The Principles of GP Appraisal for Revalidation
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.'
Introduction

This document seeks to update the core Principles of GP Appraisal document issued by the Royal College of General Practitioners (RCGP) in 2008. Much has changed since appraisal was introduced into secondary care in 2001 and into primary care in 2002. During the intervening years systems and processes have been put in place to support the management of appraisal and its quality assurance. The latest figures reveal that 90.3% of all GPs in England are being appraised regularly by their designated bodies (figures for 2012/13) and similar progress has been made in the other countries of the UK.

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This document will provide an update on the core principles of appraisal and will also signpost doctors to the inputs required by appraisers, along with the outputs needed by responsible officers in order to make a positive recommendation to the GMC.

The white paper Trust, Assurance and Safety from the Chief Medical Officer in 2007 requires the medical royal colleges to provide leadership and a signpost to the relevant and expected supporting information to support the revalidation decision. This document will therefore not only seek to update you on the core principles of appraisal but will also signpost you to what outputs appraisers and responsible officers are looking for to be able to make a positive recommendation to the General Medical Council (GMC).

Much work has been done by the GMC, the RCGP, the Academy of Medical Royal Colleges (AoMRC), the Revalidation Support Team (RST) (whose function has now been absorbed by NHS England from 1 April 2014) and the Department of Health. Reference to these bodies of work has been included in this summary document.

Medical appraisal

Medical appraisal is a professional developmental process that enables identification of learning needs. Doctors are expected to submit a portfolio of supporting information that includes data regarding the scope and nature of their work, along with appropriate supporting information as defined by the GMC.

Medical appraisal can be used for four purposes:

1. To enable doctors to discuss their practice and performance with their appraiser in order to demonstrate that they continue to meet the principles and values set out in the GMC’s Good Medical Practice and thus to inform the responsible officer regarding their revalidation recommendation to the GMC
2. To enable doctors to enhance the quality of their professional work by planning their professional development
3. To enable doctors to consider their own needs in planning their professional development
4. To enable doctors to ensure they are working productively and in line with the priorities and requirements of the organisation in which they practice.

Revalidation

Revalidation is the process by which licensed doctors demonstrate to the GMC that they are up to date and fit to practise. Doctors are required to undertake an annual medical appraisal. Every five years, the responsible officer will consider information provided at the annual appraisals, and other information available from local clinical governance systems, and will make a recommendation to the GMC. The GMC will then consider the responsible officer’s recommendation and decide whether to renew the doctor’s licence to practise.

Core principles of GP appraisal for revalidation

1. General principles

1.1 Appraisal is an annual responsibility for all doctors. It is a requirement for GPs in order to remain on a Performers List, as well as the cornerstone of revalidation.

1.2 Appraisal should be generic and applicable to all GPs regardless of their status or role.

1.3 All doctors on the general practice register should be able to demonstrate that they meet the standards for appraisal and revalidation.\(^1\)

1.4 The appraisal should be formative and supportive, while also recognising the summative elements that are required for revalidation.

1.5 Appraisal should encourage the doctor to reflect on improving the quality of the care they provide to patients and to implement any identified learning.

1.6 Appraisal is based on a system that reflects the GMC’s Good Medical Practice Framework\(^6\) and incorporates the GMC’s core set of supporting information for appraisal and revalidation.\(^7\)

1.7 Guidance on specialty-specific content for GPs is signposted and described by the RCGP in The RCGP Guide to the Revalidation of General Practitioners,\(^8\) which is based on the GMC’s generic Supporting Information for Appraisal and Revalidation guidance.\(^7\)

1.8 Follett Review Principles for all medically qualified academic staff: NHS England officers will make provision for joint appraisal where this may be appropriate.

2. Appraisal inputs

2.1 Prior to the appraisal meeting, the appraiser should have access to the doctor’s revalidation portfolio, which includes supporting information for the current appraisal and the outputs of appraisals from the current revalidation cycle including personal development plans (PDPs) and appraisal summaries.

2.2 Documentation should be submitted that covers the key requirements for appraisal and revalidation, in a format that encourages learning, reflection and quality improvement, and which
can be accessed easily by appraisers and responsible officers. GPs should have a choice of the portfolio they use as long as the resource used facilitates the secure storing, submission and receipt of information required by the GMC for appraisal and revalidation.

2.3 The portfolio needs to produce an output that is aligned to the MAG form in England and compatible with the required outputs in the devolved countries.

2.4 NHS medical appraisals should be comprehensive, covering the whole scope of a doctor’s work (whether they work within the NHS or for other employers). The supporting evidence provided within the portfolio needs to be congruent with the scope of practice of the practitioner.

2.5 Supporting information should be anonymous so that, e.g., patients, carers, relatives, staff members and professional colleagues cannot be identified.

3. **Appraisal outputs**

3.1 There should be defined output summary with appropriate national statements signed off in accordance with GMC requirements.

3.2 The output summary documentation should be agreed by the doctor and the appraiser, and make provision for both the doctor and the appraiser to send comments back to the responsible officer.

3.3 After the appraisal the appraiser submits the outputs of appraisal to the responsible officer, highlighting any patient safety or fitness to practise issues, if identified. The doctor should be aware of any information highlighted in this way.

4. **Designated bodies**

4.1 Designated bodies should have an overarching appraisal policy that should be clearly defined and measurable, and which should contain policies on the process of appraisal, allocation of appraisers, timing of appraisals, conflict of interest and appearance of bias, non-engagement with appraisal, complaints, patient and public involvement, information governance, quality assurance of the process and the appraisers, and external/lay scrutiny.

4.2 There should be a process for appraiser allocation.

4.3 There should be a policy in place for requesting the postponement of appraisal.

4.4 There should be a complaints process.

4.5 There should be a methodology for passing appraisal/revalidation information securely between designated bodies.

4.6 A potential GP appraiser should be appointed with an agreed role description, person specification and competencies in a fair and open way, and be accessible to all those who are eligible.

4.7 The appraiser will normally be a licensed doctor with knowledge of the context in which the doctor works.
4.8 Appraisers should receive ongoing support and training, and have a named lead appraiser to provide advice.

4.9 There should be a system of quality management of appraisers and appraisal outputs as well as external scrutiny to ensure the required standards of appraisal are met.

5. **Information governance**

5.1 The information within a doctor’s appraisal and revalidation portfolio is confidential and access should be limited to the doctor, the appraiser and the responsible officer (or an appropriate person with delegated authority).

5.2 The discussion in the appraisal meeting should remain confidential unless fitness to practise or patient safety issues are identified.

5.3 All information presented by the doctor at appraisal should be retained by the doctor and made available to the responsible officer on request. No information relating to the doctor or the portfolio is to be retained by the appraiser.

5.4 The GMC can access all information relevant to the licensure of doctors.

**Context around core principles**

**Formative and summative elements of appraisal**

When appraisal was first introduced, the process was primarily formative, i.e., encouraging the professional development of doctors by helping identify their strengths and development areas. It gave them an opportunity to look back on their previous year’s work and learning, and to consider the year ahead, possibly with some informal feedback or advice from the appraiser.

This formative part of appraisal remains extremely important and it is vital that it is not lost. However, the introduction of revalidation in 2012 also introduced a summative element to the appraisal process. Appraisers are now also expected to assess whether relevant evidence has been submitted and judge whether it is of sufficient quality.

The appraiser will not be deciding whether or not the doctor should be revalidated but will be assessing the following questions:

- Has an appropriate quantity of supporting information been produced that meets the requirements set out by the GMC in its supporting information document?
- Is the quality of the supporting information sufficient to meet the requirements for revalidation and has the doctor reflected on the evidence and identified any subsequent development need?

**Scope of work and appropriate supporting information**

One annual medical appraisal should now cover the entirety of a doctor’s work for which he or she
requires a licence to practise. This will include clinical work, along with other roles such as teaching, management or non-NHS work.

It may be helpful to consider what appraisers are looking for in GP portfolios:

**Reflection**
- This has been highlighted as key by the GMC.
- Doctors need to consider what they have learned and how this can be used in their current practice.
- They also need to consider if there are any additional learning needs.

**CPD**
- Should be relevant to and reflect all of the doctor’s roles.
- Should be balanced, demonstrating use of a variety of different learning methods, e.g. courses, elearning, case reviews, etc.
- Should be effective and worthwhile – Has it helped the doctor become a better practitioner? How can they prove or demonstrate this?
- Quality not quantity. Doctors often complete large amounts of CPD but are not so good at recording it. Doctors should consider what is most relevant and submit their ‘best’ credits.
- May need to include any mandatory training required by employers, e.g. safeguarding, basic life support, etc.
- Extended roles (i.e. those beyond the scope of core GP training, including commissioned roles such as GPwSI).
- The appraiser will want to know how doctors are qualified for the role, how they stay up to date and how they know they are competent or doing a good job.
- Doctors should append any reviews in other roles to their appraisal portfolios.

**Evidence of professional development.**
- This should show evidence of progress over time, e.g. new types or topics of learning, preferably building on previous knowledge and skills.
- It includes reviewing the previous PDP and also progress towards meeting the requirements of revalidation.

**Generic and specialty-specific supporting information**
In 2012, the GMC issued its guides on *Supporting Information for Appraisal and Revalidation* and *The Good Medical Practice Framework for Appraisal and Revalidation*. These documents outlined the broad areas that need to be covered in an appraisal and also described six types of supporting information needed for revalidation:
1. Continuing professional development
   - A minimum of 50 CPD credits annually.
   - Reflection required on all CPD credits submitted.
   - Additional evidence will be required to show evidence of impact when claiming ‘impact credits’.

2. Quality improvement activity
   - A minimum of one quality improvement project per five-year revalidation cycle.
   - Usually for GPs this will incorporate a two-stage audit cycle. However, other suggestions are also outlined in the guide – this is particularly helpful for doctors without a practice base, such as GP locums, and also for doctors with an extended scope of practice, such as those with educational or management roles etc.

3. Significant events
   - These may include significant untoward incidents (SUls) or the more usual primary care significant event analyses (SEAs).
   - A minimum of two SEAs should be submitted each year.
   - These should be written up on a standardised pro forma and discussed with colleagues to maximise and share learning.

4. & 5. Feedback from colleagues and patients
   - A minimum of one colleague and patient survey should be completed during each five-year revalidation cycle.
   - Doctors are expected to reflect on the results of these surveys.
   - The GMC has developed guidance on the criteria that responsible officers should look for in a colleague or patient questionnaire tool.

In addition, specialty-specific guidance is available from the RCGP in The RCGP Guide to the Revalidation of General Practitioners. This document provides details on the specific supporting information required from GPs, along with examples of how this could be achieved.

A short summary of GP specialty-specific requirements is presented below but doctors are referred to The RCGP Guide to the Revalidation of General Practitioners for further information.
• Survey data should be collected anonymously and not inputted and collated by the doctor.

6. Review of complaints and compliments

• All GPs should report all complaints or compliments annually in the information submitted.
• Data should be anonymised.
• This should include reflections on how the complaint arose, the response and any further actions taken.

The RCGP Guide to the Revalidation of General Practitioners can be accessed on the RCGP Revalidation Support page on the RCGP website:


Reflection

A simple definition of reflection can be ‘consciously thinking about and analysing what you are doing and what you have done; thinking about what and how you have learnt’.\(^{10}\)

In discussing supporting information, the appraiser will be interested in what the doctor did with the information and the doctor’s reflections on that information, not simply that it was collected and maintained in a portfolio. The appraiser will want to know what the doctor thinks the supporting information says about his or her practice, and how the doctor intends to develop or modify his or her practice as a result of that reflection.\(^{7}\)

Reflection should occur as soon as possible following the activity or event to ensure as much recollection and meaning as possible. Good reflection goes beyond descriptive observation. Instead, it is demonstrated through evidence of analytical thinking, learning and action planning.\(^{11}\)

Useful questions for doctors to ask themselves include:

1. What have I learnt?
2. How has this influenced my practice?
3. Looking forward, what are my next steps?

The appraisal discussion

The appraisal discussion should include:

1. A review of last year’s PDP and what has been achieved
   a. Reasons for non-achievement of PDP elements need to be made explicit
   b. New personal development items that occur in the year and have been added need to be understood
2. A review of the CPD log for the last 12 months, ensuring that a minimum of 50 credits have been recorded that comply with the RCGP guidance.  
3. Presentation of any supporting information as required for revalidation. This will be assessed by the appraiser in terms of quantity and quality. A peer discussion may be used to enhance reflection and identification of any developmental needs.  
4. Discussion of aspirations, challenges and achievements.  
5. Consideration of health and probity issues.  
6. Construction of an agreed PDP for the coming year.  
7. Any other issues that the doctor may wish to discuss.  

**Appraisal outputs**  
There should be a defined output summary and appropriate national statements signed off in accordance with GMC requirements.  

The appraiser should complete a summary of the appraisal discussion under the following headings:  

- scope of practice  
- knowledge, skills & performance  
- safety & quality  
- communication, partnership & teamwork  
- maintaining trust.  

The summary should also include a review of the previous year’s PDP and should be agreed by both the appraiser and the doctor.  

The appraisal outputs will also include a new PDP for the coming year.  

In England, the appraiser will also be expected to sign off the five national statements:  

1. An appraisal has taken place that reflects the whole of a doctor’s scope of work and addresses the principles and values set out in *Good Medical Practice*.  
2. Appropriate supporting information has been presented in accordance with *The Good Medical Practice Framework for Appraisal and Revalidation* and this reflects the nature and scope of the doctor’s work.  
3. A review that demonstrates appropriate progress against last year’s PDP has taken place.  
4. An agreement has been reached with the doctor about a new PDP and any associated actions for the coming year.
5. No information has been presented or discussed in the appraisal that raises a concern about the doctor’s fitness to practise.

**Follett Review Principles**

NHS England responsible officers will make provision for joint appraisal where this may be appropriate, e.g. for clinical academics who are GPs. In Follett cases of joint appraisal, at least one of the appraisers who will be responsible for the final sign-off statements will have been recruited, trained, supported and reviewed in accordance with the RST guidance assuring the quality of medical appraisers.\(^4\)\(^1\)\(^2\)

**Postponement of appraisals**

All doctors, if they wish to maintain a licence to practise, are obliged to undergo an annual appraisal. There are however circumstances where a doctor may request an appraisal to be deferred, e.g. breaks in practice due to sickness, maternity or adoption leave, absence abroad, sabbaticals and unforeseen personal or work-related issues. Each case will be dealt with on its merits and no doctor will be disadvantaged or unfairly penalised as a result of pregnancy, health issues or disability.\(^1\)\(^2\)

**Appraiser allocation**

There should be a process for appraiser allocation with broadly two methodologies used across the UK. Either the relevant appraisal officer will allocate an appraiser to the doctor or the doctor will select an appraiser him or herself from a pool of appraisers. GPs should check the method used in their region. Whichever of the two methods above is used, the relevant responsible officer would need to ensure that this is managed in such a way as to ensure the suitability and objectivity of the appraiser. This would include limiting the size of the pool, checking the selection and suitability of the appraiser to ensure objectivity before the appraisal takes place, and ensuring that the appraiser is aware of his or her responsibility to make a declaration that there is no potential for conflict of interest or appearance of bias prior to appraisal.\(^1\)\(^2\)

If a doctor or another person objects to the allocated appraiser he or she should complete an appeal form explaining his or her reasons and send it to the responsible officer and/or appraisal organiser. The appeal process should be repeated once. If there is still no agreement after the appeal an external appraiser will be allocated by the regional responsible officer and his or her decision will be final.

A doctor should have no more than three consecutive appraisals with the same appraiser and must have a period of at least three years before being appraised again by that same appraiser. A doctor should not act as an appraiser to a doctor who has acted as his or her appraiser within the previous five years.
There should be a process of recognising an appearance of bias or a conflict of interest between a doctor and his or her assigned appraiser, and there should be policies in place to manage this scenario.

**Quality assurance of the appraisal process**

Responsible officers must ensure that the medical appraisal system is of sufficient quality to support their revalidation recommendations. The quality of the medical appraisal workforce is a major determinant of this.\(^{12}\)

Medical appraisers should be selected through a structured recruitment process. There is a suggested role description and person specification developed by the NHS RST and adopted by NHS England, and similarly robust processes are established in the devolved nations.\(^{12,13}\)

Medical appraisers should develop an appropriate set of skills to ensure that appraisal is a positive process, driving quality and improvement through the motivation and development of the individual doctor.

Medical appraiser competencies include:

1. Professional responsibility – to maintain credibility as a medical appraiser
2. Knowledge and understanding – to understand the role and purpose of the medical appraiser and to be able to undertake effective appraisals
3. Professional judgement – to analyse and synthesise information presented at appraisal and to judge engagement and progress towards revalidation
4. Communication skills – to facilitate an effective discussion, produce good-quality outputs and deal with any issues or concerns that might arise
5. Organisational skills – to ensure the smooth running of the appraisal system including timely responses and effective IT skills.

It is recommended that appraisers undergo an annual review, which should include a review of the core competencies, a review of summary statements and PDPs against benchmarked criteria (e.g. Excellence Tool), feedback from the doctors appraised and the appraisal team within which they work.
References


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