

Mythbusters: Appraisal and revalidation

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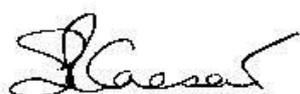
Introduction

The GMC provides the definitive guidance on supporting information for appraisal and revalidation purposes. This is complemented by specialty specific guidance that helps doctors satisfy the GMC's requirements.

Mythbuster guidance is aimed primarily at the individual doctor but is relevant to everyone involved in appraisal and revalidation, including the appraiser and the responsible officer.

We want to dispel some of the confusion that has been identified and clarify recommendations and requirements. We also want to provide an equal experience of appraisal and revalidation for all doctors, regardless of their context or geographical location.

This guidance is expected to be reviewed and updated regularly, so check back if you are unsure. Please contact us if you find any of the clarifications unclear or you want more information.



Dr Susi Caesar

Chair of the Academy's Revalidation and Professional Development Committee

1. The role of appraisal in the regulation of doctors

1.1 Myth: I can choose my designated body or where to have my appraisal

You cannot choose your designated body or your responsible officer (RO). There is a strict hierarchy of connections set out in legislation. There are [tools on the GMC website](#) which will help you to identify which designated body you should be connected with (usually your employing trust or health board if you work in the NHS, or postgraduate deanery or equivalent if you are a trainee).

We recommend that you check your designated body is correctly assigned on GMC Online and that you update your connection promptly whenever there is a substantive change in your circumstances, e.g. going from being a trainee to becoming a consultant or SAS doctor. It is your responsibility to ensure that you keep your connection up-to-date and have an annual appraisal.

1.2 Myth: I can't revalidate because I am not connected to a designated body

If you work in an organisation that does not have designated body status but is a managed environment there might be a Suitable Person – this is an individual who undertakes a similar role to a responsible officer (RO) and can provide the GMC with a revalidation recommendation about you. Refer to the [GMC guidance on Suitable Persons](#).

If you don't have a designated body, and cannot find a Suitable Person, you [can revalidate directly with the GMC](#).

1.3 Myth: Appraisal is a pass/fail event

Appraisal is not a pass/fail assessment. Appraisal is the opportunity for you to demonstrate that you are adhering to the principles of Good Medical Practice, in accordance with GMC guidelines.

Engagement in the process is a GMC requirement.

1.4 Myth: My appraiser will decide my revalidation recommendation

Appraisers do not have the authority to make your revalidation recommendation. As part of their role, your appraiser will document your appraisal and provide an output summary for your responsible officer (RO).

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

1.5 Myth: I need to undertake five appraisals to revalidate successfully

You are expected to engage fully in the annual appraisal process to revalidate successfully. However, there is no requirement to have five annual appraisals before a revalidation recommendation can be made. There are many reasons for having approved missed appraisals, such as maternity leave or sick leave. You could be given a revalidation due date that is less than five years from your first appraisal. It is important that any appraisals missed in the revalidation cycle are agreed by your responsible officer (RO) as necessary and appropriate.

Before the RO can make a positive recommendation to revalidate, you must have collected all the GMC supporting information required to provide assurance that you are up-to-date and fit to practise, and have reflected on it during your appraisal. This is likely to take at least two appraisals – one to define what you need and design a personal development plan (PDP) that supports you in achieving it all, and a second where you can reflect, with your appraiser, on all your supporting information, in particular your feedback from colleagues and patients.

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

Potential issues relating to poor performance, conduct and health are almost never first brought to light during appraisal. They are usually discovered through clinical governance processes and become part of an entirely separate investigative process that takes the doctor outside revalidation.

If either the appraiser or appraisee reveals a performance concern for the first time during the appraisal, the [GMC Duties of a Doctor](#) requires that action is taken to protect patients. The appraisal would be stopped, and advice would need to be sought.

1.7 Myth: Known performance concerns are not considered at appraisal

Where a performance concern is readily known prior to appraisal it should be included for reflection and discussion between the appraisee and appraiser. The appraisal provides the opportunity to reflect on the matter from a developmental point of view. The appraiser should not be judgemental – it is for the local governance process to manage a performance concern.

1.8 Myth: If I share my concerns about another doctor with my appraiser, my appraiser will have a responsibility to report my concerns

It is your responsibility to act in accordance with the GMC Duty of Care to report concerns. Your appraiser should provide you with support and signpost the correct steps for you to take. [The GMC guidance states](#) (Paragraph 19):

“All doctors have a responsibility to encourage and support a culture in which staff can raise concerns openly and safely. (Paragraph 20) Concerns about patient safety can come from a number of sources, such as patients’ complaints, colleagues’ concerns, critical incident reports and clinical audit. Concerns may be about inadequate premises, equipment, other resources, policies or systems, or the

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

We recommend that appraisers record that concerns have been raised at appraisal in the summary of discussion. This should not include details about the concern, but should include written advice about the next steps and actions agreed with the appraisee. An appropriate note should be made in the comments box to make the responsible officer (RO) aware that a concern was raised.

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

Only your responsible officer (RO) can decide whether to recommend that your revalidation date should be deferred. It is possible that, if you have not engaged sufficiently with the appraisal process, or taken appropriate opportunities to ensure that you are ready for revalidation, the RO will decide that it is more appropriate to tell the GMC you are failing to engage with revalidation.

Deferral is a neutral act and usually used in circumstances where more time is needed to demonstrate your continued competence, either because your portfolio of supporting information and reflection at appraisal is not yet complete, or because your practice is currently under investigation due to a significant event or complaint. Your existing licence to practise continues, allowing you additional time to meet the GMC requirements for supporting information in full, or for a local process to be completed.

If you feel that your revalidation date should be deferred, for example because you are struggling to collect all the supporting information, you should discuss your options and the reasons why with your RO or appraisal lead at the earliest opportunity. This will help to demonstrate that you are engaged with the process.

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

There are a variety of ways to allocate your appraisal month. Many appraisal systems spread appraisals through the appraisal year based on having your appraisal in your birth month, as recommended in the [NHS England Medical Appraisal Logistics Handbook](#).

This is often seen as the default position. However, in other designated bodies, the appraisal policy may have a different way of allocating your appraisal month. There might be an appraisal season, during which everyone has an appraisal. There are therefore many situations where your appraisal may not be in your birth month. In addition, even if it starts in your birth month, your appraisal month might move after a period of maternity or sick leave, and you may resume a rolling twelve-month appraisal period with the new month as your appraisal month.

You are advised to check when your appraisal will be due as soon as possible after moving from one designated body to another. Your new responsible officer (RO) may ask you to change your month to ensure that you fit in with the local appraisal and revalidation policy and process.

1.11 Myth: It is my responsible officer's responsibility to ensure that I have an appraisal

GMC statutory guidance states that to maintain your licence to practise you must ensure that you have an annual medical appraisal and demonstrate your continued competence across your whole scope of practice. Your responsible officer (RO) has a statutory responsibility for ensuring that the appraisal process is fit for purpose, but you must play your part in engaging fully with the process.

1.12 Myth: I cannot demonstrate my engagement with revalidation if I am not in work when my appraisal is due

There is currently no GMC guidance that lays out exactly how you should demonstrate your engagement if you are not going to be in work at the time when your appraisal is due. Most responsible officers (ROs) have a process whereby those doctors who are going to be on maternity or sick leave, or away on a sabbatical, can let the RO know their circumstances so that a postponement of the appraisal month, or an approved missed appraisal, can be agreed. It is best practice to do this in advance to demonstrate your engagement with the process.

If you are planning a significant period of time out of work for any reason (including, but not restricted to, sabbaticals, elective surgery or maternity, paternity or adoption leave), you should be proactive in planning your annual appraisal by having a conversation with your RO (or local appraisal lead).

There will always be occasions when you have a significant break from practice due to maternity or parental leave, sickness or sabbaticals. Your RO has the option of deferring your revalidation recommendation to allow more time to collect the supporting information you need. The Academy of Medical Royal Colleges has issued guidance for doctors and employers regarding the process to undertake for arranging a return to work after a period of absence. [Return to Practice Guidance \(2017\)](#).

1.13 Myth: I need to undertake a minimum number of professional activities to revalidate as a doctor

Revalidation assesses your fitness to practise as a doctor. There are no GMC requirements that relate to the number of sessions you need to work. For any part of your scope of work, no matter how little time is spent on it, the GMC expects you to reflect on how you:

- keep up-to-date with what you do
- review your practice to demonstrate your continued competence at what you do
- seek out and respond to feedback from colleagues and patients about what you do

To a certain extent, continuing professional development (CPD) can substitute for volume of clinical practice and experiential learning, but the less experiential learning possible, the more CPD is likely to be needed to keep up-to-date. You need to be confident that you can demonstrate that you practise safely in every role you undertake, no matter how little of that work you do.

1.14 Myth: The GMC requires doctors to complete mandatory training annually in order to revalidate successfully

Revalidation requires doctors to demonstrate that they are up-to-date and fit to practise as a doctor. The GMC does not set any specific revalidation requirements in relation to types of training.

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

It is important that doctors recognise the difference between the requirements for revalidation and training requirements for other purposes, and that their appraisers and ROs do not allow the two to become confused.

2. Appraisal documentation

2.1 Myth: I have to use an electronic portfolio defined by my responsible officer to revalidate

The format of the portfolio of supporting information is not prescribed by the GMC, so having an electronic portfolio is not a requirement for revalidation. However, an electronic portfolio will allow your supporting information to be stored one place, which can then be submitted easily.

Most designated bodies require appraisal documentation to be sent electronically using, for example, the [NHS England Medical Appraisal Guide \(MAG\) Form](#), this provides the template for other appraisal forms, so having your supporting information in electronic format is clearly advantageous. Some items of supporting information, such as original complaint letters or compliment cards, which may be handwritten, are usually best kept in paper form and shared privately with your appraiser to maintain confidentiality. They can then be referenced anonymously by the appraiser in the summary of discussion area of the appraisal form.

Your responsible officer (RO) may have expressed a preference among the available options, or may have commissioned bespoke IT solutions for their doctors to use to avoid having to struggle with managing multiple formats used by doctors in their organisation. You should check your designated body requirements and variations with your RO.

If your RO has not expressed a preference about which electronic portfolio should be used locally, you should choose a solution that suits you. Remember that your portfolio, with all the GMC required supporting information, needs to be available to your RO potentially at short notice.

In Scotland and Wales there are national appraisal and revalidation platforms used by all doctors (*SOAR*: <http://www.appraisal.nes.scot.nhs.uk/> and *MARS*: <https://medical.marswales.org/> respectively).

2.2 Myth: My appraisal portfolio is confidential

The record of your appraisal will be accessible to your responsible officer (RO) (and/or appraisal lead, depending on how your designated body runs the process), because your RO has to be able to confirm that an appropriate appraisal has taken place, with all essential elements covered, before making a revalidation recommendation. Your RO also has a duty to pass on any concerns about your performance or behaviour to your new RO if you change employment.

Furthermore, some information discussed at appraisal may already be available to others by other routes; for example, your job plan will already be available to your local managers.

Your designated body is expected to have a document, sometimes called an Access Statement or a Fair Processing Notice, which describes who may have access to your personal information and under what circumstances. However, beyond this, appraisal documentation is confidential. Appraisal documentation cannot be demanded by anyone else (with the possible exception of the court system, in exceptional circumstances). If a request to disclose is made you should seek legal advice.

The Academy of Medical Royal Colleges has issued [guidance for entering information onto E-portfolios \(2016\)](#). The guidance is for trainees, but the same principles apply to any qualified doctor's continuing professional development CPD, appraisal and revalidation portfolio.

3. Supporting information

3.1 Myth: I must document all my learning activities

No, you do not have to document all your learning activities, but you do need to document enough to give assurance that you are keeping up-to-date in the work that you are doing.

We recommend that you focus on the quality not quantity of your supporting information. You should be selective about documenting your reflection on your most valuable and meaningful learning, over the course of the year.

If you find it convenient and helpful to record extensively all of your continuing professional development (CPD) for your own benefit to capture your learning then that is your choice, but your appraiser will focus on the quality of your learning and reflection.

3.2 Myth: It is reasonable to spend a long time getting supporting information together for my appraisal

No. It is recommended that your supporting information should be generated from your day-to-day work and added to your portfolio as you go along. Producing a continuing professional development (CPD) log can be difficult and time consuming as a retrospective exercise. It is much easier to make regular entries into your learning diary throughout the year. There are now many tools and apps to help you to do this in a simple and timely way.

The final stage of organising the supporting information and completing your portfolio before your appraisal should take no more than half a day. If it is taking longer than this, or the effort feels disproportionate, you should discuss with your appraiser how to simplify what you do. Some doctors with complex portfolio careers and several roles to include may take a little more time than this, but you should seek advice if it takes more than a day to organise.

3.3 Myth: I need to provide all six types of supporting information about my clinical role only

No. The GMC requires doctors to provide appropriate supporting information across the whole of their scope of work that requires a licence to practise, not just clinical roles.

You must declare all parts of your scope of work and, for each of them where appropriate, provide all six types of supporting information over the revalidation cycle:

- continuing professional development (CPD)
- quality improvement activity (QIA)
- significant events, if there are any
- patient feedback
- colleague feedback
- complaints and compliments, if there are any

We recommend that you keep the documentation of your supporting information reasonable and proportionate while ensuring that you have demonstrated that you are up-to-date and fit to practise in every scope of work. Your appraiser will help you determine whether there are any gaps in your portfolio of supporting information and support you in working out how best to fill those gaps. Your responsible officer (RO) will tell you if your portfolio demonstrates sufficient engagement in reflective practice and provides the supporting information required by the GMC.

If you have any queries that your appraiser cannot resolve, we recommend that you seek early confirmation from your RO that what you are planning is acceptable.

3.4 Myth: Supporting information from work overseas cannot be included in my appraisal portfolio

The GMC requirement is that your appraisal and revalidation portfolio should include supporting information about every part of your scope of work that requires a UK licence. Your responsible officer (RO) has the discretion to consider supporting information from other settings in making his/her revalidation recommendation.

The [GMC Protocol for responsible officers \(ROs\)](#) making revalidation recommendations states (2.3.2):

“Doctors may practise in settings where they do not require a UK licence – for instance, they may work abroad, or they may undertake specific functions in the UK that do not legally require a licence to practise. Where this is the case, it is at your discretion whether you consider supporting information from these practice settings in making your judgement. You should consider whether such information is material in your evaluation of their fitness to practise, taking account of whether it is demonstrably relevant to the doctor’s licensed UK practice and the proportion of the doctor’s supporting information that it represents.”

Even in UK practice, you may attend continuing professional development (CPD) events overseas. It is appropriate to check that the content of such an event is applicable to your scope of work rather than assuming that it will be acceptable. It is likely that clinical work overseas will have a significant overlap with clinical work in the UK. It may well be appropriate to include supporting information relating to work overseas when it demonstrates the quality of your reflective practice.

3.5 Myth: Having a ‘disagree’ statement from my appraiser is always a bad thing

There are five key sign-off statements that are normally agreed by your appraiser at the end of your appraisal. If your appraiser decides that one, or more, should be marked as ‘disagree’, this sends a message to you, your next appraiser and the responsible officer (RO) that something may not be ready for revalidation. This is not, in itself, a bad thing. It is an important part of ensuring that the appraisal supports you in preparing a portfolio of supporting information appropriate for a positive recommendation to revalidate. Ultimately, your RO makes the decision about your revalidation recommendation, not your appraiser.

There are two different comment boxes for the appraiser, and one comment box for you, to provide an explanation for the disagree statement. It is relatively common for a doctor to have made no progress with their previous personal development plan (PDP), either because they had no previous PDP, in the case of a first ever appraisal, or because circumstances changed significantly during the year, making the earlier PDP goals less appropriate. In these circumstances, it is appropriate for the appraiser to mark disagree to the statement about progress with the previous PDP, and enter an explanation in the comments box.

Even the fifth sign-off statement, which states that there are no concerns arising from the appraisal documentation or discussion that suggest a risk to patient safety, may sometimes need to be marked as disagree. For example, if a doctor is currently under investigation, and has their annual appraisal in the period before the investigation is resolved, they could not be revalidated as there are outstanding concerns, then the appraiser should indicate this by marking the fifth statement as disagree. It is important that the appraiser adds an explanation in the comments box provided in every case where they have marked a statement as disagree.

In all cases, you also have a box in which to enter your comments, although you do not have to comment if you have nothing to add to the appraiser's explanation.

3.6 Myth: I must get sign off statements from all parts of my scope of work every year

We do not recommend that you seek sign-off statements that there are no concerns about your practice in all of your roles every year. Instead, you should reflect on how the safety of patients is being assured and the governance, clinical or otherwise, of the systems you are working in. You should always know how to report on a significant incident and how you would find out if there has been a complaint about you.

It is also important that you ensure that your responsible officer (RO) knows how to contact the clinical governance leads from any part of your scope of work not for your main designated body so they can seek the assurance they need when they need it.

Any governance concerns arising about a doctor should be communicated to the RO as and when they arise by those responsible for the governance surrounding a doctor's work. It is crucial that concerns are dealt with in a timely fashion and not linked to the revalidation cycle.

4. Reflection

4.1 Myth: Reflection is difficult

Reflection – thinking critically about what, how and when we do something and whether it could have been done differently – shouldn't be difficult. It is something doctors should do all the time and is part of a doctor's professional training. Reflecting on professional practice is also an important part of appraisal and revalidation.

In appraisal, many doctors find that their appraiser helps their reflection through active listening, careful questioning and feedback. The appraisal discussion may be an important trigger to generate new reflective insights which can be captured in your appraisal summary.

You do not have to record all your reflections; this would be disproportionate. It is important to find a method of capturing reflection that works for you and to keep it simple and proportionate. Some people are more natural reflectors than others. Discuss any concerns with your appraiser; they have training and knowledge to help you.

4.2 Myth: Documented reflection has to be longwinded and in-depth

Your appraiser will be interested in your reflections on the supporting information you present in appraisal. The difficulty for many doctors is in recording their reflection in a way that feels as natural as the act of reflection itself. In most cases documented reflection for each item of supporting information should be meaningful to you but brief and to the point. It is clearly not necessary to record every thought about patient care and practice that you have every day. This would be disproportionate.

The Academy of Medical Royal Colleges has developed a [reflective template](#) with guidance notes applicable to all forms of supporting information in revalidation, with three main questions asking:

- what has been learnt?
- how has it influenced your professional practice?
- looking forward, what are your next steps?

Where an activity has been particularly productive in terms of learning and insights gained (or when you want to compile an end-of-year reflective summary of CPD), you may want to record a more detailed reflection. This does not necessarily have to be done at once, or immediately after the activity, as further reflection and insights might occur as you implement this learning in the workplace.

5. Continuing professional development

5.1 Myth: Only formal courses and conferences count as continuing professional development

Continuing professional development (CPD) activities should be very broadly defined and include personal, opportunistic and experiential learning as well as activities targeted at identifying unknown unknowns. Any learning activity where you spend time learning something and deciding how it can be put into practice in your current, or proposed, work can be counted as CPD. You should only expend time and energy in documenting a sample of your most relevant and important learning.

The aim is to demonstrate a balance of learning across the curriculum relevant to your scope of work over the five-year revalidation cycle. You should choose to demonstrate reflection on your most valuable learning events across a variety of learning. These events are not limited to only courses and conferences and should include:

- personal reading and online research
- online modules
- professional conversations about clinical care
- everyday learning from your work

5.2 Myth: I need a formal certificate to show that I have taken part in a continuing professional development activity

Obtaining and keeping a certificate confirming participation in continuing professional development (CPD) activities is not a GMC requirement for revalidation. Appraisers should not be asking to see certificates of attendance; they should be asking what your most important new learning has been over the past year and what difference it has made to your practice. However, we encourage doctors to obtain and keep any official documentation confirming their attendance at external events issued by CPD providers. This documentation could be in the form of a certificate, email, letter or attendance list. Keeping such documents may act as a prompt for reflection when preparing for your next appraisal.

5.3 Myth: Time spent on quality improvement activity, such as audit, is not regarded as continuing professional development

Many doctors benefit educationally from the process and output of any quality improvement activity (QIA) such as audit. As such, you should record the details and reflection on this learning and any changes made to your professional practice as part of your continuing professional development (CPD). The same principle applies to learning from significant events, feedback from patients and colleagues and review of any complaints and compliments. If you can demonstrate the learning and impact on your practice, then it is legitimate to consider it as CPD.

5.4 Myth: For revalidation, I can do all my continuing professional development in one go or from one source

Over a five-year revalidation cycle there should be a balanced approach to your continuing professional development (CPD) in terms of:

- learning from a variety of external, internal and personal study activities. For example, not all of your CPD should be from reading journal articles
- amount of CPD undertaken. This does not have to be exactly the same each year, but it would be unusual for you to participate excessively in CPD one year but none (or very little) whatsoever the next. The key consideration is actively to keep up-to-date as part of your professional practice
- development areas covering the scope of your professional work – including your clinical and non-clinical roles

5.5 Myth: As a part-time doctor, I only need to do part time continuing professional development

Less than full-time doctors will not be able to demonstrate that they keep up-to-date or are fit to practise, across the whole scope of their work, if they engage with continuing professional development (CPD) on a part-time basis. A doctor in this position will have less experiential or 'on-the-job' learning to draw on and therefore most certainly need at least the same amount and level of planned CPD (conferences, educational meetings, personal study, etc.) as those working full-time.

5.6 Myth: A long-term career break means I am totally excused from undertaking any continuing professional development

If you are planning to take a long-term career break one option is to relinquish your GMC licence (but retain your GMC registration). By doing so, you will not be liable to participate in any revalidation activity including continuing professional development (CPD). However, as a medical professional planning to return to work, you may want to remain up-to-date in your areas of practice through personal study or keeping in touch days (especially those focused on CPD) with an employer. On re-entering professional practice, your employer may require you to participate in a return to work programme and this should include consideration of any immediate CPD needs. The Academy of Medical Royal Colleges has provided [return to practice guidance \(2017\)](#).

5.7 Myth: A detailed and comprehensive reflective note has to be made for each recorded continuing professional development activity

Doctors are required to reflect on their continuing professional development (CPD). Documenting reflection should be proportionate to the CPD activity and recording a vast amount of information is unnecessary. We offer the following tips:

- Keeping it simple may work best for you. A brief reflective note for each activity, even if it lasts all day or longer, is often sufficient to capture the most important lessons learned and any changes that you plan to make as a result or to record that learning has been consolidated, nothing new has been gained, and the activity has served to reinforce existing knowledge and skills
- A selective approach can be taken by recording your reflection on only those CPD activities that are valuable and meaningful to you
- The brief notes for each recorded activity could act as prompts when providing a more detailed end of year summary of your CPD for appraisal. The summary should focus on what

you have learnt from CPD and whether it has any impact (or is expected to) on professional performance and practice

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

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

5.9 Myth: My appraiser will be impressed by hundreds of credits

The GMC does not set any specific revalidation requirements in relation to continuing professional development (CPD) or training. You need to demonstrate that you have done sufficient relevant CPD to keep up-to-date with what you do.

You should not expect your appraiser to review huge amounts of supporting information over and above what is required. You should not spend a disproportionate amount of time and effort on CPD credits that you have already recorded. You should not spend a disproportionate amount of time and effort on documenting your reflection on everything you learn throughout the year. Try to create sensible habits that make your documentation simple and streamlined and use the knowledge and skills of your appraiser to help you.

5.10 Myth: I must do 50 credits of continuing professional development every year

The focus of continuing professional development (CPD) should be on its quality and reflection of its impact on your practice, rather than the amount of time spent on the activity. You will need to collect evidence to record your CPD, normally using a structured portfolio. CPD schemes or programmes organised by Colleges or professional associations can be a convenient way of doing this.

You are required by the GMC to do enough appropriate CPD to remain up-to-date and fit to practise across the whole of your scope of work. There is no regulatory requirement to acquire a particular number of 'credits' each year. However, for doctors who wish to be guided by a credit-based approach, a target of 50 credits each year and 250 credits over five years is recommended.

5.11 Myth: I cannot include contractual training as part of my continuing professional development

We recommend that all learning activity should be eligible to be counted as continuing professional development (CPD). It is important to reflect on contractual or required training, as it is required for good reason and part of being able to demonstrate that you are 'fit for purpose' in your role. The appraisal documentation is a good place to record when any mandatory training was completed and reflect on lessons learned and any changes made as a result. Because of the importance of being able to demonstrate compliance with this training in meeting contractual or National Performers List obligations, it is appropriate to upload your certificates of attendance as well as your reflective note.

If you have more than one part of your scope of work with the same training requirements, for example, equality and diversity training, we recommend that you negotiate to ensure that the

training that you do will meet the needs of all your roles. This avoids duplication of effort and the unnecessary burden of repeating the same training for different employers.

6 Patient and colleague feedback

6.1 Myth: I must use the GMC questionnaires for both my colleague and patient feedback

There is no requirement to use the GMC questionnaires in obtaining feedback from your colleagues and patients. The expectation is that feedback is collected using standardised questionnaires that comply with GMC guidance in this area. Other questionnaires meeting the GMC guidance have been developed which may be more suitable for your colleague and patient groups, professional scope of work, or circumstances. Some questionnaires have been adapted to make them accessible for hard to reach patient groups, including those with communication and/or information processing difficulties. Instructions as to the use of a questionnaire will give an indication as to the minimum number of responses required for a reliable and valid set of results. The GMC questionnaires and guidance can be found in the [colleague and patient feedback section](#) of the GMC website. The GMC has also published [FAQs on which questionnaires to use](#).

6.2 Myth: All my colleague and patient feedback must be from standardised questionnaires

Patient and colleague feedback formally collected using standardised questionnaires complying with GMC guidance are required at least once every five years. However, it is recommended that you take the opportunity once a year at appraisal to discuss your reflections on your relationships with colleagues and patients. To provide insight into these discussions other types of feedback – solicited or not – can be useful, for example, feedback from students and personal narratives from patients provided in comment cards or posted on specially commissioned websites. Although not required by the GMC, doctors with multiple roles may find seeking additional feedback from different client groups worthwhile and the resulting information meaningful in developing their professional skills. The appraisal discussion should cover whether this information is useful or reliable for informing on your professional development. It is also important that any feedback in your revalidation portfolio and presented at appraisal is appropriately anonymised, i.e. any personal identifiable information is redacted.

6.3 Myth: I can collect feedback directly from patients and collate the information myself

You should not directly hand out questionnaires to patients, or collect the responses in such a way that patients think you might be able to read them, or choose only the best. Patient anonymity is an important part of the feedback process. One mechanism is the use of a sealed deposit box and the responses are collected and collated by someone external to the physician-patient relationship –

such as the questionnaire provider. The responses are collated into a report prior to your next appraisal.

7. Quality improvement activities

7.1 Myth: I have to do all of my quality improvement activity myself

You do not need to do all the background work and data collection or analysis for your quality improvement activity yourself. Someone else being delegated to undertake a literature search, or do some of the research, is a reasonable and proportionate use of your time. Many quality improvement activities (QIAs) such as clinical audits are team-based anyway, involving colleagues in the hospital, or are regional or national projects. Personal audits you undertake will also no doubt involve colleagues in the collection and collation of data.

7.2 Myth: There are specified types of quality improvement activities that I must participate in

For the purposes of revalidation, you are required to participate in quality improvement activity although no single type is mandated. The GMC provides broad examples in their revalidation guidance including: audit, review of clinical outcomes, case reviews, and impact and effectiveness evaluations. We recommend that you select activities according to what is relevant and important to you in improving the quality of care and services you or your team provides. What is also expected for revalidation is reflection on any quality improvement activity. Your personal reflective notes should include an explanation about your role and a description of the findings, including any lessons you have learned and the impact they have had on the quality of care or services provided.

7.3 Myth: I have to do at least one clinical audit in the five-year revalidation cycle

Clinical audit is not a revalidation requirement. However, participating in quality improvement activities is a requirement, and many doctors choose to participate in local, regional and/or national clinical audit. It is worth considering:

- The type and level of involvement in clinical audit will vary according to a doctor's specialty (national clinical audits are being run in some but not all specialties). See the HQIP guide on the use of national clinical audit data in appraisal
- Where a personal or local audit is undertaken, the methodology should be robust and systematic. Include an element of evaluation and action, and, where possible, demonstrate an outcome or change

7.4 Myth: I have to provide clinical outcome data for my appraisal and revalidation

Providing clinical outcomes of your work based on data is not a revalidation requirement. However, if validated and robust national clinical outcome data is regularly collected in your specialty or subspecialty and is made accessible in a database, any relevant data should be taken to appraisal. The data should be accompanied by evidence of reflection and, where relevant, improvement in practice. You should reflect on the personal data at least once in the five-year revalidation cycle. Self-awareness of the quality of care provided in relation to the clinical skill is important.

7.5 Myth: National clinical audits or outcome data does not exist in my specialty and therefore I do not have to participate in any quality improvement activity

Many doctors choose to participate in clinical audit or review outcome data as activities in meeting the quality improvement requirement for revalidation. Where this is not possible, an alternative activity is case review or discussion with documentation of appropriate reflection and action taken. Doctors working in a non-clinical area should discuss options for quality improvement activity with their appraiser. Possible options include evaluation of teaching or management practice.

8. Significant events

8.1 Myth: All unintended or unexpected events are regarded as significant for the purposes of revalidation

The [GMC guidance on supporting information for appraisal and revalidation](#) states: “A significant event (also known as an untoward or critical incident) is any unintended or unexpected event, which could or did lead to harm of one or more patients. This includes incidents which did not cause harm but could have done, or where the event should have been prevented.”

In interpreting this guidance, it is recommended that any event deemed significant is one that meets your employing organisation’s threshold for formally reporting untoward, critical or patient safety incidents.

8.2 Myth: I need to review and present two significant events at my annual appraisal

There is no minimum or maximum number of significant events that you should present at appraisal. You may not have been involved in any significant event. In which case, you just need to make a declaration to that effect for your appraisal.

If there have been any significant events, you should summarise the details, together with any resulting reflection, learning and action points, for discussion at your appraisal. Demonstration of your reflection and learning could be through focusing on one or two patient safety related significant events.

It is also worth remembering that significant event management and analysis in healthcare is often a team activity. The outcomes of any team review of significant events can also be brought to appraisal, especially if you have learned about the quality of the care provided and what, if any, changes should be made as a result.

8.3 Myth: My appraiser’s role is to investigate any significant event I have been involved in

No. The main purpose of appraisal is to facilitate reflection on your significant events for a formative developmental purpose. The focus is on reflection, learning and improvements in practice. This is distinct from the separate local governance process managing the significant event when it occurred.

9 Personal development plan

9.1 Myth: My personal development plan must include...

There is nothing that the GMC requires your personal development plan (PDP) to include.

Your goals should be taken from your appraisal. The GMC requires you to make progress with your PDP each year or explain why that has not been possible. They require you to reach agreement with your appraiser on a PDP for the coming year based on your appraisal portfolio and discussion. Your PDP should be:

- personal
- developmental
- a plan for the future

It should meet your needs in the context within which you work. We recommend that you develop SMART (Specific, Measureable, Achievable, Relevant and Timely) goals with your appraiser.

Performance objectives should be part of job planning and not necessarily part of your appraisal and revalidation PDP unless you wish to include them. It often helps to work out how you can demonstrate that a change planned as one of your PDP goals has made a difference, by considering its impact on patients.

9.2 Myth: My personal development plan cannot include...

The only personal development plan (PDP) goals that are inappropriate are ones that are not specific to you or irrelevant to your needs.

Your appraiser is trained to help you work out how to write your PDP so that it is a professional record of your personal development planning for your needs. The PDP goals should be balanced across the five-year cycle and across your whole scope of work. Goals around being a good role model for patients and maintaining your personal health and wellbeing in a period of great pressures on the healthcare system are entirely appropriate. However, it is not appropriate to include non-specific goals in your PDP that could apply to any doctor and do not apply to your personal needs. Your goals should not normally be part of what everyone is required to do to be fit to practise. These goals should be re-framed and described in more specific terms so that you can demonstrate:

- where they have arisen
- why they apply to you now
- how you will achieve them
- how you will demonstrate that your goal has been met
- that achieving the goal will make a difference

9.3 Myth: I must have a set number of personal development plan goals and a set number must be clinical goals

The GMC requires you to agree a new personal development plan (PDP) each year that reflects your needs as defined by the portfolio of supporting information and the appraisal discussion. This is a matter for agreement between you and your appraiser.

There is no GMC requirement about the number of PDP goals you should include or if those goals are clinical or non-clinical. Some doctors like to record many PDP items; it is your PDP. Most doctors find three or four PDP items are sufficient to capture their priority goals. You could also have one substantial objective that you then break down into a number of interim or bite-sized goals.

While it would be usual to include some clinical goals, there is no requirement to do so.