MAKING A START WITH APPRAISAL

A guide for Non-Principals,
Produced By The North-east Employed and Locum GPs Group (NELG)

MAKING A START WITH APPRAISAL : a guide for non-principals, by *NELG*

Introduction

This pack has been prepared by the North-east Employed and Locum GPs Group (NELG) to help non-principals in the North East make a start with Appraisal. Appraisal is a requirement for all doctors including non-principals starting sometime in the financial year 2003/2004. For many GPs Appraisal generates anxiety, particularly because of its links with Revalidation. It is hoped that this pack will both help NPs to see the positive side of appraisal and give them access to the people and information they need.

Three PCTs (Newcastle, North Tyneside and Sunderland) have kindly given us copies of their folders to help us with putting together this starter pack. In time PCTs may send their folders to the non-principals on their supplementary lists. In the meantime we thought it might be helpful to show non-principals how they can get started.

This pack aims to address many of the issues which pertain specifically to non-principals. Useful documents about ongoing discussions regarding npn-principal Appraisal and Revalidation can be found on the website for the NANP (National Association of Non-Principals).

We have aimed to keep this starter pack short and user friendly. Much more information is available; websites and contacts details are included in this pack. NELG membership fees and some pharmaceutical sponsorship helped finance this project hence the need for brevity ! We suggest you photocopy the tools and keep them in your personal folder to fill in week by week.

We aim to produce updates as developments occur. We will place it on the NELG website along with other useful documents and PCT appraisal folders. Any additions, suggestions or amendments would be gratefully received. The North-east Employed and Locum GPs (NELG) Group aims to continue to support non-principals and carrying out a questionnaire about your experience of appraisal.

Paula Wright, on behalf of the North-east Employed and Locum GPs (NELG) Group , October 2003

Second Edition
The second edition includes a summary of the recently published ScHARR repoprt *Extending Appraisal to Non-principals*. It also include a new grid for cross-referencing types of evidence to the different sections of the appraisal form. The revised edition has been produced for the workshop “Preparing for appraisal” on the 18th October 2003 organised by the NELG and the Northern Deanery.

Acknowledgements:
Comments were gratefully received from Dr Rebecca Viney (Associate Dean for General Practice Non-principals CPD, London), Dr G McBride (GP tutor, Sunderland Career Start), Professor Tim van Zwanenberg (Director of Post-Graduate General Practice Education), Dr Di Jelley (on behalf of North Tyneside PCT), Dr Tina Ambury (NANP), Dr Janette Foo (Gp Tutor for non-principals, Tyne and Wear), Dawn Solomon (on behalf of Newcastle PCT), Alison McMurrough (on behalf of Sunderland PCT), Helen Lumley (on behalf of Gateshead PCT), Dr Simon Fisher (NELG), Dr Rachel Bailey (NELG), Dr Josephine Fagan (NELG).
Some of the tools have been adapted with permission (details given in the tools section).

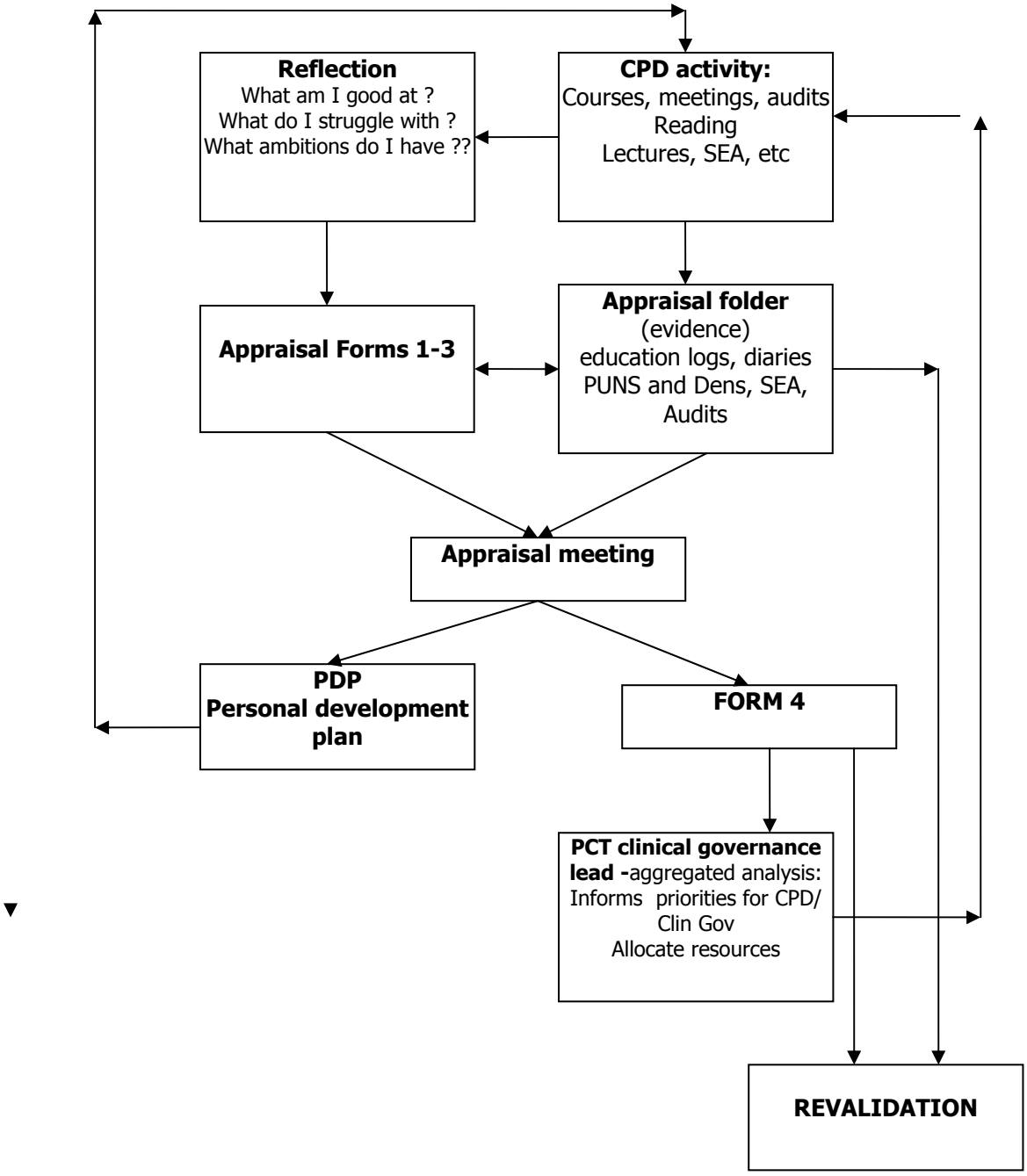
Summary of Appraisal:

1) Appraisal has become an annual requirement for most doctors and will apply to all doctors in time.
2) It is expected that annual Appraisals will become the basis to successful Revalidation. E.g. 5x Appraisal=Revalidation but further guidance is yet to be issued on this. There will also be an "independent" route to Revalidation also based on the elements of the GMC's Good Medical Practice but without using Appraisal.
3) 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)
4) It is based on the GMC's booklet Good medical Practice which identifies the following areas:
    i) Good clinical care
    ii) Maintaining good medical practice
    iii) Relationships with patients
    iv) Working with colleagues
    v) Teaching and training
    vi) Research
    vii) Management
    viii) Probity
    ix) Health
5) It is a developmental and formative process to help doctors improve their practice.
6) It is confidential between appraisee and appraiser, although an agreed summary (form 4) must be submitted to the PCT's clinical governance lead.
7) All Appraisal reports within the PCT will be anonymously aggregated to look for common themes which the PCT may need to act on e.g. common educational needs.
8) Appraisers must be properly trained to understand the roles and responsibilities of different groups of non-principals.
9) Appraisees, whether they are principals or non-principals, should have a choice of appraiser. Appraisers of non-principals should be appropriately trained to deal with appraisal in the context of the role and working arrangements of non-principals in so far as they differ considerably from those of principals.
10) Some non-principals may feel more comfortable being appraised by another non-principal. Appraisal can be a damaging experience where there is a mismatch of appraisee and appraiser. PCTs will need to offer appraiser training to non-principals on the same basis as it is offered to principals (non-principals represent 25% of the GP workforce).
11) 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.
12) All GPs can expect protected time in which to prepare and undergo Appraisal whether they are self-employed (partners or locums) or employed. A number of PCTs currently reimburse principals undergoing Appraisal for 2 sessions at current locum rates.
13) 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.
14) The appraiser and appraisee should arrange to review progress at least once later in the year. This can be done by telephone.
15) Each PCT has a procedure for dealing with grievances regarding the implementation of its appraisal system. NELG members may also raise any concerns through the NELG.
16) The GMC has recently written to all Doctors regarding Appraisal and Revalidation: the link is explained in the booklet "A licence to practice & Revalidation". It is also worth reading about the revalidation piloting exercise which considers whether information for appraisal was sufficient for revalidation :
17) http://www.revalidationuk.info/datastore/Report%20of%20stage%20two.htm

18) This summary is not comprehensive and further details about the national guidance is found in the Scharr report which can be downloaded from the department of Health Webpage on Appraisal- http://www.doh.gov.uk/pricare/gpAppraisal.htm.

Most PCTs have produced folders for Appraisal (for principals) with more specific information about arrangements within each PCT. The lead individuals for Appraisal are listed later in this document.

Flow chart of appraisal , PDPs and Revalidation.



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 non-principals 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) and your non-principal peers.
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 (contacts listed in this pack):
    i) 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.
    ii) to obtain their list of trained appraisers (you may wish to ask which ones have experience of working as non-principals)
    iii) to find out how you access training to become an appraiser
7) If you are a salaried non-principal
    i) 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).
    ii) 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.)
    iii) Arrange an appropriate date for your appraisal between yourself and your appraiser.
8) Visit the websites listed later in this document to find out more about Appraisal and to try out the electronic NHS Appraisal toolkit.

Extending appraisal to all GPs- ScHARR report on non-principal appraisal.

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

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

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

Responsibilities of PCTs:

- To ensure Non-principals 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 non-principals 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 Non-principals:

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

Responsibilities of practices

To involve NPs in practice meetings and discussions (e.g. education, significant event audit etc)
To facilitate access of NPs to professional materials (journals) and patient data (to allow follow through and audit)
Support steps NPs might take to learn the views of patients and colleagues
Ensure that principals are available for handover discussions, and generally for clinical communication and exchange
To provide non-principals and locums in particular with induction packs

Who should appraise non-principals

Other GPs !
"Appraiser should have a confident understanding of non-principal work"
Non-principals 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 non-principals thought more administrative support may be available to principals in data collection.

Specific challenges for non-principals

EVIDENCE

Non-principals (and locums specially) face particular difficulties in collecting what is traditionally known as audit data:

- 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 non-principals in the practice).
- Short term placements mean that locums are neither in a position to institute nor to follow through changes arising from audit findings.
- Not having a Prescribing number means that prescribing analysis is much more difficult.
- 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.
- They often receive no help from administrative staff with audit /data collection and analysis.
- 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 NPs 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 non-principals 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, non-principals 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 non-principals on the same basis as principals.

Employed non-principals 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 non-principal) 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 non-principal. Your PCT should be able to provide you with a list of trained appraisers for you to choose from.

BECOMING AN APPRAISER

Non-principals 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.

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

General Practitioners Committee - Non-principals subcommittee and webpage www.bma.org.uk then go to GPs then non-principals.

NANP- national association of non-principals- lots of useful information tool and documents and links to local non-principal 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 Non-principals Janette Foo.

North-east Employed and Locum GPs (NELG) Group : despite name has always had salaried doctors involved and becoming more of a non-principal group www.nelg.org.uk. Chairman Dr Simon Fisher (simonfisher@doctors.org.uk)

Other educational Tools
http://www.medirect.com/professional-development/
http://www.medirect.com/professional-development/pages/forms.html

PCTs, supplementary lists, clinical governance and recruitment.

CONSULTATION
All non-principals are required to be registered on a supplementary list and these are the responsibility of PCTs. PCTs are responsible for implementation of Appraisal for all GPs including the non-principals on their supplementary list. PCTs have developed Appraisal systems for principals over the last year in consultation with local LMC (local medical committees). Many PCTs held open meetings about Appraisal and set up working groups with GP representatives. Some also wrote to all principals to invite comments, concerns or suggestions.

This coming year PCTs will need to implement Appraisal for NPs. Although LMCs may be the first port of call for consultation about Appraisal for non-principals it is recognised that NPs have very limited involvement with many LMCs. PCTs may also consult directly with the NPs registered on their supplementary lists or consult with local NP groups (e.g. NELG).

Some PCTs have included a survey of personal experience of appraisal as part of their ongoing quality control of the implementation of appraisal. The NELG supports this approach to quality control of appraisal systems in preference to an approach which relies on reporting of grievances in much the same way that practices should not rely purely on patient complaints as the source of feedback about care but should also use patient surveys.

CLINICAL GOVERNANCE
Appraisal is only one piece in the jigsaw of clinical governance- which is about improving the quality of patient care. The quality of care which non-principals can provide depends upon many factors, both personal and organisational. Amongst the latter NPs need to be included in the PCTs overall clinical governance strategy: PCTs need to consider whether the way they communicate with GPs who are based in practices effectively reaches their non-principals specially locums. NPs make up around 25% of the GP workforce. A communication strategy which misses out NPs creates inequities in the standards of care provided. For locums who move around PCTs may need to consider mailing them at their home address or personal email addresses. Types of communications and mailings which PCTs need to consider include:

- PCT education events: multidisciplinary "time out" sessions which are often held for all primary care staff, with PCT funded cover from PrimeCare. As well as offering excellent multidisciplinary education these sessions also offer an opportunity for principals to meet non-principals e.g. potential future partners and salaried doctors.
- PCT funded "time in practice": protected sessions for education held in practices again with PCT funded cover. These sessions allow educational to be targeted at the specific needs of a practice Equivalent opportunities should be offered to non-principals: PCT could offer to fund sessions of education for groups of non-principals who meet to identify and address learning needs specific to them e.g. updating clinical computer systems skills, or child health surveillance, etc.
- Clinical Guidelines (both local and national) which are distributed to NPs.
- Alerts (medicine, public health and devices)
- Prescribing strategy and incentives scheme

RECRUITMENT AND RETENTION
Locums who work across a number of PCTs may find themselves basing their choice of host PCT on the way that these consult with NPs, communicate with NPs and support their educational and Appraisal needs. This choice may in turn have considerable impact on recruitment and retention of GPs for each PCT.

PCT contacts for Appraisal

PCT	Lead: name and contact details	PCT first point of contact
Newcastle	Dr Debbie Freake Medical Director Newcastle PCT Benfield Road Walkergate Newcastle upon Tyne NE6 4PF Debbie.Freake@newcastle-pct.nhs.uk	Dawn Solomon Primary Care Support Manager Newcastle PCT Benfield Road Walkergate Newcastle upon Tyne NE6 4PF Dawn.Solomon@newcastle-pct.nhs.uk Tel (0191) 219 6037 Fax (0191) 219 6066
North Tyneside	David Chappel Director of Public Health and Clinical Quality Benfield Road Newcastle upon Tyne NE6 4PF Direct Line: 0191 219 6042 Direct Fax: 0191 219 6041 E-Mail Email: david.chappel@northtyneside-pct.nhs.uk	Mrs Jacqui Douglas PCT Administrator for GP Appraisal Audit and Education Co-ordinator Benfield Road Newcastle upon Tyne NE6 4PF Direct Line: 0191 219 6063 Direct Fax: 0191 219 6008 Email: Jacqui.Douglas@northtyneside-pct.nhs.uk
South Tyneside	Dr Arthur Muchall Marsden Rd Health Centre Marsden Rd South Shields NE346SR 01914540457	Walter Hall South Tyneside PCT Ingham House Horsely Hill Road South Shields NE333DP 01914014500 walter.hall@stpct.nhs.uk
Gateshead	None identified by PCT at present	Helen Lumley Practitioner Liaison Manager helen.lumley@ghpct.nhs.uk tel: 497 1501 Julie Cox Clinical Governance Support email julie.cox@ghpct.nhs.uk tel:4971469.
Sunderland	Dr Geoff Stephenson Clinical Governance Lead Armstrong House District 2 Washington NE371PR	Alison McMurrough OD & Staff Development Manager email: alison.mcmurrough@suntpct.nhs.uk 0191 4186883
Northumbria	Dr Gill Fraser Director of Clinical and Care Governance Northumberland Care Trust Merley Croft Loansdean MorpethNE61 2DL 01670 394400 gill.fraser@northumberland-haz.org.uk	Peter Owens Head of Development Support Northumberland Care Trust Room 15a Wansbeck Business Park Rotary Way Ashington NE63 8QZ 01670 394719 peter.owens@northumberland-haz.org.uk

Educational opportunities for Non-principals.

There has been much change in this area recently in the North East. Traditionally hospitals ran regular meetings/lectures for GPs on a monthly or weekly basis. In many PCT areas these have been replaced by multidisciplinary half-day events which occur on an ad hoc basis 4-6 times a year. PCTs often fund deputising cover for practices to be able to participate. Locums have found it difficult to obtain information about the timing, content and venue of these events.
It is hoped that the establishment of 3 dedicated GP tutors for non-principals (Dr Janette Foo, and Dr Paula Wright for Tyne and Wear abd Northumberland and Dr Karen Smith for Cumbria) will make it easier for Non-principals to find out about these events as efforts are being made to post ALL mainstream educational events on a single website : go to www.ncl.ac.uk/pimd then "GP" then "doctors in transition". A CPD newsletter is currently sent to all Non-principals on supplementary lists for Tyne and Wear and Northumberland.

If you wish to receive more information by email : please email either janettefoo@hotmail.com or pfwright@doctors.org.uk or telephone Dr Janette Foo 0191 2106680 (The Grove Medical Group) or Dr Wright (07812 170528)

Higher Professional Education
Recently qualified GPs working as non-principals should be aware of the educational opportunities provided through Higher Professional Education (HPE). HPE is a National Scheme to both support and nurture General Practitioners in the critical time, after completing the GP Registrar year. There are two types of funding :
Funding (to a maximum of twenty days per annum) for locum cover to facilitate time out of scheduled service provision and minimise loss of service provision to patients. Payments are made to the practice releasing the GP.
Funding (to a maximum of £450 per annum), to support educational activity, such as half-day release, some course fee costs, and facilitating support to Self-Directed Learning Groups.
Details of this scheme can be found at
http://www.campus.ncl.ac.uk/pimd/gp/HPE/Hpeintro.doc.

MONTHLY MEETINGS

- monthly on a Thursday organised by Dr Janette Foo at Newcastle General Hospital, Westgate Road, Newcastle at 8pm.
- Duke of wellington Pub, Kenton Road, Newcastle- run by North-east Employed and Locum GPs (NELG) Group. First Wednesday of the month 8pm.
- Retainers Scheme- monthly on a Wednesday at Dr Wadge's practice on Osborne Road, Jesmond, Newcastle.

North-east Employed and Locum GPs Group (NELG).

This is voluntary support group for non-principals which has been running for 8 years. Members meet monthly at the Duke of Wellington Pub on Kenton Road in Newcastle on the first Wednesday of the month at 8pm (from July 03, prior to this was a Tuesday). The three executive officers run the group in their spare time with the administrative support of Sunderland PCT. Membership includes The group welcomes locums and salaried GPs and its website is www.nelg.org.uk. There is a small membership fee (£15). The group publishes a monthly list of its members who are available for locum work. This list is available to practices needing locums, by ringing Sunderland PCT 01915699833. The group also discusses working conditions.

Chairman Dr Simon Fisher, 01912612793, 07932597026, 1 Wallace St Spital Tongues, NE24AV. Simonfisher@doctors.org.uk

Secretary Dr Rachel Bailey, d.b.chappel@newcastle.ac.uk,

Treasurer/ membership secretary/ LMC rep Dr Paula Wright, 07812170528, pfwright@doctors.org.uk

north east employed and locum GPs: Membership Form

For joining and renewal. www.nelg.org.uk

Please PRINT clearly- and answer ALL the questions.

FIRSTNAME SURNAME
ADDRESS   POSTCODE
HOME PHONE
MOBILE PHONE
EMAIL
FAX
PCT
GMC number
Supplementary list number of Medical List number

1) I want to be contacted about locum vacancies **Yes No** (delete as appropriate)
   a) If Yes I would like to be contacted by home telephone/ mobile/ email (delete as appropriate)

2) I would like to receive information by **post** or **email** (please delete as appropriate)

about (delete as appropriate):
   a) Education, courses, appraisal (from Deanery, GP tutors, PCTs).
   b) Local Clinical guidelines and services (usually PCT information)
   c) The Local Medical Committee
   d) Job vacancies (from PCTs)
   e) Out of hours locum/job vacancies (from Co-ops, Primecare etc)

   You can change these options at any time (online or by post).

3) Working arrangements please select the ones which apply:

locum	yes/no
retainer/ Flexible Career Scheme,	yes/no
salaried to practice,	yes/no
salaried to PCT,	yes/no
principal,	yes/no
academic,	yes/no
teaching,	yes/no
other please specify	yes/no

Signed.....

To join OR RENEW you need to send the following o the treasurer Dr P Wright 34 Alwinton Tce Gosforth Newcastle NE31UB.

- proof of inclusion on a supplementary list or medical list,
- GMC certificate,
- cheque for £15 payable to 'The Northeast Employed and Locum GP Group'. If Joining in March- to August £7.50. Renewals in September

GP tutors

(from PIMD website)

GP Tutors are responsible for developing and stimulating Postgraduate General Practice education in their local area. All Doctors in General Practice should be aware that they can contact their local GP Tutor if they have a query or concern relating to educational matters. New General Practitioners (Principals and non-principals) working in the Deanery are encouraged to contact their local GP Tutor in order to find out what educational activities are available in their local Primary Care Community. This list was downloaded from the Deanery website.

Darlington	Dr Will Elliott	Whinfield Surgery Whinbush Way Darlington Co Durham	01325 481321
Derwentside	Dr Paul Milne	Park House Surgery Station Road Lanchester Co Durham DH7 0PE	01207 520877 parkhousesurgery@derwentside.org.uk
Durham	Dr Vikram Maini	Claypath Medical Practice 26 Gilesgate Durham DH1 1QW	0191 333 2830
Durham	Dr Alan Sensier	Adan House St Andrew's Road Spennymoor Co Durham DL16 6QA	01388 817777 alan.sensier@which.net
Durham	Dr Paul Bowron	Bishopgate Medical Centre Newgate Street Bishop Auckland Co Durham DL14 7EJ	01388 603983 bishopmc@globalnet.co.uk
East Cumbria	Dr Clyde Mitchell	Education Centre Cumberland Infirmary Carlisle CA2 7HY	01228 529171 106360.2730@compuserve.com
Gateshead	Dr Anil Doshi	Crawcrook Medical Centre Back Chamberlain Street Crawcrook NE40 4TZ	0191 413 2243
Gateshead	Dr Varun Kaura	The Croft Surgery Wrekenton Gateshead Tyne and Wear NE9 7BJ	0191 487 9288

Langbaurgh	Dr Amanda Smith	The Garth Surgery Westgate Guisborough Cleveland TS14 6AT	01287 632206 a.smith107@ntlworld.com
Newcastle North	Dr Valerie Wadge	43 Osborne Road Jesmond Newcastle NE2 4AL	0191 281 4060
Newcastle East	DR Paula Wright	34 Alwinton Tce Gosforth NE31UB	pfwright@doctors.org.uk 07812170528
North Tyneside	Dr Ashley Liston	Lane End Sugery Manor Walk Four Lane Ends Newcastle upon Tyne	0191 266 5246 thelistons@aol.com
Newcastle West	Dr John Bookless	Back Victoria Terrace Throckley Newcastle upon Tyne NE15 9AA	0191 267 4005 mailto:g.s.pilkington@ncl.ac.uk
Central Northumberland	Dr Mike McCubbin	Seaton Hirst Primary Care Centre Norham Road Ashington Northumberland NE63 0NG	01670 813167
Northumberland	Dr Mike Guy	The Bondgate Practice The Bondgate Surgery Infirmary Close Alnwick NE66 2NS	01665 510888 michaeljohn.guy@which.net
West Northumberland	Dr Pat Feeney	Branch End Surgery Stocksfield Northumberland NE43 7LL	01661 842626
Sunderland	Dr Gerry McBride	St Bede Medical Centre Lower Dundas Street Sunderland SR6 1QQ	0191 567 5335 gerryatwork@hotmail.com

Tees	Dr Dennis Herbert	Cambridge Medical Group 10a Cambridge Road Linthorpe Middlesborough TS5 5NN	01642 851177 dennis.herbert@virgin.net
Tees	Dr Stephen Sylvester	Tennant Street Surgery Stockton on Tees TS18 2AS	01642 613331 s.sylvester@btinternet.com
North Tyneside	Dr Stephen Blair	Village Green Surgery The Green Wallsend Tyne and Wear NE28 7BB	0191 295 8500
South Tyneside	Dr Arthur Muchall	Marsden Road Health Centre Marsden Road South Shields Tyne and Wear NE34 6RE	0191 454 0457
West Cumbria	Dr Fiona Galloway	Beech House Main Street Egremont Cumbria CA22 2DB	01946 820203
Non-Principals Tyne and Wear and Northumberland	Dr Janette Foo	Highfield House Brewery Close Stamfordham Newcastle upon Tyne NE18 0PG	01661 886832 or 0191 210 6680 janettefoo@hotmail.com
Non-Principals Tyne and Wear and Northumberland	Dr Paula Wright	34 Alwinton Tce Gosforth NE31UB	07812170528 pfwright@doctors.org.uk
Non-Principals Cumbria	Dr Karen Smith		drkpsmith@aol.com

Tools for evidence

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:

- The audit section
- Table "Educational Tools and their applications"
- Mapping evidence to appraisal form
- Feedback form from practice

The following are adapted: (original copyrights reserved where indicated)

- Patient questionnaire : from GPAQ with permission
- Significant event audit (analysis of roots causes adapted from *Doing Less Harm* (National Patient Safety Agency)
- Clinical Queries, Reflective Diary, Educational Log- adapted from London Deanery's Personal learning Plan document (from their website).

The following tools (tables) have been adapted from those found in the PCT folders (Newcastle, North Tyneside, Sunderland):
Probity
Audit record table
Complaints table
Teaching and training record
Significant event audit (table)
Peer feedback

Evidence types for each section.

Examples of documentation you might refer to and supply (copied from Appraisal form 3). There are some examples of these in this pack (see marked with asterisk). A number of these educational tools can be used for more than one purpose e.g. for identifying educational needs and setting personal aims and to collect supporting evidence for the different sections of the appraisal form.

Good Clinical Care

audit data (as appropriate); prescribing analyses (if applicable); PCT clinical governance reviews (as appropriate); relevant clinical guidelines you use; records of any significant event audits (*) or critical incident reports; any complaints and records of their investigation; any reflective diary (*) you keep about these events; any plaudits you have received; any 'in-house' or personal monitoring materials you use; references or feedback from colleagues.

Maintaining Good Medical Practice

Personal Development Plan (*); your practice development plan (if applicable); records of all CPD/CME activity or other education/courses- educational log (*); membership of a non-principals group or other opportunities for group learning with colleagues. Please summarise your professional reading habits. PUNS and DENs.

Relationships with Patients

Information for patients about services in the practice(s) in which you work; any complaints material, including your handling of it; appreciative feedback; patient survey data (as appropriate); relevant significant event reports; peer reviews; protocols e.g. for handling informed consent in the practice(s) in which you work. You might be able to obtain some of this information from the practices in which you have worked over the last year. The GPAQ adapted survey is included here.The GMC is currently developing patient surveys for use in Appraisal.

Relationships with Collegagues

a description of the team structure in which you work (if applicable); records of any peer reviews (*) or systematic feedback; references from colleagues; information about any problems that have arisen between you and colleagues (including consultants); membership of a non-principals group.

Teaching and training activities

A summary of your formal teaching/training work and any informal supervision or mentoring; any recorded feedback (*).

For the other sections see the appraisal forms.

Educational tools and their applications

(*) 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 non-principals 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 (&*)					✓

MAPPING EVIDENCE ACROSS THE SECTIONS OF APPRAISAL

This grid is to help link the different documents submitted as "evidence"`in your appraisal folder to the different areas referred to in the appraisal documentation :

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

It can be used to help appraisees spot areas where evidence is sparse or lacking and can help appraisers get an overview of what documents are submitted and which areas they are relevant to.

	GCC	MGMP	RP	RC	TT	R	M	P	H

AUDIT FOR NON-PRINCIPALS

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 for non-principals to be able to carry out this type of audit it is necessary for the locum to:

1) 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) Have time for access to records outside of booked surgeries and other clinical work (often there is no room available outside of surgery times and a locum cannot expect staff to pull and file notes required)
3) Be in a position to participate in improvements in practice
4) Be placed in a practice long enough to see changes implemented
5) For obvious reasons all of these pose challenges for non-principals 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 speciality 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 computerised, 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.

Clinical Computer Skills
For more accomplished audits the locum will need to be able to consistently use Read codes during consultations and to carry out computer searches. Unfortunately locums are presently disadvantaged from accessing any form of clinical computer systems training as this is usually practice based and locum sessions are generally usually fully dedicated to clinical work. Of course as PCTs and practices need to collect more and more data about clinical care for NSF and quality aspects of the new contract it will become even more important that locums are able to use computers (and Read codes) to the same consistent standards as permanently placed GPs. As 25% of GPs are non-principals the percentage of clinical care they deliver and therefore data they generate is quite significant- too significant for practices or indeed PCT to disregard. There is therefore a good argument for PCTs to consider carefully how they will ensure that clinical data across the PCT is collected to the same consistent standard.

However there are some audits which can be done by non-principals 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 :

- 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.
- 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)
- 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 symtpoms or new concerns", e.g. "repeat Bpx3 with p nurse and if still high increase dose of ACEI",).

QUALITY OF DATA RECORDED IN ELECTRONIC RECORDS

See notes above
Tick when found:

	Problem-	Advice given to patient	Recording of patient's concerns expectations or health beliefs	Safety-netting, or follow up
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
Total				
%				

Interesting findings and comments:

COMMUNICATION DURING CONSULTATIONS:

This audit may generate ideas about appropriate ways of communication during and outside of surgery times.

Record telephone calls received by doctor during surgery:

Patient query at desk
Patient query on phone
Query from pharmacy about prescription
Clinical emergency
Query from another health carer e.g. practice nurse
Personal call
Patient arriving late
Call from hospital or other health professional outside the practice (returning call or new call?)
Other

Time or #	Interrupted consultation Y/N ?	Reasons (see choice above)	Details

Consider : did the call interrupt a consultation, was it appropriate, were there alternative ways to help the caller, did the caller know how to leave a message for me, know when I would be available after surgery, could other messaging or communication systems be used in each case, is the locum giving patient incorrect advice about services in the practice, etc. There may be useful lessons to learn for both sides.

Suggestions for improvement:

TELEPHONE CALLS MADE BY ME DURING SURGERY

Use the table below to record these

request for equipment
request for forms in room,
request for information re "in-practice" services (e.g. missing from induction file)
request for information re services in local hospitals and outside the practice (e.g. missing from induction file)
request for chaperone,
panic call (violence),
computer problem,
missing notes,
missing letters or results,
to organise an admission,
to get a second opinion.
Other

Time Or #	Reasons (see choice above)	Details:

This audit can help practices fine tune their induction information and also consider appropriate ways of communication during and outside of surgery times.

Suggestions for improvement:

EDUCATION LOG.

Date	Course/Meeting/Event	Organised by/ PGEA approved ? Time taken, certificate attendance given ?

(adapted from London Deanery PLP document (see website))

REFLECTIVE DIARY

This is a personal and confidential written record of your learning needs, experiences and outcome. Everything from a tricky consultation to a lecture can be a source of reflection; simply take a few minutes regularly to think about what it was that benefited or challenged you and what you could do to change the outcome next time. Make sure you make your records soon after each event to ensure everything is fresh in your mind.

Date; Event (consultation/ visit/ lecture/ /meeting /correspondence) Subject: What happened ?	What have I learnt? How did I feel ? What does this tell me about myself, my practice, my PCT, etc ? How might I change my practice ?

(adapted from London Deanery PLP document (see website))

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, interprofessional, organisational	Outcome/ Answer/ Source e.g. local, national guidance, journals, specialist advice, patient support groups.

(adapted from London Deanery PLP document (see website))

PATIENT QUESTIONNAIRE

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.
The NELG has sought permission from NPRDC to adapt the questionnaire for use by non-principals as part of evidence they may wish to submit for appraisal under the headings "relationships with patients". It is recommended that permission if sought from the practice before using it. The following instructions are extracts downloaded from GPAQ website.

How many questionnaires does each practice need to collect for GPAQ surveys?
We recommend analysing 50 questionnaires per doctor.
Using GPAQ with children and non-English speaking patients
GPAQ is designed for adults aged at least 16 years. There is no upper age limit for its use. GPAQ is currently only available in English. Where GPAQ is administered in the surgery waiting room, patients who cannot speak English are sometimes accompanied by an English-speaking friend or relative. Under these circumstances, we generally encourage the friend or relative to help the patient complete the form. We think that the potential bias that this may produce is probably less than excluding the non-English speaking patient from the survey all together.
Analysing questionnaires
NPCRDC does not provide a service for analysing GPAQ questionnaires. Instead, they have produced a standard report form which can be downloaded from their website. If you enter your questionnaire results into the spreadsheet at the back of the report, it will automatically produce charts and results throughout the report. If you want to do more complex analyses, you can use the SPSS syntax which is in the GPAQ manual.

The following are some useful points to remember when you administer a GPAQ survey in the surgery.
Preparation
Ensure you have plenty of pens and clipboards available for patients to use. Photocopy around 120 questionnaires if you want 100 returns (i.e. 20% extra). Number the questionnaires beforehand, and add the name of the doctor whose session you are including. Display posters/notices informing patients that the survey is being carried out. Provide a suitable box in which patients can confidentially return their questionnaires.
The sample
It is very important that you give a questionnaire to every patient on the list who is able to complete one. Leaving some patients out will give biased results. Make sure that respondents are in fact patients of the practice. Don't include temporary residents. Make sure the patient is at least 16 years old. If a patient does not speak English well enough to understand the questionnaire, they can really only complete it if there is a relative or friend with them who is able to translate and help them fill it out. Explain that the questionnaire asks about patients' views of the practice and the quality of care they receive from their GP.
Patients can look at the questionnaire before they go in to see the doctor, but they should not fill it in until they come out. When patients book in, ask them if they could stay behind for a few minutes to complete the questionnaire when they have seen the doctor. Receptionists should remind people on their way out. If patients can't wait, they should be given a stamped addressed envelope to return the questionnaire in. It is very important to try and get as many back as possible. If you can have one member of staff responsible for running your survey on a particular day, this will make it easier.

Dear Patient
I would be grateful if you would complete this survey about your visit today. I would like to provide the highest standard of care and feedback from this survey will help me to improve. Your opinions are therefore very valuable. Please answer ALL the questions that apply to you. There are no right or wrong answers. You do not need to write your name on this sheet. Thank you.

Dr …… Date…….

Thinking about your consultation with the doctor today, how do you rate the following: (please tick)

	Very poor	Poor	Fair	good	Very good	Excellent	Does not apply
a) How thoroughly the doctor asked about your symptoms and how you are feeling?							
b) How well the doctor listened to what you had to say?							
c) How well the doctor put you at ease during your physical examination?							
d) How much the doctor involved you in decisions about your care?							
e) How well the doctor explained your problems or any treatment that you need?							
f) The amount of time your doctor spent with you today?							
g) The doctor's patience with your questions or worries?							
h) The doctor's caring and concern for you?							

After seeing the doctor today do you feel... (please tick)

	Much more than before the visit	A little more Than before the visit	The same or less than before the visit	Does not apply
a) able to understand your problem(s) or illness?				
b) able to cope with your problem(s) or illness?				
c) able to keep yourself healthy?				

PLEASE HAND THIS IN TO RECEPTION. THANK YOU.

PEER REVIEW FEEDBACK FORM

Area of practice for peer review:
_____

Feedback questionnaire for Dr _____ Date: _____

	What are the Dr's strengths in this area?	*Where could there be improvement?*
Good clinical care		
Keeping up-to-date		
Good relations with patients		
Working with colleagues		
Teaching and training Management Probity Health		

(adapted from Tyne and Wear PCT folders (see nelg website for originals))

FEEDBACK FROM PRACTICE – STRUCTURED FORM

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
1. Made appropriate clinical decisions			
2. Made appropriate follow up arrangements with patients (results of treatment failure)			
3. Prescribing appropriate			
4. Correct use of practice repeat prescribing systems			
5. Prescribed according to practice incentive scheme			
6. Records accurate, complete and contemporaneous			
7. Used in-practice services appropriately e.g. bloods, minor surgery dietician			
8. Made appropriate use of appointment system			
9. Made appropriate referrals to services outside practice (including protocols for urgent cancer referrals and fast tracks)			
10. Made appropriate use of practice staff/ PHC team members			
11. Feedback from patients has been positive.			
12. Communicated clearly and courteously with staff and clinicians			
13. Shared clinical problems when appropriate with other members of PHCT (including handovers)			
14. Responded promptly when appropriate to messages from staff and patients			
15. Communicated clearly with practice manager when arranging booking- re dates, fees workload.			
16. Worked to agreed workload, agreed dates , punctual,			
17. 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.

SIGNIFICANT EVENT ANALYSIS

An adverse patient incident is any event or circumstance arising during NHS care that could have or did lead to unexpected or unintended harm loss or damage. Incident that did lead to harm are referred to as adverse incidents and events which could have lead to harm are "near misses"[1].
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 ones own performance and that of one's organisation and to develop learning aims for oneself and one's organisation. As a locum for example a "near miss" might highlight something which you think should have been included in the practice's "locum induction pack" and which you might want to make a habit of enquiring about each time you start in a new practice e.g. are side effects of disease modifying drugs for RA monitored by the practice or the local hospital.

This is the format used by the National Patient Safety Agency to analyse causes of significant events:

Causal analysis checklist

- 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

[1] "Doing Less Harm." National Patient Safety Agency 2002.

Significant event analysis

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).

PROBITY RECORD

Probity date & Instance	Concern about probity	Examples of good practice	Action

(adapted from Tyne and Wear PCT folders (see nelg website for originals))

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:
actions to maintain skills and the level of service to patients
actions to develop or acquire new skills
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.

PERSONAL DEVELOPMENT PLAN- TEMPLATE

OBJECTIVE NUMBER :

Define your learning/ development need/ objective. How did you identify it (audit, reflective diary, significant event, analysis) ?
How will you address this need ? What methods will you use and what resources will you need ?
How will your practice change as a result of the development activity? How will you demonstrate achievement of your learning objective ?
Planned completion by: Completed: Signed off:

OBJECTIVE NUMBER :

Define your learning/ development need/ objective. How did you identify it (audit, reflective diary, significant event, analysis) ?
How will you address this need ? What methods will you use and what resources will you need ?
How will your practice change as a result of the development activity? How will you demonstrate achievement of your learning objective ?
Planned completion by: Completed: Signed off:

AUDIT RECORD TABLE

Audit date **Standard/Question** **Or Topic**	**Key Findings and implications for practice**	**Actions taken; change achieved, Learning Points, results of re-audit.**

(adapted from Tyne and Wear PCT folders (see nelg website for originals))

TEACHING AND TRAINING RECORD

(when appraisee is involved in teaching or training others)

Date and Duration	Topic, Learners and teaching method	Outcome/ Reflection: assessment /feedback method used and outcome; areas for improvement.

(adapted from Tyne and Wear PCT folders (see nelg website for originals))

COMPLAINTS RECORD

Date and nature of Complaint	Management of complaint : in house / external. Professionals or staff groups involved.	Action/ Learning Points and Review date : Clinical issues, organisational issues, issues arising at level of personal, performance practice, PCT, or interface with other agencies e.g. social services/ secondary care

(adapted from Tyne and Wear PCT folders (see nelg website for originals))

NHS APPRAISAL

Appraisal for General Practitioners working in the NHS

FORMS

www.doh.gov.uk/gpAppraisal

ANNUAL APPRAISAL FOR GENERAL PRACTITIONERS

Introduction

This pack includes the documentation necessary for your annual Appraisal.

There are five forms:

1. Basic details

2. Current medical activities

3. Material for Appraisal

They must be completed by you before the Appraisal discussion. The first two forms are brief and factual. Form 3 requires care. You are invited to submit documents in support of Form 3 and these will need to be assembled. Your PCT may be able to help with some material.

Form 3 is prefaced with explanatory notes.

Some of the material you provide now will carry forward without further work to future Appraisals.

Your appraiser will bring two further forms to your meeting. Form 4 is the formal summary of the Appraisal and should be completed during and immediately after the discussion. This is the responsibility of your Appraiser. Form 5 may be used to make a more detailed and confidential record of the Appraisal discussion, but it is optional.

ANNUAL APPRAISAL FOR GENERAL PRACTITIONERS

FORM 1: BASIC DETAILS

Name

Registered address and telephone number

Main practice address and telephone number

Qualifications UK or elsewhere, with dates

GMC Registration Type now held, registration number and date of first full registration

Date of last Revalidation If any

Date of certification JCPTGP certificate or date of starting practice if before 1981

Date of appointment to current post If different

Main current post in general practice eg GMS Principal or PMS doctor with a patient list

Other current posts Please list any other current appointments with (1) starting dates (2) average time spent on them (3) whether public sector e.g. Benefits Agency, or private sector e.g. nursing home

Previous posts NHS and elsewhere, last five years, with dates

Other relevant personal details Please give any other brief information you wish that helps to describe you e.g. membership of professional groups or societies

FORM 2: CURRENT MEDICAL ACTIVITIES

This form requires a *brief and factual* description of the work you do in the practice and in other posts. You will be able to give more detail later.

Please summarise the 'in-hours' activities you undertake in your practice e.g. minor surgery, child health services

Emergency, on-call and out-of-hours work

Brief details of other clinical work e.g. as clinical assistant, hospital practitioner etc

Any other NHS or non-NHS work that you undertake as a GP e.g. teaching, management, research, examiner, forensic

Work for regional, national or international organisations

Other professional activities

FORM 3: MATERIAL FOR APPRAISAL

This form, and the papers you supply with it, will be the main basis of your Appraisal. It is organised around the headings used by the General Medical Council in *Good Medical Practice* and the Royal College of General Practitioners in *Good Medical Practice for General Practitioners*, and it is strongly recommended that you look at these documents as prompts. The same headings will be used to summarise your Appraisal discussion.

The wording under each heading differs, but typically you are asked to provide:

a commentary on your work
an account of how your work has improved since your last Appraisal
your view of your continuing development needs
a summary of factors which constrain you in achieving what you aim for.

It is not expected that you will provide exhaustive detail about your work. But the material should convey the important facts, features, themes or issues, and reflect the full span of your work as a doctor within and outside the NHS. The form is a starting point and framework to enable you and your appraiser to have a focused and efficient discussion about what you do and what you need. It is a tool, not an examination paper or application form, and it can be completed with some flexibility. **Common sense should be exercised if you feel you are repeating yourself, or if you want to include something for which there is no apparent opportunity. And if a section or a page really needs only a word or two there is no need to do more.**

The work you put into completing this form is your main preparation for Appraisal, and the value of your Appraisal will largely depend on it. It will also be an important part of your appraiser's preparation.

The form is fairly open-ended, although some prompts and suggestions are supplied to help you. Please expand the spaces available as necessary, or attach extra sheets.

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, but your appraiser will probably want to test some of them with you through discussion and the documents will help both of you.

The papers you assemble in support of the form should be listed in the appropriate spaces and supplied for your appraiser in a folder, organised in the same order. If the same material is listed in the form more than once, to illustrate different points, do not include it twice in the folder but explain on the form where it is to be found.

The first papers in your folder should be the summary of your last Appraisal and your Personal Development Plan (i.e. last year's Form 4).

All the papers may well be appropriate for inclusion in your Revalidation Folder.

Good clinical care
Commentary - what do you think are the main strengths and weaknesses of your clinical practice? Examples of documentation you might refer to and supply: up-to-date audit data; prescribing analyses; PCT clinical governance reviews; relevant clinical guidelines; records of any significant event audits or critical incident reports; any complaints and records of their investigation; any 'in-house' monitoring materials you use.
How has the clinical care you provide improved since your last Appraisal?[2] Refer as appropriate to your last Appraisal and Personal Development Plan.
What do you think are your clinical care development needs for the future? This is in preparation for agreeing an updated PDP.
What factors in your workplace, or more widely, constrain you significantly in achieving what you aim for in your clinical work? It may be constructive to focus on issues that can be addressed locally.
Documents list 1 2 etc

[2] If this is your first Appraisal, look at the last year; this applies throughout the forms.

Maintaining good medical practice

The last section asked about the quality of your clinical care and how it has improved; this one is about *how* you have kept up to date and achieved improvements.

Commentary - what steps have you taken since your last Appraisal to maintain and improve your knowledge and skills?

Examples of documentation you might refer to and attach: your PDP and practice development plan; records of all CPD/CME activity or other education/courses . Please summarise your professional reading habits.

What have you found particularly successful or otherwise about the steps you have taken?

Do you find some teaching/learning methods more effective than others? How will you reflect this in your future approach to maintaining good medical practice?

What professional or personal factors significantly constrain you in maintaining and developing your skills and knowledge?

How do you see your job and career developing over the next few years?

Documents list

1
2
etc

Relationships with patients

Commentary - what do you think are the main strengths and weaknesses of your relationships with patients?

Examples of documentation you might refer to and supply: information for patients about your services; any complaints material, including your handling of it; appreciative feedback; patient survey data; relevant significant event reports; peer reviews; protocols e.g. for handling informed consent.

How do you feel your relationships with patients have improved since your last Appraisal?

Refer as appropriate to your last Appraisal and PDP.

What would you like to do better? What do you think are your current development needs in this area?

This is in preparation for agreeing an updated PDP.

What factors in your workplace or more widely constrain you in achieving what you aim for in your patient relationships?

What can be addressed locally?

Documents list

1
2
etc

Working with colleagues

Commentary - what do you think are the main strengths and weaknesses of your relationships with colleagues?

Examples of documentation you might refer to and supply: a description of the team structure in which you work; records of any peer reviews or systematic feedback; information about any problems that have arisen between you and colleagues (including consultants).

How do you feel your relationships with colleagues have improved since your last Appraisal?

Refer as appropriate to your last Appraisal and PDP.

What would you like to do better? What do you think are your current development needs in this area?

This is in preparation for agreeing an updated PDP.

What factors in your workplace or more widely significantly constrain you in achieving what you aim for in your colleague relationships?

What can be addressed locally?

Documents list

1
2
etc

Teaching and training

Commentary - what do you think are the main strengths and weaknesses of your work as a teacher or trainer?

Examples of documentation you might refer to and supply: a summary of your formal teaching/training work and any informal supervision or mentoring; any recorded feedback.

Has your teaching or training work changed since your last Appraisal? Has it improved?

Refer as appropriate to your last Appraisal and PDP.

Would you like to do more? What would you like to do better? What do you think are your current development needs?

This is in preparation for agreeing an updated PDP.

What factors constrain you in achieving what you aim for in your teaching or training work?

Arranging cover, for example. What can be addressed locally?

Documents list

1
2
etc

Probity
What safeguards are in place to ensure propriety in your financial and commercial affairs, research work, use of your professional position etc? Have there been any problems? Please supply and refer to any records of concerns.
Has the position changed since your last Appraisal or in the last year? Please refer as appropriate to your last Appraisal and PDP.
Do you feel the position needs to change? How? Does anything need to be included in your updated Plan?
What factors in your workplace or more widely significantly constrain you in this area?
Documents list 1 2 etc

Management activity
Please describe any management activities you undertake that are not related to your practice or the practice in which you work. How would you describe your strengths and weaknesses? You may already have mentioned a role in your PCT, for example, or advisory work for the Strategic Health Authority or an NHS Trust, or a national position you hold. This section is about how well you think it works.
Do you think your management work has improved? Please refer as appropriate to your last Appraisal and your Personal Development Plan.
What are your development needs? What might be included in your updated PDP?
What are the constraints?
Documents list 1 2 etc

Research
How would you appraise any research work that you do? You may have mentioned your research activity already but this is an opportunity to say more, and how well you think it goes. You might supply and refer to any reports or publications.
Do you feel your research skills have improved? Please refer if appropriate to your last Appraisal or Personal Development Plan.
Do you have development needs in this area to reflect in your updated Plan?
What are the constraints?
Documents list 1 2 etc

Health
Do you feel there are any health-related issues for you that may put patients at risk? Please mention any problems or concerns raised during the year and any steps you feel should be taken to safeguard the position.
Documents list 1 2 etc

Overview of development during the year

With your Personal Development Plan in mind, please look back over the previous sections. How well have you achieved the goals agreed last year? Where you did not succeed, can you describe the reasons?

Overview of development needs

Please summarise what you think your main development needs are for the coming year. Where relevant, how will the reasons for not succeeding last year be overcome?

Overview of constraints

Please summarise the chief factors that you have identified as addressable constraints.

Sign off

We confirm that the above information is an accurate record of the documentation provided by the appraisee and used in the Appraisal process, and of the appraisee's position with regard to development in the course of the past year, current development needs, and constraints.

Signed:

Appraisee

Appraiser

Date:

FORM 4:

SUMMARY OF APPRAISAL DISCUSSION WITH AGREED ACTION AND PERSONAL DEVELOPMENT PLAN

This form sets out an agreed summary of the Appraisal discussion and a description of the actions agreed, including those forming your personal development plan.

The form will be completed by your appraiser and then agreed by you.

SUMMARY OF APPRAISAL DISCUSSION

Good clinical care

Commentary

Action agreed

Maintaining good medical practice

Commentary

Action agreed

Relationships with patients

Commentary

Action agreed

Working with colleagues

Commentary

Action agreed

Teaching and training

Commentary

Action agreed

Probity

Commentary

Action agreed

Management activity

Commentary

Action agreed

Research

Commentary

Action agreed

Health

Commentary

Action agreed

Any other points

PERSONAL DEVELOPMENT PLAN

Using the template provided here, the appraiser and appraisee should identify key development objectives for the year ahead which relate to the appraisee's personal and/or professional development. They will include action identified in the summary above but may also include other development activities agreed or decided upon in other contexts. Please indicate clearly the timescales for achievement.

GPs approaching retirement age may wish to consider their retirement intentions and actions that could be taken to retain their contribution to the NHS.

The important areas to cover are:

action to maintain skills and the level of service to patients
action to develop or acquire new skills
action to change or improve existing practice.

PERSONAL DEVELOPMENT TEMPLATE

This plan should be updated whenever there has been a change - either when a goal is achieved or modified or where a new need is identified. The original version should also be retained for discussion at the next Appraisal.

What development needs have I?	How will I address them?	Date by which I plan to achieve the development goal	Outcome	Completed
Explain the need.	Explain how you will take action, and what resources you will need?	The date agreed with your appraiser for achieving the development goal.	How will your practice change as a result of the development activity?	Agreement from your appraiser that the development need has been met.
1				
2				
3				
4 etc				

Sign off

We agree that the above is an accurate summary of the Appraisal discussion and agreed action, and of the agreed personal development plan.

Signed:

Appraiser (GMC Number)

Appraisee

Date:

Please record here the names of any third parties that contributed to the Appraisal and indicate the capacity in which they did so

FORM 5:

DETAILED CONFIDENTIAL ACCOUNT OF APPRAISAL INTERVIEW

This form provides an *optional* framework for keeping a fuller account of the Appraisal discussion than is recorded on Form 4. It might inform or help the next Appraisal round.

Although, as the guidance makes clear, an appraiser has a duty to pass on any serious concerns arising during Appraisal that could affect patient care, this form is *confidential* and is not intended to form part of the documentation going to the Clinical Governance Lead and Chief Executive (see Appraisal guidance).

You should nevertheless exercise great caution in commenting on third parties. Any comments you make about third parties should be supported by firm evidence. You should not use this form to record concerns about the performance of colleagues on which action should be taken under a separate procedure, for example GMC fitness to practise procedures (see section in guidance, 'Outcomes of Appraisal').

Completion of this form is not obligatory.

Good clinical care

Maintaining good medical practice

Relationships with patients

Working with colleagues

Teaching and training

Probity

Management activity

Research

Health

Sign off

We agree that the above is an accurate account.

Signed:

Appraiser

Appraisee

Date: