Royal College of General Practitioners

# RCGP Mythbusters – Addressing common misunderstandings about appraisal and revalidation

Dr S R Caesar, RCGP Medical Director for Revalidation, October 2016

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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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# Contents

# Introduction


The General Medical Council (GMC) provides the definitive guidance on **supporting information for appraisal and revalidation** and the Royal College of General Practitioners (RCGP) guidance complements that with specific examples of supporting information that will help GPs satisfy the GMC's requirements.

The RCGP's recommendations are included in the ***Guide to Supporting Information for Appraisal and Revalidation (March 2016)***, which was developed with support from a wide range of stakeholders, including the GMC. The consultation prior to publication was intended to ensure that the Guide is appropriate for GPs across the whole range of working contexts, is aligned to GMC requirements and sets a benchmark for GPs that is level with other medical royal colleges. Through contact with our membership, it has become evident that GMC requirements and RCGP recommendations are being interpreted inconsistently, resulting in appraisal and revalidation being implemented in a way that is unnecessarily burdensome for some GPs. Misconceptions can occur at individual level, and the natural tendency of GPs to want to demonstrate that they are outstanding may lead to disproportionate levels of documentation. They can also occur at the level of the appraiser, or even the responsible officer (RO).

This document is intended for everyone involved in appraisal and revalidation: the individual GP, their appraiser and their RO. The RCGP wants to dispel some of the ‘myths’ that have been identified, clarify recommendations and requirements and promote an equitable experience of appraisal and revalidation for GPs, regardless of their context or geographical location.

This document is seen as a working document, in the sense that there is a need for it to be reviewed and updated frequently so that new ‘myths’ can be addressed as they are identified, and additional clarifications made. The RCGP would **welcome your feedback** if you become aware of any inconsistencies in local application of the GMC requirements and RCGP recommendations, or if you find any of these answers are still unclear.

# Key Messages

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

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


**1.1. Myth: I can choose my designated body / where to have my appraisal**

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

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

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

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

## 1.1. Myth: I can choose my designated body / where to have my appraisal

You cannot choose your designated body or who your responsible officer (RO) is. There is a strict hierarchy of connections set out in legislation. There are tools on the **GMC website** which will help you to identify which designated body you should be connected with.

In exceptional circumstances, such as where you have a prior relationship (personal or business) with the RO, there may be a perceived conflict of interest in you being connected to the RO for your own designated body, in which case you should be assigned to an alternative RO.

If you work in a managed environment, in an organisation that does not have designated body status, there might be a **Suitable Person**, who is somebody who undertakes a similar role to an RO and can provide the GMC with a revalidation recommendation about you. Where there is no obvious connection to a designated body, you may in some circumstances be able to join one, such as the Independent Doctors Federation or the Faculty of Medical Leadership and Management. They will then provide your appraisal and your RO (for a fee). If you can demonstrate that all other options are exhausted, you can revalidate directly with the GMC, which involves providing an annual return containing evidence of GMC-compliant appraisal and sitting the appropriate examination (at your own cost) once in your revalidation cycle.

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

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

Potential issues relating to poor performance, conduct or health are almost never first brought to light during appraisal. They are usually discovered through clinical governance processes and become part of an entirely separate ‘Responding to Concerns’ investigative process that takes the doctor outside revalidation. If either party reveals such an issue for the first time during an appraisal, the **GMC Duty of Care** requires that action is taken to protect patients. The appraisal would be stopped and advice would need to be sought.

To justify the time and resources involved in a route to revalidation based on annual appraisals, rather than high stakes exams, the appraisal needs to offer opportunities far beyond the baseline of demonstrating patient safety. Appraisals should support doctors so that they can maintain their resilience in the light of current pressures on healthcare systems, and encourage and stimulate them to maintain and improve the quality of patient care they can provide.

## 1.3. Myth: Appraisal is a pass/fail event

Appraisal is not a pass/fail assessment. Appraisal is, or should be, part of a formative and developmental process (see glossary). It provides an annual chance to reflect with the help of a trained appraiser, in protected time. Beyond helping you to collect a portfolio of supporting information that meets your needs and enables your responsible officer to make a recommendation to revalidate, it is about facilitating your reflection and encouraging you to consider your personal and professional development needs and how best to meet them. Appraisal should always include support, encouragement and stimulation; it is a valuable protected time with a trained peer to look back over the past year and review achievements and

challenges and to look forward and plan for the coming year in the light of any aspirations you may have and any needs relating to the context in which you work. At a time of great stress in general practice, appraisal has an important role in helping GPs who may be struggling and signposting them to local support services, with the aim of retaining GPs within the profession.

The reflective process that is central to appraisal has an important role in helping us all to think about what has happened and to look for learning, recognising both what went well – those things we should try to do more of or share – and any areas for development, or that we find challenging – those things we should try to improve or change. The support of a trained appraiser can facilitate the process and help us in working out how to address learning needs before they cause any concerns. If any shortcomings in the portfolio of supporting information are identified, these should be addressed in a supportive way and plans to overcome them should be included in the agreed PDP.

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

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

Your RO has the statutory responsibility for making a revalidation recommendation to the GMC. Their decision is based on their determination about whether you have sufficiently engaged in annual appraisal, provided a portfolio of supporting information that meets the GMC requirements, and whether there are any outstanding concerns for any part of your scope of work.

The GMC will make the revalidation decision about whether to continue your licence to practise.

Supporting you to produce an appropriate portfolio that covers the full scope of your practice includes helping you to plan your professional development in such a way that enhances the quality of your professional work. Insufficient engagement is often around the quality of reflection and the relevance of the supporting information across the whole scope of work, so the appraiser is a valuable resource to help you improve the quality of the documentation of your reflection and ensure your portfolio contains relevant supporting information.

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

Revalidation applies to fitness to practise as a doctor. There are no GMC requirements that relate to the number of sessions worked in any particular scope of work.

For any part of your scope of work, no matter how little time is spent on it, the GMC expects you to reflect on how you keep up-to-date at what you do, how you review your practice and how you seek out and respond to feedback from colleagues and patients about what you do (as well as reporting and reflecting on all complaints and Significant Events that reach the GMC threshold of harm). It may be hard to achieve all those different types of supporting information in relation to only one or two sessions per year worked in a particular role, but with careful planning, it is not impossible.

There will always be some GPs who have a significant break from practice due to maternity or parental leave, sickness or sabbaticals and there is provision for approval to miss, or postponement of, annual appraisal accordingly. If a GP has been out of practice entirely for more than two years, they will be subject to the Induction and Returner Scheme provisions.

The number of sessions you need to work per year to be a GP within the NHS is related to your engagement under the Performers List regulations and is related to your fitness for purpose, not your fitness to practise. Within the NHS, the number of sessions that a GP needs to work in undifferentiated primary care to remain up-to-date and fit to practise in that setting is currently the subject of considerable debate nationally.

In England, NHS GPs are registered on the Performers List of the local Area Office where they do the 'majority' of their NHS work. There are similar National Performers Lists in the devolved nations. According to current RO regulations, if you only do one session for the NHS, then that one session constitutes the majority of your NHS work and entitles you to a connection to that designated body and an annual appraisal. Although the GMC does not require a minimum number of sessions of GP work each year, many ROs feel that providing only one session of undifferentiated primary care per year, for more than one year, is insufficient for a GP to demonstrate that they are up-to-date and fit to practise, which has led to inappropriate local variations in implementation. This issue needs to be resolved nationally so that all GPs are treated fairly and transparently.

The current RCGP position is that how much clinical work you need to do to remain clinically up-to-date and fit to practise depends on several factors, such as your prior knowledge and experience, how recently you reduced your sessional commitment, and what other medical activities you are doing. It is a matter for your professional judgement, facilitated by your appraiser and agreed with your RO. To a certain extent, CPD can substitute for volume of clinical practice and experiential learning, but the less experiential learning possible, the more CPD is likely to be needed to keep up-to-date.

# 2. Appraisal documentation


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

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

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

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

The format of the portfolio of supporting information is not prescribed by the GMC, so having an electronic portfolio is not a requirement for revalidation.

The RCGP recommends that your portfolio of supporting information should include all the **core elements required by the GMC** in a format that is professionally presented, typed so that it is legible, and capable of being transmitted electronically. Some other items of supporting information, such as original complaint letters or compliment cards, which may be hand-written, are usually best kept in paper form and shared privately with your appraiser to maintain confidentiality. They can then be referenced anonymously by the appraiser in the summary.

In some areas, responsible officers (ROs) have commissioned bespoke IT solutions for their doctors to encourage them to use a single system e.g. Scottish GPs have SOAR and Welsh GPs have MARS, but NHS England clearly says that, while they require appraisals to be submitted electronically and not on paper, the individual GP should have a choice about which toolkit to use (**https://www.england.nhs.uk/revalidation/wp-content/uploads/sites/10/2015/05/medical-appraisal-policy-0415.pdf**, page 15).

The Medical Appraisal Guide Model Appraisal Form has just been updated and it provides a free interactive pdf: the MAG4, available from the **NHS England website**. This provides the template for all other toolkit providers. Other providers have worked hard to create online electronic portfolios that can be accessed from a variety of devices and platforms.

Your RO may have expressed a preference among the available options, which they are entitled to do under RO regulations, in order to avoid the appraisers and the revalidation team having to struggle with managing multiple formats.

The RCGP recommends that you ensure that you are aware of any requirements made by your designated body and that you agree any variations in advance with your RO if there are exceptional circumstances to be considered. For example, special arrangements might need to be made to solve an issue of accessibility for a GP with a protected characteristic. If you move to a new area of the country it is worth checking if there is a preferred local choice of portfolio.

If your RO has not determined which electronic portfolio should be used locally, the RCGP recommends that you review the available options and choose a solution that meets your needs. You may find discussion with your appraiser, who will be very familiar with the different options, helpful.

The RCGP reminds you that your portfolio, with all the GMC required supporting information, needs to be available to your RO, potentially at short notice, to inform the revalidation recommendation decision. You should ensure that, whatever format you choose, this important documentation is securely stored and readily available.

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

The RCGP recommends that you consider your appraisal and revalidation portfolio in the light of the principles of best practice in information governance and data protection. It is inappropriate to include any third party identifiable information, whether about patients or colleagues without their explicit permission.

It may be helpful to consider the portfolio as subject to the same levels of confidentiality as clinical notes, which have strict rules about what information is available to whom, and under what circumstances, but which are not restricted to just the patient and the doctor. It is a professional document and reflective notes included in it should be written in a professional way.

Reflective notes included in the portfolio of supporting information could be subject to a requirement to disclose, just as clinical notes can be. If they are appropriately written, they can demonstrate your learning and insight into any incident under investigation. The BMA recommends that legal advice is sought if any request to disclose is made.

The RCGP is aware that the Academy of Medical Royal Colleges (AoMRC) has recently issued guidance to trainees about confidentiality of their e-portfolios and that further guidance for qualified GPs and specialists is likely to be issued soon.

# 3. Supporting information


**3.1. Myth: I have to document all my learning activities**

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

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

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

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

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

## 3.1. Myth: I have to document all my learning activities

You do not have to document all your learning activities. The RCGP recommends that you focus on the quality not quantity of your supporting information. You should be selective about documenting your reflection on your most valuable and meaningful learning, over the course of the year, rather than obsessively recording and reflecting on every learning activity that you do.

If you find it convenient and helpful to record significantly more than 50 CPD credits for your own benefit to capture your learning then that is your choice. Your appraiser will be interested in your reflections on the most important learning for you (see also **6.8. Myth: My appraiser will be impressed by my hundreds of credits**).

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

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

The ***RCGP Guide to Supporting Information for Appraisal and Revalidation (March 2016)*** makes clear that GPs should consider the definition 'one CPD credit = one hour of learning activity demonstrated by a reflective note on lessons learned and any changes made as a result'.

Recording and demonstrating your CPD by scanning and storing certificates that only record time spent, without indicating what you learned, is unlikely to be a profitable use of your time. For appraisal and revalidation, the RCGP recommends that a reflective note on the learning, which can in some cases be written in the same time as would be taken to locate and scan the certificate, is preferable and all that is needed.

The RCGP recommends keeping a simple learning log in a way that is convenient to you so that you can capture your key learning points and their implications for the quality of your care. There are several useful apps (e.g. the **GMC CPD app**) and some electronic platforms include learning diaries that can be accessed or emailed from your Smartphone or other devices, but a documentary record, table or spreadsheet can work equally well.

There are occasionally learning activities that are well documented by a certificate because the certificate is designed to help you capture your reflection on the learning at the time. For your own convenience, it may also be worth scanning certificates relating to training specifically required by your designated body or any organisations in which you work. This does not make them part of the GMC requirements for revalidation but it does allow you to collect and keep important documentation securely.

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

The process of pulling together the supporting information that you have gathered throughout the year into your portfolio, and making the sign-offs and statements prior to the appraisal discussion, should not take long. The RCGP recommends that your supporting information should be generated from your day-to-day work and added to your portfolio as you go along. Producing a CPD log can be difficult and

time consuming as a retrospective exercise looking back over the previous year. It is much easier to make regular entries into your learning diary throughout the year. There are now many tools and apps to help you to do this in a simple and timely way.

The RCGP recommends that the final stage of pulling together the supporting information that you have gathered all year and completing your portfolio before your appraisal should take no more than half a day (3.5 to 4 hours). If it is taking longer than this, or the effort feels disproportionate, you should discuss with your appraiser how you can simplify what you do.

A very few doctors with complex portfolio careers and several roles to include may take a little more time than this, but they are also recommended to seek advice if their portfolio takes more than a day to pull together.

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

The GMC requires doctors to provide appropriate supporting information across the whole of their scope of work that requires a licence to practise, not just clinical roles. You need to declare all parts of your scope of work and provide all six types of supporting information: CPD, QIA, Significant Events (if any), Patient and Colleague Feedback (if applicable) and Complaints and Compliments (if any), for each of them over the five years of the revalidation cycle (where appropriate).

The RCGP recommends that you keep the documentation of your supporting information reasonable and proportionate while ensuring that you have demonstrated that you are up-to-date and fit to practise in every scope of work. Your appraiser is a resource to help you determine whether there are any gaps in your portfolio of supporting information and to support you in working out how best to fill those gaps. Your responsible officer (RO) will determine whether your portfolio demonstrates sufficient engagement in reflective practice and provides the supporting information required by the GMC. Therefore, if you have any queries that your appraiser cannot resolve, the RCGP recommends that you seek early confirmation from your RO that what you are planning is going to be acceptable.

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

Your supporting information has to cover the whole scope of work for which you require a licence to practise, whether or not you are working in the NHS. There are GPs working entirely in private practice who maintain a licence to practise through revalidation. Even if the NHS provides your designated body and responsible officer, your medical appraisal for revalidation has to cover your whole scope of work, including any roles outside the NHS for which you require a licence to practise.

Appraisers need to be trained and supported to provide whole scope of work appraisals and to facilitate reflection on supporting information from inside and outside the NHS.

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

The **GMC Protocol for responsible officers** (ROs) making revalidation recommendations states at 2.3.2: ’Doctors may practise in settings where they do not require a UK licence – for instance, they may work abroad, or they may undertake specific functions in the UK that do not legally require a licence to practise.

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

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

Even in UK practice, you may attend CPD events overseas. It is appropriate to check that the content of such an event is applicable to your scope of work rather than assuming that it will be acceptable.

The RCGP recommends that you discuss any proposal to include any such additional supporting information with your RO in advance of your revalidation recommendation date. It is likely that clinical work overseas will have a significant overlap with clinical work in the UK and it may well be appropriate to include supporting information relating to work overseas where it has wider application in demonstrating the quality of your reflective practice. If you are unsure, use your appraisal as an opportunity to reflect on what is appropriate and proportionate with your appraiser, and then agree it with your RO in good time before your revalidation recommendation is due.

# 4. Reflection


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

### 4.1. Myth: Reflection is difficult

### 4.2. Myth: Documented reflection has to be longwinded

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

## 4.1. Myth: Reflection is difficult

Reflection is a professional habit that all doctors should have. No-one would want to be treated by doctors who never considered how effective their care was or whether it could be any better. We all reflect on what we do. Reflection – thinking critically about what we do, why and how and where and when we do it, and whether it could have been done differently – is something doctors do all the time. It is part of our professional training.

Like any habit, for some doctors, reflection can be such a subconscious activity that it can be hard to bring it to conscious awareness in order to capture it or write it down – for appraisal or any other reason. The difficulty for many doctors is in recording their reflection in a way that feels as natural as the act of reflection itself. Many doctors find that their appraiser facilitates their reflection through active listening, careful questioning and feedback. The appraisal discussion is an important trigger to generate new reflective insights which can be captured in the appraisal summary.

Another difficulty for many doctors is a feeling that they have to record all their reflections – which feels like having to record every thought about patient care and practice that they have every day. This would clearly be disproportionate.

It is important to find a method of capturing reflection that works for you and to keep it simple and proportionate. Some people are more ‘natural’ reflectors than others – and it is helpful to understand your own preferred ‘learning style’. Well trained and supported appraisers can be a useful resource to discuss this with.

## 4.2. Myth: Documented reflection has to be longwinded

Documented reflection should be brief and to the point as far as possible. Capturing the key learning points that have influenced, or will influence, your practice, and thinking about any changes that you may make as a result can be recorded in bullet points, a couple of sentences, or a short paragraph. Some doctors are experimenting with recording brief audio reflections. Do what is appropriate for the particular reflection. Experiment with a variety of styles. Some methods may work better for some types of learning than others. While it is possible that you might choose for your own benefit to write a whole reflective essay, including a literature review (particularly if you are doing a postgraduate qualification), in most circumstances this would be disproportionate.

Some doctors find structured reflective templates that walk you through a process of reflection helpful. Others prefer not to be constrained. The RCGP recommends that you keep it simple and record what is meaningful to you.

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

The RCGP recommends that you provide only one reflective note for each CPD activity, even if the event lasts all day.

The reflective note should be seen as a way to capture the most important lessons learned and any changes that you plan to make as a result. Your appraiser does not want to read a summary of what you looked up online, the whole article, or all that you were taught at an educational event or learned at a conference. If you find it helpful to make notes on the detail, you should do so, as a personal choice based on your learning preferences, but it is not important to your appraiser. You should reflect on the impact

of what you have learned on what you already do, or plan to do, in your supporting information for your appraisal.

Ideally, your CPD log should be a record of your most important and relevant learning throughout the past twelve months in a succinct and useful format.

# 5. Impact


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

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

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

You can now claim credits for all time spent on learning activities involved in having an impact on quality of care, provided they are demonstrated by a reflective note on lessons learned and any changes made as a result.

This is a more flexible and proportionate system than the former provision for the ‘doubling’ of credits for demonstrating impact – which has been phased out, and ended on 31 March 2016. In practice, the old system was inconsistently implemented and was sometimes arbitrary and inflexible. In the new system, the RCGP intention is to increase the emphasis on demonstrating the impact of what you learn in practice, not to reduce it.

For example, one hour of traditional CPD learning activity (reading an article, doing an online module, going to a meeting) may result in a question about whether all patients are on the right combination of treatment. You may therefore perform a ‘search and do’ activity where you spend another two hours searching to see if you have any patients whose medication needs to be altered and acting to change their management if appropriate. You may then share this learning with your colleagues in a meeting lasting another hour and agree a way to avoid inappropriate combinations of treatment arising in future. All four hours can appropriately be considered continuing professional development if you document your reflection on the lessons learned and changes made as a result.

# 6. Continuing Professional Development (CPD)


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

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

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

**6.4. Myth: My CPD for each part of my scope of work has to be different**

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

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

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

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

### 6.9. Myth: I have to do 50 credits of CPD every year

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

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

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

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

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

CPD activities should be very broadly defined and include personal, opportunistic and experiential learning as well as activities targeted at identifying 'unknown unknowns'. Any learning activity where you spend time learning something relevant to your current, or proposed, scope of work, and working out how to put your learning into practice, can be counted as CPD, but you should only expend time and energy in documenting a proportionate amount of your most relevant and important learning (see also **6.8. Myth: My appraiser will be impressed by my hundreds of credits**).

The aim is to demonstrate a balance of learning across the curriculum relevant to your scope of work over the five year revalidation cycle. GPs should be choosing to demonstrate reflection on their most valuable learning events across a variety of ways of learning, including personal reading and elearning from looking things up, as well as online modules, learning from professional conversations about clinical care and all the everyday sources of learning that arise from their work, and feedback about their work, not just from time taken out to go to courses and conferences. As there is so much learning in primary care that takes place in teams, it is advisable, where applicable, to demonstrate where this has led to important changes and developments. It is also important, where possible, to demonstrate some learning with others outside the usual workplace to allow for external calibration of ideas and processes.

For any learning activity, you need to reflect on what you have learned and any changes you have made as a result (or that no changes were appropriate).

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

You do not have to do the same amount, or variety, of CPD every year. Your revalidation recommendation will be informed by a portfolio that will (normally) cover a five year cycle.

The RCGP recommends that GPs should learn from a wide variety of sources and ensure that they are actively keeping themselves up-to-date at all times (when they are fit to work) as part of normal professional practice. The documentation of CPD for appraisal and revalidation purposes should be viewed as a selective process that must be kept reasonable and proportionate, with GPs choosing to document their reflection on their most important learning and any changes made as a result. In order to demonstrate that you keep up-to-date every year, it is important to reflect on your CPD every year.

It is reasonable to average out CPD and ensure that there is a spread over the GP curriculum over the five year cycle – which may involve making up a shortfall or gap in one year over the following years. Sometimes it is obvious that a major commitment, such as a postgraduate qualification, will take up almost all the CPD in one year, without demonstrating a spread over the GP curriculum or the whole scope of work. Often, in discussion with the appraiser, it is clear that there have been far more than 50 hours of CPD, but fewer than 50 credits are documented. Well trained and supported appraisers can help you to recognise and document your CPD appropriately. They can also help you to plan to ensure that your portfolio covers the GP curriculum over the five year cycle.

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

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

GPs providing undifferentiated primary care (see glossary) cannot expect to be able to demonstrate that they keep up-to-date and fit to practise on part-time CPD, as they need to cover the whole of the GP curriculum. The RCGP recommends that part-time GPs, who have less experiential learning to draw on (opportunistically looking things up and learning from patients / clinical incidents) need the same amount of CPD as full time GPs (who have more experiential learning) to keep up-to-date and fit to practise. It would be inappropriate for a doctor working one surgery a year as a GP in undifferentiated primary care to suggest that they could demonstrate that they were up-to-date for such work after completing only one credit of CPD relevant to such work.

## 6.4. Myth: My CPD for each part of my scope of work has to be different

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

If different organisations, in different parts of your scope of work, have elements of required training in common, such as Equality and Diversity training or Information Governance updates, an annual update in one organisation should be accepted by others to avoid unnecessary duplication which could take doctors away from clinical care.

The RCGP recommends that you confirm with any organisations in which you work that you are doing the most appropriate training to cover all your roles. Organisations should be prepared to accept the equivalence of appropriate learning and understand the importance of not taking doctors away from front line care to repeat updates that they have already done elsewhere in the same year.

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

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

The RCGP recommends that the original supporting information from parts of the scope of work ‘appraised’ prior to the main medical appraisal for revalidation does not always need to be included again in the portfolio of supporting information. However, a signed off summary of the ‘appraisal’ discussion and outputs, with appropriate contact details for the ‘appraiser’ and/or relevant organisation, so that the responsible officer can follow up on that part of the scope of work if appropriate, should always be included in the portfolio.

If part of the scope of work is not appraised elsewhere, the GMC required elements of supporting information, and reflections about that part of the scope of work, all need to be shared in the portfolio and discussed in the main appraisal.

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

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

The RCGP recommends that GPs providing undifferentiated primary care (see glossary) demonstrate how they have covered the breadth of the GP curriculum over the five year cycle to demonstrate fitness for purpose as a GP. Some GPs might demonstrate that they are up-to-date and fit to practise as a doctor, without being able to demonstrate that they are fit for purpose as a GP, if they are no longer in a GP role and their CPD is no longer covering the GP curriculum. The GP curriculum includes demonstrating competence in Basic Life Support and Safeguarding Level 3 training, so keeping these up-to-date is an RCGP recommendation, but not a GMC requirement.

The organisations in which you work might set specific training requirements, or your inclusion on a Performers List might require you to undertake particular types of training. These are not requirements for revalidation. Any such requirements are about demonstrating your continued fitness for purpose in a particular role, and/or staying on a Performers List.

In many areas, responsible officers (ROs) have asked doctors to include additional training requirements in their portfolio of supporting information for appraisal, for convenience, and to ensure that organisational requirements are understood by every doctor. This does not make them part of the GMC requirements for revalidation.

The RCGP recommends that GPs keep themselves aware of any training required by their organisation, as well as any training required for inclusion on a Performers List, and ensure that they continue to demonstrate that they are fit for purpose as well as fit to practise. However, it is important that GPs recognise the difference between the requirements for revalidation and training requirements for other purposes, and that their appraisers and ROs do not allow the two to become confused.

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

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

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

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

The RCGP does not recommend that you spend time that would be better spent on your patients, family or relaxation on documenting credits over and above the recommended amount (i.e. sufficient to keep up-to-date). (See also **6.9. Myth: I have to do 50 credits of CPD every year**).

If you wish to demonstrate more than 50 credits, rather than being more selective about what you include, it is your responsibility to ensure that the way that you record and demonstrate your CPD is proportionate and reasonable and does not become burdensome. Your appraiser should be trained to challenge you to keep your documentation proportionate and ensure that your recording of your reflection is done in a way that is useful to you. You should not expect your appraiser to review huge amounts of supporting information over and above what is required to demonstrate that you are keeping up-to-date and fit to practise.

You are not advised to spend a disproportionate amount of time and effort on cutting down CPD credits that you have already recorded. Nor are you advised to spend a disproportionate amount of time and effort on documenting your reflection on everything you learn all year. Try to create sensible habits that make your documentation simple and streamlined and use the knowledge and skills of your appraiser to help you.

(See also **3.1. Myth: I have to document all my learning activities**)

## 6.9. Myth: I have to do 50 credits of CPD every year

The emphasis for CPD is on the quality of reflection on what has been learned and the impact on quality of care, not quantity of credits documented.

In fact, it is impossible to put a number on the credits that you need to do to keep up-to-date and fit to practise. The GMC requires you to do enough CPD to keep up-to-date across your whole scope of work but they do not attempt to define or require a quantity. An average of 50 credits for every twelve months in work is an RCGP recommendation, provided to help you to calibrate what is right for you as an individual GP, and not a GMC requirement. If you meet this recommendation your portfolio will not need any additional scrutiny of your CPD. If you do not meet this recommendation, then it is likely that your RO will want to understand exactly why you believe that your (more limited) CPD is sufficient to keep you up-to-date and fit to practise across the whole of your scope of work.

In an ideal world, every doctor would ‘know’ instinctively exactly how much CPD they need to do as an individual to keep up-to-date. In practice, the RCGP recommendation that you demonstrate 50 credits of CPD is a pragmatic attempt to set a level that is reasonable and proportionate as a benchmark. It is a recommendation, not a requirement, and relates to the current Academy of Medical Royal Colleges (AoMRC) recommendations for all doctors to try to ensure that there is a level playing field for everyone (which is also only a recommendation and is currently under review).

The RCGP recommends that those who have a restricted scope of work should discuss with their appraiser what constitutes sufficient CPD to keep up-to-date at what they do – which will vary according to the scope of work – and to agree this with their responsible officer if necessary. For example, those who were historically GPs but now have a very restricted role providing only family planning services, will follow the recommendations of the Faculty of Sexual and Reproductive Healthcare (FSRH) for their CPD,

and will not need to complete 50 credits to demonstrate that they are fully up-to-date across the whole of their scope of work. However, GPs who wish to remain entitled to undertake undifferentiated primary care sessions (see glossary), need to keep up-to-date across the whole of the GP curriculum in order to be safe to undertake such work.

(See also **6.10. Myth: I need 50 credits of clinical CPD every year** and **6.11. Myth: I have to demonstrate 50 credits each year even if I have not been able to practise for much of the time**)

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

The RCGP recommends 50 credits across the whole GP curriculum, which is much broader than purely clinical CPD. (See also **6.9. Myth: I have to do 50 credits of CPD every year**). It has always been important to have a balance across the whole GP curriculum relevant to the work that you do.

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

The RCGP recommends that those who have a prolonged career break in an appraisal period, for example, due to maternity or sick leave, should demonstrate CPD proportionate to their time in work. They should not be burdened with a double load of CPD in the year when they return to work. While many may choose to front load their CPD in order to be up-to-date and confident to return to work, this would not be appropriate for everyone. Similarly, those who have a shortened appraisal interval, for example because they have pulled their appraisal forwards for organisational or personal reasons, are only recommended to provide CPD proportionate to the time in work between the appraisals. (See also **6.9. Myth: I have to do 50 credits of CPD every year**).

The GMC requirements to reflect on your scope of work, your CPD, your review of what you have done, any feedback that you have received (including complaints and compliments) and any GMC level Significant Events remain constant, irrespective of whether the period under review is three months in work, due to sickness or maternity leave, for example, or twelve. For example, if your appraisal is brought forward so that it is nine months after the previous one, then you should consider what supporting information is proportionate for a nine month period in work. The RCGP recommends that you focus on making progress with your previous PDP, even if not all goals can be achieved, and that you document reflection on a proportionate number of credits of CPD as well as the other types of supporting information above. Similarly where an appraisal takes place more than twelve months after the previous one, the supporting information presented should be proportionate to the whole time spent in work between appraisals. If you have any questions about what is appropriate and proportionate, you are advised to discuss it in advance with your appraiser first, and your responsible officer (RO) if necessary.

If it has been impossible for you to demonstrate all the GMC required supporting information before your revalidation recommendation due date, for good reason, then the RO has the option of deferring your revalidation recommendation to allow you more time to collect the information you need. The explicit intention is that deferral is a neutral act to enable you to maintain your licence to practise during the deferral period. For many doctors, a deferral decision, which provides additional time, can be preferable to trying to produce a disproportionate amount of supporting information after a period when they have not been able to work.

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

The GMC requires you to do enough CPD to keep up-to-date across the whole of your scope of work. This may require more, or less, than 50 credits depending on the scope of work and your prior qualifications and experience in each area of work. The RCGP recommends that GPs who are providing undifferentiated primary care (see glossary) should complete an average of 50 credits of CPD over the breadth of the GP curriculum per twelve months of work as a benchmark. (See also **6.9. Myth: I have to do 50 credits of CPD every year**).

It is a matter for the individual to determine what is 'enough' CPD for them to keep up-to-date and fit to practise across the whole of their scope of work, in discussion with their appraiser and, sometimes, with the explicit agreement of their RO. A very few doctors, with complicated portfolio careers and several roles to include, may feel they need to demonstrate more than 50 credits, in order to demonstrate reflection on appropriate CPD to keep up-to-date for each part of their scope of work. This will be the exception, rather than the rule, and they should keep the detailed documentation proportionate and reasonable. Most doctors find it easier to keep a learning log that builds up as they go through the year and this may well amount to well over 50 credits by the end of the year. As long as the documentation of the reflection has not been allowed to become disproportionate, the GP should be the one to decide what works for them. The appraisal discussion should focus on the 50 (or so) credits that reflect on the most valuable and representative learning that has taken place.

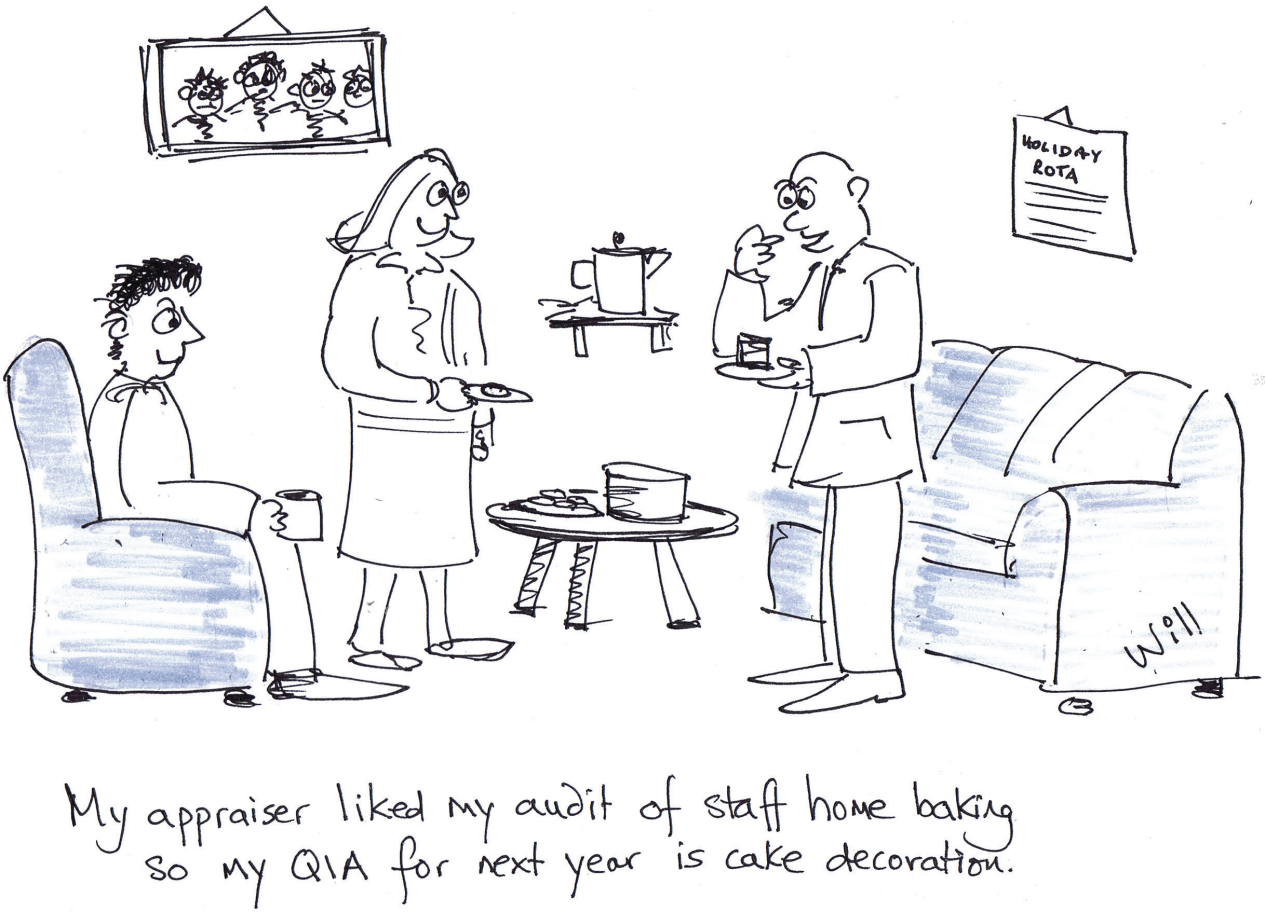
The RCGP recommends that you should reflect on the balance of your CPD and discuss it with your appraiser. If you are still working as a GP providing undifferentiated primary care, the RCGP recommends that you demonstrate 50 credits of CPD relating to the breadth of the GP curriculum. Clearly some elements of CPD are applicable across several roles and it is entirely appropriate to avoid duplication where possible. (See also **6.4. Myth: My CPD for each part of my scope of work has to be different**).

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

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

You should not change your professional habits of learning – but you need not document all your learning and reflection. You should focus on what has been particularly important or valuable to you at all times – and especially once you have reached sufficient credits to demonstrate that you are up-to-date across your scope of work.

# 7. Quality Improvement Activities (QIA)




**7.1. Myth: Time spent on Quality Improvement Activities (QIA) is not CPD**

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

**7.3. Myth: I have to do all of my Quality Improvement Activities (QIA) myself**

**7.4. Myth: There are specific types of Quality Improvement Activities (QIA) that I must include**

## 7.1. Myth: Time spent on Quality Improvement Activities (QIA) is not CPD

All learning activities can be included in CPD credits, if they are demonstrated by an appropriate reflective note about the time taken, lessons learned and any changes made as a result. The RCGP guidance emphasises that reflecting on learning activities (traditional CPD), reviewing and improving what you do (QIA, Significant Events) and reflecting on feedback (patient and colleague feedback, complaints and compliments) are all part of continuing professional development. (See example in **5.1. Myth: I can't claim credits for impact now**)

It is important to avoid unnecessary duplication and, once you have demonstrated sufficient CPD to keep up-to-date across your whole scope of work, it may not be appropriate to write an additional reflective note about a piece of supporting information that you have already included elsewhere in your portfolio. You will not stop learning, and reflecting on what you learn, but the RCGP recommends that you stop documenting what you have learned and reflected on, except where it is of particular importance to you.

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

Clinical audit is not a revalidation requirement – although it can form part of quality improvement activities or a quality improvement project.

For the purposes of revalidation, the GMC requires that all doctors demonstrate that they regularly participate in activities that review and evaluate the quality of their work. Earlier RCGP guidance recommended that you should complete two examples of reflection on your significant event analysis and/or reflective case review every year, and a formal two cycle audit once in five years. If you continue to do this, you will still meet the GMC requirement to demonstrate reflection on review of your work.

The RCGP has accepted feedback that that the former recommendation (above) was too restrictive for many GPs who were doing excellent quality improvement activities from a whole range of different types that were more appropriate to their circumstances.

The RCGP has broadened its former recommendation to make clear that there are many different types of quality improvement activity, other than audit, that are equally acceptable as quality improvement activities, in showing that you have:

- thought about the quality of care you are actually providing
- reviewed your care in the context of current guidance on good practice
- made changes where necessary or appropriate in order to improve (or celebrated the fact that what you have measured has shown that there are no changes that you need to make)
- revisited the question to see whether the changes you have made have resulted in an improvement (or maintained your existing high standards) – the quality assurance stage

It is important that you routinely review the effectiveness and appropriateness of the care that you provide in order to keep patients safe. Demonstrating that this is a professional habit is a matter of choosing appropriate examples, that show what you do and how you do it, not documenting every review of your work that you do. Depending on your circumstances, different quality improvement tools will be helpful, including reflective case review, Significant Event Analysis, review of personal outcome data, 'Search and Do', 'Plan, Do Study, Act' and clinical audit (among many others). The RCGP, and others, provide many **useful resources** for quality improvement activities.

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

## 7.3. Myth: I have to do all of my Quality Improvement Activity (QIA) myself

You do not need to do all the background work and data collection or analysis for your quality improvement activity yourself. Delegating someone else to run a search, or do some of the research, is a reasonable and proportionate use of your time. The RCGP recommends that you select quality improvement activities that allow you to review what you do. Your personal reflective notes should include an explanation about your role in the quality improvement activity and a description of the findings, including any lessons you have learned and the impact they have had on the quality of care that you provide.

GPs work in teams and much of the quality improvement activity that it is important for us to reflect on arises from teamwork. Significant Event Analysis in primary care is a team activity. You can learn from the review of data, incidents or events, and the RCGP recommends that you try to learn from the mistakes and near misses of others. The questions to ask yourself are about what you have learned about the quality of the care you provide and what, if any, changes you should make as a result.

## 7.4. Myth: There are specific types of Quality Improvement Activities (QIA) that I must include

(See also **7.2. Myth: I have to do at least one clinical audit in the five year cycle** and **8.2. Myth: I have to include two significant events every year**).

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

The GMC requirements are sufficiently broad to recognise all activities that allow you to review what you do.

The RCGP recommends that where you maintain a clinical skill, such as IUS insertion or minor surgery, you keep a log of your personal outcome data that you can reflect on at least once in the revalidation cycle to ensure that you are aware of the quality of care you are able to provide in these areas, but this is not a GMC requirement.

The RCGP recognises the value of reflective case review and significant event analysis as useful quality improvement activities but no longer recommends that you include two of these every year, or one two cycle audit every revalidation cycle. Although these types of QIA are appropriate for many GPs, there are numerous other types of quality improvement activity that may be equally, or more, suitable for your circumstances, and will meet GMC requirements.

# 8. Significant Events


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

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

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

The GMC definition of a significant event is not the same as that commonly used in primary care. In *Supporting information for appraisal and revalidation*[1] the GMC says:

'A significant event (also known as an untoward or critical incident) is any unintended or unexpected event, which could or did lead to harm of one or more patients. This includes incidents which did not cause harm but could have done, or where the event should have been prevented.' The GMC requires you to declare and reflect on those significant events in which you have been personally named or involved and in which a patient, or patients, could have, or did, come to harm in the Significant Event section of the portfolio.

This means that significant events that meet the GMC threshold of harm must be included and reflected on at your appraisal. There is no limit to the number of such significant events that you must include – you must include all those that you are personally named or involved in. However, if you have had no significant events that meet the GMC threshold of harm, you should declare that in the appropriate sign-off statement.

The RCGP recommends that you do not put GP significant events, which are essentially any event (positive or negative) that has triggered a learning process for the individual or the team in the Significant Event section of the portfolio. They should be reflected on and included as quality improvement activities, where you are demonstrating your learning from incidents.

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

There are a very wide range of possible types of quality improvement activity that can be used to demonstrate review of work, not just Significant Event Analysis (SEA). (See also **7.2. Myth: I have to do at least one clinical audit in the five year cycle**). Several years ago, the RCGP did recommend that GPs should include two detailed case reviews and/or significant event analyses every year as an easy way to demonstrate review of work, but this was sometimes misinterpreted as a requirement, rather than a recommendation. While Significant Event Analysis is still an entirely acceptable way of demonstrating review of practice, the updated RCGP recommendations make clear that there are many other equally appropriate types of quality improvement activity that may be included as supporting information.

1 General Medical Council (March 2012), *Supporting information for appraisal and revalidation*, 9

# 9. Patient and colleague feedback


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

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

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

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

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

The GMC questionnaires provide the template on which many appropriate patient and colleague feedback tools are now based. There is no GMC requirement to use the GMC questionnaires. They are not suitable for all patient / client groups, or accessible to all, and there may be better tools for your circumstances, whether they relate to a very specific scope of work, or a hard to reach group. The GMC has provided **guidance on developing, commissioning and administering patient and colleague questionnaires** as part of revalidation.

You do not need to use any tool in particular, but you should choose one that is appropriate to your patient population and is accessible to all the different types of patient across your scope of work as far as possible. You should include feedback from at least the minimum number of patients required by the tool you choose to use. The feedback should be gathered in such a way that the patients are entirely clear that their responses will be anonymous. For example, you must not collect the responses yourself in such a way that patients think you might be able to read them, or choose only the best. One option is for them to be collected into a sealed box that it opened by someone else who passes them on to someone outside your own practice, such as the questionnaire provider, to collate. The results should be externally collated into a report that gives you the feedback you need so that you can reflect on the results in preparation for your appraisal.

The most sophisticated tools provide a chance for you to provide your self-reflection about your performance against the same questions, and some indication about how the feedback you get compares with benchmark data for doctors in your sector and area. However, as new tools are developed, this is not always possible in the early stages as there have not been enough responses to create meaningful benchmarks to calibrate your feedback against. You should also be aware that there may be an early adopter bias that makes early benchmarks for new tools unrealistically high.

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

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

Some of the most powerful feedback is not anonymous. Some roles do not have enough patients or colleagues to meet the numbers required by a particular feedback tool. Sometimes including representation from across the whole of your scope of work in one survey can work and provide helpful feedback. Sometimes roles are so different that this may make the results hard to interpret.

The RCGP recommends that feedback is sought across the whole of your scope of work in ways appropriate to each context and recognises that sometimes this means that some feedback will (appropriately) not meet the GMC requirements. The main patient survey from your clinical work and the main colleague survey from your clinical work, normally undertaken once every five years, should be fully GMC compliant, but other feedback need not be.

It is important to remember that feedback included in the portfolio should be appropriately anonymised, so in many cases you will choose to include your reflection on the feedback, and to present the raw data

separately to your appraiser, or redact it. If you are in any doubt about the best way to collect and reflect on feedback, your appraiser should be a valuable resource and you should seek advice and support at an early stage.

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

You only have to do one fully GMC compliant patient survey in the five year revalidation cycle, like all other doctors.

The RCGP recommends that GPs, who have many patient contacts every day, should reflect on their relationship with their patients during every appraisal, but this does not require GPs to do additional patient surveys.

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

The RCGP recommends that GPs, who have many patient contacts every day, should reflect on their relationship with their patients during every appraisal, but this does not require GPs to do additional patient surveys or actively seek feedback every year.

The RCGP had feedback from patients that they expect you to reflect on all the sources of feedback that already exist, not that you should do extra surveys over and above those required of all doctors. The RCGP recommends that you take the opportunity once a year at your appraisal to discuss your reflections on your relationship with your patients and any feedback that you have had during the year, whether this has been an informal unsolicited comment or card, or the more formal feedback from ‘Friends and Family’ or the national patient survey, for example. You are not expected to do any extra work in actively seeking additional feedback, unless you want to seek targeted feedback for some particular reason.

# 10. My Personal Development Plan (PDP)


**10.1. Myth: My Personal Development Plan (PDP) must include…**

**10.2. Myth: My Personal Development Plan (PDP) cannot include…**

**10.3. Myth: I have to have 3/4/5 Personal Development Plan (PDP) goals (or I have to have 3/4/5 clinical PDP goals)**

## 10.1. Myth: My Personal Development Plan (PDP) must include…

There is nothing that the GMC requires your PDP to include – your goals should derive from your appraisal as an individual and your specific needs. The GMC requires you to make progress with your PDP each year (or explain why that has not been possible) and reach agreement with your appraiser on a PDP for the coming year that arises from your appraisal portfolio and the appraisal discussion.

Your PDP should be Personal, Developmental and a Plan for the future that meets your needs in the context within which you work. The RCGP recommends that you develop SMART (Specific, Measureable, Achievable, Relevant and Timely)[2] goals with your appraiser. Performance objectives should be part of job planning and not necessarily part of your appraisal and revalidation PDP unless you wish to include them. It often helps to work out how you can demonstrate that a change you plan as one of your PDP goals has made a difference by considering what the impact on patients will be.

## 10.2. Myth: My Personal Development Plan (PDP) cannot include…

The only PDP goals that are inappropriate are ones that are flippant, not specific to you, or irrelevant to your needs. Your appraiser will have been trained to help you work out how to write your PDP in such a way that it is a professional record of your personal development planning appropriate to your needs. The PDP goals should be balanced across the five-year cycle and across your whole scope of work. The RCGP takes the view that goals that are around being a good role model for patients and maintaining your personal health and wellbeing in a period of great pressures on the healthcare system are entirely appropriate.

It is rarely appropriate to include non-specific goals in your PDP that could apply to any doctor and do not apply to your personal needs, or that are part of what you are required to do anyway e.g. ‘I need to keep up-to-date’. Such goals should be re-framed and described in more specific terms such that you can demonstrate where they have arisen, why they apply to you now, how you will achieve them, and how you will demonstrate that your goal has been met and that achieving the goal will make a difference.

## 10.3. Myth: I have to have 3/4/5 Personal Development Plan (PDP) goals (or I have to have 3/4/5 clinical PDP goals)

The GMC requires you to agree a new PDP each year that reflects your needs as defined by the portfolio of supporting information and the appraisal discussion. This is a matter for agreement between you and your appraiser. There is no GMC requirement about how many PDP goals are appropriate, or about whether the goals are clinical or non-clinical.

Some doctors like to record lots of PDP items – it is your PDP. Most doctors find three or four are sufficient to capture their top priority goals. You might have one very big objective that you have broken down into separate interim or smaller goals. While it would normally be the case that there would be some clinical goals, if your main goal was becoming a GP trainer, for example, there might appropriately be no specific clinical objectives in a given year.

2 Doran, G. T. (1981). There’s a S.M.A.R.T. way to write management’s goals and objectives. Management Review, 70(11), 35-36

# Glossary

- AoMRC = Academy of Medical Royal Colleges
- CPD = Continuing Professional Development
- Formative = a developmental assessment to promote quality improvement by facilitating reflection and providing feedback to help in identifying strengths and weaknesses and making plans to target areas for development. Formative interventions are context specific and used in an educational way, to facilitate improvement over time, although they may include the learning from summative assessments (see below)
- FSRH = Faculty of Sexual and Reproductive Healthcare
- GMC = General Medical Council
- PDP = Personal Development Plan
- QIA = Quality Improvement Activities
- One credit = one hour of learning activity demonstrated by a reflective note on lessons learned and any changes made as a result
- RCGP recommendation – based on the ***RCGP Guide to Supporting Information for Appraisal and Revalidation (March 2016)*** and calibrated with other stakeholders prior to publication of this 'Mythbusters' paper
- Summative = an end point assessment against an external standard to provide a points score or pass/ fail result. Note: Summative assessments can be used formatively to give feedback on performance that helps to promote further development (see also formative above)
- Undifferentiated primary care = Providing the full range of general medical services and treating all patients in a primary care setting without prior restriction in the type of presenting complaint