How to use this Toolkit

The Revalidation Toolkit has been produced by the Royal College of General Practitioners (Scotland) (RCGP Scotland), in consultation with the Scottish General Practitioners Committee (SGPC), NHS Education for Scotland (NES) and the General Medical Council (GMC). It has been designed to help you provide evidence for revalidation and will support both the appraisal and independent routes to revalidation.

The layout follows the Revalidation Folder and each section generally contains the following:

- an explanation of what evidence is required
- proformas, which you may wish to use to present your evidence
- a worked example*

Pages have been colour-coded for ease of reference as follows:

Guidance materials	buff
Proformas	white
Examples	blue

Please note:

All proformas can be downloaded from **www.rcgp-scotland.org.uk** and **www.nes.scot.nhs.uk**

As this is an educational toolkit, examples are provided throughout for educational tools and templates. *Examples are not given of practice policies or for issues relating to terms of service.

Future updates will only be made to the web version.

Feedback from those using this Toolkit will be invaluable in updating and improving it. Please send any comments to RCGP Scotland: education@rcgp-scotland.org.uk

Acknowledgements

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Additional printed copies can be purchased from:

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RCGP Scotland is the Scottish Council of the Royal College of General Practitioners (RCGP). The College's aim is to encourage, foster and maintain the highest possible standards in general medical practice by providing leadership and support to GP members in relation to clinical standards and professional development; as well as to provide personal support to members and to promote general practice as a profession.

Index and Checklist of Evidence for Scottish Revalidation Folder

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3A(1b) Prescribing *(if 3A(1a) not possible)*	Management plan proforma **OR** Case report proforma	
*3A(2) Referral	Referral proforma	
*3A(3) Review of clinical practice	2 audits (1 involving doctors practice) **AND**	
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*to be completed in depth once in 5 years

Index and Checklist of Evidence for Scottish Revalidation Folder

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*to be completed in depth once in 5 years

Personal and Registration Details 1

Name:

Date of birth:

GMC number:

Contact Address:

Qualifications including all degrees and diplomas *(with dates)*:

Date of JCPTGP Certification or equivalent *(if appropriate):*
If exempt, please indicate why:

Date of last GMC Revalidation *(if applicable):*

Any breaks in registration in past five years?: Yes ☐ No ☐

Describe and date any erasure or suspension of registration:

Record any conditions on registration imposed by the GMC:

Evidence 2A and 2B: Details of the Job You Do 2

Current Professional Appointments (non-practice activities for healthcare organisations):

Describe the practice(s) in which you work:

Describe your clinical work, including any clinical duties which require particular knowledge or skills, or for which you have particular clinical responsibility:

Details of on-call and out of hours responsibility:

Details of management/administrative responsibility and activity:

Details of teaching and/or research activities:

Details of work for regional, national or international organisations:

Details of other professional activities:

Section 3A(1)

Prescribing

In this section you are asked to provide evidence that your prescribing is both effective and efficient.

You are only required to provide evidence for <u>one of the following sections:</u>

3A(1a)

OR

3A(1b) ***(N.B. only <u>one of the options</u> is required)***

Section 3A(1a)

Prescribing

You are asked to look at your prescribing within one therapeutic grouping in the British National Formulary (BNF). This information can be accessed by:

- Requesting your SPA level 2 data from:

  Primary Care Information Group
  ISD Division
  Trinity Park House
  South Trinity Park
  Edinburgh
  EH5 3SQ

OR

- If you have access to a prescribing adviser or practice pharmacist then he/she will be able to provide you with comparative prescribing data from Prisms.

Once you have accessed the prescribing data you are then asked to analyse this, covering the following points:

- What are ***the top 4 drugs*** in this therapeutic grouping that you use (either by cost or by item over a 3 month period [one quarter])?
- What is ***the range of drugs*** that you use?
- ***The cost effectiveness*** of drugs prescribed – i.e. could less expensive drugs be used without detriment to the care of your patients?
- ***The clinical effectiveness*** of the drugs you use – i.e. is your choice of drugs based on evidence? N.B. for many conditions treated in primary care there may not be an evidence base, and guidelines, local prescribing patterns and experience may influence your choice.

Can you now identify any learning need from this analysis of your prescribing data? If so, this should be included in your ***personal development plan.***

Section 3A(1b)

Prescribing

Where it is not possible for a doctor to access SPA level 2 data or feedback on his/her prescribing from a prescribing adviser or practice pharmacist, evidence about the effectiveness and efficiency of their prescribing can be demonstrated by ***one of the following:***

A management plan

This involves the doctor describing a management plan (referenced to a specific national or local protocol, guideline or evidence base) that they used in the treatment of a patient with a chronic disease. The plan should illustrate a prescribing issue and demonstrate the specific areas in management of the patient where the protocol, guideline or evidence base was used.

OR

A case report

A case report is a reflective account of the care you have given to a patient. This should involve a prescribing issue and if possible be referenced to a protocol, guideline or evidence base.

3A(1a)

Analysis of Prescribing Data

Using SPA level 2 data, or individualised feedback from an appropriate source (e.g. practice pharmacist), complete the following proforma.

Data source:

☐ SPA level 2 data

☐ Individualised feedback (please specify)……..

Therapeutic grouping (BNF classification):

List of top four drugs used:

1.

2.

3.

4.

Comment on the range and number of drugs used in this therapeutic group:

Comment on the **clinical effectiveness** of the various drugs used:

Comment on the **cost effectiveness** of the various drugs used:

Learning points or discussion points identified:

Where appropriate, any changes made or action taken:

Signed..... Date.....

Name.....

3A(1b)

Management plan

Describe a management plan illustrating a prescribing issue, referenced to a specific written national or local protocol, which you have used in the management of a patient with chronic disease in your practice. Your management plan should clearly illustrate compliance with the guidance.

Management Plan:

Please indicate for this patient where you used your guideline/evidence base in their management plan:

Signed…… Date……..

Name……

3A(1b)

Case Report

Select one problem or random case from your normal surgeries for reflection and analysis. This case should illustrate a prescribing issue.

Explain why this case is clinically significant for you.

What decisions did you take in relation to this case and why?

What thoughts or reflections do you have in relation to this case?

What learning points have emerged from this case for you?

How will this learning be used in future?

Supporting case record available? Yes ☐ No ☐

Signed…… Date……..

Name ……

3A(1a)

Analysis of Prescribing Data

Using SPA level 2 data, or individualised feedback from an appropriate source (e.g. practice pharmacist), complete the following proforma.

Data source:

☑ SPA level 2 data

☐ Individualised feedback (please specify)……..

Therapeutic grouping (BNF classification):

LAXATIVES

List of top four drugs used:

1. SENNA
2. LACTULOSE
3. ISPAGHULA HUSK
4. MOVICOL

Comment on the range and number of drugs used in this therapeutic group:

I seem to use all types of laxatives. I think this is probably appropriate given the different types of patients and causes of constipation. Movicol is non generic – but I don't know the generic name!

The biggest disappointment is that lactulose is my second choice of laxative. This surprises me as I am unaware of using it by choice. This data however came from PRISMs and may include other doctors in the practice. I am also aware that we used to prescribe lactulose by choice so perhaps some of these have been on repeat prescription for some time.

Comment on the **clinical effectiveness** of the various drugs used:

I am unaware of any actual guidelines such as SIGN for use of laxatives and in general prefer bulk forming laxatives as the action is more natural. I work in a fairly deprived area and I guess a low fibre (and vitamin) diet predominates.

I would imagine that stimulant laxatives work equally well as bulk laxatives – indeed senna seems to be my first choice.

Comment on the **cost effectiveness** of the various drugs used:

Senna and ispaghula husk are cheap when generically prescribed.

Lactulose is expensive and needs large daily doses.

Movicol is also expensive and I'm not sure why this is my number 4 choice.

Learning points or discussion points identified:

I need to consider if there is a local guideline that I can follow to rationalise my prescribing in this group.

Where appropriate, any changes made or action taken:

I will reduce my prescribing of lactulose. Practice pharmacist has agreed to meet with me again in 6 months to review this. ? also to help develop a policy on when to use lactulose. I will find out how MOVICOL works and only use it if there is a logical need.

Signed…… Date 12/07/03

Name David Adams

3A(1b)

Management plan

Describe a management plan illustrating a prescribing issue, referenced to a specific written national or local protocol, which you have used in the management of a patient with chronic disease in your practice. Your management plan should clearly illustrate compliance with the guidance.

Management Plan:

Treatment of hypertension

55 year old patient

1995

? hypertensive. 180/110. Referred to hypertension clinic. Normal U & E's, normal echo, 24 hr mean BP 155/99. No evidence of end organ damage, patient not keen to start therapy. Advice re non drug measures and yearly monitoring suggested

1999

BP 180/106. BP each year runs at this level. Now father has a retinal vein thrombosis along with hypertension and further CVA. Keen to start treatment.

2000 *Practice protocol followed:*

Jan *Risk assessment – non-smoker, keeps fit, normal BMI, cholesterol 2.8!, alcohol within normal limits*

June *3x high BP reading by practice nurse*
Started bendrofluazide 2.5mg
Control still poor – atenolol 50mg added

Sept *BP control still poor despite adequate B blockade*

Nov *Amlodipine 5 mg started*
Stopped due to ankle odema
Ramipril 2.5 mg with pre and post starter U & E's
Ramipril dose increased to 10mg – U & E's normal

2002

Now on routine review
BP 130 /90
6 monthly checks

Please indicate for this patient where you used your guideline/evidence base in their management plan:

Before starting antihypertensive therapy:
Routine bloods to assess end organ damage and three readings were made before therapy was started

Antihypertensive treatment:
First line use of a low dose thiazide diuretic or B blocker is recommended

2nd/3rd line treatment:
Additional add-in therapy using a calcium channel blocker was next

Side effects or problems:
ACE added with monitoring of U & E's as per protocol

Final comment:
Perhaps at this stage aspirin should be added or we might continue to try to achieve lower BP

Signed…… Date 12/07/03

Name David Adams

3A(1b)

Case Report

Select one problem or random case from your normal surgeries for reflection and analysis. This case should illustrate a prescribing issue.

Explain why this case is clinically significant for you.

54 year old man. Longstanding history of low back pain. Permanently off work.

Seen in 1998 by a partner with SOB and wheeze. Was taking propranolol for anxiety episodes. Family history of asthma (son). Treatment given – propranolol was stopped and budesonide turbohaler started. When reviewed at 1 month wheeze had subsided and budesonide turbohaler was added to his repeat scripts.

January 2002. Seen by practice nurse at our new asthma/COPD clinic.

Spirometry performed which showed a restrictive defect. Nurse noted that his inhaler technique was poor and gave help with this. In view of his abnormal spirometry she also advised that he move to higher dose of inhaled budesonide (400mcg – 800mcg).

February 2002. Seen in surgery by myself. Felt his inhaler at the higher dose was not working. I advised changing the inhaler to a "normal" MDI and use this with a volumatic. Patients Rx changed to becotide 200mcg – 4 puffs twice daily.

A review appointment was organised.

What decisions did you take in relation to this case and why?

Due to the start of our asthma/COPD clinic we had spent an evening with the practice nurses on spirometry training. We also learned that turbohalers require significant inspiratory flow if they are to work and many patients are unable to use them.

I made the assumption that this patient had asthma and his control could be optimised by following the BTS guidelines. Hence I thought that the advice he had been given to move from low dose inhaled steroid to higher dose (Step 3) was correct.

At his review appointment the patient reported no improvement in his condition. I was considering moving to Step 4 – addition of a long acting b2 agonist. However I was uneasy at my lack of expertise in spirometry and I took time to look at his reading from the asthma clinic. On doing this I realised that spirometry had shown a RESTRICTIVE defect. This was not an asthmatic pattern.

What thoughts or reflections do you have in relation to this case?

Spirometry and nurse led asthma/COPD clinics are a new development in our practice. It is quite easy to assume that any objective reading such as spirometry is a better measure of a clinical condition than your own clinical estimate and simply rely on the reading. We had only had one session on interpretation of spirometry results and as I didn't feel confident in this I did not question the nurse's actions and interpretation of the test.

Again using a standardised management protocol such as the BTS guidelines tends to make you move from step to step without questioning why the patient is not getting better. Our treatment would have been perfect – ***if the patient had had asthma!***

What learning points have emerged from this case for you?

If as a practice we are going to offer enhanced services such as nurse led asthma/COPD clinics with spirometry we must all be fully versed in what the tests are and mean.

Protocols for treatment of chronic illness are very important to improving the quality of care, but we must treat the patient and not simply follow the protocol.

How will this learning be used in future?

New BTS guidelines are out soon and we need to keep up to date here.

A further reinforcement session on use and interpretation of spirometry has been arranged for the practice.

Supporting case record available? Yes ☐ No ☐

Signed…… Date 12/07/03

Name David Adams

Section 3A(2)

Referral

The referral of patients to secondary care and other agencies occurs in about 10% of all GP/patient contacts. Being able to access the right care at the right time for patients is one of the key skills of general practitioners.

As the quality of care that your patients receive may be determined by the quality of your referral letter, you can review the effectiveness (referring the right patients to the right services) and efficiency (referring at the right time) by analysing your referral letters.

This activity may lead to identification of new learning needs which should be incorporated into your Personal Development Plan or may result in you considering changes to your referral behaviour. These learning points can be discussed with your appraiser.

Each doctor should consider his/her referrals on one occasion over the 5 year revalidation cycle.

It is recommended that you consider 10 anonymised referral letters and for each one consider which of the following details have been included:

- Administrative details of patient
- Reason for referral
- Drugs prescribed
- Relevant past medical history
- Relevant examination
- Relevant psychosocial details
- Date

You should now consider in light of your analysis whether you have identified any learning needs, or changes that you would like to make to your referral behaviour.

A referral proforma will help you in analysis of your referral letters. A completed proforma is included for your information (N.B. for sake of space the anonymised referral letters have not been included).

Referral letters

3A(2)

You should provide a sample of 10 consecutive referral letters or a random sample of 10 referral letters and show, by ticking the appropriate boxes below, which criteria are met. All of the criteria should be met in at least 50% of letters. Copies of the anonymised letters should be attached to this form to support your analysis.

Letter	Date	Patient Administrative Details	Reasons for Referral	Drugs prescribed	Relevant past medical history noted	Relevant examinations recorded	Relevant psychosocial details recorded
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							

Signed …… Date ……

Name ……

Learning points or discussion points identified:

If appropriate, any changes proposed to referral behaviour:

Signed…… Date……..

Name……

Referral letters

3A(2)

You should provide a sample of 10 consecutive referral letters or a random sample of 10 referral letters and show, by ticking the appropriate boxes below, which criteria are met. All of the criteria should be met in at least 50% of letters. Copies of the anonymised letters should be attached to this form to support your analysis.

Letter	Date	Patient Administrative Details	Reasons for Referral	Drugs prescribed	Relevant past medical history noted	Relevant examinations recorded	Relevant psychosocial details recorded
1	✓	✓	Only symptoms given	✓	✓	✓	Not done
2	✓	✓	✓	✓	✓	✓	✓
3	✓	✓	✓	✓	Omitted	✓	✓
4	✓	✓	✓	✓	✓	✓	✓
5	✓	✓	✓	✓	✓	Omitted	Not done
6	✓	✓	Only symptoms given	✓	✓	✓	✓
7	✓	✓	✓	✓	✓	✓	✓
8	✓	✓	✓	✓	✓	✓	✓
9	✓	✓	✓	N/A	N/A	Omitted	Not done
10	✓	✓	✓	N/A	N/A	N/A	N/A

Signed ..... Date 12/07/03

Name David Adams

Learning points or discussion points identified:

I tend to keep my referral letters to the end of the week before writing them. On one occasion I was aware that I had not included RELEVANT psychosocial details because I had forgotten the exact details. There seems to be a variety of opinions in our practice as to what is best/most efficient, but I think in future I will try to dictate all referrals each day.

I tend not to include negative examination findings and on reviewing these referrals from the point of view of the receiving doctor I would have liked to have been aware of ALL the examination findings.

If appropriate, any changes proposed to referral behaviour:

On discussion with the partners I noted that a referral to ophthalmology could have been improved if I was clearer in my own mind as to the cause of "floaters". I will review some basic ophthalmology as part of next year's learning plan.

Signed…… Date…12/07/03……..

Name……David Adams……

Section 3A(3)

Review of Clinical Practice

In this section of the revalidation folder you are asked to ensure that you regularly review your clinical practice and that you achieve acceptable standards of care.

As evidence for this section you should:

- Undertake a minimum of two audits. At least one audit should be a practice based audit to which the doctor has contributed. Ideally one audit should involve two sets of data with an intervening change (8 criteria audit).
- **Non-Principals** could undertake the above and for those who may have difficulty in completing an audit they can choose to complete either **a management plan** or **a case report.**

AND

- Complete the proforma for Significant Event Analysis.

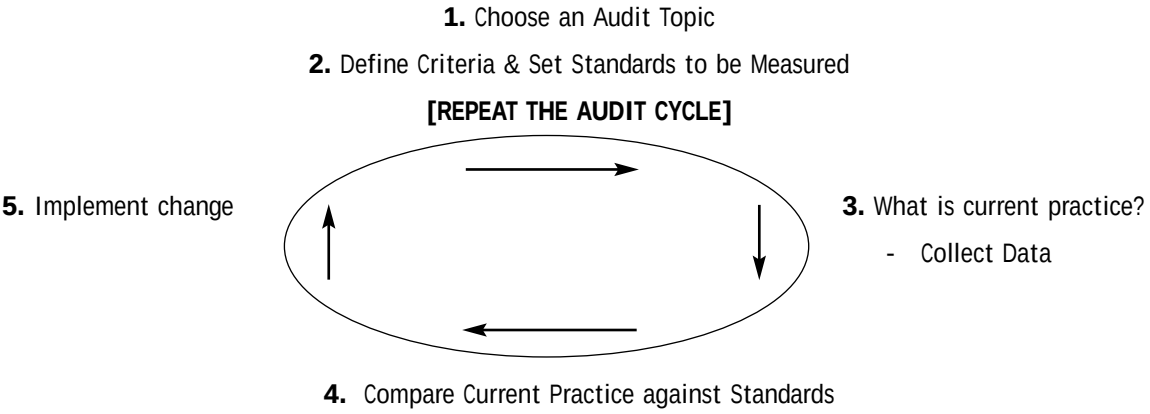
3A(3)

GUIDANCE NOTES ON UNDERTAKING AN AUDIT & DRAFTING A REPORT

Introduction

The audit cycle or loop is the traditional method followed when carrying out an audit project (Figure 1). As the term suggests, audit involves completing a cycle of different activities, the end purpose of which is to improve the quality or effectiveness of patient care. There are a number of different stages to the audit cycle and all of them must be closely followed to enable a successful audit outcome. Failure to do so invariably leads to an audit project being left incomplete or abandoned altogether.

Figure 1. The Audit Cycle



Choosing an audit topic

This is a very important first step that must be given careful consideration. There should be consensus and agreement within the practice that the chosen topic for audit is a worthwhile area to study i.e. you are unsure of current practice in that area or there is agreement that this is an area where practice could be greatly improved.

Example:

If we take the example of aspirin prescribing for patients who have previously suffered an acute MI, we have an audit topic where there is a solid evidence base and which the vast majority of GPs would agree was important, worthwhile and relatively easy to undertake.

Undertaking an audit project in isolation from colleagues will potentially lead to a number of difficulties and ideally should be avoided. For example, staff or colleagues may not be as keen to help with data collection if they feel uninvolved or suspect that the audit has been imposed on them. Similarly, you may experience difficulty or even hostility in getting others to change practice in light of your audit findings if they have not been informed or involved since the start. It is extremely important that all relevant staff are aware of what you intend to do, how you intend to do it, are agreed that it is a worthwhile exercise and are willing to support you.

The Audit Report Format

In this section we outline how to write-up the findings of a new audit project (see Forms A and B). We illustrate what should happen at each stage of the audit cycle and how this should be reported by using a commonly undertaken audit topic as a practical example. The layout of the final audit report should be structured with the following headings:

[Stage 1 - Reason for the audit]

The opening section of the report should clearly explain why the audit topic was chosen and that as a result of this choice there is the potential for change to be introduced which is relevant to the practice or you as an individual practitioner.

Choosing a topic in an area where you know the practice is strong will not lead to a completed audit cycle being achieved. For example, if the data from your initial audit findings clearly suggest that you do not have to consider the introduction of any change, or carry out a second data collection, then it is evident that this topic was not a problem area in your surgery. You should consider concentrating on prioritising workload and clinical topics in areas where there is a consensus amongst colleagues that practice could potentially be improved.

Points to consider:

- Explain why the particular audit topic was chosen. For example, there may be a perceived deficiency in practice or it is an area in which it is recommended that audit should be carried out routinely and there is a perception that practice could be improved.
- Explain what potential benefits there will be to the individual undertaking the audit and/or the practice in general.

[Stage 2 - Criteria to be measured]

Criteria and standards are often cited as the most confusing terms associated with audit. Both cause doctors and others the greatest difficulty in understanding and putting audit into practice. Understanding the difference between an audit 'criterion' and a 'standard' gives a good grounding in basic audit method.

Criteria are simple, logical statements *used to describe a definable and measurable item of health care, which describes quality and can be used to assess it*.

Simple examples of audit criteria:

1. Patients with a previous myocardial infarction should be taking aspirin, unless contraindicated.
2. Patients with chronic asthma should be assessed by the practice at least every 12 months.
3. Patients should wait no longer than 20 minutes past their appointment time before consultation.
4. The GPs' medicine bag should contain a supply of in-date adrenaline.
5. Surgeries should start within 5 minutes of their allotted time.
6. The blood pressure of known hypertensive patients should be <140/85.

Remember that it is best to restrict the number of criteria to be measured for any given audit. Attempting to audit too many criteria is a common problem that often results in a project failing to be completed, leading to frustration for those involved. Focusing on just a few (or even one) criteria makes data collection much more manageable and the introduction of change to practice much less challenging. Overall, it offers a better chance of the audit being completed successfully within a reasonable time span. Bear in mind that most successful audits are small studies that often involve simple changes to practices being introduced; rarely do they result in a large-scale overhaul of a particular service.

It is important that any criteria you choose to audit should, where possible, be backed up with quoted evidence (e.g. from a clinical guideline or a review of the relevant literature). Occasionally, because of the type of topic chosen, suitable evidence is not readily available and therefore cannot be cited. If this is the case then simply explain that there is a lack of evidence on the subject, but also stress that there is consensual agreement amongst your colleagues on the importance to the practice of the particular topic and criteria that have been chosen.

Points to consider:

- The criteria should be very relevant to the actual audit topic chosen.
- Follow the style (short, simple logical statements) used in the above example for each criterion, where possible.
- Focus on a few criteria where possible, smaller projects have more success.
- You must justify why each criterion is chosen, for example with reference to current literature, clinical guidelines or other evidence if available.

[Stage 3 - Setting Standards]

An audit standard quite simply describes the *level of care* to be achieved *for any particular criterion*. It is unlikely that you will find actual percentage standards quoted in the literature or in clinical guidelines. Ideally you should arrive at the desired level of care (standard) by discussing and agreeing the appropriate figures with colleagues. There is no hard and fast rule about standard setting – the agreed level is based on both you and your colleagues' professional judgement and this will obviously vary between practices for a variety of medical, practical and social reasons.

Examples of audit standards:

1. **90%** of patients with a previous myocardial infarction should be prescribed aspirin, unless contraindicated.
2. **80%** of patients with chronic asthma should be assessed at least every 12 months.
3. **75%** of patients should wait no longer then 20 minutes after their allotted appointment time.
4. **100%** of GPs' medicine bag should contain a supply of in-date adrenaline.
5. **95%** of surgeries should start within their allotted times.
6. **70%** of blood pressure measurements of known hypertensive patients should be <140/85.

Agree on a standard, which you all believe to be an ideal or desired level of care and briefly explain why each standard was chosen (remember that different standards can be applied to each criterion). The standard(s) set should be outlined together with a time-scale as to when you expect it to be achieved (for example within 4 months if that is how long you envisage to complete the audit project). In some cases you might require to set realistic targets and a time scale towards the desired standard over a longer period of time. For example, 50% of asthmatic patients should have a management plan within 4 months, rising to 70% in 12 months, and surpassing 80% within 24 months.

Points to consider:

- Agree on and set a measurable standard for each criterion (as in the above example).
- A time scale towards achieving this standard should be included alongside.
- Briefly explain why each standard was chosen.

[Stage 4. Preparation & Planning]

This is an important section that is often overlooked when compiling an audit report. As previously explained, audit should not be undertaken in isolation - consensus on a topic is necessary, findings should be shared and recommendations for change need to be agreed amongst the team if the audit is to have a successful outcome. Teamwork is therefore essential to most audits and this must be demonstrated during the audit and evidence of this should be provided in the report. Ideally you should explain who was involved in discussing and planning the audit, how the data were identified, collected, analysed, and disseminated and who gave you assistance at any stage of the project (e.g. with a literature review or with collecting or analysing data) if this was required.

Points to consider:

- Describe the preparation and planning involved in undertaking the audit.
- Demonstrate evidence of teamwork in the preparation and planning of the audit.

[Stage 5 - Data collection (1)]

The initial data collected should be presented using simple descriptive statistics in table format or using graphs (bar charts, pie charts etc.). Remember to quote actual numbers (n) as well as the percentage (%). Do not quote irrelevant data (for example, on age, gender, or past medical history) if it bears no relation to your chosen audit criteria. It is also important to comment on the difference between the first collection of data (current practice in this area) and the standard previously set (the desired level of care).

Points to consider:

- Present initial data in a simple way, remembering to include actual numbers as well as percentages.
- Do not present irrelevant data that is unrelated to your audit criteria.
- Always comment on how the initial data findings compared with your standard.

NB. For revalidation it is desirable but not essential that you complete a full audit cycle (an 8 criteria audit). If however you are completing a 5 criteria audit then at this stage of the audit it is important that you reflect on Data Collection (1) and produce detailed proposals for change (see Form C).

If you are completing an 8 criteria audit then go onto stage 6.

[Stage 6 - Description of change]

The essence of audit is to change practice in order to improve patient care and services. This section should adequately describe any change that was discussed, agreed and introduced to practice by the team. The role of others involved in this process should also be described. An explicit example of the change that was introduced should be attached in evidence as an appendix to the report, where this is possible. Examples of this could include a new or amended protocol, guideline or flow chart that is introduced to practice, or a letter that is sent to a group of patients inviting them in for a review or check.

Points to consider:

- Adequately describe change to be implemented together with the role of staff involved in this and when and how it was implemented.
- Attach an explicit example/illustration to provide evidence of the change that was introduced, where this is possible.

[Stage 7 - Data collection (2)]

After change has been agreed and implemented and a reasonable period of time has elapsed to allow any new practices or systems to take effect, then you should complete the audit cycle. Undertaking a second data collection will increase the chance of your audit project being completed and maximise the opportunity to make improvements in patient care. It also is more satisfying for you and your team to see your time and effort put to good use.

Completion of the audit cycle is achieved by carrying out a second data collection in order to measure and evaluate what impact the newly introduced change or changes has had on improving practice in the area being audited. If no change has been introduced or it has not been given enough time to take effect then there is no point in undertaking a second data collection – the findings are unlikely to show any improvement in the time that has elapsed because there has been no intervention.

Data from the second data collection should be presented in a similar way to the first round of data, but also include the results from data collection (1) and your desired standard so that comparisons can be easily made.

Remember to comment on the comparison between data collections (1) and (2), and the desired standard to be achieved. If the standard is not attained or surpassed, explain why you think this is the case and how you would propose to reach it in future.

Points to consider:

- Present the findings from data collection (1) and (2), briefly compare them with each other and the standard(s) set and discuss the outcome.
- If the standard is not reached speculate as to why this was the case and how you might reach it in future.

[Stage 8 - Conclusions]

The final section of the audit report should conclude by briefly and simply summarising what the audit achieved and the main learning points gained from this exercise. In doing this, the benefits accrued through the audit should be discussed, along with any problems encountered with the process or findings. If the standards set have not yet been reached then comment on why you think this is. Consider adjusting the standard to a more realistic level in future if this is the case. Some thought should be given as to whether the audit will be repeated in future and if so when.

Attachments

Clinical Audit

Audit Proforma (8 criteria) (Form A)

Audit Proforma (5 criteria) (Form B)

Sample Audit Project Report (Form C)

Further reading

AUDIT:

Bowie P, Garvie A, McKay J (2002). Ideas for audit: a practical guide to audit and significant event analysis for general practitioners. NHS Education for Scotland, www.show.scot.nhs.uk/nes/audit

Connolly Y, Jones A, Hancock J (2000). Sampling for clinical audit: A flow chart for primary care. Journal of Clinical Governance, 8(1) 45-47.

Crombie IK, Davies HTO et al (1993). The audit handbook: improving health care through clinical audit. John Wiley & Sons, UK.

Adapted with permission from Bowie P, Garvie A and McKay J.

CLINICAL AUDIT 3A(3)

Suggestions for those who want to do more than the minimum

Year 1	-	Complete a 5 or 8 criteria audit
Year 2	-	Complete an 8 criteria audit
Year 3	-	Collect a 2nd or further set of data for the audit undertaken in year 1
Year 4	-	Collect a further set of data for the audit undertaken in year 2
Year 5	-	An 8 criteria audit should be undertaken on a different clinical topic from previously

FORM A **Audit Proforma (8 criteria)** **3A(3)**

Title of project:

Audit reports tend to range in length from a few to a dozen pages, depending on the size of the audit.

1. Reason for the audit

2. Criterion or criteria to be measured

3. Standard(s) set

4. Preparation and planning

5. Results of data collection ONE

6. Description of change(s) implemented

7. Results of data collection TWO

8. Conclusions

Signed…… Date……

Name……

FORM B **Audit Proforma (5 criteria)** **3A(3)**

Title of project:

Audit reports tend to range in length from a few to a dozen pages, depending on the size of the audit.

1. Reason for the audit

2. Criterion or criteria & standards to be measured

3. Preparation and planning

4. Results & interpretation of data collection ONE

5. Detailed proposals for change

Signed..... Date.....

Name.....

FORM C

SAMPLE AUDIT PROJECT REPORT

Audit Project: Secondary Prevention of Ischaemic Heart Disease

Practice: McKowie & Partners

Population: 3,425

Address: 75 Highland Way, Paislarbert.

Date of Completion: March 2003

1. Reason for the Audit

Ischaemic heart disease (IHD) is a major cause of morbidity and mortality throughout the UK, but especially in west central Scotland. Secondary prevention of IHD is a national health care priority and a clinical guideline containing evidence-based recommendations has been developed to assist clinical staff take appropriate measures. IHD is also a priority audit area for the local primary care trust. Our practice contains a large number of patients who have had an MI but we have yet to adequately monitor how we are dealing with this patient group. We believe there is the potential to make substantial improvements to the way we monitor and treat these patients within the practice, leading to demonstrable improvements in the care of this important patient group.

2. Criteria to be Measured

Based on the evidence-based recommendations contained in the relevant SIGN guideline [1], we agreed to measure performance with regard to the following 3 criteria:

- Patients post MI should be taking an anti-platelet, unless contraindicated.
- Patients post MI should be prescribed beta-blockers, unless contraindicated.
- Patents post MI should have a cholesterol <5mmol/l.

3. Standards Set

We agreed the following standard levels were attainable within a 6-month period:

- 90% of patients post MI should be taking an anti-platelet, unless contraindicated.
- 70% of patients post MI should be taking beta-blockers, unless contraindicated.
- 70% of patents post MI should have a cholesterol <5mmol/l.

We chose these particular standards because it should be quite straightforward to ensure that the majority of patients are taking an anti-platelet. However, more patients are likely to have contra-indications to taking beta-blockers, be non-compliant or potentially suffer side effects.

4. Preparation and Planning

The decision to undertake the audit was discussed and agreed at a practice team meeting involving all three partners, the practice nurses and the practice manager in September 2002. The practice manager undertook to identify all post MI patients on the practice computer system and this was cross checked against those who were on repeat prescriptions for the 3 drugs outlined. A copy of the relevant section of the appropriate SIGN guideline had been circulated for comment. The casenotes of patients who were not on one or more of the relevant drugs were pulled and reviewed by a designated practice nurse.

5. Data Collection (1)

In total 60 post MI patients were identified from the computer search. A review of the casenotes of those not prescribed the relevant drugs found two patients who were consistently non-compliant in attending practice appointments and a number who had contra-indications.

Criterion	Standard	Contraindications	Currently Prescribed?
		(n)	n(%)
Patients post MI should be taking an Anti-platelet	**90%**	0	40/60 **(67%)**
Patients post MI should be prescribed Beta-blockers	**70%**	6	30/54 **(56%)**
Patients post MI should have a cholesterol <5mmol/l	**70%**	0	32/60 **(53%)**

It is clear from the results that all three criteria were not meeting the standards set and that practice in this area could be improved.

6. Implementation of Change

The practice nurse presented the results of the first data collection at the team meeting in October 2002. The team agreed the results were disappointing but were confident that improvements could be made. In the short term, the following measures were agreed:

- To immediately write to all post MI patients not on the relevant drugs or without a cholesterol level asking them to attend the surgery for a review of their medication and/or cholesterol.
- To look at the potential of developing a nurse-led protocol for managing patients with both IHD and cebrovascular disease.
- To repeat the data collection in 3-months time and on an annual basis for the next 3 years.

7. Data Collection (2)

In total 58 patients were identified from the practice computer system. Two patients had died in the intervening period since the first data collection.

Criterion	Standard	Contraindications	1st Data Collection	2nd Data Collection
		(n)	n(%)	n(%)
Patients post MI should be taking an Anti-platelet	**90%**	0	40/60 **(67%)**	56/58 **(97%)**
Patients post MI should be prescribed Beta-blockers	**70%**	0	30/54 **(56%)**	37/52 **(71%)**
Patients post MI should have a cholesterol <5mmol/l	**70%**	0	32/60 **(53%)**	43/58 **(74%)**

The figures from the second data collection clearly show that the results have improved since the initial data collection and that the various standards set have now been reached within the time-scale specified.

8. Conclusions

The audit has shown some marked improvements in the way we manage our patients post MI. It was initially disappointing that we did not come closer to the standards we first set ourselves. However, the changes we introduced and evaluated through a second data collection have shown us that we can measurably improve the care we provide to this patient group by using the audit process, at least in the short term. The challenge for the practice is to set up an evidence-based protocol-based system for these patients that can be managed by the practice nurse with complementary input from the practice medical staff. We will repeat this audit on an annual basis in the immediate future in order to monitor the care we provide in this area.

REFERENCES

1 Scottish Intercollegiate Guidelines Network (SIGN) Guideline Number 41. Secondary Prevention of Coronary Heart Disease following Myocardial Infarction, January 2000.

Please see section 3A(1b) Prescribing for an example of a completed management plan and case report.

3A(3)

Management plan

Describe a management plan, referenced to a specific written, national or local protocol, which you have used in the management of a patient with chronic disease in your practice. Your management plan should clearly illustrate compliance with the guidance.

Management Plan:

Please indicate for this patient where you used your guideline/evidence base in their management plan:

Signed…… Date……..

Name……

3A(3)

Case report

Select one problem or random case from your normal surgeries for reflection and analysis.

Explain why this case is clinically significant for you.

What decisions did you take in relation to this case and why?

What thoughts or reflections do you have in relation to this case?

What learning points have emerged from this case for you?

How will this learning be used in future?

Supporting case record available? Yes ☐ No ☐

Signed…… Date……..

Name ……

3A(3)

GUIDANCE NOTES ON UNDERTAKING SIGNIFICANT EVENT ANALYSIS & DRAFTING A REPORT

Introduction

Significant event analysis (SEA) is strongly encouraged in primary care as a structured way of learning, improving patient care and minimising risk. It is a form of audit but unlike the method of (criterion-based) audit previously explained, it deals with reviewing single cases or events rather than groups of patients with specific conditions or high-volume workload issues. That is not to say, however, that a single event cannot act as a trigger for a conventional audit to be undertaken in these areas.

SEA is mainly a team-based activity where the emphasis is on learning from an event and changing practice in order to minimise the chances of it recurring in future. It is a non-threatening technique that encompasses a 'no blame' approach, where we look at what (systems) is wrong and **not** who (individuals) is wrong. Failure to adopt this philosophy in the practice will discourage team members from highlighting and discussing significant events and lead to missed opportunities to address issues requiring change.

What is a significant event?

"Any event thought by anyone in the team to be significant in the care of patients or the conduct of the practice". (Pringle *et al*, 1995)

The definition of a significant event outlined here is a very broad based one. It should be noted that significant events do not have to be 'critical' or 'adverse', but can also 'celebrate' the confirmation of good practice. In reality, however, most significant events, whether clinical or administrative, can be broadly categorised as adverse occurrences, near misses or errors i.e. they tend to deal with 'negative' incidents.

Selection of significant event topics

The selection of significant event topics is very important as the wrong selection can lead to conflict, bad feeling and low morale – so care must be taken when considering events for discussion.

SEA topics that should not be used for discussion include those where individuals or groups of staff have a hidden agenda. Other topics that are inappropriate for SEA include those where individual poor performance (e.g. lateness, slackness, work difficulties) has been identified. SEA is not the forum for this, nor is it the forum for personal matters (e.g. personal hygiene, dress code, attitude), confidential matters (staff health) or contractual matters (pay, working-hours etc). The practice should have appropriate mechanisms in place to deal with these issues.

What is a significant event ANALYSIS?

Simply acknowledging and discussing a significant event amongst colleagues after it happens is not enough – it is likely to recur if that is all that is done. The SEA technique allows for a structured analysis to be performed so that a clear picture of what happened and why is established, insight into the event is demonstrated, change is introduced (if appropriate) and lessons are learned. The end result being that the chance of the event happening again is hopefully minimised.

Drafting a SEA Report

When undertaking and documenting a significant event analysis we should ask ourselves four questions (see forms D and E):

1. What happened?

2. Why did it happen?

3. What has been learned?

4. What has been changed?

What Happened?

In this section of the report all of the facts relating to the identified significant event should be described so that those reading the report (e.g. your Appraiser or Practice Accreditation Assessor) can get a clear picture of the details of the event - including dates and times. The significant event being described should be evaluated because it deals with a quality of care or patient safety issue, or has personal impact on staff or an effect on the practice as a whole.

Why did it happen?

In this section clear reasons should be provided as to why the event occurred based on the evidence collated from those directly and indirectly involved. This allows the team to identify and focus on the issues that may require to be addressed.

What have you learned?

An explanation should be given of any learning you and the team have identified. For example, these may be related to learning issues concerned with therapeutics, disease management or administrative procedures. However, it could also reflect a learning experience in dealing with patients, colleagues, staff, or other organisations.

What have you changed?

With most significant events, a change in some aspect of care is required to improve the quality of care and/or minimise the risk that a similar event will occur. If this is the case then a description of the change actually implemented should be given rather than a "wish list" of thoughts, which may minimise risk but have not yet been carried out.

On occasions it may not be possible to implement change either because the likelihood of the event happening again is so rare or because change is outwith the control of the individual or the organisation. If this is the case then the reasons behind this should be clearly documented.

Finally, significant events need not necessarily be adverse events or near misses, but can reflect high quality care. In this case the reason for not changing any aspect of care can be easily documented, as it is obviously not required.

Attachments

Significant Event Analysis Proforma (Form D)

Sample SEA Report (Form E)

Further Reading

SIGNIFICANT EVENT ANALYSIS:

Bowie P, McKay J, Lough M (In Press). Peer assessment of significant event analyses: being a trainer confers an advantage. *Education for Primary Care.*

McKay J, Bowie P, Lough M (2003). Evaluating significant event analyses: implementing change is a measure of success. *Education for Primary Care,* **14**(1): 34-38.

Pringle, M., & Bradley, C. (1994). Significant event auditing: a users' guide. Audit Trends, **2**, 70-73.

Pringle M., Bradley C, Carmichael C, Wallis H, & Moore, A (1995). Significant event auditing: A study of the feasibility and potential of case-based auditing in primary medical care. Royal College of General Practitioners, London.

Sweeney G, Westcott R, Stead J (2000). The benefits of significant event audit in primary care: a case study. Journal of Clinical Governance, 8:128-134.

Adapted with permission from Bowie P, McKay J and Lough M.

FORM D **3A(3)**

SIGNIFICANT EVENT ANALYSIS

Title:

Date of significant event:

Date of significant event meeting:

Date report compiled:

What happened?

Why did it happen?

What have you learned?

What have you changed?

Signed..... Date.....

Name.....

FORM E 3A(3)

SIGNIFICANT EVENT ANALYSIS (CASE STUDY)

SAMPLE SEA REPORT

Title: Prescription collection mix-up leading to a patient overdosing
Date of significant event: 10 March 2002
Date of significant event analysis meeting: 15 March 2002
Date report compiled: 18 March 2002

What happened?

A patient arrived at the reception desk to pick up a prescription for Amitriptyline. He was given the prescription for Amitriptyline dated the previous day, but in addition there was also a prescription for Amitriptyline which had been lying from the month before and he was also given this prescription. The patient therefore had a large amount of Amitriptyline at home and over the following few days an overdose was taken, with hospital admission and monitoring required.

Why did it happen?

The partners, nurse and practice manager discussed the event at a practice meeting and identified the following issues that could have contributed to the event:

The practice does not have a system to identify which prescriptions have not been collected after a given period of time. In addition there is no system to minimise the quantity of potentially dangerous drugs available to patients. Both these issues had contributed to a depressed patient having a large quantity of Amitriptyline. It was also felt that because this man was attending secondary care he had not been formally reviewed in the recent past by any of the partners and so any suicidal intent was not identified by the practice.

What have you learned?

There is no foolproof system to stop this patient hoarding medication and subsequently overdosing, however, risk can be reduced.

Change needs to be implemented to put in place a system which regularly checks for "old" prescriptions and allows action, if necessary, to be taken.

What have you changed?

The practice decided to implement the following:

A named person to review prescriptions in the prescription box once per month. Prescriptions which have been in the box for 3 weeks or more will be brought to the prescriber's attention and a decision made to keep the prescription and contact the patient or destroy it.

Signed..... Date 12/07/03

Name David Adams

Section 3A(4&5)

Drugs, Equipment and Emergency Care

3A4 In this section you are asked to provide evidence to show that all necessary and appropriate clinical equipment and drugs to manage common conditions, including emergencies, are available to you within and outwith your practice.

You can either use a current practice accreditation certificate **OR** complete the drugs and equipment proforma.

3A5 In this section you are asked to provide evidence that you can appropriately manage emergencies in practice. This can be demonstrated by completing **one of the following**:

Significant event analysis of managing an emergency

This involves you describing an event which you thought significant relating to a patient presenting to you as an emergency. You should analyse this event as per the enclosed proforma describing the event, giving information about why it happened, what you personally learned from it and what you have changed as a result of it.

OR

A case report from out of hours co-operative

Most out of hours co-operatives keep records of the patients seen and action taken. Such a report detailing a patient who presented through the out of hours co-op to you as an emergency and was managed by you would be acceptable.

OR

Case report of managing an emergency

A case report is a reflective account describing the care you have given to a patient. For this section you should describe how you dealt with a patient presenting as an emergency.

Drugs and Equipment Proforma

3A(4)

Equipment available in the consulting room and in medical bag (including emergency drugs)

Equipment	Available in the practice	Available in the consultation room	Available in the bag
Auriscope/specula			
Sphygmomanometer (with date tested)			
Ophthalmoscope			
Stethoscope			
Peak flow meter			
Thermometer			
Tongue depressor			
Torch			
Weighing scales/height measure			
Examination gloves			
Syringes and needles			
ECG machine			
Basic surgical instruments			
Blood sampling equipment			
Charts for assessing vision			
Emergency bag with resuscitation equipment/oxygen			
Vaginal speculum			
Spatulae for cervical smears and/or cytobrush			
Measuring tape			
Fluorescein/local anaesthetic eye drops			
Refrigerator with temperature monitor			
Nebuliser			
Autoclave			
Tuning Fork			
Urine testing sticks			
Ear syringe			

Any other equipment of note and comments:

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Emergency drugs - please indicate with a tick which of the following drugs are available:

Drugs	Available in the practice	Available in the consultation room	Available in the bag
Pain:			
Diamorphine (5mg or 10mg powder in vials plus water for injection)			
Diclofenac (75mg/3ml injection)			
Dihydrocodeine (30mg tablets)			
Paracetamol (500mg tablets or 120mg/5ml paediatric oral solution or suspension)			
Ibuprofen (100mg/5ml paediatric suspension)			
Naloxone (400mg/ml injection) for opioid overdose			
Other drugs used by the practice:			
Vomiting:			
Cyclizine (50mg/ml injection)			
Prochlorperazine (12.5mg/ml injection, 5mg tablets)			
Metoclopramide (5mg/ml injection, 10mg tablets)			
Haloperidol (5mg/ml injection)			
Other drugs used by the practice:			
Psychiatric emergencies:			
Chlorpromazine (25mg/ml injection, 25mg tablets)			
Haloperidol (5mg/ml injection, 1.5mg tablets or 1mg/ml liquid)			
Diazepam (5mg/ml injection eg Diazemuls, 5mg tablets)			
Other drugs used by the practice:			

Drugs	Available in the practice	Available in the consultation room	Available in the bag
Infection:			
Benzylpenicillin (600mg vials)			
Amoxycillin (250mg/vial, 250mg capsules or 125mg/1.25ml paediatric suspension)			
Trimethoprim (200mg tablets)			
Flucloxacillin (250mg capsules)			
Erythromycin succinate (250mg tablets or 125mg/ml mixture)			
Cephalexin or co-amoxiclav			
Other drugs used by the practice:			
Hypoglycaemia:			
Glucose (oral gel Hypostop, 50 per cent solution plus large syringe for injection) or glucagon (1mg/ml Injection)			
Other drugs used by the practice:			
Convulsions:			
Diazepam (5mg/ml, 2ml ampoule for injection as Diazemuls, or 2-4mg solution for rectal administration)			
Other drugs used by the practice:			
Bleeding:			
Saline (0.9 per cent solution, physiological)			
Syntometrine (ergometrine maleate 500micrograms plus oxytocin 5 units/ml injection)			
Other drugs used by the practice:			
Allergic reactions/Anaphylaxis:			
Epinephrine (Adrenaline) 1 mg/ml ampoules (1:1,000)			
Intravenous hydrocortisone (100mg powder plus water for injection)			
Oxygen and airways			
Chlorpheniramine (10mg/ml injection)			
Other drugs used by the practice:			

Drugs	Available in the practice	Available in the consultation room	Available in the bag
Myocardial infarction:			
Aspirin (300mg soluble tablets)			
Fibrinolytic drugs, such as streptokinase, anistreplase, alteplase			
Atropine (600 micrograms/ml injection)			
Glyceryl trinitrate (aerosol 400micrograms metered dose)			
Diamorphine (see pain)			
Other drugs used by the practice:			
Left heart failure:			
Frusemide (10mg/ml injection)			
Diamorphine (5mg powder in vials plus water for injection)			
Other drugs used by the practice:			
Dehydration:			
Compound sodium chloride and glucose powder (such as Dioralyte or Rehydrat)			
Other drugs used by the practice:			
Asthma:			
Salbutamol (1mg/ml solution) or terbutaline (2.5mg/ml solution) via nebuliser, or multiple actuations of metered dose inhaler into spacer device			
Ipratropium 250 micrograms/ml nebuliser solution			
Hydrocortisone (100mg powder as sodium succinate plus water for injection) or prednisolone (5mg and 20mg tablets)			
Other drugs used by the practice:			

The above list is based on the recommendations published in the Drug and Therapeutics Bulletin September 2000 (Vol. 38 No. 9).

Any other comments about drugs available for emergencies:

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What system does the practice use to ensure that these drugs have not expired?

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Comments on storage of drugs including controlled drugs and vaccines:

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Signed: ..... Date: .....

Name: .....

(Form adapted from that used by the GMC Performance Procedures)

3A(5)

Significant Event Analysis Proforma

Title:

Date of significant event:

Date of significant event meeting:

Date report compiled:

What happened?

Why did it happen?

What have you learned?

What have you changed?

Signed…… Date……

Name……

3A(5)

Case Report

Select one problem or random case from your normal surgeries for reflection and analysis.

Explain why this case is clinically significant for you.

What decisions did you take in relation to this case and why?

What thoughts or reflections do you have in relation to this case?

What learning points have emerged from this case for you?

How will this learning be used in future?

Supporting case record available? Yes ☐ No ☐

Signed…… Date……..

Name ……

Section 3B

Personal Development Plan

This is a key section of your revalidation folder and an important outcome from your annual appraisal. Whereas the old system of PGEA was based on attendance at accredited meetings, your personal development plan will allow you to plan your learning to suit your needs and circumstances.

Along with your appraiser you should identify key development objectives for the year ahead, and these will be reviewed at your next year's appraisal.

Your personal development plan (PDP) is laid out as a structured proforma **(GP Scot 2),** which helps you to organise your learning for the following year. There are eight steps to your personal development plan:

1. What is your learning need?

2. How did you identify this need?

3. Priority.

4. What is/are your objective(s)? (What do you hope to do differently as a result of meeting this need)?

5. How do you plan to meet this need (methods)?

6. How will you know whether your learning has been successful?

7. Has the objective been met and what have you learned?

8. Date of completion.

This may seem complex but the following guide and examples will help you to devise your own plan.

Personal Development Plan Guide

Steps 1 & 2

Learning need and how need has been identified

This is often referred to as an educational needs assessment. It is one of the most important parts of your personal development plan and it is worthwhile first to consider some of the most frequently asked questions about educational needs assessment:

What is an educational/learning need?

There are many books and articles that put forward a variety of definitions of educational needs. A simple definition, however, is that an educational need is an area of your professional life where learning will lead to a change in your understanding and practise of medicine.

Why bother assessing your learning needs?

Until recently, most continuing professional development (CPD) was concerned with attending specific accredited courses. For many doctors these were either not relevant to their practice or rarely made a significant impact in their understanding or changes to their practice of medicine. Having knowledge of your own educational needs, however, means that courses, reading and other educational events can be targeted at specific areas where you wish to change or improve your practice.

Does this mean I should stop going to courses unless they fit in with my "learning needs"?

No. For all of us a great deal of worthwhile and enjoyable learning is opportunistic. The nature of practice is unpredictable and general CPD will always remain important. This will be recorded in your ***record of learning*** and form a part of your appraisal. Interest in medicine and each individual's motivation is the main driver for learning, so don't think that learning for interest and fun is unimportant! It is getting a balance that is important and ensuring that some of the year's learning is based on your educational needs.

I'm a fairly average sort of doctor. Surely my learning needs will be the same as other doctors. Can't I just leave it to others and attend what's available locally?

There is good evidence that doctors have different areas of uncertainty and that it is not the method of learning (i.e. which course you attend etc.), but the processes of identifying learning needs and reinforcement of learning that has taken place that maximise the effectiveness of your learning. Remember attending courses may only be a part of your ongoing learning and reading, teaching, team meetings and many other learning methods can be included in your personal development plans.

I'm already aware of some areas where I could learn more – is this ok?

The more focused you can be in defining your learning needs, the easier it will be to plan and learn effectively. Some topics in medicine are vast and trying to cover the whole of the topic may mean spending time on areas that you are familiar and comfortable with and where there may be little scope for any new learning. For example rather than identifying "diabetes" as a learning need you may wish to focus on drug therapy for type 2 diabetes and the action of metformin or the new "glitizones". Similarly, concentrating exclusively on areas that are of particular interest to you (so called educational wants), may not result in any new learning.

How can I assess my learning needs?

You probably already do! Doctors work in a rich learning environment and are continually assimilating new information and skills, and through discussing problems in practice with colleagues, may change the way they approach issues. A desire to remain competent and keep abreast of new developments is a feature of all our practices. Educational needs assessment is really just a more systematic way of recording our learning needs and prioritising what we should concentrate on. Some examples are given on the next page.

How do I get started?

As we are surrounded in every day practice by potential leaning opportunities there is a danger of being flooded out by good intentions. A structured approach can help determine how and where you gather information. Learning needs may come from three main areas:

- Your professional practice
- Feedback about your work
- Local and national priorities

Will I be expected to produce a perfect PDP?

No you will not. Completing a PDP for the first time will be a learning experience for many and help in the plan construction will be available at appraisal and also from your local CPD Adviser.

Identifying your learning needs

The following menu is not exhaustive but gives some ideas on how you might start.

The menu is designed for you to make your own choices and you can use different methods over the years.

Each section is explained in the following pages.

Identifying development/learning needs from ***your professional practice***	
• Keeping a diary	• Referrals
• PUNs and DENs	• Complaints
• Significant events	• Teaching activities
• Courses and meetings	• Research

Identifying development/learning needs from ***feedback about your practice***	
• Audit	• Observation of your practice
• Feedback from your patients	• Self assessment of your knowledge
• Feedback from your peers	• Prescribing information

Identifying development/learning needs from ***local & national priorities***	
National initiatives, e.g.	Local LHCC initiatives, e.g.
• Coronary heart disease	• Protected learning time
• Mental Health	
• Cancer	

Identifying development/learning needs from your professional practice

Keeping a diary	Note any blind spots, areas where you feel unsure of how to proceed when dealing with patients. Simply note these down as they happen during your working week. Once a month review the diary and consider if any are important enough to explore further in your ***personal development plan***. You may wish to use the ***case report proforma*** (refer to section 3A(3)) to help structure your thoughts.
PUN and DENs	A more structured form of a diary. After seeing a patient ask yourself the question "Was I equipped to meet this patient's needs?" If not then you have identified a Patient's Unmet Need (PUN). Now consider if you could or should be able to meet that need and if so what you would need to learn in order to meet the patient's need. This forms your Doctor's Educational Need (DEN). Remember not all unmet needs can be met by your learning and in many cases unless changes in organisation and social structures change then the unmet needs will remain. Again review your PUNs and DENs monthly and prioritise those important enough to be explored in your ***personal development plan.***
Significant events	In ***Section 3A(3)*** significant event analysis is explained. This can be an important source of identifying learning needs.
Referrals	In ***Section 3A(2)*** use of your referrals are explained. Again this is useful information in helping to identify your learning needs.
Complaints	Reflections on complaints are part of the appraisal process, and written complaints are covered in ***Section 3C(2).*** Learning from complaints may identify learning needs. This requires a careful breakdown of the complaint to consider if it arose as a result of systems problems or problems with the delivery of care, and if so how this could be avoided in the future. Some complaints may be unjustified and reflect general dissatisfaction or unavoidable adverse outcomes. Although these require sensitive handling they may simply lead to greater insights into the doctor patient relationship rather than new learning.
Teaching activities	For some GPs, teaching medical students occurs as part of their working day. All of us can use this interaction to identify gaps in our knowledge and skills. More formal teaching sessions – tutorial groups, GP registrar teaching – usually involves the teacher in considerable preparation. In other words a learning need has been identified, tackled and reinforced, and should be recorded in your ***personal development plan*** and also included as evidence for your ***Revalidation Folder*** in the ***Teaching and Training Section 3E(1).***
Research activities	Involvement in research may vary from collaboration with research projects or may be participative where you are involved in design of the research or preparation of grant applications or papers for publication. Learning needs are identified and tackled in considerable depth. These should be recorded in your ***personal development plan***.
Courses and meetings	Although a method of learning, attending courses and meetings whether at your place of work or locality or national/international conferences can be a good way to highlight your own learning needs. Local initiatives such as ***Protected Learning Time*** meetings will use information collated from appraisals to inform the learning needs in your locality.

Identifying development/learning needs from feedback about your practice	
Audit	An important source of ideas for new learning, audit is fully explained in ***Section 3A(3)*** of this toolkit.
Feedback from patients	Information about our communication skills, ability to manage problems, accessibility and practice organisation can be obtained by getting direct feedback from patients. ***Section 3C(1)*** explains the range of options available to you***.***
Feedback from your peers	As a measure of your professionalism and areas where peers think you perform well, or where your performance could be improved the ***Ramsay Peer Questionnaire*** can be used. This is given to 10 clinical colleagues. The information is collated and can help inform your learning needs and can be included in ***Section 3D(1)***.
Observation of your practice	This is a powerful learning tool which can highlight areas of your practice that you may wish to improve or study further. An explanation of the range of options to explore communication is explained in ***Section 3C(1)***.
Self assessment of your knowledge	RCGP Scotland has produced ***PEP-2000*** and ***PEP-QB,*** which are available on CD-ROM to help assess clinical knowledge and identify learning needs through a series of Multiple Choice Questions and Patient Management Problems. Helpful feedback on your performance is given, and all answers are referenced to up-to-date evidence. Refer to ***Section 5*** for further details.
Prescribing information	SPA level 2 data or feedback from a prescribing adviser attached to your practice, gives important insight into one of our major activities as GPs. In ***Section 3A(1a)*** an explanation and example of analysis of prescribing data is provided.

Identifying development/learning needs from Local and National Priorities	
Local and national priorities	Our learning needs should take into account the priorities of the LHCCs where we work. These may relate closely to the national priorities, e.g. clinical priorities, national guidelines or policy statements. If a protected learning time initiative operates in your area the topics chosen and the multiprofessional learning environment may inform your learning needs.

Personal Development Plan Guide

Step 3

Priority

Probably the most self explanatory part of your personal development plan. Having identified your development/learning needs it is important to prioritise your personal development plan so that your learning is targeted and achievable.

Priority falls into one of three categories:

A Urgent e.g. ***must do*** within the next twelve months

B Important e.g. ***should do*** within the next twelve months

C Less important e.g. ***could do*** within the next twelve months

As stated above, in order to maximise your learning and make the plan achievable and relevant, this is an important step to discuss and agree with your appraiser. Your personal development plan will be reviewed annually with you at your appraisal, so it is important that you are comfortable with which of your development needs you set out to definitely achieve within the year **(A – must do**), and those that you would ideally like to cover as well **(B – should do)**.

An outcome of your appraisal will be a *Summary of the Action Agreed* **– GP Scot 4**. This will include issues arising from your appraisal interview, both the personal development plan and any other action (excluding areas of confidentiality). Your appraiser will be responsible for producing an anonymised amalgamated report of all the appraisals that he/she has undertaken over the year. This will produce a local profile of developmental needs that will be an important resource for your LHCC to consider when planning educational events.

Personal Development Plan Guide

Step 4 **Learning objective**

When identifying your development/learning needs, the more specific you can be about what you hope to do differently the easier it is to target your learning. Is there a specific area of your practice that you wish to change or improve? Does your objective relate to an increase in knowledge, development of a skill, alteration in a belief or to a change in behaviour? While this may seem self evident or obvious, in practice it is quite difficult to describe exactly how you would like to see your practice change as a result of a development activity. As part of your personal development plan you will be asked to consider – has the developmental need been met? **(Step 7)**. This will only be possible if you have specified what it is you want to be able to do differently as a result of the learning. For example, what changes to your day to day practice you expect to take place. Your objectives should be able to be easily undertaken and measured to see if they have been achieved.

Consider the following examples:

A. I would like to learn more about diabetes to improve the care of my diabetic patients

Learning need	Learning more about diabetes
	Problem: A vast topic. Where do you start and what do you learn. You may end up spending time on areas of diabetes where you are already confident and gain little in the way of new learning
Objective/ changes to practice	To improve the care of diabetic patients
	Problem: What does this mean? Again too vast a subject to even start to measure. More specific measures include: *Structures of care* i.e. running a diabetic clinic *Processes of care* i.e. measuring HbA1c annually *Outcomes of care* i.e. reducing patients progressing to renal failure

As you can see the less specific you are the less achievable and relevant the task

B. I would like to revise the role of metformin in the treatment of type 2 diabetes and prepare a protocol for use of metformin in my type 2 diabetic patients

Learning need	Revise role and action of metformin.
Objective/ changes to practice	To develop a protocol for use of metformin in my type 2 diabetic patients. To keep a record of new treatments initiated.

More specific and can be measured

Use of "Action Verbs" is the easiest way to ensure you are focused and specific in the changes to your practice. For example, prepare, write, revise, record, describe are action verbs.

Personal Development Plan Guide

Step 5

Learning method to be used

Having identified and focused your learning need, you now need to consider which method of learning you would like to use to tackle it. It is again worth noting at this stage that the more specific and focused you are in identifying the learning need the easier it is to consider which would be the best way for you to proceed.

Your chosen learning method will be influenced by personal preference, availability, convenience and timing. Some of the learning methods you may choose are listed below. ***Usually a mixture of learning methods is the best way to approach your learning needs.***

Learning method to be used	
• Reading	• Academic activities
• Learning with colleagues in small group	• Courses
• Meetings	• Clinical attachments
• One to one discussion with colleague	• CD ROM
• Internet	• Workshops
	• Practical skills sessions

Remember: the resources for your chosen method might not be available and you would need to consider other methods of learning.

Guide to action & resources

Reading

Reading is probably the main learning activity that underpins learning of new knowledge. Most doctors value reading highly although under the previous PGEA system this was not included as accredited learning! Your reading may be:

- General for interest i.e. medical journals
- Focused round a problem – text books or guidelines
- As part of a formal course – text books or specific papers
- As part of research – critical appraisal of papers

Learning with partners and colleagues

Practice meetings, journal clubs and protected educational time are increasingly important ways to learn. In some areas LHCCs have started protected learning time initiatives. Once annual appraisal is up and running, collated learning needs from your area will be available to inform your protected learning time initiative, meaning that at least some of your learning needs are likely to be met in this forum.

Meetings

Currently a small industry based round the requirements for PGEA, meetings are an important part of most GPs learning. This will vary from a formal lecture by an expert to a more interactive meeting with case discussions and small groups. Whereas previously attendance at a meeting has been the main way in which doctors education was accredited, the meeting now becomes a method of learning about an educational need that you have identified. This may mean that you become more focused about the meetings you attend and have clearer expectations about what you should take from the meeting. This may also mean that providers will tailor content and format of meetings more to your agenda. Meetings are likely to remain a major factor in doctors' CPD.

Academic activities

Teaching and research are important sources of learning for doctors involved in academic activities. The work involved in preparing a teaching session or grant application often results in worthwhile learning.

Courses

Formal educational courses – varying from individual events, e.g. locally run IT training to higher degrees. Participation in these will be influenced by local availability and resources.

Clinical attachments

It may be possible for you to attend a local clinic in an area you have identified from your learning needs assessment. A chance to shadow another health professional and discuss cases can help build your confidence and expertise.

Personal Development Plan Guide

Steps 6 & 7

How will you evaluate your learning and what have you learned?

Having made an accurate assessment of your development/learning needs **(Steps 1 & 2)**, with clear educational objectives **(Step 4)** targeted at a specific area of your practice that you wish to improve, identified resources and taken action to meet the development need **(Step 5)**, there are two final steps.

How will you know whether your learning has been successful (how will you evaluate it)?
AND
What have you learned?

While the above steps 1 – 5 ensure that your personal development plan has purpose and relevance, reinforcement and application of your new learning is a key step. There are many ways to reinforce your learning and ensure that the needs identified have now been met and will not simply re-appear in future years development needs. If reinforcement of learning occurs in the setting of your daily practice then it is likely to be most effective. It is important for you to know whether your learning has been successful. Has the effort been worthwhile and have you been able to do what you wanted to? If not – why not – and this can be a learning exercise too.

Methods of showing whether your learning has been successful	
Disseminating your new learning/skills • Within your practice • Within your locality • In teaching and research Changes in your practice • Prescribing • Referral • Teamwork • New services • Protocol Audit	Self assessment • PEP-2000/PEP-QB • Communication skills Reflective diary or record of learning Peer assessment Accreditation or certification • PA / QPA / FBA • Diplomas or higher degrees

This list is not exhaustive and most of the above have been covered in the previous sections or in the other sections of your revalidation toolkit. It is important for you to note down what you have learned as a summary so you have a record (and won't have to go through the steps again) and also to reinforce your learning and make sure it 'sticks'.

Confidential

GP Scot 2

Personal Development /Action Plan

Appraisee's Name:	Appraisal Date:

A. Personal Development Plan

Against each learning need you have identified, you should indicate how you have identified it and the priority using the following scale A – C as indicated. You should also identify which learning methods you would intend to use to achieve your objectives and how you could evaluate whether you have met each one.

You should complete a separate page for each learning need you identify.

i. What is your learning need?

ii. How did you identify this need?

iii. Is this need a priority? (please circle)

A	(urgent i.e. must do within next twelve months)	**B**	(important i.e. should do within next twelve months)	**C**	(could do within the next twelve months)

iv. What is/are your objective(s) (what do you hope to do differently) as a result of meeting this need?

v. How do you plan to meet this need (what methods will you use)?

vi. How will you know whether your learning has been successful?

This section should be completed when you review your plan the following year:

vii. Has the objective been met and what have you learned?

viii. Date of completion:

B. Other Actions to be taken as a Result of the Appraisal Discussion

In addition to the learning needs you have identified, there may be additional actions you can take which will support your development over the appraisal period. Section ii should be reviewed and completed before your next appraisal.

Section i			Section ii	
Are there changes you would like to make to your role or the way you practise medicine over the next 12 months?	What support (and from whom) do you need to support these changes?	Timescale	Has the action been taken?	What was the outcome?

Signed .....
Appraiser
Date .....

Signed .....
Appraisee
Date .....

Example 1

SCOT 2

Personal Development Plan

Against each educational need you have identified, you should indicate how you have identified it and the priority using the following scale A – C as indicated. You should also identify which learning methods you would intend to use to achieve these needs and how you could evaluate whether you have met each one.

1. What is your learning need?

I need to find out more about the up to date evidence regarding HRT so that I can advise patients whether to stop taking HRT.

2. How did you identify this need?

Since the newspaper coverage about ischaemic heart disease and HRT one or two patients have asked questions about whether they should stop it when coming in for their six month review.

3. Priority

(A)	B	C
Urgent *e.g. must do within next 12 months*	*Important* *e.g. should do within next 12 months*	*Less Important* *e.g. could do within next 12 months*

4. What is/ are your objective(s) (what do you hope to do differently as a result of meeting this need)?

I want to be able to understand the risks to women of ischaemic heart disease, DVT, stroke and breast cancer if taking HRT.

I want to be able to explain the risks of HRT with regard to ischaemic heart disease, DVT, stroke and breast cancer in a way that patients will understand.

5. How do you plan to meet this need (methods)?

I plan to ask my postgraduate library for the articles on HRT regarding the above and I will also try the e-library. I seem to recall a document from the health board giving information on this and I will check with my practice manager whether we have this within the practice. If so I will take a copy of it and read it. I will also have a discussion with my partner who deals with more patients on HRT and ask how she deals with patient queries.

6. How will you know whether your learning has been successful?

I plan to evaluate whether I have met my objectives by summarising on a sheet of paper what I have learned about HRT and IHD, DVT, stroke and breast cancer. I will also produce a short information leaflet which I could give to patients.

7. Has the need been met, and what have you learned?

Yes. I have learned the risks of IHD, DVT, stroke and breast cancer per 10,000 women on HRT and have produced a leaflet with the figures. (I keep one my drawer to use when explaining to patients. I have learned that women who started HRT for its cardio-protective benefits should be advised to stop.)

8. Date of completion of each objective?

16 February 2003

Example 2

SCOT 2

Personal Development Plan

Against each educational need you have identified, you should indicate how you have identified it and the priority using the following scale A – C as indicated. You should also identify which learning methods you would intend to use to achieve these needs and how you could evaluate whether you have met each one.

1. What is your learning need?

I need to find out how to run a patient satisfaction questionnaire.

2. How did you identify this need?

As part of my revalidation I need to provide some evidence about my communication skills. I have decided to ask patients to complete a patient satisfaction questionnaire. I have never done this before and am unsure how this should be run within the practice and what the results might mean.

3. Priority

(A)	B	C
Urgent e.g. must do within next 12 months	*Important e.g. should do within next 12 months*	*Less Important e.g. could do within next 12 months*

4. What is/ are your objective(s) (what do you hope to do differently as a result of meeting this need)?

- *To find out how to give out the questionnaires e.g. which patients should they be given to, when should they be given and by whom, what information should patients be given about the whole procedure.*
- *I want to be able to look at my results and have a greater understanding of what they mean.*

5. How do you plan to meet this need (methods)?

I plan to read information contained within this folder on carrying out the questionnaire. I also plan to look at the website address given and download some information on how to administer the questionnaire and what some of the results might mean.

6. How will you know whether your learning has been successful?

I plan to evaluate whether I have met my objective by being able to run the patient satisfaction questionnaire in my practice.

7. Has the need been met, and what have you learned?

Yes. 50 questionnaires have been completed and analysed. I read the information in this folder and had a discussion with the practice manager about how to carry it out. I did the Grogan questionnaire and I made the following action point for me – I need to spend more time explaining to patients what is wrong with them.

8. Date of completion of each objective?

10 January 2003

Example 3

SCOT 2

Personal Development Plan

Against each educational need you have identified, you should indicate how you have identified it and the priority using the following scale A – C as indicated. You should also identify which learning methods you would intend to use to achieve these needs and how you could evaluate whether you have met each one.

1. What is your learning need?

I need to find out how to undertake a significant event analysis.

2. How did you identify this need?

As part of my revalidation for the review of clinical practice session I require to undertake a significant event analysis and as I have not done this before I am unsure how to do it.

3. Priority

(A)	B	C
Urgent *e.g. must do within next 12 months*	*Important* *e.g. should do within next 12 months*	*Less Important* *e.g. could do within next 12 months*

4. What is/ are your objective(s) (what do you hope to do differently as a result of meeting this need)?

I want to be able to complete the significant event analysis proforma adequately and hopefully to learn about how significant event analysis can work in practice.

5. How do you plan to meet this need (methods)?

There is a local course on significant event analysis being run by my CPD adviser and I plan to attend this. I will also read the notes in the revalidation toolkit.

6. How will you know whether your learning has been successful?

I plan to evaluate whether I have met my objective by being able to complete the significant event analysis proforma and have positive feedback on it at my appraisal.

7. Has the need been met, and what have you learned?

Yes. I have completed the proforma for one significant event I had in practice and discussed it at a practice meeting. I have not yet had my appraisal. However I have shown it to my local CPD Adviser and received helpful constructive feedback.

I learned that you do need to describe what happened but more importantly you need to think carefully about why and how it happened. Only then can you begin to think of solutions to stop it happening again. Also it was more interesting to do than I thought.

8. Date of completion of each objective?

22 March 2003

Section 3B

Review of Learning Activities

Whilst the previous section asks you to describe your plans for learning over the forthcoming year, this section deals with the opportunistic day to day learning that can take place outwith the learning you have planned to do. This covers the learning that just happens day to day. This would include the learning that can take place as a result of having discussions with colleagues, practice based meetings, reading, preparing for teaching activities and looking things up to help with the management of individual patients.

The aim of this section is for you to describe the activity and, more importantly, the main learning points for you. This enables you to keep a record of the opportunistic, day to day learning that happens all the time but as it is usually not recorded it can be forgotten.

3B(1)

Review of Learning Activities

Brief Details of Learning Activity

Main Learning Points for You

Proposed Implementation

Signed…… Date……..

Name ……

Review of Learning Activities 3B(1)

Brief Details of Learning Activity

We recently had a practice based meeting on personal development plans. We held this because as part of appraisal we have to undertake a personal development plan on an annual basis. As I have never completed one I was unsure about what to do.

Main Learning Points for You

The main learning points for me were:

1. *I learned that day to day consultations with patients can be a useful way of identifying learning needs. Previously if I was unsure of something I tended to either ask my colleague quickly or not get round to dealing with it.*
2. *I learned what educational objective means and to try to write these as follows:*

I want to be able to…..

Proposed Implementation

I intend over the next week to take a note of one or two patients in which I am uncertain of their management. I will use this as the basis for part of my personal plan.

I also intend to look through the revalidation folder and select my main area to be discussed at appraisal. I will then use this to enter into my personal development plan.

Signed…… Date 12/07/03

Name David Adams

Section 3C(1)

Communication Skills

In this section you are asked to provide evidence of some form of assessment of your communication skills with a reflection on the results. **You can choose one of the following methods:**

- An approved patient satisfaction survey of fifty successive consultations, with details of the doctor's reflections on the results with identification of learning points.

OR

- A patient enablement questionnaire of fifty successive consultations, with details of the doctor's reflections on the results with identification of learning points.

OR

- A formative observation session (e.g. sitting in or video) undertaken by a colleague or an approved video assessor, with details of the doctor's reflections on the results with identification of learning points.

OR

- Evidence of completion of an approved simulated surgery assessment.

OR

- A certificate from a recognised video assessment process e.g. MRCGP, Membership by Assessment of Performance (MAP), Formative Peer Assessment.

Section 3C(1)

GPAQ (General Practice Assessment Questionnaire)

GPAQ is a patient questionnaire which has been developed at the National Primary Care Research and Development Centre in Manchester. Building on several years of development and testing, GPAQ helps practices find out what patients think about their care. It specifically focuses on certain aspects of general practice, for example, access into personal aspects of care and continuity of care.

GPAQ is free to use and information on how to get started, how to download the questionnaire and manual, how to order printed copies of the questionnaire, and to find out how to produce reports can be found on the following website: www.gpaq.info

3C(1)

IPQ (Improving Practice Questionnaire)

IPQ is an example of a patient feedback tool which may assist individual general practitioners in monitoring and improving the quality of their services to the public.

What are its origins?

The development of the IPQ was based on a similar questionnaire used within general practice accreditation schemes in other countries. The questionnaire is structured around commonly agreed standards for general practice (as determined by the Royal College of General Practitioners (RCGP)). The IPQ was further refined after extensive consultations with patients, clinical governance leads and other primary care staff.

How has it been applied in the UK?

To date, several PCTs and their affiliated general practices are using the IPQ as a means of gathering patient perceptions of the quality of general practice services. Comparative data is currently available from over 200 general practices including over 1200 GPs and nurses. Over 40,000 patients have completed the questionnaire.

UK practices have assessed the activity as very favourable because of the quality and promptness of the information provided, and its ease of administration.

A component of the IPQ, namely the section on communication skills, is being considered by the General Medical Council (GMC) as an endorsed tool for doctors to use when submitting evidence on their relations with patients.

In addition, the IPQ is one of the patient survey options which practices can implement in order to fulfil requirements of RCGP's Quality Team Development initiative.

What results do the practice and individual practitioners receive?

Overall results include all the written comments from patients, summary tables and graphs. Individual practitioners receive results of patient feedback on their interpersonal skills. Comparison scores for other doctors and nurses are also provided.

Who administers the IPQ?

The IPQ is administered by the Client-Focused Evaluations Program (CFEP).

Fees

Please refer to www.cfep.net for information.

For more information:

CFEP
PO Box 51
Exeter
EX4 4WT

Tel: (01392) 252740

Email: cfep@dialstart.net

Website: www.cfep.net

3C(1)

GPSQ (The Grogan Patient Satisfaction Questionnaire)

This patient satisfaction questionnaire is a development of Baker's two questionnaires on patient satisfaction with general practice services and general practice consultations (1,2). The questionnaire is a 40 item scale and covers patient satisfaction with;

- The consultation
- Access
- Practice nurses
- Appointments
- Facilities

This allows patients to express satisfaction/dissatisfaction with different areas of general practice services, which has been identified as a necessary feature of a useful satisfaction scale. The questionnaire has been fully validated and piloted in British general practice (3,4).

The questionnaire included in this toolkit was piloted in the Tayside revalidation project. Four questions concerning satisfaction with the practice nurse have been removed from this version, as this was not felt to be useful in the context of revalidation of the individual general practitioner.

FURTHER READING

(1) Baker R. Development of a questionnaire to assess patient's satisfaction with consultations in general practice. British Journal of General Practice 1990; 40:487-490.

(2) Baker R. Characteristics of practices, general practitioners and patients related to levels of patient's satisfaction with consultations. British Journal of General Practice 1996; 46:601-605.

(3) Grogan S, Conner M, Willits D, Norman P. Development of a questionnaire to measure patient's satisfaction with general practitioner's services. British Journal of General Practice 1995; 45:525-529.

(4) Grogan S, Conner M, Norman P, Willits D. Validation of a questionnaire measuring patient satisfaction with general practitioner services. Quality in Health Care 2000; 9(No 4):210-215.

APPROVED PATIENT SATISFACTION SURVEY

3C(1)

(GPSQ) Grogan Patient Satisfaction Questionnaire

The Doctor whom you have just seen is taking part in a patient satisfaction survey this week.

You are invited to complete this questionnaire, asking you what you think about your visit to the doctor. The first 20 questions concern the consultation you have just had with the doctor. The other 16 questions ask you about other aspects of service from the surgery.

Some of the questions will appear similar. This is deliberate and is necessary to make sure they are reliable. Please answer them all. For each question ✓ the answer that is closest to what you think. "Neutral" means you have no feeling either way.

Your views are completely anonymous.

Thank you for you co-operation.

APPROVED PATIENT SATISFACTION SURVEY

GPSQ

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
The Consultation	☐	☐	☐	☐	☐
1. The Doctor always puts me at ease	☐	☐	☐	☐	☐
2. The Doctor always gives me every chance to talk about all my problems	☐	☐	☐	☐	☐
3. Even when the Doctor is busy I am examined properly	☐	☐	☐	☐	☐
4. The Doctor is very careful to check everything when examining me	☐	☐	☐	☐	☐
5. The Doctor is always very understanding	☐	☐	☐	☐	☐
6. The Doctor is always interested	☐	☐	☐	☐	☐
7. The Doctor shows a genuine interest in my problems	☐	☐	☐	☐	☐
8. The Doctor does enough tests to find out what is wrong	☐	☐	☐	☐	☐
9. The Doctor does everything needed to arrive at a diagnosis	☐	☐	☐	☐	☐
10. The Doctor clearly explains what is wrong before giving any treatment	☐	☐	☐	☐	☐
11. The Doctor fully explains how the illness will affect my future health	☐	☐	☐	☐	☐
12. I do not feel rushed when I am with the Doctor	☐	☐	☐	☐	☐
13. The Doctor always asks about how my illness affects everyday life	☐	☐	☐	☐	☐
14. I sometimes feel I have not been given enough information by the Doctor					

APPROVED PATIENT SATISFACTION SURVEY

GPSQ

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagre
15. I do not feel confident discussing my problems with the Doctor	☐	☐	☐	☐	☐
16. Sometimes the Doctor makes me feel like I am wasting his/her time	☐	☐	☐	☐	☐
17. The Doctor seems to want to get rid of me as soon as possible	☐	☐	☐	☐	☐
18. The Doctor does not tell me enough about the treatment	☐	☐	☐	☐	☐
19. The Doctor knows when tests are necessary	☐	☐	☐	☐	☐
20. The Doctor sometimes fails to appreciate how ill I am	☐	☐	☐	☐	☐
Access					
21. The Doctor is always available to give advice over the telephone	☐	☐	☐	☐	☐
22. It is easy to get advice over the telephone	☐	☐	☐	☐	☐
23. I feel it is easy to speak to my Doctor by telephone	☐	☐	☐	☐	☐
24. I can speak to a receptionist privately if I wish	☐	☐	☐	☐	☐
25. The receptionists ask patients the right questions	☐	☐	☐	☐	☐
26. The practice has good facilities for dealing with emergencies which occur when the surgery is closed	☐	☐	☐	☐	☐
27. The receptionist explained things clearly to me	☐	☐	☐	☐	☐
28. I am satisfied with the out-of-hours service	☐	☐	☐	☐	☐

GPSQ

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
Appointments					
29. Getting an appointment at a convenient time is easy	☐	☐	☐	☐	☐
30. Appointments are easy to make whenever I need them	☐	☐	☐	☐	☐
31. It is often difficult to get an appointment with a Doctor	☐	☐	☐	☐	☐
32. It is easy to see a Doctor of my choice	☐	☐	☐	☐	☐
Facilities					
33. The waiting room is uncomfortable	☐	☐	☐	☐	☐
34. The surgery building could do with some improvements	☐	☐	☐	☐	☐
35. The waiting room seats are uncomfortable	☐	☐	☐	☐	☐
36. There are not enough seats in the waiting room	☐	☐	☐	☐	☐

	16-19	20-29	30-39	40-49	50-59	60-69	70-79	80+
37. Age	☐	☐	☐	☐	☐	☐	☐	☐

	Male	Female
38. Sex	☐	☐

Thank you

CARE (Consultation and Relational Empathy) 3C(1)

The CARE Measure is a consultation process measure that has been developed in the Departments of General Practice in Glasgow and Edinburgh. It is based on a broad definition of empathy in the context of the therapeutic relationship within the consultation. The wording reflects a desire to produce a holistic, patient-centred measure that is meaningful to patients irrespective of their social class, and has been developed and applied in over 3,000 general practice consultations in areas of high and low deprivation in the west of Scotland.

The scoring system for each item is 'poor' = 1, 'fair' = 2, 'good' = 3, 'very good' = 4, and 'excellent' = 5. All ten items are then added, giving a maximum possible score of 50, and a minimum of 10. Up to two 'Not Applicable' responses or missing values are allowable, and are replaced with the average score for the remaining items. Questionnaires with more than two missing values or 'Not Applicable' responses are removed from the analysis.

The theoretical background and validation of the CARE Measure can be found in:

Mercer S.W, Reynolds W.J. Empathy and quality of care. BJGP 2002, 52 (Supplement); S9-S12. Further unpublished validation data is available from the first author.

The CARE Measure can be used free of charge, but users are requested to register with the author and feedback their data, in order to build up a larger data-set of normative values which will allow individuals to compare themselves with others.

If you would like to use the Measure or would like more information, please contact:

Dr Stewart Mercer
Email: Stewmercer@blueyonder.co.uk

APPROVED PATIENT SATISFACTION SURVEY

The CARE Measure

Please rate the following statements about today's consultation. Please tick one box for each statement and answer every statement.

How was the doctor at ...	Poor	Fair	Good	Very Good	Excellent	Does Not Apply
1. Making you feel at ease... (being friendly and warm towards you, treating you with respect; not cold or abrupt)	☐	☐	☐	☐	☐	☐
2. Letting you tell your "story"... (giving you time to fully describe your illness in your own words; not interrupting or diverting you)	☐	☐	☐	☐	☐	☐
3. Really listening ... (paying close attention to what you were saying; not looking at the notes or computer as you were talking)	☐	☐	☐	☐	☐	☐
4. Being interested in you as a whole person... (asking/knowing relevant details about your life, your situation; not treating you as "just a number")	☐	☐	☐	☐	☐	☐
5. Fully understanding your concerns... (communicating that he/she had accurately understood your concerns; not overlooking or dismissing anything)	☐	☐	☐	☐	☐	☐
6. Showing care and compassion... (seeming genuinely concerned, connecting with you on a human level; not being indifferent or "detached")	☐	☐	☐	☐	☐	☐
7. Being Positive... (having a positive approach and a positive attitude; being honest but not negative about your problems)	☐	☐	☐	☐	☐	☐
8. Explaining things clearly... (fully answering your questions, explaining clearly, giving you adequate information; not being vague)	☐	☐	☐	☐	☐	☐
9. Helping you to take control... (exploring with you what you can do to improve your health yourself; encouraging rather than "lecturing" you)	☐	☐	☐	☐	☐	☐
10. Making a plan of action with you... (discussing the options, involving you in decisions as much as you want to be involved; not ignoring your views)	☐	☐	☐	☐	☐	☐

Section 3C(1)

Enablement

Enablement is a measure of outcome in the consultation which is related to, but different from, patient satisfaction. As many consultations in general practice are multi-dimensional with physical, psychological and social elements, measuring the gain a patient feels as a result of a visit to the doctor can be difficult. Enablement is the process whereby doctors help patients to understand the nature of their problems and by doing so empower them to manage their own illnesses. Enablement has therefore been considered to be a useful indicator of quality care in the consultation.

3C(1)

Enablement Questionnaire

Guidelines for reception staff

At the start of each surgery please make sure that there are adequate supplies available of the following:

- Questionnaire forms
- Pens
- Patient information leaflets
- A box for completed questionnaires

Procedure

- All patients 12 years of age and over are appropriate
- If patients are given a *patient information leaflet* as they arrive for their appointment, this will tell them to expect the questionnaire after their consultation with the doctor is finished
- If asked about the questionnaire please be positive about its purpose i.e. to help the doctors provide better care
- Please do not show the questionnaire to the patients before they see the doctor as this will inevitably make it unfit for inclusion
- When the patient finishes his/her consultation, offer a questionnaire and a pen if required and ask them to put the completed questionnaire in the box
- If a patient decides not to participate do not try to change their mind. It is their decision and nobody should be made to feel obliged
- Please do NOT help a patient to answer any of the questions as it may affect the score
- At the end of each surgery collect the completed questionnaires and give them to the practice manager

PATIENT ENABLEMENT

Patient Information on Enablement Questionnaire 3C(1)

- I would be very grateful if you would fill in the short questionnaire after your visit to me today
- It is only seven questions and will take very little time
- You do not need to put your name on the questionnaire
- You are under no obligation to take part if you do not want to
- Please do not discuss the questionnaire with the doctor during your consultation as this may affect your answers
- Please try to answer ALL the questions. The receptionist has been asked not to offer help, as this may affect the final score

ENABLEMENT QUESTIONNAIRE

PLEASE COMPLETE THE QUESTIONS BELOW
(tick one of the boxes for each question)

As a result of your visit to the doctor today, do you feel you are …

	MUCH BETTER	BETTER	SAME OR LESS	NOT APPLICABLE
able to cope with life	☐	☐	☐	☐
able to understand your illness	☐	☐	☐	☐
able to cope with your illness	☐	☐	☐	☐
able to keep yourself healthy	☐	☐	☐	☐

	MUCH MORE	MORE	SAME OR LESS	NOT APPLICABLE
confident about your health	☐	☐	☐	☐
able to help yourself	☐	☐	☐	☐

How well do you know the doctor you saw today?
(please place a circle round one of the numbers below):

(don't know the doctor at all) 1 2 3 4 5 ***(know the doctor very well)***

		(please tick)	
Age		**Male**	☐
		Female	☐

Data Input 3C(1)

- Please ensure that there is a minimum of 50 EVALUATABLE questionnaires completed for each doctor. To achieve this we estimate 75 questionnaires need to be issued for each doctor.
- If more than 1 question is answered by ticking "not applicable" exclude that questionnaire in your analysis.
- If a question is not answered count this as "not applicable". Therefore one "not applicable" and one not answered should result in a discarded questionnaire.
- Score as follows:

much better/much more	=	2
better/more	=	1
same or less	=	0
"not applicable"		leave blank

- Please save your data – DO NOT DELETE IT.

Section 3C(1)

OBSERVATION OF CONSULTING

Informal

1. One method of reviewing your communication skills that you may wish to use involves asking a colleague to observe you consulting with patients. This can either be done by a colleague sitting in when you are consulting, or videotaping a consultation and looking at this with a colleague.

   Your colleague is asked to comment on your clinical skills, communication skills and problem solving skills for each five consultations. You are then asked to reflect on the discussion that you have had with your colleague for each consultation.

OR

Formal

2. Another method of reviewing your communication skills involves videotaping nine consultations and submitting the tape for formative feedback (i.e. positive areas will be highlighted and suggestions for improvement given). You will receive feedback from two general practitioners who are trained in the process. The areas you will receive feedback on are the following: communication; partnership; health enablement; knowledge; appropriate management plan; and insight and understanding of doctor.

OBSERVATION OF CONSULTING - INFORMAL

Following the observation of a doctor's consultation by a colleague, both doctor and colleague should complete the proforma below.

Communication skills	**Comments (by doctor observing the consultation/video)**
Patients were able to express their views	
The doctor listened to the patient	
Appropriate language was used throughout the consultation	
Social and psychological factors were considered where appropriate	

Clinical skills	**Comments (by doctor observing the consultation/video)**
Adequate clinical details were elicited	
Examinations were competent and appropriate	

Decision-making skills	**Comments (by doctor observing the consultation/video)**
The patient was involved in decisions about his/her care	
An appropriate management plan was formulated and agreed	
Prescribing was appropriate	
No action occurred that compromised patient safety	

Name and position of doctor observing consultation

Signature: _____

continued...

OBSERVATION OF CONSULTING - INFORMAL

Consultation Self-assessment

Summary of the main issues in consultation:

Main issues discussed with colleague:

Main learning points from consultation:

Signed..... Date.....

Name.....

OBSERVATION OF CONSULTING - INFORMAL

Following the observation of a doctor's consultation by a colleague, both doctor and colleague should complete the proforma below.

Communication skills	**Comments (by doctor observing the consultation/video)**
Patients were able to express their views	*Doctor encouraged patient to talk*
The doctor listened to the patient	*Good eye contact throughout*
Appropriate language was used throughout the consultation	*Didn't use jargon*
Social and psychological factors were considered where appropriate	*Doctor had insight into the patient's social circumstances i.e. a working mother's need for a reliable form of contraception*

Clinical skills	**Comments (by doctor observing the consultation/video)**
Adequate clinical details were elicited	*Took a family history of DVT before prescribing the pill*
Examinations were competent and appropriate	*BP was checked*

Decision-making skills	**Comments (by doctor observing the consultation/video)**
The patient was involved in decisions about his/her care	*A two way discussion took place about other family planning methods available*
An appropriate management plan was formulated and agreed	*The oral contraceptive pill was prescribed with a three month review following discussion*
Prescribing was appropriate	*Good advice re concurrent use of antibiotics*
No action occurred that compromised patient safety	

Name and position of doctor observing consultation

Signature: _____

continued...

OBSERVATION OF CONSULTING - INFORMAL

Consultation Self-assessment

Summary of the main issues in consultation:

The patient was put at ease. The consultation was not hurried. There was evidence of both interest in the patient's presentation and her circumstances and knowledge shown. It was a reasonably straightforward case of contraceptive care with no other agendas.

Main issues discussed with colleague:

The relaxed consultation style was discussed and the fact that the patient was not rushed although the consultation was relatively short (7 minutes). The patient's contribution was encouraged by using how, what, when questions and details were clarified by asking specific questions to which the patient could answer yes or no. My ability to discuss the pros and cons of different family planning methods was reassuring although I was uncertain about some newer methods. It was useful to be able to give the patient some written information to take away.

Main learning points from consultation:

I was pleased I was able to communicate well with this patient. It reinforced the importance of involving the patient and asking how, what, when type questions. I displayed some uncertainty about newer methods of contraception and it's prompted me to read more about this or perhaps attend a course on family planning. It would be valuable to include this in my personal development plan.

Signed..... Date 12/07/03

Name David Adams

Section 3C(1)

APPLICATION FOR VIDEO TAPE SUBMISSION FOR PEER FEEDBACK

I hereby submit my videotape and completed log for feedback.

I can confirm that all consent procedures have been carried out correctly.

This is the first time I have submitted a videotape for peer review Yes / No

I am happy for this tape to be used for educational purposes Yes / No

Signature: _____ **Date:** _____

Name: _____

Checklist

Please confirm that the following have been completed :

Videotape ☐

Logbook ☐

Application form ☐

WHAT IS INVOLVED?

What is involved in the videotaping process?

This is outlined in detail under Guidelines on a Code of Practice for Videotaping Consultations, contained within this section (3C(1)). The most important thing is that the patient is given full information about the process and is given an opportunity before and after the consultation to withdraw their consent if they wish to do so. You should leave your camera running and any examination should be done outwith the sight of the camera. Switching off the camera means that the assessor may miss valuable information which is important for the consultation. Further information about the videotaping process and the duration of the tape is dealt with under Technical Issues, detailed separately within this section.

How do I get started?

The first thing to do is to decide on what day you intend to videotape your surgery. You should inform your practice staff so that when patients telephone for an appointment they can be informed that the surgery will be videotaped. It is probably preferable for you to run a normal surgery although you are free to edit the tape if you wish. **We require you to have a minimum of nine consultations**. If you do not own a video camera please check with your Postgraduate Department who may have one which they could lend to individual GPs.

What information is required to be submitted?

You should contact NES on 0141 223 1450 to obtain a contact name and then send your videotape, together with the logbook and a signed application form, to:

NHS Education for Scotland (NES)
Third Floor
2 Central Quay
89 Hydepark Street
Glasgow
G3 8BW

The logbook is a vital part of the assessment. **It must be typed** and completed for each consultation to place the consultation in context. This will help the assessors make the feedback more relevant to you. For each consultation you are asked to reflect on your own performance using the six criteria being used by the assessors. It is therefore important that you review the videotape while completing your logbook and before sending it in for assessment.

Who looks at the videotape?

The videotape and an anonymised log will be sent to two general practitioners. This is a peer review process and the assessors are working general practitioners who have been trained in assessment.

Each assessor will watch at least six consultations on the videotape and give detailed feedback with suggestions for improvement. Three of the selected consultations will be watched by both. Confidentiality is important and the assessors do not discuss the tape during the assessment process. Once both assessors have viewed the tape and given their comments you will receive the confidential written feedback from each assessor.

FEEDBACK

It is important to remember that the feedback is formative. The assessors will highlight the positive areas in your consulting but also give suggestions for improvement where appropriate. The most useful way of using the feedback is to review the tape with the assessors' comments.

What form will the feedback take?

The feedback will normally be in written form. The assessors will assess the tape under the following headings:

- **COMMUNICATION**
- **PARTNERSHIP**
- **HEALTH ENABLEMENT**
- **KNOWLEDGE**
- **APPROPRIATE MANAGEMENT PLAN**
- **INSIGHT AND UNDERSTANDING OF DOCTOR**

The areas being assessed under each of these headings and how they are being rated is detailed overleaf.

CRITERIA FOR ASSESSMENT – COMMUNICATION

Definitions for a doctor whose performance scores five (excellent)

The patient will be made to feel welcome at the start of the consultation: the exact format of the welcome will depend on the doctor's prior knowledge of the patient. The doctor will be aware if the appointment is a follow up to a previous encounter.

The patient will be encouraged to express the reasons for the consultation, initially with the minimum of interruption.

An organised process of listening and responding to verbal and non verbal cues will take place, usually with open questioning proceeding to closed questioning when appropriate.

The doctor will explain clearly to the patient the nature and extent of any physical examination which is planned and the nature and purpose of any suggested investigations.

The doctor will explain clearly the diagnosis and management options without using medical jargon. Any medical terminology used will be explained.

Throughout the consultation the doctor will use language appropriate to the particular patient.

At the end of the consultation, the doctor will check that the patient has fully understood all that has transpired during the consultations, and is aware of arrangements to be made for further investigations, and that a follow up is appropriate.

Definitions for a doctor whose performance scores three (adequate)

The doctor fails to welcome the patient, but the patient appears at ease during the consultation.

History taking is adequate but contains too many interruptions and/or closed questions.

The doctor tells the patient that she wishes to examine him but fails adequately to explain the nature and extent of the examination.

The doctor explains the diagnosis and management plan but on occasion uses inappropriate language or medical jargon.

The doctor and patient part company on good terms but without the doctor making an adequate check of the patient's understanding of what has transpired during the consultation.

Definitions for a doctor whose performance scores one (needs attention)

The doctor is brusque, rude or disinterested.

The doctor conveys to the patient that he does not have time to listen to what is being said.

The doctor fails to be welcoming and fails to put the patient at ease.

The doctor interrupts the patient when the problem is being presented.

The doctor spends significant time not in eye contact with the patient, for example, making notes or looking at the computer.

continued...

Definitions for a doctor whose performance scores one (needs attention)(con't)

The doctor speaks to the patient while not looking at her/him.

The doctor uses inappropriate language, including medical jargon.

History taking is disorganised, proceeding to examination before sufficient information has been collected.

History taking consists of a series of closed questions.

The doctor misses or ignores cues either verbal or non-verbal.

The doctor provides an inadequate or incoherent explanation of the diagnosis and management plan.

The doctor fails to offer management options, if appropriate.

The doctor fails to check that the patient has understood the diagnosis and management plan.

CRITERIA FOR ASSESSMENT – PARTNERSHIP

Definitions for a doctor whose performance scores five (excellent)

The excellent partnership will only take place when excellent lines of communication have already been opened during the consultation.

The excellent doctor will explore the patient's wishes and views, giving the patient options and explanations if appropriate, and will involve the patient in the eventual decision making process.

Negotiation with the patient about what the patient would like to achieve and what may be realistically achieved will lead to a management plan based on the doctor knowledge and the patient's wishes.

The excellent consultation may include a review of the plan and confirmation of the patient's agreement and understanding of that plan.

Definitions for a doctor whose performance scores three (adequate)

Good partnership will be dependent on good communication and it is likely that average or adequate partnership will follow-on from adequate or average communication during the consultation.

The adequate doctor may exhibit some of the features of the excellent doctor but be lacking in others. It is likely that adequate partnership will result from a more doctor-centred consultation where exploration of patient's wishes and views are not adequately sought and where patients are not adequately involved in decision making. Negotiation about what may be achieved may not take place and the management plan may be based on inadequate information.

An adequate partnership will probably not involve a good review of the patient's agreement and understanding.

It is important in assessing the performance of 3 or adequate that absence of some of the qualities that make 5 or excellent scores does not necessarily result in a reduction in the scoring of the consultation. There will be consultations where it is not appropriate to have all of the excellent qualities present but in the adequate or scoring 3 consultation the assessor will be aware that a better consultation partnership would be obtained had some of the above areas been covered more adequately.

Definitions for a doctor whose performance scores one (needs attention)

Good partnership is dependent on good communication and poor partnership is likely to co-exist with poor communication.

The poor consultation will not explore, or may ignore, the patient's wishes and ideas and will not involve the patient in the eventual decision making process.

The consultation will probably be doctor centred. The management plan, if formed at all, will lack logic or even safety and it might be that the doctor's knowledge will be found wanting.

There will be no review of the management plan, if any formed at all, and at the patient's agreement and understanding of any plan will not be sought.

CRITERIA FOR ASSESSMENT – HEALTH ENABLEMENT

1. Where relevant
2. It may be clear from the written summary that health promotion data is recorded already in the case file and it appears to repeat it for the sake of the tape.

Definitions for a doctor whose performance scores five (excellent)

The doctor extends the consultation beyond dealing with the presenting complaint to establish risk factors and risk taking behaviour. He/she explores the patient's understanding and beliefs and offers appropriate advice or action to reduce risk. He/she makes use of techniques such as motivational interviewing and reflection to ensure the patient's understanding and responsibilities towards their own influence on their health.

Definitions for a doctor whose performance scores three (adequate)

The doctor displays awareness of factors in a patients life events and life choices which affect the presentation but fails adequately to help the patient address them.

Definitions for a doctor whose performance scores one (needs attention)

The doctor fails to recognise the wider health promotion elements of a symptom or diagnosis. He/she fails to establish risk factors or to explore the patient's exposure including family history, reversible habits and risk taking behaviour or the patient's knowledge or belief. There is absence of even basic advice or treatment directed towards health promotion.

CRITERIA FOR ASSESSMENT – KNOWLEDGE

Definitions for a doctor whose performance scores five (excellent)

1. Factual knowledge judged to be correct and up to date, possibly beyond that expected.
2. Imparting of knowledge to patient may involve balance of judgements.
3. Admits when unsure or knowledge-base is in doubt and acts on it.

Definitions for a doctor whose performance scores three (adequate)

1. Some gaps in knowledge demonstrated but would not cause actual or potential harm to patient.

Definitions for a doctor whose performance scores one (poor)

1. Obvious gaps in knowledge or incorrect knowledge.
2. Actual or potential harm demonstrated as a result of knowledge-gap.
3. Imparting of knowledge which would be of use to the patient ignored.

CRITERIA FOR ASSESSMENT – APPROPRIATE MANAGEMENT PLAN

Definitions for a doctor whose performance scores five (excellent)

Uses the information gathered from the history and examination appropriately to formulate the management plan. The management should be medically necessary and where possible based on evidence and informed by the doctor's knowledge of patient's circumstances.

The plan should be explained to the patient using appropriate language and agreed with them. Patient input should be encouraged and a range of options given where appropriate. Appropriate review arrangements should be made.

Definitions for a doctor whose performance scores three (adequate)

Uses the information gathered from the history and examination to formulate an appropriate management plan. Some decisions not based on sound evidence, and knowledge of patient's circumstances not always incorporated. Some use of medical terminology in explanation, but does try to seek patients views. Gives a limited range of options. Review arrangements mostly satisfactory.

Definitions for a doctor whose performance scores one (poor)

Does not use information from history or examination to problem solve and formulate management plan. Management often incorrect, not based on evidence with over referral and over investigation. Uses a lot of medical jargon in explanation. Doctor centred with no options offered to patient and fails to safety net appropriately.

CRITERIA FOR ASSESSMENT – INSIGHT AND UNDERSTANDING OF DOCTOR

Definitions for a doctor whose performance scores five (excellent)

The excellent consultation will take cognisance of additional factors surrounding the consultation, such as family illness, disability, sibling and extended family problems, financial constraints, employment considerations. The doctor should show that previous medical, surgical and psychiatric history has been taken into consideration along with previous illness patterns and the patient's expectation and previous outcomes.

A great deal of the information regarding insight and understanding will be by its very nature contained in the log diary and will not necessarily be overt in the consultation. The log diary should reflect the factors mentioned above. Insight and understanding also applies to doctor's own analysis of his/her own performance.

Definitions for a doctor whose performance scores three (adequate)

Doctor is aware of contextual factors but fails to adequately take these into account either in consultation or log diary.

Definitions for a doctor whose performance scores one (poor)

Has no clear idea or has a mistaken idea for the reason for the consultation and is unable to justify decision making in log.

Demonstrates failure to recognise own shortcomings.

TECHNICAL ISSUES

The tape should consist of a minimum of nine consultations in standard VHS format. If you have a camera which uses any other format this must be transcribed onto a standard VHS tape. All patients being video taped must sign a consent form, before and after a consultation. If the consent form is unsigned, the video camera should be switched off. It should be made clear to patients that a recording will not be undertaken without a patient's consent and that the camera will be switched off on request. There is no need to switch off the camera between consultations unless the gap is likely to be a large one.

The examination couch should not be in view, and intimate examinations should not be recorded, but the tape must be kept running for sound while the examination takes place.

The tape should be checked for quality of sound and picture, prior to submission. The picture should show both the doctor's and patient's face. A camera clock is important, as it allows you and the assessor to navigate through the tape. If your camera does not have a clock a possible alternative is to have a clock visible on the desk.

Guidelines on a Code of Practice for Videotaping Consultations

Information

Patients should be informed at the time of booking an appointment that videotaping is planned for that surgery.

On arrival, the patient will be given the information leaflet and consent form and the receptionist will explain the procedure to the patient, including the fact that should the patient be unwilling to be videotaped this will not affect their consultation with the doctor. The receptionist should ensure that the patient understands why the recording is being made, the purposes for which it will be used, who will see it and how long it will remain in existence.

If the patient is accompanied by a friend or relative during the consultation it should be made clear that they are there at the invitation of the patient and they should also be informed of their right of confidentiality and consent.

Consent Form

The consent form should be signed by the patient before being taken to the doctor. The consultation can only be video recorded, if the consent form is signed by the patient and/or others accompanying the patient.

If unsigned, the video camera should be switched off.

Consent forms should be available in languages other than English so that the patients whose first language is not English clearly understand what they are being asked to do.

Where patients are unable to give consent because they suffer from a mental disability, or for any other reason, consent must be sought from a close relative or carer. In the case of children and young people who lack the understanding to consent on their own behalf, the consent of an adult with parental responsibility must be obtained. The person giving consent must understand the rights set out above and on the next page.

Procedure After The Consultation

Following the consultation the patient should take the form back to the receptionist and should be reminded by the receptionist to sign the post-consultation form if the patient is still agreeable for the recording of the consultation to remain on tape.

The patient must be offered the opportunity to view the recording, in the form in which it is intended to be shown, before the recording is used and have the right to withdraw consent to the use of the recording at that stage.

If a patient, following the consultation, wishes the recording to be erased from the videotape, then he/she should tell the receptionist and should not sign the consent form. The doctor should then erase the consultation at the first available opportunity and confirm to the patient that this has been done.

The receptionist should make clear to the patient that if after leaving the surgery he/she would prefer the recording to be erased, he/she should notify the practice as soon as possible.

The recording is only to be used for the purposes to which consent has been given.

Storage and Erasure

The videotape should be stored with the same security and confidentiality as patient medical records. They should be stored with the consent forms attached and a list of people who are allowed to view the recordings.

Consent forms should be kept with the medical records of the patient and the fact of a video taped consultation recorded on computer. One copy of the consent form should be held with the video recording.

The responsibility for security, confidentiality, storage and erasure falls to the general practitioner in the practice. The tape will be erased as soon as possible but definitely no later than one year after the date of recording.

Transport

Videotapes should be transported by the general practitioner or their representative (e.g. personal messenger). Postal services should only be used for registered mail delivery.

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OBSERVATION OF CONSULTING - FORMAL

PRACTICE INFORMATION LEAFLET

Dr ..... is making a video recording of his/her consultation with patients today. This will be used for the doctor's own medical education. We thank you for your help with this important part of the doctor's education and hope that you will agree to your consultation being videotaped, but recognise your right not to take part. If you do not want the video camera to record your consultation, then all you have to do is tell the receptionist. This will not affect your consultation or treatment in any way. If you agree to be recorded you will be asked to sign a consent form. No intimate examinations will be recorded and the camera will be switched off whenever you wish.

The video tape is as confidential as your medical records and will be kept with the same security. The doctor making the recording will ensure that the tape is only used for educational purposes and that it is erased. The tape will be used for assessing the doctor's skill in the consultation, to teach the doctor how to improve and for research - all of which help patients to get better care.

Apart from the doctor, other doctors from outside the practice will be allowed to see the tape for assessment purposes/feedback. You will be asked for your permission first and those other viewers will give you a written promise to keep what is on the tape confidential.

OBSERVATION OF CONSULTING - FORMAL

VIDEO CONSENT FORM

Date		**Name of consulting doctor**	
Name of patient		**Names of persons accompanying patient to consultation**	

Dr …….. is making a video recording of his/her consultations. Intimate physical examinations will not be recorded and the camera will be switched off on request.

The tape will be used for the purposes of assessment of the doctor, research, learning and teaching purposes. It will be seen only by persons who have legal access to your medical records.

Dr …….. is responsible for the security and confidentiality of the video recording. If the tape is to leave the practice premises it will be sent registered post or by personal messenger.

Today's recording will be seen inside your practice and it may also need to be seen outside the practice by other doctors who will give feedback to your doctor on his/her consultations. The tape will be erased as soon as possible but definitely not later than one year after the date of the recording.

TO BE COMPLETED BY THE PATIENT

I have read and understand the information leaflet (please tick appropriate box)

☐ I give my permission for my consultation to be video recorded

☐ I do not give my permission for my consultation to be video recorded

State here if you wish to limit the use to which the tape might be put and whether you require the tape to be erased within a specified period of time.

……

Signature of patient **BEFORE CONSULTATION**

…… Date: ……

Signature of person accompanying patient to consultation

…… Date: ……

Following my consultation I am still willing/I no longer wish my consultation to be used for the above purposes

Signature of patient **AFTER CONSULTATION**

…… Date: ……

Signature of person accompanying patient to consultation

…… Date: ……

OBSERVATION OF CONSULTING - FORMAL

Consultation No	*Date and Clock Time*	*Main reason for consultation with relevant background information including medication*	*Age and sex of patients*	*Degree of difficulty*	*Consent Y/N*
1					
2					
3					
4					
5					

OBSERVATION OF CONSULTING - FORMAL

Consultation No	*Date and Clock Time*	*Main reason for consultation with relevant background information including medication*	*Age and sex of patients*	*Degree of difficulty*	*Consent Y/N*
6					
7					
8					
9					

VIDEO OF CONSULTATIONS

CONSULTATION NUMBER ON TAPE: _____

Please rate consultation from 1 – 5 (poor – excellent) by circling the appropriate number

Communication	1	2	3	4	5
Partnership	1	2	3	4	5
Health Enablement	1	2	3	4	5
Knowledge	1	2	3	4	5
Appropriate Management Plan	1	2	3	4	5
Insight and Understanding of Doctor	1	2	3	4	5

OBSERVATION OF CONSULTING - FORMAL

Consultation No	*Date and Clock Time*	*Main reason for consultation with relevant background information including medication*	*Age and sex of patients*	*Degree of difficulty*	*Consent Y/N*
1	06.02.03 08.55 am	Child had a cough for five days and Mum was concerned it was not settling. Was keeping family awake. Child was not a frequent consulter. No other illness or medication. All examination findings and PFR were normal.	6 years Female	Moderate	Yes
2	06.02.03 09.09 am	Patient was concerned re headaches for the past month. Was under stress at work and wondered if related but also worried about migraine or a 'blood clot' as Gran recently had a stroke. Medication co-codamol and oral contraceptive. Examination was normal. Impression was tension headache.	30 years Female	Moderate	Yes
3	06.02.03 09.16 am	Patient needed more of medication for rheumatoid arthritis – DMARD and wanted to discuss deteriorating function of ankle. Wondered about possibility of surgery. Long list of medication – sheet attached. 58 years.	58 years Female	Difficult	Yes
4	06.02.03 09.28 am	Baby with conjunctivitis. Family about to go on holiday. Mum concerned he may get worse abroad.	4 months Male	Straight-forward	Yes
5	06.02.03 09.36 am	Patient with low lumbar pain for six days. Works as a joiner – work difficult. There were no red flag symptoms or signs and I think he has mechanical back pain. Concern may become chronic as he is having problems with work and is trying to rest – against my advice.	39 years Male	Difficult	Yes

OBSERVATION OF CONSULTING - FORMAL

Consultation No	*Date and Clock Time*	*Main reason for consultation with relevant background information including medication*	*Age and sex of patients*	*Degree of difficulty*	*Consent Y/N*
6	06.02.03 10.03 am	Child had few molluscum on trunk and Mum was concerned they were not settling. Natural history was explained and Mum was happier.	7 years Female	Straight-forward	Yes
7	06.02.03 10.09 am	Patient presented with increasing frequency of angina over the past two weeks. The episodes had also occasionally occurred at rest. They were helped by GTN but it was taking longer to work than usual. He had a MI six years ago.	70 years Male	Moderate	Yes
8	06.02.03 10.19 am	Patient had injured his knee while playing football four days ago. He twisted his knee and it was now tender over the right medical collateral ligament. His knee was stable with no effusion.	28 years Male	Moderate	Yes
9	06.02.03 10.27 am	Patient presented with stress at work. She has a very busy job, two young children and has recently moved house. She was quite tearful and was not sleeping. She felt her mood low but had no thoughts of self harm. She was not a frequent attender.	34 years Female	Moderate	Yes

Section 3C(2&3)

Complaints

This section of the revalidation folder asks you to:

3C(2) Ensure that an effective complaints procedure is in place.

This may be evidenced by either a:

- Current practice accreditation certificate*.

OR

- Description of the complaints procedure used in the practice.

(Non-principals are exempt from this criterion)

3C(3) Ensure that any written complaints involving you should be considered, responded to with learning needs identified and plans for change made.

This may be evidenced by recording and analysing written complaints using the proforma in this section. Anonymised copies of any written complaints may be required for revalidation evidence.

* A practice accreditation certificate includes a current:
  - RCGP Scotland Practice Accreditation Certificate

  OR

  - NES Training Practice Accredition Certificate

  OR

  - RCGP Quality Practice Award Certificate

Complaints Procedure **3C(2)**

Describe the complaints procedure used in your practice.

Signed ..... Date .....

Name .....

3C(3)

Record of Complaint

Brief Outline of Complaint

Why it happened

Description of Resolution or Non–Resolution

Learning Outcomes/Plans for Change of Practice

How these plans have been acted upon

Section 3C(4)

Removal of Patients from List

This section of the revalidation folder asks you to ensure that you have a system where patients are removed from your list when there are acceptable reasons and that the patients are informed of the reason for their removal.

As evidence for this section you can either:

Include your current practice accreditation certificate*.

OR

Complete the proforma overleaf describing the policy in your practice for removing patients from the practice list. You should also include sample letters.

* A practice accreditation certificate includes a current:
  - RCGP Scotland Practice Accreditation Certificate

  OR

  - NES Training Practice Accredition Certificate

  OR

  - RCGP Quality Practice Award Certificate

Removal of Patients from List 3C(4)

Describe the practice's policy for removing patients from the list. You should include sample letters explaining reasons for removal.

Signed …… Date ……

Name ……

Removal of Patients from GP's list – Guidance from the Royal College of General Practitioners (RCGP)

(A) Guidance on when it is reasonable to remove a patient from a GP's list

The relationship between a doctor and patient should be a therapeutic and beneficial one. However there are a few circumstances where it would normally be considered reasonable to remove a patient. Even in these circumstances a GP may decide to retain the patient.

Situations which justify removal:

• Violence

When a patient:-

• Is physically violent towards a doctor, practice staff or other patients on the practice premises.

• Causes physical damage to practice premises or other patient's property.

• Gives verbal abuse or makes threats towards the doctor, practice staff or other patients.

• Gives racist abuse, orally or physically.

• Is violent or uses or condones threatening behaviour to doctors (or some other members of the primary health care team) while visiting the patient's home. Such behaviour may involve the patient, a relative, a household member, or pets (such as unchained dogs).

Crime & Deception

Where a patient:-

• Fraudulently obtains drugs for non-medical reasons.

• Deliberately lies to the doctor or other member of the primary health care team (eg by giving a false name or false medical history) in order to obtain a service or benefit by deception.

• Attempts to use the doctor to conceal or aid any criminal activity.

• Steals from practice premises.

Distance

• Where a patient has moved out of the designated practice area and has failed to register with another GP.

Removal of Patients from GP's list – Guidance from the Royal College of General Practitioners (RCGP)

(B) Guidance on when it is not reasonable to remove patients from a GP's list

Given the current guidelines from the General Medical Council there are a few circumstances where removing a patient is inappropriate.

Situations which never justify removal:

- Where there is an exacting or highly dependant patient, condition or disability.
- Where a patient exhibits high levels of anxiety or "demand" about perceived serious symptoms.
- Where discrimination is displayed by a patient in relation to age, gender, ethnic origin, religion or sexual orientation.

There are then a number of other circumstances where it may not be considered reasonable to remove a patient from a GP's list.

Situations which do not normally justify removal:

- A patient's decision on clinical matters

Where a patient:-

- Chooses a home confinement.
- Refuses to undertake cervical cytology screening.
- Tries to prevent immunisation of children.
- Does not comply with therapeutic or other health advice.

Critical questioning and/or complaints

Where a patient:-

- Persistently questions practice standards or safety (eg sterilisation of instruments, clinical techniques or other practice matters).
- Complains via the In-House complaints system.

Removal of Patients from GP's list – Guidance from the Royal College of General Practitioners (RCGP)

(C) Guidance on Removing patients due to irretrievable breakdown of the doctor- patient relationship

Occasionally patients persistently act inconsiderately and their behaviour falls outside that which is normally considered to be reasonable. In such circumstances there may be a complete breakdown in the doctor-patient relationship. It is important not to lose sight of the problem and to remember that the circumstances surrounding the breakdown may be perceived differently by the patient and the doctor. It is under these conditions that the potential for misunderstanding is at its greatest. The following guidance suggests a process which could be adopted or adapted by practices in order to attempt to restore the relationship or failing that to facilitate the constructive removal of the patient from the GP's list. However, it is recognised that frequently it may be impossible or impractical to go through all of these steps.

Steps to be taken within the practice

- Inform all appropriate members of the practice about the problem.
- Discuss carefully and confidentially the possible reasons for the patient's behaviour (eg disagreeableness, cultural differences, mental illness, personality disorder).
- Consider whether any aspect of the running of the practice is contributing to the problem (eg an over stressed GP, a receptionist with poor interpersonal or communication skills, bad surgery design or layout).
- Consider implementing within the practice solutions or procedures which may help (eg making sure that the patient always sees the same doctor, more thorough training of practice reception staff, the ability to arrange rapid telephone consultation with a member of the primary health care team).

Steps to be taken with the patient

- Inform the patient personally that there is a problem and consider arranging a meeting to discuss matters. It may be considered more appropriate to inform the patient by letter but a GP should seek the advice of his Defence Society before corresponding with the patient.
- Attempt to explain to the patient the nature of the problem. (It may be useful to use a specially skilled or sympathetic member of the practice to facilitate this).
- Try to elicit the patient's perspective and interpretation of the situation.
- Be prepared to negotiate with the patient over specific problems (eg too frequent requests for home visits may be reduced by a promise of easier telephone consultations with the doctor).

Steps to be taken if discussion fails to resolve the problem

- Suggest that another GP within the practice might better fit with the patient's needs and expectations. Consideration will need to be given to the patient's reaction if they have to consult with the same GP in an emergency or out of hours situation.
- Consider advising the patient about other practices in the area with whom the patient may wish to register.

Steps to be taken in actually removing the patient

- Inform the appropriate Health Authority in writing of your decision. (In Northern Ireland inform the Central Services Agency and inform the Health Board in Scotland).
- Consider writing to the patient informing him or her of the decision and the reason for removal from the list. It may be prudent to take the advice of a Medical Defence Society prior to sending such a letter.
- Explain to the patient that he or she will not be left without a GP.
- Give the patient information on how to begin the process of registering with another GP.

Removal of patients from GP lists – Guidance from the General Practitioner Committee (GPC)

Background

A good patient-doctor relationship, based on mutual respect and trust, is the cornerstone of good patient care. The removal of patients from GPs lists should continue to be an exceptional and rare event, and a last resort in an impaired patient-doctor relationship. When trust has irretrievably broken down, it is in the patient's interest, just as much as that of the doctor, that they should find a new GP.

GPs have the right to ask for a patient to be removed from their list under paragraph 9 of the terms of service (paragraph 7 in Scotland). There is no contractual obligation to give a reason for such a request but the GPC believes that, normally, patients should be provided with one.

The health authority (or health board) must be informed in writing of the request and the removal will not take effect until the eighth day after the request is received by the authority[1] unless the patient is accepted by, allocated or assigned to another GP sooner than this. The patient is always notified by the authority.

Whilst some removals might occur because of disagreement between doctor and patient, there are also cases where doctors request removal because they have become aware that the patient has moved to an address which is outside their practice area. This is necessary because otherwise the GP may still be under an obligation to visit the patient when medically necessary at a location outside their practice area.

Patients also have a right to change their doctor. They are not required to give their reasons, nor is there any period of notice or requirement to notify the doctor.

Public perception of removals

Government figures for removals do not differentiate between those removed because of a breakdown in the relationship and those who are removed for administrative reasons, such as moving to an address outside the doctor's practice area. In any case the number of removals must be considered in the context of there being 35,000 GPs in the United Kingdom and some 250 million consultations between patients and GPs in the course of any one year.

On the basis of the published figures, the average GP will exercise his or her right to remove a patient less than once a year. Unfortunately, some cases have given rise to unfavourable publicity for the doctor and practice concerned and for GPs in general. A number of aggrieved patients have claimed that they do not know why they have been removed.

There is also an increasing public perception, fuelled by reports in the media, that patients are being removed from GPs lists because their care is too costly, because of their clinical condition or even their age.

The General Practitioner Committee (GPCs) advice to GPs

The GPC will defend vigorously the rights of both doctors and patients to terminate a relationship which is not working and offers the following advice.

Removals for administrative reasons/change of address

These occur when a patient has died, or has moved to an address outside a doctor's practice area and has not re-registered with another GP.

[1] *Or, if the doctor is treating the patient at intervals of less than seven days, eight days after treatment ceases.*

Breakdown of the doctor-patient relationship

- **Normally the sole criterion for removal should be an irretrievable breakdown of the patient-doctor relationship.**
- **Violence or threatening behaviour by the patient is a special case.**

  It usually implies a total abrogation by the patient of any responsibility towards the doctor and will normally result in removal from the list. As well as having a right to protect themselves GPs have a duty as employers to protect their staff.

  Changes to the terms of service negotiated by the GPC and brought into effect on 1 April 1994 mean that it is possible to request the immediate removal of any patient who has committed an act of violence or caused a doctor to fear for his or her safety. The police (or in Scotland, either the police or the procurator fiscal) must have been informed of the patient's behaviour and the doctor must notify both the health authority (or health board) and the patient of the removal in writing.

  The GPC believes that GPs will use their clinical judgement to determine the appropriate course of action in those rare cases where a patient's violent behaviour results from their medical condition.

Complaints and removals

- **The GPC does not support or condone the removal of patients solely because they have made a complaint.**

  The current NHS complaints procedure has now been in operation since 1996 and it is a requirement under the terms of service for all GPs to ensure that their practice has an in-house complaints procedure. Patients should normally raise a complaint with their practice in the first instance. There is public concern that patients may be removed from the list simply for making a complaint. However, complaints made in a reasonable and constructive manner can help GPs to improve services to patients.

  It is also perfectly possible to use the practice-based complaints procedure to discuss any instances where a patient is felt to be behaving inappropriately. This gives patients early notification of a possible problem in their relationship with their doctor along with an opportunity to discuss ways of preventing further difficulties. As well as preventing the need for removals, this procedure should reduce the number of incidents where patients appear to have been removed without any prior indication that the relationship with the doctor was less than satisfactory.

  The GPC believes, however, that complaints which take the form of a scurrilous personal attack on the doctor or contain allegations which are clearly unfounded are usually indicative of a serious breakdown of the patient-doctor relationship.

  It is a breakdown of the relationship rather than a complaint per se which must form the basis of any decision to remove a patient from the list; it may then be in the patient's best interest to seek care at another practice.

Cost and age and removals

- **GPs should never remove patients from their list because their treatment is too costly.**

  There are no grounds ever for removing patients because of cost. Where the costs of treating an individual patient are higher than anticipated, adequate mechanisms exist to enable doctors to seek and be granted an increase in their prescribing budget.

- **GPs should never remove patients because they are suffering from a particular clinical condition.**

  The GPC is striving continuously in its discussions with government to ensure that any arrangements emerging from the NHS changes do not operate to the detriment of patient care, and that GPs are able to provide all necessary and appropriate clinical care for their patients without financial penalty.

- **GPs should never remove patients on grounds of age.**

  Looking after patients 'from the cradle to the grave' is the essence of general practice. Some, but by no means all, elderly patients may have an increased need for medical attention. This is recognised in higher capitation fees for patients over 75 and normally also in the formula for allocating prescribing budgets.

  Sometimes it is not the patients themselves but carers, particularly staff of private nursing and residential homes, who can generate excessive and inappropriate demand for services from the doctor or practice. In these cases the GPC recommends that the practice attempt's to resolve the problems through the in-house procedure or using the help of the LMC and/or the health authority or board.

What to do if removal appears to be necessary

In cases other than violence and abuse, the GPC recommends that the decision to remove a patient from the list should only be made after careful consideration and not in the heat of the moment. Alternatives, short of removal, should be considered such as transferring the patient's care to a partner (with the consent of both parties) or persuading the patient that it would be better for all concerned for them to go to another doctor outside the practice.

Patients who are misusing services may sometimes alter their behaviour if this is brought to their attention. It may be appropriate to advise them that continued misuse may lead to their removal from the list.

If all else fails the GPC believes that it is not in the best interests of either patient or doctor for an unsatisfactory relationship to continue and it will be necessary to remove the patient from the list.

How to remove a patient from the list if necessary

1. Where GPs intend to remove a patient because of the irretrievable breakdown of the doctor-patient relationship, they should first consider discussing the problem confidentially with an independent party, such as their LMC secretary.
2. GPs should send a written notice to the health authority (or health board), giving the patient's name, address, date of birth, and NHS number. They should state that they wish to have the patient removed from their list under paragraph 9 (paragraph 7 for Scotland) of the terms of service[2].
3. The GPC recommends that when GPs send the request to the health authority (or health board) they should also normally **send a letter to the patient informing them of the removal and briefly outlining the reasons.**

There are three reasons for suggesting this:

> First, it is a matter of common courtesy. Even in circumstances where patients have been less than courteous it is essential for doctors to maintain a high standard of professionalism.
>
> Secondly, it helps to explain to patients how their behaviour has affected the doctor or the practice and may help them in forming a better relationship with their next doctor or in making more appropriate use of practice services. The act of removal often makes patients aware of the need not to misuse health services in future.
>
> Thirdly, it will help to avoid or counteract any public speculation about the doctor's motivation in making a removal.
>
> Care should be taken to ensure that the reasons given are factual and that the tone of the letter is polite and suitably informative. In cases of doubt it is worth discussing the wording of the letter with a partner, the LMC secretary or a medical defence organisation.

Removing other members of the household

If the behaviour of one member of a household or family has led to their removal, this does not mean that the removal of other family members should automatically follow. An explicit discussion with other family members about the problem and the doctor's concerns will often obviate the need for any further action.

In rare cases, however, because of the possible need to visit patients at home it may be necessary to terminate responsibility for other members of the family or the entire household. The prospect of visiting patients where a relative who is no longer a patient of the practice by virtue of their unacceptable behaviour resides, or being regularly confronted by the removed patient, may make it too difficult for the GP to continue to look after the whole family. This is particularly likely where the patient has been removed because of violence or threatening behaviour and keeping the other family members could put doctors or their staff at risk. Again the GPC would suggest that reasons are given clearly.

The GP should always consider how it would look to outside observers if a family were to be summarily removed from the list, in haste, without explanation, for a single misdemeanour or disagreement with one family member.

Practice leaflets

It may be helpful if GPs set out in their practice leaflets the arrangements for removal of patients from the list, and their policy for dealing with threats or incidents of violent behaviour.

Copies of this and other GPC guidance are available at www.bma.org.uk/gpc.nsf

2 Special provisions apply under paragraph 9A (paragraph 7A in Scotland) which are used to achieve the immediate removal of abusive or violent patients.

This form has been reproduced with the kind permission of GPC (General Practitioner Committee).

Section 3D(1)

Working with Colleagues

The quality of care our patients receive is influenced by how well primary care professionals work together in a team approach and how well we communicate with colleagues in secondary care and other agencies.

Evidence of the effectiveness of your team-working skills can be demonstrated by **one** of the following methods:

Current practice accreditation certificate*.

OR

Description of an example which demonstrates team working between the doctor and other members of the team

OR

Feedback on the effectiveness of your individual team working skills using ***either***:

- Ramsay peer questionnaire

OR

- 360 degree feedback including members of the primary care team in which the doctor works

* A practice accreditation certificate includes a current:

- RCGP Scotland Practice Accreditation Certificate

OR

- NES Training Practice Accredition Certificate

OR

- RCGP Quality Practice Award Certificate

3D(1)

STEPS FOR COMPLETING THE PEER REVIEW SURVEY

The survey aims to test the feasibility and acceptability of peer review as a way of providing useful evidence for a doctor's revalidation folder. **Your responses will be completely anonymous.**

The doctor is asking up to 15 professional peers to participate in this survey, with a view to obtaining at least 10 completed responses. If there are less than 10 returns, the survey results may not be valid.

Please answer each question to the best of your ability. If you feel you cannot comment in respect of any question, then you can select the "unable to evaluate" option. An example of how to answer each question is given below.

A modified version of this survey, which has been used by the American Board of Internal Medicine for some years, was piloted nationally in 2002 by the General Medical Council.

WORKED EXAMPLE: PLEASE CIRCLE THE APPROPRIATE NUMBER OR SYMBOL

Rating Scale										
	Lowest score								Highest score	Unable to evaluate
Responsiveness to patients:	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**#**
Unresponsive to patients' needs and wishes									Very responsive to patients' needs and wishes	
A rating of 1 would indicate that Doctor X is the worst GP with whom you have worked in his/her responsiveness to patients' needs and wishes. A rating of 2 would indicate that Doctor X is among the bottom few GPs with whom you have worked in this characteristic									A rating of 8 would indicate that Doctor X is among the top two or three GPs with whom you have worked in his/her responsiveness to patients' needs and wishes. A rating of 9 would indicate that Doctor X is the single best GP with whom you have worked in this characteristic	

PEER REVIEW SURVEY

1. Respect	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**#**
Shows inadequate personal commitment to honouring the choices and rights of other persons, especially regarding their medical care									Always shows exceptional personal commitment to honouring the choices and rights of other persons, especially regarding their medical care.	
2. Medical Knowledge	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**#**
Limited and fragmented									Extensive and well-integrated	
3. Diagnosis and patient management	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**#**
Very poor ability to diagnose and treat patients and co-ordinate care in the surgery setting									Excellent ability to diagnose and treat patients and co-ordinate care in the surgery setting	
4. Integrity	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**#**
Shows inadequate commitment to honesty and trustworthiness in evaluating and demonstrating own skills and abilities									Always shows exceptional commitment to honesty and trustworthiness in evaluating and demonstrating own skills and abilities	
5. Psychosocial aspects of illness	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**#**
Does not recognise or respond to psychosocial aspects of illness									Recognises or responds to psychosocial aspects of illness	
6. Management of multiple complex problems	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**#**
Very limited ability to manage patients with multiple complex medical problems									Excellent ability to manage patients with multiple complex medical problems	
7. Compassion	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**#**
Shows inadequate appreciation of patients' and families' special needs for comfort and help or develops inappropriate emotional involvement									Always appreciates patients' and families' special needs for comfort and help but avoids inappropriate emotional involvement	
8. Responsibility	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**#**
Does not accept responsibility for own actions and decisions: blames patients or other professionals									Fully accepts responsibility for own actions and decisions	
9. Problem solving	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**#**
Fails to critically assess information, risks and benefits; does not identify major issues or make timely decisions									Critically assesses information, risks and benefits; identifies major issues and makes timely decisions.	
10. Overall clinical skills	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**#**
Very poor overall clinical skills									Outstanding overall clinical skills	

PEER DEMOGRAPHICS

The following questions are for statistical purposes. The GP will not be able to identify you, nor will this GP see your responses. Please tick the boxes as appropriate.

11. What is your speciality?

1. General practitioner ☐
2. Hospital specialist ☐
3. District Nurse ☐
4. Health Visitor ☐
5. Practice Nurse ☐
6. Pharmacist ☐
7. Other (please specify)

_____

12. Please enter your gender:

1. Male ☐
2. Female ☐

13. Please indicate your professional relationship with this doctor:

1. I am in medical partnership with this doctor ☐
2. I work as part of a primary healthcare team with this doctor but am not employed by his / her medical practice ☐
3. I work in secondary care and this doctor refers patients to me ☐
4. I work as part of a primary healthcare team with this doctor and am employed by the doctor's medical practice ☐
5. Other (please specify)

_____

14. How long have you known this doctor as a professional colleague?

1. Less than one year ☐
2. More than one year ☐

Thank you very much for participating in this pilot peer review survey.

Use of peer ratings to evaluate physician performance. Ramsay, PG/Wenrich, MD/Carline, JD/Inui, TS/Larson, EB/LoGerfo, JP JAMA 1993-Vol. 269, No.13.

3D(1)

Teamwork Account

Describe one episode illustrating how you interact with other primary care colleagues in the delivery of patient care.

Team members involved:

-
-
-

Describe the episode:

Outcomes as a result of teamwork:

Learning points:

a) Personal

b) For the team

Signed …… Date ……

Name ……

3D(1)

Teamwork Account

Describe one episode illustrating how you interact with other primary care colleagues in the delivery of patient care.

Team members involved:

- *Health visitors*
- *CPN*
- *Psychiatrist*

Describe the episode:

Obese 23 year old wished referral for breast reduction. I initially felt she had unusual ideas about her self image and low self esteem. Tearful at suggestion of weight loss and not willing to consider psychological assessment. Returned to see another partner next day – now noted to be more agitated. Community mental health team contacted and "urgent appointment" made for 4 days later.

Seen by out of hours service 1 day later – probable overdose and admitted to A & E.

Discharged following morning and assessed at home by health visitor. HV unhappy about patient and joint visit arranged with CPN from community mental health team.

Follow up organised by CPN at our practice and after discussion with psychiatrist started on clomipramine. Now doing well.

Outcomes as a result of teamwork:

Good lines of communication between myself and health visitor. Ability to do joint home visit with community mental health team clarified problem an action required.

Practice CPN had direct contact with psychiatrist and myself.

Learning points:

a) Personal – *unusual presentations need careful assessment.*

b) For the team – *open lines of communication between team members allow good co-ordination of care.*

Signed …… Date 12/07/03

Name David Adams

3D(1)

360° Feedback Tool

This tool can be used to find out what your colleagues think about working with you.

Colleagues can complete a questionnaire giving you feedback in three broad areas – clinical, colleagues, and education/research.

The tool has been developed by Edgecumbe Consulting who also provide an analysis of responses.

Please refer to www.edgecumbe.com for cost information.

For more information contact:

Edgecumbe Consulting Group Ltd
125 Pembroke Road
Clifton
Bristol
BS8 3ES

Tel: 0117 973 8899
Fax: 0117 973 8844

Web: www.edgecumbe.com
Email: consulting@edgecumbe.co.uk

Reference

1. King J. 360° appraisal. BMJ 2002; 324: S195

Section 3D(2)

Medical Records

An entry in your patient's medical records should be sufficient to allow another doctor to take over the care of your patient should this be necessary. In order for this to happen your medical records should include the following:

- Presenting complaint
- Significant findings
- Treatment given
- Date of consultation

In the case of manual records they should also be legible, although it is accepted that this is a subjective judgement.

This may be evidenced by ***either:***

Current practice accreditation certificate*

OR

Analysis of 10 medical records. If you wish to use this method a medical records proforma is available for your use and a worked example given (for sake of space the record entries are not included).

* A practice accreditation certificate includes a current:

- RCGP Scotland Practice Accreditation Certificate

OR

- NES Training Practice Accredition Certificate

OR

- RCGP Quality Practice Award Certificate

Medical records 3D(2)

You should analyse a sample of 10 consecutive extracts from medical records or a random sample of 10 extracts from medical records by ticking the appropriate boxes below. Copies of the anonymised extracts should be available in your folder to support your analysis.

Medical record	Presenting complaint	Significant findings	Treatment given	Record dated
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

Signed……Date……

Name……

Medical records 3D(2)

You should analyse a sample of 10 consecutive extracts from medical records or a random sample of 10 extracts from medical records by ticking the appropriate boxes below. Copies of the anonymised extracts should be available in your folder to support your analysis.

Medical record	Presenting complaint	Significant findings	Treatment given	Record dated
1	✓	✓	✓	✓
2	✓	✓	✓	✓
3	✓	✓	✓	Date omitted
4	✓	✓	✓	✓
5	✓	✓	✓	✓
6	✓	✓	N/A	✓
7	✓	✓	✓	✓
8	✓	✓	N/A	✓
9	✓	✓	✓	✓
10	✓	Partial record	✓	✓

Signed…… Date…12/07/03……

Name…David Adams……

Section 3D(3)

Out of Hours Contacts

This section of the revalidation folder asks you to ensure that you have a system to ensure that out of hours contacts are recorded in the patient record for continuity of care.

For this section you can either:

Use a current practice accreditation certificate*.

OR

Complete the proforma overleaf describing the system you have in your practice.

* A practice accreditation certificate includes a current:
  - RCGP Scotland Practice Accreditation Certificate

  OR

  - NES Training Practice Accredition Certificate

  OR

  - RCGP Quality Practice Award Certificate

3D(3)

Medical Records – Out of Hours

Describe the practice system for ensuring that out of hours encounters are recorded in the patient record.

Signed ..... Date .....

Name .....

Section 3E(1)

Teaching and Training

You should only complete this section of the revalidation folder if you are involved in the teaching of students, doctors in training, other health care professionals or ancillary staff.

If you have a contract with a university or are a designated trainer or deputy trainer of general practice registrars, you should provide a copy of your trainer approval or a statement or certificate from the university with whom you have a contract. The statement could be the result of a teacher appraisal or feedback process. Similarly, if you have a current qualification in medical education or are a member of the Institute for Learning and Teaching in Higher Education please include a statement or certificate.

If you do not have a contract with a university or are a designated trainer or deputy trainer but are involved in teaching you should complete the proforma overleaf for an Occasional Teacher.

Occasional Teachers 3E(1)

Describe the teaching/training activity you are involved in. You should include an example of an evaluation of your teaching or some feedback from learners whom you have taught.

Signed ..... Date .....

Name .....

Section 3(F)

Good Medical Practice: Probity

Procedure

1. The Annex below reproduces a pro-forma which the GMC has developed as part of the work to provide tools to support revalidation. This pro-forma is in draft format and is therefore subject to change. We will publish the finalised version on our website: **www.gmc-uk.org**. This pro-forma may be freely reproduced, and can be used in appraisal.

2. For revalidation purposes, it will be suitable to provide a declaration about probity in matters which might affect your fitness to practice medicine. However you may present evidence of your probity in some other way, if you so wish. You must ensure that you disclose information that relates to events within the whole of your current appraisal/revalidation cycle.

3. The GMC retains the right to ask for additional information if it is considered that the information presented for revalidation is insufficient. If you use other products or formats which have not been tested by the GMC this could increase the chance that you will be asked for additional information and/or evidence.

Guidance

4. Paragraphs 48-58 of *Good Medical Practice* provide a list of professional obligations that you should consider when signing a declaration on probity. There are, of course, other types of obligations/information that you should also consider, for example, any form of disciplinary, regulatory or criminal procedures which have been applied to you, or which you know are in progress or pending.

   The extract below is taken in full from the GMC's guidance *Good Medical Practice*.

'Probity

Providing information about your services

48. If you publish information about the services you provide, the information must be factual and verifiable. It must be published in a way that conforms with the law and with the guidance issued by the Advertising Standards Authority.

49. The information you publish must not make unjustifiable claims about the quality of your services. It must not, in any way, offer guarantees of cures, nor exploit patients' vulnerability or lack of medical knowledge.

50. Information you publish about your services must not put pressure on people to use a service, for example by arousing ill-founded fear for their future health. Similarly you must not advertise your services by visiting or telephoning prospective patients, either in person or through a deputy.

Writing reports, giving evidence and signing documents

51. You must be honest and trustworthy when writing reports, completing or signing forms, or providing evidence in litigation or other formal inquiries. This means that you must take reasonable steps to verify any statement before you sign a document. You must not write or sign documents which are false or misleading because they omit relevant information. If you have agreed to prepare a report, complete or sign a document or provide evidence, you must do so without unreasonable delay.

Research

52. If you participate in research you must put the care and safety of patients first. You must ensure that approval has been obtained for research from an independent research ethics committee and that patients have given consent. You must conduct all research with honesty and integrity. More detailed advice on the ethical responsibilities of doctors working in research is published in our booklet *Good Practice in Medical Research – The Role of Doctors*

Financial and commercial dealings

53. You must be honest and open in any financial arrangements with patients. In particular:

- you should provide information about fees and charges before obtaining patients' consent to treatment, whenever possible;
- you must not exploit patients' vulnerability or lack of medical knowledge when making charges for treatment or services;
- you must not encourage your patients to give, lend or bequeath money or gifts which will directly or indirectly benefit you. You must not put pressure on patients or their families to make donations to other people or organisations;
- you must not put pressure on patients to accept private treatment;
- if you charge fees, you must tell patients if any part of the fee goes to another doctor.

54. You must be honest in financial and commercial dealings with employers, insurers and other organisations or individuals. In particular:

- if you manage finances, you must make sure that the funds are used for the purpose for which they were intended and are kept in a separate account from your personal finances;
- before taking part in discussions about buying goods or services, you must declare any relevant financial or commercial interest which you or your family might have in the purchase.

Conflicts of interest

55. You must act in your patients' best interests when making referrals and providing or arranging treatment or care. So you must not ask for or accept any inducement, gift or hospitality which may affect or be seen to affect your judgement. You should not offer such inducements to colleagues.

Financial interests in hospitals, nursing homes and other medical organisations

56. If you have financial or commercial interests in organisations providing health care or in pharmaceutical or other biomedical companies, these must not affect the way you prescribe for, treat or refer patients.

57. If you have a financial or commercial interest in an organisation to which you plan to refer a patient for treatment or investigation, you must tell the patient about your interest. When treating NHS patients you must also tell the health care purchaser.

58. Treating patients in an institution in which you or members of your immediate family have a financial or commercial interest may lead to serious conflicts of interest. If you do so, your patients and anyone funding their treatment must be made aware of the financial interest. In addition, if you offer specialist services, you must not accept patients unless they have been referred by another doctor who will have overall responsibility for managing the patient's care. If you are a general practitioner with a financial interest in a residential or nursing home, it is inadvisable to provide primary care services for patients in that home, unless the patient asks you to do so or there are no alternatives. If you do this, you must be prepared to justify your decision.'

ANNEX

Probity declaration

Professional obligations

I accept the professional obligations placed upon me in paragraphs 48 to 58 of *Good Medical Practice.*

Signature..... Date.....

Name in capitals.....

GMC Registration Number.....

Convictions, findings against you and disciplinary action

- Since my last appraisal/revalidation **I have not**, in the UK or outside:
- Been convicted of a criminal offence (including any spent convictions) or have proceedings pending against me.
- Had any cases considered by the GMC, other professional regulatory body, or other licensing body or have any such cases pending against me.
- Had any disciplinary actions taken against me by an employer or contractor or have had any contract terminated or suspended on grounds relating to my fitness to practise.

Signature..... Date.....

Name in capitals.....

GMC Registration Number.....

(Notes: If you are able to sign both of the above declarations then you do not need to complete the rest of the pro-forma below. However, if you are not able to sign both of the declarations above then you will need to complete the full pro-forma below.)

ANNEX

Probity declaration pro-forma

Convictions, findings against you and disciplinary action

1. Since your last appraisal/revalidation[1], have you been convicted of a criminal offence (including any spent conviction) either inside or outside the UK?

Yes ☐ No ☐

If yes, please give details:

.....

.....

.....

2. Do you have any criminal proceedings pending against you inside or outside the UK?

Yes ☐ No ☐

If yes, please give details:

.....

.....

.....

3. Since your last appraisal/revalidation, have you had any cases considered, heard and concluded against you by any of the following:

a. The General Medical Council.

b. Any other professional regulatory or other professional licensing body within the UK.

c. A professional regulatory or other professional licensing body outside the UK.

Yes ☐ No ☐

If yes, please give details:.....

.....

.....

.....

4. Are there any cases pending against you with any of the following organisations:

a. The General Medical Council.

b. Any other professional regulatory or other professional licensing body within the UK.

c. A professional regulatory or other professional licensing body outside the UK.

Yes ☐ No ☐

If yes, please give brief details:.....

.....

.....

.....

5. Since your last appraisal/revalidation, have there been any disciplinary actions taken against you by your employer or your contractor – either in the UK or outside - that have been upheld:

Yes ☐ No ☐

If yes, please give brief details:.....

.....

.....

.....

6. Since your last appraisal/revalidation, has your employment or contract ever been terminated or suspended – in the UK or abroad - on grounds relating to your fitness to practise (conduct, performance or health):

Yes ☐ No ☐

If yes, please give details:.....

.....

.....

.....

[1]If this is your first appraisal and you have not yet gone through the process of revalidation then please fill in the pro-forma answering the questions as they apply to you at the current time.

Section 3(G)

Good Medical Practice: Health

Procedure

1. The Annex below reproduces a pro-forma which the GMC has developed as part of the work to provide tools to support revalidation. This pro-forma is in draft format and is therefore subject to change. We will publish the finalised version on our website: www.gmc-uk.org. This pro-forma may be freely reproduced, and can be used in appraisal.

2. For revalidation purposes, it will be suitable to provide a declaration about your personal health in matters which might affect your fitness to practice medicine. However you may present evidence of your health in some other way, if you so wish. You must ensure that you disclose information that relates to your health over the whole of your current appraisal/revalidation cycle.

3. The GMC retains the right to ask for additional information if it is considered that the information presented for revalidation is insufficient. If you use other products or formats which have not been tested by the GMC this could increase the chance that you will be asked for additional information and/or evidence.

Guidance

4. Paragraphs 59 to 60 of *Good Medical Practice* set out some of the health obligations that you should consider when signing a declaration. There are other types of obligations/information that you should also consider for example whether there are any formal or voluntary restrictions to your practice because of illness or a physical condition. This would include any conditions imposed by an employer or contractor of your services, any proceedings under the GMC's Health Procedures or Health Committee or similar proceedings of other professional regulatory or licensing bodies within the UK or abroad.

   The extract below is taken in full from the GMC's guidance *Good Medical Practice*

'Health

If your health may put patients at risk

59. If you know that you have a serious condition which you could pass on to patients, or that your judgement or performance could be significantly affected by a condition or illness, or its treatment, you must take and follow advice from a consultant in occupational health or another suitably qualified colleague on whether, and in what ways, you should modify your practice. Do not rely on your own assessment of the risk to patients.

If you think you have a serious condition which you could pass on to patients, you must have all the necessary tests and act on the advice given to you by a suitably qualified colleague about necessary treatment and/or modifications to your clinical practice.'

ANNEX

Health Declaration

Professional obligations

The GMC's guidance *Good Medical Practice* and *Serious communicable diseases* says that if a doctor has a serious condition which they could pass on to patients or colleagues they must have any necessary tests and act on the advice given to them by a suitably qualified colleague about necessary treatment and/or modifications to their clinical practice. Moreover, if their judgement or performance could be significantly affected by a condition, illness, physical disease or by taking medication, they must take and follow advice from a consultant in occupational health or another suitably qualified colleague on whether, and in what ways they should modify their practice.

I accept the professional obligations placed upon me in paragraphs 59 to 60 of *Good Medical Practice* and *Serious communicable diseases.*

Signature..... Date.....

Name in capitals.....

GMC Registration Number.....

Regulatory and voluntary proceedings

Since my last appraisal/revalidation **I have not**, in the UK or outside:

Been the subject of any health proceedings by the GMC or other professional regulatory or licensing body.

Been the subject of medical supervision or restrictions (whether voluntary or otherwise) imposed by an employer or contractor resulting from any illness of physical condition.

Had a condition or illness, or taken medication which might affect my professional judgement or performance.

Signature..... Date.....

Name in capitals.....

GMC Registration Number.....

(Notes: If you are able to sign both of the above declarations then you do not need to complete the rest of the pro-forma below. However, if you are not able to sign both of the declarations above then you will need to complete the full pro-forma below.)

Health declaration pro-forma

Your own health

The GMC acknowledges that medicine can be a demanding profession and that doctors who become ill deserve help and support. Doctors also have to recognise that illness can impair their judgement and performance and thus put patients and colleagues at risk (this is particularly so in the case of psychiatric conditions, drug and alcohol abuse). The GMC therefore encourages doctors seek professional advice and consider whether, for health related reasons, they should modify their professional activities.

1. Do you have any illness or physical condition that has since your last appraisal/revalidation[1] resulted in your restricting or changing your professional activities?

Yes ☐ No ☐

If yes, please give details of the changes in your professional activities which it is - or was - necessary for you make:

_____

_____

_____

Regulatory and voluntary proceedings

2. Are you - or have you been since your last appraisal/revalidation been the subject of any proceedings under the GMC's Health Procedures or Health Committee or similar proceedings of other professional regulatory or licensing bodies within the UK or abroad?

Yes ☐ No ☐

If yes, please give details:

_____

_____

_____

ANNEX

3. Are you currently or since your last appraisal/revalidation been subject to medical supervision, voluntary or otherwise, and/or any restrictions voluntary or otherwise, imposed by your employer or contractor resulting from any illness or physical condition within the UK or abroad?

Yes ☐ No ☐

If yes, please give details:

_____

_____

_____

Have you reflected on the implications of your condition and or medication

and sought appropriate professional advice?

Yes ☐ No ☐

If yes, please give details:

_____

_____

_____

5. All the information in this declaration is true to the best of my knowledge.

Signature..... Date.....

Name in capitals.....

GMC Registration Number.....

[1]If this is your first appraisal and you have not yet gone through the process of revalidation then please fill in the pro-forma answering the questions as they apply to you at the current time.

Confidential

GP Scot 4a
GMC Summary of Interview
5 Year Overview

This sheet should be used to track how the five core categories of evidence are covered by appraisal over your five year revalidation period.

Appraisee's Name:	

Core Category of Evidence covered in Depth	**Appraisal Period in which covered:**
Prescribing	
Referrals & Peer Review	
Clinical Audit	
Significant Event Analysis	
Communication Skills	

Confidential

GP Scot 4b
GMC Summary of Interview

This sheet should be used to summarise the broad areas discussed with reference to the evidence reviewed at the appraisal interview and the categories of Good Medical Practice, excluding areas of confidentiality. ***Use a new*** **sheet for each appraisal period.**

Appraisee's Name:			
Appraisal Date:		**Revalidation Year No:**	

Good Clinical Care

Written Evidence (please tick):				Summary of Points Discussed:
Prescribing		Audit		
Referrals		SEA		

Maintaining Good Medical Practice

Written Evidence (please tick):		Summary of Points Discussed:
Personal Development Plan		
Review of Learning Activities		

Relationship with Patients

Written Evidence (please tick):		Summary of Points Discussed:
Communication Skills		
Complaints		

Working with Colleagues

Written Evidence (please tick):		Summary of Points Discussed:
Peer Review		

Teaching and Training Written Evidence (please tick):

Summary of Points Discussed:

Probity Area Covered (please tick):

Any Comments:

Health Area Covered (please tick):

Any Comments:

Signed .....
Appraiser
Date .....

Signed .....
Appraisee
Date .....

RCGP Initiatives

PA – Practice Accreditation

Practice Accreditation (PA) was introduced by RCGP Scotland in 1999 in partnership with SGPC and other primary care professionals. It's aim was to help practices meet the demands of the quality and clinical governance agenda. PA is set at a level which allows the primary care team to demonstrate that they have in place the essential elements to provide good general practice. In June 2000, PA was endorsed by the Clinical Standards Board for Scotland (reconstituted to NHS Quality Improvment Scotland- January 2003) as its recommended method of accrediting standards in general practice in Scotland.

QPA - Quality Practice Award

Quality Practice Award (QPA) was developed in Scotland and launched in 1997 as a UK-wide College initiative. Through collection of evidence against standards, general practices are awarded this quality marker. QPA is highly regarded and indicates a high standard of quality patient care, which is delivered by every member of the practice team.

MAP - Membership by Assessment

Membership by Assessment of Performance (MAP) was introduced in April 1999. This provides general practitioners, who have been in practice for at least five years and who are currently not members of the RCGP, the option to join through a route other than examination. The essence of MAP is that it assesses knowledge, skills and attitude through the end point of these attributes - the performance of the doctor in the surgery.

FBA - Fellowship by Assessment

Fellowship by Assessment (FBA) measures the highest standards of clinical care provided by individual members of the College. Any GP who has been a member of the College for five years continuously may undertake this assessment. FBA assesses all major domains of general practice through peer review, and measures patient care by a general practitioner in the setting of the practice.

Further information on the above initiatives is available from our website at www.rcgp-scotland.org.uk **or alternatively contact:** The Quality Department, Royal College of General Practitioners (Scotland), 25 Queen Street, Edinburgh EH2 1JX Tel: 0131 260 6800

E-mail:scottishc@rcgp.org.uk

RCGP Educational Tools

The Royal College of General Practitioners is a key provider and developer of educational initiatives designed to support general practitioners respond to their needs in relation to professional development. Two specific products that are of note are:

PEP-QB

PEP-QB, available on CD-Rom, offers 160 new multiple-choice questions covering the full range of clinical areas in general practice. Developed in 2002, it provides interactive self-assessment exercises with instant detailed feedback, including correct answers and recommended references for further reading. The results will provide good evidence to allow an accurate assessment of individual clinical learning needs.

This programme will allow you to:

- Evaluate your skill level to inform your own Personal Development Plan;
- Use a comparative scoring system to calculate your own actual scores against your own confidence ratings;
- Work at a time of your choosing and at your own pace.
- This product has been extensively tested and statistically validated to ensure your results will provide good evidence.

PEP-2000

PEP-2000 is a set of interactive self-assessment programmes available on 2 CD-Roms – CD1 Medical and CD2 Primary Care. Each CD contains a series of instructive programmes on a range of primary health care related subjects and has been designed to test knowledge, provide educational detail and information.

- Each programme consists of a set of Multiple Choice or Single Best Answer Questions and a series of Patient Management Problems, which can be completed at one sitting or separately, with the opportunity to choose which section to look at first. Answers are provided so that knowledge can be checked and verified.
- All the programmes can be used to identify educational strengths and weaknesses and can be used as a basis for small group discussions, and in all sorts of learning environments whether at home or in the practice.
- On completion of each programme, scores can be printed and used to inform personal development plans.
- All, except the "MRCGP programme", contain extensive feedback information which can be printed and retained for future reference and discussion.
- The Patient Management Problems especially can be a useful basis for lively debate between colleagues and for GP Registrar tutorials.

For purchase details or further information please contact: RCGP Scotland, 25 Queen Street, Edinburgh EH2 1JX Tel: 0131 260 6800 or visit our website at www.rcgp-scotland.org.uk

Learning Styles Questionnaire

The Honey & Mumford Learning Styles Questionnaire is a useful way to find out your preferred learning style. Knowledge of your learning style allows you to seek out learning experiences that are best suited to you. The questionnaire involves completing 80 simple statements with which you either agree or disagree. This takes about 10 – 15 minutes to complete. You then analyse your responses by using a grid and find out which of the four learning styles suits you best.

Descriptions of the four learning styles are given below:

Activists

Activists like to take direct action. They are enthusiastic and welcome new challenges and experiences. They are less interested in what has happened in the past or in putting things into a broader context. They are primarily interested in the here and now. They like to have a go, try things out and participate. They like to be the centre of attention.

So, in summary, Activists like:

- to think on their feet
- to have short sessions
- plenty of variety
- the opportunity to initiate
- to participate and have fun.

Reflectors

Reflectors like to think about things in detail before taking action. They take a thoughtful approach. They are good listeners and prefer to adopt a low profile. They are prepared to read and re-read and will welcome the opportunity to repeat a piece of learning.

So, in summary, Reflectors like:

- to think before acting
- thorough preparation
- to research and evaluate
- to make decisions in their own time
- to listen and observe.

Theorists

Theorists like to see how things fit into an overall pattern. They are logical and objective "systems" people who prefer a sequential approach to problems. They are analytical, pay great attention to detail and tend to be perfectionists.

So, in summary, Theorists like:

- concepts and models
- to see the overall picture
- to feel intellectually stretched
- structure and clear objectives
- logical presentation of ideas.

Pragmatists

Pragmatists like to see how things work in practice. They enjoy experimenting with new ideas. They are practical, down to earth and like to solve problems. They appreciate the opportunity to try out what they have learned/are learning.

So, in summary, Pragmatists like:

- to see the relevance of their work
- to gain practical advantage from learning
- credible role models
- proven techniques
- activities to be real.

If you wish to purchase the Honey and Mumford Learning Styles Questionnaire or get further details, this can be done by visiting the following website:

www.peterhoney.com

Audit

Audit Booklet:- Ideas for Audit

A practical guide to audit and significant event analysis for general practitioners.

For information on the above, please contact:-

NHS Education for Scotland
3rd Floor, 2 Central Quay
89 Hydepark Street
GLASGOW
G3 8BW

Tel: 0141 223 1463
Fax: 0141 223 1480

Email: Paul.Bowie@nes.scot.nhs.uk

CELT (Computerised Evaluative Learning Tool)

This is a computerised tool that can help you with the learning activity section (3B1) and Significant Event Analysis

REFERENCE

Kelly D R & MacKay L. (2003) CELT: a computerised evaluative learning tool for continuing professional development. Medical Education: 37: 358-367.

For further information on the above, please contact:-

NHS Education for Scotland
3rd Floor, 2 Central Quay
89 Hydepark Street
GLASGOW
G3 8BW

Tel: 0141 223 1473
Fax: 0141 223 1480

Email: Marion.Howat@nes.scot.nhs.uk

Learning Needs Matrix

You may use this form when preparing for your appraisal interview to help identify areas in which you have learning needs.

Appraisee's Name:		**Appraisal period:**	
Cipher No:		**LHCC (if applicable):**	

Clinical Skills

		Priority (A, B or C)	Learning Objective	Learning Method
A	General Medicine			
B	Elderly Medicine			
C	Surgery			
D	Paediatrics			
E	Obstetrics / Gynaecology			
F	Psychiatry			
G	ENT			
H	Dermatology			
I	Ophthalmology			
J	Palliative Care			
K	Orthopaedics/ Rheumatology			
L	A & E			
M	Prescribing Therapeutics			
N	I M & T			
O	Complementary Medicine			

		Priority (A, B or C)	Learning Objective	Learning Method
P	Consulting Skills			
Q	Communication Skills			
R	Teaching Skills			
	Other			

Teamwork Skills

		Priority (A, B or C)	Learning Objective	Learning Method
S	Practice / Organisation Working			
T	NHS Organisation Working			
U	Working with colleagues			
V	Research Skills			
W	Other			

Support Needs

Enter in priority boxes (blank if no need)
A = Urgent (i.e. must do within next twelve months; priority need within 1 year)
B = Important (i.e. should do within next twelve months)
C = Could address (i.e. could do within the next twelve months)

		Priority	Details
Premises	Space		
	Consulting Rooms		
	Branch Surgeries		
	Equipment		
People	Partners		
	Practice Manager		
	Attached Staff		
Relationships	Partners		
	Practice Manager		
	Practice Staff		
	LHCC		
	Primary Care Trust		
	Health Board		
Resources	Investment in Practice		
	Time		
	Training Funding		
Health	Physical Health		
	Mental Health		
	Stress		
Personal	Career Advice		
	Counselling Advice		
	Financial Advice		
	Superannuation Advice		
	Retiral Advice		
Other			

Appraiser

Signed: _____

Date: _____

Appraisee

Signed: _____

Date: _____