

# Appraisal for revalidation: a guide to the process

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# 1.0

# Introduction: purpose of this document

Much information about the appraisal process itself and about the qualities and attributes expected of an appraiser is already available.<sup>1,2,3</sup> This document is not designed to repeat that information, but to build upon it, emphasising the areas where the appraiser needs to give particular consideration to elements of the supporting information in relation to:

- The specialist practice of the doctor
- The need to maintain the formative, supportive and developmental aspects of the appraisal process
- Recognition of the difference between the GMC's *requirements for revalidation* and the drive for excellence that is common to the majority of doctors, their Colleges/Faculties and their specialist organisations.

This document will be helpful to doctors preparing for their appraisal so that they know what to expect from their appraiser. It also provides guidance to appraisers on key elements that may have particular relevance in different specialist areas. It will help to structure the supporting information and the appraisal discussion in a way that allows a proper evaluation of a doctor's progress since the previous appraisal, and supports the development of the subsequent Personal Development Plan (PDP).

The document will consider each component of the required supporting information<sup>4</sup> in turn:

- A description of professional roles
- Probity and health
- Continuing professional development
- Quality improvement activity
- Significant events
- Feedback from colleagues
- Feedback from patients
- Complaints and compliments.

# 2.0

# Background

Medical appraisal may be defined as 'A process of facilitated self-review supported by information gathered from the full scope of a doctor's work'<sup>1</sup> It addresses professional and personal development needs through a process of constructive challenge and development planning. It now forms the basis upon which medical revalidation is based, but support and development of the doctor should remain the primary focus. The supporting information required by the GMC, and reflection on it, will demonstrate to the appraiser that the doctor meets the principles and values of Good Medical Practice.<sup>5</sup>

In order to ensure that appraisal for revalidation achieves these objectives the process needs to include a number of key elements. These include a consideration of the doctor's professional roles and activities, a review of progress against the previous Personal Development Plan (PDP), a detailed consideration of the supporting information provided, an evaluation and summary by the appraiser of the degree to which the supporting information demonstrates compliance with Good Medical Practice, agreement with the doctor on the new PDP and a structured report on the outcome of the appraisal given to the Responsible Officer (RO).

## 2.1 Role of the appraiser

An appraiser may be allocated by a doctor's organisation, or a doctor may be able to choose an appraiser from a pool of trained individuals. All doctors will need to have two different appraisers during a five-year revalidation cycle. An appraiser should have received training in the process of appraisal for revalidation ("strengthened appraisal"). Many appraisers will have carried out this role before the introduction of revalidation, and the skills and processes used in high quality appraisals should remain. The new elements that are necessary for revalidation should build on this foundation.

All appraisers should:

- Consider the requirements of the doctor's professional roles
- Consider the doctor's most recent Personal Development Plan (PDP) and their progress with it
- Consider the supporting information that the doctor has provided in relation to the requirements of the GMC for revalidation
- Agree a new PDP with the doctor for the year ahead
- Make the required "statements" to the doctor's Responsible Officer
- Provide a "sounding board" to help the doctor to discuss their current and future development needs, where relevant
- Be aware of any difficulties that may prevent the doctor from making progress with their PDP.

## 2.2 Quantity and quality of supporting information

Many doctors have asked "how much" supporting information is required in each category. There is no universal answer to this question. The appraiser needs to be helped to make a judgement as to whether the doctor is meeting the minimum requirements of *Good Medical Practice*, so that the quality of the information to demonstrate this is more important than the quantity. A discussion between appraiser and appraisee during the year may help achieve this aim. There may be specific elements of information that will be needed to show progress with a doctor's PDP, and these should have been agreed at the doctor's last appraisal.

Since a doctor's supporting information is likely to reflect their specialty, guidance on appropriate information will be found in relevant specialty documentation.<sup>7</sup>

## 2.3 Reflection

Reflection is a common theme running through the supporting information and the appraisal discussion. This should not be a complex or time-consuming process, and essentially involves considering each element of the supporting information, thinking about what a doctor has learned and documenting how this learning has influenced their current and future practice.

Although the GMC sets out in general terms what is required, there is scope for each doctor to select supporting information within these categories that best reflects the quality of their practice. Thus, another positive element in which reflection plays a role is in the identification by individual doctors of the supporting information that will best represent the quality of their practice. They might, for example, ask themselves why the practice selected is representative of their work? What has been learned from that particular activity? Or how that activity could be built upon to enhance the quality of their practice further? The Academy of Medical Royal Colleges provides a reflective template for revalidation.<sup>6</sup>



# 3.0

# Scope and nature of work

The doctor should record the scope and nature of all of their professional work carried out to ensure that the appraiser and the responsible officer understand the doctor's work and practice. This should include all roles and positions for which a licence to practise is required, and should include work for voluntary organisations, work in private or independent practice and managerial, educational, research and academic roles.

Types of work may be categorised into:

- Clinical commitments
- Educational roles, including academic and research
- Managerial and leadership roles
- Any other roles.

Although the supporting information brought to appraisal for revalidation should cover the whole scope of a doctor's practice, this coverage does not have to take place every year of the five year cycle. It is permissible for a doctor to concentrate on specific areas of practice each year, and then to discuss with their appraiser how and when the remaining areas will be covered during the five-year cycle.

# 4.0

# Review of last year's Personal Development Plan (PDP)

The doctor should provide commentary on the previous year's PDP and may also wish to comment on other issues arising from the previous year's appraisal discussion.

# 5.0 Probity

The doctor should provide a statement indicating compliance with the requirements on probity set out in *Good Medical Practice*.<sup>5</sup> This may take various forms depending on the appraisal portfolio that the doctor is using, but it should be clear that the doctor has considered all elements of the probity requirements of the GMC's guidelines before making the statement.

On occasion, there may be on-going investigations or disciplinary matters where progress towards resolution should be reviewed at appraisal. Appraisal is not the place where these matters should be resolved, but they should be acknowledged in a probity declaration.

#### **The doctor's obligation to take action where there are concerns about patient care**

In the section on probity, College and Faculty guidance on supporting information states that doctors should sign a declaration to the effect that:

*'If you have become aware of any issues relating to the conduct, professional performance or health of yourself or of those with whom you work, that may pose a risk to patient safety or dignity, you have taken appropriate steps without delay, so that the concerns could be investigated and patients protected where necessary'* <sup>4</sup>

In Supporting Information for Appraisal and Revalidation the GMC states:

*'As a doctor you have a responsibility to log incidents and events according to the reporting process within your organisation'*

*'You should be able to demonstrate that you are aware of any patterns in the types of incidents or events recorded about your practice'* <sup>4</sup>

The doctor's appraiser should enquire whether there have been any situations where such action should have been taken, and whether it was.

# 6.0

# Health

*Good Medical Practice* also sets out the requirements for a doctor to ensure their health does not pose any risk to patients. A declaration that the doctor has considered and complied with these requirements should be viewed and agreed by the appraiser.

Certain specialties may have specific requirements in relation to health, such as immunisation and infection control procedures. The appraiser should *refer to the relevant specialty guidance* when considering the health declaration.<sup>7</sup>



# 7.0

# Keeping up to date

## 7.1 Continuing Professional Development

The doctor should be participating in Continuing Professional Development (CPD) activity that covers the whole scope of his/her professional practice. It is not expected that CPD will be undertaken in every area of professional work every year, but the doctor should ensure all aspects are supported adequately over the five year cycle.

- What is the doctor's job? Has the appraiser considered the description of the scope of practice in the appraisal documentation?
- Is the CPD relevant to the current and emerging knowledge, skills and behaviours required for the doctor's specialty or practice, professional responsibilities and proposed areas of professional development and work?
- Has the appraiser considered current guidance in the doctor's specialty from the relevant College/Faculty or specialty association?

### The balance of CPD activities

There should be a balance of learning methods and experiences. It is particularly important that doctors undertake some of their CPD activities with colleagues outside their normal place of work (often termed 'external' CPD). Other CPD activity should take place with colleagues within the workplace on topics directly related to the doctor's professional practice (often termed 'internal' CPD) and learning will also come from personal reading and from internet-based learning.

### The quality and effectiveness of CPD

Some idea of the quality of a CPD activity may be gained by considering it against a set of 'quality criteria' before the activity takes place, and to do this many organisations have accreditation or approval processes for CPD activities. This means that the activity has been evaluated against pre-identified criteria and is considered more likely to have a positive educational outcome.

The effectiveness of a CPD activity, in terms of achieving its educational objectives, can only be apparent after the event. This may be judged by the doctor (through reflection) by the appraiser (through the appraisal process) or by the provision of data that specifically considers professional behaviours or outcomes.

### Reflection and outcomes

As part of the supporting information, the doctor should provide reflection on what has been learned from CPD, and how this has influenced practice. The process of reflection will allow the consideration of CPD activity to focus on learning outcomes, rather than on a consideration of time spent.

The appraisal discussion itself provides a further opportunity for reflection on how the CPD activity has supported current practice and how future CPD may support future professional development.

The discussion should therefore focus on:

- Why was this activity selected for CPD? What was the learning need or objective that was addressed?
- How has the CPD contributed to the development of the doctor's knowledge, skills or behaviour?
- What has been the impact on quality and patient care/safety?
- Has the CPD reinforced aspects of current practice?
- Has the CPD led to actual or potential changes in practice?
- Has the doctor identified any further learning or development needs through CPD? If so, how will these be addressed?

### Time and resources to undertake CPD

There should be adequate provision of protected time and the necessary resources for the doctor to undertake CPD activities to the level recommended by their College or Faculty. If this is not happening the doctor should make their appraiser and/or responsible officer aware of this.

### Further information

Further information about the recommended approach to CPD activity and its consideration at appraisal may be found on the website of the Academy of Medical Royal Colleges<sup>8</sup> and the individual Colleges and Faculties.<sup>9</sup>

College CPD schemes usually provide recommendations on the minimum number of CPD credits to be achieved through external, internal and personal study activities. Evidence of CPD taking place with colleagues outside the normal place of employment is extremely important, particularly for those doctors working within a small group and isolated in their day to day work.

Achievement of at least 50 credits per year of the revalidation cycle, or at least 250 credits over 5 years, is recommended by all Colleges and Faculties as being the minimum time likely to be required in order to remain up to date in a doctor's specialty. There are different ways of awarding credits, and these do not always relate to the number of hours spent on the activity. The doctor should refer to the relevant College and Faculty specific guidance.

It is important to remember, however, that 50 hours of activity does not guarantee that all educational needs have been met. Emphasis should be placed on the quality of the CPD activities rather than simply on the number of hours spent.

# 8.0

# Review of practice: evaluating the quality of the doctor's professional work

## 8.1 Quality improvement activity

For the purposes of revalidation, the doctor will have to demonstrate that they regularly participate in activities that review and evaluate the quality of their work. These should be systematic and relevant to their work and should include an element of evaluation and planned future action. Where possible, these activities should be able to demonstrate an outcome or change.

### 8.1.1 Clinical audit

#### Definition of clinical audit

‘Clinical audit is a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria. Where indicated changes are implemented at an individual, team, or service level and further monitoring is used to confirm improvement in healthcare delivery.’

National Institute for Clinical Excellence, 2002

Audit in the context of revalidation has a slightly different emphasis than when it is applied to clinical governance. The Academy publication *Clinical Audit and Revalidation*<sup>10</sup> highlights that it is participation in, and reflection on, good quality audit that provides evidence for revalidation, rather than the audit outcome *per se*.

#### Audit quality criteria

The criteria and key indicators for a high quality clinical audit have been published by the Academy<sup>10</sup> and are summarised as three Principles:

Principle 1: Participation in high quality clinical audit

Principle 2: Reflection on the results of clinical audit

Principle 3: Taking action on the results of clinical audit

The key attributes of a high quality clinical audit are:

- The relevance of the topic chosen
- The appropriateness of the standards of patient care set
- The reflection on current care
- The appropriateness of changes planned
- The implementation of change for patients
- The demonstration of change by the doctor.

There is no expectation that the doctor, as an individual, should undertake the data extraction and/or analysis personally, but they should be sufficiently aware of the process to ensure its quality and to understand any limitations and the implications of the findings.

A description of a clinical audit should include:

- The title of the audit
- The reason for the choice of topic
- Dates of the first data collection and the re-audit
- The criteria to be audited and the standards set, with their justification
- The clinical condition or process of care to be audited (referenced to guidelines etc.)
- The results of the first data collection in comparison with the standards set
- A summary of the discussion and changes agreed, including any changes to the agreed standards
- The changes implemented
- The results of the second data collection in comparison with the standards set
- The quality improvement achieved
- Reflection on the clinical audit in terms of:
  - o Knowledge, skills and performance
  - o Safety and quality
  - o Communication, partnership and teamwork
  - o Maintaining trust.

### Working in teams

In some specialties, clinical audit is likely to be undertaken collaboratively and reflect the performance of a clinical team, rather than that of individual practitioners. It is acceptable to include this type of audit as supporting information for appraisal for revalidation, but the doctor must have contributed to the choice of topic and the standards to be used. The doctor must be able to state that the care identified within the first audit and the re-audit reflects the care that they personally deliver. They must state what changes they instituted and be able to demonstrate the effects of those changes on their own practice.

### Interpretation of audit activity by the appraiser

The account above describes the ideal audit process to which doctors should aspire. However, it is not realistic to expect that every single item in the above list will have been achieved to perfection in the early days of revalidation. The appraiser will make a judgement of the adequacy of the process in the individual case, and will look particularly for reflection, learning and an appropriate action plan.

### General Practitioners without a fixed practice base

For some GPs – particularly those without a fixed practice base, or employed GPs who usually have no managerial role and therefore no or limited organisational influence to bring about change in the behaviour of colleagues – audit in its traditional format may be more challenging and less relevant to the individual's appraisal. Additional challenges that audit presents to locum GPs include limited access to records, a lack of continuity in the place of work and the ability of the GP to influence other team members. The essential elements of audit – reviewing, reflecting and improving – should, however, be incorporated into other review exercises which support quality improvement in the individual.<sup>11</sup>

## 8.1.2 Review of clinical outcomes

Where robust, attributable and validated data are available, documentation of a doctor's clinical outcomes, coupled with reflection, learning and, where necessary, practice change will be carried out in a similar manner to clinical audit. Many specialties have well-documented clinical outcomes that reflect key aspects of a doctor's practice, and this is especially true of surgical specialties.<sup>12</sup>

The measurement of clinical outcomes is complex with several different methods available:

- National clinical audits specifying a doctor's outcomes
- Outcomes derived from routinely collected data, e.g. hospital episode statistics
- National clinical audits specifying the surgical team/unit's outcomes
- Local audit of outcomes
- Structured peer review of outcomes.

The surgical specialty associations have devised guidance on how outcomes in each specialist area of practice should be measured. These measures depend on robust data systems and processes by trusts, which are not always available. It is recognised that improvement is required in systems to allow access to data and correct attribution. However, if that data is available, it should be taken into account in a doctor's appraisal.

If the doctor's specialty recommends the use of a logbook to record their personal outcome data this should be presented at the their appraisal.

Consideration of clinical outcomes may include morbidity and mortality statistics or complication rates where these are routinely recorded for local or national reports and individual contributions to national specialist databases.

### Working in teams

In some specialties, a number of individuals may have the same type of clinical practice and it may be more efficient for data to be collected collaboratively rather than by each individual separately. It is acceptable to include clinical outcome data of this sort as supporting information for appraisal, but, the doctor should have compared their own data with those of their colleagues within the unit and taken advantage of the opportunity for local benchmarking. Where a doctor's outcomes differ from those of others, they should be able to discuss what changes have been made by the doctor and their unit and be able to demonstrate the effects of those changes on their own practice or how they will be monitoring the effect of those changes in the future.



## 8.1.3 Case review or discussion

These are the terms used to describe a documented account of educational or challenging cases that a doctor has discussed with a peer, a doctor from another specialty or within a multi-disciplinary team. This activity is more of a practice improvement activity than a quality improvement activity, but if done in a formal way it will contain all of the elements of quality improvement.

Namely:

- Identification of a problem
- Determining the solution
- Reflecting on what has been learned
- Making a change in professional practice or supporting current good practice
- Documenting the change in relation to future practice

There are several positive features of this type of activity:

- Areas of uncertainty are embedded in the doctor's professional practice
- Any indicated change can usually be implemented immediately
- The process is (or should be) part of every doctor's routine practice
- The method can be used for non-clinical as well as clinical activity.

This method of demonstrating engagement with a quality improvement process should not be used as a substitute for clinical audit or clinical outcomes if these more robust methods are available. If they are not, then appraisers should expect to review at least two such documented discussions in each year of the revalidation cycle.

### Case-based discussion for the Royal College of Psychiatrists

For psychiatrists, the process of case-based discussion is more formal than for some other specialties. The Royal College of Psychiatrists (RCPsych) recommends that a minimum of ten case-based discussions are undertaken over a five year period (two discussions per year). At each case-based discussion, the discussion will focus on whether the psychiatrist has satisfactorily met the standards being evaluated from *Good Psychiatric Practice*. Positive aspects of the clinical care will be highlighted, together with the identification of areas of improvement. Each area for improvement will then link to the Personal Development Plan, which will be followed up at appraisal.<sup>13</sup>

## 8.2 Quality improvement activity for those with non-clinical roles

### Quality improvement for educationalists

For educationalists not involved in clinical work the GMC recommends that quality improvement is demonstrated through auditing and monitoring of the effectiveness of an educational programme. This may be challenging as educational outcomes from programmes provided to groups of learners are difficult to measure objectively and may take a long time. Other ways of demonstrating effectiveness would include the presentation of feedback data from those taught and possibly the views of learners on how their own knowledge and practice had changed.

### Quality improvement for medical managers

For medical managers without clinical activities the GMC recommends that quality improvement is demonstrated through an evaluation of the impact and effectiveness of a piece of health policy or management practice. This should form part of normal management processes but, for revalidation, should include the elements of reflection and learning that are common to all other forms of quality improvement activity.<sup>14</sup>

### Quality improvement for those with multiple roles

If managers or educationalists are also involved in clinical work with patients, then appraisers should expect to see evidence of quality improvement activity directed at patient care within the portfolio of supporting information during the five-year revalidation cycle.

### 8.2.1 What the appraiser is looking for

The GMC states that the following areas should be considered in relation to quality improvement activities:<sup>4</sup>

- Have you participated actively in the selected quality improvement processes?
- Do the selected processes reflect key elements of your professional work?
- Have you evaluated and reflected on the result of the quality improvement activity?
- Have you taken appropriate action in the form of practice change, service development or other activities in order to respond to the findings?
- Have you undertaken, or planned to undertake, a review of the changes made?

# 9.0

# Significant events and significant untoward incidents

## Definitions

‘In secondary care the term “significant untoward incident” (SUI) is used to refer to an unexpected event that could or did cause harm to one or more patients or members of staff or the public. These are therefore essentially negative occurrences.’

National Institute for Clinical Excellence, 2002

## Definitions

‘In primary care the term “*significant event*” includes positive occurrences where there was a good outcome, and from which something may be learned – in other words, these are similar to case discussions.’

National Institute for Clinical Excellence, 2002

The purpose of presenting data on significant events at appraisal is not to discover what went wrong (where this happened) but, to agree and build upon the learning that resulted - whether the event was a positive or a negative one. Significant events should therefore not be discussed for the first time at an appraisal meeting. An anonymised summary of the event together with reflection, the learning gained, and any changes in practice that followed should be included in the appraisal portfolio.

In secondary care, clinical incidents are usually distinguished from SUIs. Most doctors will be involved in very few SUIs and so all of these should be considered at appraisal, focusing on the actions that should already have been taken by the individual and the organisation. A doctor and his/her team may have been involved in a number of clinical incidents each year. Most of these do not result in significant harm to patients but have the potential to do so.

Confusion exists regarding the distinction between those significant events in which a consultant has been ‘named’ and those for which a consultant may have been directly involved. It is less important to make distinctions between levels of involvement than to focus on reflection, learning and action taken and these should be summarised for inclusion in appraisal.

The GMC states:

‘You should discuss significant events involving you at appraisal with a particular emphasis on those that have led to a specific change in practice or demonstrate learning.’<sup>4</sup>

### Significant events in independent practice

Doctors in independent practice should ensure that they keep a personal record of any such events. This applies to independent practitioners who also work in the NHS as well as those who do not.

### Significant events in primary care

The following points should be considered by doctors in primary care when discussing and recording significant events:

- Each of the submitted events must demonstrate, through the analysis, areas for improvement, reflection and the implementation of change
- Wherever possible, the doctor should only submit analyses of significant events in which they have been directly involved
- Wherever possible, the event should be discussed in a team meeting (usually a significant event audit meeting) with an appropriate selection of other primary care team members present and where the changes involve the doctor themselves, perhaps as the person responsible for implementing the change. If that is not possible, the doctor should try to demonstrate what steps were taken to involve other members of the team or what steps have been made to discuss the issue with colleagues
- For doctors without a fixed practice base, the discussion of the significant event in a peer group or learning group allows reflection, learning and planning of changes
- If there is a patient safety concern or event (also known as a serious incident) within the doctor's clinical practice, that event must be included as one of the 10 significant event audits and included in the doctor's revalidation portfolio.

### What the appraiser is looking for

It is not the appraiser's role to conduct investigations into serious events. Organisational clinical governance systems and other management processes are put in place to deal with these situations. The appraiser should concentrate on discussing the learning that has taken place and any impact on your professional practice.

The GMC states that the following areas should be considered in relation to significant events:<sup>4</sup>

- What has been your participation in logging any incidents or events and in clinical governance meetings where incidents or events were discussed?
- What learning has taken place?
- What solutions and improvements have occurred?
- What actions did you take and/or what changes did you implement to prevent such events or incidents happening again?

# 10.0

## Feedback on the doctor's practice: how others perceive the quality of the doctor's work

## 10.1 Colleague and patient feedback

Feedback from colleagues and patients should be obtained using a validated questionnaire that meets the standards set by the GMC.<sup>15</sup> The key principles are that acceptable questionnaires must:

- Be consistent with the principles, values and responsibilities set out in the GMC's core guidance, *Good Medical Practice*
- Be piloted on the appropriate population, and demonstrate that they are reliable and valid
- Reflect and measure the doctor's whole practice
- Be evaluated and administered independently from the doctor and their appraiser to ensure an objective review of the information
- Provide appropriate and useful information that can be used in discussions with a supervisor or mentor, or through appraisal
- Help the doctor to reflect on their practice and identify opportunities for professional development and improvement.

Several questionnaires exist that meet these principles including those developed for the Academy of Medical Royal Colleges.<sup>16</sup>

### Timing and sharing of results

It is recommended that colleague and patient feedback is carried out no later than the third year of the revalidation cycle in order to allow time for changes in behaviour and performance to be re-evaluated if required. The process itself takes up to three months if doctors use a commercial system to help with the analysis and presentation of results.

The results of colleague and patient feedback should be shared with the doctor with sensitivity and the results should not be given to them for the first time at their appraisal meeting. Ideally the results should be returned to an independent person who is trained in giving feedback, and the process should be completed prior to the submission of supporting information to the appraiser. It may be acceptable for the results to be shared with the doctor by their appraiser, but in this case the appraiser must be appropriately trained and the results should be shared separately from, and before, the appraisal meeting.

### Colleague feedback – defining a 'colleague'

Those invited to complete colleague feedback should include a representative spectrum of those with whom a doctor works. For those in mainly clinical practice this would include consultant colleagues, nursing staff, professions allied to medicine, clerical staff, trainees and students (if any). For those predominantly involved in management, 'colleagues' will include members of their management team, clinicians who have been involved in management processes and members of outside bodies with whom the manager has had regular contact.

In cases where there is a wide range of professional activities, or where a doctor works across a number of sites, the total number of raters may need to be increased to provide a meaningful outcome, or it may be necessary to carry out more than one colleague feedback exercise. The best approach to this has not been defined.



### Patient feedback

It is recognised that feedback from 15-20 patients once in five years is not a robust method of evaluating the quality of a doctor's relationship with his or her patients. Some further information may be gained from consideration of complaints and compliments (see 10.2) and a few simple rules will help the current requirements to achieve the greatest benefit. The process should at least adhere to the GMC's requirements and in particular the doctor should be unaware which patients have been asked to provide feedback. It is important that the doctor engages with patients from across the range of their professional activities, and this may include inpatients as well as outpatients.

Many patients relevant to particular specialties may have difficulty communicating (those with dysphasia, for example), may only have contact with you for a short period (anaesthesia) or may have patients for whom the process would be stressful (palliative medicine). Specialties have developed ways to meet these challenges and specialty guidance should be consulted.

For doctors who have no patient contact the GMC comments:

'You should assume that you do have to collect patient feedback, and consider how you can do so. We recommend that you think broadly about who can give you this sort of feedback. For instance, you might want to collect views from people who are not conventional patients but have a similar role, like families and carers, students, or even suppliers or customers'.<sup>4</sup>

While this approach will be helpful to many of those in clinical practice there may not be a great difference between suppliers or customers and 'colleagues' for those in medical management. Guidance regarding equivalent groups to 'patients' may be obtained through the Faculty of Medical Leadership and Management as well as from the GMC's published guidance.<sup>17,4</sup>

The majority of patient and colleague feedback will, fortunately, be positive. It is in the free text comments that small areas for improvement may be found and it is important that the appraiser gives time for supportive consideration of this aspect during the appraisal discussion.

### What the appraiser is looking for

- Has the doctor received and considered the results of colleague and patient feedback before the appraisal?
- Have areas for further professional development been identified through the feedback process?
- Did the colleagues and patients chosen reflect the full spectrum of the doctor's professional activity?
- Was the method used to distribute patient questionnaires robust and was the doctor aware of which patients were to be included?
- Did the number and spectrum of respondents meet the criteria set out when the questionnaires used were validated?

## 10.2 Complaints and compliments

As a matter of probity, doctors should include all complaints, even when the doctor is the only person aware of them. Complaints not directly relating their own practice can still provide important learning and should also be included. In most NHS organisations it is the consultant responsible for the patient's care who is asked to provide a response to the complaint. Where this is the case, there will be an opportunity to document any learning and to document any practice or service change that has resulted. The doctor should document any change in their own practice that they have made, or that they have ensured in members of their team.

Compliments should also be presented at appraisal as they, too, provide a source of learning and reinforcement.

Complaints and compliments should be summarised and anonymised before they are included in the portfolio of supporting information.

### What the appraiser is looking for

It is not the appraiser's role to conduct investigations into complaints. These should be dealt with as part of the organisation's clinical governance systems in a timely manner. The appraiser should concentrate on discussing the learning that has taken place and any impact on the doctor's professional practice.

- How has the doctor been involved in responding to complaints and is there evidence that they have adhered to the advice given in *Good Medical Practice*?
- What is the learning that has resulted from the complaints?
- What action has the doctor taken to embed this learning in their practice or in the organisation

# 11.0

# Achievements, challenges and aspirations

The appraisal should provide an opportunity for consideration of the doctor's achievements, challenges and aspirations. This important part of the confidential appraisal discussion offers the doctor an annual opportunity to review practice, chart progress and plan for development, and it ensures that the appraisal is a useful process for all doctors.

**This may not be a requirement for revalidation but it is a vital part of the appraisal process and should be prepared for and addressed appropriately.<sup>4</sup>**

The doctor should prepare for the appraisal by considering how the principles and values set out in the four domains of the *Good Medical Practice Framework for Appraisal and revalidation*<sup>18</sup> have been met. Many commercial or specialty-based revalidation systems will allocate the individual items of supporting information to the appropriate categories, but this should be checked and reflected on by the doctor. Areas of *Good Medical Practice* that are less well supported will form an important element of the personal development plan for the following year.

# 12.0

# Agreeing the new Personal Development Plan (PDP)

Consideration of the supporting information will generate a number of further development needs and these should be agreed between the appraiser and the doctor, together with an appropriate timescale for implementation and the means by which achievement of the objective will be demonstrated. This timescale may be more or less than one year and must be realistic. If the time is more than one year, progress towards this target will be considered at the next appraisal. If less than one year and if the development need is significant in relation to the doctor's practice, then there should be a review of progress with the appraiser at an appropriate time, ahead of the next revalidation appraisal.

### **Personal development planning and job-planning**

It is recognised that a doctor's personal development will need to fit with the needs of the employing organisation and that the appraiser must be aware of the job-plan in order to carry out an effective appraisal. However, appraisal must be separated from the process of job-planning, even though this creates an additional time-commitment. With the start of revalidation, it is likely that job-planning will be conducted with medical managers and that these managers will frequently not be the doctor's appraiser (although they may be). This separation will help to distinguish the two processes and will help to strengthen both.

# 13.0

# Conclusion

Much of the focus of medical revalidation in the UK has been on the supporting information that must be brought to annual appraisals in order to allow the appraiser to make a judgement about the doctor's practice. This process risks focusing too closely on 'ticking off' each requirement in turn and thus the overview of the quality of a doctor's practice, which was the core of previous medical appraisals, may be lost.

This must not be allowed to happen, despite the increased time that is required for the new appraisal and revalidation processes. It is only by retaining the formative and supportive approach while building on the learning and development opportunities that the new process provides, that doctors will remain engaged and patients will benefit.



## REFERENCES

- 1 NHS revalidation Support Team (2013) *Medical Appraisal Guide – A guide to medical appraisal for revalidation in England*. Available at: [www.revalidationsupport.nhs.uk/CubeCore/uploads/documents/pdf/rst\\_medical\\_appraisal\\_guide\\_2013.pdf](http://www.revalidationsupport.nhs.uk/CubeCore/uploads/documents/pdf/rst_medical_appraisal_guide_2013.pdf) [Accessed April 2014]
- 2 NHS revalidation Support Team (2014) *Quality Assurance of Medical Appraisers: Engagement, training and assurance of medical appraisers in England*. Available at: [www.revalidationsupport.nhs.uk/CubeCore/uploads/documents/pdf/Quality\\_assurance\\_medical\\_appraisers\\_main\\_document\\_v5.pdf](http://www.revalidationsupport.nhs.uk/CubeCore/uploads/documents/pdf/Quality_assurance_medical_appraisers_main_document_v5.pdf) [Accessed April 2014]
- 3 NHS Employers. *revalidation: appraisal and supporting information*. Available at: <http://www.nhsemployers.org/your-workforce/retain-and-improve/standards-and-assurance/professional-regulation/medical-revalidation/revalidation-appraisal-and-supporting-information>
- 4 General Medical Council (2012) *Ready for revalidation: Supporting Information for Appraisal and revalidation*. Available at: [http://www.gmc-uk.org/Supporting\\_information\\_for\\_appraisal\\_and\\_revalidation.pdf\\_48977650.pdf](http://www.gmc-uk.org/Supporting_information_for_appraisal_and_revalidation.pdf_48977650.pdf)
- 5 General Medical Council (2013) *Good Medical Practice*. Available at: [http://www.gmc-uk.org/guidance/good\\_medical\\_practice.asp](http://www.gmc-uk.org/guidance/good_medical_practice.asp) [Accessed May 2014]
- 6 Academy of Medical Royal Colleges (2012) *Academy reflective template for revalidation*. Available at: [http://www.aomrc.org.uk/doc\\_download/9556-academy-reflective-template-for-revalidation](http://www.aomrc.org.uk/doc_download/9556-academy-reflective-template-for-revalidation) [Accessed May 2014]
- 7 Royal College and Faculty guidance on Supporting Information for Appraisal and revalidation. Available at: <http://www.aomrc.org.uk/revalidation/specialty-advice.html> [Accessed May 2014]
- 8 Academy of Medical Royal Colleges CPD documents. Available at: [www.aomrc.org.uk/directors-of-continuing-professional-development/cpd-documents.html](http://www.aomrc.org.uk/directors-of-continuing-professional-development/cpd-documents.html) [Accessed May 2014]
- 9 Medical Royal College and Faculty approach to CPD activity. Available at: <http://www.aomrc.org.uk/directors-of-continuing-professional-development/college-support-for-cpd-for-revalidation.html> [Accessed May 2014]
- 10 Academy of Medical Royal Colleges (2009) *Clinical Audit and revalidation*. Available at: [http://www.aomrc.org.uk/doc\\_details/40-clinical-audit-and-revalidation](http://www.aomrc.org.uk/doc_details/40-clinical-audit-and-revalidation) [Accessed May 2014]
- 11 Royal College of General Practitioners. *Revalidation: Guidance for GPs*. Available at: [www.rcgp.org.uk/revalidation-and-cpd/new-revalidation-guidance-for-gps.aspx](http://www.rcgp.org.uk/revalidation-and-cpd/new-revalidation-guidance-for-gps.aspx) [Accessed May 2014]

- 12 *Revalidation: Guide for Surgery*: Federation of Surgical Specialty Associations | The Royal College of Surgeons of Edinburgh | The Royal College of Surgeons of England | The Royal College of Physicians and Surgeons of Glasgow. Available at: <http://www.rcseng.ac.uk/surgeons/working/docs/revalidation-guide-for-surgery>
- 13 Royal College of Psychiatrists (2012) *Revalidation guidance for psychiatrists*. RCPsych. Available at: <http://www.rcpsych.ac.uk/files/pdfversion/CR172.pdf> [Accessed January 2014]
- 14 Faculty for Medical Leadership and Management (2012) *Supporting information for appraisal and revalidation: guidance for doctors in leadership and management roles*. Available at: <https://www.fmlm.ac.uk/leadership-landscape/challenges-ahead/revalidation/revalidation-guidance> [Accessed May 21014]
- 15 General Medical Council (2012) *Ready for revalidation: Colleague and Patient Questionnaires*. GMC. Available at: [http://www.gmc-uk.org/doctors/revalidation/colleague\\_patient\\_feedback.asp](http://www.gmc-uk.org/doctors/revalidation/colleague_patient_feedback.asp) [Accessed May 2014]
- 16 Academy of medical Royal Colleges (2009) *Multi-source Feedback, Patient Surveys and revalidation*. Available at: [http://www.aomrc.org.uk/doc\\_download/56-multi-source-feedback-patient-feedback-and-revalidation](http://www.aomrc.org.uk/doc_download/56-multi-source-feedback-patient-feedback-and-revalidation) [Accessed May 2014]
- 17 Faculty of medical Management and Leadership revalidation Helpdesk. Available at: [www.fmlm.ac.uk/professional-development/revalidation/revalidation-helpdesk](http://www.fmlm.ac.uk/professional-development/revalidation/revalidation-helpdesk) [Accessed May 2014]
- 18 GMC (2013) *The Good Medical Practice Framework for Appraisal and revalidation*. Available at: [http://www.gmc-uk.org/GMP\\_framework\\_for\\_appraisal\\_and\\_revalidation.pdf\\_41326960.pdf](http://www.gmc-uk.org/GMP_framework_for_appraisal_and_revalidation.pdf_41326960.pdf) [Accessed May 2014]

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