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# **Mythbusters: Addressing common misunderstandings about appraisal and revalidation, including those affecting retired and retiring physicians**

**Updated: January 2018**

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# FOREWORD

## Introduction to the Mythbusters document

Of all the myths surrounding the requirements for appraisal preparation and revalidation, the one that strikes me most is this:

Myth: Annual appraisal and revalidation processes are neither beneficial nor a good use of busy doctors' time.

A doctor's time has undoubtedly become more squeezed in recent years, with pressure to deliver additional service requirements, less time to interact with colleagues, as well as limited time for learning and reflection. That is precisely why appraisal, when done properly, is so important for today's doctors. Spending dedicated and quality time with a trusted, respected and knowledgeable colleague allows for in-depth discussion around issues that matter to you. Appraisal provides a platform for reflection and the sharing of concerns, challenges and achievements in a constructive and supportive environment. Gathering and reviewing evidence for the revalidation portfolio can support the reflective process, allowing you to consider what has been achieved during the year, as well as the challenges you have faced in your daily practice. Appraisal can in addition be an affirmative reminder of all the work you have done and all that you personally have delivered, both clinically and non-clinically, in the space of a year. The annual appraisal is *your* appraisal, and is there to meet *your* needs and support *your* development.

This document is designed to facilitate the process of information gathering and prepare you for appraisal. It will hopefully not just provide guidance, but also give you confidence to focus on what is actually required rather than what you imagine is required to collate a portfolio of relevant supporting information to confirm your fitness to practice, and provide you with the reassurance that you will ultimately provide the best quality care for your patients. Our hope is that this will be a 'living document', constantly updated in response to your feedback, identification of new myths, and/or changes in GMC policy and requirements.

Thank you to all the contributors to this document. In particular, I acknowledge Dr Susi Caesar, whose first iteration of *Mythbusters: Addressing common misunderstandings about appraisal and revalidation* was written by her for the Royal College of General Practitioners and has subsequently been updated and revised. Other important contributions to demystifying the process of appraisal and revalidation can be found in a more generic (rather than physician-specific) 'Mythbusters' document published by the [Academy of Medical Royal Colleges](#), and for retired and retiring physicians, a short summary of the content of this Mythbusters document will soon be published by Dr Harriet Gordon, Director of the [RCP London Medical Workforce Unit](#) in a document entitled Later Careers.

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# 1. Role of appraisal in the revalidation of doctors

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

You cannot choose your designated body or who your responsible officer (RO) is. There is a strict hierarchy of connections set out in legislation. There are tools on the GMC website which will help you identify the designated body you should be connected with (usually the organisation employing you, eg trust or health board if you work in the NHS, or postgraduate deanery or equivalent if you are a trainee). In exceptional circumstances, such as where you have a prior personal or business relationship with the RO, there may be a perceived conflict of interest, in which case you should be assigned to an alternative RO. If you work for an organisation that does not have designated body status but is a managed environment, there might be a 'suitable person', who is somebody who undertakes a similar role to an RO and can provide the GMC with a revalidation recommendation about you. Refer to the [GMC guidance on suitable persons](#). [\[Back to list of contents\]](#)

## 1.2 Myth: I will have the same responsible officer for the rest of my career

Your RO will probably change when you change jobs or when your employer appoints a new RO. You should check that your designated body has been correctly assigned on GMC Online and that you update your connection promptly whenever there is a substantive change in your circumstances, eg going from being a trainee to being a consultant physician, or changing the NHS trust or health board for which you work. It is your responsibility to ensure that you keep your connection up-to-date and have an annual appraisal. [\[Back to list of contents\]](#)

## 1.3 Myth: Having no obvious connection to a designated body presents insurmountable difficulties in revalidation

It is possible to have a 'zero hours' contract (eg on the bank staff) with an NHS trust or health board which, if arranged, allows the doctor to use the trust's or health board's RO. This can be particularly helpful for partially retired doctors or doctors working in other reasonable roles where there is no RO, including guidance and advisory bodies, research funders, system regulators and professional organisations such as medical royal colleges. All of these organisations rely heavily on senior members of the profession, doctors and other clinicians, for their expertise and experience in a variety of roles, and in a [letter to the trusts and health boards dated 7 July 2017](#) from the four chief medical officers (England, Northern Ireland, Scotland and Wales), the chair of the GMC, and the medical director of NHS England, every employer in the NHS throughout the UK and its boards were urged to look favorably on requests from doctors applying for absence in order to undertake national work for the wider benefit of the public and health services across the UK.

Where there is no obvious connection to a designated body, physicians may in some circumstances be able to join one, such as the [Independent Doctors Federation](#) or the [Faculty of Medical Leadership and Management](#). This may be especially relevant for doctors who have retired from mainstream clinical practice but still wish to work in some capacity that requires a GMC licence. They will then provide your RO and appraisal. These services are often provided for a fee (separately or part of membership). There are also independent appraisal providers who offer medical appraisals (for a fee) that your designated body may find appropriate for the purposes of revalidation. Revalidating directly with the GMC is possible if you can demonstrate that all other options are exhausted. This involves providing an annual return containing evidence of GMC-compliant appraisal and sitting the appropriate assessment (at your own cost) once in your revalidation cycle. The GMC website provides information on the [annual](#)

[return and revalidation assessment](#) for doctors who do not have a designated body, RO or suitable person. [\[Back to list of contents\]](#)

#### **1.4 Myth: My appraiser will decide about my revalidation recommendation to the GMC**

Appraisers do not have the authority to make a decision about your revalidation recommendation to the GMC. The role of the appraiser is to facilitate your reflection, support and stimulate your professional development and help you present an appropriate portfolio of supporting information for your RO to consider. Your RO has the statutory responsibility for making a revalidation recommendation to the GMC. The decision to recommend is based on a determination about whether you have sufficiently engaged in annual appraisal, provided a [portfolio of supporting information that meet 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 practice. [\[Back to list of contents\]](#)

#### **1.5 Myth: Appraisal is all about reviewing my professional performance**

One of the four domains of [Good Medical Practice](#) is 'knowledge, skills and performance' and this provides the basis for any performance review in appraisal and revalidation. However, the review undertaken should be formative in orientation, to identify and deal with any shortfalls in performance through the personal development plan and CPD. It must be remembered that appraisal is very much focused on the professional development of doctors. [\[Back to list of contents\]](#)

#### **1.6 Myth: Appraisal is a pass/fail assessment**

Appraisal is NOT a pass/fail assessment. Appraisal is, or should be, part of a formative and developmental process. It provides the opportunity and protected time each year to reflect with the help of a trained appraiser, who should also encourage you to consider your personal and professional development needs and how best to meet them. The appraisal is also about helping you to develop a portfolio of supporting information that meets your needs and enables your RO to make a revalidation recommendation to the GMC at the end of a five-year cycle. If any shortcomings in the portfolio are identified during appraisal, these should be addressed in a supportive way and through objectives to overcome them in the agreed personal development plan (PDP). [\[Back to list of contents\]](#)

#### **1.7 Myth: Appraisal is the main way to identify performance, conduct or health concerns for the first time**

Issues relating to poor performance, conduct or health are almost never brought to light for the first time during appraisal. They are usually identified prior to appraisal through clinical governance processes and managed outside of revalidation through an organisational investigative process in response to a concern. If either the appraiser or appraisee reveals a performance concern issue for the first time during an 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. [\[Back to list of contents\]](#)

#### **1.8 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 – this is for the local governance process in managing any performance concerns. [\[Back to list of contents\]](#)

#### **1.9 Myth: If I share with my appraiser concerns about another doctor, the appraiser will have**



### **the responsibility to deal with it, and I won't need to be the whistleblower**

It is your responsibility, as the doctor who has first-hand evidence of a concern, to act in accordance with the [GMC guidance on raising and acting on concerns about patient safety](#). Your appraiser should provide you with support and can signpost the correct steps for you to take, but it is your responsibility to raise the concern. Your appraiser may also be required to share your concerns with those involved in local governance processes and the RO. Part 2 (acting on a concern) of 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.

The Royal Colleges of Physicians recommend that appraisers record the fact that there has been a whistle-blowing discussion and the actions agreed with the physician. This will serve as an aide-memoire for the physician's next appraisal. The record should be made in the summary of discussion section on the appraisal form and exclude details of the substance of any allegations. [\[Back to list of contents\]](#)

#### **1.10 Myth: I need to undertake a minimum number of professional activities (PAs) to revalidate as a physician**

Revalidation is about ensuring that a doctor is fit to practise. There are no GMC requirements that relate to the number of sessions worked in any particular scope of work. For any part of your scope of work, no matter how little time is spent on it, the GMC expects you to reflect on how you keep up-to-date at what you do, how you review your practice and how you seek out and respond to feedback from colleagues and patients about what you do (as well as reporting and reflecting on complaints and significant events that reach the GMC threshold of harm). It may be hard to achieve all those different types of supporting information in relation to only one or two sessions per year worked in a particular role, but with careful planning, it should be possible. [\[Back to list of contents\]](#)

#### **1.11 Myth: Taking a career break means I cannot do appraisal every year and this will affect my revalidation**

Your decision to take a significant career break (due to, for example, maternity or parental leave, sickness or sabbaticals) should not be overly influenced by the process of revalidation. There is provision for approval to miss or postpone annual appraisal accordingly. If the career break is for a lengthy period time you should consider relinquishing your GMC licence (but keep your GMC registration). By doing so you are not obliged to take part in appraisal and revalidation. When you go back to work apply to the GMC for your licence to be restored. If you have been out of practice entirely for more than two years, you will be subject to return to practice and induction arrangements of the employing health organisation. The Academy of Medical Royal Colleges provides [guidance on return to practice \(2017\)](#). [\[Back to list of contents\]](#)

## 2. Revalidation, appraisal and continuing professional development documentation

### 2.1 Myth: I have to use an electronic revalidation and/or CPD portfolio

The format of your revalidation and CPD portfolio has not been prescribed by the GMC. However, having an electronic portfolio will allow your supporting information to be stored in one place, which can then be submitted electronically to your appraiser. Most designated bodies require appraisal documentation to be sent electronically using, for example, the [NHS England Medical Appraisal Guide \(MAG\) Form](#) (this also provides the template for other appraisal forms), so having your supporting information already in electronic format is clearly advantageous. Some items of supporting information, such as original complaint letters or compliment cards, which may be hand-written, are usually best kept in paper form and shared privately with your appraiser to maintain confidentiality. They can then be referenced anonymously by the appraiser in the summary of discussion area of the appraisal form. [\[Back to list of contents\]](#)

### 2.2 Myth: I have to use the revalidation and/or CPD portfolio designated by my responsible officer

Physicians need to maintain a portfolio of supporting information for revalidation and CPD purposes. Many ROs have commissioned bespoke IT solutions for their doctors to encourage them to use a single revalidation and CPD system. The Federation also provides the [Online CPD Diary and App](#) for physicians to record their learning activities and reflections, which can then be summarised and electronically uploaded into an external revalidation portfolio. Physicians do have a choice about which portfolio(s) to adopt, although your RO may express a preference (which he or she is entitled to do under the RO regulations) in order to avoid having to struggle with managing multiple formats used by doctors in the organisation. You should ensure that you are aware of any requirements made by your RO and that you agree any variations in advance if there are exceptional circumstances to be considered. Whatever format you choose, you need to ensure that your supporting information is securely stored and readily available, potentially at short notice to inform the RO revalidation recommendation decision. [\[Back to list of contents\]](#)

### 2.3 Myth: My revalidation and CPD portfolios are entirely confidential

The Federation recommends that you consider your revalidation and CPD portfolios in the light of the principles of best practice in information governance and data protection. 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 CPD, appraisal and revalidation portfolio. It is worth remembering the following:

- It is inappropriate to include any third party identifiable information, whether about patients or colleagues, without their explicit permission.
- Consider the portfolio as subject to the same levels of confidentiality as clinical notes, which have strict rules about what information is available to whom, and under what circumstances, but which are not restricted to just the patient and the doctor.
- The portfolio is a professional document and any reflective notes should be appropriately written. Reflective notes included in the portfolio could be subject to a

requirement to disclose, just as clinical notes can be. If they are appropriately written, they can demonstrate your learning and insight into any incident that is under investigation. The BMA recommends that legal advice is sought if any request to disclose is made.

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## 3. Supporting information for appraisal and revalidation

### 3.1 Myth: I need to spend a long time getting supporting information together for my appraisal

The process of pulling together the supporting information that you have gathered throughout the year and placed in your portfolio, and making the sign-offs and statements prior to the appraisal discussion, should be straightforward. Your supporting information should be generated from your day-to-day work and added to your portfolio as you go along. The final stage of pulling together the supporting information before your appraisal should take no more than half a day (3 to 4 hours). If it is taking longer, or the effort feels disproportionate, you should discuss with your appraiser how you can simplify what you do. [\[Back to list of contents\]](#)

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

Your supporting information has to cover the whole scope of work for which you require a GMC licence to practise, whether or not you are working in the NHS. The Royal College of Physicians of London has produced [resource guides and example portfolios of supporting information for sub-specialty groups of physicians](#). Even if the NHS provides your designated body and RO, your medical appraisal for revalidation has to cover your whole scope of work, including any roles outside the NHS for which you require a licence to practice. There are physicians working entirely in private practice who maintain a GMC licence through revalidation. Appraisers need to be trained and supported to provide whole scope of work appraisals and to facilitate reflection on supporting information from inside and outside the NHS. [\[Back to list of contents\]](#)

### 3.3 Myth: Supporting information from work outside the UK cannot be included in my revalidation portfolio

Supporting information gathered from outside the UK may be acceptable – as indicated by the [GMC protocol for responsible officers \(ROs\) making revalidation recommendations \(2015\)](#). This flexibility is particularly important for physicians who spend the majority of their time working internationally and only a small amount in the UK (for which they require a GMC licence). These physicians will have difficulty gathering sufficient supporting information from their UK work. It is worth remembering the following:

- Your RO will need to approve that supporting information from outside of the UK can be included in your appraisal. This approval is based on whether the information can be verified, is in line with the requirements set by the GMC and relevant to your scope of work in the UK.
- The Federation recommends that you discuss any proposal to include any such supporting information with your RO in advance of your revalidation recommendation date. It is likely that clinical work outside the UK will have a significant overlap with that undertaken in this country and it may be appropriate to include supporting information relating to this international work where it has wider application in demonstrating the quality of your reflective practice. If you are unsure, use your appraisal as an opportunity to reflect on what is appropriate and proportionate with your appraiser, and then agree it with your RO in good time before your revalidation recommendation is due.

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## 4. Reflection

### 4.1 Myth: Reflection is always difficult

Reflection can be difficult at first or when done very infrequently. However, reflection – thinking critically about what, how and when we do something and whether it could have been done differently – is something doctors should do all the time. It is part of our professional training. Reflecting on professional practice is also an important part of appraisal and revalidation. The following is worth considering:

- In appraisal, many physicians find that their appraiser facilitates 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 the appraisal summary.
- Tools such as the reflective cycle encourage you to think about your professional practice in logical stages – feelings, evaluation, analysis and future action.
- Reflection in your appraisal should take into account the professional attributes of a doctor set out in [Good Medical Practice \(GMP\)](#). See also the [GMP framework for appraisal and revalidation](#) issued by the GMC.
- Documenting your reflection on practice and intentions to improve for scrutiny by an appraiser is something that some physicians find uncomfortable.

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### 4.2 Myth: My reflections need to be extensively documented for the purposes of appraisal

Your appraiser will be interested in your reflections on the supporting information you present in appraisal. You will be asked to document your initial reflections before the appraisal. The difficulty for many physicians 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. A few sentences in the form of bullet points or a short paragraph should be sufficient in capturing key learning that has or will influence or change your professional practice. Recording every thought about patient care and practice that you have every day is not necessary and would clearly be disproportionate for appraisal purposes.

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

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## 5. Continuing professional development

### 5.1 Myth: Only formal courses and conferences count as CPD

All learning activities relevant to your current or proposed clinical and non-clinical scope of work count as CPD for the purposes of revalidation. Learning activities are too numerous to fully list here ([see Annex 4](#)) but include courses, conferences and other educational sessions held externally and internal to your place of work, as well as personal study in keeping up-to-date with your professional practice through the current literature, streamed live events and web-based resources. Opportunistic and experiential learning derived from your day-to-day clinical practice counts as CPD, as does learning from any teaching, research and management duties you may have. [\[Back to list of contents\]](#)

### 5.2 Myth: Only those learning activities approved by the Federation count as CPD

Not all learning activities are submitted to the Federation for approval, yet they can still be counted as CPD. The Federation's CPD scheme does approve events and distance learning materials, as a way of assuring the quality of educational content in order to help physicians decide on the suitability of potential activities. You should consider recording and reflecting on any learning activity – whether it is approved by the Federation or not – relevant to your professional role as a physician. [\[Back to list of contents\]](#)

### 5.3 Myth: I need a formal certificate to show that I have taken part in a CPD activity

Obtaining and keeping certificates confirming participation in 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. We do however encourage physicians 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. Members of the Federation CPD scheme may be asked to take part in the end-of-year quality assurance audit, and this requires submission of these documents. [\[Back to list of contents\]](#)

### 5.4 Myth: I need to electronically scan certificates to provide supporting information about my CPD

You may find it more convenient to keep your paper certificates in a box file. The advantage of scanned versions is that they can be attached to records detailing CPD activities and reflections in an electronic portfolio – but in some cases the effort involved in scanning these certificates may not be a profitable use of your time. Those certificates designed to capture and include your reflections on a learning activity may be worth scanning. Also worth scanning are certificates relating to employer-mandated training as they provide proof of attendance. This does not make them part of the GMC requirements for revalidation but it does allow you to collect and keep important documentation securely. [\[Back to list of contents\]](#)

### 5.5 Myth: Time spent on quality improvement activity, such as clinical audit, is not regarded as CPD

Many physicians benefit educationally from the process and output of engaging in quality improvement activity (QIA), which includes local improvements, system changes and clinical 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 CPD. The same principle applies to learning from significant events, feedback from patients and colleagues and review of any complaints and

compliments. The Federation's CPD scheme and online diary allows you to document this reflection and record this learning as personal and/or internal CPD credits ([see Annex 3](#)). The same information can be used in other areas of your revalidation portfolio, in providing evidence of your QIA and review of any significant events, feedback, formal complaints and compliments. [\[Back to list of contents\]](#)

### **5.6 Myth: For revalidation I can do all my CPD in one go or from one source**

Over a five-year revalidation cycle there should be a balanced approach to your CPD in terms of:

- Learning from a variety of external, internal and personal study activities.
- Amount of CPD undertaken – 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 keeping up-to-date at all times as part of your professional practice.
- Development areas covering the scope of your professional work – including your clinical and non-clinical roles.

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### **5.7 Myth: I have to exceed 50 CPD hours or credits of learning every year and 250 over five years**

The GMC does not set any requirements as to the amounts of CPD undertaken for revalidation. Quality matters more than quantity in CPD, in demonstrating that you are keeping up-to-date in what you do. The Federation's CPD scheme is a credit-based system where one credit equals one hour of learning, and 50 per year is an indicative amount. It provides you with a structure to conveniently plan and record a balanced approach to CPD over the five-year revalidation cycle, across clinical and non-clinical, and external, internal and personal study activities that are relevant to your scope of practice ([see Annex 3](#)). However, just recording and showing that you have met or exceeded 50 CPD credits per year is not enough for revalidation, and your appraiser may not necessarily be impressed if you have recorded hundreds of CPD credits. You will need to reflect and discuss in your appraisal how your CPD is relevant to your work and keeping you up-to-date. [\[Back to list of contents\]](#)

### **5.8 Myth: I need only to do part-time CPD if I work on a less than full-time basis**

Less than full-time (LTFT) physicians 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 CPD on a part-time basis. Those physicians working LTFT will have less experiential or on-the-job learning to draw on and therefore most certainly need the same amount and level of planned CPD (conferences, educational meetings, personal study, etc) as those working full-time. [\[Back to list of contents\]](#)

### **5.9 Myth: A long-term career break means I am totally excused from undertaking any CPD**

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 CPD, during the break. 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). When you

return from your career break, your employer may require you to participate in, or you may want to complete, a return to work programme which should take into account any immediate CPD needs. The Academy of Medical Royal Colleges has provided [return to practice guidance \(2017\)](#). [\[Back to list of contents\]](#)

#### **5.10 Myth: I have to take part in training mandated by my employer in order to revalidate**

Mandatory training is NOT a requirement of appraisal and should not be a condition of appraisal taking place. While it is not unreasonable for your employer to require job-related mandatory training (eg fire safety and manual handling), as part of the contractual obligations of all staff, completion of mandatory training should be part of job planning and should not be used as a lever for appraisal taking place.

There is a clear distinction between the requirements of local appraisal processes and the decision-making process leading to a revalidation recommendation. Failure to undertake mandatory training that is *not* necessary to your scope of professional practice and development should *not* adversely affect your revalidation. If the mandatory training is necessary for your professional practice and development, it should be recorded as CPD and discussed in appraisal. When the contents of mandatory training are not relevant to CPD, compliance with reasonable employer requirements that address safety, risk, governance, etc, is probably relevant to all aspects of good medical practice, and should therefore be included in the appraisal discussion.

Finally, if you work for different organisations that have common mandatory training requirements, eg covering equality and diversity or information governance, an annual update in one organisation should be accepted by the other(s) in order to avoid unnecessary duplication in your training. [\[Back to list of contents\]](#)

#### **5.11 Myth: I have to document all my learning activities**

A list of CPD activities in which you have participated would be useful for appraisal. You may want to take a selective approach in listing only those activities you found most valuable and meaningful rather than recording every learning activity undertaken (a quality rather quantity approach). This is perfectly acceptable in demonstrating your engagement with CPD. [\[Back to list of contents\]](#)

#### **5.12 Myth: A detailed and comprehensive reflective note has to be made for each recorded CPD activity**

Physicians are required to reflect on their CPD. Documenting your reflection should be proportionate to the CPD activity and providing a large 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 is often sufficient in capturing the most important lessons learned and any changes that you plan to make as a result.
- A selective approach can be taken in recording your reflection on only those CPD activities which are valuable and meaningful to you.
- A reflective note for activities resulting in no new learning could simply say that learning has been consolidated and it reinforces existing knowledge and skills.



- The brief notes for each recorded activity could act as prompts when providing a more detailed end-of-year summary reflection of your CPD for appraisal. The summary will aid discussion of CPD at 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.
- Tools and resources are available to help you record your reflections such as the [reflective template with guidance notes](#) (Academy of Medical Royal Colleges) and [guide to reflection on CPD for physicians](#). The [Federation's CPD online diary comes with a mobile app](#) with built in voice transcription allowing you to record your reflection on any learning while on-the-go.

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## 6. Quality improvement activities

### 6.1 Myth: No-one else can be involved in the quality improvement activities I undertake for revalidation

You do not need to do all the background work and data collection or analysis for your quality improvement activity (QIA) yourself. Someone else undertaking a literature search, or doing some of the research, is a reasonable and proportionate use of your time. Many QIAs such as clinical audits are team-based, involving colleagues in the hospital, or are regional or national projects. Personal audits that you undertake may also involve colleagues in the collection and collation of data. [\[Back to list of contents\]](#)

### 6.2 Myth: I have to participate in certain types of quality improvement activities

For the purposes of revalidation you are required to participate in quality improvement activity (QIA) although no single type is mandated. The GMC provides broad examples of QIAs in their revalidation guidance: clinical audit, review of clinical outcomes, case reviews, and impact and effectiveness evaluations, and these may include local improvement activities, and/or system-wide change. What is expected is that you participate in QIAs at least once every five years. The Federation recommends that QIAs are selected according to what is relevant and important to you in improving the quality of care and services you or your team provide. What is also expected for revalidation is reflection on any QIA. 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, ie what difference you and the QIA more broadly have made. [\[Back to list of contents\]](#)

### 6.3 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 physicians choose to participate in local, regional and/or national clinical audit. It is worth considering:

- The Federation currently recommends that physicians should participate in at least one complete audit cycle during the five-year revalidation period.
- The type and level of involvement in clinical audit will vary according to a physician'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](#) and [NHS Getting It Right First Time \(GIRFT\) programme](#).
- 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. The Royal College of Physicians of London has developed the [online personal clinical audit tool \(p-CAT\)](#) to guide users through the audit process and cycle, record personal reflection, develop an action plan and generate reports for revalidation.

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

The provision of clinical outcome data based on your work as a clinician is not a requirement for revalidation. 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. The Federation also recommends that where you maintain a clinical skill that is particularly important to you or your specialist area of practice, a log of your personal outcome data is kept (although this is not a GMC requirement). 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. [\[Back to list of contents\]](#)

#### **6.5 Myth: Patient feedback on health outcomes or status and service delivery by my team or organisation cannot be used in appraisal**

Validated and robust outcome measures, including patient reported (PROMs), relevant to your professional practice can be used to demonstrate the quality of your practice for the purpose of revalidation. Benchmarking the data against national data in your specialty may also be useful. Patient feedback on satisfaction and experience of overall health services provided by your team or organisation can also be used in appraisal, especially if you have a management or leadership role in delivering these services. [\[Back to list of contents\]](#)

#### **6.6 Myth: There is no national clinical audit or outcome data available in my specialty and therefore I do not have to participate in any quality improvement activity**

Many physicians choose to participate in clinical audit or review outcome data as activities in meeting the quality improvement requirement for revalidation. The quality improvement activity may involve using different methodologies, eg Team Learning for Quality Improvement, Experience-Based Co-Design (EBCD), Model for Improvement (MFI). Where participation in clinical audit or review of outcome data is not possible, an alternative activity is case review or discussion with documentation of appropriate reflection and action taken. The Federation suggests ten case reviews be documented over the five-year revalidation cycle. A [case review and discussion template](#) has been made available by the Royal College of Physicians of London. Doctors working in non-clinical areas should discuss options for quality improvement activity with their appraiser. Possible options include evaluation of teaching or management practice. [\[Back to list of contents\]](#)

## 7. Significant events

### 7.1 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 the Federation recommends that any event deemed significant is one that meets your employing organisation's threshold for formally reporting untoward, critical or patient safety incidents. [\[Back to list of contents\]](#)

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

There are no minimum or maximum numbers of significant events that you should present at appraisal. It may be that no significant event has been logged against you or your team during the year, 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. An [untoward incidents template](#) has been developed by the Royal College of Physicians of London to capture this reflection and learning. 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. [\[Back to list of contents\]](#)

### 7.3 Myth: The appraiser's role is to conduct an investigation into any significant event I have been involved in

You should reflect on any significant event (if any) during your appraisal. The focus during appraisal is on reflection, learning, professional development and improvements to practice. This is distinct from the local governance process which carries out investigations into and manages any significant events occurring. [\[Back to list of contents\]](#)

## 8. Colleague and patient feedback

### 8.1 Myth: I have to 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 or professional scope of work. 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 for the use of a questionnaire will give an indication of 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 their website. The GMC has also published [FAQs on which questionnaires to use](#). [\[Back to list of contents\]](#)

### 8.2 Myth: All my colleague and patient feedback has to be from standardised questionnaires

Patient and colleague feedback collected using standardised questionnaires complying with GMC guidance are both required at least once every five years. However, the Federation recommends that you take the opportunity once a year at appraisal to discuss your reflections on your relationships with colleagues and patients. To inform these discussions other types of feedback – solicited or not – can be useful, eg feedback from students given on evaluation forms, or personal narratives from patients provided in comment cards or posted on dedicated websites. Although not required by the GMC, physicians with multiple roles may find seeking additional feedback from different groups worthwhile and the resulting information meaningful in developing their professional skills. The appraisal discussion should cover whether this information is useful and the extent to which it is thought to be reliable, especially if it is to be used to inform your professional development. It is also important that any feedback in your revalidation portfolio, or introduced during the appraisal discussion, is appropriately anonymised, eg any personal identifiable information is redacted. [\[Back to list of contents\]](#)

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

Where possible, you should not hand out questionnaires to patients, or collect the responses directly from them. 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 collation process by an external third party protects patient anonymity and includes all responses (positive and negative feedback) from patients. [\[Back to list of contents\]](#)

## 9. Review of complaints and compliments

### 9.1 Myth: For reasons of data protection I should not document any formal complaints made against me or my team in the appraisal form

A brief reflective documented summary, rather than the full details, of formal complaints made against you or your team over the course of the year is required for appraisal. The summary should also include details of your participation in any investigations. It is worth remembering:

- Formal complaints, for the purposes of appraisal and revalidation, are regarded as another source of feedback for learning and professional development.
- A [summary of complaints template](#) has been developed by the Royal College of Physicians to record the nature of any complaints, issues arising, how they were resolved and whether there has been any relevant practice change and learning.
- The clinical governance team or PALS office in your designated body should send you the full details of any formal complaints in a timely manner prior to your next appraisal. It is not necessary to document these details in full for your appraiser but if you do, make sure you redact the identity of individuals involved in the complaint. The information governance guidelines in your designated body should be followed in this regard.
- The confidentiality guidance provided by NHS England in [Improving the Inputs to Medical Appraisal](#) says: *You must take care to ensure that your whole appraisal submission is free from patient and staff personal identifiable information. In particular, due to data protection issues, the attaching of original material from significant events, complaints and compliments to your appraisal submission is not encouraged. It is recommended that you refer to them and provide your reflection on them in your appraisal submission but provide any supporting documentation separately to your appraiser.*

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### 9.2 Myth: All my thank-you letters, cards, emails and other forms of compliments have to be submitted for appraisal

Discussing the successes and positives of your professional practice is an essential feature of appraisal. It would be useful to provide a documented summary of any compliments received together with your reflections on how they have influenced professional practice, relationship with others, learning and development. Scanning and submitting electronic copies of thank-you letters is not a requirement for revalidation. Compliments are often hand-written and signed, and it is perhaps more practical to show them privately to your appraiser, which also helps to maintain confidentiality. They can then be referenced anonymously by the appraiser in the summary of discussion area of the appraisal form. [\[Back to list of contents\]](#)

## 10. Personal development plans

### **10.1 Myth: My personal development plan needs to contain a specific number of objectives**

The GMC do not specify a particular number of objectives for a personal development plan (PDP). The number will vary from physician to physician, and from year to year. It is based on the outcome of the annual appraisal discussion of CPD needs covering the scope of professional practice. Some physicians may want to meet an ambitious or long-term objective through setting a number of staged objectives for the year or longer. The Federation recommends that objectives should be SMART – specific, measurable, achievable, relevant and timely. [\[Back to list of contents\]](#)

### **10.2 Myth: Job performance objectives are an essential element of my personal development plan**

Setting performance objectives is part of job planning and not necessarily included (unless you want to) in the personal development plan as a result of your appraisal. This is because appraisal is formative and is about you developing as a medical practitioner. [\[Back to list of contents\]](#)

### **10.3 Myth: I will be penalised if I am unable to meet one of the objectives in my personal development plan**

As part of revalidation you are required to review the progress made with your personal development plan (PDP). Theoretically, your employers could impose a penalty if you were unable to complete an agreed PDP objective. However, there are many valid reasons for non-completion, including unexpected changes in workload or priorities during the year or insufficient provision of protected time and the necessary resources. Further, there is currently no mechanism within NHS trusts and health boards to make sure that PDPs are put into practice. The appraisal is the opportunity for you to explain, review whether the objective is still achievable and relevant, and what support you need to resolve any difficulties in meeting the objective. The objective could be rolled over to the next year or deleted from the PDP if no longer achievable or relevant. Also, the PDP objective may be a long-term target (covering two or more years) and you are in the progress of meeting it. [\[Back to list of contents\]](#)

# Annex 1: Useful publications and resources for appraisal, CPD and revalidation

## Royal Colleges of Physicians (see also the individual websites for RCP London, RCP Edinburgh and RCPS Glasgow)

- [CPD guidance](#)
- [Feedback for revalidation](#)
- [Guide to reflection for continuing professional development for physicians \(2014\)](#)
- [Personal clinical audit tool – p-CAT](#)
- [Physician specialty resources and example revalidation portfolios](#)
- [Supporting information for appraisal and revalidation: guidance for physicians \(2014\)](#)
- [Tools and templates for supporting information](#)

## GMC

- [Colleague and patient feedback for revalidation](#)
- [Continuing professional development: guidance for all doctors \(2012\)](#)
- [Good medical practice framework for appraisal and revalidation \(updated March 2013\)](#)
- [Guide for doctors: revalidation and maintaining your licence \(updated January 2017\)](#)
- [Meeting the GMC's requirements for revalidation](#)
- [Revalidation: frequently asked questions for retired doctors and those preparing to retire \(2014\)](#)
- [Revalidation: what you need to do](#)
- [Supporting information for appraisal and revalidation \(2012\)](#)
- [Sir Keith Pearson's review of medical revalidation: Taking Revalidation Forward \(2017\)](#)

## Academy of Medical Royal Colleges

- [Academy reflective template for revalidation](#)
- [Appraisal for revalidation: a guide to the process \(2014\)](#)
- [CPD guidance framework for appraisers and appraisees](#)
- [CPD reflective note guidance and template](#)
- [Retired doctors and revalidation guidance](#)
- [Return to practice guidance \(2017\)](#)

## NHS England

- [Getting It Right First Time \(GIRFT\) programme \(quality improvement\)](#)
- [Improving the inputs to medical appraisal](#)
- [Medical appraisal guide: a guide to medical appraisal for revalidation in England](#)

## HQIP

- [The use of national clinical audit data in appraisal \(2017\)](#)



## Annex 2: Glossary of terms, abbreviations and explanatory notes

### Term (abbreviation)

Continuing professional development (CPD)

### Explanatory note

A continuing process, outside formal undergraduate and postgraduate training, that enables individual doctors to maintain and improve standards of medical practice through the development of knowledge, skills, attitudes and behavior. Continuing professional development should also support specific changes in practice. It includes both formal and informal learning activities.

Federation of the Royal Colleges of Physicians of the UK

The Federation is a partnership between the Royal College of Physicians of Edinburgh, Royal College of Physicians and Surgeons of Glasgow and Royal College of Physicians of London.

GMC online

A password-protected area on the GMC website allowing doctors to manage their GMC registration and revalidation details.

Personal development plan (PDP)

The PDP is the outcome of an appraisal in determining and structuring your CPD needs for the forthcoming year.

Responsible officer (RO)

A RO is nominated or appointed by a designated body (usually the doctor's employer) and will make a revalidation recommendation about the doctor to the GMC.

Suitable person

A 'suitable person' can make revalidation recommendations for doctors who do not have a connection to a designated body.

## Annex 3: Definitions of categories of CPD credits

The Federation of the Royal Colleges of Physicians of the UK provides the following definitions:

### Categories of CPD credits

CPD credits can be either clinical or non-clinical and can be derived from personal, internal or external activities:

Clinical	Clinical credits concern any event in which the educational content directly relates to clinical topics.
Non-clinical	Non-clinical credits concern an educational event that is not directly related to clinical issues, eg management courses, ethical and legal issues, appraisal training, etc.
External	External credits are given for events outside the hospital or trust such as attending conferences and study days. These may be regional, national or international meetings, and are often held by specialist societies, or are meetings that attendees pay for.
Internal	Internal credits are events within or organised by the hospital or trust, or provided solely for local clinicians, eg hospital grand rounds, journal clubs, clinico-pathological conferences, local evening medical meetings, etc.
Personal	Personal credits relate to study such as private reading, lecturing, carrying out research, etc.
Exemption	Exemption credits may only be claimed in exceptional circumstances when a physician is unable to meet the annual minimum requirement of 50 CPD credits due to illness, maternity leave or long absence from work.

### Registration of CPD credits

Physicians who are members of the Federation's CPD scheme can register their CPD credits in the following categories:

Approved external activity	External educational activities (eg conferences) formally approved by the Federation for CPD.
Approved distance learning	Distance learning materials (including e-learning) formally approved by the Federation for CPD.
Self-certified activity or distance learning	Physicians can self-certify internal and personal educational activities as being relevant to their CPD. The same applies to external activities that have not obtained formal CPD approval from the Federation.

## Annex 4: Types of CPD activities

Educational activities that can quality as CPD:

- Carrying out information searches
- E-learning, web-based and other types of distance learning
- External educational meetings (eg conferences)
- Internal (eg hospital-based) educational meetings
- Internal trust- or employer-mandated training
- Participating in audit meetings
- Participating in committees or working parties
- Participating in grand rounds or specialty clinical meetings
- Participating in morbidity and mortality meetings
- Participating in seminars or workshops
- Making new presentations at conferences
- Reading journals and texts
- Refereeing articles and texts
- Undertaking a research project
- Undertaking quality assurance/enhancement/peer reviews
- Participating in web-based or internet-streamed lectures
- Undertaking a work-related MSc or equivalent activity
- Writing examination questions or examining
- Writing review articles and texts