health problems to appropriate support where possible, including access to doctors trained in the RCGP Health for Healthcare Professionals programme ● Providing professional development services.

The RCGP is working with others, especially the British Medical Association (BMA), to identify the resources required for targeted support, including 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.

It is important to bear in mind two features of revalidation relevant to remediation. First, revalidation is a 5-year process. A doctor whose practice gives cause for concern, and for whom remediation may be required, should be identified through annual appraisals and normal clinical governance processes. In a perfect world, a poorly performing doctor should never be revealed for the first time when the responsible officer reviews that doctor's revalidation portfolio.

The second relevant issue is that revalidation will, in most instances, reveal problems or give urgency to addressing performance problems that are longstanding, and which employers have failed to address over the years. Although revalidation is the stimulus to action, it is not the reason why many intractable issues must now be confronted.

To prepare for its roles, the RCGP has been working closely with the GMC, the General Practitioners Committee (GPC) of the BMA, 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) and patient groups. This document takes into account the views of all these valued partners.

The RCGP is also developing an ePortfolio for revalidation that will enable GPs to store all the information required for revalidation and will be an important learning and professional development tool.

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 advisers, 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; **they must be 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.

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 will meet the requirements for revalidation. It also gives guidance to those who will assess GPs' revalidation portfolios.

Although many of the statements in this section concerning supporting information apply to all GPs, it is recognised that there are specific issues for sessional doctors (particularly peripatetic locums), emergency care and out-of-hours doctors, GPs in independent practice and those in hierarchical organisations such as the DMS and secure environments. There are also specific issues for those GPs who take breaks from work through illness, pregnancy, career breaks, sabbaticals or working abroad. All these issues are addressed in Section 3.

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 supporting information, building an overall picture against all GMC attributes.

For the purpose of this document, the revalidation period is taken to start officially in April 2012. Of course, the start date is very much dependent on external decisions, and some key infrastructural changes will need to be in place 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 is likely to see the first GPs revalidating in 2012. A GP will not be penalised for not providing supporting information for the period prior to April 2012 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 expectation 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. This is likely to be the easiest and least time-consuming approach.

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.

They should record all their 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, unless taking part in pilots. 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 and responsible officers 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

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.

have undertaken. For most, the latter will be 'clinical primary care in undifferentiated general practice consultations' but they should also describe other medical roles if appropriate.

Advice for appraisers, advisers and responsible officers

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 and responsible officer 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, advisers and responsible officers to provide context in evaluating the GP's portfolio. For further advice on significant exceptional circumstances see Section 3 of this Guide.

Advice for appraisers, advisers and responsible officers

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 and responsible officers 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 responsible officer will need to be satisfied that any stated exceptional circumstances are indeed legitimately exceptional. If the responsible officer is in doubt, the portfolio should be referred to the RCGP's National Advisory 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 and responsible officers 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 April 2012 (see Section 2 of this Guide). 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 that are not resolved satisfactorily with their PCO or employer, they should 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, advisers and responsible officers

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, targeted support 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 Advisory 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 April 2012 (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-bounded 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, advisers and responsible officers

In assessing a GP's PDP, the responsible officer 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 goal and what it was intended to achieve can be understood
- **Measurable** – specifying how the GP, the appraiser and the responsible officer 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 and responsible officer should only accept the GP's PDP if he or she shows 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 Advisory 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 a doctor's roles in the provision of a safe system of health care for patients (www.institute.nhs.uk/medicalleadership).

Advice for appraisers, advisers and responsible officers

In assessing the comments on the goals set in the previously agreed PDP, the appraiser or responsible officer 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 the responsible officer has significant doubt about reflection or the level of achievement of goals, the portfolio can be referred to the RCGP's National Advisory 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 1 Learning Credit. However, if that education leads to positive 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. **'Educational activity' can include formal courses, lectures, seminars, small-group or practice-based learning events, online learning, reading, learning a new skill, mentoring someone, action learning, becoming a trainer, doing individual reflective activity, etc. A log of learning should satisfy an appraiser that each recorded activity was educational. Over a revalidation cycle a GP will be expected to demonstrate a broad range of general practice education appropriate to the work he or she does, with at least 50 Learning Credits being achieved and confirmed by the appraiser each year.**

Advice for appraisers, advisers and responsible officers

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 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 responsible officer 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 there are significant doubts about the Learning Credits claimed by a GP, the responsible officer should refer the portfolio to the RCGP's National Advisory Panel, where consistent national standards can be applied.

Supporting information area 7

Multi-Source Feedback from colleagues

Advice for GPs

Multi-Source Feedback (MSF) from colleagues is a recognised way for a person to gain formative information on how he or she is seen by those with whom the person works. 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, half clinical and half non-clinical, 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.

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, advisers and responsible officers

The first requirement that appraisers and responsible officers will look for is the presence of the required number of MSFs in the GP's revalidation portfolio. They 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, they 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 responsible officer is 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 the responsible officer has significant doubt about the results from, or a GP's response to, an MSF or MSFs, the revalidation ePortfolio can be referred to the RCGP's National Advisory 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 secure environments, 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, advisers and responsible officers

The first requirement that appraisers and responsible officers will look for is the presence of the required number of patient surveys in the GP's revalidation portfolio. They 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, they 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 responsible officer 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 there is significant doubt about the results from, or the GP's response to, a patient survey or patient surveys, the portfolio can be referred by the responsible officer to the RCGP's National Advisory 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 underperformance. The local post-graduate 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. **The responsible officer will not 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 complaints initiated or resolved within the revalidation period. A formal complaint is one that activated, or should have activated, the practice complaints procedure, and involved the PCO or 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 responsible officer to satisfy him or herself regarding these two points, and should include:**

- a description of the events that resulted in a formal complaint
- the concerns expressed by the complainant
- the assessment of that complaint
- any actions resulting from that assessment
- the outcome of the complaint
- 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.

Advice for appraisers, advisers and responsible officers

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 responsible officer 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 responsible officer 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 Advisory Panel, where consistent national standards can be applied.

Supporting information area 10

Significant Event Audits

Advice for GPs

Significant Event Auditing (also known as learning event audits, action learning or significant event analysis) is an increasingly routine part of general practice. It is a technique to reflect on, and learn from, individual cases to improve quality of care overall. When revalidation is fully established, 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 differently?**
- reflections on the event in terms of:
 - knowledge, skills and performance
 - safety and quality
 - communication, partnership and teamwork
 - maintaining trust
- what changes have been agreed:
 - for me personally
 - for the team
- changes carried out and their effect.

The revalidation ePortfolio will have a standard form in which to record these fields.

Advice for appraisers, advisers and responsible officers

The appraiser and responsible officer 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 responsible officer has significant 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 Advisory 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 state that the care identified within the first audit and the re-audit reflects the care that he or she delivers.** The GP must state what changes he or she instituted and be able to demonstrate the effects of those changes.

If a GP takes part in a national audit, it can be used as supporting evidence for revalidation if the GP can demonstrate that he or she agreed with the standards being set, reviewed the audit results for his or her patients, and put in place actions to improve care and improvements in the next national audit of the GP's patients.

A description of a Clinical Audit should include:

- the title of the audit
- the reason for the choice of topic
- dates of the first data collection and the re-audit
- **the criteria to be audited and the standards set with their justification (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

- o safety and quality
- o communication, partnership and teamwork
- o 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:
 - o knowledge, skills and performance
 - o safety and quality
 - o communication, partnership and teamwork
 - o maintaining trust.

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

Advice for appraisers, advisers and responsible officers

The appraiser and responsible officer 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 responsible officer has significant doubt about the Clinical Audits provided, either in terms of their quantity or quality, the portfolio can be referred to the RCGP's National Advisory 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 that:

- 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); **a statement that the doctor has a health condition which is being treated adequately and that the doctor's doctor has no concerns should be acceptable**
- 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, advisers and responsible officers

The appraiser and responsible officer 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 responsible officer has significant doubt about the statements on probity or health provided, the portfolio should be referred to the RCGP's National Advisory 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 normally 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, advisers and responsible officers

The appraiser and responsible officer 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 2012/13. 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. 32). 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

In the first year of the introduction of revalidation, the RCGP will work with the Early Adopter sites, which will include 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 the last strengthened annual appraisal
- a PDP agreed with the appraiser in the annual appraisal
- either self-accreditation of a minimum of 50 learning credits in the year of revalidation or a description of all CPD experienced in the year of revalidation 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 the year prior to revalidation or in the year of revalidation
- 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

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 the last two annual appraisals prior to revalidation
- PDPs agreed with the appraiser in the two appraisals
- reviews of the PDPs agreed in at least one appraisal, 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 of two years (in either of the two years prior to revalidation and/or the revalidating year), 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 either the 2 years prior to revalidation and/or the year of revalidation
- 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

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 the last three annual appraisals
- PDPs agreed with the appraiser in the three appraisals
- two reviews of the PDPs agreed in two 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 3 years (in the 3 years prior to and including the year of revalidation), 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 the 4 years prior to and including the year of revalidation
- 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

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 at least four annual appraisals
- PDPs agreed with the appraiser in the appraisals
- three reviews of the PDPs agreed in three 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 4 years, in the 4 years prior to and/or the year of revalidation, 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 the 5 years prior to and including the year of revalidation
- 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 onwards

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 5-year revalidation cycle, with PDPs agreed with the appraiser in each of the five appraisals
- four reviews of PDPs agreed in the 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 250 Learning Credits, at least 50 credits in each of 5 years, 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.

Table 2: Supporting information required for revalidation, year by year, during the introductory period

Evidence	Year 1	Year 2	Year 3	Year 4	Year 5
Description of roles	✓	✓	✓	✓	✓
Exceptional circumstances	✓	✓	✓	✓	✓
Supporting information of appraisals	One	Two	Three	Four	Five
PDPs	One	Two	Three	Four	Five
Reviews of PDPs		One	Two	Three	Four
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 in special groups

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. **Such GPs may submit a portfolio containing equivalent supporting information – an equivalent portfolio. This group includes:**

1. Those in clinical general practice who may find elements of a standard portfolio difficult to accumulate; this includes doctors whose main or only work is as:
 - o peripatetic locums
 - o out-of-hours doctors (and those working in similar clinical contexts such as in walk-in centres)
 - o GPs in remote or very small practices
 - o GPs in the DMS or the Foreign and Commonwealth Office
 - o GPs working in secure environments.
2. Those who were not in work for all years in the 5-year revalidation cycle or who are on extended career breaks, including those working overseas.
3. GP registrars whose licence becomes due for renewal.
4. Those whose only or predominant work as a doctor is not as a clinical GP, but is in NHS management, educational management, political roles, health informatics, academia or staff appointments within the DMS.

GPs who work part time, as retainers, flexible career scheme doctors, salaried GPs or long-term locums, with a fixed practice base, would not normally be considered to be 'non-standard'. Part-time GPs, however they carry out their work, need to maintain their skills at the same level as their colleagues. They will normally be expected to submit a full standard portfolio, with any notes relating to special circumstances that have affected the amount of information collected, such as maternity leave or ill health, being recorded in their revalidation portfolio (supporting information area 2, exceptional circumstances). GPs working in private practice only should also be able to provide a standard portfolio. When a doctor proposes to provide an equivalent portfolio of supporting information he or she must be able to justify that choice and his or her appraiser must agree with that justification. Ultimately the decision must be acceptable to the responsible officer – if doubts are raised at appraisal, this should be discussed promptly with the responsible officer.

Standard and equivalent portfolios share many elements. All portfolios have to reflect the working life and context in which a doctor works. Those aspects of supporting information

specifically discussed in this section may vary for a doctor who can justify compiling an equivalent portfolio.

General guidance about equivalent portfolios

The requirement to ensure that a doctor is up to date and fit to practise is the same for all doctors. The overall standard must be the same. However, it has to be recognised that the supporting information described in Section 1 cannot be applied universally. For example, it would be challenging for a GP only working on an island with a few hundred patients and one staff member to undertake a survey of colleagues.

If the working life of a GP justifies an equivalent portfolio of supporting information and the rationale is accepted by that doctor's appraiser, the portfolio should indicate this fact in supporting information area 2 (exceptional circumstances). The portfolio should be processed through revalidation just like any other portfolio.

The alternative methodology for accumulating supporting information in an equivalent portfolio must still meet the underlying attributes that each area of supporting information is intended to demonstrate. For example, Clinical Audits are included in the standard portfolio to demonstrate that GPs: set themselves appropriate criteria and standards; reflect on the care they deliver; and improve their care when necessary. These attributes must also be demonstrated satisfactorily in the supporting information in an equivalent portfolio using an approved alternative to clinical audit if appropriate to do so.

An equivalent portfolio is intended to reflect and to be more appropriate to the working environment of the doctor concerned. Not all the groups referred to above will be considered in detail in this section since the pilots for all these groups have not been completed yet. This section is, therefore, a work in progress.

One key aspect for peripatetic locums and doctors who work in out-of-hours services or in walk-in centres is the frequent absence of organisational and peer group support. One key solution is the development of mechanisms to reduce the professional isolation that many of these doctors experience. The models identified for this include:

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

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

Specific guidance on equivalent portfolios in specific groups of GPs

Those in clinical general practice who may find elements of a standard portfolio difficult to accumulate

This group includes those GPs whose main or only work is as peripatetic locums, in out-of-hours work, in walk-in centres and in remote or very small practices. [Pilots of revalidation of these doctors have yet to be completed but this guidance takes account of the emerging findings; pilots for the DMS and GPs working in secure environments will not be complete until 2011 and will inform later versions of this Guide].

Although many areas of the standard portfolio are suitable for this group of GPs, there are four areas of supporting information that present particular challenges. Alternative methods of collecting such supporting information are given in the table below:

<i>The challenging supporting information area</i>	<i>The reason it is challenging</i>	<i>Alternative supporting information</i>
Multi-Source Feedback from colleagues (supporting information area 7)	Peripatetic locums and out-of-hours doctors may not be well enough known to those they work with for them to form a viable opinion; a survey at any point in time may be conducted long after they worked in a particular setting. Some questions in conventional colleague surveys only apply to principals in general practice. GPs in small, remote practices may have insufficient colleagues	<p>Colleague surveys designed for locums and out-of-hours doctors should be piloted and validated</p> <p>The results of colleague surveys should compare locums and out-of-hours doctors with their peer groups (as well as GPs in general)</p> <p>A doctor in a professional organisation (chambers etc.) might include colleagues in that organisation for colleague feedback</p> <p>A doctor may submit an online questionnaire to practices and organisations in which he or she works to be completed immediately after working there, accumulating the evidence from these surveys</p>

<i>The challenging supporting information area</i>	<i>The reason it is challenging</i>	<i>Alternative supporting information</i>
		<p>A doctor may be observed in practice by a suitably qualified and trained colleague (such as a trained appraiser or vocational trainer) over a period of at least 2 hours, with assessment of his or her team-working, communications, note keeping and clinical care</p> <p>Evidence from out-of-hours clinical governance reviews may include peer review of the performance of individual doctors and can be used by them as supporting information</p>
Feedback from patients (supporting information area 8)	Locums and out-of-hours doctors usually lack a long-term relationship with their patients; locums may be working in practices that are under stress; they may not be in one setting long enough to recruit a coherent cohort of patients	<p>The results of patient surveys should compare locums and out-of-hours doctors to their peer groups (as well as GPs in general)</p> <p>The patients for a survey conducted by a locum or out-of-hours doctor should be consecutive (or randomly selected if the survey is ongoing), but can be recruited from a series of clinical settings if necessary</p> <p>Evidence from out-of-hours clinical governance reviews may include patient views on the performance of individual doctors and can be used by them as supporting information</p>
Significant Event Audits (supporting information area 10)	Although the clinical governance procedures in out-of-hours and walk-in centres normally require significant events to be discussed with the doctor concerned, locums and out-of-hours doctors often are not notified of any significant events arising from their work, and getting access to the case notes of such patients can be challenging	<p>The responsibilities of those who engage locums (including general practices) to support access for quality assurance must be made clear and included in terms and conditions of employment</p> <p>Although a significant event should be ideally discussed with the clinical team involved, it will be acceptable to discuss and reflect with a peer group (for example chambers or educational group), demonstrating the improvements in care</p>

<i>The challenging supporting information area</i>	<i>The reason it is challenging</i>	<i>Alternative supporting information</i>
		<p>The doctor can use case notes review of complex cases with an appropriately skilled and experienced colleague or colleagues in which challenging cases are reviewed, reflection occurs and improvements are identified</p> <p>A serial case analysis (ten consecutive cases from a randomly chosen consulting session) or a problem-based case series (ten cases with a specific condition) can be used, discussing the process and outcome of each consultation with an appropriately skilled and experienced colleague or colleagues in which reflection occurs and improvements are identified</p> <p>Trigger tools are becoming available in which the care of patients with certain high-risk characteristics is reviewed systematically.⁹ Evidence from the use of trigger tools can be used for revalidation</p>
<p>Clinical Audits (supporting information area 11)</p>	<p>Clinical Audits are much easier to undertake when working over time in one organisation and where there is access to the organisation's administration. These advantages do not normally apply to locums and out-of-hours doctors</p>	<p>There are some Clinical Audit topics that can be successfully reviewed by locums and out-of-hours doctors including:</p> <ul style="list-style-type: none"> ● 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 <p>The RCGP will work with locum doctor groups to provide worked examples.</p>

⁹ www.institute.nhs.uk/safer_care/primary_care_2/introductiontoprimarycaretriggertool.html.

<i>The challenging supporting information area</i>	<i>The reason it is challenging</i>	<i>Alternative supporting information</i>
		<p>A locum or out-of-hours doctor may undertake an 'action audit' in which the care of presenting cases of a defined nature are continually reviewed against pre-set criteria and standards with continuous reflection and improvement recorded. One example might be keeping a log of all referrals and patients causing concern, and then on return to the practice or clinic following the patient up, learning lessons from the outcomes</p> <p>A doctor may undertake a random case analysis, in which clinical decision making, record keeping and standards of care in twenty consecutive consultations are reviewed, using a standardised format, with an appropriately skilled and experienced colleague or colleagues; reflection occurs, and improvements agreed and demonstrated</p> <p>The Scottish Online Appraisal Resource (www.scottishappraisal.scot.nhs.uk) provides detailed guidance on how locums can approach clinical audit, with worked examples</p>

There may be other methods that are suitable for these doctors to demonstrate the attributes of a safe and competent GP. The RCGP will consider all such proposals and incorporate them if they are suitable. All these proposals will need the approval of the GMC before implementation.

Sources of advice for locum and sessional doctors include:

- individual postgraduate deaneries
- www.rcgp.org.uk
- www.bma.org.uk
- www.pallantmedical.org.uk
- 'Appraisal Evidence for Sessional Doctors' from peterberrey@hotmail.com
- www.scottishappraisal.scot.nhs.uk/toolkit.htm
- Significant Event Audit Toolkit at www.nrls.npsa.nhs.uk/resources/?entryid45=61500
- www.nasgp.org.uk/cpd/revalidation.

Those who were not in work for all years in the 5-year revalidation cycle or who are on extended career breaks

If a doctor is not able to be revalidated because of not working in the UK at the time, his or her licence will lapse. However, the doctor can retain his or her registration with the GMC and can, for example, apply for a Certificate of Good Standing. When the doctor returns to work he or she can apply for a licence to practise, which is provided by the GMC after a minimal check. The licence may stipulate that the doctor needs to be revalidated in, say, 2 years and it may be conditional on the doctor working in a managed environment (which means in reality the NHS) for the initial period.

If such a doctor wishes to be entered on a Performers List and to start working as a GP, the PCO may want evidence that the doctor is suitable. In reality this will normally mean that, after sustained absence from clinical general practice in the United Kingdom, a doctor will require an assessment that may indicate the need for a targeted re-entry educational experience before returning to clinical general practice. If a doctor has been working in, for example, New Zealand as a GP, his or her re-entry education may be solely to re-familiarise that doctor with the British health service, such as clinical guidelines, pathways and referrals, safeguarding vulnerable people, etc. If a doctor has not been clinically active for years, a formal re-entry or returners' scheme will probably be indicated.

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 or more with no Learning Credits or appraisal during that time.

However, there are many doctors who will be absent from British clinical general practice for periods of 2 years or less due to pregnancy, illness, career breaks, sabbaticals, working abroad or taking on non-clinical roles. For such doctors, the RCGP recommends that there has to be a minimum content to a portfolio if it is to be considered in the routine manner by a responsible officer.

When revalidation is fully established over a 5-year cycle the RCGP proposes that the minimum supporting information that a responsible officer will normally need before a GP's portfolio can be considered for revalidation will be:

- active participation in approved appraisal with a PDP agreed and a review of a previous PDP in at least 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 (of which 100 should be undertaken 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 and be conducted in an approved environment within the United Kingdom. The sessions will be undertaken as a generalist and require the doctor to be on the GMC's GP Register but can be within a range of settings.

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

responsible officer may consult the RCGP's National Advisory Panel. The responsible officer will also want to consider:

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

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

GP registrars whose licence becomes due for renewal

A future GP will be licensed between his or her two foundation years. He or she will then need to be revalidated at regular intervals (usually every 5 years). During the training phase the doctor's responsible officer will be the Postgraduate Dean who is overseeing his or her education. The Postgraduate Dean will need to be satisfied that each doctor in training is fit to practise and will need to address any issues identified.

For those doctors who go straight from their second Foundation Year into a 3-year GP speciality training scheme, which they complete without taking time out, there will be no requirement for the Postgraduate Dean to formally revalidate these doctors.

When a doctor passes the MRCGP (and is entered onto the General Practice Register) his or her revalidation cycle as a GP should commence. We therefore expect the doctor's next revalidation to normally occur 5 years later.

There will be some exceptions to this, including:

- those doctors whose training for general practice takes 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. In time it will include those doing a longer GP speciality scheme if general practice training is extended.
- those doctors who have changed career intentions and who are, at 5 years from full registration or from their last revalidation, undergoing training for general practice.

The RCGP expects that these doctors will be recommended for revalidation on the basis of the evidence provided for progression through training in their trainee portfolio plus supporting statements from their educational and clinical supervisors (GP trainer and hospital post consultants).

Their evidence will need to be assessed in the light of their experience over the previous 5 years and their current post. If, for example, they have only undertaken a short post in general practice before starting a rotation of hospital posts, much of their evidence will relate to their hospital posts.

Those only or predominantly working as a doctor and not as a clinical GP

This includes a small number of GPs in NHS management, educational management, political roles, health informatics, academia or staff appointments within the DMS.

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.

A non-clinical GP will submit a portfolio to his or her responsible officer that demonstrates that the GP is fit to undertake his or her non-clinical roles. This will include evidence of satisfactory annual appraisal, that the PDPs have been agreed upon and reviewed, and that the GP is keeping up to date in his or her area (supporting information areas 1–6). He or she should submit a colleague survey and a description of any cause for concern or formal complaint (supporting information areas 7 and 8). He or she should provide a statement on probity and health, and documentation that meets the requirements of extended practice (supporting areas 12 and 13).

Section 4

Processes of revalidation of GPs

This section of the document describes the 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 an electronic portfolio (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 2009 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 practise as part of Revalidation'.¹⁰ 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 be assessed 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. The responsible officer will then make a recommendation to the GMC, which will then make the revalidation decision.

The RCGP will offer advice and support to the responsible officer throughout the 5 years on the interpretation of the specialist standards for general practice. We also propose to offer to every responsible officer the opportunity for a regular meeting with an RCGP external adviser and a lay adviser. This meeting will be to advise on any issues arising from submitted portfolios of supporting information and to quality assure the local processes. 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.

The responsible officer will use this Guide to inform his or her 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 RCGP adviser and the lay adviser will be a resource that helps to ensure consistency between responsible officers and to offer advice based on experience in other trusts and on the RCGP National Advisory Panel. However, the decision is for the responsible officer and the responsible officer alone to make.

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 responsible officer is unable to recommend revalidation to the GMC, that GP's portfolio will be referred to the GMC. A doctor can only 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.

¹⁰ Defined within Department of Health consultation on responsible officers: For more information, see: www.dh.gov.uk/en/Consultations/Liveconsultations/DH_086443.

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 advisers, be assured that local systems are effective, review 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:</i> <i>Good Medical Practice for General Practitioners</i> (second edn) (RCGP and GPC. London: RCGP, 2008),¹¹ 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</p> <p>And</p> <p><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</p> <p>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 (2 e)</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</p> <p><i>Standards: Good Medical Practice for General Practitioners</i> (second edn), Section 1: Good clinical care, pp. 5 to 17</p> <p>And</p> <p><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</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> <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>

<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:</i> <i>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:</i> <i>Good Medical Practice for General Practitioners</i> (second edn), Section 2: Maintaining good medical practice, pp. 19 to 21</p>	<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</p>

GMC attribute	GMC standards	RCGP criterion and standards	RCGP supporting information and evaluation
	<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	RCCP criterion and standards	RCCP 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

<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> 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
			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
Act with honesty and integrity	<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) 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) Inform patients about any fees and charges (72a)</p>	<p><i>Criterion:</i> A GP must act with probity and honesty <i>Standards:</i> <i>Good Medical Practice for General Practitioners</i> (second edn), Section 6: Probity, pp. 45 to 52</p>	Statement of probity Results of relevant questions in at least two MSF surveys from colleagues, with evidence of reflection, appropriate change and discussion in appraisal

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
Adviser	A trained and supported person who will advise responsible officers and the RCGP on portfolios of supporting information being prepared or submitted for revalidation. There will be two types of adviser: <ul style="list-style-type: none"> • a responsible officer and RCGP adviser from outside the immediate area • a lay adviser
Appraisee	The GP being appraised
Appraiser	A trained and supported GP who undertakes the appraisal of colleagues
Clinical governance	A framework through which NHS organisations are accountable for improving quality of services and care, and promoting patient safety
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 Advisory Panel (the RCGP's)	A group of trained clinical and non-clinical advisers 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
Revalidation ePortfolio	An electronic portfolio used for the purposes of appraisal and revalidation
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