

This is an advisory document for discussion. It is for voluntary use by individuals and organisations, to support the quality of appraisal. It is not guaranteed that gathering the evidence listed will meet the eventual requirements for revalidation.

Evidence for medical appraisal:

Essential / Optional

October 2006

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Introduction

The evidence that can be supplied for appraisal is limitless. Indeed, it is inherent to the developmental ethos of appraisal that a doctor can introduce any evidence to his or her appraisal that he or she believes is relevant to their professional work, for discussion in confidence with their appraiser.

At the same time, to achieve consistency of appraisal, it helps to define some key evidence for every doctor to produce to show professional activity in the main areas of *Good Medical Practice*¹. This point was made by the NHS Clinical Governance Support Team in our framework document: *Assuring the Quality of Medical Appraisal*². We recommended that there should be a core of “valid and verifiable evidence” informing the appraisal discussion.

This paper sets out suggestions for this core of evidence. It is designed to be generic for all doctors in clinical practice, regardless of speciality, location or nature of employment. It distinguishes between that evidence which is essential, that which is highly desirable, and that which is optional.

In another publication: *Defining the evidence for revalidation* CGST considered those factors which help define meaningful evidence. These are:

1. Equivalent to that required of other disciplines
2. Level or relationship to the individual
3. The nature of the doctor's work
4. Face value credibility
5. Ease of production
6. Source of production
7. Level of objectivity
8. Level of verifiability
9. Whether “SMART”

These factors have informed the choice of evidence for this new document. Further explanation of each factor has been reproduced from *Defining the evidence for revalidation* in Appendix³

Essential evidence (personal) is that which should be produced by all doctors, and without *which an appraisal should be deferred* until the evidence is available.

Essential evidence (organisational) is that which should be produced by all doctors unless there are clear reasons why it is not available. Where a doctor is unable to produce such evidence, this should be discussed with his or her host organisation, and if necessary at appraisal, to establish whether there are means by which it can be generated.

Optional evidence is other evidence that the doctor chooses to provide for appraisal, either because he or she wants to discuss issues that the evidence illustrates, or to show a level of excellence of professional activity. Clearly this

Comment [m1]: Does this need further qualification Maurice? Do you need to explain why an appraisal should not take place without this evidence? MK

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category is limitless in its scope, and this paper seeks only to illustrate with examples the sort of evidence that might be relevant.

The Evidence

In addition to the evidence listed on the following pages, **completion of the appraisal preparatory paperwork is essential in order for the appraisal to proceed** (Forms 1, 2 and 3).

The forms must be:

- Legible (typed forms should be the norm)
- Coherently completed
- Passed to the appraiser in good time (normally at least a week prior to the appraisal, to allow review before the appraisal)

We suggest use of the secure facility of the NHS Appraisal Toolkit, <https://www.appraisals.nhs.uk> as a vehicle to help doctors undertake their NHS appraisal.

This framework comes in the context of *Good doctors, safer patients*, the report by the Chief Medical Officer of England and Wales into the requirements for medical revalidation. It comes at a time when the General Medical Council are revising and refining their standards for good medical practice. We also expect that the professional colleges and faculties, through the Academy of Medical Royal Colleges, will soon develop guidance for their members relating to the evidence in the specific areas of:

- maintaining good medical practice (through continuing professional development (CPD) arrangements)
- probity and health.

This framework is intended to support these processes, and to be compatible with future Academy, GMC and NHS processes.

For other items we have provided templates to assist doctors in producing and presenting their evidence. The intent is that evidence will be presented in a consistent way which will also help the doctor in the process of self-reflection.

We welcome feedback on this framework. Please contact: maurice.conlon@ncgst.nhs.uk with your comments.

NHS Clinical Governance Support Team

July 2006

Section of Good Medical Practice	Essential Evidence (Personal) (In the absence of any of the evidence listed in this column, the appraisal should be deferred until the evidence is available)	Essential Evidence (Organisational) (Evidence should normally be present for the large majority of doctors. If not presented, the reasons why should be discussed at appraisal)	Optional Evidence (Evidence which the doctor may choose to include for the purpose of discussion within the appraisal, and/or for the purpose of demonstrating his/her good practice. This list cannot be exhaustively defined,; examples of evidence are listed for the purpose of illustration)
Good Clinical Care	Current PDP	Key organisational audits, with reflection⁶. (These are audits generated by the organisation in which the doctor works, and which inform day to day performance. Examples include: Quality and Outcomes Framework data for GPs, Departmental audits, MRSA rates.) The doctor is not expected to generate these figures, but must complete a reflective piece describing his/her response to the data.	Personal audits with reflection
	Last year's Appraisal Summary (Form 4)	Significant event report⁴. (Where the doctor works in an environment where there are mechanisms for significant event analysis, he/she should include evidence to indicate his/her participation in these. Where there have been no significant events relating directly to the doctor, he/she should still prepare at least one reflective piece ³ indicating how they have generated personal learning from the significant events of others in the team.	Personal Significant events with reflection
		Current Job Plan (Consultants only)	
	Two Structured Case Reviews ⁵		Reflective diaries
	One audit reflection ⁶		Plaudits
			Evidence of Learning events relating to Good Clinical Care

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Maintaining Good Medical Practice	Evidence of having met the criteria set out by the relevant College/Faculty for Continuing Professional Development (CPD)		Practice/departmental development plan
			Evidence of participation in additional learning events to those of College/Faculty CPD requirements
			Evidence of membership of organisations where learning occurs
			Personal learning diary
			Evidence of knowledge assessment. (e.g. Formal examination results, self-assessments etc)

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Relationships with Patients	The results of the most recent patient survey ¹ , supported by a completed self-reflective template ⁷ (This must have been carried out within the past 3 years, and must relate to the individual practice of the appraisee. Where the feedback exercise has been performed more than 1 year previously, a record of subsequent action must be included)	Additional patient feedback data. (Where the system within the doctor's organisation means that patient feedback is obtained more frequently than every three years, then these data should be included.)	Additional information for patients (e.g. Details of website, examples of leaflets and other formats of communication with patients.)
	Complaints data ⁸ , or declaration of no complaints ⁹	The organisation's complaints policy/protocol	Consent policy
		Information for patients about services (e.g. Practice/departmental leaflet)	Confidentiality policy
			Evidence of learning in the context of patient relationships (e.g. Communication skills workshops)
			Evidence relating to other aspects of patient relationships (e.g. involvement with patient participation groups)

¹ Patient surveys and Multi-source Feedback Surveys. It is expected that over time a preferred format for these will develop, probably moulded to some extent to reflect the differing nature of the various specialities. In the meantime, it is recommended that individual doctors use a format for each of these of their choosing, including self-designed surveys. Whatever format the doctor uses, they must remember that the underlying purpose of these exercises to generate learning needs for inclusion in personal development plans, and so a reflective template should also be provided to the appraiser, in order to facilitate this discussion.

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Relationships with Colleagues	A record of the results of the most recent multi-source feedback exercise, supported by a completed self-reflective template ¹⁰ . (The exercise must have been carried out within the past 3 years, must relate to the individual practice of the appraisee, and must have been facilitated by a third party. Where the feedback exercise has been performed more than 1 year previously, a record of subsequent action must be included)	Additional multisource feedback data. (Where the system within the doctor's organisation means that patient feedback is obtained more frequently than every three years, then these data should be included.)	Evidence of learning in the context of colleague relationships (e.g. Team-building exercises, equal opportunities and diversity training)

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Other professional roles (to include Teaching, Research, Management, and any other clinical and non-clinical professional responsibilities)	Full declaration of all such roles in the appraisal preparatory paperwork (Forms 2 and 3)	Evidence of on-going performance review in these contexts. (Where such review is coordinated by a discrete organisation, e.g., deanery, trust or PCT, through a formal performance review/process of reaccrreditation, this evidence must be provided. Where the employing organisation has no structured process for reviewing the doctor's performance in the relevant context, this should be noted in the appraisal preparatory paperwork, and discussed at appraisal.)	Evidence of learning in the relevant context (courses attended, learning modules completed, self-assessment tools used, etc)
			Evidence indicating performance in the relevant context (e.g. Publications, commendations, feedback from students, diplomas, degrees and other awards)

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Probity	Self-declaration of performance management status/disciplinary status within the Host Organisation		Other evidence relating to probity which the appraiser chooses to present, to demonstrate good practice (e.g. Evidence of gift register)
	Self declaration of GMC Status, NCAA Status, Criminal Status		Other evidence which the appraiser chooses to present, so as to discuss at the appraisal
	Completion of probity questionnaire, as defined by relevant GMC and ARMC		Evidence of participation in learning activities relating to probity
Health	Self-declaration of health status, as defined by either GMC and ARMC		Other evidence relating to health which the appraiser chooses to present, to demonstrate good practice
			Evidence of participation in learning activities relating to health (e.g. Attending Stress-reduction workshops)

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References and appendices

Reference:¹ General Medical Council *Good Medical Practice* London, GMC, 2001

Reference:² NHS Clinical Governance Support Team (2005) *Assuring the quality of medical appraisal* Available at:
[http://www.appraisalsupport.nhs.uk/files2/Assuring the Quality of Medical Appraisal.pdf/](http://www.appraisalsupport.nhs.uk/files2/Assuring_the_Quality_of_Medical_Appraisal.pdf)
(accessed June 28, 2006)

Appendix ³

Factors to consider relating to evidence

There is no piece of evidence that has been identified, which meets all of the desirable attributes for the purpose. Any piece of evidence that may be useful, therefore, has its advantages and disadvantages. Those attributes, which might be considered to be of greatest importance when weighing a piece of evidence, are:

1. **Equivalent to that required of other disciplines.** Whilst each professional discipline will have items of evidence reflecting the specialised nature of the discipline, it is important to ensure that the overall burden of requirement for revalidation is the same for all.
2. **Level of relationship to the individual.** Generally speaking, more evidence currently exists, relating to organizational activity, than to the individual doctor. Ideally, revalidation requires data to be assessed, relevant to the individual. The disadvantages of much information that currently relates to the individual are that it may be less standardised, preventing comparisons, and it may be more difficult to verify.
3. **The nature of the doctor's work.** Despite the above limitations, much more information is available for stable senior doctors (Consultants, GP Principals) than for peripatetic doctors, e.g. locums, staff grade hospital doctors and non-principals GPs. In addition, the presence of a departmental or practice infrastructure makes it easier for Consultants and GP Principals to generate personally related data. The recommendations for "essential" evidence in this document include options that can be produced by peripatetic doctors.
4. **The level of "face-value" credibility.** An item that is perceived by the profession as lacking in value could be damaging to this new process at a critical early stage. It is worth acknowledging that, for most of the items of evidence in this paper there is no substantive evidence base in terms of their impact on patient care. Indeed, for certain items of evidence, it is extremely difficult to move beyond face-validity. Nevertheless, where possible, establishing this evidence base is a key requirement for immediate development
5. **Ease of production.** Ideally, evidence should be produced as a by-product of another process. Hence, departmental data, or, in Primary Care, Quality and Outcomes Framework (QOF) data may be included, despite its being group-based. Also, evidence already being produced for appraisal, such as a description of the doctor's practice, or a significant event report, might be included to minimise duplication.
6. **Source of production.** Where possible, data should be collected with minimum disruption to the doctor. Hence, for example, Trusts and PCTs should provide data where possible. On the other hand, to a degree, involvement in the creation of evidence is important for ownership on the part of the doctor. A balance has therefore been sought in this regard, by the use of personal reflective templates, to ensure that the doctor provides a link between the organisation information and his or her individual practice.
7. **Level of objectivity.** Typically, a highly personal piece of evidence, e.g. personal audit, is difficult to standardise for the purposes of comparison.
8. **Level of verifiability.** Similarly, personally-produced data is less verifiable than, say, is organisationally-produced data.
9. Whether "SMART" or not. Where possible, each item of evidence should be written in "SMART" terms, i.e. Specific/Measurable/Achievable/Realistic/Timely

Adapted from: NHS Clinical Governance Support Team (2004) *Defining the evidence for revalidation – supporting the Royal College of General Practitioners* Full document available at:
http://www.appraisalsupport.nhs.uk/files2/11092004090353defining_the_evidence_for_revalidation_pdf_late_edit.pdf
(accessed July 12, 2006)

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Appendix⁴

Significant event audit (SEA) Template	
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:	

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Appendix ⁵

Structured case review template	
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.	

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Appendix⁶

Audit self-reflection template

Name of doctor:

GMC No:

Audit title:

Reason for choice of audit:

Audit criterion:

Audit standard:

Audit target:

Audit findings:

Learning outcome and changes made:

New audit target:

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Appendix ⁷

Patient survey self-reflection template

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).

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Appendix ⁸

Complaint report template	
Name of doctor:	GMC No:
Date of complaint:	
Nature of complaint:	
Status of complaint: On-going / resolved	
Involvement of other bodies: Responsible organisation / SHA / NCA / GMC / Other	
If resolved, what were the findings?	
How will my practice change?	

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Appendix ⁹

Declaration of absence of 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:

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Appendix ¹⁰

Multi-source feedback self-reflection template	
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.	