



Royal College of
General Practitioners

**THE
RCGP GUIDE
TO THE
REVALIDATION
OF
GENERAL
PRACTITIONERS**

**VERSION 9.0,
SEPTEMBER 2014**



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The Royal College of General Practitioners was founded in 1952 with this object:

'To encourage, foster and maintain the highest possible standards in general practice and for that purpose to take or join with others in taking steps consistent with the charitable nature of that object which may assist towards the same.'

Among its responsibilities under its Royal Charter the College is entitled to:

'Diffuse information on all matters affecting general practice and issue such publications as may assist the object of the College.'

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Please note: this document is intended as the definitive guide to revalidation for general practitioners. It is continually evolving in the light of policy decisions from the General Medical Council, Departments of Health and the Academy of Medical Royal Colleges. If you wish to refer to it, we strongly recommend that you download the document from the RCGP website where the latest version will be posted.

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Later editions of the guide were developed in line with the GMC's *Supporting Information for Appraisal and Revalidation* guidance and the Academy of Medical Royal Colleges' *Supporting Information for Appraisal and Revalidation: core guidance framework*. NHS England's Medical Appraisal Guidance (MAG) should be considered an essential adjunct to this guide, as should equivalent guidance to MAG in the devolved nations.

We would like to acknowledge the input of the RCGP Specialty Advisers in the development of this ninth version of the guide, and that of a number of stakeholders, particularly the BMA General Practitioners Committee (and Sessional GP Subcommittee), Dr Di Jelly and Dr Paula Wright of the Northern Deanery and the RCGP Clinical Innovation and Research Centre (CIRC).

We would also like to thank individual GPs who have contacted us with questions, comments and concerns, and helped develop the guide around developing information needs.

REVALIDATION SUMMARY

Revalidation is the process by which licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practise. Revalidation aims to give extra confidence to patients that their doctor is being regularly checked by their employer and the General Medical Council (GMC).

Revalidation started in December 2012. By March 2016 it is expected that the majority of licensed doctors will have been revalidated for the first time. In most circumstances, licensed doctors will revalidate at five-year intervals after their first revalidation (see www.gmc-uk.org/doctors/revalidation/9611.asp).

This section summarises what most GPs need to know for their revalidation.

- ➔ You will have been licensed to practise by the GMC. For established doctors these licences were issued in November 2009.
- ➔ Most licensed doctors have a connection with one organisation that provides them with a regular appraisal and helps them with revalidation. This organisation is called a 'designated body'. Each designated body has a responsible officer who will make a recommendation about you to the GMC – normally every five years after your first revalidation – that you are up to date, fit to practise and should be revalidated.

- If you are on an NHS Performers List, your designated body is the UK primary care organisation (PCO)¹ that manages the list you are on.²
- If you are a GP in England working in the NHS, your designated body is NHS England and your responsible officer is based in one of the 27 Area Teams.³
- If you are not working in an NHS PCO, you are likely to have a connection to one of a number of non-NHS designated bodies. The GMC provides a list of designated bodies.⁴
- If you do not know your designated body, you should use the GMC's online help tools in the first instance and contact the GMC if you are still unclear.⁵
- If you are in training in Scotland, your designated body is NHS Education for Scotland. If you are training in Wales or Northern Ireland, your designated body is your postgraduate deanery. If you are training in England, your designated body is one of the 13 Local Education and Training Boards (LETBs), e.g. Health Education North West. Your revalidation recommendation will be made by your postgraduate dean based upon your training activities and Annual Review of Competence Progression (ARCP) submissions. You do not need to collect additional supporting information.
- A small number of GPs will not have a connection to a designated body. You should use your GMC Online account (or set up an account if you do not have one) to inform the GMC that you do not have a connection to a designated body.⁶ The GMC can

1. The acronym PCO is used throughout this document to denote NHS Area Teams in England, NHS Boards in Scotland, Health and Social Trusts in Northern Ireland and NHS Health Boards in Wales.

2. The exception would be if you are on an NHS Performers List but the majority of your practice is with the armed forces, in which case your designated body would be the service that you practise in, either the Army, Royal Air Force or Navy. Similarly, GPs who spend the majority of their time working for the Foreign and Commonwealth Office (FCO) would have a prescribed connection to that organisation.

3. As above, this would not apply if the majority of your practice was with the armed forces or FCO.

4. www.gmc-uk.org/help/list_of_designated_bodies.htm

5. www.gmc-uk.org/doctors/revalidation/designated_body_tool.asp

6. www.gmc-uk.org/doctors/information_for_doctors/gmc_online.asp

accept recommendations about doctors who can demonstrate that they do not have connection to a designated body from an approved 'suitable person', somebody who performs the same function as a responsible officer in respect of revalidation.⁷ If a GP wishes to maintain his or her UK licence to practise and is unable to establish a connection to a suitable person, the GP may be able to revalidate directly with the GMC.⁸

- ➔ If you wish to keep your licence but do not have a designated body or approved suitable person, you will need to provide the GMC with robust evidence that you are up to date and fit to practise. The GMC needs this evidence, in the absence of any assurance from the governance systems overseen by responsible officers or approved suitable persons, to enable them to make a decision about whether you should retain your licence.
- ➔ All doctors with a licence to practise are required to participate in revalidation. Doctors who are working wholly outside of the UK should consider relinquishing their licence in line with GMC guidance.⁹
- ➔ The GMC will have given you a date for your first revalidation. If you have not received a date, then you need to contact the GMC.
- ➔ In order to recommend you for revalidation your responsible officer will need to be satisfied that:
 - ➔ you have participated in an annual appraisal process that has covered your full scope of work; and that you and your appraiser have signed off appraisals that have had *Good Medical Practice* as their focus since the start of revalidation in December 2012

7. www.gmc-uk.org/doctors/revalidation/20386.asp

8. www.gmc-uk.org/doctors/revalidation/23523.asp

9. www.gmc-uk.org/Revalidation_FAQs_for_overseas_regulators_and_overseas_organisations___DC5322.pdf_54464136.pdf

TABLE 1 Summary of supporting information recommended for appraisals before your revalidation date

<i>Supporting information</i>	<i>Quantity</i>
<i>General information</i>	
Personal details	At a minimum, relevant to the period from December 2012
Scope of your work	
Record of annual appraisals	
Personal Development Plans	
Probity declaration	
Health declaration	
<i>Keeping up to date</i>	
Continuing professional development	50 learning credits representative of the scope of practice, including reflection – and ideally with evidence of implementation of learning such as the impact on your practice, each year from the start of revalidation in December 2012
<i>Review of your practice</i>	
Annual quality improvement activity – to include: significant event analyses/individual case reviews	At least two quality improvement activities are required each year. These can be significant event analyses ¹⁰ /individual case reviews in which you have had a personal involvement. The GMC requires ALL significant adverse events to be included in your revalidation portfolio. Must be relevant to scope of work
quality improvement project	Once per revalidation cycle and could be a full clinical audit with second data collection or a quality improvement project with evaluation of impact (see 'Review of practice' section). Must be relevant to scope of work
<i>Feedback on your practice</i>	
Colleague feedback	One of each in the five years before your revalidation recommendation; and each must be relevant to the scope of your work at the time of revalidation and include reflection on the core learning points. After their first revalidation, doctors may consider collecting colleague and patient feedback in the first three years of the cycle to allow time for follow-up questionnaires if issues are identified
Patient feedback	
Formal complaints	A description of any formal complaints (i.e. complaints that have activated a practice or organisation's complaint procedure) and your response to them in the period since December 2012

10. In the GMC document *Supporting Information for Appraisal and Revalidation*, the term 'significant events' refers to critical or serious untoward incidents in a secondary care setting. It is clarified, however, that in general practice 'significant event analysis' is used to describe case reviews (as described in an earlier section of that document) and is used to illustrate events that may not have a serious outcome but highlight issues which could be handled with greater clinical effectiveness and patient safety, and from which lessons could be learnt.

- you have brought to your appraisals appropriate supporting information (see below)
- there are no unresolved concerns about your performance as a doctor.
- If your appraiser thinks that your eligibility for revalidation is in doubt, he or she should seek advice from your responsible officer so that things can be put right if possible; revalidation is a continuous process, not a high-stakes examination at a fixed point in time.
- When your date for revalidation comes due, your responsible officer can recommend to the GMC that your licence is continued (in other words that you are revalidated); that the decision is deferred; or that it is impossible to make a recommendation because you have not engaged with the process. A responsible officer can notify the GMC that a doctor is not engaging with the revalidation process at any time; he or she does not need to wait until a doctor's recommendation is due.
- The vast majority of doctors will be recommended for revalidation and the GMC (which makes the final decision) will continue your licence; you will then be told when you will need to be revalidated again – usually after a further five years.

All these points are covered in more detail in the rest of this guide, as is advice for GPs who work in a variety of contexts.

KEY THINGS TO DO NOW

- ➔ Ensure that you have a responsible officer or suitable person – if not, inform the GMC.¹¹
- ➔ Ensure that your annual appraisals are conducted properly with *Good Medical Practice* as their focus.
- ➔ Use an electronic portfolio or (for GPs based in England) a Medical Appraisal Guide (MAG) Model Appraisal Form to collect your supporting information for appraisal and revalidation.
- ➔ Record your continuing professional development (CPD) and Personal Development Plan (PDP) objectives and outcomes.
- ➔ If you haven't participated in patient and colleague feedback surveys that are relevant to your current scope of practice within the five-year period prior to your first revalidation date, plan to do them.
- ➔ Ensure that you are participating in annual quality improvement activity, providing significant event analyses/individual case reviews each year.
- ➔ If you haven't completed a two-cycle clinical audit or quality improvement project since April 2011, plan to do one.

11. www.gmc-uk.org/doctors/information_for_doctors/gmc_online.asp

HOW REVALIDATION WORKS

BACKGROUND

The General Medical Council (GMC) introduced licences to practise in November 2009. All registered doctors were given the opportunity to request a licence to practise; all doctors eligible for registration with the GMC since November 2009 have also been licensed. From its introduction, the GMC licence rather than GMC registration signifies to patients that a doctor has the legal authority to write prescriptions and sign death certificates etc. GPs working in the NHS, either on a permanent or locum basis, will need to be:

- licensed by the GMC
- listed on the GMC's General Practice Register
- included on an NHS Performers List.

Only licensed doctors are subject to revalidation. In common with all doctors, GPs need to demonstrate that they are up to date and fit to practise in order to maintain their licence to practise. This is achieved through a process called revalidation, for which GPs provide supporting information that shows that they are keeping up to date and remain fit to practise.

Revalidation is not concerned with the GMC's Specialist or General Practice Registers, only the doctor's licence. This means that GPs who are no longer in active clinical general practice but who are active as doctors (for example those in medical management, occupational health or doing referral surgical procedures) will continue to be on the General Practice

Register, but will be revalidated for what they do.

In order for doctors to maintain their licence to practise they are expected to have annual appraisals based on the General Medical Council's (GMC) core guidance for doctors, *Good Medical Practice*.¹² Revalidation involves a continuing evaluation of doctors' fitness to practise and is based on appraisal and local systems of clinical governance.

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

- ➔ *Good Medical Practice*¹³
- ➔ *Good Medical Practice Framework for Appraisal and Revalidation*¹⁴
- ➔ *Supporting Information for Appraisal and Revalidation*.¹⁵

For doctors in England, the GMC guidance should be read in conjunction with NHS England's Medical Appraisal Guide (MAG) document, which is designed to help doctors understand what they need to do to prepare for and participate in annual appraisal. Equivalent guidance to MAG exists in the devolved countries of the UK, including the *Scottish Guide to Medical Appraisal* in Scotland and the *All Wales Medical Appraisal Policy* in Wales.

The RCGP has the responsibility to support the above documents with specialty-specific guidance for GPs and to give advice to responsible officers on the interpretation of our guidance. All royal colleges and faculties have agreed a core set of supporting information for revalidation,¹⁶ and GPs are not being asked for any more or any less than other doctors.

There may be occasions when a primary care organisation (PCO) asks for more supporting information than is specified

12. www.gmc-uk.org/guidance/good_medical_practice.asp

13. As above.

14. www.gmc-uk.org/doctors/revalidation/revalidation_gmp_framework.asp

15. www.gmc-uk.org/doctors/revalidation/revalidation_information.asp

16. www.aomrc.org.uk/revalidation/speciality-frameworks-and-speciality-guidance.html

in this guide. PCOs can request additional information for local and contractual reasons (e.g. CPR or safeguarding), but it is not acceptable for your PCO to request additional information for the purposes of revalidation.

CHANGES IN THIS NINTH EDITION OF THE RCGP GUIDE TO REVALIDATION

The key changes to this version (Version 9.0) of the guide are as follows:

- ➔ the document seeks to address variations in process between the four countries of the UK
- ➔ this version of the guide explains the function of 'suitable persons' and the 'alternative route to revalidation' in relation to those GPs without a prescribed connection to a designated body who wish to maintain their licence to practise
- ➔ the concepts of *fit to practise* (i.e. what is required by the GMC to hold a licence to practise) and *fit for purpose* (i.e. what might be required by an employer for contractual reasons, but not necessarily for the purposes of revalidation) are described
- ➔ the patient and colleague feedback process is described in more detail
- ➔ following the introduction of GMC guidance on the development, administration and commissioning of questionnaires, the Royal College of General Practitioners (RCGP) is no longer recommending specific patient and colleague feedback questionnaires for use in revalidation
- ➔ the 'Review of practice' section has been expanded, with particular attention on definitions of various quality improvement activity
- ➔ GPs are discouraged from 'double counting' by

- including activity recorded elsewhere in their portfolio in their 50 annual learning credits
- links are provided to a number of new RCGP and external resources.

YOUR POSITION IN 2014

All doctors undertaking clinical work in the UK must hold a GMC licence and will in most cases have a connection to a responsible officer (or suitable person). In addition, all those GPs working in the NHS must be on a Performers List and be on the GMC's General Practice Register. Doctors in non-clinical practice may be required to have a licence depending on the employment requirements of their organisation. If you do not have an attachment to a designated body and responsible officer, the GMC will advise you on your options.

If you are not currently working in the UK but start to do so in the future, you will need to establish a connection to a responsible officer or suitable person at the time you start working here. If you have had a prolonged break from UK practice, you will be required to work in an Approved Practice Setting¹⁷ (which effectively means a designated body, such as an Area Team or Health Board) until the point of your first revalidation. Your prospective responsible officer can clarify arrangements with you. Further information can be found in the 'GPs taking a break from UK practice' section of this document.

If you are not working in the UK, the GMC would recommend that you consider giving up your licence until you return to the UK. You can however choose to remain on the GMC's register, although that does not give you the rights of a doctor, such as prescribing. When you wish to return to work as a doctor in the UK, you will need to re-apply to the GMC for your licence to practise – you are entitled to a licence on

17. www.gmc-uk.org/doctors/before_you_apply/approved_practice_settings.asp

the basis of your qualifications unless there are unresolved concerns about your practice.¹⁸ Then you will need to establish a connection to a responsible officer or suitable person and participate in annual appraisal with an appraiser who is appropriately trained.

THE REVALIDATION TIMETABLE

The GMC has given all doctors a date for their revalidation. If you have not received your date, contact the GMC as soon as possible. In the first four months (December to March 2013) the responsible officers and other doctors in leadership roles were revalidated. The 'roll out' of revalidation started in April 2013 and the intention is that the majority of doctors will be revalidated for the first time by March 2016.

THE REVALIDATION PROCESS

You need to ensure that each of your annual appraisals covers the requirements for revalidation, and that you are sharing the required supporting information with your appraiser.

Your appraiser is key to your revalidation. Your appraiser reviews your supporting information with you and offers your responsible officer or suitable person reassurance that your supporting information and your reflection on it are appropriate.

Your responsible officer is required by law to deliver effective annual appraisals, clinical governance and revalidation oversight to the doctors within your designated body. Your responsible officer will need to be continuously satisfied that there are no unresolved concerns about your practice or that if there are any concerns they are being managed appropriately.

18. www.gmc-uk.org/doctors/registration_applications/relinquish_options.asp

Similarly a suitable person must ensure that doctors for whom they are approved have access to annual appraisal and that appropriate systems are in place to provide the information they need to make a revalidation recommendation.

The responsible officer or suitable person should not wait until your revalidation date to act on any concerns. Rather, any concerns should be addressed as soon as they become apparent. Revalidation is a continuous process to protect the public and promote better practice, not a once in five years test.

However, your responsible officer or suitable person is required to make a revalidation recommendation to the GMC when your revalidation date becomes due. He or she will recommend revalidation if your appraiser and you have signed that your appraisal has been properly conducted and if there are no unresolved local concerns about your performance.

When your responsible officer or suitable person makes a positive recommendation to the GMC, the GMC will check their files and, provided they have no concerns, will normally revalidate you. However, it is important to note that the definitive revalidation decision lies with the GMC, not your responsible officer or suitable person.

Your responsible officer or suitable person will have two other choices concerning your revalidation. In addition to a positive recommendation, he or she can request a deferral of the recommendation because there is a need for more information (e.g. after a period of sick leave or maternity leave) or the completion of a local performance process. He or she can also notify the GMC that you have failed to engage in the local processes and systems, such as appraisal, that support revalidation. A responsible officer or suitable person can notify the GMC of a doctor's non-engagement at any point in the revalidation cycle.

HOW YOU SHOULD COLLECT AND STORE YOUR SUPPORTING INFORMATION FOR REVALIDATION

Although some GPs still present information to their appraiser on paper, most are now submitting their appraisal information electronically and storing their supporting information in an electronic portfolio or form. There are a number of resources available for GPs to store and submit their appraisal revalidation, including the Clarity & RCGP Appraisal Toolkit for GPs,¹⁹ NHS England's MAG Model Appraisal Form (for GPs in England) and other commercial toolkit providers. It should be noted that GPs in Scotland are required to use the Scottish Online Appraisal Resource (SOAR) system²⁰ and GPs in Wales are required to use the Medical Appraisal and Revalidation (MARS) system.²¹ The RCGP and the British Medical Association (BMA) General Practitioners Committee (GPC) have agreed that GPs should have a choice of the portfolio they use (if they have chosen to use one), as long as the resource used facilitates the storing, submission and receipt of the information required by the GMC for appraisal and revalidation.

SCOPE OF WORK

Licensed doctors must provide supporting information that covers the full scope of their work. The GMC describes six types of supporting information that doctors are expected to provide and discuss at their appraisal:²²

- ➔ continuing professional development
- ➔ quality improvement activity
- ➔ significant events

19. <https://appraisals.clarity.co.uk>

20. www.appraisal.nes.scot.nhs.uk/

21. <https://medical.marswales.org/>

22. www.gmc-uk.org/doctors/revalidation/revalidation_information.asp

- ➔ feedback from colleagues
- ➔ feedback from patients
- ➔ review of complaints and compliments.

With the exception of patient surveys for those who do not see patients,²³ doctors are expected to provide the information listed above and all portfolios have to reflect the circumstances and context in which a doctor works, including extended roles (described in more detail in the 'General information' section of this guide). The requirement to ensure that a doctor is up to date and fit to practise is the same for all doctors and the overall standard must be the same. However, the particular role of the doctor must be taken into account when deciding the precise nature of his or her supporting information. In all cases supporting information must meet the underlying attributes that each area of supporting information is intended to demonstrate.

General practice is a heterogeneous professional group including, among others, GP partners, locums (some highly peripatetic), sessional and employed doctors, GPs in secure environments, out of hours GPs (and those working in similar clinical contexts such as in walk-in centres), GPs in the Defence Medical Services, private GPs and GPs who work in very remote or small practices. Additionally, many GPs have portfolio careers and work in a variety of contexts. This guide seeks to reflect the diverse nature of general practice in later sections; these address specific supporting information requirements. Additionally, the RCGP has developed a selection of example portfolios that demonstrate how GPs in a diverse range of roles can demonstrate that they are meeting the requirements for revalidation.²⁴

23. The GMC recommends that doctors think broadly about what constitutes a 'patient' in their practice. If a doctor does not see patients they may consider collecting feedback from other sources, such as families and carers.

24. Available from: www.rcgp.org.uk/revalidation-and-cpd/new-revalidation-guidance-for-gps.aspx

NON-CLINICAL GPs

Non-clinical GPs are a small but important group, especially prevalent in NHS management, academic practice and independent healthcare systems. These doctors must be in good standing with the GMC in order to undertake the work they do, but they may not be in active clinical practice for significant periods of time. If the doctor does any clinical work in the NHS they will need to meet the Performers List requirements and demonstrate that they are up to date and fit to practise in their clinical role.

Non-clinical GPs will submit a portfolio to their responsible officer or suitable person that demonstrates that they are fit to undertake their non-clinical roles. This will include supporting information in all areas except patient surveys – although the GMC recommends that doctors think broadly about what constitutes a ‘patient’ in their practice (e.g. a GP educator may seek feedback from trainees or students). This will include evidence of satisfactory annual appraisal, PDPs agreed and reviewed, and evidence that they are keeping up to date in their area of practice. They should submit a colleague survey and a description of any cause for concern or formal complaint. They should provide a statement on probity and health, and documentation that meets the requirements of extended practice. For doctors who undertake very limited clinical work, they need to be able to demonstrate that they are up to date and fit to practise in the clinical component of their work with appropriate CPD, quality improvement activity and reflection. The Faculty of Medical Leadership and Management has produced *Supporting Information for Appraisal and Revalidation* guidance, which focuses on the leadership and management aspects of a doctor’s scope of practice.²⁵ Non-clinical GPs may find this guidance helpful.

25. www.fmlm.ac.uk/leadership-landscape/challenges-ahead/revalidation/revalidation-guidance

GPs WORKING PART TIME

Part-time general practitioners need to maintain their skills at the same level as their full-time colleagues. They will normally be expected to submit a full portfolio, with any notes relating to special circumstances that have affected the amount of information collected, such as maternity leave or ill health, being recorded in their revalidation portfolio.

GPs TAKING A BREAK FROM UK PRACTICE

Doctors who continue to hold a licence to practise while working overseas and outside a UK designated body need to revalidate if they wish to keep their licence. They need to remain connected to a governed system in the UK (usually a designated body) that will support them in their appraisal and revalidation. Alternatively, they must provide evidence directly to the GMC on an annual basis so that the GMC can decide whether they can retain their licence.^{26,27}

Doctors who do not undertake any work in the UK should consider whether to relinquish their licence to practise.²⁸ Such doctors can remain registered without a licence while overseas, indicating that they are in good standing with the GMC. When the doctor plans to return to UK practice he or she can apply for his or her licence to be restored – the licence is an entitlement based on qualifications provided there are no unresolved concerns. The GMC may, however, require the doctor to be revalidated within, for example, two years of his or her return. It is important that doctors provide the GMC with up-to-date contact details at all times.

Usually, supporting information for revalidation will be collected within the context of the NHS or a UK designated

26. www.gmc-uk.org/Revalidation_FAQs_for_overseas_regulators_and_overseas_organisations__DC5322.pdf_54464136.pdf

27. www.gmc-uk.org/doctors/revalidation/23523.asp

28. www.gmc-uk.org/doctors/registration_applications/relinquish_licence.asp

body, such as the Defence Medical Services, because the privileges implied by the licence to practise only apply to practice in the UK. However, ultimately the responsible officer or suitable person will make a decision as to whether supporting information collected outside a UK setting can be relied upon for the purposes of revalidation. For a minority of doctors who choose to maintain their licence while overseas and revalidate directly with the GMC, the GMC will make a judgement on the appropriateness of the evidence presented to them.

It is recognised that some doctors have roles that require them to work overseas for some periods in the revalidation cycle. We would advise that such doctors discuss their revalidation with their responsible officer or suitable person and appraiser. Doctors should, where possible, maintain their continuing professional development (CPD) while working abroad and keep up to date with developments in UK practice, including new guidelines, as this will help them on their return.

The restoration of a doctor's licence will indicate that he or she is *fit to practise* in the UK. However, if a returning doctor then wishes to be entered on a Performers List and start working as a general practitioner in the NHS, the PCO may want evidence that the doctor is *fit for purpose*. In reality this would normally mean that, after a sustained absence from clinical general practice in the UK, a doctor would require an assessment that may indicate the need for a targeted re-entry educational experience before returning to clinical general practice. If a GP has been working in, for example, New Zealand as a GP, his or her re-entry education may be solely to re-familiarise that doctor with the UK health service, such as evidence-based clinical guidelines, pathways and referrals, and safeguarding vulnerable people.

The arrangements for re-entry to general practice in the NHS in England are detailed in NHS England's national primary care Performers List standard operating procedure. At present, if a doctor has not been in UK clinical practice for two years or more and wishes to enter a Performers List, a re-entry needs assessment is standard practice. Your responsible officer can provide more information about needs assessments and local arrangements regarding the induction and returner scheme. It is the duty of the doctor to ensure that he or she is safe to return to UK general practice, whether following work overseas or for other reasons, and responsible officers must establish systems to evaluate and support doctors to ensure their safe return to the workplace.

It should be noted that there are variations in approach to returners between the four countries of the UK. For information about returners processes in Wales, Scotland and Northern Ireland GPs are encouraged to contact the Wales Deanery, NHS Education for Scotland and the Northern Ireland Medical and Dental Training Agency (NIMDTA) respectively.

There are many doctors who will be absent from UK clinical general practice for periods of two years or less due to pregnancy, illness, career breaks, sabbaticals, working abroad or taking on non-clinical roles. The revalidation process is designed to be flexible and accommodate these circumstances. If a GP is seeking entry onto an NHS Performers List, a responsible officer will consider any portfolio submitted but may make a decision to defer revalidation until he or she feels there is sufficient supporting information. The responsible officer may consider:

- ➔ the environment in which the GP has worked and whether the supporting information of clinical governance and annual appraisal from that environment can be relied upon

- ➔ the GP's learning credits both over the revalidation period and within each appraisal year
- ➔ the supporting information of annual appraisal, annual Personal Development Plan (PDP) and PDP review
- ➔ supporting information relating to feedback from colleagues and patients
- ➔ any assessment of clinical skills or knowledge
- ➔ any outcome from a re-entry programme.

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

GP REGISTRARS WHOSE LICENCE BECOMES DUE FOR RENEWAL

The introduction of revalidation means that the Postgraduate Dean, as responsible officer, will be in receipt of any relevant information about trainees that reside with their employing organisations(s). Through the use of an enhanced Form R, this information is available to the Annual Review of Competence Progression (ARCP) panels so that any issues or concerns can be recorded and monitored. The majority of GP trainees will revalidate at the point of Certificate of Completion of Training (CCT) via their final ARCP panel.²⁹ Full engagement with the General Practice Specialty Training (GPST) curriculum and assessments will suffice. In most cases, GPs will revalidate five years after CCT. If, however, a doctor takes longer than five years to complete training from the point that he or she is licensed, the Postgraduate Dean would (in most cases) make a recommendation to the GMC prior to the completion of CCT and again at completion of CCT.³⁰

29. In order to accommodate changes in the CCT date, revalidation occurs approximately 60 days following CCT.

30. www.gmc-uk.org/doctors/revalidation/12383.asp

ORGANISATIONAL AND PEER SUPPORT

One key aspect for peripatetic locums and doctors who work in out of hours services or in walk-in centres is the frequent absence of organisational and peer group support. The employers of GPs who work as locums or in out of hours services have a responsibility to include all doctors working for them in educational activities. They also need to share their own quality assurance processes with the GPs they employ. An example of this is the audit of telephone consultations that out of hours providers should be carrying out. Information from this audit can be used by GPs in their professional development and as supporting documentation for revalidation.

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

- ➔ general practices, federations and out of hours organisations that frequently employ general practitioners on short-term, sessional contracts. These must recognise their responsibility to all their employees, including these doctors. They should inform and involve the doctor in any significant event or complaint that relates to them; they should facilitate access to the clinical records of patients treated by these doctors for the purposes of clinical audit and quality improvement; and they should support the conduct of patient surveys
- ➔ professional organisations that support the working lives and professional development of peripatetic locums are becoming more established. The National Association of Sessional GPs (www.nasgp.org.uk/) has developed the 'chambers' model through which

contracts, bookings, education and quality assurance are supported collectively by other locum doctors. Other organisations such as the North East Sessional GP Group (www.nesg.org.uk) act as an information forum in a specific area, advertising local educational events, running educational meetings and providing space for locums and practices to advertise. The GPC's Sessional GPs Subcommittee (<http://bma.org.uk/about-the-bma/how-we-work/negotiating-committees/general-practitioners-committee>) considers and reviews all matters affecting salaried and locum GPs, including revalidation, and provides regular updates

→ educational groups (locum groups, self-directed learning groups, etc.) have also developed. In these, doctors working outside supportive organisations in an area meet to share experience and to learn together. Additionally, for some peripatetic locums these groups may provide the only forum in which to discuss significant events with colleagues and explore learning opportunities from 'near misses' and adverse events. It may also be the main forum in which impact from learning can be demonstrated for GPs without organisational influence or managerial responsibility (who therefore cannot implement protocols or procedures in practices). Such educational groups may well be virtual if that works for the participants.

Although there are some circumstances in which such mechanisms are impractical, it is the view of the RCGP that all general practitioners need to consider how they achieve peer support to prevent professional isolation. For some this is a supporting practice; for others it may be a single-handed doctors' group, a new practitioners group, a chambers or an educational group. Doctors who work in professional

isolation miss out on many of the benefits of working in a team. They have fewer opportunities for peer support and to receive informal feedback, and fewer chances to exchange new information, which may make them feel disconnected from the profession and may make them more vulnerable to stress, exhaustion and burnout. Importantly, lack of opportunities to discuss day-to-day clinical work results in missed opportunities to ‘benchmark’ their practice against that of their peers – a key mechanism that operates informally among more connected doctors in maintaining standards. This may also lead to them finding it more difficult to identify areas in which they could improve their knowledge and care standards. One potential benefit of revalidation activities may be the encouragement of inter-professional linking and joint learning throughout the revalidation cycle.

SUPPORTING INFORMATION FOR REVALIDATION: OVERVIEW

As described in the GMC’s document *Supporting Information for Appraisal and Revalidation* and the Academy’s *Guidance on Supporting Information for the Revalidation of General Practitioners*,³¹ your supporting information, grouped into four main headings, is as described in Table 1 (see page 4).

It is important to note that, even in the first cycle of revalidation, the GMC expects responsible officers and suitable persons to be satisfied that supporting information has been seen at appraisal for all areas.

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

31. www.rcgp.org.uk/revalidation-and-cpd/~/_media/Files/Revalidation-and-CPD/Revalidation/Guidance-for-GPs/2-RCGP-Supporting-information-for-appraisal-and-revalidation-for-GPs.ashx

GENERAL INFORMATION

Providing context to what you do in all areas of your professional practice

PERSONAL DETAILS

Your revalidation portfolio should include the following details:

- title and name
- email address
- work address and telephone number
- preferred contact address and telephone number
- primary medical degree and awarding institution
- professional and medical qualifications
- General Medical Council (GMC) number, registration date, licence date and date of entry onto the General Practice Register
- date of last revalidation (when applicable).

SCOPE OF WORK

You need to record your professional roles and update your entries annually. This should include:

- all current posts and those within the revalidation period – date started, time commitment, contracting authority or employer (including address); if clinical, whether within an organisation with a quality-assured system for clinical governance;³² role content/description and performance review/appraisal within this post

32. Organisations with quality-assured systems for clinical governance will include: the NHS; independent providers of primary care such as the Defence Medical Services and the Prison Service; and PCO-endorsed out-of-hours providers.

- any voluntary roles undertaken in the capacity of a doctor and which require you to have a licence to practise to carry out the role
- free-text elaboration of any unusual supporting information.

Revalidation is based on what a doctor actually does in practice. In order for appraisers, responsible officers or suitable persons to understand what the GP does, all posts undertaken as a doctor, whether paid or not, must therefore be included. GPs in the Defence Medical Services, for example, need to provide details of their extended responsibilities in clinical areas. These may include pre-hospital emergency medicine, occupational medicine, travel medicine, sports and exercise medicine, public health, environmental health, aviation medicine, diving medicine and military community psychiatry.

For sessional doctors who locum for multiple providers over the revalidation period there is no requirement to specify every one in which they worked. Instead they are expected to give the dates and sessions over which they have been working, practices/organisations in which they have worked regularly or frequently, and to indicate the general nature of the role(s) they have undertaken. For most, the latter will be 'clinical primary care in undifferentiated general practice consultations' but you should also describe other medical roles if appropriate.

This area of recording is also used for two other types of supporting information:

- details of extended practice
- any exceptional circumstances.

Extended practice is:

- ➔ an activity that is beyond the scope of GP training and the MRCGP, and that a GP cannot carry out without further training (e.g. surgical services)
- ➔ or an activity undertaken within a contract or setting that distinguishes it from standard general practice (such as work as a GP with a Special Interest)
- ➔ or an activity offered for a fee outside of care to the registered practice population (teaching, training, research, occupational medicals, medico-legal reports, cosmetic procedures, etc.).

Some GPs will indicate that they have nothing to include in this supporting information area. However, many doctors do have areas of extended practice and they will be required to demonstrate that they are fit for these roles. In essence 'extended roles' are those for which the GP is remunerated on a regular basis. They should not include occasional (less than once a quarter) activity for which an honorarium is paid (such as delivering continuing education to colleagues or writing opinion articles), but should include all clinical activities undertaken for which any payment is made.

There is a group of common activities for which the supporting information should be straightforward:

- ➔ teaching of undergraduates – a review of performance statement from the university department
- ➔ GP training – a statement from the postgraduate organisation (deanery etc.) including the date and outcome of the last trainer approval
- ➔ research (including collaboration in research studies) – a statement from recognised research institution(s) involved and a statement from the Research Governance Team in the local primary care organisation (PCO)

- ➔ appraisers – a record of annual review of their work as an appraiser
- ➔ out of hours work – a statement from the out of hours provider that regular reviews have been satisfactory
- ➔ GPs with a Special Interest under contract to a PCO – a statement from their contracting organisation that they have maintained accreditation for the role.

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

For clinical activities, you should describe in detail the role and provide supporting information that satisfactorily answers the following three questions:

1. How did you qualify to take on this role? This should include prior experience, education and qualifications
2. How do you keep up to date in this role? This should include reference to all new and refresher education or development and refresher education and training undertaken for this role in the revalidation period, including any learning credits recorded
3. How can you demonstrate that you are fit to practise in this role? This should include appropriate audits of care delivered, including reference to any information from third-party observation of your work, and sign-off from an appropriate consultant/expert/colleague who knows your work.

This section of the portfolio is also the opportunity for you to explain any unusual aspects of your working life during the revalidation period that may help the appraiser and responsible officer (or suitable person) to understand and interpret your supporting information. There will be an opportunity to record anything relevant including:

- ➔ prolonged or significant illness
- ➔ career breaks including sabbatical or maternity leave

- periods working abroad (including for charities and non-governmental organisations)
- important changes in working circumstances including the dissolution of a partnership or a move to another practice.

This list is not intended to be exhaustive – there may be other circumstances that you may wish to include. This supporting information area is used by appraisers and responsible officers (or suitable persons) to provide context in evaluating your portfolio.

It is important that you discuss any planned career breaks with your responsible officer in advance.

ANNUAL APPRAISALS

All GPs are expected to take part in regular annual appraisal and they must bring supporting information for their revalidation to their appraisal. Further guidance around the appraisal process, and what GPs should expect from their appraisal, can be found in the latest version of the RCGP *Principles of GP Appraisal* document.³³

All doctors on an NHS Performers List or working within an organisation with a quality-assured system of clinical governance, including locums, should receive administrative support in undertaking annual appraisals. If you experience significant problems that are not resolved satisfactorily with your PCO or employer, you should draw this to the attention of your responsible officer or suitable person at an early point in the revalidation period and include it in your portfolio as exceptional circumstances.

33. The RCGP's *The Principles of GP Appraisal for Revalidation* document is available from: www.rcgp.org.uk/courses-and-events/cpd-credits-and-appraisal.aspx

An annual Personal Development Plan (PDP) should be derived from participation in each annual appraisal. It should be signed off by you and your appraiser, and should represent the agreed plan for the forthcoming year. The portfolio should contain one PDP for each year in the period of revalidation.

A PDP consists of a number of objectives. There is no minimum or maximum number of objectives. For example, a doctor setting the objective of achieving recognition as a vocational trainer might regard that as a sufficient single objective for a year; most GPs will set themselves between three and five objectives that reflect the breadth of their practice, responsiveness to the health needs of their local population, and their own development needs. All objectives need to be 'SMART' (Specific, Measurable, Achievable, Realistic and Time-bound) although some may, of necessity, be less measurable and time-bound than others.

A valid PDP must contain the following key elements for each objective:

- ➔ a statement of the development need
- ➔ an explanation of how the development need will be addressed (the action to be taken and the resources required); objectives are more likely to be achieved if consideration is given to several ways of meeting them
- ➔ the date by which the objective will be achieved
- ➔ the intended outcome(s) from the objective.

For each PDP objective submitted there should be a column recording the outcome of the objective. The entries in this column should be agreed between the appraiser and the GP at the appraisal following the one in which the PDP was agreed.

The entries reviewing the outcome of agreed objectives are likely to reflect the following:

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

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

Over a five-year period you should not only consider clinical learning and development but also non-clinical competencies, which may include leadership, management or teaching, recognising the importance of all a doctor's roles in the provision of a safe system of health care for patients. Further information about the PDP can be found in the RCGP PDP toolkit.³⁴

STATEMENTS ON PROBITY, HEALTH AND USE OF HEALTH CARE

You will be asked to verify a standard statement or to provide an alternative statement. The standard statement will cover:

- ➔ that there are no issues of probity in your work

34. The RCGP PDP Toolkit is available from: www.rcgp.org.uk/revalidation-and-cpd/new-revalidation-guidance-for-gps.aspx

- whether you have been suspended, had restrictions placed on your practice or been subject to an investigation since your last appraisal
- whether your designated body or responsible officer has requested you to bring specific information to your appraisal
- that there are no health issues that might affect your ability to deliver safe care to patients (including infections, immunisation status such as against hepatitis B, problems with drugs and alcohol, mental health concerns and other significant diagnoses or problems); a statement that you have a health condition which is being treated adequately and that your doctor has no concerns should be acceptable
- you are in a position to receive independent, impartial healthcare advice (for example you are not consulting a family member³⁵) and that you access health care appropriately. Unless there is a good reason it is best practice for a general practitioner to be registered in a practice in which he or she does not work
- you have appropriate and current insurance or indemnity cover for all aspects of your work. You will be asked to provide the name of the organisation providing insurance or indemnity cover and the membership number.

35. Paragraph 30 of the GMC's *Good Medical Practice* says: 'You should be registered with a general practitioner outside your family.'

KEEPING UP TO DATE

Maintaining and enhancing the quality of your professional work

All medical royal colleges have adopted a learning credit system that requires doctors to collect 50 credits a year and 250 credits in a five-year cycle to support a positive revalidation decision. However, unlike other college schemes, the Royal College of General Practitioners (RCGP) credit system³⁶ is not purely based on time spent but also reflects the impact of learning.

In essence, 1 hour of education accompanied by a reflective record is 1 learning credit. However, if you can demonstrate to your appraiser that a particular episode of learning was implemented in practice with positive benefit for patients, yourself or the practice, you can claim 2 learning credits for each hour of such education. The RCGP Impact Toolkit includes several examples of ways in which impact can be demonstrated.³⁷

Your credits are self-assessed and verified at appraisal. The pattern of credits should, over the revalidation cycle, reflect the working life of the general practitioner. For example, a GP with a Special Interest in respiratory medicine should have a mixture of general practice and respiratory learning credits.

You will, therefore, be expected to record your educational activity and award yourself credits based upon the hours involved and the impact of the education on yourself, your

36. www.rcgp.org.uk/revalidation-and-cpd/~media/Files/Revalidation-and-CPD/Credit-Based-System-for-CPD.ashx

37. The RCGP Impact Toolkit is available from: www.rcgp.org.uk/revalidation-and-cpd/new-revalidation-guidance-for-gps.aspx

patients or the service in which you work. 'Educational activity' can include formal courses, lectures, seminars, small group or practice-based learning events, online learning, reading, learning a new skill, mentoring someone, action learning, becoming a trainer, doing individual reflective activity, etc. You may choose to include an activity associated with a local primary care organisation (PCO) initiative, such as case reviews relating to a local commissioning pathway, but this should not be compulsory for the purposes of revalidation. A reflective log of learning should satisfy an appraiser that each recorded activity was educational. Over a revalidation cycle you will be expected to demonstrate a broad range of general practice education appropriate to the work you do, with 50 good-quality and representative learning credits being achieved and confirmed by the appraiser each year.

There are many areas within a revalidation portfolio where credits can be claimed. However, it is inappropriate, for example, to claim credits for quality improvement activities if they are also included in the quality improvement component of the revalidation portfolio. Hence 'double counting' should be avoided.

REVIEW OF PRACTICE

Evaluating and improving the quality of your professional work

The General Medical Council (GMC) states that quality improvement activities ‘could take many forms’ depending on the role the doctor undertakes and the work that he or she does. The RCGP has defined significant event analysis (SEA)/individual case reviews and clinical audit as the core information to be included under Review of Practice. GPs who do not feel that it would be feasible for them to participate in clinical audit activity should produce alternative evidence of quality improvement and discuss this with their appraiser.³⁸ Similarly, if it is not feasible for a GP to submit SEAs because of his or her working circumstances, the GP may wish to include individual case reviews that have been discussed with colleagues and demonstrate reflection and learning in his or her portfolio instead. It is important that all GPs record and reflect upon any serious clinical incidents in which they have been involved.

Most GPs are involved with a broad range of quality improvement activities, including case discussions and briefer reviews of clinical and other work, and these should also be submitted. You should submit evidence of quality improvement activity for every appraisal to show that you regularly review your practice and learn from events, concerns, errors, audits, etc.

38. The RCGP Quality Improvement Toolkit contains examples of quality improvement activity other than clinical audit. Available from: www.rcgp.org.uk/revalidation-and-cpd/new-revalidation-guidance-for-gps.aspx

SIGNIFICANT EVENT ANALYSIS/INDIVIDUAL CASE REVIEWS

Significant event analysis (also known as learning event auditing, critical incident analysis or significant event auditing) is a routine part of general practice and is based on individual events or case reviews. It is a technique to reflect upon, and learn from, individual cases or events to improve quality of care overall. The expectation is that you provide an analysis of at least two significant events/individual case reviews in which you have been directly involved for each appraisal as a demonstration of annual quality improvement activity. For more information about significant event analysis, including definitions of activity associated with significant events, see the RCGP Significant Event Analysis Toolkit.³⁹

The National Patient Safety Agency (NPSA) defines significant event analysis as:

A process in which individual episodes (when there has been a significant occurrence either beneficial or deleterious) are analysed in a systematic and detailed way to ascertain what can be learnt about the overall quality of care, and to indicate any changes that might lead to future improvements.⁴⁰

Here it should be noted that significant event analysis, as described here, is referred to by the GMC as case reviews. [The GMC document *Supporting Information for Appraisal and Revalidation* refers to serious incidents as significant events. A subsequent footnote clarifies that this does not refer to significant event analyses that are, in the GMC definition, case

39. The RCGP Significant Event Analysis toolkit is available from: www.rcgp.org.uk/revalidation-and-cpd/new-revalidation-guidance-for-gps.aspx

40. NPSA. *Significant Event Audit: guidance for primary care teams* (2008). www.nrls.npsa.nhs.uk/EasySiteWeb/getresource.axd?AssetID=61501

studies. If you have a serious incident, it should be included as a significant event in your portfolio, but many of your significant events will not be serious incidents.]

Significant events can be very wide-ranging and can reflect good as well as poor practice. Examples could include underage pregnancy, coping with a staffing crisis, complaints or compliments received by the practice, breaches of confidentiality, a sudden unexpected death or hospitalisation, an unsent referral letter, a diabetic registered blind or a delay in cancer diagnosis.

SEAs are a qualitative process; they involve a structured dissection of events. Whether clinical, administrative or organisational the process should enable the practice to answer the following questions:

- what happened and why?
- how could things have been different?
- what can we learn from what happened?
- what needs to change?

An account of an SEA should not allow patients to be identified and should comprise:

- title of the event
- date of the event
- date the event was discussed and the roles of those present
- description of the event involving the GP
- what went well?
- what could have been done differently?
- reflections on the event in terms of:
 - knowledge, skills and performance
 - safety and quality
 - communication, partnership and teamwork
 - maintaining trust

- what changes have been agreed:
 - for me personally
 - for the team
- changes carried out and their effect.

For the purposes of revalidation, you must *only* submit an analysis of a significant event in which you have been directly involved, where the event was discussed with other colleagues. For practice-based GPs the expectation would be that the discussion around a significant event would occur within the practice-based team meeting (usually an SEA meeting) with an appropriate selection of other primary care team members present, so that necessary changes can be made within the practice. Sometimes, however, employed doctors may not have sufficient influence over meetings and their employer to see their significant events discussed in this formal way. For doctors without a fixed practice base the discussion of the significant event in a peer group or learning group allows reflection, learning and planning of changes. For the SEA to be appropriate to your appraisal the changes arising from the discussion should involve yourself, perhaps as the person responsible for implementing the change or as someone who needs to change his or her own practice.

If there is a patient safety concern or event (also known as a serious incident) within your clinical practice, the GMC requires that each event should be included as one of your ten SEAs/case reviews and included in your revalidation portfolio.

A significant event may occur in the period immediately before an appraisal, leaving insufficient time for you to reflect, change and demonstrate that change. In this case, the event can be carried through to the next appraisal and discussed more fully then.

Although the clinical governance procedures in out of hours and walk-in centres normally require significant events to

be discussed with the doctor concerned, locums and out of hours doctors often are not notified of any significant events arising from their work, and getting access to the case notes of such patients can be challenging. The responsibilities of those who engage locums (including general practices) to support access for quality assurance must be made clear and included in terms and conditions of employment. Doctors working out of hours should seek opportunities to report and discuss significant events within their organisations so that they can contribute to organisational learning. However, where such processes are not fully established the doctor should seek to take the significant event to an alternative forum for discussion and reflection with peers such as a self-directed learning group or peer group.

If it is impractical for a GP to provide evidence of SEA because of his or her working circumstances, the GP may wish to provide individual case reviews instead. Typically, a case review would be structured using the same headings as an SEA but discussion of the review can take place within a peer group rather than a practice team if more appropriate. Trigger tools are becoming available in which the care of patients with certain high-risk characteristics is reviewed systematically.⁴¹ Evidence from the use of trigger tools can be used for revalidation by doctors for whom SEA is not feasible.

It is important, however, that *all* serious clinical incidents a GP is involved with are recorded and reflected upon.

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

CLINICAL AUDIT

Clinical audit, defined by the Healthcare Quality Improvement Partnership (HQIP) and endorsed by the National Institute for Health and Care Excellence (NICE) is:

a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change.⁴²

Clinical audit is a process or cycle of events that helps ensure patients receive the right care and the right treatment. This is done by measuring the care and services provided against evidence-based standards; changes are implemented to narrow the gap between existing practice and what is known to be best practice. Ideally, a clinical audit is a continuous cycle that is constantly measured with improvements made after each cycle.

If a clinical audit is your chosen quality improvement project, this should be recorded in your revalidation portfolio. This should be a full-cycle clinical audit (initial audit, change implemented, re-audit to demonstrate improvement).

The key attributes of a clinical audit are: the relevance of the topic chosen; the appropriateness of the standards of patient care set; the reflection on current care and the appropriateness of changes planned; the implementation of change for the GP's patients; and the demonstration of change by the GP. There is no expectation that you will actually undertake the data extraction and/or analysis.

Several GPs who work together as a team may undertake a common audit or quality improvement project. If you are

42. www.hqip.org.uk/assets/Images/Uploads/HQIP-What-is-Clinical-Audit-Nov-09.pdf

doing a clinical audit for your revalidation portfolio, you must have contributed properly to the choice of topic and the standards set, and made your involvement explicit in your submission. You must be able to state that the care identified within the first audit and the re-audit reflects the care that you deliver. You must state what changes you instituted and be able to demonstrate the effects of those changes.

A description of a clinical audit should include:

- ➔ the title of the audit
- ➔ the reason for the choice of topic
- ➔ dates of the first data collection and the re-audit
- ➔ the criteria to be audited and the standards set, with their justification; the clinical condition to be audited; or the process of care to be audited (all referenced to evidence-based guidelines etc.)
- ➔ preparation and planning
- ➔ the results of the first data collection in comparison with the standards set
- ➔ a summary of the discussion and changes agreed, including any changes to the agreed standards
- ➔ the changes implemented
- ➔ the results of the second data collection in comparison with the standards set
- ➔ quality improvement achieved or reasons for not achieving the anticipated change with justification provided
- ➔ reflections on the clinical audit in terms of:
 - ➔ knowledge, skills and performance
 - ➔ safety and quality
 - ➔ communication, partnership and teamwork
 - ➔ maintaining trust.

Clinical audits tend to involve *retrospective* data collection and are therefore much easier to undertake when working over time in one organisation and where there is access to

the organisation's administration. These advantages do not normally apply to peripatetic locums and out of hours doctors. However, there are some clinical audit topics that involve the *prospective* collection of data which may be more suitable for locums and out of hours doctors. These include:

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

Practice audits

The GMC has accepted that many clinical audits are undertaken by practice teams. These are acceptable provided you have reflected on what that audit means for your own practice and that you indicate your role in the audit process.

Local and national audits

Participation in local or national audit is acceptable as long as the audit itself has been designed to encourage reflection, change and re-audit by individuals. The data must apply to you and you must be able to demonstrate the relevance of the audit to your personal practice. You might, for example, use data from the national diabetic audit and relate this data to your own personal practice. You must indicate your role in the audit process.

Quality and Outcomes Framework audits

If you have a sustained interest in a Quality and Outcomes Framework (QOF) area, agreed with the QOF standards, reflected on one year's QOF audit in that area and put in

place changes to your clinical practice that you can document – and then can demonstrate an improvement in that area of QOF – then this should be acceptable to your appraiser and responsible officer. However, simply producing two years of QOF data in which there is an improvement from one year to the next would not be sufficient.

ALTERNATIVE QUALITY IMPROVEMENT PROJECTS

Clinical audit with retrospective data collection is one of a number of established tools for improvement of quality in systems and teams. For doctors with managerial responsibility within their practice this may be one form of quality improvement activity to submit as it will demonstrate they are involved in continuously improving the quality of their systems of health care. For some GPs, however – particularly those without a fixed practice base or employed GPs who usually have no managerial role and therefore no or limited organisational influence to bring about change in the behaviour of colleagues – audit in its traditional format may be more challenging and less relevant to the individual's appraisal. Additional challenges that audit presents to locum GPs include limited access to records, a lack of continuity in the place of work and the ability of the GP to influence other team members. The essential elements of audit – reviewing, reflecting and improving – can however be incorporated into other review exercises that support quality improvement in the individual; these are discussed further below.

A quality improvement project can be designed to review and improve systems of care and may include a review of pathways of care experienced by a specific group of patients. A quality improvement project can include defining an area of clinical practice to review and the standards required, then prospectively

collecting data, reviewing and evaluating, planning change and followed by a further data collection and review. A description of a quality improvement programme should include:

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

It is helpful if you submit supporting information that gives precise information on as many of the above items as possible.

Quality improvement projects (as an alternative to clinical audit) may include:

- ➔ a review of your prescribing, e.g. looking at the use of sedatives and hypnotics in a nursing home you look after, or reviewing nephrotoxic drugs in your patients with declining renal function
- ➔ looking at the complication rates of minor operations you carry out, performing a risk assessment on the surgery to improve patient safety and reduce complication rates, and detailing how you have addressed each area of risk

- ➔ setting up a new service, e.g. a teenage health clinic, a community obesity reduction project, or a new primary care team approach to patients in a community hospital
- ➔ looking at and improving patient safety issues such as:
 - ➔ the effective monitoring of hazardous drugs, e.g. warfarin, TNF-alpha blockers
 - ➔ addressing an area where patient follow-up has been a problem and diagnosis and management have been sub-optimal
 - ➔ using a validated trigger tool to identify high-risk patients and prevent harm, e.g. using an NHS Primary Care Trigger Tool to identify and reduce patient safety incidents in patients with left ventricular failure
- ➔ setting up and evaluating a new educational or research initiative, e.g. developing a regional programme of multidisciplinary learning, or being the lead person involved in enabling the practice to become accredited for research
- ➔ evaluating the impact and effectiveness of a new policy or practice, e.g. a new system for near patient testing, or the piloting of nurse triage within the practice
- ➔ setting up and piloting a new system of nurse triage within the practice, and evaluating the effectiveness of this
- ➔ conducting a case notes review of complex cases with an appropriately skilled and experienced colleague or colleagues in which challenging cases are reviewed, reflection occurs and improvements are identified. A serial case analysis (ten consecutive cases from a randomly chosen consulting session) or a problem-based case series (ten cases with a specific condition) can be used, discussing the process and outcome of each consultation with an appropriately skilled

and experienced colleague or colleagues in which reflection occurs and improvements are identified. A case notes review is one way in which GPs who can only influence their own personal practice (not that of their team) may demonstrate quality improvement of the care they personally deliver by reviewing their own practice

- ➔ conducting a condition-based review by selecting a clinical area that you feel may merit improvement for which there are good (preferably) evidence-based guidelines and for which you see a reasonable number of cases, e.g. UTIs, depression, COPD, asthma, anxiety
 - ➔ carry out a prospective collection of encounters printing off (anonymised) the consultation and patient summary and meds
 - ➔ once you have collected at least ten, look carefully at how you have managed these in the context of the guidelines you have found and see whether there are any patterns or themes or learning points as to aspects of diagnosis or care that you have omitted or need to improve
 - ➔ identify key changes that you need to make in your personal practice
 - ➔ repeat the exercise

[The above example is taken from the North-East Sessional GP (NESG) group's *Guidance on Evidence for Appraisal for Sessional GPs*.]⁴³

- ➔ review of referrals – see Scottish Online Appraisal Resource (SOAR) Sessional GP Appraisal Toolkit.⁴⁴

Further guidance on quality improvement projects can be found in the RCGP Quality Improvement Toolkit.⁴⁵

43. www.nesg.org.uk/content/Appraisal%20and%20Revalidation

44. www.appraisal.nes.scot.nhs.uk/

45. The RCGP Quality Improvement Toolkit is available from: www.rcgp.org.uk/revalidation-and-cpd/new-revalidation-guidance-for-gps.aspx

FEEDBACK ON PRACTICE

How others perceive the quality of your professional work

FEEDBACK FROM COLLEAGUE SURVEY

A survey feeding back from colleagues (previously called multisource feedback or MSF) is a recognised way for a person to gain formative information on how they are seen by those with whom they work. It is not a 'pass/fail' assessment, but provides an opportunity for a doctor to reflect and, if appropriate, change his or her behaviour. As such, colleague surveys can be used to demonstrate that a general practitioner is both reflecting and improving.⁴⁶ You will be expected to provide a colleague survey and discuss this with your appraiser in every revalidation cycle. The survey for your first revalidation can date from up to five years before the date of your recommendation as long as it remains relevant to your current scope of work. We recommend that you undertake a colleague survey in the first three years of the revalidation cycle to enable time for a follow-up survey if any issues are identified and subsequently discussed with an appraiser. If your role changes significantly within the revalidation cycle (e.g. you move from clinical general practice to a medical management post) we would recommend that you participate in a new colleague survey prior to your revalidation date.

The process

You will need to identify a number of clinical colleagues and other people (practice manager, practice secretary,

46. The RCGP Feedback Toolkit is available from: www.rcgp.org.uk/revalidation-and-cpd/new-revalidation-guidance-for-gps.aspx

receptionist, etc.) with whom you work sufficiently closely to enable informed and representative opinions to be made. If you work in multiple roles you should ask individuals from as many of these roles as possible to provide feedback, accepting that some colleagues may not be able to comment directly on your clinical practice. Following completion of a self-assessment, the selected colleagues, who should represent an appropriate mixture of clinical and non-clinical, will be asked by email – via the survey tool you are using – to complete a questionnaire giving their view on key attributes concerning yourself. Questionnaire providers will state a minimum number of colleagues to ensure reliable feedback. In uncomplicated cases the questionnaire should take 10 to 20 minutes to complete, but it may take longer if reflection and consideration are required. The information colleagues provide will be anonymised and a summary report will be created.

Requirements

Your colleague feedback survey should:

- ➔ be focused on your scope of work and the quality of your care for your patients
- ➔ be conducted confidentially
- ➔ contain data that have been externally inputted, collated and analysed to ensure an objective review of the information provided⁴⁷
- ➔ contain your individual feedback compared against an appropriate peer-group and GPs nationally.

If you feel that you will experience difficulty in meeting the above requirements, you should highlight this to your appraiser.

47. You should not input and/or collate data yourself, and we would advise that these functions are not undertaken by a practice manager either, as they are essentially a practice employee.

Which questionnaires to use

You should check whether or not your responsible officer recommends any specific colleague feedback questionnaire. If not, it is important that you use a validated colleague feedback questionnaire that has been developed in accordance with *Good Medical Practice* and the GMC's guidance on developing, implementing and administering colleague feedback questionnaires.⁴⁸

Reflection and implementation of change in practice

The most important aspect of doing colleague surveys is reflecting upon the results and, if appropriate, implementing changes. The result of your survey should be discussed in your annual appraisal, and the revalidation portfolio will need to show supporting information from that discussion. Any agreed actions should be included in that appraisal's PDP and should be reviewed at the next appraisal. You should undertake a colleague survey reasonably early in the revalidation cycle (i.e. in the first three years) to allow time for a follow-up survey later in the cycle if problems are identified. Although it is not always practical to do so, we would recommend that you nominate a suitable colleague to receive your feedback report and discuss the results with you. Because the feedback process is intended to assist your development, you should expect to receive some 'constructive criticism' from colleagues. Some comments may even be perceived as being negative. These should be considered and reflected upon, but not instantly taken out of proportion before discussion with your mentor and appraiser.

Locums, out of hours and isolated GPs

Some GPs, such as peripatetic locums, out of hours GPs and GPs working in small or remote practices, might find it

48. www.gmc-uk.org/doctors/revalidation/colleague_patient_feedback_admin.asp

challenging to identify adequate numbers of colleagues who can provide informed feedback. In such circumstances, after discussion with your appraiser and/or responsible officer, equivalent supporting information could be provided. For example:

- a locum or out of hours GP could provide questionnaires to a series of practices or organisations immediately after he or she has worked there to enable colleague feedback to be accumulated over an extended period of time
- a locum GP could be observed in practice by a suitably qualified and trained colleague (such as a trained appraiser or vocational trainer) over a period of at least two hours. The observer could then provide feedback on that GP's team working, communication, note keeping and clinical care. An early conversation with the employing practice and/or locum agency may help facilitate this
- out of hours GPs could use organisational clinical governance reviews that include peer review of their performance. An early conversation with the out of hours organisation concerned may help facilitate this.

FEEDBACK FROM PATIENTS – PATIENT SURVEY

You will be expected to provide a patient survey and discuss this with your appraiser in each revalidation cycle. The survey for your first revalidation can date from up to five years before the date of your recommendation as long as it remains relevant to your current scope of work. We recommend that you undertake a patient survey in the first three years of the revalidation cycle to enable time for a follow-up survey if any issues are identified and discussed with an appraiser.

The process

GPs commonly arrange for the reception to hand a paper questionnaire to a patient before the consultation. The patient will complete the questionnaire following the consultation and give it to the practice receptionist or another member of staff to input the results into a survey questionnaire tool. Some survey tool providers offer a stamped addressed envelope to enable the patient to send his or her feedback directly to the survey tool provider for input. This service can be used by GPs without a fixed practice base who may not have administrative support within their place(s) of work. Additionally, some survey tool providers allow a patient's email address to be entered for inclusion on an electronic request for feedback. It is important, however, that GPs do not rely exclusively on email feedback as they are unlikely to capture feedback from a representative range of their patients by doing so. As with the colleague questionnaire, GPs will be invited to complete a self-assessment at the beginning of the process.

Survey tool providers will state a minimum number of patients to ensure reliable feedback.

Requirements

Your patient feedback survey should:

- ➔ be anonymised
- ➔ be focused on your personal scope of work and the quality of your care for your patients. Practice-based patient surveys and postal surveys of your whole practice commissioned by your primary care organisation (PCO) are not acceptable
- ➔ include feedback from successive patients (who may have been seen in more than one place of work)

- contain data that have been externally inputted, collated and analysed to ensure an objective review of the information provided⁴⁹
- contain your individual feedback compared against an appropriate peer-group and GPs nationally.

If you feel that you will experience difficulty in meeting the above requirements, you should highlight this to your appraiser.

Which questionnaires to use

You should check whether or not your responsible officer recommends any specific patient feedback questionnaire. If not, it is important that you use a validated patient feedback questionnaire that has been developed in accordance with *Good Medical Practice* and the GMC's guidance on developing, implementing and administering patient feedback questionnaires.⁵⁰

Reflection and implementation of change in practice

The most important aspect of undertaking patient surveys is the reflection upon the results and, if appropriate, implementing changes. The result of each patient survey should be discussed at your annual appraisal, and your revalidation portfolio will need to show supporting information of that discussion. Any agreed actions should be included in that appraisal's PDP and should be reviewed at the next appraisal. Although it is not always practical to do so, we would recommend that you nominate a suitable colleague to receive your feedback report and discuss the results with you. Because the feedback process is intended to assist your development, you may receive some 'constructive criticism'

⁴⁹ You should neither hand out the patient questionnaires personally, nor input and/or collate the patient data yourself.

⁵⁰ www.gmc-uk.org/doctors/revalidation/colleague_patient_feedback_admin.asp

from patients. Some comments may even be perceived as being negative. These should be considered and reflected upon, but not instantly taken out of proportion before discussion with your mentor and appraiser.

GPs in a variety of working contexts

All GPs need to assume that they have to collect a form of patient feedback, but the GMC recognises that GPs in some scopes of work might find this challenging.

Non-clinical GPs

GPs who do not see patients should consider collecting 'patient' feedback from other sources (e.g. a GP educator may seek feedback from trainees or students). The GMC recommends that doctors think broadly about what constitutes a 'patient' in their practice. If a doctor does not see patients he or she may consider collecting feedback from other sources, such as people to whom the doctor provides a service.

Locums

It is recognised that locums usually lack a long-term relationship with their patients. Accordingly, it is acceptable for such GPs to gain feedback from consecutive patients seen in different clinical sessions and, if necessary, different clinical settings.

Out of hours GPs

Out of hours GPs can also gain feedback from consecutive patients seen in different clinical sessions and, if necessary, different clinical settings. Organisational clinical governance reviews that include peer review of their performance may also be used. An early conversation with the out of hours organisation concerned may help facilitate this.

Secure environments

GPs working in secure environments may find eliciting their patients' views challenging. Benchmarking data against other GPs working in prisons or police custody suites might be possible, but appraisers and responsible officers should recognise the potential for negative bias within patient feedback obtained within a secure environment (e.g. negative feedback about a prison GP might actually reflect a prisoner's discontent with organisational healthcare processes beyond that GP's control).

Defence Medical Services

Working within a hierarchical organisation, such as the Defence Medical Services, does not preclude the importance of gaining patient feedback. Military GPs should ensure that they gain feedback from service patients of differing ranks (both senior and junior to their own), registered family members and other entitled civilian patients where appropriate.

DESCRIPTION OF ANY CAUSE FOR CONCERN AND/OR FORMAL COMPLAINT; AND COMPLIMENTS

Failure to disclose any cause for concern at appraisal is a significant breach of probity. Responsible officers and suitable persons should have in place a mechanism for ensuring that GPs who are currently giving cause for concern should have their appraisal paperwork checked after the appraisal meeting to ensure that the issues have been discussed and the discussions recorded.

Some GPs may have been identified as giving cause for concern during their revalidation period. Any cause for

concern⁵¹ should be recorded and reported on in this supporting information area. The key elements of the report, which should not identify patients or other relevant individuals, should be:

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

If a serious cause for concern (which, if substantiated, might call into question a doctor's fitness to practise) is unresolved at the time of revalidation, the responsible officer or suitable person may ask the GMC to defer that doctor's recommendation submission date.

There will be many more GPs who have had a formal complaint or complaints initiated or resolved within the revalidation period. A formal complaint is one that has activated, or should have activated, the practice complaints procedure, involved the PCO, or involved any other formal health service organisation.

Although many complaints are satisfactorily resolved at an early stage, your revalidation portfolio should include all such complaints.⁵² The intention is to look for two points: a pattern of complaints that may suggest systemic issues; and to confirm your appropriate level of response to receiving

51. A 'cause for concern' is significant for revalidation purposes if the local responsible officer judges it to be so and is unresolved until the responsible officer is satisfied that there are no continuing issues that would compromise revalidation.

52. The RCGP Complaints Toolkit is available from: www.rcgp.org.uk/revalidation-and-cpd/new-revalidation-guidance-for-gps.aspx

complaints (reflection, lessons learnt, etc.). The description of such complaints should be sufficient for the responsible officer or suitable person to satisfy him or herself regarding these two points and should include:

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

In this part of their portfolio general practitioners can also record unsolicited compliments that they have received from patients or their carers or relatives.

GLOSSARY

<i>Term</i>	<i>Definition</i>
Academy of Medical Royal Colleges (AoMRC)	The organisation that represents the views and interests of all the medical royal colleges and faculties collectively
Appraisal GP appraisal annual appraisal	Each GP on an NHS Performers List should be appraised every year (April to March). An appraisal assists the GP to review his or her performance and draw lessons from it
Appraiser	A trained and supported GP who undertakes the appraisal of colleagues
Clinical governance	A framework through which NHS organisations and other designated bodies are accountable for improving quality of services and care, and promoting patient safety
Designated body	An organisation, which most licensed doctors should have a connection with, responsible for supporting doctors through appraisal and revalidation. Each designated body has a responsible officer (see below) who recommends doctors to the GMC to be revalidated
General Practice Register	The register maintained by the GMC of those doctors who have satisfactorily completed vocational training (or equivalent in other countries) and are eligible to work in the NHS as a GP
Learning credit	A unit of education that includes a reflective record to demonstrate learning
Locum chambers	Small groups of freelance GPs performing all their work within a clinical governance framework in small self-governing managed teams
Performers List	NHS England holds a list of doctors able to work in general practice in England and Performers Lists are held for Scotland, Wales and Northern Ireland
Portfolio	The collective supporting information accumulated for an individual GP's purposes, for appraisal and for revalidation
Primary care organisation	This is a generic term used in this document that covers Area Teams in England, NHS Boards in Scotland, Health and Social Trusts in Northern Ireland and NHS Health Boards in Wales
RCGP	The Royal College of General Practitioners; its remit covers standards, education research and quality of patient care, but not contractual issues
RCGP Specialty Adviser	A trained and supported person who will provide generic advice to responsible officers and similar stakeholders on complex or unusual revalidation queries

<i>Term</i>	<i>Definition</i>
Registers	The GMC maintains three main registers: a Medical Register of doctors in good standing; a Specialist Register for those who have achieved a level of expertise (and who may work as a consultant in the NHS); and the General Practice Register for those who have the expertise to work as a GP
Responsible officer	Every organisation ('designated body') with a quality-assured system of clinical governance is required to appoint a locally based senior doctor as a responsible officer to oversee appraisal, local concerns and revalidation
Suitable person	GMC regulations describe two types of suitable person: an existing responsible officer; or a person who holds a post in an organisation that includes responsibilities similar to that of a responsible officer. A suitable person will perform the same functions as a responsible officer for doctors without a designated body
Revalidation	The periodic confirmation that a doctor remains up to date and fit to practise
Revalidation eportfolio	An electronic portfolio used for the purposes of appraisal and revalidation
Sessional GPs	Fully qualified GPs such as salaried GPs, GP locums or retainer GPs. Their working arrangements are invariably stipulated in terms of sessions covered rather than contracted for services
Specialist Register	The register maintained by the GMC of those doctors who have obtained a Certificate of Completion of Specialist Training (or equivalent in other countries) and are eligible to work in the NHS as a consultant

OTHER SOURCES OF ADVICE

RCGP revalidation Helpdesk

revalidation@rcgp.org.uk

RCGP revalidation web pages

These include:

- ➔ a comprehensive set of FAQs
- ➔ example portfolios
- ➔ toolkits:
 - ➔ Complaints
 - ➔ Feedback
 - ➔ Impact Credits
 - ➔ PDP
 - ➔ Quality Improvement
 - ➔ Significant Event Analysis
- ➔ useful links
- ➔ signposting for doctors in difficulty.

www.rcgp.org.uk/revalidation-and-cpd.aspx

RCGP revalidation elearning

The RCGP revalidation elearning course, hosted on the RCGP Online Learning Environment, contains four interactive modules:

- ➔ revalidation – general overview
- ➔ keeping up to date
- ➔ review of practice
- ➔ feedback from colleagues and patients.

The Clarity & RCGP Appraisal Toolkit for GPs

An electronic system designed specifically to help GPs collect supporting information for appraisal and revalidation, developed in partnership with Clarity Informatics.

<https://appraisals.clarity.co.uk>

Other key portfolios

- ➔ Scottish Online Appraisal Resource (SOAR).
- ➔ Medical Appraisal and Revalidation (MARS) system.
- ➔ Medical Appraisal Guide (MAG) Model Appraisal Form.

RCGP resources for continuing professional development

The RCGP resources for continuing professional development (CPD) web page provides links to a number of resources and services to support GPs in CPD. These include:

- ➔ Online Learning Environment
- ➔ Essential Knowledge Updates and Challenges
- ➔ e-GP programme
- ➔ courses and events
- ➔ Personal Education Planning (PEP)
- ➔ Guidance on Personal Development Plans (PDP) and appraisal.

www.rcgp.org.uk/revalidation-and-cpd/resources-for-continuing-professional-development-cpd.aspx

Clinical audit

The RCGP Clinical Innovation and Research Centre (CIRC) has developed comprehensive guidance on clinical audit.

www.rcgp.org.uk/clinical-and-research/clinical-resources/clinical-audit/audit-guidance.aspx

Guidance on appraisal and revalidation processes in the four countries of the UK

NHS England Medical Appraisal Guide (MAG)

www.england.nhs.uk/revalidation/appraisers/med-app-guide/

Medical Appraisal Scotland

www.scottishappraisal.scot.nhs.uk/

Revalidation in Wales

<http://revalidation.walesdeanery.org/>

GP Appraisal and Revalidation (Northern Ireland)

www.nimdta.gov.uk/general-practice/gp-appraisal/

External guidance and tools

Further guidance and advice can be found at the following sources:

www.gmc-uk.org/doctors/revalidation.asp

www.england.nhs.uk/revalidation/

www.bma.org.uk

www.aomrc.org.uk/revalidation.html

NHS Health Education England – Local Education and Training Boards (LETBs)

<http://hee.nhs.uk/about/our-letbs/>

Chambers organisations

www.pallantmedical.org.uk

www.nasgp.org.uk/appraisal-and-revalidation

Sessional/out of hours GPs

National Association of Sessional GPs
www.nasgp.org.uk/

North East Sessional GP Group
www.nesg.org.uk/

BMA General Practitioners Committee (GPC) Sessional GPs Subcommittee
<http://bma.org.uk/working-for-change/negotiating-for-the-profession/bma-general-practitioners-committee/committee/sessional-gps-subcommittee>

Scottish Online Appraisal Resource (SOAR) Sessional GP Appraisal Toolkit
www.scottishappraisal.scot.nhs.uk/toolkits/sessional-gp.aspx

Scottish Online Appraisal Resource (SOAR) Out Of Hours (OOH) GP Appraisal Toolkit
www.scottishappraisal.scot.nhs.uk/toolkits/ooh-gp.aspx

External toolkits

Significant Event Audit Toolkit at www.nrls.npsa.nhs.uk/resources/?entryid45=61500

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Royal College of
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The Royal College of General Practitioners is a professional membership body with over 50,000 GPs working to improve care for patients. We work to encourage and maintain the highest standards of general medical practice and act as the voice of GPs on education, training, research and clinical standards.