SESSIONAL GP APPRAISAL

COLLECTING THE EVIDENCE

June 2006
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When and How to Collect Your Evidence

It can be challenging preparing the documentation for your appraisal, whether you a Sessional or a Contracted GP, but the best way to prepare is to start collating evidence the day after you’ve completed your last appraisal!

There are different ways of doing this;

The Department of Health appraisal forms can be obtained from the ESGPT website. This is a downloadable Word document that can be printed off and completed by hand or edited on screen according to preference.

A way favoured by many is by recording evidence using the NHS Appraisal Toolkit.

There are other tools that can be found on the Internet including:

Eastern Deanery's PDP Toolkit

London Deanery’s PDP Toolkit

Some e-learning sites also allow you to explain why study was undertaken and learning is recorded for collation later.

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1 ESGPT website: [www.esgpt.org.uk](http://www.esgpt.org.uk)
2 NHS Appraisal Toolkit: [www.appraisals.nhs.uk](http://www.appraisals.nhs.uk)
3 Eastern Deanery’s PDP Toolkit: [www.pdptoolkit.co.uk/Files/worksheets.htm](http://www.pdptoolkit.co.uk/Files/worksheets.htm)
4 London Deanery’s PDP Toolkit: [www.londondeanery.ac.uk/gp/primary_care_development/personal_development_plans/index.asp](http://www.londondeanery.ac.uk/gp/primary_care_development/personal_development_plans/index.asp)
The Appraisal Forms 1 - 5

There are 5 forms to complete for GP Appraisal. All sections can be downloaded from - and saved as a word document or completed as part of the toolkit. The first three are to be completed by you prior to your appraisal and sent with your documentation at least two weeks before the agreed date of your appraisal.

Form 1

Form 1 requests information that will tell your appraiser who you are i.e. your basic details.

- Your registered address
- The practice address where you work - if you are freelance, explain this and give your appraiser an idea of the number of surgeries that employ you
- Your qualifications
- Your GMC registration
- Your last revalidation (no-one has had one yet!)
- Date of certification
- Date of appointment to current post – if different and applicable
- Previous posts in the last 5 years – NHS or elsewhere
- Any other personal data – e.g. membership of any professional groups or societies

Form 2

Form 2 gives your appraiser an idea of how you spend an average working week.

It is perfectly acceptable to write “non” or “not applicable” if you do not undertake something – e.g. any out of hours work.

- In hours activities you undertake
- Emergency, on-call and out of hours work
- Brief details of other clinical work, e.g. clinical assistant
- Any other NHS/non-NHS work – e.g. teaching, management, researcher, examiner, forensic
- Work for regional national or international organisations
- Other professional activities

Forms 1 and 2 may be cut and pasted from one year to the next if your circumstances do not change.
Form 3

Form 3 is the most challenging. You are invited to submit documents in support of form 3.

It is organised by the 9 headings used by the General Medical Council in *Good Medical Practice* and the Royal College of General Practitioners in *Good Medical Practice for General Practitioners*, and it is strongly recommended that you look at these documents as prompts.

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

- A commentary on your work
- An account of how your work has improved since your last appraisal (or in the last year if this is your first appraisal) Refer where appropriate to last year’s PDP
- Your view of your continuing development needs – useful for this year’s PDP
- A summary of factors, which constrain you in achieving what, you aim for.

It is not expected that you will provide exhaustive detail about your work. The material should convey the important facts, features, themes or issues, and reflect the full span of your work as a doctor within and outside the NHS.

The form is a starting point and framework to enable you and your appraiser to have a focused and efficient discussion about what you do and what you need. It is a tool, not an examination paper or application form, and it can be completed with some flexibility.

Common sense should be exercised if you feel you are repeating yourself or if you want to include something for which there is no apparent opportunity. If a section or page really needs only a word or two, there is no need to do more.

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

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

You are not expected to “prove” your assertions about your work, but your appraiser will probably want to test some of them with you through discussion and the documents will help you both.

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

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

The 9 headings are:

- Good clinical care
- Maintaining good medical practice
- Relationships with patients
- Working with colleagues
- Teaching and training
- Probity
Good Clinical Care

This section starts off with a commentary of what you think your main strengths and weaknesses are. It relates to your individual or practice organisation – how well the practice runs - with evidence supplied from, for example; up-to-date audit data; prescribing analyses; PCT clinical governance reviews; relevant clinical guidelines; records of any significant event audits or critical incident reports; any complaints and records of their investigation; any ‘in-house’ monitoring materials you use.

The practice manager should be able to supply you with much of this material.

You should attend significant event/critical incident meetings if possible.

Developing your own method for recording personal significant events, critical incidents and performing personal audits are a valuable way of reflecting on and learning from your practice.

Examples of audits could be looking at your referrals to see if any patterns emerge on departments referred to – is there a lack of knowledge in this area or do patients choose you because you are an “expert”?

Have you included all the relevant useful information when referring? Examples include:

- Social history, details of carers where appropriate, drug history etc
- What actions have the consultants made? Hence was the referral appropriate?
- Looking at your prescribing of antibiotics, NSAIDs, anti-depressants, modified release drugs, and delayed prescribing etc
- Outcomes of home-visits

If you are unable to attend significant event meetings, keep a record of your own significant events and their outcomes – e.g. seeing the wrong Mrs Jane Smith, or seeing a collapsed patient and nobody knew where the oxygen was kept.

Resources supplied in Appendices:
- Locum sessions form (Appendix 1)
- Audit form (Appendix 2)
- Critical event/complaint form (Appendix 3)
- Sticky moment form (Appendix 4)
- Review of PACT figures (Appendix 5)

Maintaining good medical practice

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

What steps have you taken since your last appraisal to maintain and improve your knowledge and skills?

Examples of documentation you might refer to and attach are:

- Your PDP and practice development plan
What have you found particularly successful or otherwise about the steps you have taken?

Do you find some teaching/learning methods more effective than others? E.g. lecture format, small group work, e learning, and in-house activities. How will you reflect this in your future approach to maintaining good medical practice?

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

You could keep PUNs (Patient unmet needs) and DENS, (Doctor’s educational needs), a logbook, reflective learning diary, surgery review, referral review, referral letter audit and notes from meetings attended, printouts from on-line learning. Clinical attachments attended. Evidence of attending recent CPR training.

Resources supplied in Appendices:
- PUNs & DENS Logbook (Appendix 6)
- A Logbook (Appendix 7)
- Reflective Learning Diary (Appendix 8)
- Surgery Review (Appendix 9)
- Referral Review (Appendix 10)
- Referral Letter Audit (Appendix 11)
- Clinical Attachments (Appendix 12)

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

**Relationships with patients**

This section is asking for a commentary on the main strengths and weaknesses of your relationships with patients.

Examples of documentation to refer to and supply:

- Information for patients about services provided at the surgery
- Any complaints material, including the handling of it
- Appreciative feedback
- Patient survey data
- Relevant significant event reports
- Peer reviews
- Protocols e.g. for handling informed consent
- Videos or audio consultations

If the practice performed a patient survey, which included you, this could be included, otherwise there are examples of other surveys, which could be used or adapted – or constructed to answer specific questions – such as involving the patient in the treatment plan.

Resources supplied in Appendices:
- Patient survey I (Appendix 13)
- Patient Survey II (Appendix 14)
- Patient feedback (Appendix 15)
- Patient checklist prior to a consultation (Appendix 16)
- Patient consent form for videoing a consultation (Appendix 17)
Don’t forget if you are asking a patient for permission to video their consultation, the patient needs to sign before AND AFTER the consultation.

The question is asked, how do you feel your relationship with patients has improved since your last appraisal? Referring as appropriate to last year’s appraisal and PDP.

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

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

What can be addressed locally?

**Working with colleagues**

What are the main strengths and weaknesses of your relationships with colleagues?

Examples of documentation to refer to and supply:

- A description of the team structure where you work
- Records of any peer reviews or systematic feedback
- Information about any problems that have arisen between you and colleagues (including consultants).

How have relationships with colleagues improved since the last appraisal?

What could be done better? What are your current development needs in this area?

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

What can be addressed locally?

Mention could be made of meetings attended with primary and secondary care colleagues, SDLGs etc.

A description of the communication system to ensure good communication between team members.

A 360° appraisal tool could be created or an existing one used at the practice. The term 360° appraisal refers to a 'full circle' of feedback from a variety of colleagues.

References could be sought. This may need the support and agreement of the partners and practice manager.

**Resources supplied in Appendices:**
- 360° Appraisal - Guidance for Practice Managers (Appendix 18)
- 360° Appraisal – Foreword from LMC (Appendix 19)
- Example 360° questionnaire (Appendix 20)
- Reference request (Appendix 21)
**Teaching and training**

What are the appraisee’s main strengths and weaknesses as he works as a teacher or trainer?

Examples of documentation to refer to and supply:

- A summary of formal teaching/training work
- Any informal supervision or mentoring
- Any recorded feedback.

Has the teaching or training work changed since your last appraisal? Has it improved? Refer as appropriate to the last appraisal and PDP.

What would you like to do more of?

What would you like to do better?

What are your current development needs?

What factors constrain you in achieving what you aim for in teaching or training work? Arranging cover, for example.

What can be addressed locally?

**Probity**

What safeguards are in place to ensure propriety in financial and commercial affairs, research work, use of your professional position etc?

Have there been any problems? Reference should be made to any records of concerns and these supplied as evidence.

Has the position changed since the last appraisal or in the last year?

Does the position need to change, if so, how?

Are there any factors in the workplace or more widely that significantly constrain you in this area?

Is there an up to date CRB check?

**Resources supplied in Appendices:**
- Probity Checklist (Appendix 22)

**Management activity**

This is an opportunity to describe any management activities undertaken that are not related to the practice in which you work. For example a role within the PCT, or advisory work for the Strategic Health Authority or an NHS Trust, or a national position held.

What are your strengths and weaknesses?

Is the management work improving compared with a year ago?
What are the development needs?
What might be included in an updated PDP?
What are the constraints?

**Research**

This is an opportunity to discuss how any research work undertaken could be appraised. Research activity already mentioned, can be amplified and discussed. Reports or publications could be supplied and referred to.

Are your research skills improving?
Are there any development needs?
Are there any constraints?

**Health**

This is an opportunity to mention any health-related issues that could put patients at risk.

Comments could be made on
  - Possessing a personal GP
  - Whether immunisations are up to date
  - When antibody status was checked
  - How stress is identified
  - Hobbies and exercise undertaken
  - The home/work balance

**Resources supplied in Appendices:**
  - Health Checklist (Appendix 23)
  - Stress Diary (Appendix 24)

**Overview of development during the year**

With the Personal Development Plan in mind, you are asked to look back over the previous sections.

How well have you achieved the goals agreed last year? (If this is not your first appraisal)

Where you did not succeed, can you describe the reasons why?

**Overview of development needs**

This is a summary of what the main development needs are for the coming year (From the 9 preceding sections) and where relevant, how the reasons for not succeeding the previous year will be overcome.

**Overview of constraints**

Again this is a summary of the chief factors that have been identified as addressable constraints.
Form 4

This is a summary of the Appraisal discussion with agreed action and the Personal Development Plan (PDP)

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

The form will be completed by your appraiser and then agreed by you at the time of your appraisal.

Personal Development Plan

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

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

The important areas to cover are:

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

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.

A copy of these (form 4 and PDP) is sent to the Clinical Governance Lead – or another agreed named person at the PCT. This information is confidential and kept secure, to be read only by the delegated people and will have been destroyed by the time of your next appraisal – so it is essential to keep your originals safe. These should be sent with all the other documents submitted to the appraiser for the following year’s appraisal.

Form 5

This is a detailed, confidential, optional account of the appraisal interview, which is a framework for keeping a fuller account of the appraisal discussion than is recorded on Form 4. It might inform or help the next appraisal round.

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

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

Good clinical care

- **Audit**: Evidence that the doctor is engaged in reflective practice. You should provide a resume of your engagement with audit, giving examples. This does not necessarily require you to generate your own audits, but you should be able to describe how your practice develops as a result of audit outcomes, be these from PCT, practice or individual measurements.

- Evidence of meaningful participation in **significant event audit** to include a minimum 5 reviews in 5 years, each to include a learning outcome, examples of suitable events include: death in-surgery, new diagnosis of cancer, terminal care at home, a complaint, a suicide, a section under the Mental Health Act.

Maintaining good clinical practice

- Evidence of re-training in basic **cardiopulmonary resuscitation** at least once in each revalidation cycle.

- Documentation of **clinical learning** over the preceding five years e.g. course certificates, learning diary, e-learning records, reading diary, clinical items included on PDPs.

Relationships with patients

- A record of at least two **patient surveys** in the preceding five years, at least one of which is individual to the doctor, with appropriate action taken.

- **Communication skills**: evidence of at least one half-day of learning in communication skills in the preceding five years, to include resulting learning points e.g. attendance at a communication skills course, shared surgeries with another doctor, peer review of audio- or video-taped surgery, self analysis of audio- or video-taped surgery.

- Production of **practice complaints procedure**

- List of all **complaints** within the past five years, involving you, and all subsequent appropriate action taken.

Relationships with colleagues

- **Audit of records** for legibility and accuracy to the standard defined by the RCGP.

Teaching (if appropriate)

- You should provide evidence of performance role within the teaching role e.g. trainer re-accreditation, record of teacher training sessions, feedback from students.

Research (if appropriate)

- Proof of adherence to local research governance procedures.

- Declaration of research involvement.
Other activities (management outside the practice, GpwSIs, GP Appraising etc)

- You should provide evidence of periodic performance review within these contexts

Probity

- Self-declaration of GMC status, NCAA (National Clinical Assessment Authority) Status, Criminal Status, to be verified by the PCT
- Self-confirmation of other potential conflicts of interest

Health

- Self-declaration of health status
Appendices
<table>
<thead>
<tr>
<th>Dates</th>
<th>Practice</th>
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</table>
Audit Summary Sheet

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<th>Date:</th>
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**Title/Subject**  What made you choose this topic for audit

<table>
<thead>
<tr>
<th>Aims/Standards to measure against</th>
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<table>
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<tr>
<th>Results. Where are we now?</th>
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</table>

Sessional GP Appraisal – Collecting the Evidence

APPENDIX 2

By kind permission: Rob Howlett www.pdptoolkit.co.uk
<table>
<thead>
<tr>
<th>Reflection. Conclusions.</th>
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<table>
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<tr>
<th>How could we change practice? Complete the audit cycle. How/when will you re-evaluate?</th>
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</table>
Critical Event/Complaint

Date: ____________

<table>
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<tr>
<th>Describe the critical event or complaint</th>
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<th>Why did it occur?</th>
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<tr>
<th>What lessons have you learnt? What was done well? What went wrong?</th>
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<tr>
<th>What could you do to stop it happening in the future? Draw up an action plan</th>
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</table>
Sticky Moment

Date: 

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<tr>
<th>Describe event (What happened?)</th>
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<th>What Personal Unmet Needs did this identify?</th>
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<th>How did you meet these needs? Reflect on any outcomes</th>
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<tr>
<th>What changes have I made in practice as a result of this attachment?</th>
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</thead>
</table>
Review of PACT Figures

Please complete the boxes below from the most recent quarterly PACT standard report (sent to you by the Prescription Pricing Authority).
Click or “tab” between the grey boxes to change from “increased” to “decreased” or “above” to “below” or to add numbers.
After completion of the relevant sections reflect on these figures.

<table>
<thead>
<tr>
<th>Change in prescribing costs from last year</th>
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</thead>
<tbody>
<tr>
<td>Your Practice</td>
</tr>
<tr>
<td>Increased %</td>
</tr>
<tr>
<td>PCO Equivalent</td>
</tr>
<tr>
<td>Increased %</td>
</tr>
<tr>
<td>National Equivalent</td>
</tr>
<tr>
<td>Increased %</td>
</tr>
<tr>
<td>Your own costs</td>
</tr>
<tr>
<td>Increased %</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Your relative costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Above PCO equivalent</td>
</tr>
<tr>
<td>% Above National equivalent</td>
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</table>

<table>
<thead>
<tr>
<th>Number of items your practice prescribes</th>
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<tbody>
<tr>
<td>Your Practice</td>
</tr>
<tr>
<td>Increased %</td>
</tr>
<tr>
<td>Prescribed generically %</td>
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<tr>
<td>Dispensed generically %</td>
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<tr>
<td>PCO Equivalent</td>
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<td>Increased %</td>
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<td>Prescribed generically %</td>
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<td>Increased %</td>
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<td>Prescribed generically %</td>
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<td>Increased %</td>
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<td>Prescribed generically %</td>
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<tr>
<td>Dispensed generically %</td>
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</table>
## Prescribing costs by therapeutic group

<table>
<thead>
<tr>
<th>Therapeutic Group</th>
<th>Your Practice compared to PCO</th>
<th>Practice Change from last year</th>
<th>PCO Change from last year</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gastro-Intestinal</strong></td>
<td>Above by %</td>
<td>Increased %</td>
<td>Increased %</td>
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<tr>
<td><strong>Cardiovascular</strong></td>
<td>Above by %</td>
<td>Increased %</td>
<td>Increased %</td>
</tr>
<tr>
<td><strong>Respiratory</strong></td>
<td>Above by %</td>
<td>Increased %</td>
<td>Increased %</td>
</tr>
<tr>
<td><strong>CNS</strong></td>
<td>Above by %</td>
<td>Increased %</td>
<td>Increased %</td>
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<tr>
<td><strong>Musculoskeletal &amp; Joint disease</strong></td>
<td>Above by %</td>
<td>Increased %</td>
<td>Increased %</td>
</tr>
<tr>
<td><strong>All other</strong></td>
<td>Above by %</td>
<td>Increased %</td>
<td>Increased %</td>
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</table>
Reflection

Review the figures above. Reflect on any trends or consider why your prescribing may be different from average

Look at your top 20 drugs by cost. Reflect on any trends
# PUNs & DENs Logbook

<table>
<thead>
<tr>
<th>PATIENT UNMET NEEDS</th>
<th>DOCTOR’S EDUCATIONAL NEED/ACTION TAKEN</th>
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<tr>
<td>Subject/Title How did you choose it? What were you trying to learn?</td>
<td>Educational Activity. What did you do?</td>
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Logbook

Name: for year ending........

<table>
<thead>
<tr>
<th>Date Completed</th>
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<tbody>
<tr>
<td>Category (DM/HP/SM)</td>
</tr>
<tr>
<td>Time Taken</td>
</tr>
<tr>
<td>Date Completed</td>
</tr>
<tr>
<td>Category (DM/HP/SM)</td>
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<tr>
<td>Time Taken</td>
</tr>
</tbody>
</table>
## Reflective Learning Diary

Complete this form ("tab" between the boxes, then enter text or space bar/click to tick/untick)

<table>
<thead>
<tr>
<th>Date</th>
<th>Patient ID</th>
<th>Diagnosis/Reason for consultation</th>
<th>Acute</th>
<th>Acute on chronic</th>
<th>Chronic</th>
<th>Alternative management: ring as many boxes as necessary or add comment in “other”</th>
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<td><strong>None</strong> Tel HCA Nurse Other (specify who)</td>
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<td>Other</td>
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<td>Other</td>
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</tbody>
</table>
## Audit for Sessional GP Surgery Review

Recall of patients that you have seen 6 months earlier

<table>
<thead>
<tr>
<th>Date</th>
<th>Patient ID Number</th>
<th>Reason for Consultation</th>
<th>Long Term Outcome</th>
<th>Learning Points</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

**Reflection**

What did I learn from the overall outcome for these patients?

What learning needs did I identify?

How can I meet these?
Audit for Sessional GPs Referral Review

Review response of referrals that you made 6 months earlier.

<table>
<thead>
<tr>
<th>Date</th>
<th>Patient ID Number</th>
<th>Reason for Referral</th>
<th>Response to Referral</th>
<th>Learning Points</th>
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</thead>
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**Reflection**

What did I learn from the response to the referrals?

What learning needs did I identify?

How can I meet these?
Referral Letter Audit

- Administrative details of patient
- Reason for referral
- Drugs prescribed
- Relevant past medical history
- Relevant examination
- Relevant psychosocial history
- Dated
Clinical Attachments

Date:

<table>
<thead>
<tr>
<th>Areas of knowledge to be covered? How were they identified?</th>
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</table>

<table>
<thead>
<tr>
<th>Learning objectives for this attachment? What skills do I want to learn?</th>
</tr>
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</table>

| What did I learn from this attachment?                                   |
|                                                                           |

| What changes have I made in practice as a result of this attachment?     |
|                                                                           |
Patient Survey I

DR

I am carrying out this survey to find out what you think I do well as a GP and in what areas you think I could improve. Would you therefore kindly fill in this ANONYMOUS questionnaire before you leave the surgery and then place it in the box with Dr ____________________ name on at the reception desk – thank you.

Please ring those answers that you feel are relevant.

Was the doctor polite?                      Yes / No
Did he/she ignore, interrupt or contradict you?    Yes / No
Did he/she have good rapport and body language?     Yes / No
Did he/she listen?                           Yes / No
Do you think he/she asked you enough questions to find out what was wrong with you?     Yes / No
Do you think he/she understood the problem?     Yes / No
Do you think he/she knew why you had come and what you wanted?                        Yes / No
Do you think he/she discovered what you thought was wrong?                           Yes / No
Did he/she look at you more than the computer?       Yes / No
Did he/she treat you with consideration?         Yes / No
Did he/she take care of your privacy and dignity – especially during physical examinations? Yes / No
Did he/she give the information you needed about your problem in a way that you could understand? Yes / No
Did he/she explain it well enough to you?         Yes / No
Did he/she check you were happy with the diagnosis/treatment? Yes / No
Did he/she ensure you understood your condition, its treatment and prognosis?         Yes / No
Did he/she involve you in any decisions about your care and offer you choices?        Yes / No
Did he/she explain what might happen and what you might do if you feel worse?          Yes / No
Did he/she respect your right to refuse a treatment or test?                         Yes / No
Did he/she respect your request for a second opinion?             Yes / No
Would you have liked more time with him/her?          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 you felt you weren’t given a chance? Yes / No
Did you feel your opinions were treated as important? Yes / No
In general were you happy with the consultation?            Yes / No
Could he/she have said or done anything that would have made you more satisfied? Yes / No
Patient Survey II

A PERSONAL REQUEST FOR YOUR HELP FROM DR

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

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
   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
   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
   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
In general
   Were you happy with our consultation Yes No
   Could I have said or done anything which would have made you more satisfied? Yes No
   If so, please tell me -

How did you feel?
Please ring any answers that you feel apply

Sessional GP Appraisal – Collecting the Evidence

APPENDIX 14

With Kind Permission NASGP: www.nasgp.org.uk
<table>
<thead>
<tr>
<th>Important</th>
<th>Neglected</th>
<th>Listened to</th>
<th>Fobbed off</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valued</td>
<td>A nuisance</td>
<td>Happy</td>
<td>Frustrated</td>
</tr>
<tr>
<td>Understood</td>
<td>Angry</td>
<td>Delighted</td>
<td>Not taken seriously</td>
</tr>
<tr>
<td>Appreciated</td>
<td>Inadequate</td>
<td>At ease</td>
<td>Uncomfortable</td>
</tr>
<tr>
<td>Let down</td>
<td>Reassured</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If you would like me to contact you about any of your responses, please write your name and 'phone number here and I will contact you

Name

Number

Many thanks for taking the time to complete this form.

Please leave this completed form with a receptionist
## Patient feedback

<table>
<thead>
<tr>
<th>Date: ____________</th>
<th></th>
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</thead>
</table>

### Describe the feedback

<p>| | |</p>
<table>
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<th></th>
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</thead>
</table>

### What lessons have you learnt? What was positive or negative?

<p>| | |</p>
<table>
<thead>
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</tr>
</thead>
</table>

### Will it change your practice? Draw up an action plan if necessary

|  |  |
Patient checklist prior to a consultation

This sheet can help your Doctor to help you and understand better why you have come and what you would like. Please the following questions as a guide for your own use. You can write on the paper and even show it to the Doctor too, if you would like

What made you decide to see the doctor today? Do you have any ideas as to what might be wrong?

How do your symptoms affect you?

People come to their Doctor for many different reasons. Please tick any boxes that might apply to you this time.

<table>
<thead>
<tr>
<th>Reassurance</th>
<th>Advice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information</td>
<td>Diagnosis</td>
</tr>
<tr>
<td>Referral to a specialist</td>
<td>Tests or investigations</td>
</tr>
<tr>
<td>Medical certificate</td>
<td>Sick note</td>
</tr>
<tr>
<td>Check-up</td>
<td>Prescription</td>
</tr>
</tbody>
</table>

What do you hope that the Doctor might do for you?

Have you thought about the best way to treat your condition?
Is there anything that you don’t want the doctor to do?

If there is time are there any other issues that you wish to ask the Doctor?
Patient Consent Form

Place of video recording....................................................... Date........................

Patient’s name..........................................................................................................................

Consent to Video Recording for Assessment Purposes

We are hoping to make video recordings of some of the consultations between patients and Dr ..............................................................................., whom you are seeing today.

We hope to use these videos to help doctors check how well they help their patients in the consultation.

The video is ONLY of you and the doctor talking together. No intimate examination will be done in front of the camera.

The video will be seen only by the Doctors within your practice it will be stored in a locked cabinet and is subject to the same degree of confidentiality and security as medical records. The tape will be erased as soon as practicable and in any event within one year.

Dr ............................................................................... is responsible for the security and confidentiality of the video recording.

You do not have to agree to your consultation with the doctor being recorded. If you want the camera turned off, please tell Reception - this is not a problem, and will not affect your consultation in any way.

But if you do not mind your consultation being recorded, we are grateful to you. Improving the assessment of GPs should lead to a better service to patients.

If you consent to this consultation being recorded, please sign below. Thank you very much for your help.

Signed ............................................................................. Date.........................

After you have finished seeing the doctor, please sign below to confirm that you are still happy to have the recording used.

Signed ...........................................                                             Date ...................................
360° Appraisal – Guidance for Practice Managers

This is a voluntary exercise and the data gathered for the benefit of the individual GP participant and practice.

Sometimes the feedback is not positive for the practitioner and the Practice Manager should be prepared to manage this eventuality.

The 360 degree appraisal questionnaire is designed so that the outcome can be discussed during the appraisal meeting under the section ‘Relationships with Colleagues’.

It is suggested that the Practice Manager should give out a number of questionnaires to a representative sector of the primary care team as indicated on the form. The number of questionnaires per practitioner is at the discretion of the Practice Manager.

The completed questionnaires should be returned to the Practice Manager who then returns them to the practitioner personally and arranges a follow up meeting, where appropriate, 5 or 6 months later.
28 July 2005

Dear Doctor

Please find enclosed a simple guide to undertaking a "360 degree" appraisal.

Those of you unfamiliar with this odd management term should understand that this voluntary process attempts to allow the participant (the GP in this case) to gain insight into how they are perceived by others in their working environment. It is a way of gaining feedback into how we work and relate to others. Rather surprisingly not everyone may think as we do, nor do all our efforts achieve their intended goals. This is therefore a potentially revealing and uncomfortable process and no-one is required to complete this exercise. Most of those who carry out 360 degree appraisal find it to be beneficial and rewarding, however it is important to realise that any negative feedback must be regarded as an opportunity to learn and improve, and not as a personal affront. As GPs we work in an intensely personal and stressful atmosphere and any criticism can be hurtful. I would urge those proposing to undergo this exercise to think carefully about how they will deal with the results and to share any negative reactions with colleagues, appraiser, or LMC. You will not be alone, whatever the situation.

The appraisal has been approved by the Essex Appraisal Steering group and is designed to give a simple and anonymous appraisal. I intend to test it myself.

Any feedback or comment, from those undergoing this exercise, or those who decide not to, would be most welcome.

Yours faithfully

Dr Brian Balmer
Chief Executive
Essex LMCs
Example 360° Appraisal Questionnaire

Name of GP _______________________________________________________________

Surgery address ____________________________________________________________

Your relationship to doctor – please tick one of the following

Medical colleague
Nursing colleague
Dispenser
Secretary/Receptionist
Managerial colleague

How do you rate this doctor’s skills in the following areas. (You may not be able to give an opinion on some questions, in which case please leave blank.)

Please score 1-5 1=poor, 2=fair, 3=average, 4=good, 5=excellent.

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<tr>
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<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>Comments</th>
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<tbody>
<tr>
<td>Ability to listen to problems</td>
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<tr>
<td>Ability to deal with problems</td>
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<td>Ability to make decisions</td>
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<td>Time Keeping</td>
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<td>Consideration for others</td>
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<td>Flexibility / Availability</td>
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<tr>
<td>Communication with Patients</td>
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<tr>
<td>Communication with Medical colleagues</td>
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<tr>
<td>Communication with Staff</td>
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<tr>
<td>Ability to delegate appropriately</td>
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Reference Request

Dear Practice Manager,

I am about to be appraised and would like a reference from your practice to include in my folder.

Please could you ask the partners to provide me with a reference?

I would be grateful if the reference could confirm that I have worked in the practice and give feedback on my clinical care ad working with colleagues. Please also include any other information that you feel might be useful for me or the appraiser to reflect on, to help develop my practice.

Many thanks for your help in anticipation.
GP Probit Checklist

Note: This is not about your appraisal. This is about collecting the right information to make sure that it is all in place when it comes to your turn for revalidation.

‘Probity n. Uprightness, honesty’
(The Concise Oxford Dictionary)

You may wish to consider the following possible areas in relation to probity:

- Do you have a practice contract?
- Does your contract have a confidentiality clause in it?
- Is a chaperone available at all times should a patient request one?
- Do you have audited practice and personal accounts?
- Are you clear about what you may and may not charge for?
- Are you clear about the appropriate response to “gifts” from patients and drug representatives?
- Have you got a copy of your declaration about criminal convictions?
- Do you have a Complaints Procedure where you work?
- Do you have a policy on data protection, password protection, logging off etc where you work?
- Do you know how to declare any potential conflicts of interest and how to ensure that they do not compromise your integrity?

Are you able to make an appropriate statement about your probity?

e.g. Having carefully read the criteria for an unacceptable GP in “Good Medical Practice for GPs” (Sept 2002), I am confident that my probity would withstand scrutiny.

Signed: .................................................. Date: ..........................
GP Health Checklist

Note: This is not about your appraisal. This is about collecting the right information to make sure that it is all in place when it comes to your turn for revalidation.

All that is required is a simple statement that you have considered your health needs on an annual basis, and taken appropriate steps to ensure they do not impinge on patient care.

i.e. Are you registered with a GP outside your own practice? Have you had your Hepatitis B status checked?

If you have got a health issue that you consider significant:

- Have the issues raised by an illness or disability been discussed with your own doctor or the Occupational Health Service?
- Are the appropriate people aware of them? (e.g. partners, in some cases patients)
- What safeguards are in place to ensure that your health problem does not interfere with your ability to carry out the full range of duties?
- What safeguards are in place to ensure that in those areas where it is impossible for you to carry out the full range of duties the safety of your patients is protected?

Are you able to make an appropriate statement about your health?

e.g. “Good Medical Practice for GPs” (Sept 2002) cites the example that the unacceptable GP:

- Ignores his or her own or a colleague’s unsafe behaviour
- Takes no advice, nor offers any to the colleague concerned
- Denies or actively conceals his or her own ill health.

Having read the above criteria, I am confident that my health is not an issue that affects patient care.

Signed: ........................................... Date: .........................
## Stress Diary

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
<th>Level of stress 1-10</th>
<th>Satisfaction gained 1-10</th>
<th>Positive points (Successful outcome, handled well etc)</th>
<th>Negative points (Effect of stress upon you etc)</th>
</tr>
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