APPRAISAL, REVALIDATION & PORTFOLIO | MODULE 03

Map your whole practice and organise supporting information

Create a proportionate evidence index that includes clinical, educational, leadership and other medical roles.

✓ 12 min reading

✓ Full teaching, practical next steps and reflection

✓ Six practice questions with answers and explanations

✓ Complete source list and jurisdiction notes

Prepared for SAS, locally employed and other UK doctors

Author: Dr N Aziz

Using this module

Independent education	This is general professional information, not individual clinical, legal, employment, immigration, regulatory, tax or pensions advice. Current official instructions and the circumstances of the individual case remain controlling. Practice scores do not establish professional competence or accreditation.

The short answer

Describe all your medical work, then map relevant supporting information to it. An index of evidence and gaps is more useful than an indiscriminate document store.

Three next actions

- List every role undertaken since the last appraisal.
- Identify the governance contact and evidence location for each role.
- Mark gaps and agree how to address them.

Learning objectives

- Describe scope without relying on grade labels.
- Map the six evidence categories to a varied working life.
- Distinguish a missing item from an agreed alternative.

Describe what you actually do

Start with a role inventory: work setting, activity, responsibility, frequency and relevant changes. Include clinical practice alongside teaching, supervision, leadership, management, research and other medical services where applicable. Identify paid and unpaid work rather than assuming that only your largest contract matters. Explain boundaries: what you do independently, where you seek advice and which activities are outside your scope.

A title such as “Specialty Doctor” is not a complete scope statement. Two doctors with the same title may work in very different services. A better description explains the patient or service group, normal work, occasional duties and relevant interfaces. Avoid exaggerating autonomy or concealing supervision. The purpose is to make your working life understandable to a reader who does not share your rota.

Use categories as prompts, not six disconnected folders

The GMC identifies CPD, quality improvement, significant events, patient or service-user feedback, colleague feedback, and complaints and compliments. Their collection and review frequencies differ; they are not six identical annual quotas. Review the current category-specific guidance and the arrangements agreed for your scope. Information about work, previous appraisals, development plans, health and probity also matters.

An original example helps illustrate overlap. An evaluation of teaching may provide quality-improvement evidence; feedback from learners may inform development; learning from that evaluation may shape CPD. These are different explanations of one piece of work. Cross-reference the source and make each inference explicit. Do not count one generic certificate several times as if it independently proves several unrelated capabilities.

Build a small, usable evidence index

For each item record a neutral reference, approximate period, relevant role, evidence category, learning or action, and where the approved source can be found. Add a status such as available, requested, planned, or alternative to agree. You usually need a route back to the source, not another uncontrolled copy. Use neutral labels in the website tool; put identifiable details only where authorised.

For example, “E03, teaching evaluation, spring term, education role, review completed, follow-up planned” is a useful planning entry. “Evidence of excellent teaching” is a conclusion without a source or limitation. A well-maintained index helps you notice whether an attractive portfolio is mostly about one role while a substantial second role has little supporting information.

Check relevance, currency and ownership

Ask four questions of an item: what does it show, how does it relate to your work, when was it generated, and what was your contribution? Team activity can be relevant, but it needs an honest account of your part. A committee report with your name in the attendance list does not necessarily demonstrate that you designed or delivered the improvement.

A useful comparison is between a presentation slide deck and evidence of the resulting change. The slides establish that a topic was presented; an agreed action and later review may establish how it affected practice. Neither needs to be inflated. Recording that an intervention did not work, and explaining the next step, can support a more thoughtful appraisal than an unsupported claim of success.

Make gaps visible and actionable

A gap may mean evidence is missing, the work has not yet been done, the evidence is not relevant, or a different approach needs approval. Those are different problems. State which applies and who can help. Do not quietly relabel an unavailable item as “not applicable”. Agree alternatives or a collection plan with the appropriate appraisal or responsible-officer team.

For a short-term doctor, the obstacle may be access to centrally held feedback after leaving a placement. The next action could be a request through the governance office and an agreed discussion of available evidence. For a doctor entering a new role, the next action may be prospective collection. Honest dates and limitations are more useful than retrospective paperwork made to look contemporaneous.

Keep the portfolio navigable

Use a clear summary, an index and selected supporting material. Give filenames or references that have meaning without exposing a patient or colleague. Remove duplicated copies only through approved arrangements, preserving required originals and version histories. A reader should be able to find the evidence for a statement without searching through dozens of loosely named attachments.

Before submission, ask a simple usability question: could an appraiser identify your scope, current development plan, main learning, unresolved gaps and requested support in a few minutes? If not, improve the signposting rather than merely deleting detail. The evidence map on this site is a planning aid, not an algorithm for deciding sufficiency or a substitute for the official portfolio.

Common mistake

Avoid this	Building a large portfolio from the main clinical post while omitting smaller medical roles or failing to explain personal contribution.

Pause and reflect

Which part of your working life is least visible in your current evidence?

Takeaways

- Map work before selecting evidence.
- Explain contribution and limitations.
- Agree gaps and alternatives openly.

Knowledge check

Choose one best answer. These practice questions support reflection; they do not assess a real case or confer accreditation. Answer positions match the browser edition.

1. Which description best supports a whole-practice appraisal?

A. Only activities with a separate payment attached.

B. The actual roles, activities, responsibilities and boundaries across the doctor’s work.

C. Only work that generated a certificate.

D. The contractual grade and main employer alone.

2. One teaching evaluation informs QI and CPD. How should it be used?

A. Upload it twice and treat the copies as separate independent evidence.

B. Describe it as proof of competence in every educational role.

C. Cross-reference the source and explain the different learning it supports.

D. Use it for only one purpose even if it genuinely informs another.

3. Which index entry is most useful?

A. A neutral reference, period, role, category, learning and approved source location.

B. A title saying only ‘excellent performance’.

C. A patient’s name and full clinical chronology.

D. An attachment count without a description of relevance.

4. A report lists a doctor as attending a project meeting. What can be claimed?

A. The doctor should omit team work unless they were the project lead.

B. The report establishes improved patient outcomes attributable to the doctor.

C. The doctor should explain their actual contribution and any further evidence.

D. Attendance establishes that the doctor led the project.

5. Formal feedback is unavailable after a placement. What is the best response?

A. Create a summary from memory and label it an official report.

B. Use a favourable informal comment as an automatic replacement.

C. Explain the gap, seek the record and agree an appropriate plan or alternative.

D. Mark the category not applicable without discussion.

6. An appraiser cannot find the main learning in a large portfolio. What helps most?

A. Adding more attachments to demonstrate diligence.

B. Reorganising only by file size.

C. Removing all source references to shorten the submission.

D. A clear summary and index that point to relevant supporting material.

Answers and explanations

1. B — The actual roles, activities, responsibilities and boundaries across the doctor’s work.

A title does not describe the whole scope. Less visible medical responsibilities may need supporting information and discussion too.

Review the named teaching section, then explain the next step in your own words.

2. C — Cross-reference the source and explain the different learning it supports.

Evidence can serve more than one purpose, but each inference needs an explanation. Duplication does not increase its evidential strength.

Review the named teaching section, then explain the next step in your own words.

3. A — A neutral reference, period, role, category, learning and approved source location.

An evidence index helps the reader find and understand material. It should not become a new repository of identifiable clinical information.

Review the named teaching section, then explain the next step in your own words.

4. C — The doctor should explain their actual contribution and any further evidence.

Team participation can be valuable, but the account must distinguish attendance, contribution and impact. Neither inflation nor unnecessary exclusion helps.

Review the named teaching section, then explain the next step in your own words.

5. C — Explain the gap, seek the record and agree an appropriate plan or alternative.

Different gaps require different actions. An alternative needs discussion and appropriate agreement, not silent relabelling.

Review the named teaching section, then explain the next step in your own words.

6. D — A clear summary and index that point to relevant supporting material.

Navigation should make scope, learning and outstanding actions easy to identify. Volume and cosmetic ordering do not solve unclear signposting.

Review the named teaching section, then explain the next step in your own words.

Official and professional sources

Confirm the current source version and applicable nation, contract, scheme or specialty. A source list is not a statement that every rule applies to every reader.

GMC: supporting information and declarations
UK · https://www.gmc-uk.org/registration-and-licensing/managing-your-registration/revalidation/guidance-on-supporting-information-for-revalidation/guidance-on-supporting-information-for-revalidation

GMC: revalidation requirements for doctors
UK · https://www.gmc-uk.org/registration-and-licensing/managing-your-registration/revalidation/guidance-for-doctors-requirements-for-revalidation/revalidation-requirements-for-doctors

GMC: quality improvement activity
UK · https://www.gmc-uk.org/registration-and-licensing/managing-your-registration/revalidation/guidance-on-supporting-information-for-revalidation/quality-improvement-activity

GMC: patient and service-user feedback
UK · https://www.gmc-uk.org/registration-and-licensing/managing-your-registration/revalidation/guidance-on-supporting-information-for-revalidation/patient-feedback---or-feedback-from-those-you-provide-medical-services-to

GMC: colleague feedback
UK · https://www.gmc-uk.org/registration-and-licensing/managing-your-registration/revalidation/guidance-on-supporting-information-for-revalidation/colleague-feedback

Edition and verification

Editorial edition: 9 September 2026. The page source-review date is 2026-09-09. A publication date, editorial edit and substantive source check have different meanings. See sasdoctors.com/corrections for material corrections and the scope of review.

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