Appraisal and Revalidation Guidance
1. INTRODUCTION

Appraisals for GPs started over 10 years ago and are now well established and are undertaken to a level of quality that can exceed many other specialties within the NHS.

Appraisals started as a formative process and with the introduction of revalidation, there were concerns that this process would lose the benefits this approach had brought and that the process would become entirely summative and be devalued.

Revalidation was introduced in December 2012 and so far about 10% of the profession have had their “Licence to Practice” renewed by the GMC. There have been some challenges to the introduction of the process. The LMC has been working closely with the Responsible Officers and their staff in the Area Teams locally to resolve these problems and hopefully the process will be much smoother for the future cohorts.

There remain a number of areas that are still causing some confusion, so I thought it might be helpful to clarify some of these issues.

Revalidation is the process by which patients and the public, employers and other healthcare professionals are assured that doctors are up to date and “Fit to Practice” which is the responsibility of the GMC. The fitness to practice in the specialty of being a GP is the guidance from the RCGP.

When negotiations took place with the profession it was agreed that there would be consistent requirements across all specialties and the Academy of Medical Royal Colleges (AoMRC) brought together all the Royal Colleges and Faculties to achieve this.

The GMC requirements can be found on their website (links below):

- The good medical practice framework for appraisal and revalidation
- Supporting information for appraisal and revalidation

The GMC guidance is backed by law and sets the basic framework and the absolute requirements which must be met in order to revalidate. The GMC delegated responsibility for the fine details for the specialties to the Royal Colleges and Faculties. As such, for general practice, the RCGP guidance is set at a higher level, is about fitness to practice as a GP, and would be considered best practice. A doctor could meet the requirements of revalidation without fulfilling all the RCGP guidance.

2. RCGP REVALIDATION GUIDANCE

The LMC is still getting quite a few questions relating to:

a) Continuing professional development
b) Quality improvement activity
c) Colleague and patient feedback
d) The process of being revalidated
a) Continuing Professional Development

You are expected to be involved in a variety of regular learning activities that are relevant to your practice and reflect your scope of work.

There is no absolute minimum number of hours defined by the GMC, who require you to do enough to keep up to date across all of your scope of work. The RCGP, in line with other specialties, recommends a minimum of 50 hours of learning per year for doctors providing the full range of general medical services. This can include attending formal conferences and lectures, informal practice meetings and professional conversations about patients, self-directed PUNs and DENS, reading and e-Learning, reviewing data, significant events, complaints or compliments and changing practice, undertaking clinical audit or even teaching.

It is important to have a system that is simple and easy to use to record your learning, your reflections and how you will implement the learning. It is also important to keep your recording proportionate and only include what is most relevant and valuable to you - as most doctors do a lot more than 50 hours of learning if they start to recognise their activity as learning – and could spend excessive time recording as a result.

Remember – the GMC is interested in evidence of lesson learned and changes made as a result. Recording one or two high quality examples of reflection is better than a large quantity of headlines only.

Further information is available on the LMC Website (link below):

Continuing Professional Development.html

b) Quality Improvement Activity

For the purposes of revalidation you are required to demonstrate that you regularly participate in activities that evaluate the quality and improvement of your work. Examples of quality improvement activities:

- **Clinical audit** - measures the quality of care individual doctors are involved in.

- **Review of clinical outcomes** – this could include review of morbidity or mortality data, minor surgery data or commissioning information.

- **Case review or discussion** - this could be peer review of an interesting or challenging case. This would include significant event reviews. It is important to reflect on the discussion, detail what has been learnt and what will change in your clinical practice as a result of the discussion.

- **Audit and monitor** – the effectiveness of a new system, process or teaching programme.

- **Evaluate the impact** – this could be a new service developed and implemented. For practices the move to named GPs for the vulnerable elderly and the case management that will be required for the new DES for admissions avoidance would be a useful area to consider.
The RCGP consider significant event review and clinical audit as being core elements to quality improvement but are happy to accept other appropriate quality improvement activities that you can demonstrate have had a positive impact on your care of patients.

It is important to remember that the GMC does not require doctors to undertake clinical audit, if there are other more appropriate methods of delivering quality improvement of your clinical care.

Each year at your appraisal you will need to demonstrate that you have been involved in quality improvement activities.

The LMC’s advice is to undertake a variety of quality improvement activities and ensure that, over the five year cycle, some of these enable you to provide evidence that demonstrates the impact and change this activity has had on your clinical practice.

Practice based audits are acceptable so long as you reflect on the outcomes personally and this impacts your clinical practice and you detail your role in the audit.

QoF is a simple way to audit quality but simply recorded and comparing 2 years results is not acceptable, you need to discuss the outcomes in one year, suggest and implement change and evaluate the impact at a later date.

Further information is available on the LMC Website (link below):

  Quality Improvement Activity.html

c) Colleague and Patient Feedback

In every 5-year revalidation cycle you are required to undertake at least one colleague and one patient feedback survey.

It is important that these are conducted appropriately.

Colleague Feedback:

You must use a recognised questionnaire and this needs to be conducted independently, with feedback that allows individuals to make comments that are anonymous. It is also important that the results are benchmarked and fed back to you in an appropriate format.

You generally need to choose about 20 colleagues and require a minimum of 12 responses for this to be valid (each tool varies slightly in its numbers and some doctors may have unique circumstances that make this inappropriate).

It is not acceptable to conduct your own colleague feedback by handing out questionnaires, collecting them and taking them with you to your appraisal to discuss the results. The feedback must be externally collated to maintain anonymity for the respondents. You should take your reflection on your feedback to your appraisal to discuss further.

Please remember that you need to complete the survey and discuss the results with your appraiser before your revalidation date.
There are a number of providers of the surveys who will analyse the results and provide you with a report suitable for revalidation.

Further information is available on the LMC Website (link below):

[Colleague Feedback.html](#)

**Patient Feedback:**

For patient feedback to be valid you need over 34 surveys, which means you normally have to distribute 50 surveys to ensure you receive an adequate number of replies (again, each tool varies slightly in its numbers).

It is acceptable for you to hand the questionnaires out to patients but they must not return them to you as an individual. The guidance from the GMC is that these surveys should be analysed external to the practice.

Further information is available on the LMC Website (link below):

[Patient Feedback.html](#)

The providers of colleague or patient feedback are:

- The Royal College of GPs [Revalidation e-Portfolio.html](#)
- Clarity Informatics [Revalidation toolkit.html](#)
- CFEP [UK Surveys.html](#)
- Edgecombe [360 Doctor Surveys.html](#)
- myLMC [Revalidation toolkit.html](#)

The LMC has been working with myLMC to develop the colleague and patient feedback. Nearly 1400 doctors have completed a colleague survey and approximately 1000 doctors have completed a patient survey.

If you have a part of your scope of work that requires feedback but the standard clinical questionnaire does not seem appropriate to your needs, e.g. as a medical leader, or aviation medical officer, myLMC offers tailored questionnaires that may be more suitable.

**d) The process of being revalidated**

The LMC is regularly approached by GPs asking who their Responsible Officer (RO) is and when will they be interviewed by them to be revalidated.

All GPs by now should know who their RO is.

Currently, for GPs working in the Wessex Area Team (Dorset, Hampshire and the Isle of Wight) the RO is Dr Stuart Ward and for Bath & NE Somerset, Gloucestershire, Swindon and Wiltshire it is Dr Liz Mearns.

Each RO is responsible for between 1 – 2500 doctors, and therefore you will not be required to have a face-to-face meeting with the RO.
A small team working with the RO will ensure you have successfully completed your annual appraisals, provided all the required supporting information, undertaken the colleague and patient surveys and discussed the results with an appraiser, and that there are no outstanding concerns or complaints and then they will feedback to the RO who submits the required positive revalidation recommendation to the GMC.

Therefore the vast majority of GPs will know nothing of the process until they receive their renewed “Licence to Practise” from the GMC.

Those doctors who have not been able to fulfil all the requirements in time for their recommendation date for good reasons, or are in an ongoing investigation, may be deferred.

Very few doctors who fail to engage with the appraisal and revalidation process will be referred to the GMC for failure to engage.

3. **LOCUM TOOLKIT**

The LMC has developed a comprehensive toolkit for sessional GPs in general but specifically aimed at locums. Others may find this useful including GP Trainees.

Further information is available on the LMC Website (link below):

[Locum Toolkit.html](Locum Toolkit.html)

4. **NURSES**

It is now a legal requirement for all relevant doctors to have a “licence to practise”. The same requirement will be introduced for nurses in the next couple of years.

This will mean that nurses will need to undertake annual clinical appraisals and then be subject to revalidation. It would seem likely that their process will mirror the system introduced for doctors.

The LMC has recently held a training event specifically aimed at nurse appraisal. The meeting was scheduled for up to 20 nurses and practice managers. Following an unexpected rise in demand the venue had to be moved and over 120 attended the ½ day event.

The LMC is about to set up a pilot, to train 12 nurse appraisers and introduce a system of nurse appraisals.

MyLMC is working with the LMC to develop a nurse appraisal toolkit and adapt the colleague and patient feedback to make it more relevant for nurses.