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RCGP Guide to the Revalidation of General Practitioners



Royal College of
General Practitioners

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The Royal College of General Practitioners was founded in 1952 with this object:
'To encourage, foster and maintain the highest possible standards in general practice and for that purpose to take or join with others in taking steps consistent with the charitable nature of that object which may assist towards the same.'

Among its responsibilities under its Royal Charter the College is entitled to:
'Diffuse information on all matters affecting general practice and issue such publications as may assist the object of the College.'

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

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Background

Please note that the text in this document sets out the current view of the Royal College of General Practitioners (RCGP). As our thinking evolves, including through comments on this document and the results of the pilots, new versions of this document will be posted on the website (www.rcgp.org.uk/revalidation/revalidation_guide.aspx). In particular, later versions will take account of policy statements from the General Medical Council (GMC), Departments of Health and the Academy of Medical Royal Colleges (AoMRC).

The GMC expects to introduce licensing during 2009. All doctors who are registered at the time that licensing is introduced will be entitled to a licence to practise. From its introduction, it will be the licence rather than registration that signifies to patients that a doctor has the legal authority to write prescriptions and sign death certificates. General practitioners (GPs) will need a licence to practise if they work as a doctor in the NHS or independent sectors, either on a permanent or locum basis. GPs will continue to be listed on both the General Medical Register and the General Practice Register.

Only licensed doctors will be subject to revalidation. In common with all vocationally trained doctors, GPs will need to be relicensed and recertified (the latter for the General Practice Register) periodically. These two outcomes will be achieved through one process – revalidation – in which GPs will need to provide evidence that they keep up to date and remain fit to practise.

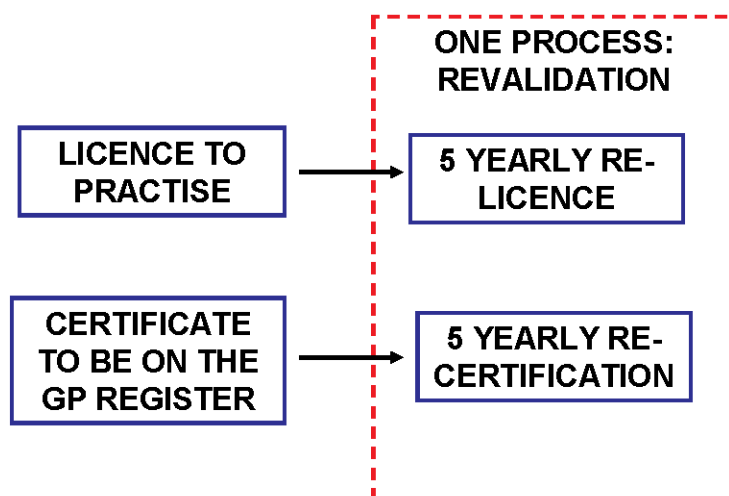


Figure 1: The revalidation process

The RCGP has the responsibility, on behalf of all GPs, to propose the standards and methods for the revalidation of GPs. However, the GMC must approve the standards and methods before they are introduced.

The first practical step towards defining the standards for revalidation was the publication by the GMC of a *Working Framework for Appraisal and Assessment*¹ based on *Good Medical Practice*. The criteria for the revalidation of all doctors are based on this document. Next, in 2008, the RCGP published its revision of *Good Medical Practice for General Practitioners*,² which set out the expectations to be held of an exemplary and an unacceptable GP.

Finally, the RCGP consulted on the sort of evidence that could reasonably be expected from GPs in both the NHS and independent sectors. Comments received on the *Revalidation for General Practitioners: a consultation document*³ have informed this guide.

The RCGP is undertaking pilots in 2009 in preparation for the anticipated commencement of revalidation. The evidence from those pilots will help to shape the revalidation process and will inform revisions of this guide. In particular, the RCGP recognises that there is still uncertainty around the roles and responsibilities of: Responsible Officers; the concept of Assessors and the local groups; the RCGP National Adjudication Panel; and the quality assurance of revalidation decisions. There are other areas where future policy may require changes to this guide.

The RCGP will need to have further discussions with the GMC and the Departments of Health in England, Scotland, Wales and Northern Ireland about how these ideas might operate in practice. Piloting on the ground with thorough evaluation and economic analysis will help to shape the final agreed system.

To prepare for its roles, the RCGP has been working closely with the GMC, the General Practitioners Committee (GPC) of the British Medical Association, the AoMRC, the Departments of Health, the Revalidation Support Team in England, and major independent providers of primary care, such as the Defence Medical Services. This document takes into account the views of all these valued partners.

This document sets out for all interested parties – GPs; other doctors; the NHS; other colleges, faculties and specialist associations; regulators; independent healthcare providers; and, most importantly, the public – the RCGP's current proposals for the evidence required for the revalidation of GPs. Although this document has been discussed with key stakeholders, several aspects are dependent on future policy decisions by others. This guide will, therefore, evolve into the definitive source of advice for GPs preparing their evidence for revalidation, appraisers and their advisers, and assessors.

The RCGP acknowledges the work of many other people who have generously allowed their documents to be used to populate this guide. It is based on the *Criteria Standards and Evidence for Revalidation* and these, in turn, were based on the GMC's *Framework for Appraisal and Assessment*. Other sources used include the GMC's *Good Medical Practice*, *Good Medical Practice for General Practitioners*, *Essential Evidence to Support Appraisal* from the Welsh Deanery, the *Leicester 2007 Conference Statement on Essential Evidence for Appraisal*, *Appraisal Evidence for Sessional Doctors*

1 www.gmc-uk.org/about/reform/gmp_framework.asp.

2 RCGP and GPC. *Good Medical Practice for General Practitioners* (second edn) London: RCGP, 2008, www.rcgp.org.uk/PDF/GMP_web.pdf.

3 www.rcgp.org.uk/practising_as_a_gp/revalidation.aspx.

4 www.revalidationsupport.nhs.uk/.

prepared by Dr Peter Berrey for NHS Education for Scotland, the Revalidation Support Team's *Enhanced Appraisal Unified Form* and the *RCGP Scotland Revalidation Toolkit*. The Revalidation Support Team has given valuable advice both to the RCGP and to the wider profession.⁴

The RCGP welcomes your comment on this *Guide to Revalidation of General Practitioners*. To make a comment please fill in the form on the RCGP website. This can be found at www.rcgp.org.uk/revalidation_guide_feedback.

Section I

Details of the evidence required for the revalidation of GPs

This section looks at each type of evidence that will be expected in a GP's revalidation portfolio. It offers advice on how GPs, including principals, sessional doctors, General Practitioners with a Special Interest (GPwSIs), and GPs in independent sectors such as the Defence Medical Services, will meet the requirements for revalidation. It also gives guidance to those who will assess GPs' revalidation portfolios.

For the purposes of this document, the revalidation period is taken to start officially on 1 April 2010. Of course, the start date is very much dependent on others, and some key infrastructural changes will need to be in place right across the UK before revalidation can begin. This will include the appointment of Responsible Officers in every Primary Care Trust and Local Health Board and the roll-out of an enhanced system of appraisal based on the *Good Medical Practice Framework for Appraisal and Assessment*.

We are working on a timetable that would see the first GPs revalidating in 2010/2011 so it is important that GPs begin putting together a portfolio of evidence from April 2009 (if they have not been doing so already). Of course, the required evidence for the year April 2009 to March 2010 will be limited to that required for annual appraisal, so should be achievable by any GP. No evidence will be required for the period prior to 1 April 2009.

Although it will be possible to complete a paper portfolio for revalidation, the clear preference will be for all GPs to complete an electronic portfolio (ePortfolio) for each appraisal, which will build into an ePortfolio covering the whole of the revalidation period. Evidence entered in the NHS Toolkit and the Wales Deanery portfolio will be usable for revalidation.

Evidence area 1

Statement of professional roles and other basic details

Advice for GPs

The statement of professional roles will need to be entered into the ePortfolio⁵ at the first appraisal, and then updated annually. The ePortfolio will indicate what other details are required within this section for revalidation, such as:

- title and name
- email address
- work address and telephone number
- preferred contact address and telephone number
- primary medical degree and awarding institution
- medical qualifications
- GMC number, registration date, licence date and date of entry onto the General Practice Register
- date of last revalidation (if applicable)
- all current posts and those within the revalidation period – date started, time commitment, employer (including address); if clinical, whether within an organisation with a quality-assured system for clinical governance;⁶ role content/description and performance review/appraisal within this post
- any voluntary roles undertaken in the capacity of a doctor
- free-text elaboration of any unusual evidence.

The GMC states revalidation will be based on what a doctor actually does in practice. In order for assessors to understand what the GP actually does, all posts undertaken as a doctor, whether paid or not, must therefore be included. The electronic portfolio will provide a format in which to record all roles. The details required will be the basics described above. GPs with extended roles, such as GPwSIs, GPs working in community hospitals, those involved in undergraduate, postgraduate or other teaching roles, or researchers, will be expected to include these roles here, and also provide fuller details in evidence area 13.

GPs in the Defence Medical Services will need to provide details of their extended responsibilities in clinical areas. These may include pre-hospital emergency medicine (e.g. BASICS), occupational medicine, travel medicine, sports and exercise medicine, public health, environmental health, aviation medicine, diving medicine and military community psychiatry.

For sessional doctors who locum for multiple providers over the revalidation period there will be no requirement to specify every one in which they worked. Instead they will be expected to give the dates over which they have been consistently working, practices/organisations in which they have worked on more than one occasion, and to indicate the general nature of the role(s) they have undertaken. For most, the latter will be 'clinical primary care in undifferentiated general

⁵ An ePortfolio, approved by the RCGP, will contain appraisal evidence, building into a revalidation portfolio. If a GP can justify it, in exceptional cases a paper-based portfolio will be accepted.

⁶ Organisations with quality-assured systems for clinical governance will include: the NHS; independent providers of primary care such as the Defence Medical Services and the Prison Service; and PCO-endorsed out-of-hours providers.

practice consultations' but they should also describe other medical roles if appropriate.

Advice for assessors

This section of the portfolio is key to understanding the GP's background and the context and content of his or her working life over the period of revalidation. Provided the section is fully completed, and there are no concerns about the honesty or truthfulness of the content of the submission, assessment of this section should be straightforward.

Evidence area 2

Statement of exceptional circumstances

Advice for GPs

This section of the portfolio is the opportunity for the GP to explain any unusual aspects of his or her working life during the revalidation period that may help the assessor to understand the evidence. Although most GPs will tick a box to indicate a nil return in this evidence area, a free-text box will offer an opportunity to record anything relevant including:

- prolonged or significant illness
- career breaks including sabbatical or maternity leave
- periods working abroad (including for charities and non-governmental organisations)
- important changes in working circumstances including the break-up of a partnership or a move to another practice.

This list is not intended to be exhaustive – there may be other circumstances that a GP may wish to include. This evidence area will be used by assessors to provide context in evaluating the GP's portfolio.

Advice for assessors

Any portfolio of evidence must meet the requirements for revalidation, including the minimum criteria specified in Section 3 of this guide. The contents of the statement of exceptional circumstances are not included in the portfolio to bypass the standards for revalidation, but to assist the assessors in interpreting the evidence presented to them. For example, there may be a year in which there is no evidence of satisfactory appraisal. If it is clear that the GP was working abroad or was on maternity leave at that time, the absence of evidence concerning that appraisal can be accepted.

The content of the statement of exceptional circumstances requires interpretation. The assessors will need to be satisfied that any stated exceptional circumstances are indeed legitimately exceptional. If there is doubt, the portfolio should be referred to the RCGP's National Adjudication Panel where consistent national standards can be applied. As experience of revalidation increases it is expected that fuller guidance based on case experience will be developed for assessors by the RCGP.

Evidence area 3

Evidence of active and effective participation in annual appraisals

Advice for GPs

All GPs in clinical practice are expected to take part in regular annual appraisal. In the early years of revalidation the evidence of active and effective participation in annual appraisal will relate to the period from 1 April 2009 (see Section 2 of this guide). Almost all revalidation portfolios will contain evidence automatically derived from the annual appraisal ePortfolio, accumulated year-on-year as the appraiser signs off each annual appraisal.

The minimum number of annual appraisals required for revalidation is set out in Section 3 of this guide. It is anticipated, however, that almost all revalidation folders will contain a complete series of satisfactory annual appraisals.

All doctors on the Performers List of a primary care organisation or working within an organisation with a quality-assured system of clinical governance, including locums, should receive administrative support in undertaking annual appraisals. If any doctors experience significant problems, which are not resolved satisfactorily with their primary care organisation or employer, they must draw this to the attention of the RCGP at an early point in the revalidation period and also list it under evidence area 2 (exceptional circumstances).

Advice for assessors

For most GPs, the assessment of this evidence area should be simply a case of checking that five appraisals have been signed off by a trained and approved appraiser within an organisation with a quality-assured system of clinical governance (see note above). If any annual appraisals are not certified, there should be an acceptable explanation in evidence area 2 (exceptional circumstances) and the minimum criteria must be met (Section 3).

If an annual appraisal has been undertaken but the appraiser was unable to sign off the GP's participation as active and effective, an explanation should be given that should include a statement from the clinical governance team where the doctor is based. One unsatisfactory appraisal may be acceptable if an investigation was undertaken, the reason was clearly established, remediation was prescribed and the doctor responded appropriately. If there are any significant doubts, or there has been more than one unsatisfactory annual appraisal, the portfolio should be referred to the RCGP's National Adjudication Panel, where consistent national standards can be applied. As revalidation is a rolling programme (not an isolated event in the final year of the revalidation cycle), it is not necessary to wait until the last year before such action is taken.

Evidence area 4

A Personal Development Plan from each annual appraisal

Advice for GPs

An annual Personal Development Plan (PDP) should be derived from participation in each annual appraisal. It should be signed off by the appraiser and the GP, and should represent the agreed plan for the forthcoming year. The portfolio should contain one PDP for each year in the period from 1 April 2009 (see Section 2 of this guide).

Usually a GP's PDP will be recorded as part of the ePortfolio for each annual appraisal and will be transferred into that GP's revalidation portfolio automatically.

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

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

- a statement of the development need
- an explanation of how the development need will be addressed (the action to be taken and the resources required)
- the date by which the goal will be achieved
- the intended outcome from the goal.

Advice for assessors

In assessing a GP's PDP, the assessor will need to be satisfied that all the PDPs submitted in a revalidation period, when taken together, represent an appropriate spread of learning areas as to reflect the statement of that doctor's practice in evidence area 1.

Some goals in a PDP are, inevitably, rather unspecific, but all of the recorded goals in the PDP should be 'SMART' (with some permitted to be less rigorous on the 'M' and the 'T'):

- **Specific** – described in such a way that the assessor can understand what the goal was and what it was intended to achieve
- **Measurable** – specifying how the GP, the appraiser and the assessor will know if it has been achieved
- **Achievable** – the goal should be realistic given the GP's position and resources available
- **Relevant** – the goal must be relevant to the needs of the GP, and the goals overall should be relevant to the clinical work undertaken by the GP
- **Time bounded** – there must be a specified time by which the goal will be achieved.

The assessor will only accept the GP's PDP if they show an overall commitment to personal development using appropriate goals. If there is significant doubt on the appropriateness of the submitted PDPs for revalidation, the portfolio should be referred to the RCGP's National Adjudication Panel where consistent national standards can be applied.

Evidence area 5

A review of the Personal Development Plan from each annual appraisal

Advice for GPs

For each PDP submitted, other than in the year immediately preceding submission for revalidation, there should be a column recording the outcome of the goal. The entries in this column should be agreed between the appraiser and the GP at the appraisal following the one in which the PDP was agreed.

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

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

It is very important that the GP reflects on the goal, the development achieved and any reasons for not achieving the goal. This reflection is an important attribute of a GP's fitness to practise.

Over a 5-year period the GP should not only consider clinical learning and development but also the competencies around leadership and management, recognising the importance of all doctors' role in a safe system of health care for patients (www.institute.nhs.uk/medicalleadership).

Advice for assessors

In assessing the comments on the goals set in the previously agreed PDP, the assessor should recognise that not all goals can always be met. However, SMART goals have a greater chance of achievement and low levels of achievement of goals may reflect the quality of PDP writing (evidence area 4). As a rule of thumb, at least two thirds of agreed PDP goals should be successfully achieved.

Normally goals, whether met or not, should show evidence of reflection on the personal development achieved and, if appropriate, the reasons for non-achievement. If in significant doubt about reflection or the level of achievement of goals is low, the portfolio should be referred to the RCGP's National Adjudication Panel, where consistent national standards can be applied.

Evidence area 6

Learning credits in each year of the revalidation period and in the revalidation period overall

Advice for GPs

The RCGP has developed a continuing professional development learning credits system to:

- ensure that every GP updates and applies his or her knowledge and skills
- promote patient confidence
- improve ultimately patient care.

The learning credits scheme is designed to be appropriate and available to all practising GPs, throughout the UK.

All medical royal colleges are using learning credit systems with a minimum of 50 credits in a year and 250 credits in a 5-year cycle to support a positive revalidation decision. However, unlike other college schemes, the RCGP credit system is not based on time spent but on the outcomes of learning.

‘A credit is a unit of professional development that is a product of the impact of a developmental activity and to a lesser extent the challenge involved in its completion.’

‘Credits are self-assessed and verified at appraisal.’

Each GP will, therefore, be expected to record his or her educational activity and award him or herself credits based upon the impact and challenge.

Impact includes:

- impact on patients (e.g. a change in practice, initiating a new drug – this has obvious overlaps with personal development)
- impact on the individual (personal development)
- impact on service (e.g. becoming a training practice, teaching others, implementing a clinic system).

Challenge is considered as:

- context related (e.g. more challenging to become a new training practice than a trainer in an established training practice)
- related to circumstances (e.g. a sessional GP undertaking audit is often faced with problems around the data and follow-up)
- related to personal ability (e.g. personal disability, prior skills, prior experience, etc.)
- related to effort expended (e.g. attending an ophthalmology clinic for a whole day to gain experience).

Over a revalidation cycle a GP will be expected to demonstrate a broad range of general practice education, with at least 50 learning credits being achieved and confirmed by the appraiser each year.

The RCGP will provide detailed advice on how a GP should assign credits and how an appraiser should validate those credits. However, it may be helpful to give some examples here.

Example

The GP presents a significant event to a significant event audit meeting, reflects on the discussion and writes up the outcome – 2 credits.

The GP does seven different courses on BMJ Learning and keeps a reflective note of how this will influence practice and patient care – 5 credits.

The GP does all the Essential Knowledge updates and passes the relevant Essential Knowledge challenges – 20 credits.

The GP records PUNS and DENS, and meets the identified needs – 10 credits.

After one half-day of Protected Learning Time on chronic kidney disease, the GP undertakes an audit, introduces a new protocol into the practice and re-audits to show improvement – 15 credits.

After another half-day of Protected Learning Time the GP reviews the practice policy on safeguarding children and checks the notes of three recent case – 6 credits.⁷

Advice for assessors

The appraiser should verify, as part of the appraisal discussion, that the credits claimed by the doctor being appraised are a reasonable estimate of the impact and challenge of the learning. The appraiser will have examined the appraisal Form 3 evidence and will have the opportunity to discuss in further depth any aspects of the credits claimed that need clarification. In the large majority of appraisals, it is expected that the appraiser will be satisfied and 'sign off' the GP's learning credits.

There are three scenarios that should lead to further discussion:

- the appraiser feels that overall the doctor has claimed too many credits
- the appraiser feels that overall the doctor has claimed too few credits
- the appraiser feels that the numbers of credits claimed for individual items bear little relation to their impact and challenge.

The assessor for revalidation will need to rely on the appraiser's 'sign off' to be satisfied that either an appropriate number of credits has been assigned by the GP or the GP's PDP reflects the need to improve the number or attribution of credits. If an appraiser is unable to 'sign off' a GP's claimed learning credits, the local Responsible Officer and the RCGP should be notified.

While the number of credits claimed should normally be more than 50 in each year, there may be exceptional circumstances that need to be taken into account. These may include the GP's statement in evidence area 2. If a GP does not achieve the 50 credits in a year and the PDP demonstrates that appropriate action is agreed to correct the shortfall in the next year, that will normally be regarded as acceptable. Repetitive or consistent failure to achieve the 50 credits per year will not normally be acceptable.

⁷ These are not 'standard' credits but illustrative for this particular doctor. The GP must reflect on the impact and challenge, and justify the credits claimed. For example, if there are many PUNS and DENS that have been well met the GP might claim 15 credits.

If in significant doubt about the learning credits claimed by GP, the assessor should refer the portfolio to the RCGP's National Adjudication Panel, where consistent national standards can be applied.

Evidence area 7

Multi-source feedback from colleagues

Advice for GPs

For multi-source feedback from colleagues (MSF) the GP will need to identify a number of GP colleagues and other people (nurse, practice manager, practice secretary, receptionist, etc.) with whom he or she works sufficiently closely to enable informed and representative opinions to be made. The selected colleagues will be asked to complete an online questionnaire giving their view on key attributes of the GP. In uncomplicated cases the questionnaire should take 10 to 20 minutes to complete, but it may take longer if reflection and consideration are required.

The RCGP has commissioned a review of MSF instruments and will recommend which ones are appropriate for use in revalidation. At present only the GMC's MSF instrument meets RCGP requirements. Although it will be permissible to scan in the results of an MSF and attach that file to the revalidation portfolio, it is expected that, in time, the results of MSFs will be automatically inserted into the GP's ePortfolio.

When revalidation is fully established, each GP will be required to submit evidence from two MSFs, one undertaken in the first 2 years of the 5-year revalidation period and one in the last 2 years. The transitional requirements are described in Section 2.

It is recognised that some attributes appropriate to principals in general practice (for example management and team leadership) are not appropriate for some doctors, such as those undertaking locum work. An MSF for sessional doctors is being developed and will be one of the options available for use in revalidation. Furthermore, if specific groups experience issues bespoke to their organisations, for example conducting MSF in hierarchical systems such as the Defence Medical Services, the RCGP will work with these partners to facilitate a satisfactory solution. The RCGP will ask organisations conducting MSF to provide peer referencing against GPs as a whole, and also an appropriate peer group (principals, salaried, locums, prison doctors, etc.).

It may be the case that peripatetic locums and/or doctors working out of hours will experience serious difficulties in undertaking conventional MSF. If the GP can show justification, the alternative of submitting the results of approved questionnaires completed by employing organisations (practices or out-of-hours providers) following episodes of service will be acceptable.

The most important aspect of doing MSFs is reflecting upon the results and, if appropriate, implementing changes. The result of each MSF should be discussed at annual appraisal, and the revalidation portfolio will need to show evidence of that discussion. Any agreed actions should be included in that appraisal's PDP and should be reviewed at the next appraisal.

Advice for assessors

The first requirement that assessors will look for is the presence of the required number of MSFs in the GP's revalidation portfolio. The assessor will then look for evidence that any issues arising from the result of each MSF have been identified, reflected on and appropriate goals set. Lastly, if there is more than one MSF in the portfolio, the assessor will look for evidence that, if any areas for improvement were identified in the first, there is evidence of some improvement

in the second, or reflection as to why this is not the case.

Provided the assessor is satisfied that there is a positive answer to the three issues above, the actual outcome from the MSF will only be of importance if the result is significantly poor compared with an appropriate peer group, or if there is other evidence that raises the possibility of concerns. The College will issue more specific advice on this matter as the evidence base develops.

If in significant doubt about the results from, or GP's response to, an MSF or MSFs, the revalidation ePortfolio should be referred to the RCGP's National Adjudication Panel, where consistent national standards can be applied.

Evidence area 8

Feedback from patients

Advice for GPs

The revalidation portfolio will, in time, contain the results of patient surveys. Section 2 of this guide describes when these will be expected in the introductory phases of revalidation. Once revalidation is fully established, the portfolio should include the results of two patient surveys, one undertaken in the first 2 years of the 5-year revalidation period and one in the last 2 years.

The RCGP has commissioned a review of patient surveys and will recommend which ones are appropriate for use in revalidation. They will need to seek the views of the patients *actually consulting* the GP – practice-based surveys of the registered population will not be acceptable. Although it will be permissible to scan in the results of a patient survey and attach that file to the revalidation portfolio, it is expected in time that the results of approved patient surveys will be automatically inserted into the GP's ePortfolio.

It is recognised that some GPs, in particular those working in the Prison Service, will find eliciting their patients' views challenging. However, the method of administering a questionnaire, with a freepost envelope, should be suitable for sessional doctors. The RCGP will ask organisations conducting the analyses of patient surveys to provide peer referencing against GPs as a whole and also an appropriate peer group (principals, salaried, locums, prison doctors, etc.).

The most important aspect of undertaking patient surveys is the reflection upon the results and, if appropriate, implementing changes. The result of each patient survey should be discussed at annual appraisal, and the revalidation folder will need to show evidence of that discussion. Any agreed actions should be included in that appraisal's PDP and should be reviewed at the next appraisal.

Advice for assessors

The first requirement that assessors will look for is the presence of the required number of patient surveys in the GP's revalidation portfolio. The assessor will then look for evidence that any issues arising from the result of each patient survey have been identified and appropriate goals set. Lastly, if there is more than one patient survey in the portfolio, the assessor will look for evidence that, if any areas for improvement were identified in the first, there is evidence of some improvement in the second, or reflection as to why this is not the case.

Provided the assessor is satisfied that there is a positive answer to those three issues the actual outcome from the patient survey will only be of importance if the result is significantly poor compared with an appropriate peer group, or if there is other evidence that raises the possibility of concerns. The College will issue more specific advice on this matter as the evidence base develops.

If in significant doubt about the results from, or the GP's response to, a patient survey or patient surveys, the portfolio should be referred to the RCGP's National Adjudication Panel, where consistent national standards can be applied.

Evidence area 9

Description of any cause for concern and/or formal complaint

Advice for GPs

Some GPs may have been identified as being a cause for concern during their revalidation period. The primary care organisation may have investigated the GP for possible or proven under-performance. The local postgraduate education organisation (e.g. deanery) or the National Clinical Assessment Service (NCAS) might have assessed the GP. There may have been a referral to the GMC. Any cause for concern⁸ should be recorded and reported on in this evidence area. The key elements of the report, which should not identify patients or other relevant individuals, should be:

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

If a cause for concern is unresolved at the time of revalidation, a revalidation portfolio cannot be considered. Neither the local group nor the RCGP centrally will be able to make a recommendation to the GMC. The GMC will, therefore, be asked to consider the GP's portfolio and decide how it wishes to handle that doctor's revalidation.

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

Although many such complaints are satisfactorily resolved at an early stage, a GP's revalidation portfolio should include all such complaints. The intention is not to rake over old events, but to look for two points: a pattern of complaints that may suggest systemic issues; and inappropriate responses to complaints (poor reflection, lessons not learnt, etc.). The description of such complaints should be sufficient for the assessors to satisfy themselves regarding these two points and should include:

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

There will be a standard form within the ePortfolio to record such information.

⁸ A 'cause for concern' is significant for revalidation purposes if the local Responsible Officer judges it to be so and is unresolved until the Responsible Officer is satisfied that there are no continuing issues that would compromise revalidation.

Some locum doctors may not be made aware of complaints concerning their care, but they should be notified by the practice or primary care organisation of all formal complaints. Some may find it more difficult to fully report the outcome of such complaints if the practice or primary care organisation does not communicate the outcome to them. The locum should use organisations such as the British Medical Association, the National Association of Sessional General Practitioners and the RCGP in a timely fashion if necessary to ensure an adequately completed portfolio.

Advice for assessors

A cause for concern will need to be resolved through local or national systems before an application for revalidation can be considered within the RCGP processes. If there has been a cause for concern during the revalidation period, the Responsible Officer will submit a statement to be included in the revalidation portfolio.

All the statements on complaints should be known to the local clinical governance team. Additionally the assessor must consider two aspects. The first is the pattern of events described in this evidence area that may show a concern that has not been detected by local processes, especially when considering the evidence within the portfolio as a whole. The second aspect is to look for evidence of the key attribute of reflection and improvement.

If the assessor has significant doubt about the evidence provided by the accounts of cause for concern and/or complaints, including the accuracy of the accounts and/or the GP's response to them, the portfolio should be referred to the RCGP's National Adjudication Panel, where consistent national standards can be applied.

Evidence area 10

Significant event audits

Advice for GPs

Significant event auditing is an increasingly routine part of general practice. It is a technique to reflect on, and learn from, individual cases to improve quality of care overall. When revalidation is fully established, a GP's revalidation portfolio will be expected to contain an analysis of at least five significant events. These can be from any time during the revalidation period. There is no requirement for 'one per year'. However, an appraiser will be concerned if a developing portfolio contains no such analyses by the beginning of the fourth year of the revalidation period; it is good practice to report significant events from throughout the revalidation period.

Although a significant event suitable for auditing can be one that demonstrates all levels of care from excellent through to poor, for the purposes of revalidation each of the submitted events must demonstrate, through the analysis, areas for improvement, reflection and the implementation of change. A GP must only submit an analysis of a significant event in which he or she has been directly involved either clinically or in terms of responsibility for the system of care used, where the event was discussed in a team meeting (usually a significant event audit meeting) by the GP with an appropriate selection of other primary care team members present, and where the changes involve him or herself, perhaps as the person responsible for implementing the change.

An account of a significant event audit should not allow patients to be identified and should comprise:

- title of the event
- date of the event
- date the event was discussed and the roles of those present
- description of the event involving the GP
- what went well?
- what could have been done better?
- reflections on the event in terms of:
 - knowledge, skills and performance
 - safety and quality
 - communication, partnership and teamwork
 - maintaining trust
- what changes have been agreed:
 - for me personally
 - for the team
- changes carried out and their effect.

The ePortfolio will have a standard form in which to record these fields.

Significant event audits need to be discussed in groups and are much easier to conduct within primary care teams. Single-handed GPs and independent locums may therefore experience difficulties in conducting significant event audits. They should try to discuss the event in a multidisciplinary meeting in the practice in which the event occurred. If that is not possible, they may join

a group of similar GPs who can, together, discuss each other's significant events. Experience shows that there are solutions to these potential problems for such GPs.

Advice for assessors

The assessor will need to be satisfied that at least the minimum number of significant events have been analysed and reported, and that they meet the qualifying criteria. Beyond that the key attributes of a satisfactory significant event audit are reflection and appropriate action undertaken.

If the assessor has major doubt about the significant event audits provided, either in terms of quantity or their quality, the portfolio should be referred to the RCGP's National Adjudication Panel, where consistent national standards can be applied.

Evidence area 11

Clinical audits

Advice for GPs

All GPs should be familiar with the principles and practice of clinical auditing. When revalidation is fully established, a GP's revalidation portfolio will be expected to contain appropriate evidence of auditing. This will normally be two full-cycle (initial audit, change implemented, re-audit to demonstrate improvement) clinical audits during the revalidation period. One clinical audit should be undertaken in years one, two or three, and one clinical audit in years three, four or five. Section 2 of this guide describes the transitional arrangements during the introduction of revalidation. However, the RCGP will be exploring other methods of clinical audit and may, in time, recommend a range of acceptable types of local, regional and national audit evidence.

The key attributes of a clinical audit are: the relevance of the topic chosen; the appropriateness of the standards of patient care set; the reflection on current care and the appropriateness of changes planned; the implementation of change for the GP's patients; and the demonstration of change by the GP. There is no expectation that the GP will actually undertake the data extraction and/or analysis, and there will be no recognition of the workload in this evidence area (it might be included in the challenge dimension of associated learning credits in evidence area 6 if it involves the GP's time and effort).

Several GPs who work together as a team may undertake a common audit. If this clinical audit is to be put into a GP's revalidation portfolio, that GP must have contributed properly to the choice of topic and the standards set. The GP must be able to identify his or her own care, or the care for which he or she is personally responsible, within the first audit and the re-audit. The GP must state what changes he or she instituted and be able to demonstrate the effects of those changes.

A description of a clinical audit should include:

- the title of the audit
- the reason for the choice of topic
- dates of the first data collection and the re-audit
- the standards set and their justification (reference to guidelines etc.)
- the results of the first data collection in comparison with the standards set
- a summary of the discussion and changes agreed, including any changes to the agreed standards
- the changes implemented by the GP
- the results of the second data collection in comparison with the standards set
- quality improvement achieved
- reflections on the clinical audit in terms of:
 - knowledge, skills and performance
 - safety and quality
 - communication, partnership and teamwork
 - maintaining trust.

The ePortfolio will have a standard form in which to record these fields.

Locums will have less infrastructure/practice support than practice-based GPs to facilitate clinical audits. Practices will be encouraged to facilitate access to clinical records for audits by locums, and the Department of Health will be encouraged to ensure that all prescribing is identified to the prescribing doctor. Guidance on audit topics suitable for sessional doctors, especially locums, will be drawn up, and a list of suggested topics may include:

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

Advice for assessors

The assessor will need to be satisfied that the required minimum number of clinical audits has been submitted, and that it meets the key attributes of a satisfactory clinical audit. These attributes are:

- the topic(s) chosen for the clinical audit(s). Given the GP's clinical roles (evidence area 1), are the topics appropriate?
- the audit reflects the care undertaken by the individual practitioner
- the standards of care set for the GP's patients. Are these based on recognised evidence and are they appropriate, or are they reflecting local or national priorities?
- reflection on current care. Has the GP reflected on the findings of the first data collection and reached appropriate conclusions?
- the changes planned after the first data collection. Has the GP decided on appropriate changes?
- the implementation of change. Has the GP acted to improve care for his or her patients?

If the standards set in an audit are appropriate and challenging, and the initial audit demonstrates exemplary care, then in these exceptional circumstances the GP may be justified in not undertaking the second data collection.

If the assessor has significant doubt about the clinical audits provided, either in terms of their quantity or quality, the portfolio should be referred to the RCGP's National Adjudication Panel, where consistent national standards can be applied.

Evidence area 12

Statement on probity and health

Advice for GPs

The GP will be asked to verify a standard statement or to provide an alternative statement. The standard statement should be very similar for all doctors. This standard statement will cover:

- there are no issues of probity in the GP's work
- there are no health issues that might affect the GP's ability to deliver safe care to patients (including infections, immunisation status such as against hepatitis B, problems with drugs and alcohol, mental health concerns and other significant diagnoses or problems)
- unless there is an exceptional reason (such as working on a military base in the Defence Medical Services) the GP is registered in a practice in which he or she does not work (or, in the case of a locum, rarely work), and that he or she accesses health care appropriately
- the GP has appropriate insurance or indemnity cover for all aspects of his or her work.

In the latter case, the GP will be asked to provide the name of the organisation providing insurance or indemnity cover and the membership number.

Advice for assessors

The assessor will need to be satisfied that this evidence area has been completed and that the statement is compatible with other evidence available in the revalidation portfolio (especially any cause for concern or complaint recorded).

If the assessor has significant doubt about the statements on probity or health provided, the portfolio should be referred to the RCGP's National Adjudication Panel, where consistent national standards can be applied.

Evidence area 13

Additional evidence for areas of extended practice

Advice for GPs

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

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

- teaching of undergraduates – a statement from the university department
- vocational training – a statement from the postgraduate organisation (deanery etc.) including the date and outcome of the last trainer approval visit
- research (including collaboration in research studies) – a statement from recognised research institution(s) involved and a statement from the Research Governance Team in the local primary care organisation
- appraisers – a statement from the employing primary care organisation
- out-of-hours work – a statement from the out-of-hours provider.

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

For clinical activities, including GPwSIs, the GP should describe in detail the role (in evidence area 1) and provide in this section of the portfolio evidence that satisfactorily answers the following three questions:

- 1 How did you qualify to take on this role? This should include prior experience, education and qualifications.
- 2 How do you keep up to date in this role? This should include reference to all education and refreshment undertaken for this role in the revalidation period, including any learning credits recorded in evidence area 6.
- 3 How can you demonstrate that you are fit to practise in this role? This should include appropriate audits of care delivered, including reference to any audits in evidence areas 10 and 11, evidence from third-party observation of your work, and sign-off from an appropriate consultant/expert/colleague who knows your work.

A GP who is working as an official GPwSI should also provide a certificate of accreditation.

Advice for assessors

The assessor will need to be satisfied that the GP's extended roles are appropriate and safe.

Section 2

Evidence required in the introductory phase of revalidation of GPs

Provided all the necessary elements can be put in place, it is expected that the first GPs to be revalidated will submit their evidence in 2010/11. Clearly these doctors cannot be expected to submit a full 5-year revalidation folder. This section sets out what evidence they, and those in subsequent years, will be expected to submit and is summarised in Table 1 (p. 28). The detailed description of the evidence is given in Section 1 of this guide.

It should be noted that the description here is the minimum evidence required and no GP will be penalised for submitting the minimum. However, most GPs will have evidence from previous years that they will wish to submit to produce as full a revalidation portfolio as they can. They will have, for example, a series of successful appraisals, some audits and significant events that they may wish to submit. All evidence submitted in a revalidation portfolio will be assessed for revalidation.

Submitting evidence in the first year (April 2010 to March 2011)

In the first year of the introduction of revalidation, the GP will be expected to submit a portfolio of evidence that contains:

- a description of all the professional roles undertaken by the GP
- a statement of any exceptional circumstances
- evidence of active and effective participation in a cycle of one annual appraisal in 2009/10
- a PDP for 2010/11 agreed with the appraiser
- either self-accreditation of a minimum of 50 learning credits in 2009/10 or a description of all CPD experienced in 2009/10 with reflection on the effects, discussed and agreed at annual appraisal
- a description of any cause for concern raised about the GP and a review of any formal complaint in which the doctor has been directly involved in 2009/10
- a minimum of one significant event audit involving the GP that demonstrates reflection and change, with evidence of discussion in appraisal
- statements of probity, health and use of health care, including registration with a GP in another practice; evidence of appropriate insurance or indemnity cover
- additional evidence for those GPs with extended roles.

Submitting evidence in the second year (2011/12)

In the second year of the introduction of revalidation, the GP will be expected to submit a portfolio of evidence that contains:

- a description of all the professional roles undertaken by the GP
- a statement of any exceptional circumstances
- evidence of active and effective participation in two annual appraisals (2009/10 and 2010/11)
- a PDP for 2009/10 and 2010/11 agreed with the appraiser
- a review of the 2009/10 PDP, with reflection on whether educational needs identified have been met, or reasons as to why they have not been or only partially met
- self-accreditation of a minimum of 50 learning credits in 2010/11, discussed and agreed at annual appraisal
- results of either one MSF from colleagues or one patient survey of his or her consultations and care, with evidence of reflection and discussion in appraisal
- a description of any cause for concern raised about the GP and a review of any formal complaint in which the doctor has been directly involved in 2009/10 or 2010/11
- a minimum of two significant event audits involving the GP that demonstrate reflection and change, with evidence of discussion in appraisal
- audit of the care delivered by the GP in at least one significant clinical area of his or her practice, with standards, re-audit and evidence of both appropriate improvement, compliance with best-practice guidelines and discussion in appraisal
- statements of probity, health and use of health care, including registration with a GP in another practice; evidence of appropriate insurance or indemnity cover
- additional evidence for those GPs with extended roles.

Submitting evidence in the third year (2012/13)

In the third year of the introduction of revalidation, the GP will be expected to submit a portfolio of evidence that contains:

- a description of all the professional roles undertaken by the GP
- a statement of any exceptional circumstances
- evidence of active and effective participation in a cycle of three annual appraisals (2009/10, 2010/11 and 2011/12)
- a PDP for 2009/10, 2010/11 and 2011/12 agreed with the appraiser
- two reviews of the 2009/10 and 2010/11 PDPs, with reflection on whether educational needs identified have been met, or reasons as to why they have not been or only partially been met
- self-accreditation of a minimum of 100 learning credits, at least 50 credits in each of 2010/11 and 2011/12, discussed and agreed at annual appraisal
- results of at least one MSF from colleagues, with evidence of reflection and discussion in appraisal
- results of at least one patient survey of the GP's consultations and care, with evidence of reflection and discussion in appraisal
- a description of any cause for concern raised about the GP and a review of any formal complaint in which the doctor has been directly involved in 2009/10, 2010/11 and 2011/12
- a minimum of three significant event audits involving the GP that demonstrate reflection and change, with evidence of discussion in appraisal
- audit of the care delivered by the GP in at least one significant clinical area of his or her practice, with standards, re-audit and evidence of both appropriate improvement, compliance with

best-practice guidelines and discussion in appraisal

- statements of probity, health and use of health care, including registration with a GP in another practice; evidence of appropriate insurance or indemnity cover
- additional evidence for those GPs with extended roles.

Submitting evidence in the fourth year (2013/14)

In the fourth year of the introduction of revalidation the GP will be expected to submit a portfolio of evidence that contains:

- a description of all the professional roles undertaken by the GP
- a statement of any exceptional circumstances
- evidence of active and effective participation in a cycle of four annual appraisals (2009/10, 2010/11, 2011/12 and 2012/13)
- a PDP for 2009/10, 2010/11, 2011/12 and 2012/13 agreed with the appraiser
- three reviews of the 2009/10, 2010/11 and 2011/12 PDPs, with reflection on whether educational needs identified have been met, or reasons as to why they have not been or only partially met
- self-accreditation of a minimum of 150 learning credits, at least 50 credits in each of 2010/11, 2011/12 and 2012/13, discussed and agreed at annual appraisal
- results of at least one MSF from colleagues, with evidence of reflection and discussion in appraisal
- results of at least two patient surveys of the GP's consultations and care, with evidence of reflection, appropriate change and discussion in appraisal
- a description of any cause for concern raised about the GP and a review of any formal complaint in which the doctor has been directly involved in 2009/10, 2010/11, 2011/12 and 2012/13
- a minimum of four significant event audits involving the GP that demonstrate reflection and change, with evidence of discussion in appraisal
- audit of the care delivered by the GP in at least two significant clinical areas of his or her practice, with standards, re-audit and evidence of both appropriate improvement, compliance with best-practice guidelines and discussion in appraisal
- statements of probity, health and use of health care, including registration with a GP in another practice; evidence of appropriate insurance or indemnity cover
- additional evidence for those GPs with extended roles.

Submitting evidence in the fifth year (2014/15)

In the fifth year of the introduction of revalidation, the GP will be expected to submit a portfolio of evidence that includes:

- a description of all the professional roles undertaken by the GP
- a statement of any exceptional circumstances
- evidence of active and effective participation in a cycle of five annual appraisals over the 5-year revalidation cycle (2009/10, 2010/11, 2011/12, 2012/13 and 2013/14)
- a PDP for each of 5 years 2009/10, 2010/11, 2011/12, 2012/13 and 2013/14 agreed with the appraiser
- four reviews of the previous year's PDP (for 2009/10, 2010/11, 2011/12 and 2012/13), with reflection on whether educational needs identified have been met, or reasons as to why they have not been or only partially met
- self-accreditation of a minimum of 200 learning credits, at least 50 credits in each of 2010/11, 2011/12, 2012/13 and 2013/14, discussed and agreed at annual appraisal
- results of at least two MSFs from colleagues, with evidence of reflection, appropriate change

and discussion in appraisal

- results of at least two patient surveys of the GP's consultations and care during the revalidation cycle, with evidence of reflection, appropriate change and discussion in appraisal
- a description of any cause for concern raised about the GP and a review of any formal complaint in which the doctor has been directly involved
- a minimum of five significant event audits involving the GP that demonstrate reflection and change, with evidence of discussion in appraisal
- audits of the care delivered by the GP in at least two significant clinical areas of his or her practice, with standards, re-audit and evidence of both appropriate improvement, compliance with best-practice guidelines and discussion in appraisal
- statements of probity, health and use of health care, including registration with a GP in another practice; evidence of appropriate insurance or indemnity cover
- additional evidence for those GPs with extended roles.

Submitting evidence in the sixth year (2015) onwards

In the sixth year of the introduction of revalidation, the GP will be expected to submit a full portfolio of evidence as described in Section 1 of this guide.

Table 1: The evidence required for revalidation, year by year, during the introductory period

Evidence	Year 1 (2010/11)	Year 2 (2011/12)	Year 3 (2012/13)	Year 4 (2013/14)	Year 5 (2014/15)
Description of roles	✓	✓	✓	✓	✓
Exceptional circumstances	✓	✓	✓	✓	✓
Evidence of appraisals	One	Two	Three	Four	Five
PDPs	One	Two	Three	Four	Five
Reviews of PDPs		One	Two	Three	Four
Learning credits	50 or CPD	50	100	150	200
MSFs from colleagues		Either one MSF or one patient survey	One	One	Two
Patient surveys			One	Two	Two
Review of complaints since 2009/10	✓	✓	✓	✓	✓
Significant event audits	One	Two	Three	Four	Five
Conventional audits		One	One	Two	Two
Statement of probity and health	✓	✓	✓	✓	✓

Section 3

Evidence required for the revalidation of GPs whose experience is not standard

This section of the document describes possible ways in which evidence might be submitted by those who would find a standard portfolio of evidence for revalidation impractical. This group encompasses: those in clinical general practice who may find elements of a standard portfolio difficult to accumulate; those who were not in work for all years in the 5-year revalidation cycle or who are on extended career breaks; and those whose only or predominant work as a doctor is not as a clinical GP. The latter group includes a small number of GPs in NHS management, educational management, political roles, health informatics, academia or staff appointments within the Defence Medical Services.

Guidance in considering non-standard portfolios

In considering whether to recommend a doctor for recertification for the General Practice Register, it is suggested that assessors and the RCGP's National Adjudication Panel will take into account the following guidance:

- if, at revalidation, a GP has not been in clinical practice at all during the revalidation period, the RCGP will not normally recommend that doctor for recertification to the General Practice Register. During the introductory phase of revalidation, a GP may submit evidence of clinical activity prior to the revalidation period but within 5 years. In some such cases the RCGP may recommend that the GMC revalidates the GP; sometimes, however, the RCGP will refer such cases to the GMC for its decision on eligibility
- if, at revalidation, a GP has been in clinical practice during the revalidation period the assessor and the RCGP's National Adjudication Panel will wish to consider the following:
 - the environment in which the GP has worked and whether the evidence of clinical governance and annual appraisal from that environment can be relied upon
 - the GP's learning credits both over the revalidation period and within each appraisal year
 - the evidence of annual appraisal, annual PDP and PDP review
 - the evidence of feedback from colleagues (MSF) and patients (patient surveys)
 - any assessment of clinical skills or knowledge
 - any outcome from a re-entry programme.

The RCGP will normally expect evidence that the GP satisfies the requirements for recertification for each year in which the GP was substantially clinically active, within the minimum requirements described below.

Of course, the RCGP is aware that a small but significant number of doctors on the General Practice Register are no longer active in terms of clinical practice but play a significant role in the

primary care context as medical directors. Many of these medical directors are likely to be appointed as Responsible Officers and to have a significant role in the revalidation of GPs within their local setting. We are aware that many of these doctors are concerned at the possibility that the process of recertification might lead to the loss of their entry on the General Practice Register, which, in many areas, is a requirement for a medical director post in primary care. This is also true of full-time medical directors in secondary care who are on the Specialist Register.

We are working with the GMC, the Departments of Health and others to ensure that the processes we develop for revalidation do not discourage GPs from taking leadership roles in a primary care context that we believe is crucial to enhancing the quality of care in general practice. The GMC is currently considering proposals on how the registers that they hold can best reflect a doctor's medical qualifications as well as an individual's current practice.

Minimum standards for considering a portfolio

When revalidation is fully established over a 5-year cycle the minimum evidence that an assessor, or the RCGP's National Adjudication Panel, will normally need before a GP's portfolio can be considered for revalidation will be:

- active participation in approved appraisal with a PDP agreed and a review of a previous PDP in at least 3 of the 5 years in the revalidation cycle
- demonstration of 50 learning credits in each of at least 3 of the 5 years in the revalidation cycle
- documentation of at least 200 clinical half-day sessions (equivalent to 1 day a week over a period of at least 2 years) in the 5 years in the revalidation cycle. A half-day would normally last 4 hours and include at least 2 and a 1/2 hours of face-to-face clinical contact.

The GP's Responsible Officer, assessors and the RCGP's National Adjudication Panel will need to be satisfied that the evidence is sufficient to demonstrate that the doctor is up to date and fit to practise at the time of revalidation.

It should be noted that the Committee of General Practice Education Directors (COGPED) recommend a re-entry course in an approved setting after a GP has had an absence of a period of 2 years with no learning credits or appraisal during that time.

Alternative evidence in a revalidation portfolio

The RCGP will be recommending to the GMC that there is some choice available to GPs who are eligible for consideration for revalidation, but who can justify a claim that the collection of a standard portfolio is unreasonably onerous.

In particular, those who wish to undertake and pass an approved knowledge assessment in their fifth year might not be required to submit evidence of 250 learning credits. A GP providing evidence of passing an approved Clinical Skills Assessment within the previous year might be able to justify not submitting significant event audits or clinical audits. The option of submitting evidence through knowledge or Clinical Skills Assessments should be used under exceptional circumstances and must be justified on the basis of the doctor's very unusual circumstances. The GP should, therefore, discuss this option with the RCGP's National Adjudication Panel before considering its use.

It should be noted that there will be no alternative to participation in appraisals and clinical governance.

GPs returning to general practice or wishing to be revalidated without an acceptable minimum portfolio

If a GP is on the GMC General Practice Register but does not meet the minimum criteria set out in this guide, then he or she should undertake and achieve satisfactory outcomes from a re-entry programme. Normally this will include the demonstration of his or her fitness to practise through passing an approved knowledge assessment and an approved Clinical Skills Assessment.

The same will apply to GPs who were previously on the General Practice Register but who are not currently certificated. The GMC will need to consider the arrangements whereby such a doctor can be licensed or certificated to allow him or her to participate in a re-entry programme, but a mechanism such as conditional certification will be required.

Non-clinical GPs

Non-clinical GPs are a small but important group, especially prevalent in the upper echelons of independent healthcare systems with quality-assured clinical governance, such as the Defence Medical Services. These doctors must be in good standing with the GMC in order to undertake the work they do, but they may not be in active clinical practice for significant periods of time. The RCGP recommends that they should submit evidence for revalidation under the principles in this document. If they have not been in active clinical practice in the 5 years of the revalidation cycle or have not met the minimum criteria agreed by the RCGP, they will not normally be recommended for recertification.

The GMC will consider whether they are eligible for relicensure, as a licence may be all they require to undertake their non-clinical role. GPs who are relicensed, but not recertified, will still need to relate to a Responsible Officer and if relicensed would need to undergo re-entry before restarting clinical practice. However, the GMC is considering a range of options whereby the General Practice Register can show that a doctor was on the register and is eligible to return to the register (through due process), but is currently in a non-clinical role.

Portfolios for revalidation for GPs

The RCGP will want to consider each portfolio of evidence submitted by a GP for recertification on its merits. There will be four main types of portfolios of evidence, as summarised in Table 2 (p. 32):

Standard portfolio

The expectation is that the vast majority of GPs will submit a standard portfolio of evidence to be assessed in a standard way.

Non-standard portfolio

Some GPs will find a standard portfolio challenging and may opt to use success in an approved knowledge assessment to replace evidence of learning credits and/or success in an approved Clinical Skills Assessment to replace evidence of significant event and conventional audits.

Partial portfolio

If a GP has not been in active clinical practice for all of the 5 years in the revalidation cycle, he or she can submit evidence that meets the minimum requirement for clinical activity in the 5 years and that he or she has kept up to date and been appraised in at least 3 of the past 5 years.

Re-entry portfolio

If a GP cannot meet the requirements for a partial portfolio, he or she will need to provide evidence of successful re-entry to clinical general practice, success in an approved knowledge assessment and success in an approved Clinical Skills Assessment.

Table 2: Evidence for portfolios

<i>Evidence</i>	<i>Standard portfolio</i>	<i>Non-standard portfolio</i>	<i>Partial portfolio</i>	<i>Re-entry portfolio</i>
Description of roles	✓	✓	✓	✓
Exceptional circumstances	✓	✓	✓	✓
Evidence of five appraisals	✓	✓	At least three	
Five PDPs	✓	✓	At least three	
Four reviews of PDPs	✓	✓	At least two	
250 learning credits	✓		At least 150	
Two MSFs from colleagues	✓	✓	Either one or two	
Two patient surveys	✓	✓	Either one or two	
Review of complaints	✓	✓	✓	
Five significant event audits	✓		One for each year in practice in the five	
Two conventional audits	✓		Either one or two	
Statement of probity and health	✓	✓	✓	✓
Approved knowledge assessment		✓		✓
Approved Clinical Skills Assessment		✓		✓
Satisfactory completion of re-entry programme				✓

Partial portfolios during the transition

It is expected that GPs will submit partial portfolios in the first two years (2010/11 and 2011/12).

In 2012/13 a partial portfolio should contain: evidence of satisfactory appraisal, PDP agreement and PDP review in 2 of the 3 years; at least 50 learning credits in each of 2 of the 3 years; and at least 100 half-days of clinical activity. In other respects the portfolio should be standard (as described in Section 2).

In 2013/14 a partial portfolio should contain: evidence of satisfactory appraisal, PDP agreement and PDP review in at least 2 of the 4 years; at least 50 learning credits in each of 2 of the 4 years; and at least 150 half-days of clinical activity. In other respects the portfolio should be standard (as described in Section 2).

In 2014/15 a partial portfolio should contain: evidence of satisfactory appraisal, PDP agreement and PDP review in 3 of the 5 years; at least 50 learning credits in each of 3 of the 5 years; and at least 200 half-days of clinical activity. In other respects the portfolio should be standard (as described in Section 2).

Section 4

Processes of revalidation of GPs

This section of the document describes submission of portfolios, their assessment, the recommendation to the GMC, the handling of portfolios that need national review and quality assurance methods.

The whole of the RCGP's proposals for revalidation, as described in this guide, must be approved by the GMC. This section, in particular, must both be approved by the GMC and be coherent with the proposals from other colleges.

Submission of the evidence

Each GP will be expected to submit a portfolio of evidence for revalidation. After the transition period, this will normally be every 5 years. It is expected that most GPs will gather an ePortfolio for their annual appraisals and revalidation. They will submit the relevant parts of that electronic portfolio for their revalidation.

One function of 'enhanced appraisal' (appraisal fit for revalidation) is for the appraiser to assess the GP's evidence being gathered for revalidation. The appraiser will be asked to check that the quantity of evidence is appropriate for that point in the revalidation cycle, and that the gathered evidence, as far as the appraiser can assess, is of appropriate quality for revalidation. If there are correctable shortfalls these should be included in the GP's PDP with a view to the developing evidence being appropriate by the next appraisal. This means that the appraiser will need access to the evidence identified for submission in revalidation, including all PDPs, in the revalidation period.

The GP's revalidation portfolio of evidence will be considered alongside evidence from other local sources including clinical governance data. Such data will be shared with the GP, who will have an opportunity to reflect on it.

All doctors must be able to relate to an appropriate Responsible Officer in whatever environment they are working in. The Department of Health (in its recent consultation) suggests that each Primary Care Trust or Health Board will have a single Responsible Officer, who will be a 'senior doctor with personal responsibility for evaluating the conduct and performance of doctors and making recommendations on their fitness to practice as part of revalidation'.⁹ Accordingly, it is intended that a Responsible Officer will usually be the medical director or equivalent who, at

⁹ Defined within DH Consultation on Responsible Officers: For more information, see: www.dh.gov.uk/en/Consultations/Liveconsultations/DH_086443.

local level, will:

- ensure that appraisal is carried out to a good standard
- support doctors in addressing any shortfalls
- ensure any concerns/complaints are addressed
- collate information to support a recommendation on the revalidation to individual doctors to the GMC.

Assessment of evidence for revalidation

This section is one that is especially liable to change as policies for assessing revalidation portfolios become clearer. However, this text sets out the RCGP's current view.

When a portfolio of evidence is submitted it will initially be sifted by the local Responsible Officer or his or her staff. This assessment will also be informed by the evidence from annual appraisals and clinical governance processes. The evidence will be initially assessed into three broad categories:

- appears satisfactory
- needs discussion
- substantial issues are raised.

In every primary care organisation there will be a group consisting of the Responsible Officer, an RCGP external assessor and a lay assessor. [If the Responsible Officer is not on the General Practice Register, the Responsible Officer will need to consider appointing an appropriate GP as his or her adviser and to attend the meeting.] All three will need appropriate and adequate training and resourcing. The trio will allocate their time appropriately, sampling satisfactory portfolios and assessing fully other portfolios.

The three members of the local group will use this guide to inform their assessment of a portfolio. This guide will be developed as experience of assessing portfolios grows and may be supplemented by special guidance for unusual portfolios. The Responsible Officer will notify the GMC of the names of those GPs that the local group is able to recommend for revalidation. The notification will be copied to the RCGP so that a sample of anonymised approved portfolios can be quality assured.

There may be circumstances where a deferment is appropriate. This might be where performance procedures are incomplete, where there is a minor fault with an otherwise satisfactory portfolio, where a new complaint has arisen, where, for example, MSF has not been completed on time by the organisation, or when a doctor moves to a new area.

Where the local trio are unable to recommend revalidation to the GMC, the portfolio will be shared centrally with the RCGP's National Adjudication Panel. The precise processes by which the decision will then be moderated have yet to be decided. At this stage some doctors will be recommended for revalidation, but others may need to be considered further by the GMC.

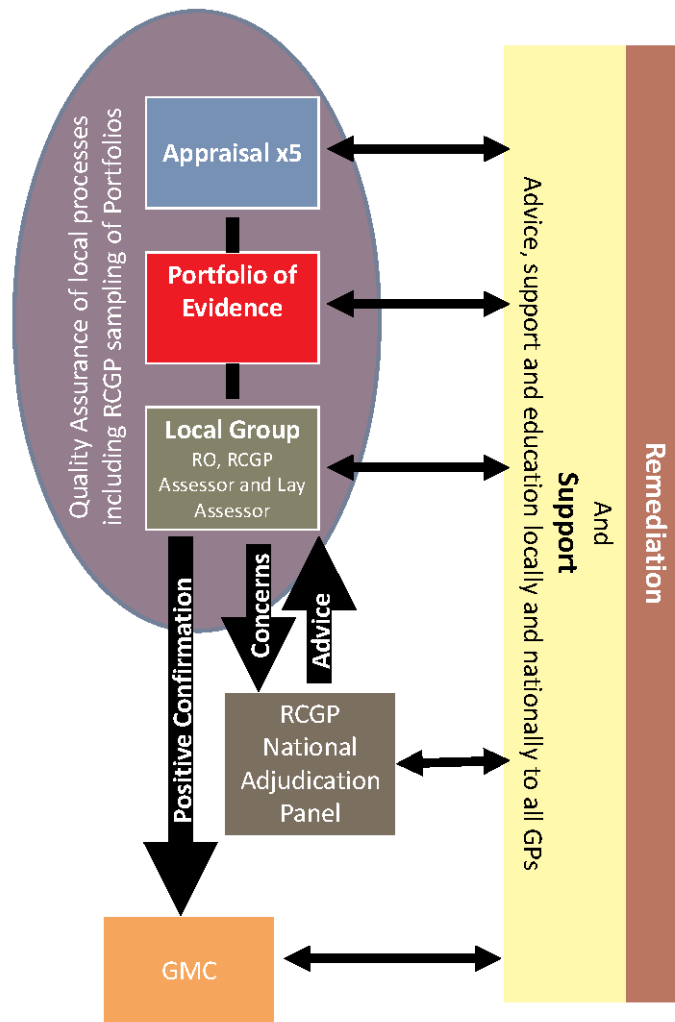


Figure 2: Quality assurance of local processes

GMC affiliates

The GMC is currently conducting pilots to develop the role of the regional GMC Affiliate. It is proposed that GMC Affiliates should offer guidance on standards and quality assurance for Responsible Officers, and provide independent assurance of the quality and consistency of local appraisal and clinical governance systems that underpin revalidation decisions.

Quality assurance

The RCGP has a key role in quality assurance of the assessment process. To do this, the RCGP will need to oversee the training and processes of the assessors, be assured that local systems are effective, review all portfolios where a local recommendation cannot be made, and review an anonymised sample of recommended portfolios. The RCGP will need to satisfy the GMC that the process of revalidation is as fair, equitable and objective as possible.

Section 5

Derivation of the evidence for the revalidation of GPs

The RCGP has published in other documents the Criteria, Standards and Evidence for the Revalidation of GPs, including the mapping to the GMC's Framework. Since this guide is intended to develop into the definitive source of information on revalidation for GPs, the table is included here for completeness.

The map of the RCGP's criteria, standards and evidence to the GMC's Revalidation Framework

GMC attribute	GMC standards	RCGP criterion and standards	RCGP evidence and evaluation
<i>Domain 1: knowledge, skills and performance</i>			
Maintain your professional performance	<p><i>Generic:</i> Maintain knowledge of the law and other regulation relevant to practice (13) Keep knowledge and skills up to date (12) Follow appropriate national research governance guidelines (71c) Develop and maintain the skills, attitudes and practice of a competent teacher (16)</p> <p><i>Clinical:</i> Undertake regular and systematic audit of your practice and the practice of the team in which you work (14c, 41d)</p>	<p><i>Criterion:</i> A GP must maintain his or her knowledge and skills, and keep up to date <i>Standards:</i> <i>Good Medical Practice for General Practitioners</i> (second edn) (RCGP and GPC. London: RCGP, 2008),¹⁰ Section 2: Maintaining good medical practice, pp. 19 to 21</p> <p><i>Criterion:</i> A GP who teaches, appraises or researches must do so properly, ethically and fairly</p>	<p>Self-accreditation of a minimum of 250 learning credits over the 5-year revalidation cycle, normally at least 50 credits each year, discussed and agreed at annual appraisal Results of relevant questions in at least two MSF surveys from colleagues, with evidence of reflection, appropriate change and discussion in appraisal</p> <p>Evaluations of teaching and appraisals by students and appraisees</p>

¹⁰ www.rcgp.org.uk/PDF/GMP_web.pdf.

GMC attribute	GMC standards	RCGP criterion and standards	RCGP evidence and evaluation
		<p>Standards: <i>Good Medical Practice for General Practitioners</i> (second edn), Section 3: Teaching and training, appraising and assessing, pp. 23 to 25 And <i>Good Medical Practice for General Practitioners</i> (second edn), Section 6: Probity, pp. 45 to 52 (particularly Research on pp. 49 and 50)</p>	<p>Results of relevant questions in at least two MSF surveys from colleagues, with evidence of reflection, appropriate change and discussion in appraisal Research governance sign-off</p>
<p>Apply knowledge and experience to practice</p>	<p><i>Generic:</i> Manage colleagues effectively (42)</p> <p><i>Clinical:</i> Adequately assess the patient's conditions (2a) Provide or arrange advice, investigations or treatment where necessary (2b) Prescribe drugs or treatment, including repeat prescriptions, safely and appropriately (3b) Provide effective treatments based on the best available evidence (3c) Take steps to alleviate pain and distress whether or not a cure may be possible (3d) Consult colleagues, or refer patients to colleagues, when this is in the patient's best interests (2c, 3a, 3i, 54, 55) Support patients in caring for themselves (21e)</p>	<p><i>Criterion:</i> A GP must have the appropriate clinical and communication skills, and apply those skills for the doctor–patient partnership, including support for self-care <i>Standards: Good Medical Practice for General Practitioners</i> (second edn), Section 1: Good clinical care, pp. 5 to 17 And <i>Good Medical Practice for General Practitioners</i> (second edn), Section 4: Relationships with patients, pp. 27 to 34</p>	<p>Results of at least two patient surveys of his or her consultations and care during the revalidation cycle, with evidence of reflection, appropriate change and discussion in appraisal Results of relevant questions in at least two MSF surveys from colleagues, with evidence of reflection, appropriate change and discussion in appraisal A review of all formal complaints directly involving the GP, with description of the circumstances, lessons learnt and appropriate actions taken, and evidence of discussion in appraisal</p>

<i>GMC attribute</i>	<i>GMC standards</i>	<i>RCGP criterion and standards</i>	<i>RCGP evidence and evaluation</i>
Keep clear, accurate and legible records	<p><i>Generic:</i> Make records at the same time as the events you are recording or as soon as possible afterwards (3g)</p> <p><i>Clinical:</i> Record clinical findings, decisions, information given to patients, drugs prescribed or other information or treatment (3f)</p>	<p><i>Criterion:</i> A GP must keep good records <i>Standards:</i> <i>Good Medical Practice for General Practitioners</i> (second edn), Section 1: Good clinical care, pp. 5 to 18 (particularly pp. 9 and 10)</p>	Results of relevant questions in at least two MSF surveys from colleagues, with evidence of reflection, appropriate change and discussion in appraisal
<i>Domain 2: safety and quality</i>			
Put into effect systems to protect patients and improve care	<p><i>Generic:</i> Recognise and work within the limits of your competence (3a) Take part in quality assurance and quality improvement systems (14d) Respond constructively to the outcome of audit, appraisals and performance reviews (14e) Provide only honest, justifiable and accurate comments when giving references for, or writing appraisals or other reports about, colleagues (18, 19) Make sure that all staff for whom you are responsible, including locums and students, are properly supervised (17) Ensure systems are in place for colleagues to raise concerns about risks to patients (45)</p>	<p><i>Criterion:</i> A GP must demonstrate commitment to reflective practice, quality assurance and improvement; and that the standards of care and patient safety achieved are appropriate <i>Standards:</i> <i>Good Medical Practice for General Practitioners</i> (second edn), Section 2: Maintaining good medical practice, pp. 19 to 21</p>	<p>Evidence of active and effective participation in a cycle of five annual appraisals over the 5-year recertification cycle A PDP for each year agreed in appraisal A review of the previous year's PDP with reflection on whether educational needs identified have been met and agreed in appraisal A minimum of five significant event audits involving the GP that demonstrate reflection and change, with evidence of discussion in appraisal A review of any concerns raised and all formal complaints directly involving the GP, with description of the circumstances, lessons learnt and appropriate actions taken, and evidence of discussion in appraisal</p>

GMC attribute	GMC standards	RCGP criterion and standards	RCGP evidence and evaluation
	<p><i>Clinical:</i> Provide information for confidential inquiries and adverse event reporting (14g) Report suspected adverse drug reactions (14h) Co-operate with legitimate requests for information from organisations monitoring public health (14i) Ensure arrangements are made for the continuing care of the patient where necessary (40, 48)</p>		Audits of the care delivered by the GP in at least two significant clinical areas of his or her practice, with standards, re-audit and evidence of both appropriate improvement, compliance with best-practice guidelines and discussion in appraisal
Respond to risks to safety	<p><i>Generic:</i> Take action where there is evidence that a colleague's conduct, performance or health may be putting patients at risk. (43, 44)</p> <p><i>Clinical:</i> Report risks in the healthcare environment to his or her employing or contracting bodies (6) Safeguard and protect the health and wellbeing of vulnerable people, including children and the elderly, and those with learning disabilities (26, 28)</p>	<p><i>Criterion:</i> A GP must be suitably trained, skilled and insured or indemnified for the roles he or she undertakes <i>Standards:</i> <i>Good Medical Practice for General Practitioners</i> (second edn), Section 1: Good clinical care, pp. 5 to 18 (particularly pp. 6 to 8)</p>	Evidence and supporting statements for his or her training, standards of care and competence in any extended clinical role (such as GPwSI) performed Results of relevant questions in at least two MSF surveys from colleagues, with evidence of reflection, appropriate change and discussion in appraisal Evidence of appropriate insurance or indemnity cover
Protect patients and colleagues from any risk posed by your health	<p><i>Generic:</i> Make arrangements for accessing independent medical advice when necessary (77)</p> <p><i>Clinical:</i> Be immunised against common serious communicable diseases where vaccines are available (78)</p>	<p><i>Criterion:</i> A GP's fitness to practise must not be compromised by health issues <i>Standards:</i> <i>Good Medical Practice for General Practitioners</i> (second edn), Section 7: Health, pp. 53 and 54</p>	Statement of health and use of health care, including registration with a GP in another practice Results of relevant questions in at least two MSF surveys from colleagues, with evidence of reflection, appropriate change and discussion in appraisal

GMC attribute	GMC standards	RCGP criterion and standards	RCGP evidence and evaluation
<i>Domain 3: communication, partnership and teamwork</i>			
Communicate effectively	<p><i>Generic:</i> Ensure any published information about your services is factual and verifiable (60, 61) Communicate effectively with colleagues within and outside the team (41b)</p> <p><i>Clinical:</i> Listen to patients (22a, 27a) Give patients the information they need in order to make decisions about their care in a way they can understand (22b, 27) Respond to patients' questions (22c, 27b) Keep patients informed about the progress of their care (22c) Explain to patients when something has gone wrong (30) Treat those close to the patient politely and offer support in caring for the patient (29) Pass on information to colleagues involved in, or taking over, your patients' care (40, 51–3)</p>	<p><i>Criterion:</i> A GP must communicate with and relate appropriately to colleagues <i>Standards: Good Medical Practice for General Practitioners</i> (second edn), Section 3: Teaching and training, appraising and assessing, pp. 23 to 25 And <i>Good Medical Practice for General Practitioners</i> (second edn), Section 5: Working with colleagues, pp. 35 to 43</p>	Results of relevant questions in at least two MSF surveys from colleagues, with evidence of reflection, appropriate change and discussion in appraisal
Work constructively with colleagues and delegate effectively	<p><i>Generic:</i> Treat colleagues fairly and with respect (46) Support colleagues who have problems with performance, conduct or health (41d)</p>	<p><i>Criterion:</i> A GP must ensure that all staff, including locums and students, are properly trained and supervised</p>	Results of relevant questions in at least two MSF surveys from colleagues, with evidence of reflection, appropriate change and discussion in appraisal

GMC attribute	GMC standards	RCGP criterion and standards	RCGP evidence and evaluation
	<p><i>Clinical:</i> Ensure colleagues to whom you delegate care have appropriate qualifications, experience, knowledge and skills (54, 55)</p>	<p><i>Standards: Good Medical Practice for General Practitioners</i> (second edn), Section 3: Teaching and training, appraising and assessing, pp. 23 to 25 And <i>Good Medical Practice for General Practitioners</i> (second edn), Section 5: Working with colleagues, pp. 35 to 43</p>	
<p>Establish and maintain partnership with patients</p>	<p><i>Clinical:</i> Encourage patients to take an interest in their health and take action to improve and maintain it (4, 21f) Be satisfied that you have consent or other valid authority before you undertake any examination or investigation, provide treatment or involve patients in teaching or research (36)</p>	<p><i>Criterion:</i> A GP must have the appropriate clinical and communication skills, and apply those skills for the doctor–patient partnership, including support for self-care <i>Standards: Good Medical Practice for General Practitioners</i> (second edn), Section 1: Good clinical care, pp. 5 to 17 And <i>Good Medical Practice for General Practitioners</i> (second edn), Section 4: Relationships with patients, pp. 27 to 34</p>	<p>Results of at least two patient surveys of his or her consultations and care during the revalidation cycle, with evidence of reflection, appropriate change and discussion in appraisal Results of relevant questions in at least two MSF surveys from colleagues, with evidence of reflection, appropriate change and discussion in appraisal A review of all formal complaints directly involving the GP, with description of the circumstances, lessons learnt and appropriate actions taken, and evidence of discussion in appraisal</p>

GMC attribute	GMC standards	RCGP criterion and standards	RCGP evidence and evaluation
<i>Domain 4: maintaining trust</i>			
Show respect for patients	<p><i>Clinical:</i> Be polite, considerate and honest, and respect patients' dignity and privacy (21a, b, d) Treat each patient fairly and as an individual (38–9, 21c) Implement and comply with systems to protect patient confidentiality (37)</p>	<p><i>Criterion:</i> A GP must have the appropriate clinical and communication skills, and apply those skills for the doctor–patient partnership, including support for self-care <i>Standards:</i> <i>Good Medical Practice for General Practitioners</i> (second edn), Section 1: Good clinical care, pp. 5 to 17 And <i>Good Medical Practice for General Practitioners</i> (second edn), Section 4: Relationships with patients, pp. 27 to 34</p>	Results of at least two patient surveys of his or her consultations and care during the revalidation cycle, with evidence of reflection, appropriate change and discussion in appraisal Results of relevant questions in at least two MSF surveys from colleagues, with evidence of reflection, appropriate change and discussion in appraisal A review of all formal complaints directly involving the GP, with description of the circumstances, lessons learnt and appropriate actions taken, and evidence of discussion in appraisal
Treat patients and colleagues fairly and without discrimination	<p><i>Generic:</i> Be honest and objective when appraising or assessing colleagues and when writing references (18–19)</p> <p><i>Clinical:</i> Provide care on the basis of the patient's needs and the likely effect of treatment (7–10) Respond promptly and fully to complaints (31)</p>	<p><i>Criterion:</i> A GP must have the appropriate clinical and communication skills, and apply those skills for the doctor–patient partnership, including support for self-care <i>Standards:</i> <i>Good Medical Practice for General Practitioners</i> (second edn), Section 1: Good clinical care, pp. 5 to 17 And <i>Good Medical Practice for General Practitioners</i> (second edn), Section 4: Relationships with patients, pp. 27 to 34</p>	Results of at least two patient surveys of their consultations and care during the revalidation cycle, with evidence of reflection, appropriate change and discussion in appraisal

GMC attribute	GMC standards	RCGP criterion and standards	RCGP evidence and evaluation
			Results of relevant questions in at least two MSF surveys from colleagues, with evidence of reflection, appropriate change and discussion in appraisal A review of all formal complaints directly involving the GP, with description of the circumstances, lessons learnt and appropriate actions taken, and evidence of discussion in appraisal
Act with honesty and integrity	<p><i>Generic:</i> Be honest in any formal statement or report, whether written or oral, making clear the limits of your knowledge or competence (63–5, 67–8) Be honest in undertaking research and reporting research results (71b)</p> <p><i>Clinical:</i> Ensure you have adequate indemnity or insurance cover for your practice (34) Inform patients about any fees and charges (72a)</p>	<p><i>Criterion:</i> A GP must act with probity and honesty <i>Standards:</i> <i>Good Medical Practice for General Practitioners</i> (second edn), Section 6: Probity, pp. 45 to 52</p>	Statement of probity Results of relevant questions in at least two MSF surveys from colleagues, with evidence of reflection, appropriate change and discussion in appraisal

Glossary

Academy of Medical Royal Colleges (AoMRC)	The organisation that represents the views and interests of all the medical royal colleges and faculties collectively
Appraisal <ul style="list-style-type: none">● GP appraisal● annual appraisal	Each GP on the Performers List of a primary care organisation should be appraised every year (April to March). An appraisal assists the GP to review his or her performance and draw lessons from it
Appraisee	The GP being appraised
Appraiser	A trained and supported GP who undertakes the appraisal of colleagues
Assessor	A trained and supported person who will assess portfolios of evidence submitted for revalidation. There will be three types of assessor: <ul style="list-style-type: none">● the Responsible Officer in the primary care organisation● an RCGP assessor from outside the immediate area● a lay assessor
Clinical governance	A framework through which NHS organisations are accountable for improving quality of services and care, and promoting patient safety
ePortfolio	An electronic portfolio used for the purposes of appraisal and revalidation
General Practice Register	The register maintained by the GMC of those doctors who have satisfactorily completed vocational training (or equivalent in other countries) and are eligible to work in the NHS as a GP
Learning credit	A unit of education that reflects the impact on patient care and the challenge involved
National Adjudication Panel (the RCGP's)	A group of trained clinical and non-clinical assessors who will act as a national reference group for ensuring equitable and fair application of national standards to revalidation portfolios
Performers List	Each primary care organisation holds a list of doctors able to work in general practice in the area; a GP can only be on one Performers List and every GP must be on a Performers List

Portfolio	The collective evidence accumulated for an individual GP's purposes, for appraisal and for revalidation
Primary care organisation	This is a generic term that covers Primary Care Trusts in England and Health Boards in Scotland, Wales and Northern Ireland
Recertification	The periodic re-confirmation of a doctor's position on either the Specialist or the General Practice Register held by the GMC; forms the second element of revalidation
Registers	The GMC maintains three main registers: a Medical Register of doctors in good standing; a Specialist Register for those who have achieved a level of expertise (and who may work as a consultant in the NHS); and the General Practice Register for those who have the expertise to work as a GP
Relicensure	The periodic renewal of the license (required by a doctor undertaking any clinical roles) issued by the GMC; forms one element of revalidation
Responsible Officer	Every organisation with a quality-assured system of clinical governance will be required to appoint a locally based senior doctor as a Responsible Officer to oversee appraisal, local concerns and revalidation
Revalidation	The periodic confirmation that a doctor remains up to date and fit to practise. It includes the requirements for relicensure and recertification
Royal College of General Practitioners (RCGP)	The royal college that relates to general practice; its remit covers education, research and patient care, but not contractual issues
Sessional GPs	Fully qualified GPs such as salaried GPs, GP locums or retainer GPs. Their working arrangements are invariably stipulated in terms of sessions covered rather than contracted for services
Specialist Register	The register maintained by the GMC of those doctors who have obtained a certificate of completion of specialist training (or equivalent in other countries) and are eligible to work in the NHS as a consultant