WESSEX
Appraisal Service

Keeping it personal. Making it real.

New Appraiser Training

Delegate Pack

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1. Introduction for participants

This two-day course provides a practical approach to new appraiser training and skills development that we hope you will find beneficial, enjoyable and suited to your training needs.

It includes all the core elements described by the NHS Revalidation Support Team (RST) and NHS England in *Quality Assurance of Medical Appraisers* and included in the RST *Revalidation training for current appraisers*. Having completed the training, you will be ready to undertake medical appraisals for revalidation and perform them to consistent standards with other medical appraisers.

Objectives

By engaging with this training, you will be able to demonstrate that you are:

- comfortable with the principles and processes underpinning medical appraisal
- competent to be a medical appraiser
- consistent in applying the key principles
- confident about your own skills in facilitating and writing up a valuable medical appraisal for a colleague

These objectives are based on the broader competencies (or abilities) that good appraisers should possess. These competencies are described in 'Competency framework for medical appraisers', taken from Appendix 3 in:
http://www.england.nhs.uk/revalidation/wp-content/uploads/sites/10/2014/05/qa-med-app-append-v5.pdf

Assessment process

The role of the appraiser is becoming increasingly important and is integral to revalidation.
Your ability to demonstrate the core appraiser competencies will be assessed, and at the end of the course there will be written feedback on your performance. You will be trained to give feedback as an appraiser and there will be opportunity to rehearse the skills and get verbal feedback throughout the two-day course. This should be used as a tool to help you develop your skills in a formative way. It will also provide useful information to reflect on in your own appraisal.

The assessment element of this programme for new appraisers can also be used to ensure that all prospective appraisers are able to demonstrate the necessary level of skill to undertake the role.

The format for the observations and post-course written feedback is included in Section 3:
'New appraiser skills assessment, observation and feedback framework'
Please familiarise yourself with this framework so you are aware of the skills that you will be seeking to observe (when you are the observer) and demonstrate (when you are the appraiser) in the trio exercises.

Many of the materials in this resource pack will be familiar to you as a doctor who has had appraisals. They will be covered during the training, and act as a resource once you become a medical appraiser. As such you will find that there is quite a lot of repetition in order that each section can work as a stand-alone reference.

2. Pre-course reading and preparation

You may wish to review the key documents that form the basis for medical appraisals for revalidation prior to the course, but you should already be aware of them and the key content will be covered, so it is not essential to do so. This links are provided for reference and for your interest:

1. Good Medical Practice Framework for appraisal and revalidation (GMC, 2013)

2. Supporting information for appraisal and revalidation (GMC, 2018)

3. Medical Appraisal Guide – a guide to medical appraisal for revalidation (2013

   This document describes the process for providing a medical appraisal for revalidation.

There are two further key documents which it would be beneficial to read and understand prior to attending the first day of the training:

4. 'Core messages'

   Sent out with pre-course information and included in resource pack.
   This document highlights the most important messages to ensure that all doctors have appraisals that are conducted to similar standards and principles.

5. 'Providing a professional appraisal'

   Sent out with pre-course information and included in resource pack.
   This document provides a framework for ensuring that all appraisers have a shared understanding of what it means to provide a professional appraisal, particularly around areas such as confidentiality and data protection.

3. New Appraiser skills assessment observation and feedback form

Appraiser: Observer:

Key: N=not observed, Y=observed

Competency being assessed	Observations/ comments	Y / N
• Understands the purpose of medical appraisal and revalidation and the role and responsibilities of the appraiser. • Applies the key messages		
• Prepares well for the appraisal discussion, making appropriate professional judgements about the documentation		
• Introduces a professional appraisal • Sets the scene, including confidentiality. • Builds rapport.		
• Eye contact • Smiles • Non-Verbal/ Paraverbal cues • Echoing • Silence • Reflective/positive body language		
• Open questions • Paired questions • Clarification • Picking up on cues • Picking up on feelings where appropriate		
• Agenda setting • Focused and doctor centred discussion • Summarising • Developing conclusions • Moving on • PDP objectives		
• Demonstrates appropriate levels of support • Affirms the doctor • Encourages quality improvements in practice		
• Demonstrates the ability to encourage reflection on the scope of work • Reflection on the supporting information • Reflection on lessons learned • Reflection on impact		

Engaged fully with the training	Y / N
Organisational skills: satisfactory completion of pre-course work – read suggested material, brought requested paperwork etc. (If not, why?)	Y / N
Professional responsibility and communication skills: group working – learned from feedback, engaged with training, contributed to group discussions, and was observant of the agreed group rules (If not, why?)	Y / N
Knowledge and understanding and professional judgement: writing SMARTER PDP objectives, assessing summaries of appraisal	
General comments (including any doctor feedback)	
Suggested areas for development	

Recommendation

[NAME] has demonstrated the core competencies necessary to undertake medical appraisals for revalidation. It would be best practice to have a supported probationary period and subsequent review of actual performance as an appraiser.

OR

At this stage, [NAME] has been unable to demonstrate all of the necessary core competencies to undertake medical appraisals for revalidation (for the reasons outlined above) and we would recommend a review to determine the appropriate next steps.

Signed **Course facilitator(s)**

4. Definitions

Revalidation is the process by which licensed doctors demonstrate that they remain up to date and fit to practise. Revalidation is based on local clinical governance and appraisal processes. Doctors need to demonstrate that they are up to date and fit to practise across the whole of their current scope of work (i.e. all jobs/roles or responsibilities for which they need their medical qualification, whether or not they are paid). For most doctors this will happen as a result of satisfactory annual medical appraisals.

The purpose of revalidation is to assure patients and public, employers and other health care professionals that licensed doctors are up to date and fit to practice.

The ***Medical Appraisal Guide*** (RST, 2013) describes how medical appraisal can be carried out effectively. It is designed to help doctors understand what they need to do to prepare for and participate in appraisal and for appraisers and designated bodies to ensure that appraisal is carried out consistently and to a high standard. It should be read in conjunction with GMC guidance, which sets out generic requirements for medical practice and appraisal.

Medical appraisal is a process of facilitated self-review supported by information gathered from the full scope of a doctor's work.

It is a protected time, once a year, for each doctor to focus, with a trained colleague, on their scope of work. This includes looking back at achievements and challenges and the lessons learned from them, including the previous year's personal development plan objectives, and looking forwards to their aspirations, learning needs and the development of new personal development plan objectives.

Medical appraisal can be used for four purposes:

- To enable doctors to discuss their practice and performance with their appraiser in order to demonstrate that they continue to meet the principles and values set out in *Good Medical Practice* and thus to inform the responsible officer's revalidation recommendation to the GMC.
- To enable doctors to enhance the quality of their professional work by planning their professional development.
- To enable doctors to consider their own needs in planning their professional development.

and may also be used:

- To enable doctors to ensure that they are working productively and in line with the priorities and requirements of the organisation they practise in.

The responsible officer is the person with the statutory responsibility for the quality assurance of the appraisal and clinical governance processes for a designated body. The responsible officer makes revalidation recommendations about individual doctors to the GMC.

Summative processes are pass or fail, with access to the next stage dependent on passing. Revalidation is summative.

Formative processes give you feedback on your progress as you go along with the aim of helping you to improve. Medical appraisal is formative.

Assessment is the process used to measure achievements against internal or externally agreed scales, normally after working through a learning program. It is usually at a staging point or end point. It can be formative or summative or both.

Performance management involves measurement against set external standards. It is comparative and summative and may be linked to rewards or sanctions.

5. Competency framework for medical appraisers

Taken from *Quality Assurance of Medical Appraisers* (RST, 2014)

The core competencies for medical appraisers are summarised in the table below:

Competency framework for medical appraisers		
	Competency	**Behaviour**
1	**Professional responsibility:** to maintain credibility as a medical appraiser	
1.1	Maintains high standards of professional responsibility, personal integrity, effectiveness and self-awareness	Maintains high professional credibility Acts as a champion and role model for appraisal and revalidation Demonstrates insight and self-awareness Declares conflicts of interest
1.2	Develops professional competence as a medical appraiser	Undertakes appropriate development in all professional roles including as a medical appraiser, reflecting development needs in their personal development plan Reflects on feedback and makes appropriate changes in behaviour Supports efforts to evaluate and improve local systems and processes
2	**Knowledge and understanding:** to understand the role and purpose of the medical appraiser to be able to undertake effective appraisals	
2.1	Understands the purpose of appraisal and revalidation and understands the role and responsibilities of the medical appraiser	Demonstrates understanding of the purpose of appraisal and revalidation Works within the limits of the medical appraiser role and responsibilities, setting appropriate boundaries
2.2	Understands quality and safety systems and relates this to the context of the doctor's work	Applies knowledge of quality and safety systems to appraisal Adapts approach to the work context of the doctor
2.3	Understands relevant legislation and guidance including equality and diversity, bullying and harassment, information governance, data protection and confidentiality	Maintains knowledge of relevant policies and legislative frameworks and applies the principles in practice Demonstrates fairness and equality and makes allowance for diversity Always deals with confidential data in accordance with information governance policies and guidelines

	Competency	Behaviour
2.4	Understands educational principles sufficiently to inform the appraisal discussion and the design of professional development objectives	Demonstrates a learner-centred approach to the doctor's professional development. Supports the role of professional development in quality improvement Facilitates review of the doctor's practice
2.5	Understands the *Good Medical Practice* framework and GMC supporting information requirements, including relevant specialty-specific guidance	Demonstrates awareness of the *Good Medical Practice* framework and GMC supporting information requirements, including relevant specialty-specific guidance
3	**Professional judgement:** to analyse and synthesise information presented at appraisal and to judge engagement and progress towards revalidation	
3.1	Evaluates the portfolio of supporting information effectively and consistently	Applies GMC standards and specialty-specific guidance appropriately Supports the doctor in developing a portfolio covering the full range of supporting information and the full scope of work appropriate to the stage of the revalidation cycle Makes appropriate sign off statement(s) to the responsible officer, highlighting the reasons for the statement(s) where necessary Reviews evaluation standards with other appraisers and adapts behaviour to improve consistency
3.2	Judges accurately and consistently whether the supporting information shows that the doctor is on track to revalidate	Makes accurate and consistent judgements about the cumulative quantity and quality of supporting information related to different stages of the revalidation cycle
3.3	Able to judge whether there is a patient safety issue or emerging conduct, health or performance concern based on the material presented through appraisal and take appropriate action	Responds appropriately to patient safety issues and early signs of emerging conduct, health or performance concerns according to local policy and procedures Demonstrates the ability to suspend the appraisal process where necessary and take appropriate further action Communicates concerns to the doctor and the responsible officer (or deputy) in a timely fashion

	Competency	Behaviour
3.4	Able to judge whether the doctor has appropriately engaged in the appraisal process and the review of their full scope of work	Makes appropriate judgements about the engagement of the doctor in annual medical appraisal across the whole scope of work Communicates concerns about the doctor's engagement to the doctor and responsible officer (or deputy) appropriately
3.5	Able to evaluate achievement of the previous years' personal development plan objectives and to confirm that the new personal development plan reflects the doctors development priorities	Reviews previous personal development plan objectives with the doctor Indicates the outcome of outstanding items from previous personal development plans clearly Ensures that the new personal development plan addresses the doctor's development priorities arising from the appraisal and gaps in the accumulating revalidation portfolio
4	**Communication skills:** to facilitate an effective appraisal discussion, produce good quality outputs and to deal with any issues or concerns that might arise	
4.1	Able to manage the appraisal discussion effectively	Prepares effectively for the appraisal discussion Sets the context and agrees the priorities for the appraisal discussion Demonstrates the ability to facilitate a well-structured and focused appraisal discussion, centred on GMC standards and the doctor's professional development Demonstrates appropriate time-keeping within the appraisal discussion
4.2	Develops, maintains and applies good communication skills including appropriate levels of support and challenge	Builds good rapport Demonstrates good communication skills including active listening, questioning and summarising Reviews achievements, challenges and aspirations Provides effective feedback and constructive challenge
4.3	Able to manage a difficult medical appraisal	Understands the factors that might contribute to a difficult medical appraisal Demonstrates a range of strategies in managing a difficult medical appraisal
4.4	Able to produce high quality written appraisal records and outputs	Completes appraisal documentation to a high standard

	Competency	Behaviour
5	**Organisational skills:** to ensure the smooth running of the medical appraisal system, including timely responses and sufficient computer skills to be an effective medical appraiser	
5.1	Manages time and workload effectively	Completes appraisal workload and documentation in a timely manner Responds in a timely way to doctors, managerial and administrative staff and the responsible officer (or deputy)
5.2	Has sufficient computer skills to perform the role of medical appraiser	Demonstrates sufficient computer skills to perform the role of medical appraiser Responds to electronic communication in a timely manner Demonstrates effective use of computerised support systems for appraisal and revalidation as required by local policy

6. Core messages

1. Revalidation does not change the nature of appraisal

Revalidation is the means by which doctors demonstrate that they are up to date and fit to practise across the whole of their current scope of work (i.e. all jobs, roles or responsibilities for which they need their medical qualification, whether or not they are paid). For most doctors this will happen as a result of satisfactory annual medical appraisals.

Annual medical appraisal is a process of facilitated self-review supported by information gathered from the full scope of a doctor's work. It is a protected time for each doctor to focus, with a trained colleague, on their scope of work. This includes looking back at achievements and challenges, and the lessons learned from them, including the previous year's personal development plan objectives, and looking forwards to their aspirations, learning needs and the development of new personal development plan objectives. This has been at the heart of appraisal since it was introduced.

2. The focus of appraisal is to promote quality improvements in practice through professional development driven by facilitated reflection

For the majority of doctors, there will be little difficulty in demonstrating practice in accordance with the GMC standards laid out in *Good Medical Practice*, so the balance of the appraisal discussion will focus on professional development as a means to drive quality improvements in practice and better patient care.

> 16. Reflection drives change in performance and is the key to effective CPD.* Good Medical Practice requires you to reflect regularly on your standards of medical practice.†
>
> 17. You must reflect on all aspects of your professional work. This should be informed by discussion with others and by specific evidence, such as data from audit, complaints and compliments, significant events, information about service improvements, results of workplace-based assessments and feedback from patients and colleagues.
>
> 18. You must also reflect on what you have learnt from your CPD activities and record whether your CPD has had any impact (or is expected to have any impact) on your performance and practice. This will help you assess whether your learning is adding value to the care of your patients and improving the services in which you work.
>
> 19. Reflection must be integral to your PDP and appraisal and job planning discussions
>
> * Moon JA (1999) Reflection in learning & professional development: theory & practice Abingdon, Oxon, Routledge Farmer
>
> † General Medical Council (2006) Good Medical Practice London, General Medical Council, paragraph 14(b)

http://www.gmc-uk.org/education/continuing_professional_development/26744.asp (accessed on 25th May 2015)

3. Appraisers support doctors in producing appropriate supporting information for their portfolio

The requirement for revalidation is to produce a portfolio of documentation and supporting information that meets the requirements laid out by the GMP *Framework for appraisal and revalidation* and GMP *Supporting Information for appraisal and revalidation.*

Appraisers will develop expertise in what is appropriate in the portfolio of supporting information. Sharing this expertise will support the doctor in developing a personal portfolio that meets all of the GMC requirements for supporting information over the revalidation cycle.

In addition appraisers have a role in helping doctors to interpret their organisational requirements and specialty specific guidance.

4. Appraisers appraise, responsible officers make recommendations and the GMC makes revalidation decisions

The appraiser

The role of the appraiser is to provide support and challenge through a doctor-centred appraisal discussion. Sharing knowledge and understanding of medical appraisal and revalidation processes are important for doctors new to appraisal, but doctors will rapidly become familiar with the requirements. The key skills are in facilitating reflection, giving feedback and promoting quality improvements in practice through support and challenge.

The responsible officer

Responsible officers needs to quality assure the medical appraisal and clinical governance processes in the organisation to enable them to make fair and reliable revalidation recommendations.

The responsible officer can make one of three recommendations:

1. A **positive recommendation** that the doctor is up to date and fit to practise.
2. A **request to defer** the date of the doctor's recommendation.
3. A notification of the doctor's **failure to engage** in medical appraisal and revalidation.

Serious concerns will be dealt with as and when they arise

It is important that issues and concerns about the health, performance or conduct of a doctor are addressed through existing processes at the time they arise. The appraisal meeting is not usually the most appropriate setting for dealing with concerns so, in most cases, these are dealt with outside the appraisal process in a management or governance setting. The handling of concerns should not be delayed until the appraisal discussion or revalidation recommendation.

The General Medical Council (GMC)

Based on all the information available, the GMC will make a decision about the doctor's fitness to practise and issue a new license to practise. The GMC will deal with deferrals and notifications of failure to engage, as appropriate.

Deferral is a neutral act that allows a doctor to retain their license to practise to give them more time to collect supporting information, or to allow an investigation to be completed. The revalidation recommendation date can be deferred for up to twelve months, but the minimum deferral period is four months.

5. The GMC, as the regulator, defines the standards required for revalidation

In making a recommendation about the fitness to practise of a doctor, the responsible officer will refer to the GMC standards in *Good Medical Practice* and the requirements in the *Good Medical Practice Framework for appraisal and revalidation*

Guidance from the royal college and faculties gives the specialty context for the supporting information required for appraisal.

Doctors should also have regard to any requirements that the employing or contracting organisation may have concerning local policies.

6. The *Medical Appraisal Guide* (MAG) defines an appraisal process suitable to support revalidation

Key elements of this process are:

- doctors have an annual appraisal which covers their whole scope of work
- doctors must provide six types of supporting information as described by the GMC in *Supporting Information for Appraisal and Revalidation*
- a doctor's appraisal must take place in the context of the four domains of the GMC's *Good Medical Practice Framework for appraisal and revalidation*
- there must be a structured review of progress with the doctor's personal development plan and the creation of new personal development plan objectives which arise through the appraisal process
- there must be formal sign-off by the doctor and appraiser confirming that no concerns about the doctor's fitness to practise have been raised by the information presented or discussed in appraisal

Key messages for appraisers

1. First: do no harm

Appraisal should be a positive experience for a doctor

An individual doctor should never come away from an appraisal demoralised and disillusioned by the process. To support continuing professional development and quality improvement, appraisal needs to empower and support doctors. Appraisers must resist their "inner head teacher", and remember that adult learning is most effective when it is learner-centred.

The effort needs to be proportionate

It is important that medical appraisal does not take doctors away from frontline care to a disproportionate extent.

Appraisers must not take on inappropriate roles even if they have the skills

Appraisers should be consciously aware of the limits of the appraiser role. They should know when and how to move a doctor on to other avenues of support, or to ask for help.

2. If in doubt…ask

Appraisers should have a low threshold for seeking advice

Appraisers should be empowered to use their professional expertise. They should regularly seek advice and calibrate professional judgements with appropriate colleagues so that they do not operate in isolation. Appraisers should have access to support networks, including peer support, appraisal leadership and access to the responsible officer.

Appraisers need access to professional support structures

Appraisers need to be able to signpost the doctor to appropriate support structures and so it is important to have information, including contact details of the local appraisal policy and performance procedures or occupational health processes.

The doctor being appraised is the expert

Without the opportunity to understand the context for a piece of supporting information or a statement in the pre-appraisal documentation, it is very easy to jump to a wrong conclusion about quality of care or the root cause of an issue. Waiting to gather as much information as possible before coming to a professional judgement about can be hard, but not doing so is a recipe for making mistakes. The appraisal discussion will provide the chance to ask the doctor to clarify.

Supporting information needs to be set in context

It is extremely rare for a doctor to present concerns about patient safety to the appraiser that are serious enough to necessitate a suspension of the appraisal and referral to the responsible officer. It will almost always be more appropriate to go ahead with the appraisal discussion to understand the context and put the appraiser in a position to make a professional judgement.

The face-to-face appraisal discussion gives an opportunity to refine the response and ensure it is entirely appropriate and timely and to signpost appropriate professional support.

7. Providing a professional appraisal

These briefing notes are a starting point for creating a shared understanding of the purpose of revalidation and appraisal, and clarifying professional boundaries, behaviour and responsibilities in relation to the appraisal process.

1. Purpose of revalidation

- To assure patients and public, employers and other health care professionals that licensed doctors are up to date and fit to practise

2. Purposes of medical appraisal

- To enable doctors to discuss their practice and performance with their appraiser in order to demonstrate that they continue to meet the principles and values set out in "Good Medical Practice" and thus to inform the responsible officer's revalidation recommendation to the GMC.
- To enable doctors to enhance the quality of their professional work by planning their professional development.
- To enable doctors to consider their own needs in planning their professional development.

  and also
- To enable doctors to ensure that they are working productively and in line with the priorities and requirements of the organisation they practise in

Most doctors should have no difficulty in demonstrating that they are up to date and fit to practise and should spend most of their appraisal discussing their continuing professional development and how to improve the quality of their practice.

3. Professionalism

- Appraisals should not be vulnerable to appearances of collusion; all doctors have a right to a robust appraisal that promotes their personal and professional development.
- Both doctor and appraiser should be punctual and professionally presented. The appraisal will be conducted in a professional manner within an appropriate working environment (i.e. professional, private/confidential, no interruptions, able to access necessary resources/internet).
- The appraiser and the doctor should report any concerns about the conduct of the appraisal to an appropriate person (e.g. appraisal lead)
- There should be a written complaints process and a process for dealing with significant incidents relating to the appraisal process.

4. Confidentiality and Good Medical Practice

- The content of the supporting information and the appraisal discussion will normally be kept confidential by the appraiser.
- The doctor and appraiser should understand that all doctors are subject to an over-riding duty to protect patients.

- If a doctor reveals during the appraisal something that gives rise to such serious concerns about their personal safety (their health) or patient safety (their fitness to practise) that confidentiality is no longer the most important principle, then the appraisal process will be suspended and other processes started (occupational health or performance procedures).
- Overall, the appraiser must apply their professional judgement, to establish whether there is a patient/personal safety issue, in accordance with section 43 of the GMC's Good Medical Practice:

> *"You must protect patients from risk of harm posed by another colleague's conduct, performance or health. The safety of patients must come first at all times. If you have concerns that a colleague may not be fit to practise, you must take appropriate steps without delay, so that the concerns are investigated and patients protected where necessary. This means you must give an honest explanation of your concerns to an appropriate person from your employing or contracting body, and follow their procedures."*
>
> Section 43, Good Medical Practice, GMC 2006

Data Protection

- The appraiser must not hold or retain (other than for the immediate purpose of undertaking the appraisal) their own independent records relating to the doctor or the appraisal.
- Electronic information must always be sent using secure email systems in accordance with local appraisal and information governance policies.
- Local information governance policies should cover whether personal computer systems and memory sticks can be used for appraisal and revalidation information and these policies must be followed
- The appraiser has a professional and legal responsibility to handle all information in accordance within legal parameters and safeguards.

Information Sharing

- The completed appraisal documentation, including the supporting information, will be available for access by the responsible officer (RO) or someone acting with appropriate delegated authority
- The appraisal documentation may be used for:
    - appraisal;
    - monitoring and managing patient safety and the doctor's fitness to practise (including making fitness to practise recommendations);
    - facilitating early recognition of patterns of capability or conduct concerns;
    - management and quality assurance of the systems and processes;
    - the protection of the public; and
    - future legal action or defence by the designated body including indemnifying the responsible officer and/or appraiser.
- The appraisal summary and PDP may be shared with named individuals according to local policy, and analysed to understand collective learning needs and constraints
- Appraisal documentation will not normally be used for any other purpose, in a non-anonymised form, without the doctor's consent. Doctors should be aware that others (e.g. employers) may ask

to see their appraisal documentation and ensure it is professionally presented, without any inappropriate third party information.

5. Venue

- The doctor will normally nominate an appropriate, mutually convenient venue for the appraisal meeting
- The venue must allow the discussion to be private and confidential, free from interruptions, and provide access to the internet and other necessary resources.
- Either the doctor or the appraiser may request reallocation if a venue cannot be agreed.
- If an unusual venue is agreed the agreement and reasons should be recorded in case an explanation is required later and it must always meet the venue criteria.

6. Timing

- The appraisal will normally be in working hours, at a time and date that is mutually convenient and allows sufficient time for the appraisal discussion.
- Either the doctor or the appraiser may request reallocation if personal timetables prove incompatible
- The appraisal meeting will normally take between 1.5-3.5 hours, depending on what is discussed and whether time is included to write up and agree the appraisal outputs.
- The doctor and appraiser will build in appropriate flexibility so that the appraisal is not cut short, they are fresh enough to give the appraisal discussion their full attention and there is appropriate time for reflection afterwards.
- If, in exceptional circumstances, doctor and appraiser mutually agree to meet at a time outside normal working hours, the agreement and reasons should be recorded in case an explanation is required later and they must ensure they are both able to give the appraisal discussion the time and energy it requires.

7. Cancellation

- If something unexpected happens, the affected party will make every effort to communicate with the other party and, where applicable, the administrative team, to explain that there has been an unavoidable change of plan (sickness, transport failure etc.)
- The administrative team will provide appropriate support in ensuring that the message is passed on and received as soon as possible.

8. Pre-appraisal documentation

- The doctor will normally provide everything that is required for the appraisal discussion to go ahead, two weeks before the appraisal date, unless another arrangement has been made by mutual agreement.
- Documentation must be legible and professionally presented, and will normally be typewritten (this may be defined in local policy)
- If the doctor has not provided the required supporting information, the appraisal discussion may need to be postponed until the information is available and the appraiser has had adequate time to prepare

- Documentation that cannot be appropriately anonymised should be made available to the appraiser for review and referenced in the summary of discussion but not attached to the portfolio

9. Post-meeting documentation

- If not completed at the time of the appraisal discussion, the appraiser will ensure that the doctor receives the post appraisal documentation as soon as possible afterwards (a limit may be defined in local policy).
- The doctor will sign off the documentation and return it to the appraiser as soon as possible after receipt (a limit may be defined in local policy).
- Any appraisal documentation that is incomplete (i.e. not fully submitted and signed off by both parties) within 28 days of the appraisal discussion, will be reported to the responsible officer as an incomplete appraisal and an explanation sought in the annual exception audit.

10. Annual Appraisal

- Engagement in annual appraisal requires the doctor to have an appraisal meetingonce every twelve months in work, or complete an appropriate postponement / "approved missed" appraisal application if this is not possible
- It is the responsibility of the doctor to complete their portfolio and engage with the annual appraisal process in a timely fashion.
- It is the responsibility of the doctor to comply with local management requirements for arranging an appropriate appraisal
- If the allocated appraiser is unable to provide a timely appraisal then it is appropriate for the doctor to be reallocated to another appraiser.

11. Setting the boundaries to the appraisal discussion

- Setting explicit boundaries to the appraisal discussion should be included in the local appraisal policy and in appraiser training so that there is a shared explicit understanding of the expectations of a professional appraisal, the roles of both doctor and appraiser, and the limitations of confidentiality, prior to the appraisal discussion.
- Designated bodies may find it helpful to produce written guidance to cover this explicitly and share it pre-appraisal with the doctor
- It is recommended that the appraiser directly addresses the issue of confidentiality and GMC requirements with the doctor at the start of the appraisal interview. This has been found, in practice, to help create a professional atmosphere without interfering with the building of rapport especially if it builds on appropriate written information in the appraisal policy and pre-appraisal. An appropriate statement at the start of the appraisal meeting makes the responsibility and accountability of both parties explicit.

Example of appraiser statement:

"This is <u>your</u> appraisal. I want to make sure that this time is useful to you and addresses the areas that are your main priorities but there are some formalities for us to agree on first… You are aware that all appraisals are conducted under GMC guidance, and that all doctors have a duty of care towards each other and to promote patient safety. We are both responsible for taking appropriate action, should either of us make any statement that raises an issue of patient safety. This might involve suspending the appraisal process, or exploring our options around how we proceed with this appraisal, until the issue has been addressed appropriately. We might have to take advice in such a situation. Do you agree?

You will also know that this discussion is confidential but that the appraisal portfolio that you have prepared and the written outputs that we produce will be available to the responsible officer and others because they form part of the evidence used to support your revalidation recommendation. We will have to be careful that they do not contain any patient or colleague identifiable details and they are always handled according to the data protection and information governance protocol. Was that clear to you beforehand?

Finally, let's check that we have arranged things so we shouldn't be interrupted, set aside enough protected time and made sure we have everything we need to hand before we start…

Are you ready?"

8. Supporting Information

CPD

The GMC states: *"You must carry out CPD activities annually and these must cover your whole practice"*

- How do you keep up to date?
- How do you identify what you need to learn?
- What have you REFLECTED on in your learning this year?
- What are the main things you have learned this year?
- What changes have you made as a result of what you have learned?
- What IMPACT has it had?
- How have you shared your learning with others?
- How do you keep the recording of learning and reflection proportionate?

QIA

The GMC states: *"Every doctor is required to demonstrate how they review the quality of their work across their whole scope of work"* and *"QIA can take many forms depending on the roles you do and the nature of your practice"*

- Quality assurance is about maintaining and patient safety
- Quality improvement is about making things better for patients – and doctors
- Doctors should be encouraged to reclaim their professionalism by defining for themselves areas for improvement and innovation
- There are many different types of QIA but they all involve reflection on learning, whether from cases, data, events or feedback

Significant Events

- A GMC level significant event is any *"unintended or unexpected event, which could or did lead to harm of one or more patients"*
- The GMC states: *"You must declare and reflect on every significant event you were involved in since your last appraisal"*

Learning events in General Practice were formerly known as significant events but this led to confusion about what to declare. They were often positive events used to identify and build on strengths, as well as events where things could have gone better, and were used as QIA. GP Significant Event Analysis (SEA) will become Learning Event Analysis (LEA)

Colleague and Patient Feedback

- The GMC states: *"At least once since you last revalidated you must collect and reflect on feedback from patients (or those to whom you provide medical services) and colleagues from across your whole practice."*
- These formal feedback exercises must meet the GMC requirements (or modifications be agreed with the RO in exceptional circumstances)

Review of Complaints and Compliments

- The GMC states: *"A complaint is a formal expression of dissatisfaction or grievance…You should discuss any change in your practice that you have made as a result of any complaints or compliments you have received since your last appraisal."*

9. Adding value to supporting information

What does an appraiser think about when assessing a piece of supporting information?

Overview / relevance

- Is it personal? Is it about the doctor?
- Is it personally meaningful? Has the doctor explained why?
- Is there any reflection?
- Why is this piece here? Why did the doctor choose to include it?
- What is the context? "seeing the wood for the trees" - especially if there is an excess of supporting information

Quality

- Is there evidence of learning?
- Is there evidence of change? (moving along the road)
- Has the doctor shown / explained the impact on their practice?

For revalidation

- Is there a serious cause for concern? If so, how will I address it?
- Which category of supporting information does it fit into?
- Is it appropriate and sufficient as supporting information for revalidation? (on its own? With other items also provided?)
- Are there any gaps in the supporting information? (considering GMC Supporting Information for appraisal and revalidation about the four areas and six types of Supporting Information)

Finally

- **Has the doctor prepared for their appraisal in a reasonable and proportionate way or have they done too much?**
- **What can I add as the appraiser in the appraisal discussion?**
- **How will I do this?**

10. Exercise: Supporting information scenarios

A range of potential supporting information dilemmas are illustrated in the decision tree and supporting notes in the resource pack. If there is any doubt about the value and relevance of the supporting information, the appraiser should seek advice e.g. from their clinical appraisal lead.

For this exercise, consider your personal responses to the issues in the table.

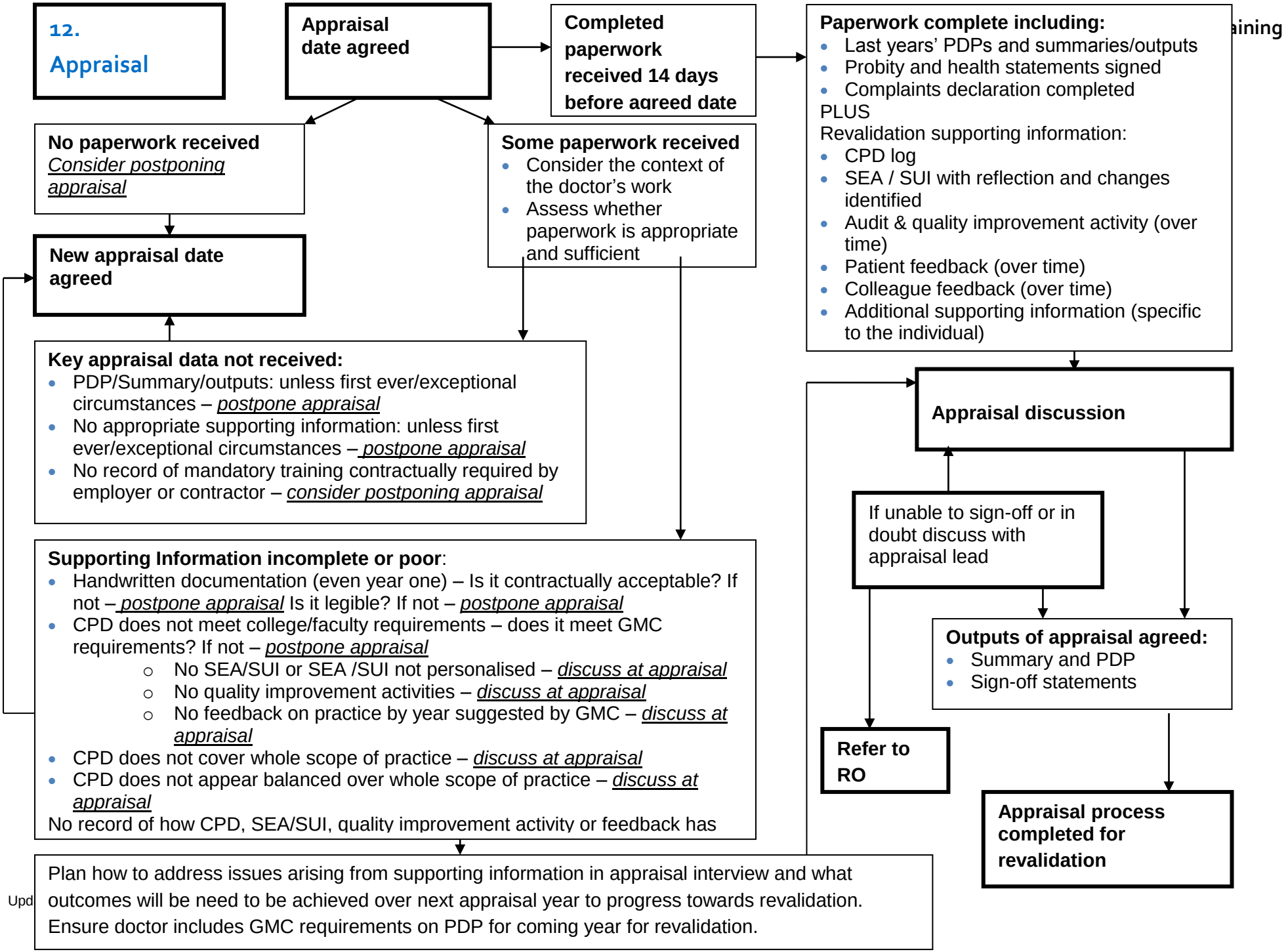
Explanation of decision point	**Your response?** Postpone or go ahead? Discuss? Put in the personal development plan (PDP)? Impact on output statements?
No documentation received by mutually-agreed date	
GMC guidance on supporting information met but college or faculty recommendations not fully met	
Supporting information does not appear balanced across the whole scope of work (e.g. light on the clinical role CPD)	
Supporting information is present but does not include reflection on impact, outcomes or changes in behaviour	

11. Supporting information scenarios: discussion points

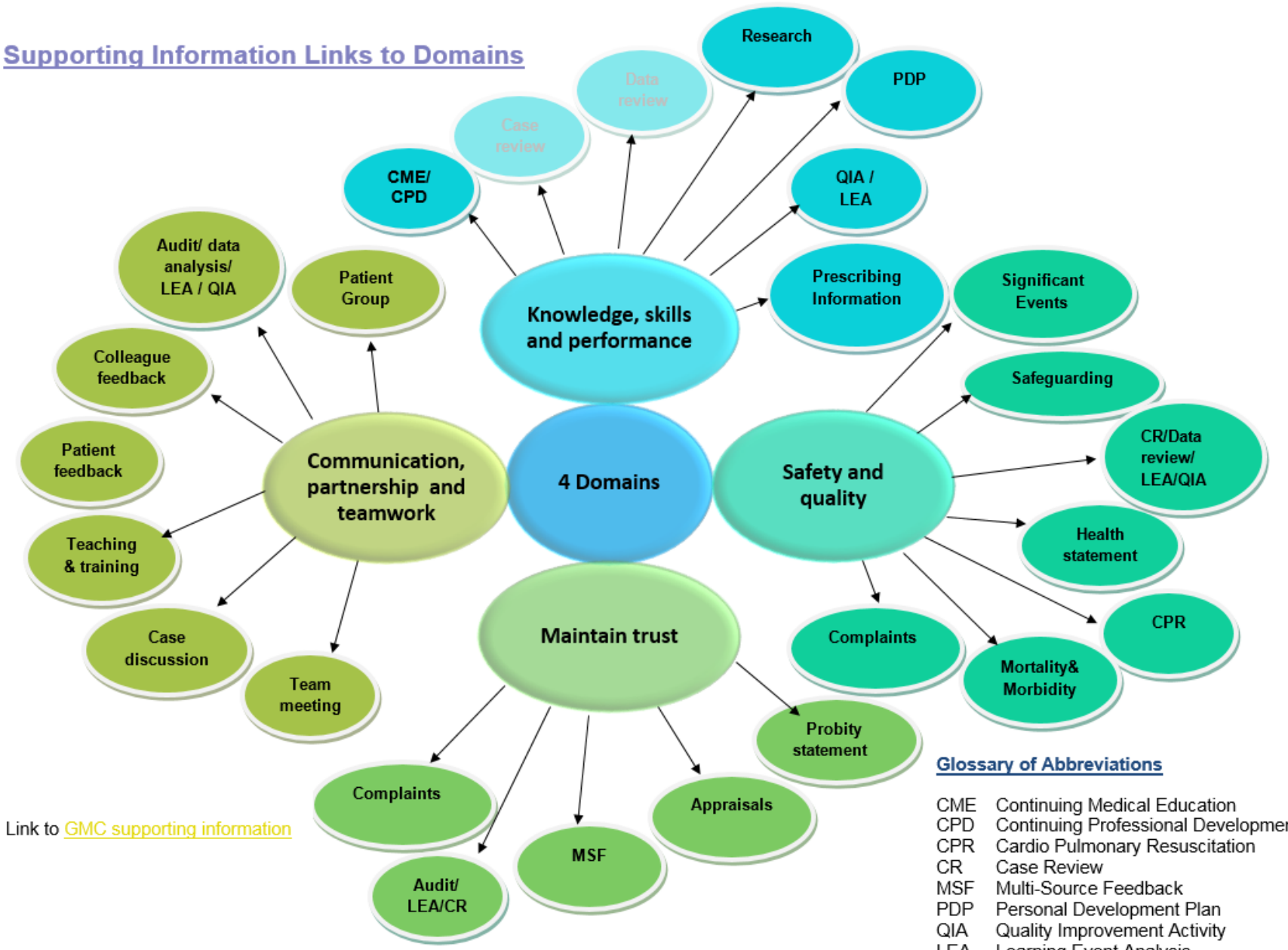
Scenario	Discussion point
No documentation received by mutually agreed date	No matter how inexperienced doctors are in appraisal, they are professionals and should value the appraisal process sufficiently to provide the appraiser with documentation in adequate time to prepare. It is reasonable for the appraiser to ask to postpone the appraisal in these circumstances, although rarely the appraiser may judge that it is more appropriate to accept the documentation with only a very short time to prepare or to go ahead with no documentation at all, particularly if it is a first appraisal, in order to understand the issues better. The local appraisal policy may have strict guidelines or the appraiser may have some discretion depending on circumstances.
Handwritten documentation (illegible)	If the documentation provided is illegible, the appraiser is in the same position as if no documentation had been provided at all (see above).
Handwritten documentation (legible)	Most designated bodies have policies that demand that the professional documents for appraisal should be typed so that they are legible and electronically available to the responsible officer at short notice. Appraisers need to know the local appraisal policy and what leeway they have to be flexible. Patient feedback may take the form of a handwritten card or letter and this is usually presented separately and the reflection on it is what is included in the portfolio If the appraisal policy does not specify typed documentation, it may be reasonable to go ahead with an appraisal with handwritten documentation (as long as it is legible).
Typed documentation, no summary, or PDP included, no previous appraisal	The appraisal documentation specifically asks for previous years' summaries and personal development plans (PDPs) because without these there is no handover from one appraisal to the next. If a doctor has not been part of an appraisal system previously, there will not be a previous summary or PDP to include. The appraisal should go ahead and the appraiser should highlight to the doctor the importance of these documents for future appraisals. It is appropriate to sign a "disagree" statement if no progress has been made with a PDP (for example, because this is a first appraisal for a doctor from outside the UK), with a note to explain the reason. All trainees need to have an appropriate PDP when they qualify through the ARCP process and so they should provide this at their first appraisal after completion of training.

Typed documentation, no summary or PDP included, has had previous appraisal(s)	A doctor who has been involved in appraisal in previous years should be able to provide the summary and PDP from the previous years of the revalidation cycle. They should be aware of the importance of these in providing the handover from one appraisal to the next. If a doctor is unable to provide this documentation, the appraisal discussion should be postponed, unless there is exceptionally good reason not to. However, the appraiser must have discretion to go ahead if the documents are not forthcoming after all reasonable attempts to retrieve them have been made. The doctor should know that failure to provide the previous PDP will mean that the statement about the progress with the previous PDP cannot be signed-off and so the issue will be highlighted to the responsible officer. Although it may be possible to sign-off the PDP statement, without the summary, the handover from one year to the next has been compromised and this omission (plus explanation) should be flagged to the responsible officer if a decision is made for the appraisal to go ahead.
Previous PDP and summary included but organisational mandatory information not included	Some organisations and specialities have mandatory training requirements that the doctor should demonstrate in the portfolio of supporting information, according to local policy. While this supporting information is not required by the GMC, if a local policy is clear that the appraisal should not go ahead without such documentation, postpone the appraisal. Alternatively, the appraiser may have discretion to go ahead and explore the context for failure to achieve the mandatory requirement and it may be an appropriate PDP objective for the coming year. Appraisers will need to know what their local policy says on this issue.
GMC guidance on supporting information met but college or faculty recommendations not fully met	If supporting information does not meet college or faculty guidance, the appraiser needs to judge whether the doctor is working in sufficiently exceptional circumstances for this to be appropriate and whether their supporting information does fulfil GMC requirements. The doctor is recommended to provide a reflective note to explain why they have not met their relevant college or faculty guidance and what they have done instead to demonstrate that they are up to date and fit to practise. Normally, the appraisal can go ahead but it will be important to explore the context for the variation and include appropriate items in the PDP and/or flag up issues to the responsible officer for support / remediation if necessary. Doctors are recommended to seek early agreement from the RO if they plan to provide supporting information that falls outside the standard guidance.

Supporting information does not appear balanced across the whole scope of work (e.g. it is light on the clinical role or CPD)	The GMC guidance is clear that the doctor must provide supporting information in the six categories for all roles that require a UK Licence to practise over the five-year revalidation cycle. Many doctors have not fully appreciated the implications of the requirement to provide supporting information across the whole of their scope of work. The appraisal discussion provides the forum to explore this and to develop suitable strategies for collecting the information needed in subsequent years. The context and detail of what is undertaken in each role will determine what constitutes sufficient continuing professional development (CPD) to remain up to date and fit to practise. The appraiser may feel that the CPD for the clinical role has been neglected in favour of other roles. This is a five-year process and the balance can be redressed in subsequent years if the issue is made explicit and understood by the doctor. The appropriate level of CPD for each role will depend on the level of complexity of the work undertaken and how supervised the work is. College and Faculty guidance will need to be taken into account. Suitable PDP objectives can drive improvements in balance across the scope of work. It is appropriate to sign a "disagree" statement if appropriate supporting information has not been presented across the whole of the scope of work, with a note about how this will be addressed through the PDP.
Supporting information is present but does not include reflection on impact, outcomes or changes in behaviour	Reflection on the impact of lessons learned, in terms of outcomes and changes in behaviour, are what drive quality improvements in care. The appraiser has a vital role in facilitating this reflection and promoting development. The appraisal discussion provides the protected time to support the doctor in improving these areas in the portfolio of supporting information. Suitable PDP objectives may need to be created to provide the focus on quality improvement. The GMC requires the doctor to demonstrate being a reflective practitioner, but the emphasis is on quality not quantity of supporting information.


12.
Appraisal
Appraisal date agreed
Completed paperwork received 14 days before agreed date
Paperwork complete including:
Last years' PDPs and summaries/outputs
Probity and health statements signed
Complaints declaration completed
PLUS
Revalidation supporting information:
CPD log
SEA / SUI with reflection and changes identified
Audit & quality improvement activity (over time)
Patient feedback (over time)
Colleague feedback (over time)
Additional supporting information (specific to the individual)
No paperwork received
Consider postponing appraisal
Some paperwork received
Consider the context of the doctor's work
Assess whether paperwork is appropriate and sufficient
New appraisal date agreed
Key appraisal data not received:
PDP/Summary/outputs: unless first ever/exceptional circumstances – postpone appraisal
No appropriate supporting information: unless first ever/exceptional circumstances – postpone appraisal
No record of mandatory training contractually required by employer or contractor – consider postponing appraisal
Appraisal discussion
If unable to sign-off or in doubt discuss with appraisal lead
Supporting Information incomplete or poor:
Handwritten documentation (even year one) – Is it contractually acceptable? If not – postpone appraisal Is it legible? If not – postpone appraisal
CPD does not meet college/faculty requirements – does it meet GMC requirements? If not – postpone appraisal
No SEA/SUI or SEA /SUI not personalised – discuss at appraisal
No quality improvement activities – discuss at appraisal
No feedback on practice by year suggested by GMC – discuss at appraisal
CPD does not cover whole scope of practice – discuss at appraisal
CPD does not appear balanced over whole scope of practice – discuss at appraisal
No record of how CPD, SEA/SUI, quality improvement activity or feedback has
Outputs of appraisal agreed:
Summary and PDP
Sign-off statements
Refer to RO
Appraisal process completed for revalidation
Plan how to address issues arising from supporting information in appraisal interview and what outcomes will be need to be achieved over next appraisal year to progress towards revalidation.
Ensure doctor includes GMC requirements on PDP for coming year for revalidation.

Supporting Information Links to Domains



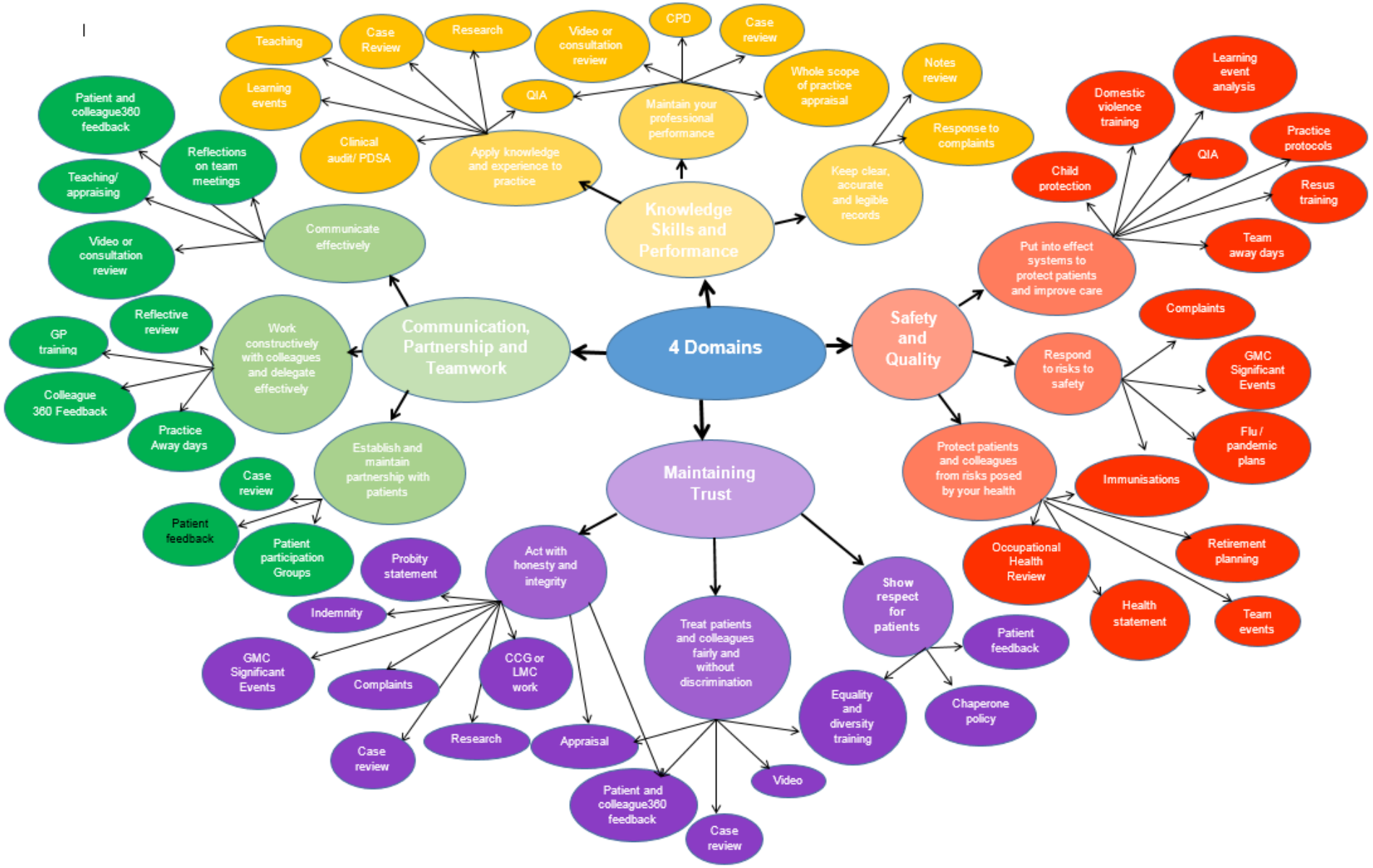
Link to GMC supporting information

Glossary of Abbreviations

CME	Continuing Medical Education
CPD	Continuing Professional Development
CPR	Cardio Pulmonary Resuscitation
CR	Case Review
MSF	Multi-Source Feedback
PDP	Personal Development Plan
QIA	Quality Improvement Activity
LEA	Learning Event Analysis

Mapping Supporting Information to the GMC Domains and Attributes

See below examples/suggestions BUT remember - most supporting information links to more than one attribute / where you put it may vary according to context



13.Communication skills for appraisers

Active listening

Active listening involves paying attention to the verbal cues (the words people use) non-verbal cues (such as body language) and para-verbal cues (such as intonation, volume and pace of speech) that lead to a fuller picture of what the doctor is trying to convey and perhaps what they are revealing unintentionally.

No rigid script for appraisal will work. Communication skills depend on being used flexibly in response to the individual and the level of rapport that has been established.

It helps to prepare some useful questions to ask. These may be used during the preparation phase and in the appraisal itself. Using them rigidly would sound stilted and prevent the free flow of the appraisal, but thinking them through beforehand can prevent difficulties with how to approach a topic with a doctor. You will rapidly develop your own style, but sometimes having a stem question or idea "up your sleeve" can help keep things moving, especially when you are new to appraising.

Open questions

Questions starting 'How' and 'What' will usually elicit much more useful responses than closed questions. "Why" can be perceived as threatening – instead try 'What made you….?"

"Please describe…" or "tell me about…" or "I am curious that…." are other useful opening phrases.

Closed questions

Closed questions are useful for refining understanding or eliciting detail and are generally those that can be answered "Yes" or "No" or with one word answers.

Clarification questions

More direct questions can be very useful in clarifying specifics in an area of discussion. They are sometimes called "funnel" questions because they lead the conversation in a particular direction. Beware of clarifying too soon. "Can you give me an example of that?" is a useful way to start to clarify an issue.

Paired questions

The use of paired opposites can be very helpful in introducing negatives in a non-threatening way. It can be an interesting and acceptable way of asking otherwise difficult questions.

e.g. "Tell me about your greatest achievement over the past year."
"Now what was your greatest disappointment over the past year?"
"What is the best/worst decision you have made this year?"

Echoing and the use of silence

When there is some ambiguity in what the doctor has said, or the appraiser is surprised and wants to buy thinking time (and find out more), or if the appraiser feels that the doctor has more to say and wants to encourage them to carry on talking, it can be very useful to echo the last thing that the doctor said, or the key phrase, or just to pause to give the doctor thinking time.

e.g. Doctor: "When I look back on the significant event, I feel really frustrated."
Appraiser: "Frustrated…" (pause)

Alternatively, the appraiser could remain silent, while giving non-verbal cues that he/she is interested and wants to hear more, such as nodding, or giving non-specific para-verbal prompts e.g. "mm".

Summarising
Towards the end of an area of discussion, it can be very helpful to check back with the doctor that there is a shared mutual understanding.

Appraiser: "So, just let me summarise what we have discussed…, then you can add anything that I may have misunderstood or missed out…"

Conclusion
"Is there anything else/further we need to discuss?"
"Is there anything you would like to mention that has not been covered?"

General ideas
Listen and look, then reflect back what you have heard and seen to check accuracy.
Share personal reflections and learning to build rapport, if appropriate.

Use of humour
While the use of humour can be a great icebreaker or defuse tension, it should be used judiciously, as the other person may not share your sense of humour.

14. Stem questions for appraisers

Stem questions are starting points, from which the discussion may go in many different directions. Below are some example stem questions you might wish to use to explore an area from the appraisal and revalidation portfolios. Use them to help prepare your interview.

A starter question
Many appraisers have found it fruitful to begin by asking the doctor about their most important area for discussion.

e.g. "What is the most burning issue for you at the moment?"
"Is there anything that *you* particularly want to use this time to discuss and think through?"
"How can we make sure that this protected time is used in the most valuable way for you?"

In business meetings, it is increasingly common for 'any other business' to be taken at the beginning of the meeting so that an important item is allocated sufficient time. Similarly with appraisal, something important may have come to light since the forms were signed-off, or it may help the doctor to raise an issue they found difficult to put on paper.

Asking questions similar to those above is a good way of ensuring that the doctor's needs do not get lost in the structure of the interview. Don't be surprised if the doctor says that there isn't a specific issue they'd like to discuss, but then spends a good proportion of the time on one issue after all!

It can also be useful to revisit this sort of question near the end of the appraisal discussion once relationships have been established. Another good starter is: "Tell me about your year…"

N.B. Remember the six types of supporting information described by the GMC and the four domains of the GMC's *Good Medical Practice Framework for appraisal and revalidation*.

The GMC requires the doctor to reflect on lessons learned and changes made as a result, so ask:
"What did you learn?" and "What changes did you make?"

Scope of work
Can you describe all the different areas that form part of your scope of work?
Which of the areas of your scope of work do you find the most important and why?
How do you keep up to date with each area?
How do you review what you actually do for each area?
How do you get feedback on your performance in each area?
Do you work for any voluntary organisations? Do you do any private work?
What supporting information have you included for these roles?

Educational/managerial roles (if appropriate)
Describe any teaching/management that you do?
Is this role appraised elsewhere? If so, have you included reflection on that appraisal?
What do you enjoy most/least about the role?
What feedback have you received about your teaching/management?
What are your strengths and areas for development in your educational/managerial role?

Which areas of education/management do you find easy/hard?
Where do you feel this area of your professional life is going?
How would you most like to improve in this part of your work?
Do you have any specific plans to do this? If so, how?

Research and academic roles (if appropriate)
Have you done any recent research? If so, what was it?
What was your role in it? Who else was involved?
What went well? How could it have been improved?
Are there any issues in relation to the research you undertake?
Where do you get appropriate support for your research?
What feedback have you received?
Is this role appraised elsewhere? If so, have you included reflection on that appraisal?
If you are a clinical academic, you could have organised your appraisal according to Follett principles – if not, why not?

Knowledge, skills and performance
How would you describe yourself as a doctor?
How do you think others would describe you?
What makes you a good doctor?
What part of your job do you most/least enjoy and why?
Any main challenges you wish to discuss?
Are there any complaints or significant events you wish to discuss?
Have you ever had feedback about:

- your clinical experience
- personal organisation
- decision-making?

How do you handle conflicting demands upon your time?
What puts you under pressure?
Describe any recent stressful situations… What did you do? Would you do the same again?
What was your best decision/most difficult decision over the last 12 months?

Continuing professional development
How do you keep up to date?
How do you learn best?
How do you tend to identify what you need to learn?
How do you record your learning? Tell me about what works for you…
Tell me about your learning log… how do you tend to make your reflective notes?
Have you found this way of learning hard or easy?
How do you organise your learning?
Tell me about what personal reading you choose to do?
What do you think of e-learning opportunities?
What experience do you have of BMJ Learning/Doctors.net/online trackers?
Are you part of a small group or action learning set?
What sort of clinical meetings do you attend?
Have you managed to attend any external meetings?
Why did you choose to attend those particular meetings?

Probity

What did you think about when you signed the probity statement in the documentation?
Are there any probity issues or potential conflicts of interest that you wish to explore?
Do you believe that your probity would withstand scrutiny?
How would you recognise a conflict of interest?
Who else helps you to ensure that your probity is beyond reproach?

Health

What did you think about when you signed the health statement in the documentation?
Are there any health issues that might affect patient care?
What safeguards do you have in place to protect your health and wellbeing?
How do you 'switch off' at the end of the day?
How do you manage the balance between work and home/family?
Who is there to support you?
Who would recognise it if you were becoming unwell?
What would you do if you recognised that you had a health issue?

Relationships with patients

How might your patients describe your care?
Describe a patient with whom you feel you have a good relationship. What makes it work well/effectively?
What about a patient with whom you have a more difficult relationship? Why do you think you find that relationship more difficult?
Have you had any difficult encounters with patients in the past year?
What did you learn or what would you do differently?
Have you done a patient satisfaction survey to individual level? What did you learn from it?
What are you particularly proud of or disappointed with in your relationships with patients?

Relationships with colleagues

Describe your team and where you see yourself within it.
How would your colleagues describe you?
What might they say is your best/worst feature?
What are you particularly proud of or disappointed with in your relationship with colleagues?
What could you do to improve your working relationships?
If you have done a colleague feedback exercise, what did you learn from it?
If you have not yet done one, when will you need to have done one by?
How will you reflect on the feedback that you get?

Personal development plans and their review

Which objectives were easiest to achieve and why?
Which objectives were most difficult to achieve and why?
Which were the most valuable learning activities and why?
Which were the least valuable learning activities and why?
In what ways have you been able to apply your learning in practice?
What benefits to your patients do you feel have occurred as a result of your learning?
Are there any learning needs that you wish to carry forward to your next personal development plan?

Achievements

What do you feel has been your biggest achievement since your last appraisal?
(Or if already described in the documentation)
I notice that you are proud of your achievement …can you tell me more?
Tell me about an example of good practice that you would like to share…

Challenges

What do you feel has been your biggest challenge since your last appraisal?
How do you feel about that?
What do you think you have learned from it?
How has it changed you?

Aspirations

What would you like to have achieved by your next appraisal?
How would you like to see your career developing?
Have you any aspirations for the next five years? Where do you see yourself in five years' time?

Revalidation

What are your concerns regarding revalidation?
How do you relate to your responsible officer?
When will you be put forward for a revalidation recommendation?
How can the annual appraisal process support you in gathering information that you will need?
What else would make you feel well-prepared for revalidation?

15.Notes on questioning, listening and reflection

APPROACHES TO QUESTIONING

1 The questioning funnel:
   a. Start with broad, open questions,
   b. Move onto probing questions, pulling out details,
   c. Drill down to specific examples,
   d. Narrow down to more closed questions in order to summarise, check understanding/clarify, highlight key points.

2 Paired questions:
   a. Invites a balanced response,
   b. Particularly good if the appraisee is not being very open, being unduly negative or inappropriately positive.

3 Questions starting with "what" or "how", rather than "why":
   a. Less likely to elicit defensiveness, or fear of judgement,
   b. Invites exploration, creative thinking.

4 Tell me about…Tell me more…
   a. Not questions, but very useful for eliciting a narrative response

5 Appreciative enquiry:
   a. Explore and celebrate the positives,
   b. "What are you most proud of?"
   c. "What went particularly well, this year?"

6 Avoid giving advice disguised as a question:
   a. Have you tried doing XXXX?
   b. Would it be a good idea to do XXXX?

   When you want to signpost a resource – own the suggestion

APPROACHES TO LISTENING

Active listening creates the space within which the doctor can become comfortable and start to reflect, think and problem solve.

1 Total body listening:
   a. With your ears, for the words
   b. With your eyes, for the non-verbal communication
   c. With your body, to demonstrate you are listening
   d. With your mind, for the whole message

2 Listen for patterns, themes, reflect the doctor's language back to them:
   a. "I notice you've used the term XXXX several times now"
   b. "I'm curious to know what you mean by XXXX"

3 Listen for what isn't being said

4 Use silence

FACILITATING REFLECTION

1 Remember that doctors have different learning styles and preferences, and although reflection should be a professional habit (of course!), demonstrating reflection comes more easily to some doctors than others. For some doctors their reflection has been almost subconscious and bringing it to conscious awareness is something you can facilitate.

2 Remember also that some doctors have developed a dislike of the term "reflection", so this may need to be carefully managed.

3 A simple template to structure the doctor's reflection:
   a. What happened?
   b. What did I learn?
   c. What will I do/have I done differently?
   d. If I've already made changes, what was the impact of this?
   e. You can use these questions to facilitate reflection but you can also teach the tool: "What? So what? Now what?" to your appraisees

4 Additional questions to help facilitate reflection:
   a. When you think about this event, what did you notice? If I was the patient/your colleague/an impartial observer, what would I notice?
   b. What did the event make you think/feel?
   c. What would you have liked the outcome to be? What would the patient/your colleague have liked the outcome to be? What would need to be different?
   d. What one thing would you do differently?
   e. What was the most positive/best part of this event?
   f. How will you respond to a similar situation in the future?

5 Keep reflection meaningful – think quality not quantity

CONFIDENTIALITY AND REFLECTION

- It is vital to ensure that examples of written reflection follow the principles of good information governance and are carefully anonymised.
- The GMC have a policy of not asking for examples of reflection when undertaking an investigation, but doctors have used their reflection on an incident in their defence in order to demonstrate their insight, honesty and integrity
- The courts have the right to subpoena any document.
- Employers have the right to make seeing documents a criteria for employment

Support your appraisees to write their reflection in such a way that it is professional and appropriate for the purpose of demonstrating reflective practice. It should focus on the lessons learned and any changes made as a result and not on the details. Description is not reflection.

16. Feedback skills

There are many ways to give feedback and most people find a structure useful. The most important goals to achieve whenever giving feedback are to be:

- honest
- balanced
- supportive - not destructive.

At the end the person receiving feedback should be clear where and how they can change to improve.

Pendleton's rules for giving feedback

Pendleton's rules[1] provide a structure for giving feedback in a particular way, as summarised below:

1. Clarify any points of information or fact
2. Ask the individual what he or she did well – ensure that they identify the strengths of the performance and do not stray into weaknesses.
3. Discuss what went well, adding your own observations
4. Ask the individual to say what went less well and what they would do differently next time.
5. Discuss what went less well, adding your own observations and recommendations
6. Close by reviewing the whole picture, focusing on what went well so that the feedback finishes in a 'safe place' for the recipient.

The 'feedback sandwich'

Some people have described Pendleton's suggested structure for giving feedback as the 'feedback sandwich' because the areas for development are sandwiched between two opportunities for positive feedback.

Some strengths of Pendleton's rules:

1. They offer the doctor the opportunity to evaluate their own practice and allow even critical points to be matters of agreement.
2. They allow initial doctor observations to be built upon by the appraiser.
3. They ensure strengths are given parity with weaknesses.
4. They deal with specifics.

Some difficulties with Pendleton's rules:

1. Doctors may find it hard to separate strengths and weaknesses in the formulaic manner prescribed. Insisting upon this formula can interrupt thought processes and perhaps cause the loss of important points. Though it sets out to protect the individual receiving feedback, it is artificial.
2. Feedback on areas of need is held back until part way through the model, although doctors' may be anxious and wanting to explore these as a priority. This may reduce the effectiveness of feedback on strengths.

[1] *The Consultation: An approach to learning and teaching* (Pendleton, Schofield, Tate & Havelock, Oxford University Press, 2003)

Holding four separate conversations covering the same performance can be time-consuming and inefficient. It can prevent more in-depth consideration of priorities.

Pendleton states:
"Much has been made of the feedback dubbed the Pendleton rules. The key to effective feedback is to offer both challenge and support but the rules are often used as reasons to be supportive without being challenging." (Pendleton, Schofield, Tate and Havelock, 1984)

Agenda-led outcome-based analysis (ALOBA)
This feedback structure is designed for use when giving feedback on a clinical consultation. However it is well-suited to giving feedback in many situations, including the appraisal discussion.

The advantage of this structure is that it is learner/doctor led. The appraiser starts by asking which area(s) the doctor would like to help with. The doctor is allowed to express their views, thoughts and possible solutions. By appropriate questioning, the appraiser can facilitate the doctor to propose ideas and solutions.

At this stage the appraiser can bring suggestions and alternatives if appropriate. However, the doctor is more likely to run with an idea they have generated themselves rather than one which, on reflection, could be seen as having been imposed by the appraiser. Although there is a useful role for the appraiser in signposting resources and opportunities the doctor may not have been aware of it is important for the doctor to 'own' the solutions / learning objectives agreed.

17.DOs and DON'Ts of giving feedback

Behaviour
Dos
Give it with care
Let the recipient invite it
Encourage self-criticism
Be specific
Outline the positive
Avoid evaluative judgements
Make the feedback actionable
Balance the positive and negative
Balance the timing of the positives and negatives
Choose the right time and place
Don'ts
Deny the other persons feelings
Be vague
Accuse
Take for granted the person has understood
Bring in third parties
Be negative
Be destructive
Be judgemental
Bring up behaviours that the person cannot help
Be overly-impressed
Be aggressive

18. Giving good constructive feedback

Why?

- Effective and honest communication is at the heart of the appraisal process.
- Giving constructive (not destructive) feedback about an individual's performance from your perspective helps them to develop their skills and qualities.
- Always remember that feedback is for the benefit of the recipient not the feedback giver. It doesn't help the doctor if you have proved how clever you are. First, do no harm!

Where?

- Use quiet conducive surroundings.
- Allow enough time and avoid interruptions.
- Plan and prepare well, agree the format and agenda.
- Help the recipient:
  - clarify what they were trying to achieve
  - identify what went well, less well and why
  - decide how to take things forward.

How?

- The appraiser should facilitate the feedback process using a structured approach that is appropriate to the circumstances
- Be honest, respectful, systematic and supportive
- Use the doctor's experience and add to their perspective.
- Guard against being destructive by:
  - building on their views
  - focusing on behavior not personality
  - using observations not judgements.
- Summarise the discussion, agree action points and finish positively.

What?

You could include:

- a strength that they need to maintain, keep doing, or do more of
- something that distracts them from their strengths
- a weakness that they should develop to a point of competence (or recognise and stop doing).

When?

- In some situations, depending on the rapport that has been developed, the doctor will feel able to invite the appraiser to provide feedback directly, although the request may be non-specific e.g. "What do you think?"
- In most instances the circumstances, or the relationship, might inhibit the doctor from doing so, even when the doctor would like more feedback or challenge, so the appraiser has to judge the timing.
- The appraiser can check whether the timing and degree of challenge are appropriate with the doctor by asking the doctor directly: "Does this level of challenge meet your needs?" or "Do you want some feedback about that?"

19. What makes a good summary of appraisal?

- It should be typed and stored electronically. It must be a professional document.
- It should be "owned" by the doctor.
- It should be an accurate and concise summary of the appraisal discussion.
- Strengths and achievements should be highlighted.
- Each section should have a succinct but informative summary of that part of the appraisal interview. This should not reiterate information submitted pre-appraisal but include observations and conclusions from the discussion.
- The commentary should include reference to supporting information seen and reviewed by the appraiser. Absence of required supporting information or failure to address previously identified PDP objectives should be noted and linked to specific action points to improve the situation before the next appraisal (giving thought to the requirements of revalidation) or to an agreement that they should be dropped.
- The appraiser should avoid judgemental statements, which include either effusive or critical adjectives. These could ultimately be challenged by the doctor (or even the GMC) and might need to be justified in depth. It is better to say "The supporting information demonstrated an example of excellence by…" rather than "The supporting information was fantastic."
- It is important to include examples of good practice and lessons learned and affirmation (where appropriate) but this should be evidence based and not unsubstantiated.
- Reference should be made to how development needs (rather than wants) have been identified.
- Action points are agreed between the appraiser and doctor and should be S.M.A.R.T.E.R

  – i.e. Specific, Measurable, Achievable, Relevant, Time-bound, Economic and Reflective
- These should include some element of agreed challenge for the following year.
- No sections should be left blank. Not applicable/see above etc. may be appropriate.
- It is a valuable document and should be kept safe for future years. Data protection and information governance legislation applies and must be adhered to.

Producing a good Appraisal Summary-why bother?

The summary of discussion is clearly important, as one of the core outputs from the appraisal process. As an appraiser you should put as much effort into writing the summary as you do into preparing for, and conducting, the appraisal interview:

1. For your appraisee, the summary is the record of their appraisal interview, documenting what was discussed and what supporting information was presented to the appraiser. It should also indicate action points for the following year, highlighting any additional supporting information that needs to be produced in progress towards revalidation. The summary will be a core document for revalidation purposes and it should do justice to the amount of time spent by both appraiser and appraisee in making the appraisal interview a reflective and developmental exercise.
2. For you as an appraiser, the summary is an indicator of the quality of your work as an appraiser. Any review of the appraisal process overall must focus primarily on the written outcomes, because this is one objective measure to judge the quality of the appraisal and discussion, in addition to asking for the views of appraisees. Writing a succinct, accurate, thoughtful summary of the core issues discussed and decisions made in the appraisal interview, reflects your skills as an appraiser as well as being very helpful for your appraisees.
3. For the responsible officer, the appraisal outputs – the summary of discussion, PDP and all the sign off statements – form the principle resource for making the revalidation recommendation. Although the RO has the right to review the detail of the whole portfolio, a well written summary can place all the key information at their fingertips such that only a sample of portfolios need to be spot checked for quality assurance purposes.
4. Appraisal summaries may be read by someone in your organisation responsible for clinical governance or continuing professional development. Well written summaries may contain useful information on shared educational needs highlighted by a number of doctors. Additionally, as an appraiser you can use the summary to highlight issues raised by doctors that the organisation should address, such as concerns over staff shortages or specific services.

Role of the appraiser: It is important that appraisers realise they are NOT being asked to make a final judgement about an individual's fitness to practise, but to be part of the process of helping the appraisee, on a year by year basis, to be in a position to demonstrate their continued competence through the collection of appropriate supporting information, reflection and discussion.

20. Reviewing the appraisal summary

Listed below are some criteria that can be used to review appraisal summaries, either by individual appraisers or by an organisation looking at its appraisal summaries as part of a quality assurance exercise. It is worth remembering that your role as an appraiser is NOT to be the ultimate judge of the doctor's fitness to practice, but to support them in being able to demonstrate their continued competence at the point of their revalidation recommendation. The summary plays a critical role in this process.

What makes a good Appraisal summary?

- **an accurate and concise summary of the whole scope of work appraisal**
- **examples of the reflective practice of the doctor demonstrating lessons learned and changes made as a result**
- **strengths and achievements should be highlighted and excellence encouraged**
- **no value judgements should be included without corroboration - sweeping statements - positive or negative - should be avoided, with the main emphasis being an accurate summary of what was reflected on in the appraisal discussion**
- **a commentary on what was achieved from last year's PDP (or why progress was not made with PDP goals) and reflection on how learning needs (rather than just 'wants') for next year have been identified**
- **a brief summary of the supporting information required by the GMC, emphasising any significant omissions (gaps) and highlighting the evidence needs to be produced for the next year's appraisal in order to fulfil revalidation requirements**
- **consideration of how the doctor has demonstrated their continued competence against the four domains of Good Medical Practice**
- **some element of agreed challenge for the following year**
- **PDP goals that are S.M.A.R.T. and meaningful, to focus the doctor's development for the coming year**

Modified from:

Di Jelley, GP Appraisal Advisor, Northern Deanery

21. Guidance for appraisers on completion of summary of appraisal discussions – for NHS England South

Domain	Information	Suggested information
Knowledge Skills & Performance *1.1Maintain your professional performance* *1.2 Apply knowledge & experience to practice* *1.3 Ensure all documentation is clear, accurate & legible*	**Scope of Practice (SOP)**	All roles for which a UK licence to practice is required should be described. On an annual basis, you either need to see (and describe) evidence of an appraisal undertaken elsewhere or you need to discuss each role, using sufficient supporting information for each. The doctor should provide some reflection on each role as an annual minimum Summarise the reflection on the scope of practice and ensure that a statement stating all roles and scope of practice have been discussed is included in the appraisal summary. 'Extended Roles' are described by the RCGP as: Any activity that is beyond the scope of GP training and the MRCGP and that a GP cannot carry out without further training Any activity undertaken within a contract or setting that distinguishes it from standard general practice (e.g. GPwER) Any activity offered for a fee outside the care to the registered practice population (teaching, research, medico-legal, occupational medicals etc) <u>If appraising any part of the scope of practice yourself</u> You will need to consider how the doctor has kept up to date, reviewed their work and sought and acted on feedback about their work: the same six types of supporting information are required. Appraise the reflections on CPD which supports each role along with any complaints/compliments or GMC Significant Events (SEs) that occurred. Check that MSF and PSQ activities cover the Scope of Practice (SOP). Check how the doctor has reviewed their practice and participated in quality improvement activities for this part of their work Some doctors may be able to ask for a 'structured reference' from employer/senior colleague which comments on competency, concerns, complaints, SEs, if this is a pre-revalidation appraisal, and if they have not had a formal appraisal in the role. Any concerns should have been communicated directly to their RO when they arose, not left for the appraisal
	CPD	All CPD credits should be demonstrated by a reflective note on lessons learned and any changes made as a result. Reflection on the impact of learning is key to demonstrating being a reflective practitioner For GP role and roles covered by scope of GP training and MRCGP expect a doctor to demonstrate 50 credits proportionately for every 12 months in work. If they cannot meet this RCGP recommendation there should be a reflective note about why not and what they have done instead to ensure they remain safe and up to date. There must be sufficient CPD to demonstrate keeping up to date for

		all other roles in SOP Often credits can overlap roles Some roles genuinely only require a small amount of credits but it is essential to document reflection on what is reasonable, and to seek agreement from the RO if appropriate <u>Reflection</u> – please record level/quality of reflection on learning. Exceptionally, if it is impossible to facilitate any reflection, please say so. You cannot sign off an appraisal as satisfactory without evidence of satisfactory reflection.
	Achievements **Aspirations** **Challenges**	Provide reflection on all three. 'Challenges' means the challenges that the doctor faces and those that you will put to the doctor, so describe these too.
	Previous PDP	Brief summary of previous PDP items and progress made with their completion Record reasons for any PDP items not being completed, plans to drop an item or carry it forward The tools used to 'quality assure' the appraisals look to see if appraisers are exploring these themes
Safety & Quality *2.Contribute to and comply with systems to protect patients* *2.2 Respond to risks to safety* *2.3 Protect patients and colleagues from any risk posed by your health*	**Quality Improvement Activity**	Acceptable quality improvement activities include reviews undertaken for quality assurance (to demonstrate that a doctor remains safe) and reviews undertaken for quality improvement (to monitor and improve an area of interest or concern) GMC requires annual review of practice with reflection on learning from cases, data and events – RCGP gives plenty of examples of what constitutes QIA Clinical audit with reflections Review of clinical outcomes – with reflections and learning points Series of case reviews on a clinical area – structured, with reflections and learning points Personal Learning Event Analyses (LEAs) – with reflections Doctors may wish to submit QIAs for other roles in their SOP too
	Significant Events	Note the distinction between GMC Significant Events (SEs) - where serious harm could have or did come to a patient or patients - and GP-style Learning Events which can be part of Learning Event Analysis (LEA) and are quality improvement activities – which happen to us frequently and are events (positive and negative) from which we can learn by reflection. SEs rarely happen in general practice – but if they do they need to be declared, and reflected on. Record 'no SEs' if there have been none and reflect on what safeguards are in place to prevent

		such events and how you would recognise and report one if it occured.
	Complaints	Any complaints must be declared, reflected upon and discussed at appraisal Record "No declared complaints" if none Record "Not asked to bring anything to discuss at appraisal by NHS England or GMC" Failure by a doctor to declare a complaint becomes a probity issue To inform your discussion, ask doctors to provide original complaint letters separate from the appraisal portfolio so that you can see them in confidence and cite them in your summary without breaching good data governance principles
	Health concerns/issues	Ask about, and discuss any health concerns raised Record any that impact on patient care and give details of the safeguards that have been put in place to protect patients Doctors are under no obligation to discuss other health matters that do not affect professional practice Add a brief comment about the doctor's response (even if they state there are none) Leicester SRT provides a good aide memoire

Communication, partnership & trust *3.1 Communicate effectively* *3.2 Work constructively with colleagues and delegate effectively* *3.3 Establish and maintain partnerships with patients*	**Colleague feedback**	Colleague feedback tools must conform to GMC standards: Questionnaires must be administered and collated independent of the doctor, appraiser & RO; collation should not be carried out by a practice employee; (practices could consider buddying for this if they want to use GMC questionnaire and not CFEP, Fourteenfish or Clarity); doctor must complete self-assessment and reflect on the results of the feedback exercise at appraisal Most tools have a minimum 12 but ideally 15 or more replies. If there is any deviation from the GMC principles around patient and colleague feedback, it must be declared, reflected on and agreed with the RO (if appropriate) Solicited feedback needs to cover the whole scope of practice, which may be done by including multisource feedback from colleagues in all the different scopes of practice in one exercise, or by undertaking separate colleague feedback in different roles. The original colleague feedback report and the doctor's reflections on it are both essential pieces of supporting information that must be included in the portfolio, and discussed at appraisal, before a positive revalidation recommendation can be made. It is particularly important to add historical ones to the current

		appraisal portfolio if it is the pre-revalidation appraisal. This allows the appraiser to review it and comment upon it. Record when last MSF if not this year
	Teaching & Training	Discuss and record any involvement in teaching or training, even if role has been appraised elsewhere Consider non-trainers' role in a training practice Encourage discussion of training or teaching related learning from cases, data or events
Maintaining Trust *4.1 Show respect for patients* *4.2 Treat patients and colleagues fairly and without discrimination* *4.3 Act with honesty and integrity*	**PSQ**	Patient feedback tools must conform to GMC standards Questionnaires must be administered and collated independent of the doctor, appraiser & RO; doctor must complete self-assessment and reflect on the results of the feedback exercise at appraisal Patient feedback needs to cover the whole scope of practice, which may be done by including patients from all roles in one survey or doing separate patient feedback exercises in different roles The minimum number of responses is determined by the tool used. If there is any deviation from the GMC principles around patient and colleague feedback, it must be declared, reflected on and agreed with the RO (if appropriate) The original patient feedback report and the doctor's reflections on it are both essential pieces of supporting information that must be included in the portfolio, and discussed at appraisal, before a positive revalidation recommendation can be made. It is particularly important to add historical ones to the current appraisal portfolio if it is the pre-revalidation appraisal. This allows the appraiser to review it and comment upon it. Record when last PSQ if not this year The RCGP recommends that all GPs should reflect on their relationship with their patients every year, using unsolicited feedback where available
	Probity	Probity should be discussed in every appraisal Even if doctor has ticked "No probity issues" it is worth reflection and discussion to check understanding. Record that the doctor has signed the statement and describe key features of the discussion
	Policies	There are many areas in GMP that may be worth discussing under this area For example indemnity, conflicts of interest between roles, the use of social media, chaperones, confidentiality policies, gifts from patients etc.
This year's PDP		There are no maximum or minimum number of PDP goals as they are personal and it depends how they are written – as subsections of a bigger goal or as separate goals. They must be "owned" by the

		doctor, so it should be clear how they arise from the appraisal and the doctor's learning and developmental needs Most doctors have between 3 and 5 goals that cover the whole of their scope of practice Innovations and quality improvement activities that will make a difference to patient care usually make good PDP goals because the care that goes into planning them makes them more achievable Ensure that PDP goals are framed in a SMART way Familiarity with the local CCGs' priorities and national priorities may help to frame some objectives where a doctor does not have specific learning needs of their own
General Summary	**Progression towards revalidation**	State venue, time and duration of appraisal, revalidation date and place in the revalidation cycle and confirm absence of identifiable third party information in the submitted portfolio Describe whole scope of practice/roles and the context in which the doctor is working Discuss progress with the previous PDP and the agreement of a new PDP arising from the appraisal Summarise progress towards revalidation and clearly record any outstanding requirements **and that the doctor is aware of these** End with a positive statement

22. Preparation for day two

Reflections
Consider what you have learnt today, and maybe jot down any reflections or any thoughts or questions to carry forward. These are purely for your own use and won't be shared. (However, you may wish to start a CPD portfolio for your appraisal role and use these as a starting point.)

Preparing for the partial appraisal on day two

On day two you will have 30 minutes to conduct a partial appraisal, based on the real appraisal information shared by the person you will be appraising. That may sound a long time, but we suspect you will see that it isn't. We have suggested that doctors provide reflection and supporting information from their last appraisal documentation, or prepare something that will be used for their next annual appraisal. Remember, that it is the doctor's appraisal, so the agenda needs agreeing at the outset. **Do not** try to cover a whole appraisal in 30 minutes or you will not have time to demonstrate the appropriate communication skills. It is better to explore one or two areas in depth.

Consider how you will start the appraisal – thinking about how you will discuss the limitations of confidentiality, set the scene and agree what you will be discussing.

Looking again at the observation tool may help you, as you structure your thoughts and how you think you will go about facilitating an effective appraisal discussion with the doctor – it is intended to help you demonstrate the core communication skills needed in the appraisal discussion.

23.Exercise: Conducting an appraisal

This is the main exercise to allow you to demonstrate the essential communication skills required for appraisal. You will be working in a different trio and you will again take each of the three roles:

- doctor
- appraiser
- observer.

The format is the same as the trio exercise looking at reflection from the first day of the training. The main difference is the length of time allowed for the discussion (30 minutes). Like a full appraisal, it is important to do appropriate scene setting and elicit an agreed agenda at the beginning.
This exercise, like the previous one, works best if the discussion focuses on issues of real importance and relevance. This is exactly what happens in full appraisals and it is very reassuring to be able to rehearse the skills needed to deal with whatever the doctor brings up during a training exercise.

The doctor
The doctor should not role-play. It is important to be yourself as the doctor being appraised. One of the benefits of this training is the chance to use the skills of your appraiser to facilitate your reflection on an issue that is current for you.

The appraiser
For 30 minutes, the appraiser will conduct a **partial** appraisal, rehearsing all the skills they need, in particular by starting with appropriate scene setting. This may seem like a long time but it will not feel like it once the discussion has started.
Do not try to complete a whole appraisal in 30 minutes; you will not be able to demonstrate your skills adequately as you will rush from one area to another. Focus on covering one or two areas in appropriate depth for a real appraisal.

The observer
The observer will use the same style observation sheet as day one to record comments and impressions; specific quotes are helpful. These will be collected by the course facilitators at the end to help in producing the written feedback to individuals after the course.
For 10-15 minutes after the partial appraisal, the observer will have the opportunity to facilitate feedback with the appraiser about their performance. Remember to ask the appraiser how they thought it went first and to check back with the doctor being appraised.

The observer should act as the timekeeper for each round. It is important that the discussion is continued for the full 30 minutes to allow ample time to demonstrate all the core communication skills, but a 5 minute warning near the end of the time can be useful to allow time to wrap up and get back to safe ground if necessary. Use your discretion about the exact point to stop.

The three cycles are repeated and there is time for a coffee break, when the trio is ready, in between the second and third cycles.

24. Producing a personal development plan (PDP)

Aims

- explore the purpose of a personal development plan (PDP)
- explore the place of PDPs in appraisal and revalidation
- explore the limitations of PDPs
- explore what makes a good PDP based on explicit criteria
- provide practical experience of working up broad aims into PDP objectives.

Background considerations

What is the PDP for?

- to provide focus to personal and professional development
- to provide a series of stepping-stones that can be used to measure progress over time
- to help clarify ideas and plans before embarking on them
- to help prioritise personal learning needs and balance them with service needs

Problems with PDPs

- only looking at them just before the next appraisal
- simplifying them to the level where there is no element of challenge because everything is already booked or easily achievable
- a snapshot view does not always fit with how the individual works/learns (global vs. sequential learning – individuals have differing preferences).
- the emphasis on achievement does not encourage aspirational objectives
- the annual cycle dictates an artificial timeframe.
- avoiding the PDP becoming a continuing professional development (CPD) log
- deciding how many items are appropriate.

What level of achievement is acceptable?

- How many items have been achieved in full?
- How many items have been discarded, superseded or are no longer appropriate?
- What if items are partially achieved?
- What about items that have more than a year timeframe?

Appraisers should use their professional judgement and expertise to form an opinion and, if in doubt, ask advice. Opinion will converge over time as the body of experience grows so the threshold for asking advice should initially be low.

Remember:
The PDP priorities are core to two statements in the appraisal outputs and need to be professionally written (usually by the appraiser based on the needs identified by the doctor). They must not be flippant or too vague for progress against them to be measurable.

Some of the best PDP objectives have the word "patient" in them because they make the impact on patient care, relationships with colleagues or patients or the resilience of the individual doctor clear.

25.What are SMARTER objectives?

S	**Specific**	each goal should be clearly defined so that the doctor has been drawn into thinking carefully about it and how it might be met. The more precisely the necessary steps are defined, the easier it will be to take them
M	**Measurable**	the impact / outcome measure(s) should be defined at the outset so that it is clear how to determine progress and when the objective has been achieved
A	**Achievable**	most objectives should be realistic and achievable although some potential objectives may be aspirational or have a timescale of more than one year
R	**Relevant**	goals should be important and meaningful – in the context of stage in career, work situation, and looking at individual and local and national priorities. The most relevant objectives arise from the appraisal documentation and discussion and are concordant with the deeper values and motives of the doctor.
T	**Time-bound**	the timescale in which the objective will be achieved should always be made clear so that there can be rigorous progress review.
E	**Economic**	objectives must be economic in terms of the resources (time and money and support) needed to achieve them, or, no matter how motivated the doctor is, they will not be achieved
R	**Reflective**	given the General Medical Council emphasis on reflection on lessons learned and changes made, it is appropriate to ensure that how to demonstrate reflection on the impact of working towards or achieving the objective is made explicit and with whom it should be shared

26. Exercise: Practise writing an effective PDP objective

Practical exercise in trios:

- framing objectives that are achievable
- identifying the actual need
- exploring methods of reaching truly useful and structured objectives.

Consider the challenge on the slide – identifying a PDP objective from the partial appraisal discussion or for the doctor as a new appraiser - very vague and non-specific.
First try to write yourself an objective using the PDP headings
Then spend time as a pair trying to help each other improve these PDP objectives to make them truly SMARTER. They will be collected at the end to help inform the post event written feedback from the facilitators.

Suggestions for encouraging the doctor to frame objectives clearly:

- *"Out of all that we have discussed, what is the one thing that you would like to take forward to work on next year?"* – useful for getting the doctor to hone down into exactly what they want to do most.
- Sometimes try adding "*What would really make a difference?"* if the doctor is still struggling to identify a priority area to work on.
- Aim for real clarity and anchor it in the doctor's experience of the change / learning. Try using the structure:
  e.g. "By….I will have….and I will feel….."

  (Try to get the doctor to be this specific – work based on Egan's 'skilled helper' model[2].)
- Look at the flowchart overleaf for building a PDP objective for ideas.

[2] *The Skilled Helper: A Problem-Management Approach to Helping, 6th revised edition* (Egan, G, Brooks/Cole, 1997)

27.Dealing with difficult appraisals

- If issues of health, conduct or performance are suspected, concerns should be reported to the appropriate person and acted on according to the severity of the issue, as soon as possible after they have arisen. This is part of the normal duties of a doctor and not restricted to appraisal.

- There are times when an individual appraiser may not know how seriously to take a 'soft' concern and talking to others with more experience will usually resolve the dilemma. This will not necessarily prevent an appraiser from signing-off an appraisal depending on the nature of the concern but is likely to lead to the need to make a comment to the responsible officer in the appropriate box.

- If the appraiser intends to report concerns this should normally be discussed with the doctor so s/he is fully aware of the concerns.

- If unacceptable standards or poor engagement with the appraisal process are identified, these should, where possible, be resolved with the doctor so that the appraisal can be satisfactorily completed. For example, an interview could be re-scheduled if paperwork were delayed.

- If an appraiser remains unable to sign off an appraisal on the basis of the above guidance, their concerns should be made known to the appropriate person. A process for managing this should be locally agreed, and clearly described in the appraisal policy.

- If an appraisal cannot be signed-off, appraisers should ensure that they have records made and dated as soon as possible after the end of the appraisal meeting in order to justify their decision if challenged.

- The appraisal policy must contain a complaints and appeals policy so that a doctor who wants to complain or appeal knows how to do so and is treated fairly and transparently.

- If, after an appraisal, an appraiser becomes concerned about an appraisal or a doctor they should contact their appraisal lead or an experienced appraiser from their support group, or another appropriate person to discuss this. Remember: if in doubt, ask…

Challenging appraisals exercise

Aims

- Explore under what circumstances an appraisal already being undertaken should be stopped
- Explore how to handle sensitive and challenging information
- Explore what actions an appraiser should take under these circumstances
- Ensure that the appraiser is aware of how to access poor performance and occupational health processes locally

In trios: Appraisee / appraiser / observer

Scenario 1:
Appraisee is a high flyer with an incredibly full portfolio, including academic and PCT roles. The appraiser innocently asks: "how do you manage to fit all this in?" at which point the appraisee blurts out they couldn't do it without the amphetamines / having a drink every night / that their marriage is falling apart
The trio take the theme from here with the appraiser rehearsing forms of words and strategies to work out the most appropriate way to proceed

Scenario 2:
At the end of the appraisal discussion, you are feeling uncomfortable because you think you have to enter "disagree" to the sign-off statements about providing appropriate supporting information and made progress with last year's PDP. The appraisee claims to have had no time for preparation and their pre-appraisal forms have been almost identical to what they wrote last year. There is very little supporting information, and no documented reflection from the doctor. The doctor so far has brushed off any comments you have made during the discussion about preparing for revalidation.
The doctor ends by saying 'well let's get on and sign the paper work off and then we can both go off and get on with the important things in life…..'

Scenario 3:
Your appraisee is a young (ish) part time (5 sessions) salaried doctor, who has prepared meticulous appraisal documentation. The patient and colleague feedback is full of praise about being clinically excellent, hardworking and popular with patients. Soon after you start the appraisal, the doctor bursts into tears and says "I'm thinking of giving up because I'm so exhausted. My working days are always at least 12 hours and I hardly get any time to discuss cases with my colleagues."

Scenario 4:
You are a junior appraiser and are appraising a senior GP, who has clearly been a high flyer, is within 2-3 years of retiring and appears to resent the appraisal process (especially being appraised by someone junior to them). He has not submitted a very full portfolio, which you need to challenge him on.

Scenario 5:
Your appraisee has shared details of a complaint, which appears to be due to an honest mistake, but has had serious consequences. It is being investigated locally, and the GMC have also become involved (the patient's family complained directly to the GMC as well as to the practice). The doctor is terrified, has no idea what to expect, and is considering resigning.

28. Suggested challenges for common appraisal problems

Too much documentation

- How did you decide how much evidence to submit?
- What could you do to make preparing for your appraisal less time-consuming?
- How do you prioritise your work? How can we prioritise what we need to discuss?
- How would you assess this supporting documentation?
- What do you think is the most important piece of work/evidence/documentation in here…why?
- Help me to hone in on what really interests you…

The high flyer

- Looking at all these impressive achievements, which means the most to you, and why?
- Do you still feel driven to achieve more? Why?
- Are you aware of the ways in which you use your influence?
- Is there anything you would like to do but you feel you could never succeed at?
- How do you feel about revealing your weaknesses?
- Where do patients come in your order of priorities?
- I feel rather inadequate, when I look at all you do. How do you think the other members of your department/practice feel?
- Within and beyond your professional activities, do you feel that anything important is being sacrificed on the altar of your success?
- How do you feel about your work/life balance?

The cynic/unbeliever/imminent leaver

- You seem to feel appraisal is merely a hoop to be jumped through… (pause).
- I'm sorry you feel like that. Do you know of anyone who has found it a positive experience?
- Let us try together to make this time as useful as possible for you. What are your top priorities this year?
- You seem very negative about the appraisal process. What upsets you about it?
- I feel that you would rather I were not your appraiser…?
- I am feeling unable to do a good job here. Is there anything I could change to make it more useful for you?
- What have you achieved that feels worthwhile? What could we achieve that would make this useful to you?

The dependent/disempowered

- How do you feel you could take control of this appraisal?

- I feel you are looking to me for answers. What are your priorities?
- How do you make decisions? Not just at work but in your life outside work too?
- I have the feeling you have felt unable to take control here…does that happen to you often?
- What do you feel about bullying? Have you ever had any experience of it?
- When you ask me what I think you should do, I feel that because this is your appraisal and your own solutions are likely to work best for you I shouldn't be giving you the answers…(pause).
- I feel that I am being useful to you, but what do you feel that you should be contributing here?
- I wonder whether I am doing too much of the talking here…?

The disclosure of poor performance

- What you have just said is really serious. Let's take a bit of time to explore that…
- You seem very upset. Do you need a break? Would this be a good time for me to go and get us both a coffee / tea?
- This seems to be outside the bounds of the appraisal discussion. Shall we stop the appraisal here for now?
- You know that what you have just said has implications for patient care… (pause)… I am glad you have felt safe to reveal that. I am here to support you in working through what to do next… (pause)… You know I will have to report this discussion because it affects patient care. We need to put things in place…What do you think we should do next?

The disclosure of illness/addiction

- Any of the challenges used for the revelation of poor performance, plus…
- You have obviously been worrying over this for some time… (pause).
- You seem to be telling me that you are seriously ill… (pause).
- Who else knows about this? Do you feel able to tell your colleagues/partners/spouse/a friend/your GP?
- What would you be telling another doctor in your position to do?

Whistleblowing

- This is a very serious accusation about your colleague. What are the implications?
- May I ask why you have raised this? What were your expectations?
- What do you feel your responsibility should be here?
- What you have told me is hearsay, but do you have evidence that needs acting on?
- What do you know about the whistleblowing policy locally?

29. Useful websites

BMA web pages on revalidation:
https://www.bma.org.uk/advice/employment/revalidation

GMC web pages on revalidation:
www.gmc-uk.org/doctors/revalidation.asp

GMC web pages on good practice:
www.gmc-uk.org/guidance/index.asp

NHS England Revalidation pages for appraisers:
http://www.england.nhs.uk/revalidation/appraisers/

Academy of Medical Royal Colleges (AoMRC):
http://www.aomrc.org.uk/revalidation-cpd/

NHS England (Wessex Area Team)
http://www.england.nhs.uk/south?s=appraisal&search=

30. Useful documents

Good Medical Practice (GMC, 2014)
https://www.gmc-uk.org/Good_medical_practice___English_1215.pdf_51527435.pdf

Good Medical Practice framework for appraisal and revalidation (GMC, 2013)
http://www.gmc-uk.org/The_Good_medical_practice_framework_for_appraisal_and_revalidation___DC5707.pdf_56235089.pdf

Supporting information for appraisal and revalidation (GMC, 2013)
https://www.gmc-uk.org/doctors/revalidation/revalidation_information.asp

Medical Appraisal Guide: A guide to medical appraisal for revalidation (2013)
http://www.england.nhs.uk/revalidation/wp-content/uploads/sites/10/2014/02/rst-medical-app-guide-2013.pdf

Quality Assurance of Medical Appraisers: Recruitment, training, support and review of medical appraisers in England (RST, 2013)
http://www.england.nhs.uk/revalidation/wp-content/uploads/sites/10/2014/03/quality_assurance_medical_appraisers_main_document_v5.pdf

NHS England Medical Appraisal Policy (2015)
http://www.england.nhs.uk/revalidation/appraisers/app-pol/

31. Support contacts

BMA Counselling Service
Tel: 0645 200169
http://bma.org.uk/practical-support-at-work/doctors-well-being/about-doctors-for-doctors

Doctors' Support Network and Supportline
Tel: 0870 765 001
A self help organisation for doctors with or who have recovered from mental illness
www.dsn.org.uk

Wessex Local Medical Committee (LMC)
Tel: 023 8025 3874
https://www.wessexlmcs.com/

Wessex Insight
Tel. 023 8025 3874
https://www.wessexlmcs.com/wessexinsight

Practitioner Health Programme
Tel: 0203 049 4505
A free, confidential service for doctors and dentists living in London who have mental or physical health concerns and/or addiction problems
http://php.nhs.uk/

Royal Medical Benevolent Fund
Tel: 020 8540 9194
Provides financial help for sick doctors
www.rmbf.org

Sick Doctors' Trust
Tel: 01252 345163
A proactive service, self-help organisation for addicted physicians
www.sick-doctors-trust.co.uk