



Royal College of  
General Practitioners

# RCGP Mythbusters – Addressing common misunderstandings about appraisal and revalidation

Dr S R Caesar, RCGP Medical Director for  
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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.'

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# Introduction



We don't disturb Dr Jekyll in the week before his appraisal

The GMC provides the definitive guidance on **supporting information for appraisal and revalidation**. This guidance complements that with specific examples of supporting information that will help GPs satisfy the GMC's requirements.

This information is intended for everyone involved in appraisal and revalidation:

- the individual GP
- the appraiser
- the RO.

We want to dispel some of the confusion that has been identified and clarify recommendations and requirements. We also want to provide an equal experience of appraisal and revalidation for all GPs, regardless of their context or geographical location.

This guidance is expected to be reviewed and updated regularly, so check our website for updates if you are unsure. Please contact us at [revalidation@rcgp.org.uk](mailto:revalidation@rcgp.org.uk) if you find any of the clarifications unclear or you want more information.



# Key Messages

- Your role in revalidation is to demonstrate that you are up-to-date and fit to practise.
- Your role in appraisal is to engage in a process that supports you as a GP, helping you to demonstrate your reflective practice and your continuing professional development, as well as facilitating quality improvements across your whole scope of practice.
- The way that you choose to record and demonstrate your supporting information should remain reasonable and proportionate, without detracting unduly from your patient care, or the leisure time that is necessary for remaining fit to practise.
- The GMC provides the definitive guidance about the requirements for revalidation. If you meet the GMC requirements that will be sufficient for successful revalidation.
- The RCGP (among others) provides guidance and recommendations to help GPs to understand how to interpret and satisfy the GMC requirements in a GP context, but RCGP recommendations are not additional requirements.
- The RCGP welcomes enquiries if there are areas that still cause confusion, or if new 'myths' are identified, and will use your feedback to update this document on a regular basis.
- Reflection is a process of looking back over knowledge, experiences or events and critically analysing what has been learned, and then planning for any changes that need to be made as a result. As a professional, you will reflect on your practice all the time, both consciously and unconsciously, but not all reflection can be (or needs to be) documented.
- You should be selective in what you document in your portfolio of supporting information, choosing to include what is of particular importance to you and focusing on quality not quantity of supporting information.
- If you are not sure how to record your supporting information, or you are finding it too burdensome, talk to your appraiser. Appraisers are trained to help you to put together your portfolio in an efficient way.
- Well trained and supported appraisers can be a valuable resource. They have expertise in understanding the requirements for revalidation and in facilitating your reflection and professional development, by creating the protected time and space during appraisal to provide support, encouragement and stimulation.
- If you are working in an unusual context, and you are not sure what is appropriate for your circumstances, talk to your appraiser or responsible officer, as they have networks of peer support and the experience to help you to determine what would be appropriate in your case.



# 1. The role of appraisal in the regulation of doctors



*You're worried! I haven't done any quality improvement activity for 2 years!*

**1.1. Myth: I can choose my designated body or my responsible officer**

**1.2. Myth: Appraisal is the main way to identify concerns about doctors**

**1.3. Myth: Appraisal is a pass or fail event**

**1.4. Myth: My appraiser will decide about my revalidation recommendation**

**1.5. Myth: I need to undertake a minimum number of GP sessions to revalidate**

**1.6. Myth: If I share my concerns about another doctor with my appraiser, my appraiser will have a responsibility to report my concerns**

**1.7. Myth: I must have five appraisals before I can have a recommendation to revalidate**

**1.8. Myth: If I am not ready for my revalidation, I can ask to be deferred**

**1.9. Myth: My appraisal month will always be my birth month**

**1.10. Myth: It is my responsible officer's job to ensure that I have an appraisal**

**1.11. Myth: I cannot demonstrate my engagement with revalidation if I miss an appraisal**

### **1.1. Myth: I can choose my designated body or my responsible officer**

You cannot choose your designated body or who your responsible officer (RO) is. There is a strict hierarchy of connections set out in legislation. There are tools on the **GMC website** which will help you to identify which designated body you should be connected with. Your designated body will normally provide your RO, unless there is a potential for bias or a conflict of interest, in which case you should declare it and you will be assigned an alternative RO.

We recommend that you check your designated body is correctly assigned on **GMC Online** and that you update your connection promptly whenever there is a substantive change in your circumstances, e.g. going from being a GP Trainee to a qualified GP. It is your responsibility to ensure that you keep your connection up-to-date and have an annual appraisal. There are now many appraisal providers who can provide appropriate medical appraisals for revalidation (for a fee).

If you don't have a designated body, and cannot find a Suitable Person, there is a route to revalidation directly through the GMC.

### **1.2. Myth: Appraisal is the main way to identify concerns about doctors**

Potential issues relating to poor performance, conduct or health are almost never first brought to light during appraisal. They are usually discovered through clinical governance processes and become part of an entirely separate investigative process that takes the doctor outside revalidation.

Appraisals should support doctors so that they can remain resilient in the light of current pressures on healthcare systems, encouraging and stimulating them to maintain and improve the quality of patient care they can provide.

### **1.3. Myth: Appraisal is a pass or fail event**

Appraisal is not a pass or fail assessment. Appraisal is part of a formative and developmental process (see glossary). It provides an annual chance to reflect with the help of a trained appraiser, in protected time.

Appraisal should always include support, encouragement and stimulation. At a time of great stress in general practice, appraisal has an important role in helping GPs who may be struggling and signposting them to local support services, with the aim of retaining GPs within the profession.

### **1.4. Myth: My appraiser will decide about my revalidation recommendation**

Appraisers do not have the authority to decide about your revalidation recommendation. Their role is to facilitate your reflection, support and stimulate your development and help you present an appropriate portfolio of supporting information for your responsible officer (RO) to consider. Part of their role is to provide a comprehensive summary of the evidence supplied to represent you to the RO and show that you are complying with the requirements for revalidation.

Your RO has the statutory responsibility for making a revalidation recommendation to the GMC.

Their decision is based on their determination about whether you have sufficiently engaged in annual appraisal, provided a portfolio of supporting information that meets the GMC requirements, and whether there are any outstanding concerns for any part of your scope of practice. The GMC will make the revalidation decision about whether to renew your licence to practise.

## **1.5. Myth: I need to undertake a minimum number of GP sessions to revalidate**

Revalidation assesses your fitness to practise as a doctor. There are no GMC requirements that relate to the number of sessions you need to work in any role. You need to be confident that you can demonstrate that you practise safely in every role you undertake, no matter how little of that work you do.

For any part of your scope of practice, no matter how little time is spent on it, the GMC expects you to reflect on how you:

- keep up-to-date with what you do
- review your practice and ensure that you can demonstrate that it remains safe
- seek out and respond to feedback from colleagues and patients about what you do.

There will always be times when doctors have a significant break from practice, for good reason, such as maternity or parental leave, sickness or sabbaticals, among others. Your designated body will have mechanisms in place for agreeing to postpone your appraisal, or even agreeing an 'approved missed' appraisal. Approved breaks in practice should be considered separately from doctors doing low volumes of clinical work on an ongoing basis.

If necessary, your responsible officer (RO) has the option of deferring your revalidation recommendation to allow more time to collect the supporting information you need. If you have been out of practice entirely for more than two years, you will need to do a refresher course: the Induction and Refresher Scheme in England, Northern Ireland and Wales and the GP Returner Scheme in Scotland.

The number of sessions you need to work per year to remain a GP on the performers list within the NHS is related to your engagement under the National Performers List regulations and is determined by your fitness for purpose, not your fitness to practise. In England, NHS GPs are registered on the performers list of the local area office where they do the majority of their NHS work. There are similar National Performers Lists in the devolved nations.

According to current RO regulations, if you only do one GP session for the NHS per year, under the hierarchy of connections in current legislation you will be connected to the relevant NHS primary care designated body and receive an annual appraisal through that organisation, even if you do more clinical work for a different employer. Although the GMC does not require a minimum number of sessions of GP work each year, many NHS ROs feel that providing only one session of undifferentiated primary care in the NHS per year, for more than one year, is insufficient for a GP to demonstrate that they are up-to-date and fit to practise in that role. There is also a feeling that it provides insufficient service commitment to justify the cost to the NHS of the appraisal and RO oversight function. The amount of clinical work for the NHS that you need to do to remain on the performers list is a hot topic that is currently under review.

Our current position is that how much clinical work you need to do to remain clinically up-to-date and fit to practise depends on several factors:

- your prior knowledge and experience
- how recently you reduced your sessional commitment
- how well supported you are and the governance arrangements for your role
- the CPD and QIA you are able to do in your role
- your engagement in annual appraisal
- other medical activities you are doing.

To a certain extent, knowledge based CPD can substitute for volume of clinical practice and experiential learning, but the less experiential learning possible, the more CPD is likely to be needed to keep up-to-date.

## **1.6. Myth: If I share my concerns about another doctor with my appraiser, my appraiser will have a responsibility to report my concerns**

It is your responsibility to act in accordance with your GMC Duty of Care to report concerns. Your appraiser should provide you with support and can signpost the correct steps for you to take. The GMC guidance on acting on a concern says:

*19. All doctors have a responsibility to encourage and support a culture in which staff can raise concerns openly and safely.*

*20. Concerns about patient safety can come from a number of sources, such as patients' complaints, colleagues' concerns, critical incident reports and clinical audit. Concerns may be about inadequate premises, equipment, other resources, policies or systems, or the conduct, health or performance of staff or multidisciplinary teams. If you receive this information, you have a responsibility to act on it promptly and professionally. You can do this by putting the matter right (if that is possible), investigating and dealing with the concern locally, or referring serious or repeated incidents or complaints to senior management or the relevant regulatory authority.<sup>1</sup>*

Appraisers should not go beyond the limits of the appraisal role to adopt other people's concerns. Third party information is not good evidence, and an appraiser could be open to criticism if they repeat something potentially defamatory or destructive to someone's livelihood, without any first-hand evidence.

We recommend that appraisers record that concerns have been raised at appraisal in the summary of discussion. This should not include details about the concern but should include written advice about the next steps and actions agreed with the GP. They should also include an appropriate note in the comments box to make the responsible officer aware that a concern was raised.

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1 General Medical Council (April 2012), *Raising and acting on concerns about patient safety*, p.12

## **1.7. Myth: I must have five appraisals before I can have a recommendation to revalidate**

You are expected to engage fully in the annual appraisal process to revalidate successfully. However, there is no requirement to have five annual appraisals before a revalidation recommendation can be made. There are many reasons for having approved missed appraisals, such as maternity leave or sick leave. You could be given a revalidation due date that is less than five years from your first appraisal. It is important that any missed appraisals in the revalidation cycle are agreed by your responsible officer (RO) as being necessary and appropriate.

Before the RO can make a positive recommendation to revalidate, you must have collected all the GMC supporting information required to provide assurance that you are up-to-date and fit to practise and reflected on it at your appraisal. This normally requires at least two appraisals.

If you are struggling to collect all the supporting information before your revalidation recommendation due date, your RO can recommend a deferral. This is a neutral act. The GMC will continue your existing licence to practise, and set a new revalidation recommendation date. You will be able to work while you collect the remaining supporting information that you need. Your RO can recommend a deferral period of between four months and one year depending on how long you will need to collect and reflect on the remaining supporting information.

## **1.8. Myth: If I am not ready for my revalidation, I can ask to be deferred**

Only your responsible officer (RO) can decide if your revalidation date should be deferred. It is possible that the RO will decide to tell the GMC you are failing to engage with revalidation, if you have not engaged enough with the appraisal process, or taken appropriate opportunities to ensure that you are ready for revalidation.

Deferral is a neutral act and is normally used in circumstances where more time is needed to demonstrate your continued competence. Your existing licence to practise will continue. This will allow you additional time to meet the GMC requirements for supporting information in full, or for a local process to be completed.

If you feel that your revalidation date should be deferred, for any reason, you should discuss your options and the reasons why with your appraiser and RO at the earliest opportunity. This will help to demonstrate that you are engaged with the process.

## **1.9. Myth: My appraisal month will always be my birth month**

There are a variety of ways to allocate your appraisal month. Many designated bodies follow NHS England guidance and spread appraisals through the appraisal year based on having your appraisal in your birth month. Other designated bodies may have a different way of allocating your appraisal month. There might be an appraisal season, during which everyone has their appraisal. You may have a period of leave which means your appraisal month might move. You might then resume a rolling twelve-monthly appraisal period with the new month as your appraisal month.

There are therefore many situations where your appraisal may not be in your birth month.

You are advised to check when your appraisal will be due when you move from one designated body to

another. Your new responsible officer may ask you to change your month to ensure that you fit in with the local appraisal and revalidation policy and process.

### **1.10. Myth: It is my responsible officer's job to ensure that I have an appraisal**

GMC statutory guidance states that, to maintain your licence to practise, you must ensure that you have an annual medical appraisal and demonstrate your continued competence across your whole scope of practice. Your responsible officer (RO) has a duty to ensure that there is a suitable, quality assured, appraisal process for you to participate in. The GMC requires you to engage with your annual appraisal process on an ongoing basis.

Some doctors do not have an RO, or a Suitable Person, and still organise their own annual appraisal that meets the GMC criteria for a medical appraisal for revalidation.

If you work in a designated body with an organisational appraisal policy, it is your responsibility to understand what that means for you and how you should be accessing your annual appraisal. Your RO has a statutory responsibility for ensuring that the appraisal process is fit for purpose but you must play your part in engaging fully with the process.

We recommend that you are proactive in ensuring that you have an annual appraisal that is meaningful and meets your personal and professional development needs in the context in which you work. If your appraisal becomes disproportionately burdensome, we recommend that you speak to your appraiser and RO. They can support you and make recommendations.

If you think that you should be offered an appraisal and you are not, we recommend that you are proactive about seeking advice from your designated body and ensuring that you are included in the appraisal process. Administrative errors do happen and you are best placed to highlight such omissions.

### **1.11. Myth: I cannot demonstrate my engagement with revalidation if I miss an appraisal**

If you are in work when your appraisal is due, it is easy to demonstrate your engagement by having your appraisal meeting before the end of the month in which it is due.

There is currently no GMC guidance that lays out exactly how you should demonstrate your engagement if you are not going to be in work at the time when your appraisal is due. Most responsible officers (ROs) have a process so you can let them know about maternity or sick leave, or if you will be away on a sabbatical. The RO can then postpone your appraisal month or approve a missed appraisal. You should do this in advance to demonstrate your engagement with the process.

We recommend that if you are planning a significant period of time out of work for any reason you speak to your appraiser or RO. Sometimes it will be appropriate to postpone or cancel your next appraisal. Sometimes it may be better to go ahead with it as planned. The important thing is for you to decide this in agreement with your RO and their team and for your summary of appraisal to record the circumstances and your reflections on them.

If you do have to miss an appraisal due to a significant period out of work, we recommend that you have an early appraisal following your return. This will give you an opportunity to reflect on all that you have

experienced and learned and to plan any changes that you now want to make. An important aim for the 'return to work' appraisal will be the development of an appropriate new PDP arising from the appraisal portfolio and discussion.

If you have been out of clinical work for more than two years, you will need to engage with the Induction and Refresher/Returner Scheme. This will mean that you are in a training role and do not require an additional whole scope of practice appraisal until after you have completed the scheme.

## 2. Appraisal documentation



I've got all my supporting information ready...  
the audits are in that pile at the back.

**2.1. Myth: I must use a portfolio defined by my responsible officer to revalidate**

**2.2. Myth: My appraisal portfolio is entirely confidential**

## 2.1. Myth: I must use a portfolio defined by my responsible officer to revalidate

The format of the portfolio of supporting information is not prescribed by the GMC, so having an electronic portfolio is not a requirement for revalidation. We recommend that your portfolio of supporting information should include all the **core elements required by the GMC** in a format that is professionally presented, typed so that it is legible, and capable of being transmitted electronically. Some other items of supporting information, such as original complaint letters or compliment cards, which may be hand-written, are usually best kept in paper form and shared privately with your appraiser to maintain confidentiality. They can then be referenced anonymously by the appraiser in the summary.

The medical appraisal guide model appraisal form (MAG4.2) is a free interactive pdf available from the **NHS England website**. This provides the template for all other toolkit providers and its use is not restricted to England. In some areas, responsible officers (ROs) have commissioned bespoke IT solutions for their doctors to encourage them to use a single system. In Scotland and Wales there are national appraisal and revalidation platforms used by all doctors. Scotland **uses SOAR** and Wales **uses MARS**. Your RO may have expressed a preference among the available options, which they are entitled to do under RO regulations. You should check your designated body requirements and variations with your RO. For example, special arrangements might need to be made to solve an issue of accessibility for a GP with a protected characteristic. If you move to a new area of the UK you should check if there is a preferred local choice of portfolio.

If your RO has not determined that a specific electronic portfolio should be used locally, you should choose a solution that suits you. Remember that your portfolio, with all the GMC required supporting information, needs to be available to your RO potentially at short notice.

## 2.2. Myth: My appraisal portfolio is entirely confidential

Your appraisal and revalidation portfolio is normally only available to you and your appraiser(s) and responsible officer (or designated deputy). It should follow all relevant information governance and data protection laws. It is inappropriate to include any third party identifiable information, whether about patients or colleagues, without their explicit permission, unless the information is already in the public domain.

Your portfolio is a professional document and reflective notes included in it should be written in a professional way. It could be subject to a request to disclose just as clinical notes can be. If they are appropriately written, your reflective notes can demonstrate your learning and insight into any incident or complaint under investigation.

### 3. Supporting information



**3.1. Myth: I must document all my learning activities**

**3.2. Myth: I need to scan certificates to provide supporting information about my CPD**

**3.3. Myth: It is reasonable to spend a long time getting the supporting information together for my appraisal**

**3.4. Myth: I only need to provide all six types of GMC supporting information about my clinical role**

**3.5. Myth: All my supporting information must apply to work in the NHS**

**3.6. Myth: Supporting information from work overseas cannot be included in my appraisal portfolio**

**3.7. Myth: Certificates of attendance are important proof of CPD**

**3.8. Myth: Having a 'disagree' statement from my appraiser is always a bad thing**

**3.9. Myth: I must get sign off statements from all parts of my scope of practice every year**

### 3.1. Myth: I must document all my learning activities

You do not have to document all your learning activities. We recommend that you focus on the quality not quantity of your supporting information.

You should be selective about documenting your reflection on your most valuable and meaningful learning, over the course of the year. You do not need to record and reflect on every learning activity.

If you find it convenient and helpful to record significantly more than 50 CPD credits for your own benefit (to capture your learning) then that is your choice, but your appraiser will focus on the quality of your learning and reflection and challenge you to highlight what has been most important over the course of the appraisal period.

### 3.2. Myth: I need to scan certificates to provide supporting information about my CPD

The GMC has not set any requirements about exactly how CPD should be evidenced or recorded.

We recommend that you should follow the definition of one CPD credit equals one hour of learning activity demonstrated by a reflective note on lessons learned and any changes made.

Recording and demonstrating your CPD by scanning and storing certificates that only record time spent, without indicating what you learned, is not a good use of your time.

For appraisal and revalidation, you only need to include a reflective note on your learning and what difference it has made (or will make). You should keep a simple learning log in a way that is convenient to you so that you can capture your learning points and their implications for the quality of your care.

There are several useful apps available, for example the **GMC CPD app**. Some electronic platforms include learning diaries that can be accessed or emailed from your Smartphone or other devices. A document record, table or spreadsheet can work just as well.

There are some learning activities that are well documented by a certificate because the certificate is designed to help you capture your reflection on the learning at the time. You might want to scan certificates relating to training specifically required by your designated body or any organisations in which you work. This does not make them part of the GMC requirements for revalidation but it does allow you to collect and keep important documentation securely and demonstrate fitness for purpose to your employer.

### 3.3. Myth: It is reasonable to spend a long time getting the supporting information together for my appraisal

Organising supporting information into your portfolio, and making the sign-offs and statements before appraisal discussion, should not take long.

We recommend that your supporting information should be generated from your day-to-day work and added to your portfolio as you go along. Producing a CPD log can be difficult and time consuming as a retrospective exercise. It is much easier to make regular entries into your learning diary throughout the year. There are now many tools and apps to help you to do this in a simple and timely way.

We recommend that the final stage of organising the supporting information and completing your portfolio

before your appraisal should take no more than half a day, around 3.5 to 4 hours. If it is taking longer than this, or the effort feels disproportionate, you should discuss with your appraiser how you can simplify what you do. Some doctors with complex portfolio careers and several roles to include may take a little more time than this, but you should seek advice if it takes more than a day to organise.

### **3.4. Myth: I only need to provide all six types of GMC supporting information about my clinical role**

The GMC requires doctors to provide appropriate supporting information across the whole of their scope of practice that requires a licence to practise, not just clinical roles.

You must declare all parts of your scope of practice and, for each of them where appropriate, provide all six types of supporting information over the revalidation cycle:

- CPD
- QIA
- significant events, if there are any
- patient feedback
- colleague feedback
- complaints and compliments, if there are any

We recommend that you keep the documentation of your supporting information reasonable and proportionate while ensuring that you have demonstrated that you are up-to-date and fit to practise in every scope of practice. Your appraiser will help you determine whether there are any gaps in your portfolio of supporting information and support you in working out how best to fill those gaps. Your responsible officer (RO) will tell you if your portfolio demonstrates sufficient engagement in reflective practice and provides the supporting information required by the GMC.

If you have any queries that your appraiser cannot resolve, we recommend that you seek early confirmation from your RO that what you are planning is going to be acceptable.

### **3.5. Myth: All my supporting information must apply to work in the NHS**

Your supporting information must cover the whole scope of practice for which you require a licence to practise, if you are working in the NHS or not.

There are GPs working entirely in private practice who maintain a licence to practise through revalidation. Even if the NHS provides your designated body and responsible officer, your medical appraisal for revalidation must cover your whole scope of practice, including any roles outside the NHS for which you require a licence to practise. Appraisers are trained and supported to provide whole scope of practice appraisals and to facilitate reflection on supporting information from inside and outside the NHS.

### **3.6. Myth: Supporting information from work overseas cannot be included in my appraisal portfolio**

The **GMC Protocol for responsible officers** (ROs) making revalidation recommendations states at 2.3.2:

*‘Doctors may practise in settings where they do not require a UK licence – for instance, they may work abroad, or they may undertake specific functions in the UK that do not legally require a licence to practise.*

*Where this is the case, it is at your discretion whether you consider supporting information from these practice settings in making your judgement. You should consider whether such information is material in your evaluation of their fitness to practise, taking account of whether it is demonstrably relevant to the doctor's licensed UK practice and the proportion of the doctor's supporting information that it represents.'*

The GMC requirement is that your appraisal and revalidation portfolio should include supporting information about every part of your scope of practice that requires a UK licence. As the above makes clear, your RO has the discretion to consider supporting information from other settings in making their revalidation recommendation.

Even in UK practice, you may attend CPD events overseas. It is appropriate to check that the content of such an event is applicable to your scope of practice rather than assuming that it will be acceptable. We recommend that you discuss any proposal to include any such additional supporting information with your RO in advance of your revalidation recommendation date. It is likely that clinical work overseas will have a significant overlap with clinical work in the UK. It may well be appropriate to include supporting information relating to work overseas when it demonstrates the quality of your reflective practice.

If you are unsure, use your appraisal as an opportunity to reflect on what is appropriate and proportionate with your appraiser, and then agree it with your RO before your revalidation recommendation is due.

### **3.7. Myth: Certificates of attendance are important proof of CPD**

Certificates of attendance may prove attendance at an event, but they are not proof of learning or development. They say nothing about what has been learned, or any changes you have made as a result.

A reflective note, no matter how brief, is far more valuable evidence of reflective practice and continuing professional development than a certificate. A lot of valuable learning takes place in ways that do not generate a certificate, such as personal reading and professional conversations with colleagues. We encourage you to think about how and what you have learnt, defining one CPD credit as one hour of learning activity as demonstrated by a reflective note on the lessons learned and any changes made as a result.

You should not waste time scanning certificates of attendance into your portfolio of supporting information, unless keeping formal proof of attendance on courses that are organisational requirements may be useful to you, such as Basic Life Support and Safeguarding. Appraisers should not be asking to see certificates of attendance; they should be asking what your most important new learning has been over the past year and what difference it has made to your practice.

Many CPD facilitators now provide certificates that include a structured format or template for you to write appropriate reflective notes about learning and planned changes that will have an impact on your practice. It is reasonable to scan these rather than rewriting the reflective note elsewhere. You can also choose not to complete the certificate at all if the reflective note is captured elsewhere in a learning log or electronic toolkit. Your aim should be to avoid duplication of effort.

### **3.8. Myth: Having a 'disagree' statement from my appraiser is always a bad thing**

There are five key sign-off statements that are normally agreed by your appraiser at the end of your appraisal. If your appraiser decides that one, or more, should be marked as 'disagree', this sends a

message to you, your next appraiser and the responsible officer (RO) that something may not be ready for revalidation. This is not, in itself, a bad thing. It is an important part of ensuring that the appraisal supports you in preparing a portfolio of supporting information appropriate for a positive recommendation to revalidate. Ultimately, your RO makes the decision about your revalidation recommendation, not your appraiser.

There are two different comment boxes for the appraiser, and one comment box for you, to provide an explanation for the disagree statement. It is relatively common for a doctor to have made no progress with their previous PDP, either because they had no previous PDP, in the case of a first ever appraisal, or because circumstances changed significantly during the year, making the earlier PDP goals less appropriate. In these circumstances, it is appropriate for the appraiser to mark 'disagree' to the statement about progress with the previous PDP, and enter an explanation in the comments box.

Even the fifth sign-off statement, which states that there are no concerns arising from the appraisal documentation or discussion that suggest a risk to patient safety, may sometimes need to be marked as 'disagree'. For example, if a doctor is currently under investigation, and has their annual appraisal in the period before the investigation is resolved, they could not be revalidated as there are outstanding concerns, and the appraiser should indicate this by marking the fifth statement as 'disagree'. It is important that the appraiser puts an explanation in the comments box provided in every case where they have marked a statement as 'disagree'.

In all cases, you also have a box in which to enter your comments, although you do not have to comment if you have nothing to add to the appraiser's explanation.

### **3.9. Myth: I must get sign off statements from all parts of my scope of practice every year**

We do not recommend that you seek sign off statements that there are no concerns about your practice in all of your roles every year. Instead, you should reflect on how the safety of patients is being assured and the governance, clinical or otherwise, of the systems you are working in. You should always know how to report on a significant incident and how you would find out if there was a complaint about you.

It is important that you have declared all the different parts of your scope of practice and provided appropriate supporting information to demonstrate that you are keeping up-to-date, reviewing and maintaining (or improving) your performance and seeking and acting on feedback in each. It is also important that you ensure that your responsible officer (RO) knows how to contact the clinical governance leads from any part of your scope of practice that is not for your main designated body so that they can seek the assurance that they need when they need it.

We recommend that any governance concerns arising about a doctor should be communicated to the RO as and when they arise, by those responsible for the governance surrounding a doctor's work. It is crucial that concerns can be dealt with in a timely fashion and are not linked to the revalidation cycle.

In some cases, a doctor will be working in an environment where there is no external governance and the reporting of any issues will depend on the professionalism of the doctor. Significant incidents and complaints can arise in every type of practice, and the GMC requires that all such incidents and complaints should be declared and reflected on at appraisal. We recommend that GPs talk to their RO, whenever they have a governance concern, to agree the best way forward and because the RO will often be able to signpost appropriate resources or courses of action.

In summary, normally concerns will be generated and ‘pushed’ to your RO as and when they occur to be dealt with in a timely fashion outside the revalidation process. As part of this, you are personally responsible, as a professional, for declaring any concerns that you are aware of as they arise. In addition, your RO needs to have up-to-date contact details for all parts of your scope of practice to ‘pull’ information about your work at any time, should this be necessary.



## 4. Reflection



Mirror, mirror on the wall  
Who's the most reflective of them all?

**4.1. Myth: Reflection is difficult**

**4.2. Myth: Documented reflection must be lengthy**

**4.3. Myth: I must write a separate reflective note for every hour of CPD I do**

### **4.1. Myth: Reflection is difficult**

Reflection is a professional habit that all doctors should have. No-one would want to be treated by doctors who never considered how effective their care was or whether it could be any better.

Reflection should be something you do all the time. It is part of your professional training. Like any habit, reflection can be such a subconscious activity that it can be hard to be sufficiently aware of it so you can capture it and write it down.

You might find that your appraiser helps your reflection through active listening, careful questioning and feedback. The appraisal discussion is an important trigger to generate new reflective insights which can be captured in your appraisal summary. You do not have to record all your reflections as this would be disproportionate. It is important to find a method of capturing reflection that works for you and to keep it simple and proportionate. Some people are more natural reflectors than others. You might find it helpful to understand your own preferred learning style. Your appraiser will have training and knowledge to help you, so you should discuss any concerns with them.

### **4.2. Myth: Documented reflection must be lengthy**

Documented reflection should be brief and to the point as far as possible. Capturing the key learning points that have influenced, or will influence, your practice, and thinking about any changes that you may make as a result, and what difference they will make, can be recorded in bullet points, a couple of sentences, or a short paragraph. Some doctors are experimenting with recording brief audio reflections. Do what is appropriate for the specific reflection. Experiment with a variety of styles. Some methods may work better for some types of learning than others. If you are doing a postgraduate qualification then you might want to include a whole reflective essay, but, in most circumstances, this would be disproportionate. Some doctors find structured reflective templates that walk you through a process of reflection helpful. Others prefer not to be constrained.

We recommend that you keep it simple and record what is meaningful to you. We suggest you focus on what you will do differently as a result of what you have learned, and how you will know if the change is an improvement.

### **4.3. Myth: I must write a separate reflective note for every hour of CPD I do**

We recommend that you provide only one reflective note for each CPD activity, even if the event lasts all day. The reflective note should capture the most important lessons learned and any changes that you plan to make as a result. Your appraiser does not want to read a summary of what you looked up online, the whole article, or all that you were taught at an educational event or learned at a conference. If you find it helpful to make notes on the detail, for your own benefit as an aide memoire, you should do so, as a personal choice based on your learning preferences, but it is not important to your appraiser.

You should reflect on the impact of what you have learned on what you already do, or plan to do, in your supporting information for your appraisal. Ideally, your CPD log should be a record of your most important and relevant learning throughout the past twelve months in a succinct and useful format.

## 5. Impact



So Dr Hawkins, how has the Diploma in Piratical Dermatology changed your practice?

### 5.1. Myth: I can't claim credits for impact now

### **5.1. Myth: I can't claim credits for impact now**

You can now claim credits for all time spent on learning activities involved in having an impact on quality of care. They must be backed up by a reflective note on lessons learned and any changes made as a result. This is a more flexible and proportionate system than the former provision for the doubling of credits for demonstrating impact, which ended on 31 March 2016.

The new system has increased the emphasis on demonstrating the impact of what you learn in practice, not reduced it. For example, one hour of traditional CPD learning activity such as reading an article, doing an online module or going to a meeting, may result in a question about whether your patients are on the right combination of treatment. You may then spend more time checking to see if you have any patients whose medication needs to be altered and acting to change their management, if appropriate. You may then share this learning with your colleagues in a meeting and agree a way to ensure only appropriate combinations of treatment are used in the future.

All the time spent can appropriately be considered continuing professional development if you document your reflection on the lessons learned and changes made as a result.

## 6. Continuing Professional Development (CPD)



So 18 holes then reflection in the clubhouse bar... must be worth 2 CPD points?

**6.1. Myth: Only courses and conferences count as CPD**

**6.2. Myth: I must do an equal amount of CPD every year despite different circumstances**

**6.3. Myth: As a part-time GP, I only need to do part-time CPD**

**6.4. Myth: My CPD for each part of my scope of practice must be different**

**6.5. Myth: My supporting information from part of my scope of practice already discussed elsewhere should be presented again at my medical appraisal for revalidation**

**6.6. Myth: The GMC requires GPs to complete Basic Life Support and Safeguarding Level 3 training annually to revalidate successfully**

**6.7. Myth: I cannot claim any credits for a learning activity if I do not learn anything new**

**6.8. Myth: My appraiser will be impressed by my hundreds of credits**

**6.9. Myth: I must do 50 credits of CPD every year**

**6.10. Myth: I need 50 credits of clinical CPD every year**

**6.11. Myth: I must demonstrate 50 credits each year even if I have not been able to practise for much of the time**

**6.12. Myth: 50 credits is always enough CPD**

**6.13. Myth: I can stop learning and reflecting once I have reached 50 credits of CPD**

**6.14. Myth: There is a maximum number of credits I can claim for any one type of learning or one activity**

**6.15. Myth: I cannot include contractual training as part of my CPD**

## 6.1. Myth: Only courses and conferences count as CPD

Continuing professional development (CPD) activities should be very broadly defined and include personal, opportunistic and experiential learning as well as activities targeted at identifying ‘unknown unknowns’. Any learning activity where you spend time learning something and deciding how it can be put into practice in your current, or proposed, work can be counted as CPD. You should only expend time and energy in documenting a sample of your most relevant and important learning.

The aim is to demonstrate a balance of learning across the curriculum relevant to your scope of practice over the five-year revalidation cycle. You should choose to demonstrate reflection on your most valuable learning events across a variety of learning. This is not just courses and conferences and may include:

- learning from cases, data and events
- personal reading and online research
- online modules
- professional conversations about clinical care
- everyday learning from your work and the experiences of others.

As there is so much learning in primary care that takes place in teams, you should demonstrate where this has led to important changes and developments. It is also important, where possible, to demonstrate some learning with others outside the usual workplace to allow for external calibration of ideas and processes. For any learning activity, you need to reflect on what you have learned and any changes you have made (or not) as a result.

## 6.2. Myth: I must do an equal amount of CPD every year despite different circumstances

You do not have to do the same amount of CPD every year. Your revalidation recommendation will be informed by a portfolio that will normally cover a five-year cycle. We recommend that you should learn from a wide variety of sources and ensure that you always keep up-to-date as part of normal professional practice.

You should view documentation of CPD as a selective process that must be kept reasonable and proportionate, documenting your reflection on your most important learning and any changes made as a result every year. It is reasonable to average out CPD and ensure that there is a spread from the GP curriculum over the five-year cycle. This may involve making up a shortfall or gap in one year over the following years.

Sometimes it is obvious that a major commitment, such as a postgraduate qualification, in one area of your scope of practice, will take up almost all the CPD in one year. You should talk and work with your appraiser to ensure that the spread and variety of your CPD are documented in future years. Your appraiser can help you to recognise and document your CPD appropriately. They can also help you to plan to ensure that your portfolio covers the GP curriculum over the five-year cycle.

## 6.3. Myth: As a part-time GP, I only need to do part-time CPD

When you are providing undifferentiated primary care, whether full-time or part-time, you cannot expect to demonstrate that you are up-to-date and fit to practise on part-time CPD. You need to cover the whole of the GP curriculum. We recommend that part-time GPs, who have less experiential learning to draw on, need the same amount of CPD as full-time GPs. It would be inappropriate for a doctor working one

surgery a year as a GP to suggest that they could demonstrate that they were up-to-date for that role after completing only one credit of CPD relevant to such work.

#### **6.4. Myth: My CPD for each part of my scope of practice must be different**

Most doctors find some of their CPD appropriately demonstrates they are up-to-date in different parts of their scope of practice. For example, the learning about diabetes done for a specialist interest role is likely to be applicable to a broader undifferentiated GP role. You can use the same CPD to demonstrate keeping up-to-date for all applicable roles.

If different organisations, in different parts of your scope of practice, have required training in common, such as Equality and Diversity training or Information Governance updates, an annual update in one organisation should be accepted by others. This avoids duplication which could take you away from clinical care. You should check with the organisations in which you work that your training will cover all your roles. Organisations should be prepared to accept equivalent learning and understand the importance of not taking doctors away from front line care.

It is the responsibility of individual GPs to check that the content of the training they undertake is appropriate to all their roles and to agree the equivalence with the organisations in which they work.

#### **6.5. Myth: My supporting information from part of my scope of practice already discussed elsewhere should be presented again at my medical appraisal for revalidation**

We recommend that the original supporting information from parts of the scope of practice subject to a robust appraisal separately to the main medical appraisal for revalidation does not always need to be included again in the portfolio of supporting information. However, your portfolio should include a signed off summary of the appraisal discussion and outputs with appropriate contact details for the appraiser and relevant organisation. Your responsible officer can then follow up on that part of work if they need to. If part of your scope of practice is not appraised elsewhere, the GMC requires the six elements of supporting information and reflections about that part of your practice to be shared in the portfolio and discussed in the main appraisal.

#### **6.6. Myth: The GMC requires GPs to complete Basic Life Support and Safeguarding Level 3 training annually to revalidate successfully**

The GMC does not set any specific revalidation requirements in relation to CPD or specific types of training. The GMC's requirements for revalidation are about maintaining your licence to practise as a doctor. You must demonstrate to the GMC that you are up-to-date and fit to practise as a doctor.

We recommend that you demonstrate how you have covered the breadth of the GP curriculum over the five-year cycle to demonstrate fitness for purpose as a GP. Some GPs might demonstrate that they are up-to-date and fit to practise as a doctor, without being able to demonstrate that they are fit for purpose as a GP, if they are no longer in a GP role.

The GP curriculum includes demonstrating competence in Basic Life Support and Safeguarding Level 3 training, so keeping these up-to-date is an RCGP recommendation, but not a GMC requirement. The organisations in which you work might set specific training requirements, or your inclusion on a performers

list might require you to undertake specific training. These are not requirements for revalidation. You should be aware of any training required by your organisation, as well as any training required for inclusion on a performers list.

In many areas, responsible officers (ROs) have asked doctors to include additional training requirements in their portfolio of supporting information. This is to ensure that organisational requirements are understood by every doctor. This does not make them part of the GMC requirements for revalidation. It is important that you recognise the difference between the requirements for revalidation and training requirements for other purposes, and that your appraiser and RO do not allow the two to become confused.

### **6.7. Myth: I cannot claim any credits for a learning activity if I do not learn anything new**

When you have spent time undertaking a learning activity, it does not always result in learning something new. If it simply reinforces your existing knowledge and skills, and you discover that you are already up-to-date without learning anything new, you can still demonstrate CPD credits by providing a reflective note that explains that there are no changes that you need to make at the current time. This can be very reassuring and we recommend that you include it in your learning log.

### **6.8. Myth: My appraiser will be impressed by my hundreds of credits**

The GMC does not set any specific revalidation requirements in relation to CPD or training. You need to demonstrate that you have done sufficient relevant CPD to keep up-to-date at what you do.

We do not recommend that you spend time that would be better spent on your patients, family or relaxation on documenting credits over and above the recommended amount. If you wish to demonstrate more than 50 credits it is your responsibility to ensure that the way that you record and demonstrate your CPD is proportionate and reasonable and does not become time consuming. Your appraiser should be trained to challenge you to keep your documentation proportionate and make sure that your recording of your reflection is done in a way that is useful to you.

You should not expect your appraiser to review huge amounts of supporting information over and above what is required. You should not spend a disproportionate amount of time and effort on CPD credits that you have already recorded. You should not spend a disproportionate amount of time and effort on documenting your reflection on everything you learn throughout the year. Try to create sensible habits that make your documentation simple and streamlined and use the knowledge and skills of your appraiser to help you.

### **6.9. Myth: I must do 50 credits of CPD every year**

The emphasis for CPD is on the quality of your reflection on what you have learned and the impact it has had on quality of care, not the quantity of credits documented. In fact, it is impossible to put a number on the credits that you need to do to keep up-to-date and fit to practise. The GMC requires you to do enough CPD to keep up-to-date across your whole scope of practice but they do not attempt to define or require a quantity.

We recommend that you undertake 50 credits for every twelve months in work. This can help you estimate what is right for you as an individual GP but it is not a GMC requirement. If you meet this

recommendation, your portfolio is unlikely to need any additional scrutiny of your CPD. If you do not meet this recommendation, then it is likely that your responsible officer (RO) will want to understand exactly why you believe that your CPD is sufficient to keep you up-to-date and fit to practise.

The recommendation that you undertake 50 CPD credits is not a requirement. It relates to the current Academy of Medical Royal Colleges (AoMRC) recommendations for all doctors, bringing the RCGP into line with other specialties, to try to ensure that there is a level playing field for everyone. We recommend that those who have a restricted scope of practice should discuss with their appraiser what constitutes sufficient CPD to keep up-to-date at what they do and to agree this with their RO if necessary.

For example, those who were historically GPs, but now have a very restricted role providing only family planning services, will follow the recommendations of the Faculty of Sexual and Reproductive Healthcare (FSRH) for their CPD, to demonstrate that they are fully up-to-date across the whole of their practice. However, GPs who wish to remain entitled to undertake undifferentiated primary care sessions need to keep up-to-date across the whole of the GP curriculum.

### **6.10. Myth: I need 50 credits of clinical CPD every year**

We recommend 50 credits across the whole GP curriculum, which is much broader than purely clinical CPD. It has always been important to have a balance across the whole GP curriculum relevant to the work that you do.

### **6.11. Myth: I must demonstrate 50 credits each year even if I have not been able to practise for much of the time**

If you have a prolonged career break in an appraisal period, for example due to maternity or sick leave, we recommend that you demonstrate CPD proportionate to your time in work. You should not be burdened with a double load of CPD in the year when you return to work.

While you may choose to front load your CPD to be up-to-date and confident to return to work, this would not be appropriate for everyone. If you have a shortened appraisal interval, for example because you have pulled your appraisal forwards for organisational or personal reasons, you can provide CPD proportionate to the time in work between your appraisals. The GMC requirements for revalidation remain constant whether the review period is three months in work or twelve, but the supporting information should be proportionate to the time in work.

For example, if your appraisal is brought forward so that it is nine months after the previous one, then you should consider what supporting information is proportionate for a nine-month period in work. We recommend that you focus on making progress with your previous PDP, even if not all goals can be achieved, and that you document reflection on a proportionate number of credits of CPD as well as the other types of supporting information. If an appraisal takes place more than twelve months after the previous one, the supporting information presented should be proportionate to the whole time spent in work between appraisals. You should discuss any question about what is appropriate and proportionate in advance with your appraiser and your responsible officer (RO) if necessary.

If it has been impossible for you to demonstrate all the GMC required supporting information before your revalidation recommendation due date, for good reason, then your RO has the option of deferring your revalidation recommendation. This gives you more time to collect the information you need. Deferral is a neutral act to enable you to maintain your licence to practise during the deferral period. For many doctors,

a deferral decision gives them time rather than trying to produce a disproportionate amount of supporting information in a shortened space of time after a period when they have not been able to work.

### **6.12. Myth: 50 credits is always enough CPD**

The GMC requires you to do enough CPD to keep up-to-date across the whole of your scope of practice. This may require more, or less, than 50 credits depending on the scope of practice and your qualifications and experience in each area of work. We recommend that GPs who are providing undifferentiated primary care should demonstrate reflection on 50 credits of CPD over the range of the GP curriculum for every twelve months in work.

You should determine what is enough CPD for you to be up-to-date and fit to practise across all of your work. You should discuss this with your appraiser and, when necessary, get explicit agreement from your responsible officer that what you are doing is appropriate for your circumstances.

As an exception, if you have a complicated portfolio career and several roles to include, you may feel you need to demonstrate more than 50 credits to demonstrate reflection on appropriate CPD to keep up-to-date for each part of your work. You should keep the detailed documentation proportionate and reasonable. Most doctors find it easier to keep a learning log that builds up as they go through the year and this could amount to over 50 credits by the end of the year. If the documentation of the reflection has not been allowed to become disproportionate, you should be the one to decide what works for you.

The appraisal discussion should focus on the credits that reflect on the most valuable and representative learning. We recommend that you should reflect on the balance of your CPD and discuss it with your appraiser. If you are still working as a GP providing undifferentiated primary care, we recommend that you demonstrate 50 credits of CPD relating to the breadth of the GP curriculum. Some elements of CPD are applicable across several roles and, where possible, you should avoid duplication.

### **6.13. Myth: I can stop learning and reflecting once I have reached 50 credits of CPD**

No doctor should ever stop learning and reflecting on their practice if they want to keep up-to-date and stay safe.

You should not change your professional habits of learning and reflection, but you don't need to document it all. You should focus on what has been particularly important or valuable to you over the course of the whole period being appraised.

### **6.14. Myth: There is a maximum number of credits I can claim for any one type of learning or one activity**

We do not recommend any arbitrary limits to the number of credits that can be claimed by a doctor.

You can allocate the number of credits per learning activity using the usual formula: one credit equals one hour of learning activity demonstrated by a reflective note on the lessons learned and any changes made as a result.

The emphasis is on keeping the recording of reflection proportionate. You do not need to go on recording copious reflective notes once you have demonstrated that you are up-to-date and fit to practise.

It is not appropriate for appraisers to be unduly critical about the exact amount of time recorded, or credits claimed, as it creates tension where none is necessary. For example, most diplomas are hundreds of hours of learning, with direct impact on patient care, so setting an arbitrary limit to the amount of credits that can be claimed is not helpful, or proportionate. Spending time cutting down credits when you have done the learning and recorded your reflection, is as disproportionate as spending time recording credits over and above those that are sufficient to demonstrate keeping up-to-date. GPs providing undifferentiated primary care need to have CPD that covers the GP curriculum over the five-year cycle. Documenting and evidencing hundreds of hours of learning from study for a diploma may not be enough CPD to demonstrate continued competence if you have not recorded any other CPD, as it might not cover your whole scope of practice.

We do not recommend an arbitrary limit for how much CPD can be attributed to one type of learning. It is possible for you to provide high quality reflective notes on 50 credits from just one type of learning that covers the whole scope of your practice. However, it is best practice to have supporting information about a variety of types of learning. To remain up-to-date across your whole scope of practice you should demonstrate:

- targeted structured learning aimed at addressing identified learning needs or your 'unknown unknowns'
- opportunistic experiential learning from cases, data, events and feedback.

It is important to include evidence of learning with others to calibrate professional judgements and support team learning.

Doctors who do not have a breadth of variety of learning types or a significant proportion of learning with others should use their appraisal to discuss this. We recommend that you share a reflective note exploring why this is and what you plan to do to ensure that your practice remains mainstream and not isolated from peer support and review. If you have not included this type of reflection in the pre-appraisal documentation, you should discuss it during the appraisal. Your appraiser should document your reflection in the summary.

### **6.15. Myth: I cannot include contractual training as part of my CPD**

We recommend that all learning activity should be eligible to be counted as CPD. It is important to reflect on contractual or required training, as it is required for good reason and part of being able to demonstrate that you are 'fit for purpose' in your role. The appraisal documentation is a good place to record when any mandatory training was completed and reflect on lessons learned and any changes made as a result. Because of the importance of being able to demonstrate compliance with this training in meeting contractual, or performers list, obligations, it is appropriate to upload your certificates of attendance as well as your reflective note.

If you have more than one part of your scope of practice with the same training requirements, for example, equality and diversity training, we recommend that you negotiate to ensure that the training that you do will meet the needs of all your roles. This avoids duplication of effort and the unnecessary burden of repeating the same training for different employers.

## 7. Quality improvement activities (QIA)



My appraiser liked my audit of staff home baking  
so my QIA for next year is cake decoration.

**7.1. Myth: Time spent on quality improvement activities is not CPD**

**7.2. Myth: I must do at least one clinical audit in the five-year cycle**

**7.3. Myth: I must do all my QIA myself**

**7.4. Myth: There are specific types of QIA that I must include**

## 7.1. Myth: Time spent on quality improvement activities is not CPD

All learning activities can be included in CPD credits. They should be demonstrated by an appropriate reflective note about the time taken, lessons learned and any changes you made as a result.

Continuing professional development can include:

- traditional CPD
- QIA
- significant events
- reflecting on feedback from patients and colleagues, including complaints and compliments.

You should avoid unnecessary duplication. Once you have demonstrated sufficient CPD to keep up-to-date across your whole scope of practice you do not need to write additional reflective notes. You should not stop learning, and reflecting on what you learn, but we recommend that you stop documenting in detail what you have learned and reflected on, unless it is important to you.

## 7.2. Myth: I must do at least one clinical audit in the five-year cycle

Clinical audit is not a revalidation requirement, but it can form part of quality improvement activities or projects.

For the purposes of revalidation, the GMC requires that all doctors demonstrate that they regularly participate in activities that review and evaluate the quality of their work.

We used to recommend that you should complete two examples of reflection on your significant event analysis or reflective case review every year and a formal two cycle audit once in five years. If you continue to do this, you will still meet the GMC requirement to demonstrate reflection on review of your work.

After getting feedback that that this recommendation was too restrictive, we have broadened our recommendation. We now recommend there are many different types of quality improvement activity, other than audit, that are equally acceptable as QIA. You should show that you have:

- thought about the quality of care you provide
- reviewed your care in the context of current guidance on good practice
- made changes where necessary or appropriate to improve the quality of care you provide
- celebrated where there are no changes that you need to make
- revisited the question to see if the changes have made an improvement.

It is important that you routinely review the effectiveness and appropriateness of the care that you provide to keep patients safe. Demonstrating that this is a professional habit is a matter of choosing examples that show what you do and how you do it. You do not need to document every review of your work that you do.

Depending on your circumstances, different quality improvement tools are helpful including:

- reflective case review
- significant event analysis
- review of personal outcome data

- search and do
- plan, do, study, act
- clinical audit.

You may wish to plan your quality improvement activities for the coming year with your appraiser and include them in your PDP. If you are aware that what you are planning as a quality improvement activity is unusual, you should discuss it with your appraiser and agree it with your responsible officer before including it.

### 7.3. Myth: I must do all my QIA myself

You do not need to do all the background work and data collection or analysis for your quality improvement activity yourself.

Delegating someone else to run a search, or do some of the research, is a reasonable and proportionate use of your time. We recommend that you select QIA that allow you to review what you do. Your personal reflective notes should include an explanation about your role in the quality improvement activity and a description of the findings, including any lessons you have learned and the impact they have had on the quality of care that you provide.

GPs work in teams and much of the quality improvement activity that it is important for us to reflect on arises from teamwork. Significant event analysis in primary care is a team activity. You can learn from the review of cases, data, incidents or events, or from feedback, and we recommend that you try to learn from the mistakes and near misses of others.

The questions to ask yourself are about what you have learned about the quality of the care you provide and what, if any, changes you should make as a result.

### 7.4. Myth: There are specific types of QIA that I must include

You do not have to include any specific type of quality improvement activity but you must reflect on the quality of your practice and how you meet the requirements of **Good Medical Practice** (GMP).

The GMC requirements are sufficiently broad to recognise all activities that allow you to review what you do. We recommend that where you maintain a clinical skill, such as IUS insertion or minor surgery, you keep a log of your personal outcome data. You can then reflect on this at least once in the revalidation cycle to demonstrate the appropriateness of the quality of care you are able to provide in these areas. We recognise the value of reflective case review and significant event analysis as useful QIA but no longer recommend that you include two every year. Similarly, we recognise the value of clinical audit but no longer recommend that you should include one two cycle audit every five years. There are many other types of QIA that may be equally, or more, appropriate for your circumstances, which will also meet GMC requirements.

Where your organisation provides you with clinical governance data about your practice, or there is a national clinical audit to which you contribute, which allows you to benchmark your work, it is appropriate to include this information in your portfolio of supporting information and reflect on what you have learned from the results and any changes you will make as a result.



## 8. Significant Events



So no significant events apart from the angry toddler?

**8.1. Myth: GMC significant events are the same as GP significant events**

**8.2. Myth: I must include two significant events every year**

## 8.1. Myth: GMC significant events are the same as GP significant events

The GMC definition of a significant event is not the same as that commonly used in primary care. The GMC says:

*'A significant event (also known as an untoward or critical incident) is any unintended or unexpected event, which could or did lead to harm of one or more patients. This includes incidents which did not cause harm but could have done, or where the event should have been prevented.'*<sup>2</sup>

The GMC requires you to declare and reflect on those significant events in which you have been personally named or involved and in which a patient or patients could have or did come to harm in the Significant Event section of the portfolio. This means that significant events that meet the GMC threshold of harm must be included and reflected on at your appraisal.

There is no limit to the number of such significant events that you must include. However, if you have had no significant events that meet the GMC threshold of harm, you should declare that in the relevant sign-off statement.

We recommend that you do not use the Significant Event section of your portfolio to record GP significant events. These are essentially any event, positive or negative, that has triggered a learning process for you or your team. They should be reflected on and included as quality improvement activities, where you are demonstrating your learning from events in your scope of practice.

## 8.2. Myth: I must include two significant events every year

There is a very wide range of possible types of quality improvement activity (QIA) that can be used to demonstrate review of work, not just significant event analysis.

We previously recommended that GPs should include two detailed case reviews or significant event analyses every year as an easy way to demonstrate review of work. This was sometimes misinterpreted as a requirement, rather than a recommendation. While significant event analysis is still an entirely acceptable way of demonstrating review of practice, our current recommendation is that there are many other types of QIA that may be included as supporting information.

In some areas, such as Northern Ireland and Scotland, the appraisal policy (and the electronic platform) still includes a requirement to include two significant event analyses. These should be seen as quality improvement activities, not as implying that GPs in these areas have more significant events that reach the GMC level of harm than GPs elsewhere. We recommend that you ensure you are aware of the requirements of your local appraisal policy in this area.

All GPs must ensure that they include all significant events that do reach the GMC threshold of harm. The GMC says:

*'A significant event (also known as an untoward or critical incident) is any unintended or unexpected event, which could or did lead to harm of one or more patients. This includes incidents which did not cause harm but could have done, or where the event should have been prevented.'*<sup>3</sup>

<sup>2</sup> General Medical Council (March 2012), *Supporting information for appraisal and revalidation*, 9

<sup>3</sup> General Medical Council (March 2012), *Supporting information for appraisal and revalidation*, 9

## 9. Patient and colleague feedback



**9.1. Myth: I must use the GMC questionnaire for my patient and colleague feedback**

**9.2. Myth: All my patient and colleague feedback must meet the GMC requirements**

**9.3. Myth: I must do a patient survey every year**

**9.4. Myth: I must find other ways to get feedback from patients every year**

**9.5. Myth: There are RCGP approved colleague and patient feedback questionnaires**

## 9.1. Myth: I must use the GMC questionnaire for my patient and colleague feedback

The GMC questionnaires provide the template on which many appropriate patient and colleague feedback tools are now based. There is no GMC requirement to use the GMC questionnaires. They are not suitable for all patient or client groups, or accessible to all. There may be better tools for your circumstances, such as a very specific scope of practice or a hard to reach group.

The GMC has provided **guidance on developing, commissioning and administering patient and colleague questionnaires** as part of revalidation. You do not need to use a specific tool, but you should choose one that is appropriate to your patient population. It should be accessible to as many different types of patient across your scope of practice as possible. You should include feedback from at least the minimum number of patients required by the tool you choose to use. Patients must understand that their responses will be anonymous.

For example, you should not collect the responses yourself in such a way that patients think you might be able to read them, or choose only the best. One option is for them to be collected into a sealed box that is opened by someone else who passes them on to someone outside your own practice to collate. You may want to use a professional questionnaire company or service. The results should be externally collated into a report that gives you the feedback you need so that you can reflect on the results in preparation for your appraisal.

## 9.2. Myth: All my patient and colleague feedback must meet the GMC requirements

You will have many sources of patient and colleague feedback, both unsolicited and formally requested. **The guidance** the GMC has on developing, commissioning and administering patient and colleague questionnaires specifically applies to the solicited patient and colleague feedback which is required once in the five-year revalidation cycle. Other feedback does not have to meet this guidance. Some of the most compelling feedback is not anonymous.

Some GP roles do not have enough patients or colleagues to meet the numbers required by the feedback tools. Including representation from across the whole of your scope of practice in one survey can sometimes work and provide helpful feedback but some roles are so different that this may make the results hard to interpret. We recommend that feedback is sought across the whole of your scope of practice in ways appropriate to each context and recognise that sometimes this means that some feedback will not meet the GMC requirements.

The main solicited patient and colleague surveys from your clinical work, normally undertaken once every five years, should be GMC compliant. Other feedback does not need to be GMC compliant. You should make sure that any feedback included in the portfolio is appropriately anonymised, which will involve presenting data that is difficult to anonymise separately to your appraiser, or redacting it if you wish to include it. The priority is to include your reflections on the feedback, any lessons you have learned and any changes you intend to make as a result, in your portfolio.

If you are in any doubt about the best way to collect and reflect on feedback you should seek advice and support from your appraiser at an early stage.

### 9.3. Myth: I must do a patient survey every year

You only have to do one fully GMC compliant patient survey in the five-year revalidation cycle, like all other doctors. GPs are not required to do additional GMC compliant solicited patient surveys for revalidation.

There are many other sources of feedback from patients. You should reflect on your relationship with your patients during every appraisal.

### 9.4. Myth: I must find other ways to get feedback from patients every year

We recommend that GPs, who have many patient contacts every day, should reflect on their relationship with their patients during every appraisal. You are not required to do additional patient surveys or actively seek feedback every year.

Patients have told us that they expect you to reflect on all the sources of feedback that already exist, not that you should do more surveys than other doctors. You should take the opportunity once a year at your appraisal to discuss your reflections on your relationship with your patients and any feedback that you have had during the year. This can be from:

- informal unsolicited comments or cards
- formal feedback from 'Friends and Family' or the national patient survey
- complaints or compliments.

You are not expected to do any extra work in actively seeking additional feedback, unless you want to seek targeted feedback on a specific area.

### 9.5. Myth: There are RCGP approved colleague and patient feedback questionnaires

We stopped recommending any particular questionnaires several years ago.

In the past, there was an attempt to collate a list of questionnaires that met the GMC standards and were appropriate for GPs to seek feedback on their performance. It proved impossible to keep up with the development of more and more questionnaires, or to avoid the appearance of bias, and so this has not been maintained for some time.

The GMC are clear that it is important to choose a tool that is appropriate for the type of feedback that you are seeking and the people that you are asking and set out some principles for the choice of questionnaire. The review by Sir Keith Pearson points out how essential it is to reach the 'hard to reach' groups and to seek meaningful feedback from all patients. Including those who cannot access written forms.

We recommend that you choose the most appropriate colleague and patient feedback tools for your circumstances. You are advised to review the GMC standards for such tools and agree, in advance, with your appraiser or responsible officer that they are happy to accept your choice.



# 10. My Personal Development Plan (PDP)



You know the worst thing is when you stop believing in yourself.

**10.1. Myth: My personal development plan must include...**

**10.2. Myth: My personal development plan cannot include...**

**10.3. Myth: I must have a set number of PDP or clinical PDP goals**

### 10.1. Myth: My personal development plan must include...

There is nothing that the GMC requires your personal development plan (PDP) to include.

Your goals should be taken from your appraisal as an individual and your specific needs. The GMC requires you to make progress with your PDP each year or explain why that has not been possible. They require you to reach agreement with your appraiser on a PDP for the coming year based on your appraisal portfolio and discussion. Your PDP should be:

- personal
- developmental
- a plan for the future.

It should meet your needs in the context within which you work. We recommend that you develop SMART (Specific, Measureable, Achievable, Relevant and Timely)<sup>4</sup> goals with your appraiser.

Performance objectives should be part of job planning and not necessarily part of your appraisal and revalidation PDP unless you wish to include them. It often helps to work out how you can demonstrate that a change you plan as one of your PDP goals has made a difference by considering what the impact on patients will be.

### 10.2. Myth: My personal development plan cannot include...

The only PDP goals that are inappropriate are ones that are flippant, not specific to you, or irrelevant to your needs.

Your appraiser is trained to help you work out how to write your PDP so that it is a professional record of your personal development planning for your needs. The PDP goals should be balanced across the five-year cycle and across your whole scope of practice.

Goals around being a good role model for patients and maintaining your personal health and wellbeing in a period of great pressures on the healthcare system are entirely appropriate. It is not appropriate to include non-specific goals in your PDP that could apply to any doctor and do not apply to your personal needs. Your goals should not normally be part of what everyone is required to do to be fit to practise. These goals should be re-framed and described in more specific terms so that you can demonstrate:

- where they have arisen
- why they apply to you now
- how you will achieve them
- how you will demonstrate that your goal has been met
- that achieving the goal will make a difference.

### 10.3. Myth: I must have a set number of PDP or clinical PDP goals

The GMC requires you to agree a new PDP each year that reflects your needs as defined by the portfolio of supporting information and the appraisal discussion. This is a matter for agreement between you and your appraiser.

<sup>4</sup> Doran, G. T. (1981). *There's a S.M.A.R.T. way to write management's goals and objectives*. Management Review, 70(11), 35-36

There is no GMC requirement about the number of PDP goals you should include or if those goals are clinical or non-clinical. Some doctors like to record lots of PDP items; it is your PDP. Most doctors find three or four PDP items are sufficient to capture their priority goals. You could have one very big objective that you have broken down into separate interim or smaller goals.

While it would be normal to include some clinical goals, you do not have a requirement to do so. If, for example, your main goal was becoming a GP trainer there might be no clinical objectives in a year.



# Glossary

AoMRC = Academy of Medical Royal Colleges

CPD = Continuing Professional Development

Formative = a developmental assessment to promote quality improvement by facilitating reflection and providing feedback to help in identifying strengths and weaknesses and making plans to target areas for development. Formative interventions are context specific and used in an educational way, to facilitate improvement over time, although they may include the learning from summative assessments (see below)

FSRH = Faculty of Sexual and Reproductive Healthcare

GMC = General Medical Council

PDP = Personal Development Plan

QIA = Quality Improvement Activities

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

RCGP recommendation – based on the **RCGP Guide to Supporting Information for Appraisal and Revalidation (March 2016)** and calibrated with other stakeholders prior to publication of this 'Mythbusters' paper

Summative = an end point assessment against an external standard to provide a point score or pass/fail result. Note: Summative assessments can be used formatively to give feedback on performance that helps to promote further development (see also formative above)

Undifferentiated primary care = Providing the full range of general medical services and treating all patients in a primary care setting without prior restriction in the type of presenting complaint

