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Oxfordshire Appraisal Guide for Sessional GPs.

How to prepare for your appraisal and revalidation

A guide prepared by 12 sessional GPs in Oxford Deanery. It is a compilation of tools they have tried and found effective in compiling evidence for appraisal and revalidation. The audit tools are based on those used by NES, the feedback tools are from local GPs and variations appear on the NASGP website. This guide is part of a larger project to establish effective CPD for sessional GPs. If we have used something you think you wrote first please let us know so we can acknowledge it, and thank you.

Honor Merriman
CPD tutor
May 2009

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Revalidation and GP Appraisal

The most useful document to guide preparation for revalidation for GPs was published by the RCGP in September 2009 Version 2.
http://www.rcgp.org.uk/PDF/PDS_Guide_to_Revalidation_for_GPs.pdf
This gives the detail applicable to all GPs omitted from this brief guide and should be read alongside it.

This guide will help sessional GPs prepare for revalidation which will begin to take effect from 2010. The final form of the revalidation process for GPs is under consultation and there are pilots of the recertification component. What is certain is that revalidation will consist of two components:

- Re-licensing which is a generic process for all doctors. It will require doctors to engage in yearly appraisal and produce evidence to support the reflections in Form 3 in their appraisal paperwork. The Leicester Statement summarises the evidence needed and is on page 7 in this guide.
- Recertification which is speciality specific. The RCGP are likely to recommend 250 educational credits spread over 5 years. There are two papers on the RCGP website which will aid understanding of what is planned for the educational credits. "Credit based system for CPD" was ratified by College Council on 14th June 2008. It may be read in full in the "practising as a GP" section under "CPD" on www.rcgp.org.uk The other article is on PDPs on the same page of the website.

Sessional GPs will need to consider how to gather the portfolio of evidence needed for both parts of the revalidation process. This guide will help with this.

The credits system for CPD which will have take into account both the impact of GP learning and the challenge of the learning:
"Impact may include:

- Impact on the individual (personal development)
- Impact on service (e.g. becoming a training practice, teaching others, implementing a clinic system)
- Impact on patients (e.g. a change in practice, initiating a new drug – this has obvious overlaps with personal development)

Challenge may be:

- Context related (e.g. more challenging to become a new training practice than a trainer in an established training practice)
- Related to circumstances (e.g. a sessional GP undertaking audit is often faced with problems around the data and follow up)
- Related to personal ability (e.g. personal disability, prior skills, prior experience etc)
- Related to effort expended (e.g. attending an ophthalmology clinic for a whole day 40 miles away to gain experience)"

This guide does not cover this as the results of current pilots will need to be analysed before definite recommendations can be made. It may be that GPs who do not work regularly at the same practice will have no problems in the new system but it's possible that not being in a position to implement change in a practice will affect

the impact of learning on clinical practice. This is not insurmountable and evidence of audits which produce changes in clinical behaviour will certainly gain CPD credits.

The RCGP Guide to the Revalidation of General practitioners http://www.rcgp.org.uk/PDF/PDS_Guide_to_Revalidation_for_GPs_April_2009_V1.0.pdf lists 13 evidence areas, it indicates the evidence needed in the introductory phase of revalidation (page 25) and covers evidence for GPs unable to provide standard portfolios (page29).
This guide has added details for the following areas of evidence which may be more difficult for sessional GPs to obtain:

Evidence area 4	A personal development plan from each annual appraisal
Evidence area 7	Multi source feedback from colleagues (MSF)
Evidence area 8	Feedback from patients
Evidence area 10	Significant event audits
Evidence area 11	Clinical audits

Information to be submitted in addition to Form 3

This is the minimum dataset agreed in the Leicester Statement February 2007

Item	Requirement	Present (tick)
Completion of new forms 1,2,3	Annual Legible Coherent Provided in good time	☐
Provision of on-going PDP, with clear description in Form 3 of degree of attainment.	Annual	☐
Last year's appraisal summary (Form 4)	Annual	☐
Case review structured reflective template (SRT)	2 annually	☐
Data collection/audit with SRT	1 annually	☐
Significant event SRT	1 annually	☐
SRT on last year's learning	Annual	☐
Patient survey SRT	Within past three years	☐
Complaint SRT(s) or declaration of no complaints	At least one annually	☐
Multi-source feedback SRT	Within past 3 years	☐
Full declaration of all other professional roles	Annual	☐
Other professional roles SRT	Annual	☐
Probity SRT	Annual	☐
Health SRT	Annual	☐

Additional information to support Form3:

The Leicester Statement gives the minimum amount that should be submitted, the list below gives additional ideas. This list is derived from appraisals for GPs in Oxfordshire. It is not prescriptive but is included to stimulate ideas.

Documents to be provided by most doctors	**Additional documents**
Good clinical care	
Work log (a record of sessions worked, as recommended in "Extending Appraisal to All GPs ScHARR 2003).	
Significant event system in practice and example of one recorded and discussed event (SRT on this in the list on the previous page)	
Audit data; could be summary of QOF data Other audits GP has performed showing how this has led to change in practice, e.g. referral to secondary care. .	Information from referrals; review meeting and how this has aided learning and future practice
Prescribing data, PACT or practice policy, in particular protocols you have written yourself. Notes from meeting with prescribing adviser. Audits on prescribing and how these have led to change.	Records: Practice protocol for updating active problem list in medical records. Protocol for linking prescribing to problems on active list.
Consultations: length of time offered each patient	System to audit demand on appointments and how this is used to alter available appointments through the week
Clinical guidelines and protocols. Those used by the GP personally whether national, local or personal.	
Maintaining good medical practice	
PDP, last years and draft of this year's. Indication on PDP of development needs added in the past year and how far all needs have been met. Reasons for not meeting specified needs.	Publications in last year in peer reviewed journals or other publications.
Records of meetings and courses attended and what has been learned from them	
Method of recording and meeting learning needs discovered in day to day practice	PUNs and DENs log or other reflective log

	Logs and reflections on reading, personal literature reviews etc
CPR skills update, record of attendance at a practical session in last 2 years	
Safeguarding children training, record of recent meeting or other update	Record of how practice team have decided to manage concerns about children and families.
Relationships with patients	
Patient survey data (PCT) with what has been learned from results, or personal patient survey. Action plan based on patient feedback.	
Practice leaflet or / and website	Practice policy for chaperones
Practice complaints procedure Learning points from complaints received by the practice or GP personally.	Personal accolades
Method of addressing any problems with patients where communication rather than clinical skills was the issue.	Record of consultation skills training, use of video to learn from consultations
Relationships with colleagues	
References from colleagues, especially practice where GP has recently worked.	
Record of when teams meet. Who meets? How are communications about patients made? How are team problems addressed?	Minutes of team meetings and away days Approaches to integration of the sessional GP into practice meetings, learning and decision making.
Results of survey of colleague feedback, 360° if feasible	
Teaching and training, appraising and assessing	
Evidence of training and qualifications for teaching role.	Feedback from students or form those attending a course you have run Teaching materials used
Record of learning from appraiser group meetings	External assessment of appraiser skills by direct observation of real or simulated appraisal.

Appraisers: Self reflection sheets from appraisals and feedback from PCT analysis of appraisee feedback.	Form 4 audit with results for other local appraisers.
Probity	
GMC certificate, CRB clearance	
PCT, GMC, NCAS, or other investigation	
Probity statement (eg NES or Appraisal toolkit SRT) and how practice handles accounts, writing cheques (if you are involved with this (unlikely if sessional)	Policy covering pharma sponsorship
Declaration of interest forms	
Health	
Statement of current health in relation to ability to work as a GP (NES statement or Appraisal toolkit SRT)	Hep B immunity What supports or interests are there for you outside your GP work?

Appraisal evidence and Sessional GPs

Providing appraisal evidence is intended to be an educational process for GPs, allowing reflection on personal practice through the year and before discussion at the appraisal interview. It is gathered under the Good Medical Practice headings with examples given in the above tables. The information will support the process of revalidation when this starts in 2010.

Sessional GPs may have particular problems with gathering data from patients and from colleagues. Audits on practice and prescribing analysis are also more difficult unless you work regularly at the same practice(s).

If you work in any practice on a regular or frequent basis, consider asking them if you can be included in their teaching and learning activities. Try asking them if you can be "adopted" by the practice for appraisal purposes. You could remind them that helping you may improve the service you give them. You may be able to attend protected learning events, audit meetings, or SEA meetings: you may also be able to get feedback from working there during any patient survey. Ask for individualised data.

Clinical audit

Clinical audit is a process for reflecting on or studying clinical practice, comparing actual work with clinical standards, identifying areas for improvement. The process involved action to make things better and finding out if it works. It is a cyclical method of continuous improvement.

Audits may be small or large scale and examples are given in Appendix 3. The most important aspect of audit is that it is motivated by a wish to do things better and is systematic. Put simply is a method of "a process of scrutinising your work to make it better".

Several sessional GPs set up a system for finding out what has happened to patients that they have seen and others use a referral log. The latter can be used to audit the appropriateness of a referral and to learn from the specialist advice sought.

Several ideas for audits may be found on the NES website
http://www.scottishappraisal.scot.nhs.uk/appraisal-preparation/sessional-gps.htm

Significant event reviews

These are most useful when discussed in the practice team where you were working as a locum. This will help the team find solutions to a problem which occurred while you were working there. This is often not possible and many sessional GPs use their peer support groups to discuss these events. Wherever the event takes places it's useful to have a format for recording it and a form for this is included in Appendix 4.

Patient satisfaction surveys

Patient surveys which provide individualised information will be needed twice in every 5 year revalidation cycle. The ideal survey has not yet been identified, the patient surveys which provided information about the practice as whole will not feature in the QOF in future.
In the interim it is important not only to try out a survey but to be able to show the lessons learned from patient feedback and how these have lead to changes in what the GP does in the future.

GPAQ was developed by the National Primary Care Research and Development Team at Manchester University. This is probably done most easily if you are able to take part in a practice's annual survey of all the doctors. Even then, some of the content of the GPAQ will be of little relevance to you, since it deals with accessibility issues, reception and other administrative aspects of the practice. Only a few sections deal with you as a doctor, and the feedback is limited. Many practices do not purchase the form of the survey which allows for individual GP feedback.

IPQ. The Improving practice questionnaire (developed by Michael Greco at Exeter University) is similar to the GPAQ, again focussing on many aspects of practice services over which you have no control as a sessional doctor. It is used by the **CFEP** Company.
The section on communication skills may be helpful to you however it is an option to consider if you want to receive feedback from patients in this area. Remember it is not funded for practice use under nGMS in most areas, so you would need to pay for its use.

GPSQ. The Grogan Patient Satisfaction Questionnaire is more doctor-centred, but it too has significant areas over which you as a visiting doctor will have no control. The questionnaire is included this guide as it is free, and you could select some of the items for personal use. You would be advised to consider modifying these questions: several of them are phrased in a way that suggests you see the patient regularly. A possible modification is shown below.

Analysis and feedback of surveys

Data collected in a survey of patients or colleagues needs to be analysed and a report prepared. This is best done by a third party. For the purposes of the sessional GP project in 2009 an analyst will do this free of charge. At the end of the project the preparation of the report will need to be funded by the GP.

Video review

It is better for a small group of you to work on this than to work in pairs: the feedback will be more objective and there is less likelihood that you will avoid giving constructive but possibly critical feedback. Remember, if you decide to undertake work of this type and you are new to it, it is helpful to work on the basic principles:

1. The observed person is invited to state what went well.
2. The observed person is invited to state what could have been done differently.

3. The observer is invited to state what went well.
4. The observer is invited to state what could have been done differently.
5. The observed person is allowed to reflect and respond, noting lessons learned

It is unlikely that you will be in a position to set up video facilities if you are visiting a surgery on a one-off basis. If you work regularly for a training or teaching practice it may be possible to video your consultations from time to time and your skills in learning from viewing videos will be valued in your work with the learners in the practice.

Complaints

Sessional GPs need to be aware that complaints about them may be made after they have completed their work at a practice. It is important that employing practices let GPs know any complaints so that they may be part of the response of the practice to that concern. There may be valuable learning from the complaint and it is essential that the complaint and what has been learned are recorded and acted on. It may be necessary for sessional GPs to contact practices after a period of employment to find out if that need to know about a complaint, significant event review or a letter of thanks.

Patient Feedback Form

I always hope, when I see patients, that when they leave they will feel that their concerns have been taken seriously and that our meeting has been helpful. When I only see people once or twice it is difficult to be sure of this; so will you please help by sparing a few minutes before you go, answering the questions below and leaving this paper with a receptionist? Thank you very much.

Please ring those answers that you feel are relevant
Please leave this completed form with a receptionist

Would you have liked more time with me?	Yes	No
Did you feel hurried?	Yes	No
Was there anything you would have liked to talk about in more depth?	Yes	No
Was there anything else you wanted to talk about but felt you weren't given a chance?	Yes	No
Did you feel your opinions were treated as important?	Yes	No
As a result of our meeting do you feel		
Able to understand your illness better?	Yes	No
Able to cope with it better?	Yes	No
Better able to look after your health?	Yes	No
More confident about your health?	Yes	No
More able to help your self?	Yes	No
Your expectations		
1. Did you expect a prescription?	Yes	No
Did you get one?	Yes	No
Did you expect a change of dose, or a different drug?	Yes	No
Was any such change made?	Yes	No
Did you understand the reason for my decision?	Yes	No
Were you happy with it?	Yes	No
2. Did you expect any tests or X-Rays?	Yes	No
Were any arranged?	Yes	No
Did you understand the reason for my decision?	Yes	No
Were you happy with it?	Yes	No
3. Did you expect to be referred to a specialist?	Yes	No
Were you referred?	Yes	No
Did you understand the reason for my decision?	Yes	No
Were you happy with it?	Yes	No
Were you happy with your consultation?	Yes	No
Could I have said or done anything which would have made you more satisfied? If so, please tell me below -	Yes	No

(adapted and used by Paul Roblin from NASGPs)

Working with colleagues

All doctors are expected to work with colleagues across a range of disciplines to provide effective medical care. Sessional doctors who may work only a single session in one practice face particular challenges in this area.
There is as yet no "official" MSF tool for GPs. The GMC will publish it's recommendations for this soon and it is likely that this will be based on a survey being developed by NHS Education for Scotland http://www.nes.scot.nhs.uk/
The research used to develop the MSF is published in the GMC website www.gmc-uk.org/doctors/licensing/revalidation/multi_source_feedback_for_doctors.asp
On reading the research, the survey with the most information about validity is SPRAT and so a simplified version of this is included in this guide. For more information about SPRAT the best website is www.hcat.nhs.uk This the website for Health Care Assessment and Training who have developed and validated a variety of different surveys for doctors including those used by RCGP e portfolio, SPRAT (used by NCAS) and the Foundation Programme.

Until the GMC publishes the final MSF survey version it would be good to try out a survey so that you gain confidence in learning from the process and the practices you work for get used to handing them out when you are there.
The main purpose of the survey is for you to gain insight for your personal development. It's good to keep this in mind while grappling with the logistics.

The STAR rating tool developed in north Northumberland has been used by GPs with useful results http://www,gp-training.net/training/tools/index.htm#asessement

You are expected to do two MSF surveys in every 5 year revalidation cycle.
It is recommended that you consider discussing your replies with a peer who is also a sessional doctor, either at sessional doctors' group or at a personal level if no group is available to you.
You could ask a practice you work in regularly to fill the adaptation of either of the surveys on the following pages with

1. a covering letter inviting them to send you feedback
2. an explicit statement that they are NOT asked to reveal their identities but that any named feedback would be helpful
3. sufficient copies of a questionnaire for at least each partner and the practice manager

MSF Survey

I would appreciate some feedback from the team on my strengths, and on areas where changes could usefully be made. This form will be given to randomly selected people in the team, filled in anonymously and a third party will collate the comments and they will be fed back to me individually.

The usual feedback principles apply. Please give constructive feedback or criticism suggesting behaviour or actions that can realistically be changed or improved – negative, destructive comments can be extremely distressing and must be avoided.

Leave blank any sections you don't feel able to comment on

Dr ………………………………………… Date Completed …………………………………………

Core Area	**What are the GP's strengths in this area?**	**In what areas might he/she improve?**
Clinical Skills and knowledge		
Communication skills and relationships with patients		
As a team member – working with colleagues		

Additional comments if any :

Colleague Feedback Survey

To help me improve the service I provide, please could you answer the following questions, circling the number which you feel is most appropriate

Patients' experience	Disagree-------------→Agree
1. Patients appear satisfied with my consultations	1 2 3 4 5
2. Patients ask to see me again	1 2 3 4 5
3. Patients seem satisfied with the care and advice given	1 2 3 4 5
Colleagues' experience	Disagree-------------→Agree
1. Working relations with colleagues in the practice are good	1 2 3 4 5
2. Staff feel able to approach me for advice or queries.	1 2 3 4 5
3. Timekeeping is adequate	1 2 3 4 5
Administration	Disagree-------------→Agree
1. Record keeping is acceptable	1 2 3 4 5
2. Data entry (for quality points etc) is acceptable	1 2 3 4 5
3. Safety netting (passing on information regarding patient care/follow up) is acceptable	1 2 3 4 5
Any other concerns	
If you have any other concerns or comments please add these below. This survey is completely anonymous, but please feel free to give me direct feedback – I want to know so that I can improve.	

Optional but can be very helpful

My role is (circle): Doctor Practice Nurse Other

Clerical/secretarial staff I'd rather not say

(from Tom Nichols and NASGPs).

360 feedback form for GPs (adapted from GP-SPRAT)

How do you rate this GP in their ability to:

	I do not know / not applicable in my working relationship with this GP	Needs further development	Good	Excellent
Good clinical care				
Formulate appropriate management plans	☐	☐	☐	☐
Make appropriate use of resources	☐	☐	☐	☐
Refer appropriately to secondary care	☐	☐	☐	☐
Maintaining performance				
Apply up to date, evidence based medicine	☐	☐	☐	☐
Monitor performance and maintain professional development	☐	☐	☐	☐
Relationships with patients				
Communicate well with patients	☐	☐	☐	☐
Practice with respect to patients and their right to confidentiality	☐	☐	☐	☐
Working with colleagues				
Communicates and works effectively with colleagues	☐	☐	☐	☐

How to produce a PDP

A guide for GPs before their appraisal

PDPs are a way of setting development goals for the next year. They arise most commonly as GPs reflect on the information they record on their pre appraisal forms on the Appraisal Toolkit. Some goals are set and then achieved in the year between appraisal meetings, it's useful to record these too to indicate a flexible and reactive learning approach.

Step one	**Learning needs** (What development needs have I? Explain the need) **Specific** **Measurable** **Achievable** **Relevant** **Time-bounded**	What are the main development and learning needs? (If you don't know exactly what you needed to develop how will you know when have got there?).
Step two	**Learning activities** (How will I address them? Explain how you will take action and what resources you will need))	What methods will be used?
Step three	**Evidence of learning** (Outcome. How will practice change as a result of the activity?)	How will the GP know if the methods used have met his or her requirements? What will the GP put in the portfolio?

Column headings from PDP template in Form 4, DH appraisal documents.

Step one
Learning needs

This is a process of selecting priorities from reflection on all the areas of good medical practice. The reflection is a continuous process for all GPs but is focussed by the completion of Form 3 before the appraisal and further clarified during the appraisal interview.
Some points to consider:

- Some clinical skills are easy to express specifically in a PDP e.g.. "To learn how to perform soft tissue injections"

- Clinical knowledge gaps should be defined; many GPs feel they do not know enough about diabetes, but in expressing this in a PDP it is more useful to the doctor if the knowledge gap is more clearly defined. This might be a need to know about how to do insulin conversion. (Put this in the PDP as insulin conversion not just as diabetes)
- Other activities might be more difficult to define, e.g. if a new member of staff is needed some GPs might have a specific learning need if they do not know how to interview applicants, other GPs would have a different learning need. This could be negotiating skills.
- In a first PDP do not attempt to tackle more than three to five topics
- In deciding what needs to go into the PDP the GP needs to find a balance between what is most important in their personal development and what is important to the practice as a whole.

Step two – Learning Activities

What **learning methods** are most appropriate to each learning need?
Knowledge gaps: reading journals, attending meetings and seminars, going on courses, e learning (e.g. BMJ learning)
Skills may be best learnt by observing somebody else and then practicing, usually with some supervision. Setting up new clinic for long term conditions or doing a simple procedure such as a soft tissue injection can be done best this way.
Attitudes can be reviewed in discussion with others, particularly in the context of clinical scenarios. Significant event reviews are a good way of doing this. Mentoring is another good way.

Are these methods appropriate?
GPs generally know which learning methods suit them best on the basis of past experience. If there is uncertainty about this use of a simple learning styles questionnaire can raise awareness and help GPs to select a learning method which can help them to learn more effectively. See section on learning styles at the end of this section.

Do these methods develop you as a learner?
Effective learning should be partly based in the workplace so that new information can be readily integrated into clinical practice.
In addition learning may be more effective if it is multi professional since GPs work as part of a team to be fully efficient. We can also learn much from our colleagues.
Self directed learning helps us to do what we need not somebody else's pet ideas.
Computer based learning allow access to many resources and can be done at a time to suit us.

Be stretched and use at least two different learning methods for each topic chosen.

Write the chosen methods on the PDP next to each associated learning need.

Step Three – Evidence of Learning

Identify examples of evidence which could demonstrate achievement for each set of learning needs and proposed methods. Questions can include:

How will you show that learning has been undertaken?
Attendance certificate
Learning log (a good tool for this is on the Appraisal Toolkit)
How will you demonstrate that you reflect on learning activities?
Learning log, evaluation and assessment sheets, reflective diary
How will you show that learning has occurred and been applied?
New learning (knowledge) can be demonstrated on MCQs or PEP CDs or by sharing with colleagues in a meeting or teaching session.
Improved communication skills can be shown on videos of consultations.
Change in personal and practice behaviour which can be captured in QOF or other audit data or in patient satisfaction surveys. A new practice guideline or protocol.
Case histories of patients.

Put the proposed evidence of learning for each learning need on the PDP.

PERSONAL DEVELOPMENT TEMPLATE

Example of poor PDP (after Amar Rughani)

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

What development needs have I?	How will I address them?	Date by which I plan to achieve the development goal	Outcome	Completed
Explain the need.	Explain how you will take action, and what resources you will need?	The date agreed with your appraiser for achieving the development goal.	How will your practice change as a result of the development activity?	Agreement from your appraiser that the development need has been met.
1. Diabetes	Attend a course	12 months	Feel better about managing patients with diabetes	
2. ENT	Attend a course	12 months	Improved ENT skills	
3 Computer skills	Attend a training session	12 months	More confident in the use of the computer	
4 etc				

Example of good PDP (after Amar Rughani)

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

What development needs have I?	How will I address them?	Date by which I plan to achieve the development goal	Outcome	Completed
Explain the need.	Explain how you will take action, and what resources you will need?	The date agreed with your appraiser for achieving the development goal.	How will your practice change as a result of the development activity?	Agreement from your appraiser that the development need has been met.
1.Diabetes: improve foot care	Arrange to sit with local podiatrist See how other local practices run their diabetic clinics Attend case discussions at hospital based service.	6 months	Improved data entry of diabetic patients Improved working relationships with colleagues who have helped me with my learning.	
2. ENT: management of chronic otitis externa	Internet search and read texts for best practice. Discuss with local ENT clinic	6 months	Improved management which will be shared with rest of PHCT in a meeting	
3 Improved use of basic computer use and improve data entry during consultations	Arrange tutorials with practice IT lead. Find about ECDL and do it	12 months	Able to use more functions on the computer. Able to audit patient data more thoroughly.	

Appendix 1

Sources of help for GPs in Oxfordshire

In Oxfordshire learning events and GP appraisal information is found on www.oxfordprimarycarelearning.org.uk The information is regularly updated so please click on to the site in these months leading up to revalidation.

The NHS toolkit has been updated and is user friendly. It is a secure password protected site and is a useful method for storing data for appraisees and can be used for Form 4 and PDPs.- The SRTs provide a useful guide for guiding reflection on all parts of GMP.www.appraisals.nhs.uk/

The GMC website has information about Good Medical Practice and revalidation. www.gmc-uk.org

NAPCE membership is open to educators (including appraisers) and offers significant membership benefits (for details look at the website www.napce.net) Separate annual conferences are run about appraisal, managing poor performance and primary care education.

The National Association of Sessional GP's website (www.nasgp.org.uk) gives some very helpful examples of how you could collect useful data on their appraisal pages and does not require membership fees to be paid to access the section.

In June 2008 the GMC published the latest edition of Good Medical Practice for GPs. We would recommend that all GPs download their own copy of this from the RCGP website www.rcgp.org.uk under the headings: practising as a GP -> revalidation.
The definitions of the exemplary GP, the acceptable GP and the unacceptable GP will guide our day to day GP practice as well as guide those responsible for making judgements about fitness to practice under the new revalidation processes.

For information about local occupational health services; the leaflet is available on 0845 2191150

GP Care is a counselling service for GPs and their families in Oxfordshire. For more details see the News section on www.oxfordprimarycarelearning.org.uk.

Appendix 2

The process of GP appraisal in Oxfordshire

How appraisals are arranged in Oxfordshire

Appraisers are allocated by the GP appraisal team at the PCT GP.Appraisal@oxfordshirepct.nhs.uk and allocations for 2009/2010 will be made in February 2009.
GPs are matched so that no GP sees the same appraiser more than twice in any five year period. The allocation takes account of locality and will try to avoid anyone having to cover long distances. The PCT does not pay for mileage or travelling time.
The PCT writes first to the appraisee to check that there is no problem with the allocated appraiser, she then informs the appraiser and leaves it to them to arrange when and where the meeting will take place.
Paperwork (Forms 1-3) should be sent in to the appraiser 2 weeks before you meet and the appraiser can chose to defer an appraisal if the paperwork is not done before you meet. It will certainly indicate that you have not made time to think about your clinical practice: Your reflections before the meeting are essential to an effective developmental interview.
We would like all doctors to move to using the appraisals website www.appraisals.nhs.uk , as soon as possible. It allows for all documents to be uploaded and prevents folders being lost in the post (which has happened to me). The PCT can know when people are due to meet (but cannot access any personal information).. It aids the transmission of Form 4 by email.
From 1st April 2009 all appraisal paperwork must be typed and sent by email. If you have not used the website yet, we would recommend that you familiarise yourself with it as soon as possible.

Please accept that the appraiser may ask you to travel to see them. Travelling times have not been factored into the sum paid to your appraiser. You should be prepared for the Form 4 and PDP to be completed at time of interview. Appraisers will not have time to chase up these documents later on.

The whole process is summarised in this table:

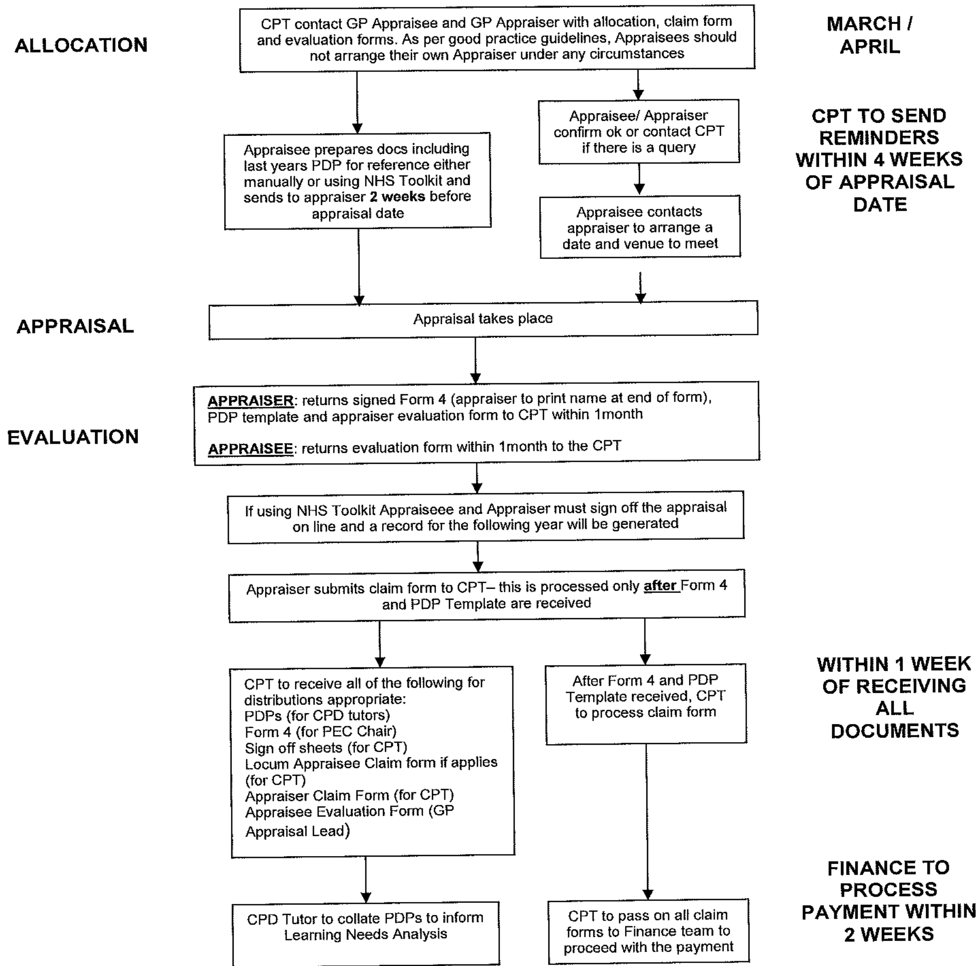
Step		**Responsibility**		
1	Allocation of an appraiser to each GP listed on the Medical Performers List at the beginning of each financial year. GPs should not have more than two appraisals in a five year	PCT Governanc e Manager with CPD		

	period by the same appraiser. GPs should not be appraised by an appraiser who works with them in the same practice.	Tutors		
2	Written notification to each GP of the name and contact details of the appraiser they have been allocated. The letter will indicate the date by which the GP should advise the PCT if they wish to be allocated a different appraiser.	PCT Governanc e Manager		
3	GPs notify the PCT Governance Manager if they would prefer a different appraiser than the appraiser they have been allocated before the specified date in the notification letter. Appraisers will not be changed if the request is not received by the specified date.		Appraisee	
4.	Alternative appraisers allocated where requested. Notification letter to be sent to GP confirming this new allocation.	PCT Governanc e Manager		
5	Appraisers advised of the GPs they have been allocated. Allocations noted on Appraisal toolkit.	PCT Governanc e Manager		
6	Appraiser contacts the appraisee as soon as possible during the financial year to arrange the month of the appraisal (exact appointment dates can be arranged nearer the time).			Appraiser
7	Appraiser advises the PCT Governance Manager once arrangements have been made.			Appraiser
8	Appraisee informs the appraiser that the online forms are completed (www.appraisal.nhs.uk) and agreed evidence is sent to the appraiser at least two weeks before the appraisal date. The appraisee should also send their last form 4 and completed PDP from their previous appraisal.		Appraisee	
9	Appraisal Interview takes place and the appraiser hands the feedback form (appendix 2) to the appraisee for completion and direct return to the PCT Governance Manager		Appraisee	Appraiser
10	Appraiser returns the signed off Form 4 Summary of Appraisal Discussion (including PDP), and invoice to the PCT Governance Manager.			Appraiser
11	The GP Clinical Governance Lead reviews and signs off all Form 4s prior to being stored in a locked filling cabinet.	Clinical Governanc e Lead		

12	Educational needs are collated by the CPD tutor from submitted PDPs and a report is prepared that details global learning needs for GPs at Oxfordshire PCT.	CPD Tutors		
13	Appraiser feedback (evaluation sheet) is collated and a report prepared.	PCT Governanc e Manager		

Note: An appeal system is available for those appraisees who have an issue about the process of the appraisal which they cannot address with their appraisal partner to their mutual satisfaction

How appraisals are arranged in West Berkshire



PRINCIPLES

- Use NHS Toolkit where possible
- Allocation of appraiser changes every 2 years
- Email based system
- Responsibility of appraisee to ensure their appraisal takes place annually
- Regular meetings for appraisers

CPT – Contract Performance Team
CPD – Continuing Professional Development

Checklist: things to do before and after your appraisal

Preparation

- Allocated appraiser – contact details
- Date, time and venue set
- Consider how to complete – use electronic toolkit on http://www.appraisals.nhs.uk
- Read through appraisee guide
- Complete forms 1,2, 3
- Reflect on last years PDP and key achievements
- Think about development needs for forthcoming year
- Consider and upload "evidence" gathered over the year on to the website.

Consider all aspects of your work – e.g. special interest, PCT role, educational role, appraiser role

2 weeks in advance - send appraiser completed forms

Forms 1,2,3

- Last years PDP
- Last years summary (form 4) if you wish
- Other key documents e.g. patient or colleague feedback

Process – key points

Your agenda
Developmental
Build on last year's
Need to review and sign off PDP
Don't forget inspirational and personal goals
Use form 5 if wish for personal use
Ensure sign off by you and your appraiser on the toolkit. If there is any electronic glitch do it in paper. It is best to reach agreement on this at time of interview.

Post appraisal

- Your appraiser will send a copy of form 4 (includes latest PDP) to PCT clinical governance lead.
- Evaluation of appraisal form to be completed and sent to PCT by email.
- Sessional GPs may claim £150 by sending an invoice to GP.Appraisal@oxfordshirepct.nhs.uk. The form is on the www.oxfordprimarycarelearning.org.uk GP appraisal page.
- Record in your portfolio (this needs to be done by you and not the PCT).

Appendix 3

Suggestions for audits (based on NHS Scotland guide)

Although audit and prescribing review are separate core topics, many doctors have undertaken a review of their prescribing which has taken the form of an audit. Prescribing review needs to be undertaken against acknowledged standards, and these are widely available. Examples are practice or local formularies, NICE and SIGN guidelines. You might decide to use an audit of your practice against a published standard in one of these areas.

The Toolkit suggests that you should be involved in two audits, at least one of which you should have contributed to, and both of which you have learned from and can show changes that you have made as a result.

It is recognised that sessional GPs may have difficulty in undertaking audit when they have no fixed practice base and are therefore unable to measure the effects of their care – for example in chronic disease management.

Using a log of some of your consultations can provide you with audit material. You can later repeat measuring similar consultation data to see whether any changes introduced after the first part of the audit have been effective.

It can also provide you with data for examining aspects of your prescribing if you need evidence for a core topic in that area.

Example 1- Antibiotics (5 or 8 criterion audit)

As a sessional doctor you will often see a high proportion of patients presenting for unscheduled care with simple infections. Your prescribing will reflect this.

For **ten** surgeries, note your use of antibiotic prescribing against your chosen set of criteria and standards. You need to consider setting criteria such as:

Patients receiving antibiotics should have a recognised condition for which antibiotics are recommended

- Antibiotics should be used which are in line with local formulary or microbiology laboratory recommendations for first line use, unless clinically contraindicated
- When appropriate, microbiology sampling should be undertaken to check on organisms and sensitivities
- All antibiotic prescribing should use the most effective dose and duration of treatment for the identified condition, in line with local formulary guidelines or the BNF.
- All antibiotic prescribing should be accompanied by a check for known past history of hypersensitivity.
- All antibiotic prescribing should be accompanied by a check for potential drug interactions.
- Broad spectrum antibiotics should only be used where clinically indicated.

- If a second line antibiotic is used, the reason for its use should be documented.
- All potentially infective lesions or conditions should be subject to local infection control policies.
- Patients with MRSA should be handled in line with agreed local guidelines.

These are only examples of criteria which you might choose from. You are recommended to use criteria which you can justify, and you will then need to justify the standards that you set for your performance. You might want to consider repeating the exercise for another 10 surgeries at a later date, to complete the "audit cycle".

Suggestions for referral reviews

GPs refer on average around 10% of their consultations to another agency. They have been criticised by hospital colleagues for both over and under referral. There is no gold standard for the "right" number of referrals, but it is also clear that we can sometimes fail to refer or we can refer inappropriately through lack of knowledge or skills. Sessional GPs have been criticised for having a higher referral rate. There is some evidence that the average rate for sessional GPs is higher, although in many cases there may be appropriate reasons for this.
Research has shown that the number of referrals made will depend on several factors:

- The case mix of patients seen
- The personal experience of the doctor – "expert" doctors may be able to handle more complex patients personally, but some actually refer more often in their own speciality
- Lack of knowledge of the patient
- Lack of home support or resources to care for the patient in the community
- Uncertainty or lack of confidence of the referring doctor
- Inability to offer follow up to monitor the situation
- Failure to appreciate that secondary care may be able to offer additional help
- Patient or carer anxiety

It may be helpful to discuss your planned referrals audit with the practice manager to facilitate follow up at a later stage and to ensure that the practice is aware that you will respect patient confidentiality. You will need to review your referrals against a set of questions.
Part 1
What proportion of all your consultations resulted in referral?

1. What conditions did you find which you felt required referral?
2. When making the referral were you able to identify details of the past medical history, current medication and psychosocial data from the practice records?
3. Did you feel it would have been possible to discuss your decision to refer with one the GP principals to explore alternatives to referral for any of these patients?

4. Did you identify any areas in which it seemed to you that the existing management of the patient was sub-optimal?

Part 2 (an additional option which has learning value)

For this section it is suggested you contact the practice manger at a later date, and arrange a visit to review the medical records of your referrals to assess the outcome. Did the outcome match your expectations?

1. Did you learn anything as a result of the referral?
2. On reflection was the referral appropriate or would you now do anything differently?
3. Did the referral follow the most effective pathway? (For example did it follow a local referral protocol, did the patient attend the most appropriate speciality, did you support your referral with appropriate initial investigations?)

Conclusion (both parts 1 and 2)

You are invited to write a reflective statement on what lessons have been learned from reviewing your referrals.

There are ideas for other audits on the NES website http://www.nes.scot.nhs.uk, the NASGP website http://nasgp.org.uk/

Data Collection Proforma

Letter number	1	2	3	4	5	6	7	8	9	10
Background information available?										
Alternatives to referral possible?										
Problems with existing management?										

Part 2

Outcome as expected?										
Any lesson learned?										
In retrospect was referral the most appropriate?										
Was the most appropriate method or pathway used?										
Appropriate investigation? (if applicable)										

Appendix 4 Significant event form

- *This is a useful way of learning from important events both good and not so good that take place during your normal working year.*
- *Take a look at a significant problem such as a death, serious illness, a complaint or something that went really well.*
- *How was this handled? How did everyone feel? Could it have been handled differently? Will you change anything in the future? What discussion took place afterwards?*

Type of Case**:** (*Clinical/Non-clinical)*

Topic:

Date:

Background to Event**:** *(What happened and why)*

Discussions Held: *(With whom)*

Analysis of Conclusions Drawn:
(Was the event due to lack of knowledge skills or performance, how did it affect patient care, how was due to poor teamwork?)

Clinical/Organisational Changes Resulting
(How did the practice change what it does, how does it affect what I do. How will we all know changes have prevented this happening again?)