TOOLS FOR GP APPRAISAL

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Tools for GP appraisal

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Comments about this guide are gratefully received. Please email the author at pfwright@doctors.org.uk

INTRODUCTION

This guide aims to help GPs prepare for appraisal in a way which anticipates some of the requirements of revalidation but more importantly may help to ensure that the appraisal meeting itself is a as fruitful as possible. It was originally produced in 2003 as appraisal was being introduced for sessional GPs and with them specifically in mind, however as it has proved useful to many non-sessional GPs it has been updated and reprinted many times (in A5 booklet form) taking on board the constantly changing influences on appraisal and the plans for revalidation.
Whilst there are many many useful sources of information on appraisal the idea of this book was a one-stop-shop resources collating widely accepted tools which are in the public domain.
For this 2008 I am particularly indebted to Di Jelley for producing very digestible summaries of the White Paper which I have adapted for this edition.

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Summary of Appraisal:

1) Appraisal has become an annual requirement for all doctors and is a condition of inclusion on GP performers' lists.
2) The aims of Appraisal are to:
    i) Help Consolidate And Improve On Individual GP's Good Performance
    ii) Identify Areas Where Further Development Might Be Necessary
    iii) Set Out Personal And Professional Development Needs
    iv) Develop And Maintain A Personal Development Plan (PDP)
3) It is a developmental and formative process to help doctors improve their practice.
4) It is confidential between appraisee and appraiser, although an agreed summary (form 4) must be submitted to the PCT's clinical governance lead.
5) Appraisers must be properly trained to understand the roles and responsibilities of different groups of sessional GPs.
6) Appraisees, should have a choice of appraiser to ensure that the appraiser has appropriate understanding of the working environment of the appraisee.
7) Appraisees should be given 2 month's notice of the date of their Appraisal and should submit forms 2 and 3 and their evidence in support of Appraisal to their appraiser 2 weeks before the date of the Appraisal.
8) All GPs can expect protected time in which to prepare and undergo Appraisal whether they are self-employed (partners or locums) or employed. Protected time is given by means of funding which for GP who are practice based will pass into the practice global Sum. Locums appraisee still receive discrete payments for each appraisal.
9) Outcome: appraiser and appraisee agree a written overview of the appraisal interview (FORM4) including the PDP for the following year, actions expected of the PCT, and a joint declaration that the appraisal has been carried out properly.
10) The appraiser and appraisee should arrange to review progress at least once later in the year. This can be done by telephone.
11) Each PCT has a procedure for dealing with grievances regarding the implementation of its appraisal system..

So where do I start ?

1) Read the Department of Health Appraisal forms (at the back of this document): these form the basis of your appraisal. A set adapted for sessional GPs is due out later this year and will be available on: http://www.doh.gov.uk/gpappraisal/index.htm. The PCT folders referred to above include worked examples of the appraisal form 3. We plan to include a worked example relevant to NPs in the second edition of this document.
2) Read *Good Medical Practice* (GMC) on which the forms are based (you can also get it from the GMC website) and *Good Medical Practice for General Practitioners (*RCGP & GPC) (http://www.rcgp.org.uk/rcgp/corporate/position/good_med_prac/index.asp).
3) Start to think about and prepare your PDP: Some of the tools in this pack can be used to start identifying the learning needs which you include in your PDP. Discuss your PDP with a GP tutor (listed in this pack), mentor, educational supervisor, peers or anyone else who you turn to for guidance.
4) Have a look through the different tools which you can use to collect evidence in support of your Appraisal: start to log as many relevant experiences as you can in each of the different tools (reflective diary, educational events, logs, etc).
5) Visit the electronic appraisal toolkit site and find out whether you feel this will be a useful way of recording information http://www.appraisals.nhs.uk
6) Contact your PCT (an updated list of contacts can be found on the nelg website www.nelg.org.uk):
   a) to obtain their Appraisal folder (see also the NELG website where you can download 3 PCT produced appraisal folders). These folders have worked examples of the appraisal forms.
   b) to obtain their list of trained appraisers (you may wish to ask which ones have experience of working as sessional GPs)
7) to find out how you access training to become an appraiser
8) If you are a salaried :
   a) decide whether you wish to be appraised in house (by a GP trainer to appraise you within your practice) or by an external appraiser (provided by the PCT).
   b) Discuss with your practice manager an appropriate time to take " time out" or protected time (2 sessions) from your working week for preparation and undergoing appraisal.

(Principals receive payment to allow them to take this time out to prepare for their appraisal.)

9) Arrange an appropriate date for your appraisal between yourself and your appraiser.
10) Visit the websites listed later in this document to find out more about Appraisal and to try out the electronic NHS Appraisal toolkit.

The appraisal Toolkit.

This website provides a variety of tools for keeping track of evidence which you can revisit on a regular basis to add to throughout the year. It also allows you to complete your appraisal forms (Form2,3 and PDP) online and edit them until the folder is finally "signed off" for your appraiser to view online.

Even if you do not wish to carry out your appraisal entirely electronically it is extremely useful to use the tools in this to keep track of :

1) PUNS and DENS (patient's unmet needs, doctors educational needs)
2) Educational activities and reflections- in a diary form
3) Significant events

It also has a range of useful features:

- a facility for allowing items which are common year on year (like employment history to be carried over to the next year).
- Automatically produced overview/summary of form3
- Documents can be uploaded (e.g. SEAs, reports etc)
- Can be accessed from a variety of sites allowing constant updating.

As a minimum and to help you prepare a well organized and clearly presented appraisal folder you should consider completing your forms and the above sections through the toolkit and printing them off for your appraisal folder.

Appraisal and sessional GPs - ScHARR report.

The Department of Health commissioned the Sheffield's School of Health and Related Research to produce a report on extending GP appraisal to sessional GPs. Here are a few key points of this report.

The GP appraisal scheme can be extended to sessional GPs and in so doing it is important that this group of doctors is not disadvantaged, that is like principals they should have:

1) a choice of appraiser,
2) protected (i.e. funded) time to undergo appraisal,
3) the same developmental and educational opportunities and
4) the opportunity to become appraisers if they wish.

Responsibilities of PCTs:

To ensure Sessional GPs on their supplementary lists are appraised.

To fund appraisees either directly (to locums or salaried GPs appraised outside working hours) or indirectly (locum costs to employers if appraisal is carried out during working time).

Ensuring that sessional GPs have access to the same information, education and developmental opportunities provided to other GPs working in their patch.

To encourage practices to have a positive approach to locums supporting them in their preparation for appraisal and providing them with the necessary support to help them perform well e.g. induction packs

Responsibilities of Sessional GPs:

1) To keep up to date (knowledge and skills)
2) To participate fully in appraisal
3) To reflect, set objectives and work towards them (PDP cycle)

Responsibilities of practices

1) To involve NPs in practice meetings and discussions (e.g. education, significant event audit etc)
2) To facilitate access of NPs to professional materials (journals) and patient data (to allow follow through and audit)
3) Support steps NPs might take to learn the views of patients and colleagues

4) Ensure that principals are available for handover discussions, and generally for clinical communication and exchange
5) To provide sessional GPs and locums in particular with induction packs

Who should appraise sessional GPs

Other GPs !

“Appraiser should have a confident understanding of sessional GP work”

Sessional GPs should have the opportunity to train and work as appraisers – thus increasing the variety of profiles of appraisers and giving appraisees more choice.

Evidence for appraisal

Some forms of evidence hard to collect (longitudinal outcomes audit, prescribing data), many tools are equally applicable by principals and sessional GPs thought more administrative support may be available to principals in data collection.

Revalidation and Appraisal

As laid out in the White Paper "*Medical revalidation- The next steps"* ; CMO July 2008
(adapted from a summary by Dr Di Jelley deanery appraisal lead)

The components of revalidation
Revalidation will have two components

- **Re-licensing** –successful completion of annual appraisal, periodic external multi-source feedback and a 'sign-off" by the Primary Care Organisation that there are no concerns about this GP.
- **Re-certification**-specification of clear standards by each Royal College, and evaluation of specialist practice against these standards

Appraisal
Appraisal, and the evidence submitted to support it, will be central to both these processes.
The aim is that the appraisal process will retain a predominantly formative emphasis, with a new the core GMC module supporting appraisees to provide the evidence of their fitness to practise required for revalidation. This module -*Good Medical Practice*- will be used in every appraisal scheme.
The GMC appraisal module has four domains:

- knowledge, skills and performance
- safety and quality
- communication , partnership and teamwork
- maintaining trust

The module will set out the types of evidence to be submitted for each of these (eg; audit , case reviews , complaints, significant event reviews, PDP review, multi source feedback etc). Appraisers will be required to make a judgements on whether their appraisee has successfully presented the agreed evidence to support appraisal, engaged in the appraisal process and produced a PDP relevant to their learning needs- i.e. that the appraisee is progressing satisfactorily towards revalidation.

Re-certification
Re-certification will provide reassurance that doctors possess the skills and competencies appropriate to their specialist area. Standards for re-certification will be broadly those required for initial entry to that speciality, but but evidence required for this will be gathered over the whole five year cycle not on a single 'big day' of assessment.

The RCGP 'credit-based' system for CPD.
Each GP will develop their own 'portfolio of learning', comprising a minimum of 50 CPD credits per year, and 250 over a five year cycle. Credits will be allocated to a wide range of CPD activities (eg: attending meetings or courses, doing audits or case reviews, internet learning modules etc), with a strong emphasis on reflection and changing practice where this is indicated. The 'credit value' of an activity will be initially judged by the learner (and subsequently checked by the appraiser at appraisal) and should reflect the degree of **challenge** it represents and the **impact** it has on personal development and patient care.
This system is to be piloted from October 2008 –the Northern Deanery is one of the pilot sites.

Local clinical governance systems.
These use a wide range of routinely available information to ensure the quality of the services provided by the clinical staff they employ are recognised by the GMC to be the key to robust revalidation. The local ***'responsible officer'*** [usually the medical director] will also ensure that appraisals are carried out to a good standard, work with doctors to address any shortfalls, ensure any concerns have been addressed, and collate this information to support the recommendation of revalidation for each individual doctor to the GMC on a five yearly basis.
Robust local performance review systems must be able to detect any concerns at an early stage, and take effective action to respond to any impaired practice.

The RCGP Credit based system for Continuing Professional Development in preparation for Re-certification.

This is based on the RCGP paper on this subject. To read the full paper visit the RCGP website. The paper states that:

"CPD is a continuing learning process that supports GPs to stay up to date and maintain and improve their standards across all areas of their practice and career development. CPD encourages and supports specific changes in the quality and delivery of a doctor's practice from professional, patient and service requirement perspectives."

"CPD includes any educational or professional activity directed towards developing the knowledge, skills, attitudes and personal effectiveness necessary to improve practice.[1] CPD may also include the impact seen on others (through teaching or dissemination of information) and the impact seen on systems (e.g. project work or implementation of guidelines etc.) Professional expertise demands a continuing awareness of new concepts, values and technologies It is important for doctors to update themselves not only on the evidence base, but also on opinion and consensus. Equally they must be aware of local needs. The ultimate aim of CPD is to support doctors to improve

the care they provide to patients through their own personal development. "

"The four domains of Good Medical Practice[1] and the core curriculum statement Being a General Practitioner[2] for GP specialty training will form a basis against which the balance of successive CPD portfolio contents over a 5 year revalidation cycle may be judged. The accreditation framework for CPD will help practising GPs fulfil the requirements of the forthcoming revalidation process for all GPs."

The number of credits claimed by an individual for an activity will be self assessed and then verified and signed off by the appraiser.

The completed CPD folder should reflect the range and circumstances of an individual GP's practice with reference to *Good Medical Practice for General Practitioners* and *Being a General Practitioner. A* narrow range of activity focused on interest is not acceptable and should be identified and addressed at appraisal.

The ***quality, quantity and diversity*** of GPs evidence will need to be addressed through quality assurance systems. *Principles of GP*

1. General Medical Council. *Good Medical Practice:* London: November 2006
2. Royal College of General Practitioners. *Being a General Practitioner:* RCGP; January 2007

Appraisal[3] and *Developing guidance of the PDP*[4] describe the criteria that should be applied.

Appendix 1: Impact and Challenge Model of Credits for Piloting

For the purposes of the pilot the following definition of a credit will be used

A credit is a unit of professional development which is a product of the impact of a developmental activity and to a lesser extent the challenge involved in its completion.

Impact in this context may include

- Impact on the individual (personal development)
- Impact on service (e.g. becoming a training practice, teaching others, implementing a clinic system)
- Impact on patients (e.g. a change in practice, initiating a new drug – this has obvious overlaps with personal development)

Challenge in this context may be

3. Sparrow N et al. *Principles of GP Appraisal*. London: RCGP Council; February 2008

4. Rughani A, Field N, Holmes S, Howard J, Lane P. *Developing guidance of the PDP*. London: RCGP Professional Development Board; 2007

- Context related (e.g. more challenging to become a new training practice than a trainer in an established training practice)
- Related to circumstances (e.g. a sessional GP undertaking audit is often faced with problems around the data and follow up)
- Related to personal ability (e.g. personal disability, prior skills, prior experience etc.)
- Related to effort expended (e.g. attending an ophthalmology clinic for a whole day 40 miles away to gain experience)

Guidance on Allocation of Credits Table

Impact → / Challenge ↓	Low	Minor	Moderate	Significant	High
Low	1-2 Credits Example 1	2-4 Credits	3-5 Credits	4-8 Credits	5-10 + Credits
Minor	1-3 Credits	2-4 Example 2	3-7	5-10	6-12 + Credits
Moderate	2-4 Credits	3-6	4-8 Example 3	6-12 Example 4	8-15 + Credits
Significant	3-5 Credits	4-7	5-11	7-15 +	10-20 + Credits
High	4-6 Credits	5-10	6-14 +	10-20 +	20 Credits + Example 5

RCGP proposals on revalidation: consultation document December 2008 (evidence)

The evidence for revalidation –summary from Professor Mike Pringle RCGP proposals –now out for consultation	
Number	**Core evidence**
1	Describe the core roles you undertake
2	Describe any exceptional circumstances over the five year period-eg sick leave ,sabbatical, career break
3	Evidence of active and effective participation in the appraisal process every year for 5 years [apart from exceptional circumstances see 2 above]
4	PDP for each appraisal year, agreed by your appraiser
5	Analysis of each completed PDP indicating aims that have been achieved with outcomes, and reasons for non-achievement of any PDP aims
6	A minimum of 250 CPD credits over 5 year period –initially self-assessed then agreed and signed off by your appraiser at each appraisal
7	Results of at least two MSF in 5 year period with evidence of reflection and discussion with your appraiser
8	Results of at least two personalised patient feedback surveys in 5 year period, with evidence of reflection and discussion with your appraiser
9	Analysis of all formal complaints in which you have been directly involved , with evidence of discussion of lessons learned and changes made as appropriate
10	A minimum of 5 SEAs over the five year period with evidence that these have been discussed and lessons learned, changes made
11	Audit of your care in two significant areas of your clinical care over the five year period, including standards set, data collected, changes put in place and data collected again
12	Probity and health declarations including medical indemnity cover and registration with a GP for own health care
	Special roles eg trainer/undergraduate teacher, appraiser GPwSI

	researcher-all roles require evidence that skills in specialist are regularly updated and reviewed

Specific challenges for sessional GPs

EVIDENCE

Sessional GPs (and locums specially) face particular difficulties in collecting what is traditionally known as audit data:

1) geographical mobility means that they may never accumulate a significant dataset in one practice to be able to compare their performance with the norm for that population (the data of the other partners in the practice or other sessional GPs in the practice).
2) Short term placements mean that locums are neither in a position to institute nor to follow through changes arising from audit findings.
3) Not having a Prescribing number means that prescribing analysis is much more difficult. Salaried GPs can now have a prescribing number and should request one from their practice and PCT.
4) Their paid time is generally allocated 100% to patient contact- all reflective/ audit/analytical work would have to be done at the cost of giving up work time.
5) They often receive no help from administrative staff with audit /data collection and analysis.
6) Locums are usually excluded from training in computer clinical systems (EMIS, MEDITEL) etc.

Principals are in a strong position to collect evidence about their practice because they routinely collect a lot of data through their employed administrative staff although this often may reflect activity but not necessarily quality. Administrative staff also play a major role in doing clinical audit for principals. Often it is not individualized to one doctor.

As practices become paperlight or paperless it may become easier for sessional GPs to carry out quantitative audit with minimal administrative support (as they often do not have the benefit of the latter). Thus if their computer skills are good and their entries Read-coded it may be possible to easily audit referral patterns, use of investigations, record keeping, continuity of care, prescribing, admission rates etc. This may well also influence the way locums choose where they work. Furthermore if sessional GPs have a unique personal login and password when using clinical systems it should be possible with the help of a practice

manager to request prescribing analysis data under the same parameters as that produced for principals (e.g. PACT data, or data for local prescribing incentive schemes). It is hoped the NPs will each soon have a unique prescribing number which will make analysis of prescribing data easier if not automatic.

However there are many "tools" around which can be used to help locums reflect on the quality of their work and which may not be considered to be in the traditional audit format: e.g. reflective diaries, etc. This is discussed in detail in section on “Educational tools and their applications”.

PROTECTED TIME

Like principals, sessional GPs should have protected time to prepare for and undergo Appraisal. Most PCTs base remuneration for time taken on Appraisal on 2 sessions regardless of the number of hours the principal works. Salaried GPs should have the same protected time for Appraisal (also regardless of the hours they work). For locums protected time means time out from work and consequently loss of earnings. PCTs will need to consider remunerating sessional GPs on the same basis as principals.

Employed sessional GPs should be aware of the distinction between Appraisal for Revalidation and in house Appraisal as part of one's terms of employment (also sometimes known as performance review). An employed GP may be required by their contract of employment to undergo an "in house" appraisal by an employing partner, in the sense of performance review. This is distinct from the Appraisal system being introduced currently and which is linked to Revalidation. National guidance for the latter clearly states that there should be a choice of appraiser (whether you are a principal or sessional GP) and for an employed GP this means the option of appraisal "in house" or by an external PCT appraiser. Where possible there should be a choice of an appraiser who is a sessional GP. Your PCT should be able to provide you with a list of trained appraisers for you to choose from.

BECOMING AN APPRAISER

Sessional GPs should have the same opportunities to become appraisers as principals. If you wish to become an appraiser contact your PCT to find out how to get on a course to be trained as an appraiser. Training is done at Close House run by the Postgraduate Institute of Medicine and Dentistry and places are

paid by PCTs so you may need to have your name put forward by your PCT.

Completing Form 3

In order to get the most out of your appraisal it is important to have a systematic approach to completing form3. This document comprises the main ***reflective*** part of your appraisal folder and the following are important components:

1. Factual statement about role (and changes) and working circumstances
2. Reflective Statements about performance showing insight into level of competence and areas of weakness, and factors which influence these.
3. Factual Statements about personal performance explicitly supported by evidence
4. Progress against last years “actions”.
5. Progress against last years “PDP aims”
6. Intentions for development linked to reflections on performance

Maintaining Good medical practice

This section relates mainly to how you keep up to date and is the section in which you discuss your education, achievement of last years PDP aims and what you have set out to do in next years PDP. The following should be considered:

1. How were learning needs identified
2. Why were these learning activities chosen ?
3. Awareness of benefits of different learning methods
4. Mixture of learning methods (SD, group, on line, PCT, lecture, etc)
5. What reflection has taken place

Websites

Department of Health Webpage on Appraisal-
http://www.doh.gov.uk/gpappraisal/index.htm

The Appraisal Toolkit is a web based toolkit for preparing your evidence and forms for Appraisal. It contains a variety of useful tools. http://www.appraisals.nhs.uk

NHS Clinical Governance Support Team
Detailed guidance on the appraisal process is also provided by the NHS Clinical Governance Support Team, at www.appraisalsupport.nhs.uk

NASGP- national association of sessional GPs- lots of useful information tool and documents and links to local sessional GP groups www.nanp.org.uk

London Deanery- Tools for Appraisal-
http://www.londondeanery.ac.uk/gp/pdpresources/home.htm
Many of the tools in this pack are from this site.

Postgraduate Institute of Medicine and Dentistry
http://www.campus.ncl.ac.uk/pimd/gp/CONTED/PDP/HOME.HTM
webpage maintained by GP Tutor for Sessional GPs Janette Foo.

North-east Employed and Locum GPs (NELG) Group :
www.nelg.org.uk.

Useful reading:

The Good appraisal Toolkit- Chambers, Tavabie, Mohana, Wakley
The appraiser's Handbook Nick Lyons, Susanne Caesar, Abayomi McEwen.

EVIDENCE

General principles

There are many ways to collect evidence for appraisal and the challenge is to find one that is relevant to the way you work and also meets the requirements of appraisal. The tools provided in appraisal folders of 3 Tyne and Wear PCTs were adapted for this section. It also includes tools from the London Deanery website in some cases adapted also. Some of the tools can also be used to identify the learning needs on which you can base your Personal Development Plan. Please note this is not an "evidence based" subject !

The ScHARR reports states:
“It is not expected that you will provide exhaustive detail about your work. But the material should convey the important facts, themes or issues, and reflect the full span of your work as a doctor within and outside the NHS. …You are invited to submit documents in support of what you say in the form. You are not expected to prove your assertions about your work…”

"The appraisal process itself will not result in the generation of significant amounts of new evidence or informatuon. Rather it will capture information that already exists.”

The following sections are **original**:
1) The audit section
2) Table "Educational Tools and their applications"
3) Mapping evidence to appraisal form
4) Feedback form from practice

How to introduce meaningful evidence into appraisal.

Ideally evidence should be
1. Relevant to the doctor’s individual work (not just practice work)
2. Relevant to patient outcomes (not just process measures)
3. Objective/ Verifiable

4. Using a Validated tool for which there are benchmarks (performance measures for comparison with peer group)

Unfortunately there is a natural tension between these attributes. The more standardized the data the less it has to do with an individual's practice e.g. QOF reflects the collective efforts of the team not an individual who can be under-performing without affecting general scores, PACT data is also widely available but is heavily influenced by repeat prescribing and most GPs will sign repeat scripts for medicines they did not initiate. The more individual the data, the harder it is to separate personal performance from other confounding factors (e.g. does one doctor see more elderly, females, children, ethnic minorities, etc).

The issue is also complicated by the fact that most clinical care in general practice is delivered by teams NOT by individuals and therefore it is difficult to link clinical OUTCOME measures to PERSONAL PERFORMANCE. PROCESS MEASURES can be more easily audited in relation to an individual (e.g. BP monitoring, TSH monitoring etc.

<u>So how do we address this problem ?</u>

1. Aim for **personal evidence** (personal audit, GPAQ etc) not just practice aggregated data
2. **Personalize** the evidence where practice data used by indicating what your personal role was (e.g. were the COPD lead, did you implement a protocol on emergency contraception).
3. Include **personal reflection** on each item of evidence submitted

Reflection on evidence submitted

1. What does this evidence SAY ? (e.g. Prescribing data shows achievement of most targets except use of sedatives, and our use of combination analgesic is back below target generic).
2. What does it say ABOUT YOU ? In what way have you to contributed to the level of achievement demonstrated ? (e.g. I gave a talk to colleagues on pain management including costs which has had an impact on practice)
3. In what way will you alter you practice in response to the performance demonstrated ? (e.g. I have taken on the role of

lead for nursing home patients and need to approach the sedative prescribing issue systematically using the help of the pharmacist).

Checklist for appraisal:

1. Form 2,
2. Form3 making reference to what has been done to follow through last years Action and PDP aims.
3. Last years Form 4
4. Last years PDP
5. Evidence for each section
6. Index of contents or sections dividers
7. Draft PDP for next year

Educational tools and their relevance

(*) indicates examples included in this pack
(&) indicates can be used to assess educational needs for PDP
This is based on the information contained in the Appraisal forms but remember- this is not a science !

	Good clinical care	Maintaining Good Medical Practice	Relationships with patients	Relationships with colleagues	Teaching and research
Audit (&) (*)	✓				
Prescribing analyses (&)	✓				
Significant event audits (*) (&)	✓		✓	✓	
Complaints (*&)	✓		✓	✓	
Education Log (*)					
Reflective diary (*) (&)	✓	✓	✓	✓	
References	✓	✓	✓	✓	
Personal Development Plan (*)	✓	✓	✓	✓	
your practice development plan (if applicable)		✓			
educational log (*)		✓			
Membership of a sessional GPs group / group learning with colleagues		✓		✓	
Professional reading habits		✓			
PUNS and DENs. (&)		✓			
Appreciative feedback			✓		
patient survey data (*&)			✓		
protocols e.g. for handling informed consent in the practice(s) in which you work			✓		
Feedback from colleagues (&*)				✓	
Teaching log (*)					✓

Informal supervision or mentoring (&)					✓
Recorded feedback about teaching (&*)					✓

Checklist for Appraisal : Leicester NAPCE Statement

At the annual appraisal conference run by NAPCE (national association of primary care educators) and NCGST (national clinical governance support team) a statement regarding evidence for appraisal was produced.For the complete document visit **www.appraisals.support.nhs.uk**.

Below is checklist developed for use in conjunction with this statement.

Summary checklist of essential evidence for appraisal		
Item	Requirement	Present (tick)
Completion of new forms 1,2,3	Annual Legible Coherent Provided in good time	
Provision of on-going PDP, with clear description in Form 3 of degree of attainment.	Annual	
Last year's appraisal summary (Form 4)	Annual	
Case review structured reflective template (SRT)	2 annually	
Data collection/audit with SRT	1 annually	
Significant event SRT	1 annually	
SRT on last year's learning	Annual	
Patient survey SRT	Within past three years	
Complaint SRT(s) or declaration of no complaints	At least one annually	
Multi-source feedback SRT	Within past 3 years	
Full declaration of all other professional roles	Annual	
Other professional roles SRT	Annual	
Probity SRT	Annual	
Health SRT	Annual	

Mapping evidence across the sections of appraisal

Complete the first column with your evidence documents an tick the column relating to the section they support.

	GCC	MGMP	RP	RC	TT	R	M	P	H

Good Clinical Care (GGC), Maintaining Good Medical Practice (MGMP), Relationships with patients (RP), Relationships with colleagues (RC), Teaching and Training (TT), Research (R), Management (M), Probity (P), Health. (H)

North of Tyne –Minimum Dataset for Evidence for GP Appraisal

	Core- essential	Additional
GENERAL	Last years form 4. SRT = Structured Reflective Template from NAPCE Leicester Statement on evidence-now available on appraisal toolkit www.appraisals.nhs.uk Or via NCGST website www.apprasialsupport.nhs.uk	
Good Clinical Care	2 out of 3 of the following • Clinical audit (see detailed comments about audits in above section)+ Structured reflective template. • Significant event audit with action points/learning outcomes • Case review -Structured reflective template The audit and SEA must relate to an area of clinical practice in which the appraisee has a personal role, has had personal involvement in discussing or which impacts on the appraisee work (to be clarified in the SRT).	QoF PACT data Practice protocols.
Maintaining Good medical practice	All of the following 1. Last years PDP with evidence (or reflections) about completion of aims 2. Certificates of CPR (18months) and child protection training (3 yearly). 3. log or diary of Educational activities throughout including reflections, personal learning points	Puns and DENS certificates of attendance/On-line module certificates personal notes from events
Relationships with patients	• Once every 3 years- Patient survey including mean scores for each question allowing comparison with national benchmarks and Structured Reflective Template • Annually -Declaration of complaints including learning points and SRT	Skills refresher training-evidence video consultation analysis Practice policies on: Patient removal Consent, Chaperone
Relationships with Colleagues	Once every 3 years: Peer feedback or 360 feedback+ Structured reflective template	Written account of effective team working
Probity	Current GMC certificate and ONE of • Probity statement- Scottish Royal college of GP (revalidation toolkit document) • NAPCE Probity Structured reflective template	Practice policy on: handling of gifts from patients dealing with drug reps CRB clearance
Health	• NAPCE Health Structured reflective template OR • Health statement- Scottish Royal college of GP (revalidation toolkit document)	

Your form 3 should indicate:

1. What does it say **ABOUT YOU** ? In what way have you to contributed to the level of achievement demonstrated ? (e.g. I gave a talk to colleagues on pain management including costs which has had an impact on practice)
2. **In what way will you alter you practice in response to the performance** demonstrated ? (e.g. I have taken on the role of lead for nursing home patients and

need to approach the sedative prescribing issue systematically using the help of the pharmacist).

Audit

Audit is traditionally supposed to be part of a process of improvement: a standard of care is set and data is collected to assess how a clinician or practice performs against this standard. Subsequently changes are made and their outcome assessed by repeating the data collection. The standard can be to do with the process of care (e.g. how many diabetics have their BP measured or outcome of care (e.g. how many diabetics have their BP within a target range).

In order to be able to produce meaningful audit the following factors may come into play:

1. to be able to select groups of patients often by disease, by time frame, (e.g. seen between dates X and Y) and linked to the appraisee (e.g. seen by him/her).
2. Having time for access to records outside of booked surgeries and other clinical work (room availability can be a problem)
3. Being in a position to participate in improvements in practice
4. Being placed in a practice long enough to see the effects of actions on clinical outcomes and also long enough to see changes implemented

For obvious reasons all of these pose challenges for sessional GPs and specially for locums.

Data collection of a qualitative kind with the aim of improving patient care- might also be considered under the umbrella of audit for appraisal purposes. Looking at one's referrals to a particular specialty to find out key messages (about diagnostic, therapeutic or other aspects) would fall under this heading and would help inform one's Personal Development Plan.

As records become increasingly computerized, and as use of Read codes becomes more consistent, it should become much easier to select patient groups for audit with disease specific questions in mind. In paperlight practices audit can also be much easier as locums need not rely on staff to pull records for audit purposes. Thus simple audits (e.g. referral rates, admission rates) can be carried out where activities can be objectively measured and for the purpose of reflection and discussion be compared with that of peers just by going through surgeries on the computer.

Audits which can be carried out by Sessional GPs

There are some audits which can be done by sessional GPs who have not been fortunate to receive training in computer searches and using clinical systems for audit.

LONG TERM LOCUMS For locums placed more longer term (e.g. maternity locums) the possibilities are greater:
datasets can be based on problems or diseases (as well as timeframe and doctor) as should generate a reasonable size cohort e.g. prescribing in patients with cough.
The audit can address issues such as diagnostic accuracy and natural history because data can be collected longitudinally e.g. outcome of referrals to dermatology, number of cancer referrals which turned out to be cancers, fast track chest pain referrals which turned out to be angina.
EXAMPLES: Outcomes of admissions (NB visits have a higher admission rate than surgery consultations), Outcomes of referrals: diagnosis confirmed, treatment offered, learning points, appropriate speed (urgent versus non-urgent).

SHORT TERM LOCUMS. Locums who are only in a practice for a few days are limited to audits which are :

1. based on patients selected by timeframe and doctor (e.g. seen by Dr X on Y date); it is far harder to select by problem or disease as the dataset will be too small.
2. usually Process related and short time span e.g. did I measure BP and record smoking status in all "pill checks". (not longitudinal- cannot follow up outcomes)
3. based on reading through consultation records or analysing other events which occur frequently: e.g. tests, referrals, prescriptions, and comparing these with other partners.

EXAMPLES
Consultation records: Did I record: a problem heading, advice given, concerns of the patient safety-netting ? See example table below.
In what percentage of consultations did I: request investigations, make a referrals, prescribe (non-repeat), carry out a medication review. You can pick say 2 consecutive surgeries done by you and 2 done by another doctor in the same practice and compare rates.
Was prescribing performance comparable to partners as regards generic prescribing and other prescribing incentive targets.
In surgery telephone calls received and made. See details below.

Audit of quality of electronic data recorded during consultations:

Pick a set of 30 consultations done by yourself and also done by another doctor in the same practice on the same day. Tick each column in the table to reflect when the relevant data was recorded. Calculate percentages for each type of data (e.g. I recorded "advice" in 50% of consultations and Dr B recorded advice in 40% of consultations). Reading the other persons consultations after reading your own may generate as many ideas for improvements as the numerical data generated by the end. There will be cases where it may not be seem relevant to do any of these - boxes not ticked are not necessarily bad. Rates merely serve as a source of reflection about what and how information is recorded and how different doctors practice and how they can learn from each other. Doing this electronically it takes about 1 hour to look at 50 consultations.

PROBLEM: Was a Read coded problem recorded: this might indicate clear problem based or diagnostic thinking, awareness of use of Read codes for disease based audit and disease registers, and the benefits of linking the consultation to previous ones with the same problem ("review"). E.g. angina, weight loss, tired all the time

ADVICE: Advice given to patient: this is often a major outcome of a consultation and a legally important one too. E.g. "advised to report fit to DVLA"

ICE: Ideas (health beliefs), Concerns and expectations : this may reflect that the doctor has really got to the bottom of why the patient has come and may explain subsequent compliance or non-compliance with advice or treatment. E.g. "wants rash to be clear by the time he goes on holiday", "worried that anti-depressants will affect ability to concentrate at work"

SAFETY-NETTING or follow up : also shows ability to think care through (e.g. for febrile child "review if no better in 48 hours or earlier if any sinister symptoms or new concerns", e.g. "repeat Bpx3 with p nurse and if still high increase dose of ACEI",).

Education diary with reflections.

Date Duration	Topic (lecture, course, e-CME module)	Learning points Reflections Action for practice

RCGP CPD pilot credit form

-Standard credit claim form – blank to be filled in by appraisee prior to the appraisal interview and submitted with the other appraisal documentation

Appraisee name…….. Appraiser name…….. Interview Date…….

CPD Activity	Credits Self assessed	Short description of activity	Reference to evidence	PDP related (Y/N)	Learning outcome	Number of credits verified by appraiser- reasons for differences – impact or challenge or both

CPR credits –alternative table (PWright)

CPD Activity: including ref to evidence	Impact rating	Challenge rating	Credits Self assessed	Impact rating	Challenge rating	Number of credits verified by appraiser-

Clinical Queries

Keep brief notes of where you have had to learn on the job to deal with new problems. Write the question you had and how you found an answer (if there was one!)

Date Query/ Dilemma Diagnostic, therapeutic, communication, ethical, inter-professional, organizational	**Learning points** (inc Source of information) e.g. local, national guidance, journals, specialist advice, patient support groups.

Structured Case Review Template

(based on NAPCE- Leicester Statement on Evidence for appraisal)

GMC number
Patient identifier **Date**
Description of clinical event: (e.g. consultations in which you were personally involved)
Reflections relating *Good Clinical Care* (e.g. appropriate diagnosis, treatment, prescribing, availability of services and tests, referrals, clinical facilities) privacy, confidentiality
Reflections relating to *Maintaining Good Medical Practice* (knowledge and skills, unmet learning needs)
Reflections relating to *Relationships with Patients* (communication skills issues, privacy, confidentiality, access, time, shared decision making, emotions, conflict, chaperone, consent)
Reflections relating to *Relationships with Colleagues* (discussing difference in clinical approach, team working, handover, individual clinical judgment, explaining mistakes or errors made by others- “open disclosure”)
Outcome: Potential learning needs/ Actions.

Working with Patients: Patient Surveys

There are 2 validated patient surveys you can carry out:

1) GPAQ
2) IPQ

General Practice assessment questionnaire (GPAQ)

GPAQ : http://www.gpaq.info/

GPAQ is a patient questionnaire which has been developed at the National Primary Care Research and Development Centre in Manchester for the 2003 GP contract. Building on several years of development and testing, GPAQ helps practices find out what patients think about their care. It specifically focuses on aspects of general practice that are not covered elsewhere in the Quality and Outcomes Framework - for example, access, inter-personal aspects of care and continuity of care. GPAQ is free to use for practices and PCTs. It can either be administered by post, or after consultations in the surgery. On the website site http://www.gpaq.info/index.htm, you can find out conditions for use, how to get started, download the questionnaire and manual, order printed copies of the questionnaire, and find out how to produce reports. You will also be able to download software for more sophisticated analyses, and look up national benchmarks for GPAQ questions. Fifty responses (completed questionnaires) are required to provided meaningful individual results for doctor.

Analysis : An excel sheet can be downloaded to facilitate data entry and analysis free of charge. Alternatively you can get it analysed by a commercial survey company and a list of them is available on this page http://www.gpaq.info/GPAQ%20services.htm.
If you are practice based and salaried the practice should be able to help you get this done and will often have a contract with the PCT for the PCT to be able to analyse the survey.

The Improving Practice Questionnaire.

“Developed as a systematic **patient feedback tool**, the IPQ gives patients the chance to provide honest feedback about the care

they have received in surgery. Owned and administered solely by CFEP UK Surveys, the IPQ is **fully validated** and approved by nGMS for doctors and nurses. The questionnaire identifies strengths surrounding **interpersonal skills** and areas which could be targeted for **personal development**." (Quotes from CFEP website).
For a fee you can receive a comprehensive report. For more info go to IPQ at : http://www.cfep.co.uk/

Working with Colleagues: feedback

It is likely that “360 feedback” or “multi-source feedback” will become a requirement for revalidation and standardized tools are being developed.

General issues

The following are important:

1. The feedback exercise is initiated at the request of the appraisee and with their involvement and not done without his or her knowledge “by” others.
2. Anonymity of respondents – so responses should be collated by a third party.
3. Use of a validated tool
4. personal feedback of the results to the appraisee (i.e. via a trained individual not just a document or website).
5. feedback which is specific and constructed in terms of behaviours not a judgement of character.

Paper based tools:

- The Scottish revalidation toolkit has a useful 360 tool which can be printed off their website http://www.rcgp.org.uk/pdf/RCGPScotSection%203D(1)%20-%20Team%20Working.pdf

http://www.rcgp.org.uk/councils__faculties/rcgp_scotland/products__services/revalidation_materials.aspx

- The North Northumberland trainers group developed the STAR rating form for staff feedback which can be found on http://www.gp-training.net/training/tools/index.htm#assessment there is also a feedback form for GPs developed as part of the in-house appraisal system called P2D2 http://www.gp-training.net/cme/appraisal/toolkit/resources_and_tools.htm

Online tools:

There are a variety of web based feedback tools available.

1. The Colleague Feedback Evaluation Tool (CFET) is owned and administered solely by CFEP UK Surveys. You provide details of colleagues prepared to give feedback and you will

receive a comprehensive report including analysis of your scores against national **benchmarks**, and **self-assessment** comparisons. Reports do not identify any particular member of staff or organisation.http://www.cfep.co.uk/

2. Edgecumbe consulting: www.doctor360.co.uk ,
3. 360 clinical from St Thomas Hospital www.360clinical.com
4. Client Focused Education Program-designers of the DISQ patient survey which is being used in many PCTs www.projects.ex.ac.uk.cfep .
5. The Sheffield Children's hospital is also piloting a package which is mapped to GMP and is currently cheaper than the other commercial options http://www.hcat.nhs.uk/gpsprat

Multisource feedback (MSF) Team Assessment Behavior (TAB) http://www.mmc.nhs.uk/download_files/360-Team-Assessment-Behaviour-TAB-Form.doc

Feedback from practice on Locum

Dear
I would appreciate feedback about my performance during my time at this practice. I would be grateful if you would take a few minutes to fill in this form. Please tick as the boxes as appropriate; Comments and suggestions can be added at the end. You may tick more than one box. Thank you.

	Yes	Not applicable	See comments/ suggestions
Made appropriate clinical decisions			
Made appropriate follow up arrangements with patients (results of treatment failure)			
Prescribing appropriate			
Correct use of practice repeat prescribing systems			
Prescribed according to practice incentive scheme			
Records accurate, complete and contemporaneous			
Used in-practice services appropriately e.g. bloods, minor surgery dietician			
Made appropriate use of appointment system			
Made appropriate referrals to services outside practice (including protocols for urgent cancer referrals and fast tracks)			
Made appropriate use of practice staff/ PHC team members			
Feedback from patients has been positive.			
Communicated clearly and courteously with staff and clinicians			
Shared clinical problems when appropriate with other members of PHCT (including handovers)			
Responded promptly when appropriate to messages from staff and patients			
Communicated clearly with practice manager when arranging booking- re dates, fees workload.			
Worked to agreed workload, agreed dates , punctual,			
Acted on problems appropriately: missing results, violent patients, near misses.			

Item no	Suggestions or comments for reflection and improvement Please note the item number your comment relates. If necessary continue overleaf.

Colleague feedback on clinical cases.

Date _____
Dear _____

I would be very grateful if you could give me some feedback on my clinical work to help me reflect on and improve my performance. (If you want some tips on giving effective feedback please see the bottom of the attached form.)

I would like feedback on _____ (**number** of) consultations.

The way I would like consultations to be **selected** on this occasion is (subject of feedback please tick):

- consultations selected by **me** (listed below)
- consultations selected at **random** from a surgery selected by me (dates given below)
- consultations selected by **you** at random
- consultations selected by you **focusing** on the area I am looking to improve
- other (please explain) _____

Dates of surgeries	Numbers of consultations

The specific areas I would like feedback about are :

(e.g. record keeping, problem solving, use of investigations in house services or referrals etc)

At the end of this request letter is a table: please write your comments in this table. I would like to receive this feedback :

- just in written form
- in person with discussion in private by the following date (_____) ideally at one of these times _____.

Thank you very Much

Dr _____ Mobile number_____
Email _____ address
_____

Feedback about clinical cases- Form

Name of Doctor_____ Date_____
Names of person giving feedback_____

Date	Patient number	Comments

Effective feedback:

1. Keep it specific (dates, times, patient etc)
2. Focus on *behaviours* not judgements of character (what I am doing not who I am)
3. Choose the right time for giving and receiving the feedback
4. Gives equal measures of positive and negative feedback

Significant event / Patient Safety Incident

A patient safety incident (previous known as “significant event”) is an 'Any unintended or unexpected incident which could have or did lead to harm of one or more patients receiving NHS funded care'.

Each of these events is an opportunity to learn and prevent real catastrophes. Each actual episode of harm is the "tip of the iceberg" statistically speaking- there are many more "near misses" and even more systematic errors. By analysing each event it is possible to reflect on one’s own performance and that of one's organisation and to develop learning aims for oneself and one's organisation.

The following are examples of patient safety incidents, but the list is not exhaustive:

- patient sustaining an accident;
- error in treatment or clinical procedure;
- medication error;
- access, admission, transfer or discharge error;
- procedure undertaken by unqualified/untrained employee;
- lack of supplies;
- malfunctioning equipment;
- documentation error;
- error in clinical assessment;
- disruptive or aggressive behaviour by staff;
- inadequate consent, breach of confidentiality or mis-communication;
- self-harming behaviour;
- inadequate infection control;
- patient abuse (by staff or third party).

Causal analysis checklist (NPSA)

- Patient Condition : Personal issues, Treatment, History, Staff-patient relationship

- Individual (staff) Competence: Skills and Knowledge, Physical and mental stressors,

- Team: Verbal Communication, Written Communication, Supervision and seeking help, Congruence/consistency, Leadership and responsibility, Staff colleagues response to incidents

- Task: Availability and use of guidelines and protocols, Availability and accuracy of test results, Availability and use of decision-making aids, Task design

- Work environment: Administration systems design and operation, including notes/records; Building, including design for functionality, Environment, Equipment/supplies, Staffing availability, Education and Training, Workload/hours of work, Time factors

- Management and organisation : Leadership, Organisational structure, Policy, standards and goals, Risks imported/exported, Safety culture, Financial resources and constraints.

- Institutional context: Economic and regulatory context, Department of Health policy and requirements Clinical Negligence Scheme for Trusts requirements, Links with external organisations

To understand more about current guidance on reporting and learning from patient incidents the following is recommended: "Seven steps to patient safety: An overview for NHS staff". This can be downloaded from the National Patient Safety website.
http://www.npsa.nhs.uk/health/resources/7steps?contentId=2664

Significant event analysis-form

Date: _____
This is usually completed following a multidisciplinary discussion about an event. If this is not possible the exercise can be done as an individual reflective exercise.

1. What happened? How did it affect: The Patient? You? The practice?	
3. Why did it happen? See Root cause analysis on previous page.	
4. Steps to be taken to avoid similar events in future.	
5. Learning needs revealed by the event. How will these be met?	

(adapted from Tyne and Wear PCT folders (see nelg website for originals))
For more about significant events see http://www.npsa.nhs.uk/index.asp
And also the eCME module on this at www.doctors.org.uk (for members only- but all doctors are eligible to be members).

STRUCTURED REFLECTIVE TEMPLATES

NAPCE LEICESTER STATEMENT ON EVIDENCE FOR APPRAISAL.

The following **structured reflective** templates **(SRTs)** were developed at the NAPCE annual conference on appraisal (February 2007). They can be downloaded from the www.appraisalsupport.nhs.uk.

Guidance accompanying the SRTs.

Philosophy:

- Reflection is a mental process, not a writing exercise. The purpose of the forms is to help this mental process, and to show that you have made the effort.
- You will get more from the SRTs if you complete them ad hoc during the year. If you leave them all until the day before your appraisal, you will struggle to complete them in a useful way.
- If you are completing a SRT and find that you have no ideas about how you can improve things then say so on the form. Your appraiser can then talk this through with you.
- Be honest. If you are filling in a SRT and find yourself thinking “this is a waste of time”, then write “I am finding this a waste of time” on the form. You can then discuss this at your appraisal.

Data collection/audit structured reflective template.

(for an organisational Audit eg from QoF data)
Requirement: one annually

Name of doctor:
Measurement/audit title: Date of data collection/audit:
Reason for choice of measurement/audit:
Audit findings:
Learning outcome and changes made: New audit target:
Final outcome after discussion at appraisal: (Complete at appraisal considering how your outcome will improve patient care)

Case review- structured reflective template

Requirement: two per year

Name of doctor:	GMC No:
Date of clinical event:	Patient Identifier:

Description of clinical event:

Hint: You may choose a single consultation at random, or you may prefer to choose a case in which you were involved over time. Either way, your involvement should have been significant. You should write from your personal perspective, and reflect on how your own professional behaviour can improve, not that of the organisation, or of others.

Reflections relating to **Good Clinical Care**:

Hints: This refers to the systems allowing effective care, and your place within them. Was all information to hand? Was there enough time for the consultation? Was the environment conducive to patient privacy and dignity? Were all required clinical facilities available? Were local guidelines available? What can I do to improve these factors?

Reflections relating to **Maintaining Good Medical Practice**

Hints: This refers to your level of knowledge. How do I judge my level of knowledge, or skill around this clinical topic? What unmet learning needs can I identify? How can I address them?

Reflections relating to **Relationships with Patients**

Hints: How well did I communicate with the patient? Did the patient feel respected? Did the patient have sufficient opportunity to tell their story? Did the patient feel a partner to the outcome of the consultation? How do I gauge these? What skills can I identify which will enhance these?

Reflections relating to **Relationships with Colleagues**

Hints: Did I take account of notes made by others prior to this event? Did I gather information appropriately from others? Did I make comprehensive, legible records for others who may see the patient subsequently? Did I appropriately respect the clinical approach of others, even if it differs from my own? What can I do to improve this area in the future?

Outcome: For completion at your appraisal:

Agreed potential learning needs for consideration for inclusion in your personal development plan, considering how your outcome will improve patient care.

Significant event audit (SEA) structured reflective template-

A personal SEA or if not available, a colleague's SEA you have discussed
Requirement: one annually

Name of doctor: GMC No:
SEA Title:
Date of incident:
Description of events:
What went well?
What could have been done better?
What changes have been agreed? Personally: For the team:
Final outcome after discussion at appraisal: (Complete at appraisal considering how your outcome will improve patient care)

Data collection/audit -structured reflective template.

on some personal data collection or audit
Requirement: one annually

Name of doctor:
Measurement/audit title: Date of data collection/audit:
Reason for choice of measurement/audit:
Audit findings:
Learning outcome and changes made: New audit target:
Final outcome after discussion at appraisal: (Complete at appraisal considering how your outcome will improve patient care)

Personal learning- structured reflective template

Requirement: annual

Name of doctor:
Considering my comments under *Maintaining Good Medical Practice* (in form 3 of my appraisal paperwork), the following strategies may help improve how I keep up to date in the next year: Date of reflection:
Final outcome after discussion at appraisal: (To complete at appraisal considering how your approach will improve patient care)

Patient or client survey structured reflective template

Requirement: One every three years.

Name of doctor:	GMC No:
Date of survey:	
Type of survey:	

What issues can I identify from the exercise?

Hints: Look at your positive findings just as carefully as the most negative. Discuss and seek advice from colleagues both peer and senior, if possible. If you have difficulty identifying learning needs from the survey, be frank about this. Skills in interpreting such information can then be considered as your first learning need in this regard.

What actions will I undertake?

Hints: These might include: improving communication techniques, restructuring ward rounds to maximise dignity and privacy, negotiating changes to the consulting environment, developing skills with respect to specific cohorts of patients, learning more about how to learn from patient surveys (as above).

Final outcome after discussion at appraisal:

(Complete at appraisal considering how your outcome will improve patient care)

Complaint report structured reflective template

Requirement: **one for each complaint** you have received.

Name of doctor: GMC No:
Date of complaint:
Nature of complaint:
Status of complaint: On-going / resolved
Involvement of other bodies: Responsible organisation / SHA / NCAA / GMC / Other
If resolved, what were the findings?
How will my practice change?
Final outcome after discussion at appraisal: (Complete at appraisal considering how your outcome will improve patient care)

Declaration of absence of complaints

Requirement: Complete annually in the absence of any complaints

Name of doctor:	GMC No:
I declare that, to the best of my knowledge, I have received no complaints relating to my professional practice since my last NHS Appraisal, on _____ (insert date of last appraisal). I enclose details of my local complaints procedure.	
Signed:	Date:

Multi-source feedback structured reflective template

Requirement: One every three years.

Name of doctor: GMC No:
Date of exercise:
Feedback scheme used (specify if self- or locally-designed):
Number of colleagues giving feedback:
Name of person who collated and gave feedback:
Designation of person giving feedback: (e.g. Clinical Director, Professional Partner, Appraiser; Professional Facilitator)
Main outcomes of feedback Hints: Look at your positive outcomes, as well as learning needs:
What learning might I undertake? Hint: It may help to separate learning from changing your behaviour. So, rather than "I will show more respect to nursing colleagues", it might be more productive to undertake learning which develops your understanding of the benefits of the diversity of teams. Your ideas in this section can be discussed further with your appraiser.
Final outcome after discussion at appraisal: (Complete at appraisal, considering how your outcome will improve patient care)

Other roles structured reflective template

Requirement: Complete annually

Name of doctor:
Considering my other clinical and non-clinical roles as listed in Form 2 of my appraisal paperwork, in the last year, these have brought the following benefits to my main clinical role:
They also brought the following drawbacks to my main clinical role:
I could consider the following actions, to maximise the benefits and minimise the drawbacks: Date of reflection:
Final outcome after discussion at appraisal: (Complete at appraisal considering how your approach will improve patient care)

Probity structured reflective template

Probity structured reflective template*
Name of doctor: GMC No:
The following are situations where issues of probity are common: Ethics of working with drug reps (All doctors) Ethics of referring to alternative practitioners (All doctors). How/whether to tell patients which local pharmacy to visit (Primary Care clinicians). Doctors receiving gifts from patients (All doctors). Teaching issues e.g. having school children doing work experience, how much responsibility to give medical students (All doctors). Conflicts when interests of the PCT/Trust (or wider NHS) conflict with what is best for individual patient care (All doctors). Partnership issues e.g. cheque signing, salaried versus profit sharing (Primary Care clinicians). Sickness certification (All doctors). Applying for research funding (All doctors). Colleagues who are ill, underperforming or negligent. Patients who divulge information challenging principles of confidentiality (e.g. epileptic who is driving). Select an instance from this list or otherwise, where there has been a dilemma in terms of probity in the last year.
Describe the dilemma:
What did I do?
What was good about the approach I took?
What could I have done to have produced a better outcome?
What changes will I make? Personally: For the team:
Final outcome after discussion at appraisal: (Complete at appraisal considering how your approach will improve patient care)

*Adapted from Whittet, Sally. *Health and probity in appraisal: what do you ask?* Available at: http://www.appraisalsupport.nhs.uk/files2/Health%20and%20Probity%20-%20Sally%20Whittet%20final%20pdf.pdf (accessed Feb 21, 2007)

Health structured reflective template

Requirement: complete annually

Name of doctor: GMC No:

The following are health issues which commonly apply to doctors:
• Are you registered with a GP?
• Have you attended your GP in the past year?
• Have you self-prescribed in the past year, or asked a colleague to prescribe?
• Have you bypassed the normal NHS referral process in the past year?
• Do you have a chronic illness?
• Are you in pain?
• Have you had a recent bereavement?
• Are you experiencing stress at work or elsewhere?
• What are your coping strategies for stress?
  ○ Do you actively self-care and consider work-life balance?
  ○ Do you have adequate holiday and study leave (and do you actually take this entitlement?)
  ○ What is your network of support at work and outside work? (Consider friends, colleagues, mentors, support groups)
• Are you concerned that you may have a dependency on alcohol or drugs?
• Are you involved in a complaint?
• Are you sleep-deprived?
Select an issue, from this list or otherwise, in terms of your health affecting your ability to provide clinical care in the last year.

What is/are the issues?
How have I approached this in the past?
What could I do in the next year to improve things?
Final outcome after discussion at appraisal: (Complete at appraisal considering how your approach will improve patient care)

*Adapted from Whittet, Sally. *Health and probity in appraisal: what do you ask?* Available at: http://www.appraisalsupport.nhs.uk/files2/Health%20and%20Probity%20-%20Sally%20Whittet%20final%20pdf.pdf (accessed Feb 21, 2007)

PDPS

How to write your personal development plan

The PDP sets personal development objectives for the following year based on personal learning needs, with dates for completion. It should encompass:

1) actions to maintain skills and the level of service to patients
2) actions to develop or acquire new skills
3) actions to change or improve existing practice.

STEP 1: WHERE am I now and what do I want to achieve? Reflect on your current strengths and weaknesses in skills, knowledge, attitudes. You can use reflective dairies, audit, PUNS and DENs, peer feedback for this.

STEP 2: Set out WHAT you are going to try and achieve (3-5 aims) over the year and set time-scales for achieving them.

STEP 3: HOW are your going to achieve your aims? Courses, experience, reading, audits, etc.

STEP 4 : Demonstrating achievement: The final step of the PDP is to demonstrate that some change has occurred as a result of you fulfilling the task you set out to do. This will not always be easy, and this should not put you off setting an objective which makes sense in terms of your day to day work and the patient's care.

DON'TS :
Let your PDP hold you back from taking on new objectives mid year.
Set yourself unachievable goals- you do not have to address ALL your weaknesses in one year.
Prepare it in isolation- get help from GP tutors and exchange ideas with your peers.

Attributes of a PDP

(South Yorkshire and Humberside Deanery model)

	Essential	Desirable
Learning/ development needs	The plan addresses at least 2 areas identified in the appraisal interview	All learning/development needs identified in the appraisal interview have been considered in the plan.
Development objectives	Objectives have been derived from the identified learning needs.	Objectives are specific, measurable, and realistic.
Achievement dates	Realistic timescales for achievement are recorded	
Activities to be used	Proposed activities are "fit for purpose" (for example, practical skills to be learned using a practical learning activity rather than solely through reading or non-interactive meetings).	The appraisee uses a range of different learning activities. Learning is reinforced using more than one activity for some of the objectives.
Outcomes or evidence	There is evidence of learning for each objective (notes made, protocols/guidelines, etc). The appraisee can describe changes made in their practice. The outcomes are relevant to improving patient care	There is evidence of change of practice (audits, PPA data, etc).
Evaluation	All sections of the evaluation form have been completed.	The evaluation informs the next PDP.