AIHO

Association of Independent Healthcare Organisations

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Mythbusters

Addressing common misunderstandings about appraisal and revalidation

This document has been adapted for the Independent Sector by the AIHO Medical Revalidation Forum with the permission of the Royal College of General Practitioners

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Introduction

Sir Keith Pearson's review of revalidation was published in January 2017. It comprised a comprehensive review of revalidation to date, and made several recommendations concerning the way forward. Amongst these were suggestions for reducing the workload involved in collating information for annual appraisals as well as improved clarity on the nature of Supporting Information which is required.

As if anticipating the Pearson recommendations, the Royal College of General Practitioners (RCGP) published a "Mythbusters" document in October 2016 aimed at addressing common misunderstandings about appraisal and revalidation. The RCGP invited other bodies to use their document as a basis for dispelling some of the 'myths' which had been identified, clarify recommendations and requirements and promote an equitable experience of appraisal and revalidation for doctors in all specialties. The Association of Independent Healthcare Organisations (AIHO) Medical Revalidation Forum which includes Responsible Officers (ROs) and others interested in appraisal and revalidation within independent healthcare thought the document provided a useful platform which could be adapted for the needs of independent healthcare practitioners. The current document is the result of those revisions.

It has become evident through the Pearson review and other sources that General Medical Council (GMC) requirements for revalidation and Royal College recommendations are being interpreted inconsistently, resulting in appraisal and revalidation being implemented in a way that can be unnecessarily burdensome for some doctors. Misconceptions about requirements can occur at individual level, with resulting disproportionate levels of documentation. Misconceptions can also occur at the level of the appraiser, or even the RO.

This document is aimed at addressing some of the 'myths' around revalidation, clarifying recommendations and requirements with the aim of promoting an equitable experience of appraisal and revalidation for doctors in all fields. This document can be updated, particularly as revalidation evolves and if the Pearson recommendations are implemented. The AIHO Medical Revalidation Forum would welcome your feedback as the process continues.

The GMC provides guidance on Supporting Information for appraisal and revalidation.

An updated version of this guidance will be published in Spring 2018.

Key Messages

1. The GMC provides definitive guidance about the requirements for revalidation. If you meet the GMC requirements, then that will be sufficient for successful revalidation.
2. The Royal Colleges, Academy of Medical Royal Colleges and NHS England provide guidance and recommendations to help doctors understand how to interpret and satisfy the GMC requirements. Royal College recommendations are not additional requirements.
3. AIHO welcomes enquiries if there are areas that continue to cause confusion, or if new 'myths' are identified, and

will use your feedback to update this document on a regular basis.

4. Your role in revalidation is to demonstrate that you are up-to-date and fit to practise.
5. Your role in appraisal is to engage in a process that supports you, helping you to demonstrate reflective practice and continuing professional development, as well as facilitating quality improvements across your whole scope of practice.
6. The way that you choose to record and demonstrate your Supporting Information should remain reasonable and proportionate, without detracting unduly from patient care, or intrude on other activities.
7. Reflection can be seen as 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 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.
8. You should be selective in what you document in your portfolio of Supporting Information, choosing to include what is of importance to you and focusing on quality not quantity of Supporting Information.
9. If you are not sure how to record your Supporting Information, or you are finding it too burdensome, talk to your appraiser. Appraisers should be trained to help you to put together your portfolio in an efficient way.
10. 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.
11. If you are working in an unusual context, and you are not sure what is appropriate for your circumstances, talk to your appraiser or RO. ROs have networks of peer support and advice as well as 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

Not usually. The RO regulations determine to which Designated Body you are connected. This is your 'prescribed connection'. The NHS is at the top of the hierarchy if you also practise elsewhere. For doctors not working in the NHS the GMC website provides a tool which will help you to identify an appropriate Designated Body. For Consultant doctors with Practising Privileges your Designated Body is usually the place where you undertake most or all of your practice. For doctors in a managed environment which is not a Designated Body then you may be able to join one (such as the Independent Doctors Federation or the Faculty of Medical Leadership and Management).

If you have no connection to a Designated Body then you may be able to find a Suitable Person, approved by the GMC to make recommendations about revalidation. These are usually doctors working in a specialty area.

I can choose where to have my appraisal

Not usually. If you are connected to a Designated Body, the RO will arrange your appraisal. If you are not connected then, after discussion with the GMC, you will be encouraged to find an independent appraiser so that annual appraisals can be submitted to the GMC. Revalidation will then be by examination every five years.

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

No, appraisal is about demonstrating Good Medical Practice by providing and reflecting on Supporting Evidence. If serious concerns are revealed for the first time during an appraisal, the appraisal would be stopped and advice would need to be sought from the RO.

Concerns or potential issues relating to poor performance, conduct or health are usually discovered through robust clinical governance processes.

1.3. Myth: Appraisal is a pass/fail event

No, appraisal is not a pass/fail assessment. Appraisal is the opportunity for you to demonstrate that you are adhering to the principles of Good Medical Practice, in accord with GMC guidelines.

Engagement in the process is the GMC requirement.

1.4. Myth: My appraiser will decide my revalidation recommendation

No, your appraiser will document your appraisal and provide an output summary for your RO. This is to show that you are complying with the requirements for revalidation. On the basis of engagement over five years, the RO will submit a recommendation to the GMC about your revalidation. It is the GMC that will make the decision about your revalidation.

1.5. Myth: I can include Supporting Information from overseas in my appraisal

Yes, any Supporting Information together with reflection, related to your whole scope of practice, can be included as Supporting Evidence for your appraisal.

1.6. Myth: If I share my concerns about another doctor with my appraiser, my appraiser will have a responsibility to deal with it, and I won't need to be the whistle-blower

It is your responsibility, as the doctor who has first-hand evidence of a concern, to act in accordance with your GMC Duty of Care. Your appraiser should provide you with support and can signpost the correct steps for you to take, but it is your responsibility to raise the concern.

This is what the GMC Guidance states: 'Part 2: Acting on a concern All doctors

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

20. Concerns about patient safety can come from a number of sources, such as patients' complaints, colleagues' concerns, critical incident reports and clinical audit. Concerns may be about inadequate premises, equipment, other resources, policies or systems, or the conduct, health or performance of staff or multidisciplinary teams. If

you receive this information, you have a responsibility to act on it promptly and professionally. You can do this by putting the matter right (if that is possible), investigating and dealing with the concern locally, or referring serious or repeated incidents or complaints to senior management or the relevant regulatory authority.

In training, appraisers are reminded that they should not go beyond the limits of the appraisal role to adopt other people's concerns. Third party information is not good evidence, and an appraiser could be open to criticism if they repeat something potentially defamatory or destructive to someone's livelihood, without any first-hand evidence. There is very little that the appraiser can take responsibility for (beyond signposting and hand-holding) if they have heard something 'on the grapevine' – or even in appraisal. The doctor with the concerns has the GMC duty to report them. Doctors who are fit to practise are fit to raise a concern, and the correct route is not through the appraiser, although the appraiser is one source of support. All the appraiser can know as a fact is 'I know that my appraisee Dr X has concerns about Dr Y'.

Some Colleges recommend that appraisers record the fact that there has been a whistle-blowing discussion, and the actions agreed with the doctor, as an aide memoire for the doctor, and a record for the next appraisal, in the summary of discussion, without recording or summarising the substance of the allegations.

If the appraiser has significant concerns from the behaviour of the appraisee, that the original concern will not be acted on, some Colleges recommend that the appraiser provides written advice to the appraisee on what to do, copied to the person that they ought to be contacting (usually the RO). This avoids the appraiser having to spread gossip (because they should not repeat things that are third party information) but raises awareness that there is a potential issue, and who should be raising it, to the appropriate person.

1.7. Myth: It doesn't matter if my appraisal slips over 31 March as long as I have an appraisal

While this is not a GMC requirement, at a local level the appraisal year for reporting purposes runs from 1 April to 31 March the following year. This makes 31 March a hard deadline when all designated bodies review their appraisal compliance figures, and report them both in their annual Board Report, and to the higher level RO at NHS England.

All doctors who are working with a licence to practise should have an annual appraisal within the appraisal year. If your appraisal month is towards the end of the appraisal year it is especially important to be pro-active about organising and having your appraisal in good time.

If for any reason, such as maternity leave or sick leave, you are unable to have an appraisal within the appraisal year, it will be reported as either an 'approved missed appraisal' or an 'unapproved missed appraisal'. It is in your interest to fill in the appropriate paperwork and ensure that your RO is kept fully informed so that you have an approved missed appraisal, rather than being unapproved.

1.8. Myth: I have to have five appraisals before I can have a recommendation to revalidate

There is no requirement to have five annual appraisals in a revalidation cycle. There are many reasons for having approved missed appraisals, such as maternity leave or sick leave, or being given a revalidation recommendation due date that may be less than five years from your first appraisal.

You must have collected and reflected at appraisal on all the GMC Supporting Information required to provide assurance that you are up to date and fit to practise. This is likely to take at least two appraisals – one to define what you need and build a Personal Development Plan (PDP) that supports you in achieving it all, and the second in which to reflect with your appraiser on all your Supporting Information, including your colleague and patient feedback.

If, for good reason, you are struggling to collect all the Supporting Information required by the GMC before your revalidation recommendation due date, your RO has the option to recommend a deferral. If accepted, the GMC will defer your revalidation date to give you additional time to collect the remaining Supporting Information that you need. Your licence is not affected and you can continue to work while you do this.

1.9. Myth: Having a "disagree" statement from my appraiser is always a bad thing

There are five key sign off statements that are normally agreed by your appraiser at the end of your appraisal. If your appraiser decides that one, or more, should be marked as "disagree", this sends a message to you, your next appraiser and the RO that something is not ready for revalidation.

This is not necessarily a bad thing. It is an important part of ensuring that the appraisal supports you in preparing a portfolio of Supporting Information appropriate for a recommendation to revalidate.

The appraiser should always complete an explanation for every disagree statement.

For example, the third statement is about having made progress with your previous PDP. (A review that demonstrates progress against last year's PDP has taken place). There are many situations in which a newly qualified doctor, or a doctor arriving in the UK from elsewhere, may not have had a previous PDP, so no progress can have been made. There may have been a dramatic change during the appraisal year that means that the whole of the previous PDP has been superseded by new learning and development needs and so no progress has been made against the former objectives. In these circumstances, it is appropriate for the appraiser to mark disagree and enter an explanation.

Even the fifth sign off statement, about there being no concerns arising from the appraisal documentation or discussion that suggest a risk to patient safety, may sometimes need to be marked as disagree. (No information has been presented or discussed in the appraisal that raises a concern about the doctor's fitness to practice). For example, if a doctor is currently under investigation, and has a whole scope of work appraisal in the period before the investigation is resolved, they could not be revalidated as there are outstanding concerns, and the appraiser should indicate this by marking the fifth statement as disagree. Once again, it is important that the appraiser puts an explanation in the comments box provided. In all cases, you also have a box in which to

enter your comments, although you do not have to comment if you have nothing to add to the appraiser's explanation.

1.10. Myth: My appraisal month will always be my birth month

While many appraisal systems are based on spreading appraisals through the appraisal year based on birth month, there are many situations where this will not be the case. For example, your appraisal month may have moved after a period of maternity or sick leave, and it will be more appropriate to resume a twelve-monthly appraisal period with the new month as your appraisal month. In some Designated Bodies, the appraisal policy has a different way of allocating appraisal month. You are advised to check when your appraisal will be due when you move from one Designated Body to another.

1.11. Myth: My appraisal month is linked to my revalidation date

There is no need for your appraisal month to be linked to your revalidation date.

If you are fully engaged in demonstrating that you remain up to date and fit to practise through an ongoing process of annual appraisal and collecting a portfolio of appropriate Supporting Information for revalidation, and there are no outstanding concerns about you raised through any other route, your RO, or Suitable Person, will be able to make a recommendation to revalidate when your recommendation is due.

Your RO can make their recommendation at any time in the four months before your revalidation recommendation due date. They will need assurance from all the different parts of your scope of work that there are no outstanding clinical governance concerns in that four-month period. This will happen whether your last appraisal was one month, or eleven months, before the revalidation recommendation date.

Note: Some doctors have previously pulled their appraisal month forwards in the appraisal year in order to provide all the required Supporting Information in time for their last appraisal before revalidation. In these cases, it may appear as if the revalidation date is linked to the appraisal date, but this is a consequence of the pull forward, not a necessary link.

1.12. Myth: I have to get sign off statements from all parts of my scope of work every year

Whilst wishing to avoid burdensome annual writing of 'statements of no concerns,' the wide scope of practice of many private doctors may mean the RO requires it. More specifically, they may require annual evidence in relation to Significant Events and complaints occurring elsewhere. The GMC requires that all such incidents and complaints (irrespective of which part of practice they relate to) should be declared and reflected on at appraisal. Doctors are advised to talk to their RO or lead appraiser whenever they have a governance concern to agree the best way forward and to be signposted to appropriate resources or courses of action. Any governance concerns arising about a doctor should be communicated to their RO as and when they arise, by those responsible for the governance surrounding a doctor's work. It is crucial that concerns can be dealt with in a timely fashion and are not linked to the revalidation due date.

Ensure you reflect on how the safety of patients is being assured and the clinical governance of the systems you are working in. You should always know how to report

a Significant Event and how you would find out if there was a complaint about you. The RO should proactively seek assurance independent of the doctor at least once in the revalidation cycle, in the four months prior to the recommendation due date, noting that it can only ever provide a snapshot of assurance and needs to be timely to the revalidation recommendation.

In some cases, a doctor will be working in an environment where there is no external governance and the reporting of any issues will depend on the professionalism of the doctor.

In summary, concerns will be generated and "pushed" to your RO as and when they occur to be dealt with in a timely fashion outside the revalidation process. As part of this, you are personally responsible, as a professional, for declaring any concerns that you are aware of as they arise. Just before a recommendation to revalidate is to be made, your RO needs to have the contact details for all parts of your scope of work to "pull" information that confirms that there are no outstanding concerns about your work at that point in time.

1.13. Myth: It is my RO's responsibility to ensure that I have an appraisal

It is your professional responsibility to ensure that you have an appropriate annual appraisal. Some doctors do not have a RO, or a Suitable Person, and still organise their own annual appraisal that meets the GMC criteria for a medical appraisal for revalidation.

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

You should be proactive in ensuring that you have an annual appraisal that is meaningful and meets your personal and professional development needs in the context in which you work. If your appraisal becomes disproportionately burdensome you should provide feedback on that, so that the difficulties can be understood and acted on.

Help to find a Designated Body can be found on the GMC website.

1.14. Myth: If my appraisal is not yet due, I can relax - even if I am planning a sabbatical, elective surgery or maternity/paternity or adoption leave

There is a GMC requirement to engage with your annual appraisal process. If you are in work when your appraisal is due, it is easy to demonstrate your engagement by having your appraisal meeting before the end of the month in which it is due. There is currently no GMC guidance that lays out how you should demonstrate your engagement if you are not in work at the time when your appraisal is due.

Doctors who are planning a significant period of time out of work, for any reason (including, but not restricted to, sabbaticals, elective surgery or maternity/paternity or adoption leave), should be proactive in planning their annual appraisal. It is often appropriate to bring the appraisal forward to ensure that you have an appraisal before you stop work, particularly if you will then be off work for the rest of the appraisal year (1 April – 31 March), so that you can plan for your time away and your return. This will result in a time period between appraisals of less than a year, but you should remember that you only have to produce

Supporting Information proportionate to the time in work between the appraisals. In particular, you will not be expected to have made progress with all your PDP goals, especially if they all had timeframes of a year (or more). Your summary of appraisal should record the circumstances and your reflections on them.

If your most recent appraisal was less than six months before your planned time away from work starts, it is recommended to seek advice from your RO or Suitable Person in order to determine the best course of action.

On your return to work, you need to demonstrate that you are, once again, keeping up to date and fit to practise for your whole scope of work. An early appraisal following your return to work provides an opportunity to reflect on all that you have experienced and learned and to plan any changes that you now want to make. Once again, you only need to produce Supporting Information proportionate to your time in work, but an important aim for the 'return to work' appraisal will be the development of an appropriate new PDP arising from the appraisal portfolio and discussion.

If you have been out of clinical work for more than two years, you will need to engage with relevant formal schemes for retraining and you will need to take advice from your College and the GMC as well as your employer.

2. Appraisal Documentation

2.1. Myth: I have to use a portfolio defined by my RO to revalidate

The format of your portfolio of Supporting Information does not have to be electronic although many Designated Bodies expect this. However, it should be typed, and capable of electronic transmission.

Your RO is entitled to express a preference about an electronic platform to be used in order to avoid multiple different formats. The Medical Appraisal Guide (MAG) Model Appraisal Form has just been updated and it provides a free interactive pdf (MAG4) available from the NHS England website.

The portfolio does need to include all six types of Supporting Evidence recommended by the GMC:

1. Continuing Professional Development (CPD)
2. Quality Improvement Activity (QIA)
3. Significant Events (also known as an untoward or critical incident) defined as any unintended or unexpected event, which could or did lead to harm of one or more patients
4. Feedback from colleagues
5. Feedback from patients
6. Review of Complaints and Compliments

You should ensure that, whatever format you choose, this important documentation is securely stored and readily available, and that the documents have been appropriately redacted to comply with Information Governance guidelines.

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

No, but your portfolio is subject to the same levels of confidentiality as clinical notes. In addition to the appraiser and your RO, the appraisal may be viewed by your employing organisation, and is subject to disclosure upon request by NHS England and the GMC.

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

Only your RO can decide whether or not to recommend that your revalidation date should be deferred. It is possible that, if you have not engaged with the appraisal process or taken appropriate opportunities to ensure that you are ready for revalidation, the RO would decide that it was more appropriate to refer you to the GMC for failing to engage. Deferral is a neutral act that asks the GMC to allow you additional time to meet the GMC requirements for Supporting Information in full, or for a local investigation to be completed. It is not your "right" as a doctor to have extra time if you have already had ample opportunity to fulfil all the GMC requirements.

3. Supporting Information

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

No, but you need to demonstrate some learning activity related to all aspects of your scope of practice. This is the value of reflection which allows you to list your activities and then provide a quality summary to show that you understand how your activities have helped you improve your practice.

3.2. **Myth:** I need to scan certificates to provide Supporting Information about my CPD

No, you can summarise your CPD, with illustrative documentation, to show that you have undertaken CPD that is relevant to all aspects of your scope of practice. It is more important that this is accompanied by a reflection note demonstrating that you understand the way in which what you learned will help improve and develop your practice.

The GMC has not set any requirements about how CPD should be evidenced or recorded but some Colleges have made recommendations that relate to their Members and Fellows. Some ROs, perhaps in response to inadequate reflection, do expect to see certificates as well. In general terms clinicians should consider one CPD credit = one hour of learning activity demonstrated by a reflective note on lessons learned and any changes made as a result. The best advice is to keep 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.

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

No, it is recommended that you accumulate your Supporting Information throughout the year as it is generated by your day-to-day work. Evidence can be added to your portfolio as you go along and it is much easier to make regular entries into your learning diary throughout the year.

3.4. **Myth:** I do not need to provide all six types of GMC Supporting Information about my clinical role

No, the GMC guidelines require that you 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). Evidence in all of these categories is necessary for all aspects of the scope of work that requires a clinical licence to practise.

3.5. Myth: All my Supporting Information applies to work only in the NHS

No, your Supporting Information will need to cover the whole scope of work for which you require a licence to practice, whether or not you work in the NHS. At your appraisal, you will need to declare your entire scope of work and provide Supporting Information to cover the whole scope.

3.6. Myth: Supporting Information from work overseas cannot be included in my appraisal portfolio (See also Myth 1.5)

This is at the discretion of your RO. 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. Your RO has the discretion to consider Supporting Information from other settings, in making their revalidation recommendation, by taking account of whether it is demonstrably relevant to your licenced UK practice and the proportion of your Supporting Information that it represents.

4. Reflection

4.1. Myth: Reflection is difficult

No, reflection is not difficult but some doctors find documentation of their reflections difficult. The GMC places great emphasis on the importance of reflection.

Thinking critically about what we do, why and how and where and when we do it, whether it could have been done differently, and what effect this might have had on the outcome, is something doctors do all the time. It is part of our professional training.

The appraisal discussion facilitates reflection through active listening, careful questioning and feedback. It is an important trigger to generate new reflective insights which can be captured in the appraisal summary.

4.2. Myth: Documented reflection has to be longwinded

No, documentation of your reflections should be brief and to the point. Important components include:

- brief summary of the Supporting Information upon which the reflection is based;
- the key learning points that have influenced, or will influence, your practice;
- thinking about how any changes that you may make will improve patient outcome.

Documentation style is personal, and a reflection can be recorded in bullet points, a couple of sentences, or a short paragraph.

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

No, your CPD should be logged and summarised to reflect important and relevant learning. Consider one reflection for each area of your scope of work.

Reflection notes should not be confined to CPD but undertaken for each of the six categories of Supporting Information.

5. Impact

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

You can now claim credits for all time spent on learning activities involved that have an impact on the quality of care, provided they are demonstrated by a reflective note on lessons learned and any changes made as a result. There is no 'standard multiplier' and each credit must be evidenced.

6. Continuing Professional Development (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 6.9. 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. Doctors should be choosing to demonstrate reflection on their most valuable learning events across a variety of ways of learning, including personal reading and e-learning 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 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: Reading is not recognised for CPD

Reading and research are potential CPD learning activities but will only be recognised if accompanied by a reflective note on lessons learned and any changes made to your practice.

It is unwise and often unacceptable to make reading the only content of your CPD. Your College or Faculty may have guidance on recommended proportions.

6.3. 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 five years.

The Royal Colleges generally recommend that doctors 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 doctors 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 relevant 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 medical 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 curriculum over the five year cycle.

(See also 6.12. Myth: I have to demonstrate 50 credits each year even if I have not been able to practise for much of the time)

6.4. Myth: As a doctor who works part-time, I only need to do part-time CPD

Doctors providing part-time care cannot expect to be able to demonstrate that they keep up-to-date and fit to practise on part-time proportionate CPD, as they need to cover the whole of the relevant curriculum. Part-time doctors, 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 doctors (who have more experiential learning) to keep up-to-date and fit to practise.

6.5. 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 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 may be accepted by others to avoid unnecessary duplication which could take doctors away from clinical care. However, this may vary from course to course and with differing roles and organisations.

You should confirm with any organisations in which you work that you are doing the most appropriate training to cover all your roles.

It is the responsibility of individual doctors 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.

6.6. 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

Supporting Information from parts of the scope of your work 'formally reviewed' in another employing organisation 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 review discussion and outputs should always be included in the portfolio. Appropriate contact details for the 'reviewer' and/or relevant organisation, so that the RO/appraiser can follow up on that part of the scope of work if appropriate, should also be included.

If part of the scope of work is not reviewed 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.

6.7. Myth: The GMC requires doctors 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.

Doctors providing private healthcare should demonstrate how they have covered the breadth of the doctor's curriculum over the five-year cycle to demonstrate fitness for purpose in their role.

The medical curriculum for practising providers of private healthcare includes demonstrating competence in Basic Life Support and Safeguarding to the appropriate level, so keeping these up-to-date is a recommendation, but not a GMC requirement. Keeping resuscitation and safeguarding skills up-to-date may also be associated with Practising Privileges. These are not requirements for revalidation. Any such requirements are about demonstrating your continued fitness for purpose in a particular role.

In many areas, 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.

Doctors should keep themselves aware of any training required by their organisation, as well as any training required for ongoing recognition as a specialist, and ensure that they continue to demonstrate that they are fit for purpose as well as fit to practise. However, it is important that doctors 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.

6.8. 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 should be included in your learning log.

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

The GMC does not set any specific revalidation requirements in relation to

CPD credits 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 Royal Colleges and faculties will often describe specialism requirements in more detail and doctors are advised to check these and ensure alignment.

You do not have to 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 6.10. 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 practice. 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)

6.10. 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 a recommendation, provided to help you to calibrate what is right for you as an individual doctor, and not a GMC requirement. If you meet this recommendation and your appraiser agrees, your portfolio is unlikely to need any additional scrutiny of your CPD. If you do not meet this recommendation, then it is likely that your 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 general 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).

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 RO if necessary.

(See also 6.11. Myth: I need 50 credits of clinical CPD every year and 6.12. Myth: I have to demonstrate 50 credits each year even if I have not been able to practise for much of the time)

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

The recommended 50 credits across the whole relevant curriculum, can be much broader than purely clinical CPD. (See also 6.10. Myth: I have to do 50 credits of CPD every year). It has always been important to have a balance across the whole curriculum relevant to the work that you do.

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

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 6.10. Myth: I have to do 50 credits of CPD every year). The RO and supporting team can usually help work out a schedule for returners.

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 from your whole scope of practise) and any Significant Events (also from your whole scope of practise) remain constant, irrespective of whether the period under review is three months in work or twelve.

For example, if your appraisal is brought forward so that it is nine months after the previous one for whatever agreed reason, then you should consider what Supporting Information is proportionate for a nine month period in work. Focusing 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 is a good way to demonstrate continuity. Similarly, where an appraisal takes place more than twelve months after the previous one (which is now defined as late), 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 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 asking the GMC to defer your revalidation date 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 continue to practise while you collect the outstanding information. 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.

6.13. 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. An average of 50 credits of CPD over the breadth of the relevant curriculum per twelve months of work is recommended.

(See also 6.10. 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 doctor 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.

You should reflect on the balance of your CPD and discuss it with your appraiser. Clearly some elements of CPD are applicable across several roles and it is entirely appropriate to avoid duplication where possible. (See also 6.5. Myth: My CPD for each part of my scope of work has to be different).

6.14. 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.

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

A learning activity could be eligible to be counted as CPD. It is important to reflect on employer required "mandatory" training, as it is a requirement for good reason, and the appraisal documentation is a good place to record when it was completed and reflect on lessons learned and any changes made as a result. It is not a GMC requirement to document mandatory training in your appraisal however. Because of the importance of being able to demonstrate compliance with this training in meeting contractual obligations, it is appropriate to upload your certificates of attendance as well as your reflective note.

If you have more than one part of your

scope of work with the same mandatory training requirements, for example, Equality and Diversity training, Some Royal Colleges recommend that you negotiate to ensure that the training that you do will meet the needs of all your roles. This avoids duplication of effort and repeating the same mandatory training for different employers.

(See also 6.7. Myth: The GMC requires doctors to complete Basic Life Support and Safeguarding Level 3 training annually in order to revalidate successfully)

7. Quality Improvement Activities (QIA)

7.1. Myth: Time spent on QIA is not CPD

Not necessarily. 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.

Although CPD in the Independent Sector is often considered to be learning and professional development from external providers (e.g. courses related to a particular scope of practice), QIA are also included. These may be more likely to involve research, enquiry or analysis (data collection, audit, review) aimed at understanding how to improve care in a particular scope of practice.

There is some overlap between QIA which involve learning a new technique or a change in practice from learning (such as reflecting on Significant Events, adopting a new evidence based care pathway or patient feedback). Common sense usually dictates which category is best used to describe or file your supporting evidence.

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

No, clinical audit is not a requirement but it is a common and well understood way of evaluating a clinical activity.

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.

Examples of QIA include:

- Considering and reflecting upon the quality of care provided;
- Review of your care with reference to local or national guidelines or guidelines on good practice;
- Audit of outcomes and make changes to your practice to improve care;
- Show by audit of data collection that changes to the care you provide are not required;
- Revisiting a previous change to demonstrate better outcomes or a maintenance of good outcomes;
- Case review or discussion – a documented account of interesting or challenging cases that a doctor has discussed with a peer, another specialist or within a multi-disciplinary team.

QIA may be part of a good PDP, enabling you to plan your activity. QIA may also be regarded as just the way standards are maintained in your organisation. Describing these and your learning from them can be just as useful.

7.3. Myth: I have to do all of my QIA myself

You do not need to do all the background work and data collection or analysis for your QIA yourself. For example, if you participate in a review of practice not confined to your own, but

you should reflect personally on the findings and consider the impact on your practice.

QIA can be included when you have been an auditor, as a doctor whose practice is audited or you may include a critical reflection of your own practice (an example of a personal QIA).

In each case your personal reflective notes should include an explanation about your role in the QIA 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.

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

No, as indicated in the previous sections, there are alternative approaches to how you demonstrate involvement in a review and evaluation of your practice. Keeping a log of procedures and outcomes to provide data for reflection is a practical example. Reflective case review and Significant Event analysis are also both acceptable QIA.

8. Significant Events

8.1. Myth: What Significant Events should I include

A Significant Event (also known as a serious untoward incident – SI or SUI) is an unintended or unexpected event, which could or did lead to important harm. This includes incidents which did not cause important harm but could have done so, or where the event should have been prevented.

The GMC wants you to outline and reflect on those Significant Events in which you have been personally named or involved and in which a patient could have or did come to harm. Significant Events that meet a 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 include, but you must include and reflect all those that you are personally named or involved in. However, if you have had no Significant Events then you need to confirm that.

Events that you have simply learnt from should be reflected on and included as QIA.

8.2. Myth: Do I have to include Significant Events

You should include all Significant Events from all areas of your scope of practice. It is important to reflect on all Significant Events and especially on your learning and how this improved your practice.

You do not have to include Significant Events if you have not been involved in any. There are many other equally appropriate types of QIA.

9. Patient and colleague feedback

9.1. Myth: How do I collect patient and colleague feedback

There is no requirement to use any specific questionnaires. 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 specific tool but you should choose one that is appropriate to your patient population and is accessible to the different types of patient across your scope of work. Some Designated Bodies do have a preferred tool, however.

The feedback should be gathered in such a way that 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. The results should be externally collated into a report that gives you the feedback you need so that you can reflect on the results.

There are no specified number of patients who should be asked to provide feedback. The organisation carrying out the survey will provide information on the minimum number of patients they require to be statistically significant. It should be noted that the Pearson review of revalidation discusses moving towards virtual constant feedback.

9.2. **Myth:** What kind of feedback can I provide

The GMC has provided guidance on developing, commissioning and administering patient and colleague questionnaires. However, this specifically applies to the patient and colleague feedback which is required once in a revalidation cycle. Other feedback does not have to meet GMC guidance.

Some roles do not have enough patients or colleagues to meet the numbers required by a feedback tool. Sometimes including representation from across the whole of your scope of work in one survey can work and provide helpful feedback.

Feedback can be sought across the whole of your scope of work in ways appropriate to your context and sometimes this means that some feedback will (appropriately) not meet the GMC requirements. You need to undertake one patient feedback exercise and one colleague feedback exercise, normally once every five years, that 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 in the appraisal, and to present the raw data separately or redact it.

9.3. **Myth:** Do I have to do a patient feedback survey or provide other feedback every year

The GMC only requires you to do one fully GMC compliant patient survey in each revalidation cycle, usually every five years. However, Care Quality Commission (CQC) may require this more frequently.

If you have regular patient contacts every week, you should probably reflect on your relationship with patients, but you do not have to complete formal patient surveys every year. This may be an informal unsolicited comment or card, more formal feedback from department or hospital or national surveys.

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

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

You should choose the most appropriate colleague and patient feedback tools for your circumstances and these may be provided by your Designated Body. You are advised to review the GMC standards for such tools and agree, in advance, with your RO that they are happy to accept your choice, if, for any reason, your tool does not fully meet those standards. In all cases, where the tool is not fully GMC compliant, you will need to reflect on why not

and provide an explanation at appraisal. For example, a doctor involved in teaching may seek feedback from all their students, but it may be impossible to collect it in such a way that the feedback can be anonymous if the number of students is small. It may not be appropriate to ask the students to contribute to a wider colleague feedback exercise if the questionnaire used is not sufficiently specific to teaching skills.

10. My Personal Development Plan (PDP)

10.1. Myth: What should my PDP 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. Appraisers are often trained to recommend SMART (Specific, Measurable, Achievable, Relevant and Timely) goals. Performance objectives are part of job planning and not necessarily part of your appraisal PDP unless you specifically 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 or services will be.

10.2. Myth: My 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 should 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 PDP appropriate to your requirements.

The PDP goals should be balanced across the five-year cycle and across your whole scope of work. Goals that focus on being a good role model for patients and maintaining your personal health and wellbeing are entirely appropriate.

It not generally useful 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 in your particular specialty and field.

10.3. Myth: How many PDP goals do I have to list

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 after all 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.

AIHO

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