

Dear Appraisers and Doctors

This year we thought we would prepare a single document for us as appraisers and appraisees, guiding us through what is needed to have a successful appraisal and ultimately revalidate. The information is relatively lengthy but our aim is that it will support us through the process.

However for those of us who only read the front page, may we share some of our experience on how to meet the GMC requirements and how to avoid some common pitfalls? There is much more detail in the rest of the document that we may find useful to dip into as we need to.

1. Scope of practice

- We should all update our scope of practice annually and remember to add all the roles, paid or unpaid for which we need our licence to practice. We should submit at least one piece of evidence which relates to each of our roles during the five-year revalidation cycle.
- If we undertake minor surgery, we need to include detail of our activity, our complication rates and any CPD related to this activity. This needs to include any family planning procedures including fitting of intrauterine devices or systems and implants.

2. Evidence

- Our appraiser will first look for evidence that supports our revalidation recommendations (the summative bit) but will plan for our meeting to be formative and supportive.
- We are looking for evidence that is personal to us and demonstrates that we are up to date and fit to practice.
- We can try to select high quality evidence – quality is always preferred over quantity!
- We must avoid including any patient identifiable information and only include the names of colleagues if really appropriate.
- If we are practising as a GP, we should ensure we include evidence relating to our own clinical practice. The RCGP's recommendation of including 2 case reviews each year is still the gold standard as this is GPs' home territory and where we often light up! This is really helpful to our appraisers.

3. Reflection

- Let's remember to be reflective about our work – if we can express a degree of critical insight, it is a very reassuring sign in an appraisal document.

4. CPD

- The RCGP recommends gathering at least 50 credits a year. The doubling of credits by claiming impact is being phased out.

5. PDP

- We need to remember to propose some PDP activities to confirm with our appraiser.

6. Quality improvement activity

- The GMC says we MUST include evidence of a quality improvement activity every year.

7. Significant events

- Significant events have previously caused us some confusion but the definition has been clarified: only those incidents where serious harm could have or did come to a patient need to be recorded in this part of the portfolio.

8. Patient and colleague feedback

- These need to be externally collected and collated. We recommend we all use a recognised system such as Clarity, Edgecumbe or Equiniti so that our feedback is benchmarked against our peers, as this helps us interpret the outcome.

9. Declarations of complaints or performance issues

- Our appraisal is a powerful tool to demonstrate that we learn from reflection prompted by a complaint, whether we have made a mistake or not. Declaration can help support us if an issue of concern is identified, so we MUST include all complaints and any performance issues.

10. Health and Probity

- We shall be asked to make a declaration of our health and probity on the toolkit.

11. Timeliness

- And lastly, we do need to please submit our evidence to our appraiser in advance. This enables our appraiser to complete the summative part quickly and allows time for a formative conversation. With all the stresses we are currently facing as GPs, a good conversation about our professional life is more important than ever!
- Most of us will come up for our second revalidation recommendation in the next 5 years. This time all 5 appraisals will contribute to our RO's decision so it is important to ensure we have an annual appraisal or request an exemption if we have a valid reason not to have an appraisal.

All the best with our appraisals!

What is needed for your appraisal?

An appraiser's summary will address the four domains and 3 attributes under Good Medical Practice.¹ This brief paper tries to describe what appraisers are looking for in our appraisals. Hopefully it will help us complete our appraisals in a way that makes the process easier and less onerous.

1. Basic concept first

Appraisal is based on this process:

Activity → evidence → reflection → learning

The process of appraisal depends on us being able to:

1. Say what we have done – **activity**
2. Provide **evidence** for that activity in the form of documents or contemporaneous notes – notes may be entered in the relevant space on the toolkit and documents can be uploaded in the relevant part of the toolkit. It isn't essential to scan attendance certificates where we have clearly demonstrated our learning through a good reflective note
3. Record our **reflection** on the activity and how it affected us – some hints on reflection are provided below
4. Identify **learning** points from the activity and reflection that determine what changes or action we will take as a result

Reflection is when we look at an aspect of our practice to learn something from it. We sometimes think reflection is just a record of what happened, but we need to take that a step further and identify the learning from it. By doing this effectively in our appraisals, we should demonstrate that we have insight. Insight is the degree to which the choice and the outcome of our reflection is considered appropriate by our peers.

It is excellent evidence if we can recognise the potential gaps in our knowledge and skills, or where we could have done something better, and that we take steps to address those need.

The following points may help us:

- Rate the event in terms of its usefulness. What was good and bad about it educationally? What did we learn? Will it have an impact on our practice and in our contacts with patients? How?

¹ http://www.gmc-uk.org/guidance/good_medical_practice.asp

- Effective reflection should lead to change – this may be a matter of providing evidence of good practice or of where we need to strive to maintain standards or of using clinical governance to improve and optimise care.
- Thinking and reflecting on our patients is rewarding; and the opportunity to reflect with a peer may help us prevent burn-out.
- Record any changes we propose as a result of our reflection

There are some documents which are available which may help us with learning to write reflectively - the links are:

- The Wessex 'reflection model' may be useful to us:
 - <http://www.wessexdeanery.nhs.uk/pdf/Wessex%20Reflection%20Model.pdf>
- Another document from the Northern Deanery gives a little more detail if you wish to pursue reflection further:
 - <http://www.northerndeaneary.nhs.uk/NorthernDeanery/primary-care/gp-specialist-training/ReflectivewritingguideHENE.pdf>
- If you are keen to pursue this further – this will be particularly helpful if you undertake a diploma in any subject which requires reflective essay writing – this is a more in-depth look at reflection and reflective writing:
 - <http://www.cetl.org.uk/UserFiles/File/reflective-writing-project/ThePark.pdf>

If we are a **sessional GP or an out-of-hours GP**, we are likely to have specific challenges around appraisal and there are documents embedded here to support us. (to be added to final document)

Domain 1 - Knowledge, skills and performance

Attribute 1 - Maintain your professional performance

2. Scope of practice

Our appraisal should cover the full scope of our professional practice including all roles that require us to be licenced. So the first few areas on Clarity set out to establish this:

- **GMC information** – basic information that we will carry over from one appraisal to another. Our revalidation date can be added manually as this does not get updated automatically
- **Personal information** – contact details, medical indemnity and registration with a GP – we just need to check each year
- **Qualifications** – we include anything that has required assessment or is accredited by a university or Royal College such as degrees, diplomas, certificates, etc.

- **Membership** – we include Royal Colleges, BMA and anything else relevant
- **Roles** – this is where we identify the scope of our practice so that our appraiser and responsible officer can understand what we do. We need to declare all roles and positions for which we need a licence to practice and this includes our work for voluntary organisations and in private or independent practice. Types of work include clinical commitments (this can include specific roles such as safeguarding lead, GPwSI, minor surgery, OOH etc), educational roles, managerial and leadership roles (LMC, CCG board membership etc) and anything else that we do, paid or unpaid.
- **note**
- **Job plans** – are very helpful for sessional GP's and can be aligned to our annual internal appraisals with our employer.

We need to remember to update our scope each year and be explicit about our roles – e.g. partner, salaried GP, sessional GP and so on – and how many sessions we spend on each role.

3. PDP and CPD

a. Last year's PDP

We need to make comments about last year's PDP including:

- What aspects we have completed and what changes have happened as a result.
- What we have not completed and why and if we want to drop it or carry it forward to the next year
- Some reflection on what we have learned

b. CPD events

The RCGP have a new definition of CPD credits. "One credit = one hour of learning activity demonstrated by a reflective note on the lessons learned and any changes made". The RCGP recommends that we accumulate 250 CPD points over each 5-year appraisal cycle and our CPD should cover the scope of our practice. We need to remember to include evidence of activity, reflection and learning – it is easiest to do at the time we undertake the activity otherwise it is onerous and difficult to recall. The easiest way is to use some form of mobile technology to enter it directly onto the appraisal toolkit but it is equally OK to add it from notes taken soon afterwards.

c. Breadth of CPD

We are encouraged to ensure our CPD covers the full scope of our work, and an overall total of 250 credits (hours) over a 5 year period is recommended by our college². A focus

for one year on, say, a diploma with more limited CPD is acceptable but over 5 years we must clearly demonstrate CPD that covers the breadth and scope of our work as a GP. We are also recommended to present a balance of learning methods and experience and to show that some of our learning takes place with colleagues outside of our normal workplace.

d. Mandatory training

There is some debate about what is 'mandatory' for CPD, if anything. However it is generally accepted that there are 3 areas we should be considering on a regular basis.

These are:

- Basic life support, automated external defibrillator and anaphylaxis update – generally accepted as being required annually – this is usually face to face training with simulation
- Children safeguarding level 3 – many CCGs recommend as a minimum 3-yearly, but some suggest yearly for practice leads – the key is to demonstrate we remain up to date with child safeguarding
- Adult safeguarding parts A&B – not mandatory but recommended by many CCGs

Other aspects that we may wish to be aware of, some of which link to CQC inspections are:

- Health & safety training (e.g. infection control, fire safety, lifting and handling, etc.)
- Equality and diversity training
- Information governance update – many CCGs recommend this annually – this is available on-line at <https://www.igt.hscic.gov.uk/igte/index.cfm> but we will need to check if our CCG has access for us and then register with the site

Apart from basic life support and information governance, the rest are available on line at <https://elearning.nsahealth.org.uk/local/sfhadmin/login/index.php>.

e. Use of impact

The RCGP is phasing out the doubling of credits for impact, but encourages accurate recording of the time spent on learning and the effect it has on our practice.³

f. PUNs and DENs

A PUN and DEN is a process by which we recognise a patient's unmet need (PUN) and translate this into a doctor's educational need (DEN) which is then met by an educational process (looking something up online or reading or attending an educational event).

³ <http://www.rcgp.org.uk/revalidation/~media/Files/Revalidation-and-CPD/2016/RCGP-Guide-to-Supporting-Information-2016.ashx>

We need to demonstrate how we identify our learning needs and one of the simplest ways to achieve this is by including some PUNs and DENs in each appraisal under 'quality improvement activities.

Ideally, the PUNs and DENs or other means of identifying our learning should form the basis of our CPD as a means of ensuring we address our identified learning needs. However, it may be simply a record of looking up the answer to a simple question using one of the online tools (www.gpnotebook.co.uk, www.patient.co.uk, etc.). Some of these (e.g. GP Notebook) will track our access and we can provide this list as evidence of our learning, as long as we include a reflection on what the log demonstrates about our pattern of learning needs.

By using these we can avoid an over-narrow CPD that does not cover the breadth and scope of our work as a GP.

Here are a few websites here which we can review that may help us in improving the quality of our PUNs and DENs entries:

- <http://gpcpd.walesdeanery.org/index.php/reflecting-on-your-learning-puns-and-dens>
- <http://www.gp-training.net/private/training/mentoring/punsanddens.pdf>
- <http://www.radcliffehealth.com/shop/puns-and-dens-discovering-learning-needs-general-practice>

The RCGP has a learning needs assessment tool called PEP (Personal Education Planning) that is available to us if we wish to take a more in-depth approach to this aspect of development:

<http://elearning.rcgp.org.uk/course/category.php?id=17>

Attribute 2 - Apply knowledge and experience to practice

4. Quality improvement activities

Our appraiser will be looking for some kind of quality improvement activity every year. These can come in a variety of forms as described below. All of them require that we can demonstrate how we use our knowledge and experience to improve practice. The RCGP does not specify the number of QIA activities we need to do every year, but we must clearly show how we review and improve the quality of our whole scope of practice on a regular and ongoing basis. If in doubt, discuss your plans for the coming year with your appraiser and/or the appraisal team.

a. Case reviews

This is where we as GPs feel most at home. The guidance encourages us to include two case reviews for each appraisal. A couple of good case reviews are excellent material to discuss at appraisal and we can demonstrate how we learn from day-to-day practice through reflecting on how we are affected by the experience. A key element is to explain how we have shared our learning with colleagues. Case review templates are available⁴.

In London, doctors may wish to use (though it is not compulsory) the MacMillan cancer template for one of the cases. A copy will be embedded here.

b. Clinical audit

Clinical audit is an excellent way of demonstrating quality improvement. A guide that's easy for us to use will be embedded here.

We can include audits where the data collection was done by a colleague if we show in our reflection what our personal involvement in the audit has been and what we have learned about our own performance from taking part in this activity. For those of us who are sessional or out-of-hours GPs, there is guidance on quality improvement activities and audit in the two documents embedded on page 4. Mini-audits are very useful as an ongoing demonstration of improvement activity and are also welcomed.

c. Developments in our work (practice development)

Anything that we have done to improve patient care can be included here. A new service set up, a new protocol or guideline implemented, better access, a change in the way appointments are handled, a new website offering better information for patients and much, much more. This is our opportunity to showcase what we have done to improve. We need to remember to include evidence and reflection.

d. Research and teaching

We may include anything from a formal teaching appointment through occasional talks to mentoring others. We simply need to outline what we do, provide some evidence and reflect on how it improves quality. Some feedback from learners is always useful.

⁴ For example: <http://www.bradfordvts.co.uk/online-resources/0002-mrcgp/noe/structured-review-templates/>
<http://doctorappraisal.com/structured-reflective-templates-srts/#sthash.PoFKJNPc.dpbs>
http://www.nbmedical.com/pdf/NB_Keep_it_Simple_Revalidation.pdf

e. SEAs

The GMC have clarified that Significant Events are serious, or critical incidents in which we are named or personally involved and in which serious harm could have or did come to a patient. Sometimes they are called Serious Incidents (SI's) or Serious Untoward Incidents(SUI's). Only incidents that reach the GMC level of harm⁵ need to be recorded as SEA's on the portfolio.⁶

Nevertheless we are encouraged to record lower level significant events, or indeed instances where things have gone well as a case review and for this reason a good appraisal usually includes at least one or two case reviews.

The key elements of SEAs are to identify what we have learned, analyse any repetitive faults and how they may be addressed, and how we have shared the learning with colleagues.

So, for each SEA we present, we need to reflect by asking:

- What have we learned?
- What went well?
- What could have gone better?
- What would we do differently in the future?
- How have we shared the learning with colleagues or discussed it with our team so everyone is able to take on board the learning?

In terms of our duty of candour, which is now required of us, we should add how the patient and carer have been involved in the process.

⁵ We advise you to look include at incidents that could cause Moderate or more Severe harm according to the classification by the National Patient Safety Agency:

No harm:

Impact prevented – any patient safety incident that had the potential to cause harm but was prevented, resulting in no harm to people receiving NHS-funded care.

Impact not prevented – any patient safety incident that ran to completion but no harm occurred to people receiving NHS-funded care.

Low: Any patient safety incident that required extra observation or minor treatment and caused minimal harm, to one or more persons receiving NHS-funded care.

Moderate: Any patient safety incident that resulted in a moderate increase in treatment and which caused significant but not permanent harm, to one or more persons receiving NHS-funded care.

Severe: Any patient safety incident that appears to have resulted in permanent harm to one or more persons receiving NHS-funded care.

Death: Any patient safety incident that directly resulted in the death of one or more persons receiving NHS-funded care.

⁶ <http://www.rcgp.org.uk/revalidation/~media/Files/Revalidation-and-CPD/2016/RCGP-Introduction-to-RCGP-Guide-to-Supporting-information-for-Appraisal-and-Revalidation-2016.ashx>

Attribute 3 – Ensure that all documentation (including clinical records) formally recording your work is clear, accurate and legible

- Here our appraiser will be ensuring that the appraisal documentation is complete and fully anonymised and that learning and reflection are fully documented. Some supporting information is difficult to anonymise: this can include SEAs, complaints and cards from patients. The reflective note on these should always form part of your portfolio but the information may sometimes be shared separately with your appraiser, who will reference this in the appraisal summary. Reflection on a sample of our medical records can provide good evidence and it may be worth considering some review of this or of our own referrals, prescribing, note keeping, etc. every few years.

Domain 2 - Safety and Quality

Attribute 1 – Contribute to and comply with systems to protect patients

5. Complaints

We have an obligation to include any and every complaint since the previous appraisal. This includes reporting any investigation or issue that has been referred to the GMC and/or NHS England. Some investigations take more than a year to conclude but we are asked to include the issue in our next appraisal, and every year until we can include the outcome, as well as documenting any restrictions placed on our practice.

If we have had no complaints we must make a statement to this effect in the box provided.

Our appraiser will be looking for evidence that we have taken the complaint seriously, responded appropriately to help resolution, been transparent about the issues involved, identified personal learning needs and changes in practice systems and implemented these, and shared the learning with colleagues. It is also helpful if we can indicate briefly the system we have for ensuring complaints are dealt with effectively and shared with colleagues.

6. Concerns about colleagues

Good medical practice reminds us of our obligations to our peers and the need to share any serious concerns about the performance of a colleague. In the first instance it is useful to discuss and reflect on our concerns with an experienced peer and the LMC may provide a good initial sounding board as is our appraiser.

7. Peer support

We need to provide evidence that we are not professionally isolated.

- Are we a member of any practitioner group or learning set?
- What meetings do we attend in the practice – informal and formal and how regular are they?
- For some GPs, almost all of their CPD can be via e-learning, reading or pharma-sponsored events. However we are encouraged to attend any CPD organised by the practice, CCG or other organisation so our learning is more interactive and peer calibrated.

8. Patient safety systems

Practice efforts to ensure patient safety provide a good source of evidence for our appraisal as do CQC reports. Processes ensuring patient safety such as systems to receive and act on patient alerts, our access to emergency drugs/equipment, handover systems, significant event processes and induction systems and packs for locum GPs are good evidence to present. The focus of this will be on whether we are cooperating with systems to protect patients from harm.

Attribute 2 – Responds to risks from safety

Here we need to be able to demonstrate to our appraiser that we are aware of safety risks including how we operate availability of chaperones, protecting ourselves and colleagues from potentially violent patients (e.g. alarm availability in clinical rooms, safety if working alone), systems for handling results and hospital letters (so important information is not missed) and maybe contingency planning (pandemics, major RTA, staff sickness, etc.).

Attribute 3 - Protect patients and colleagues from any risk posed by your health

We are likely to be asked to confirm that we have no health concern that may impact on our practice or patient care. This may seem intrusive initially but can be an opportunity to discuss stress levels – common for all of us – and how we manage these. This gives our appraiser chance to explore our work life balance together. We will also be able to say that we are registered with a GP and do not prescribe for our self or our family.

Our hepatitis B immunity should be up to date and evidence uploaded. (Immunity requires an initial course of 3 injections followed by a blood test – If the titre is >100mIU/ml, one booster at 5 years is required and then no further action. If it is <100mIU/ml further investigations will be required to establish if HBIG is needed if exposed to risk.)

Domain 3 - Communication, Partnership and Teamwork

Attribute 1 - Communicate effectively

Our appraisal is a good opportunity to demonstrate our range of communications skills and may include any specific communication skills training, how we communicate using interpreters, advocates or on the telephone and any in-house systems for communicating within the practice team.

9. Patient and colleague feedback

The GMC says that patient feedback should be at the heart of doctors' professional development.

We are required to have patient and colleague feedback at least once in every appraisal cycle of 5 years. Gathering the feedback can take longer than we expect so we are encouraged to do this early in our 5 year appraisal cycle.

Doctors who have recently attained their CCT will need to gather new patient and colleague feedback before they revalidate and not rely on their PSQ's and MSK's from their time as a trainee.

In summary patient and colleague feedback:

- Needs to be gathered through a validated questionnaire – there are many commercially available; there is a modest charge for the paper version of patient feedback on Clarity which covers the cost of the printed questionnaire, SAEs, analysis and report back ; or is free if patient email addresses are used instead of the paper-base system; the colleague feedback is entirely email based and free
- Should be independently collected and collated
- Must gather evidence from the number of patients or colleagues determined by the individual validated questionnaire
- Should be obtained from successive patients as far as is possible (who may have been seen in more than one place of work)
- Should be benchmarked against local and national averages to enable meaningful reflection on the outcome. . All recognised toolkits automatically benchmark the outcome against our peers.
- Needs to be reflected on by us with the intention of identifying where we are performing well and where we could improve. We are encouraged to develop an action plan with our appraiser if we benchmark below most of our peers.

The RCGP now recommends that we reflect on informal feedback from patients annually in our appraisal: this can include feedback in the form of cards and compliments, Friends and Family test etc.

For the very few of us who are not currently working directly with patients, please ask your revalidation team for advice on how to obtain 'patient' feedback and don't assume that it is not required.

Attribute 2 - Work collaboratively with colleagues to maintain and improve patient care

This is about how we work as part of team and manage our relationships with colleagues and staff. We may find it helpful to explore how we prevent professional isolation, when and how we meet in clinical and management meetings, any involvement in supervision or peer support and an opportunity to air any challenging relationships in a safe environment. We could refer to any team building work done using tools such as Myers Briggs⁷ or Belbin⁸ and reflect on what we have learned. We may wish to cover areas such as partnership agreements, employment contracts and engagement with colleagues in GP commissioning.

Attribute 3 – Teaching, training, supporting and assessing

This is an opportunity to ensure that we gain some feedback from any teaching or training that we undertake and include it as evidence.

Attribute 4 – Continuity and coordination of care

Case reviews or SEA's are good opportunities where we can demonstrate that we coordinate our patients care and if we work regularly in one location that we offer continuity of care.

Attribute 5 - Establish and maintain partnerships with patients

During the appraisal we may be given an opportunity to reflect on how well we relate to patients and where we have experienced difficulties, perhaps with challenging patients. A specific area could relate to our engagement with any patient participation activity in the practice or elsewhere.

⁷ The Myers–Briggs Type Indicator (MBTI) is an introspective self-reported questionnaire designed to describe your personality type and your preferences in how you perceive and interact with other people and how you make decisions.

⁸ Belbin is another personality test which comments on your role within a team.

Domain 4 -Maintaining Trust

Attribute 1 - Show respect for patients

We may discuss a number of issues here including how well we manage our time and how we maintain confidentiality.

Attribute 2 - Treat patients and colleagues fairly and without discrimination

There may be a chance for us to talk about how we work with our colleagues as well as any leadership roles we have accepted. It is an opportunity to identify our learning needs in these areas.

Attribute 3 - Act with honesty and integrity

Here we can range over our management of any complaints or significant events, our handling of finances including any gift policy, and ethical approval/governance for any research in which we are engaged. In some circumstances the Responsible Officer may request that we discuss specific issues with our appraiser. This is so that we can show how we have reflected on the events and it is important that our appraiser records the outcomes of our discussion in the appraisal summary.

Proposed PDP

We also need to construct a proposed PDP which we can discuss at the appraisal meeting. It is the appraiser's job to support us in that choice, not to do it for us. So it is worth us putting thought and effort into what we want to prioritise in terms of our personal development for the next year. It is helpful if we aim for 3 to 5 items that cover the scope of our practice. It is also worth considering how we can both pursue an interest and plug gaps in our knowledge and skills.

12th May 2016