[Audio transcription of module 2]

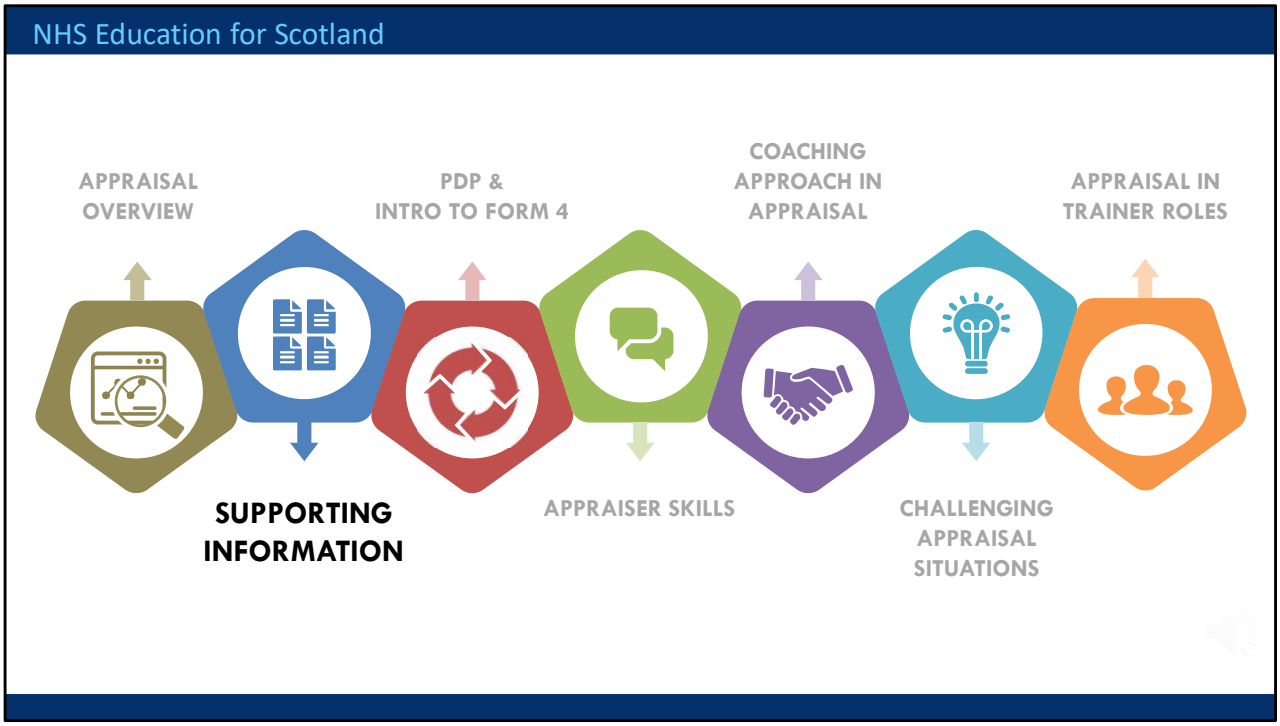
New Appraiser Training

Medical Appraisal Scotland

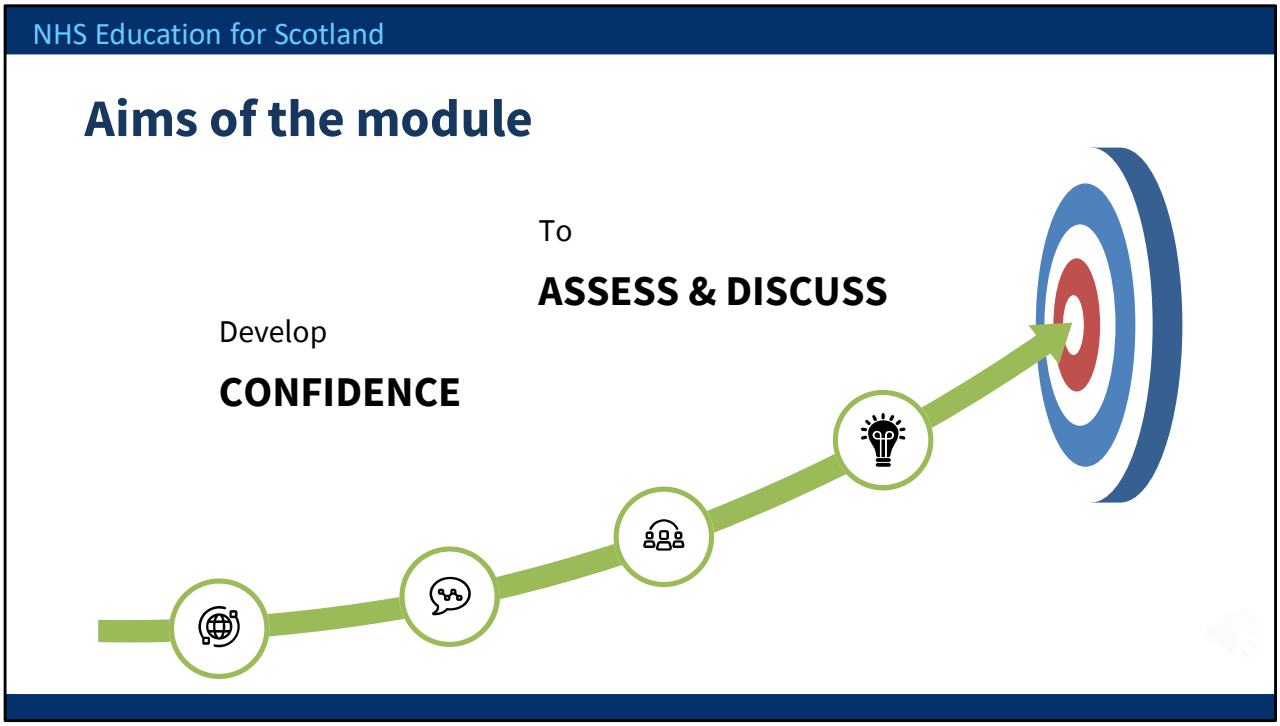
Supporting Information

Module 02

Welcome to Module 2 of the Medical Appraisal Scotland, New Appraiser Training.
This module looks at Supporting Information for Appraisal & Revalidation.

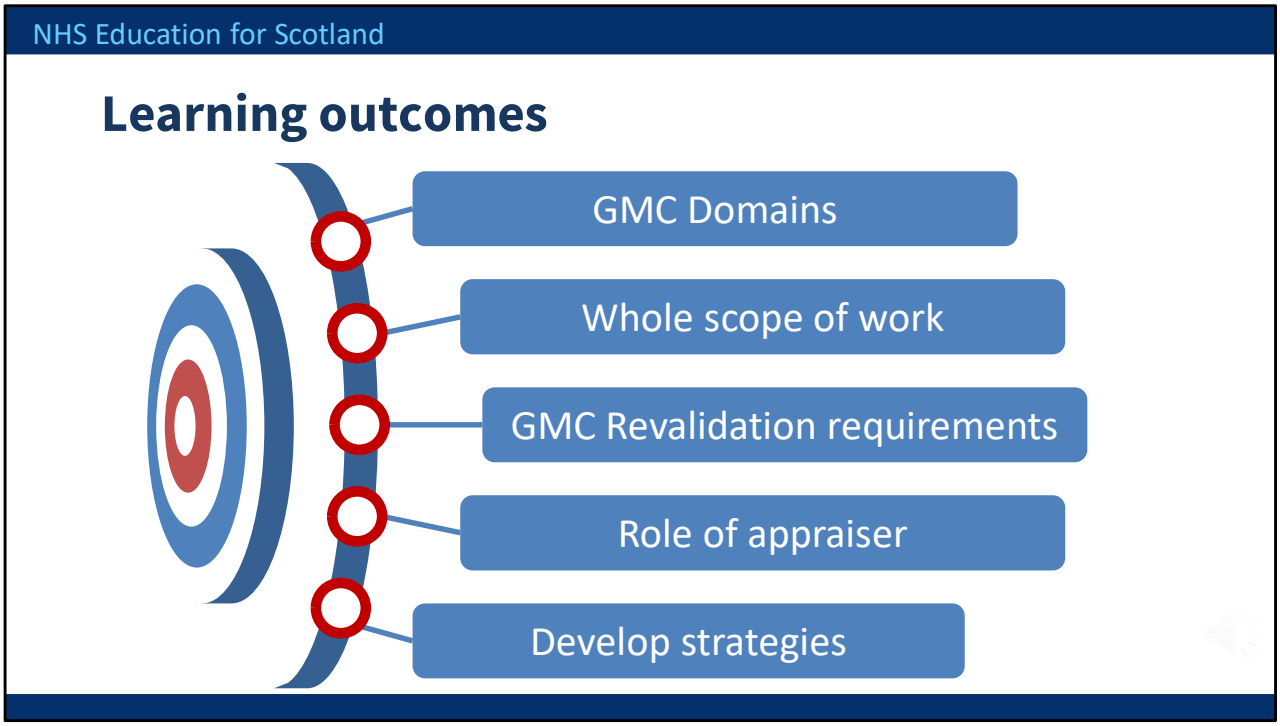


As a prerequisite for attending the NES New Appraiser training, potential participants are asked to complete a series of online modules in preparation for the large and small group discussions.



The aim of this module is to help you develop confidence in assessing the supporting information that doctors submit in advance of their appraisal.

As part of the appraisal discussions, you will help your appraisees to reflect on the relevance of the information provided and help them to determine if it is sufficient for the preparation of revalidation, or whether they need to address additional items as a follow-up in their next appraisal.

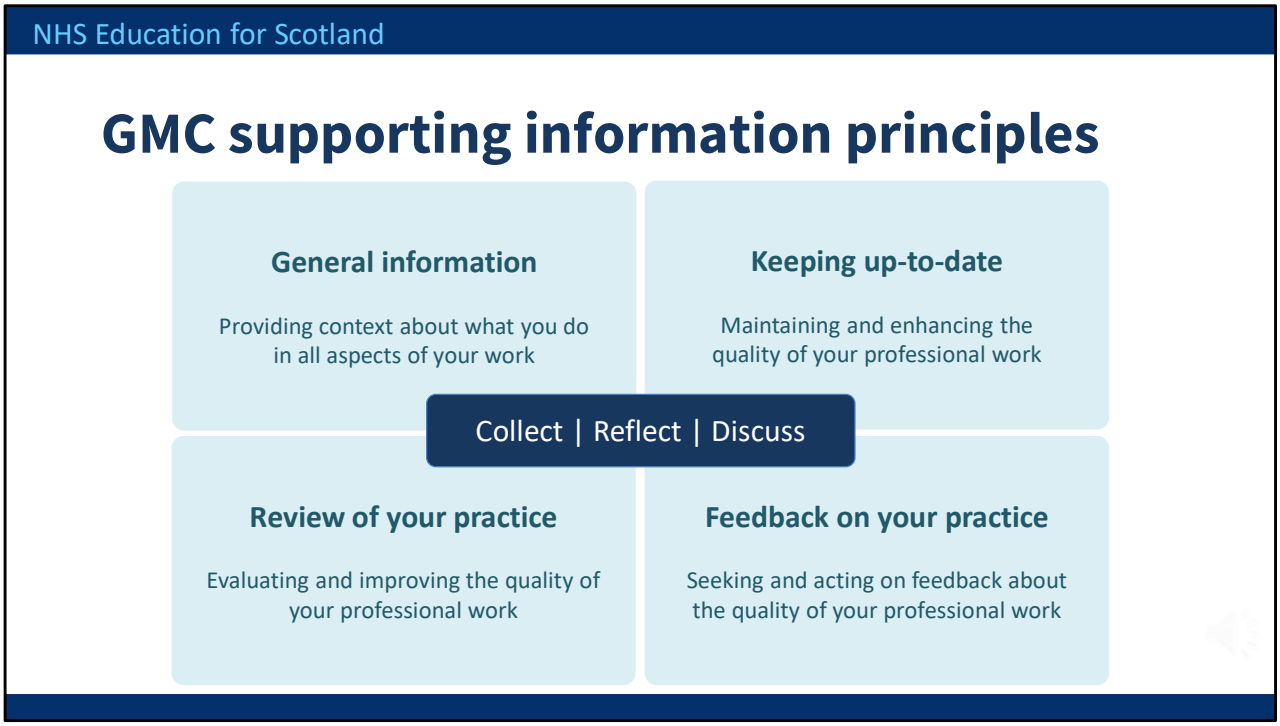


By the end of this module, you will have a good understanding of how to assess the supporting information against the GMC domains. You will look at how to ensure supporting information covers the **whole scope** of work **and** meets the **minimum** requirement for revalidation set by the GMC.

You will also understand the Role of the appraiser in encouraging doctors to reflect on their supporting information; and will have developed some strategies for challenging poor or missing elements of supporting information.

As you progress through this module consider how - during an appraisal - would you ensure that your doctor has covered all their roles within their supporting information. How would you judge if the information is both appropriate and sufficient for revalidation purposes?

Use the workbook provided to note down your thoughts and reflections so that you can refer to it later.



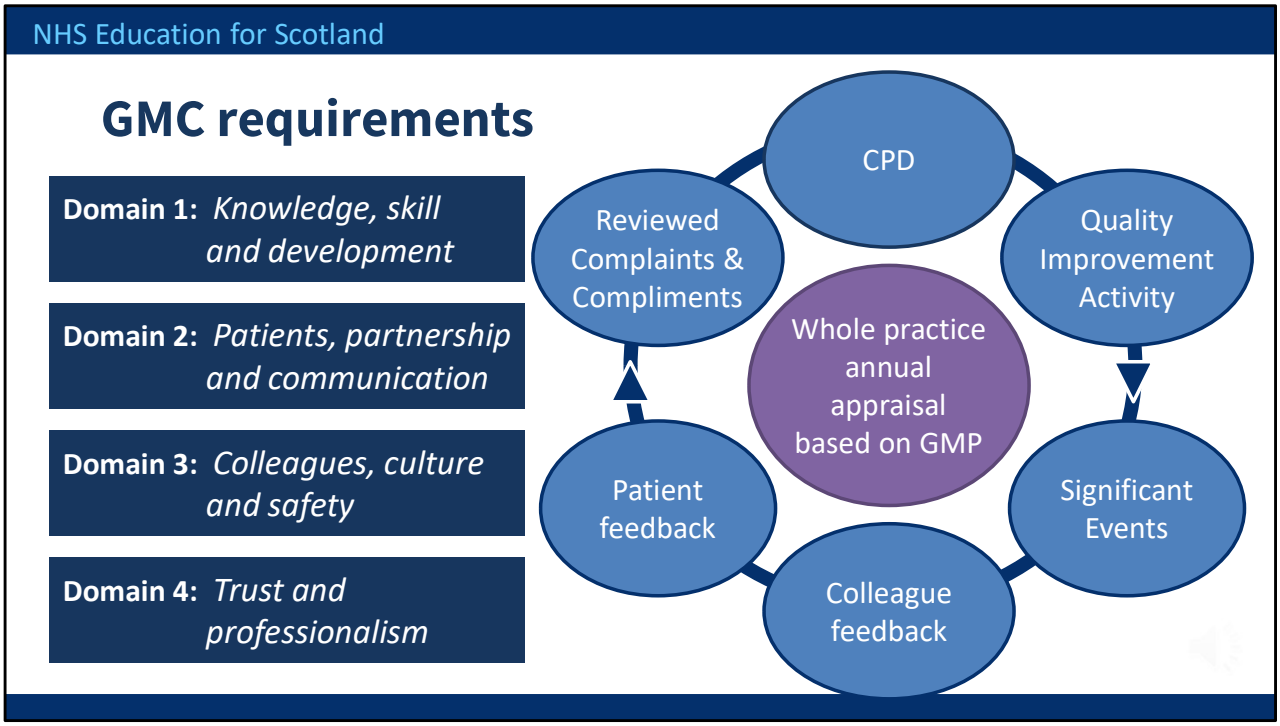
The four key areas which underpin the GMC supporting information requirements are:

- The need to describe context and all aspects of work;
- Demonstrate how the doctor keeps up-to-date;
- Show that they review and improve the quality of their practice regularly; and
- Actively seek and reflect on feedback.

In all these areas, the doctor **collects** the information, **reflects** on it, and then **discusses** their finding during the appraisal.

It is worth noting that the GMC requirements are the absolute baseline for fitness-to-practice. For most roles, doctors would also have to meet the fitness-for-purpose requirements, and these are set by the organisations or royal colleges.

Whilst these would generally be discussed as part of the appraisal, they are **not** an underlying requirement for revalidation. It would be hard to justify a decision that a doctor could not revalidate if they meet all the GMC supporting information principles.



Here is an overview of the GMC requirements. It sets out the four different domains reflecting the Good Medical Practice, including the six required types of supporting information.

It is also another reminder that the annual appraisal needs to cover the whole practice, which means **all** roles that a doctor has needs to be included in the discussion over the five-year revalidation cycle - including any private work the doctor may undertake.

Let's explore these areas in more detail.

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Domain 1: Knowledge, skill and development

- Maintaining knowledge and skills
- Providing good clinical care
- Developing and improving performance

- Quality Improvement Activities (QIA)
- Continuing Professional Development (CPD)
- Personal Development Plans (PDP) and review

Image: Free for Canva users

The GMC expects medical professionals to be competent, keep their knowledge and skills up to date, and provide a good standard of practice and clinical care whilst also striving to develop and improve their professional performance - with regular reflection on their standards of practice using feedback and evidence - to develop personal and professional insight.

Supporting information expected in Domain 1 includes:

- Quality Improvement Activities,
- Continuing professional development, and
- Personal Development Plans

Medical professionals are expected to recognise that patients are individuals with diverse needs. This includes not making assumptions about the options or outcomes a patient will prefer, as well as listening to patients and working in partnership with them. They do their best to make sure all patients receive good care and treatment that will support them to live as well as possible, whatever their illness or disability.

Supporting information expected in Domain 2 includes: Feedback from patients, and compliments and complaints declarations on SOAR.

If the appraisee has received any compliment or was involved in a complaint, a reflection on this - focussing on any relevant learning outcomes - is also required.

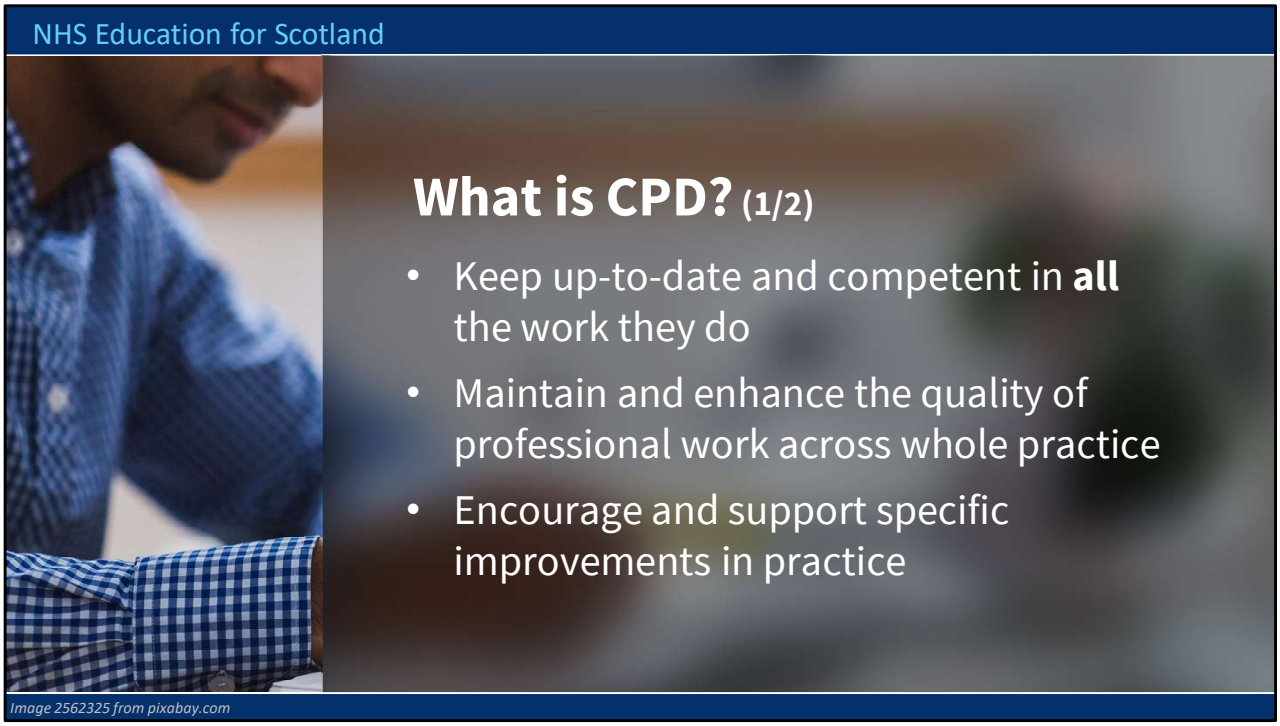
The GMC expects medical professionals to communicate clearly and work effectively with colleagues in the interests of patients. To develop their self-awareness, manage their impact on others, and do what they can to help create civil and compassionate cultures where all staff can ask questions, talk about errors and raise concerns safely.

Supporting information expected in Domain 3 includes: Review of Significant (or learning) events, Feedback from colleagues, Health statement, and if applicable, recognition of trainer.

Medical professionals are expected to uphold high personal and professional standards of conduct. They should be honest and trustworthy, act with integrity, maintain professional boundaries and should not let their personal interests affect their professional judgements or actions.

Supporting information expected in Domain 4 includes the completion of the Probity declaration on SOAR.

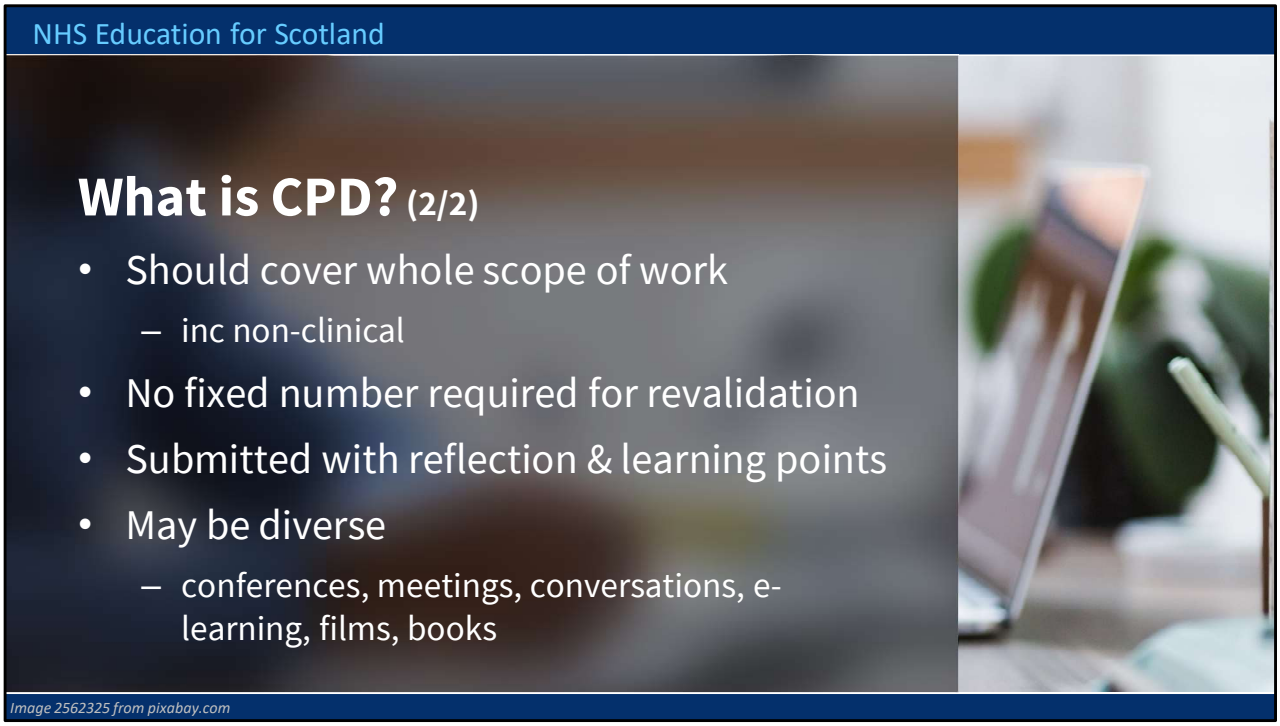
Let's now start looking at Continuing Professional Development. This is a significant part of the evidence you would expect to see for Domain 1.



Continuing Professional Development helps doctors keep up-to-date and competent in all the work they do. It is used to maintain or enhance quality of professional work across the **whole** practice, so it is worth remembering that it needs to cover **all** roles that doctors have.

For example, one of your new areas of practice will be as an appraiser.

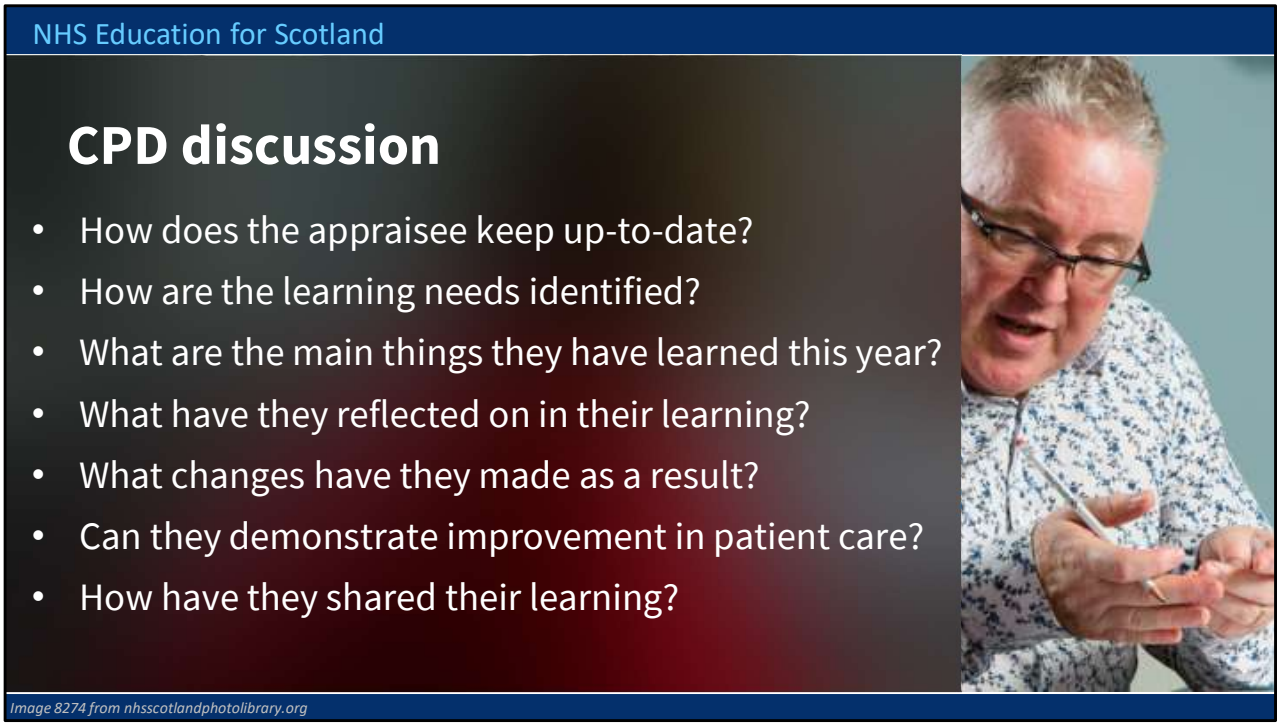
It is also used to encourage and support specific improvements in practice or developing new areas that will be part of their scope of work in the future.



CPD for most doctors will cover both universal skills, like communication, as well as clinical work. Effective CPD will help anticipate and respond to the needs of patients and the service and there is no fixed number required for revalidation.

The important thing is that it is submitted with reflection **and** learning points, this can include examples of how the current practice is still up-to-date.

Many diverse illustrations are suitable. Importantly, conferences **can** give an attendance certificate, but may not **actually** cover what is required as part of the development plan for a specific doctor. Other areas that are very useful are conversations with colleagues, or observation of practice using e-learning, or for example reflecting on book chapters.



Here are some examples of questions you may wish to use during the CPD discussion.

Some of the discussions may arise from the appraisee, for example, having identified a new learning need as part of the changing nature of medical practice; or it may be in response to feedback that they have received; or as a result of learning from incidents or complaints that have highlighted an area they may wish to approach differently.

What did they learn? Has it changed their practice?

Audit results can also be useful in identifying where current practice could be improved; and that may be a result of an individual doctor responding differently to departmental requirements. It's also worth asking the appraisee if they have considered sharing their learning with others.

NHS Education for Scotland

‘Mandatory training’ as part of CPD

- Not defined by the GMC
- Refer to organisational requirements
- May align to role:
  - CPR and safeguarding training
  - Information governance
  - Equality and diversity, health and safety

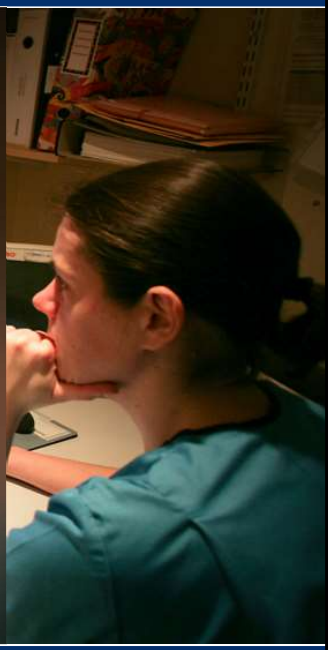
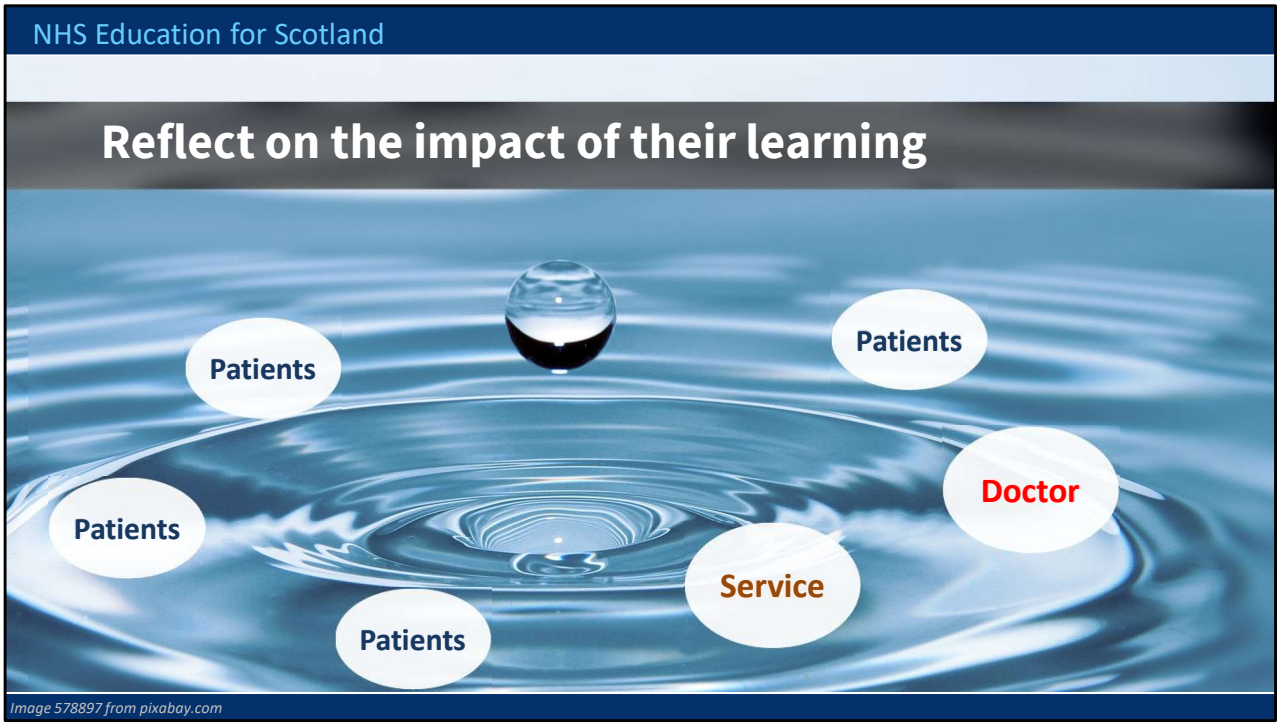


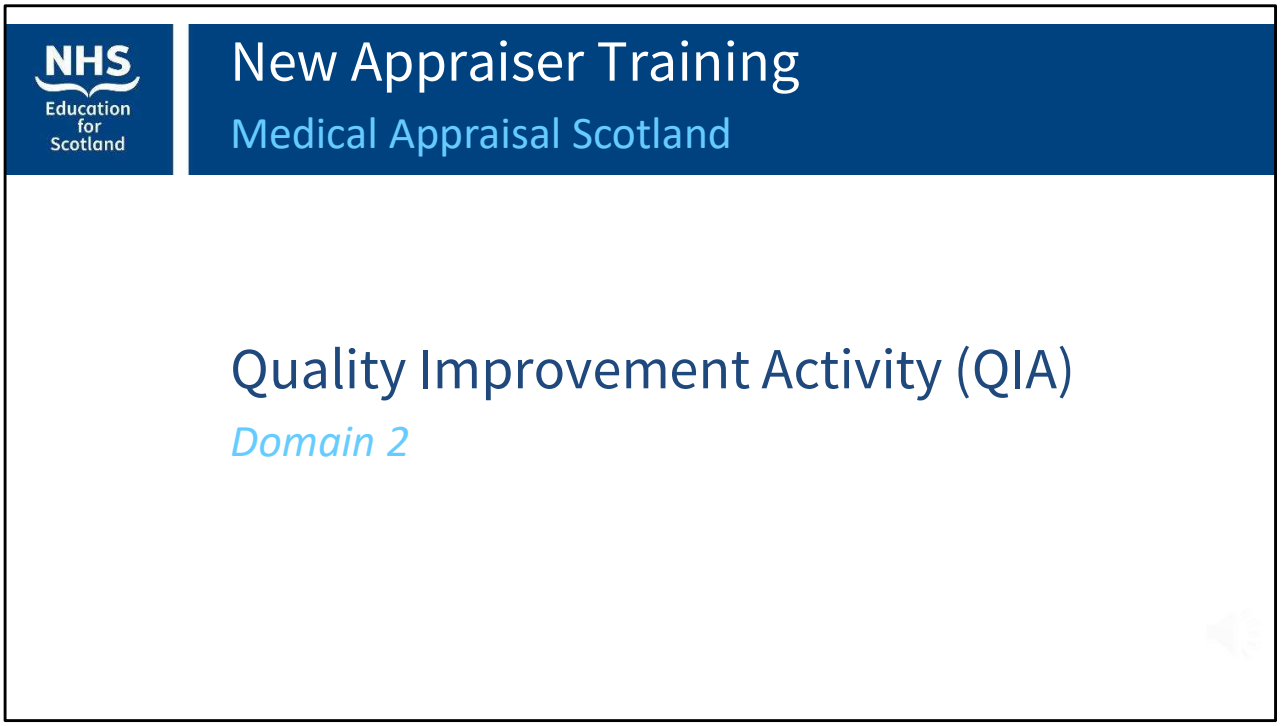
Image 6057 from nhsscotlandphotolibrary.org

Many doctors will also include elements of mandatory training as part of their CPD... It should be noted that there is **no** definition by the GMC on the specific requirements for **revalidation** to cover **any** mandatory training.

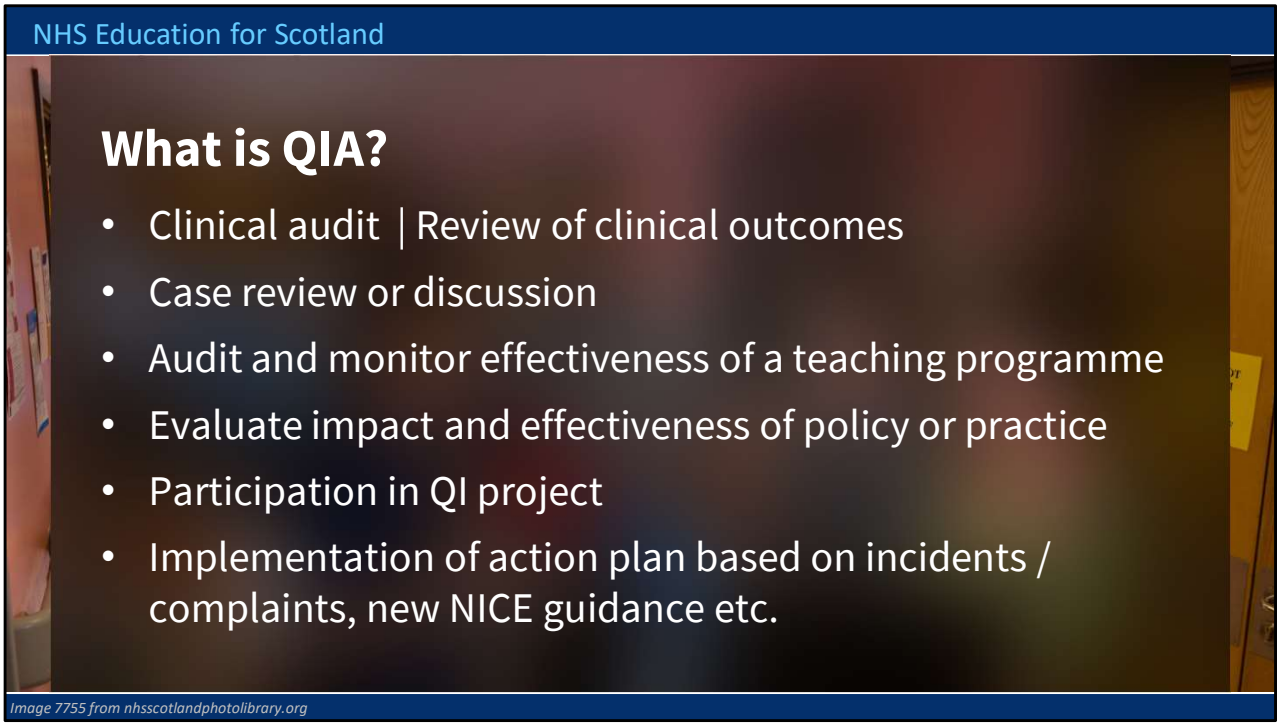
Mandatory training would generally be an organisational requirement, but it **may** also be aligned to specific role requirements, for example, up-to-date equality and diversity training is a requirement for recognition of trainer.



The most important part of the CPD discussion is around the impact it has had on patients, as well as the doctor and the service. It should be a reflection on how clinical care has changed as a result of the lessons they have learned, and it should be demonstrated through reflection rather than attendance certificates of CPD events.



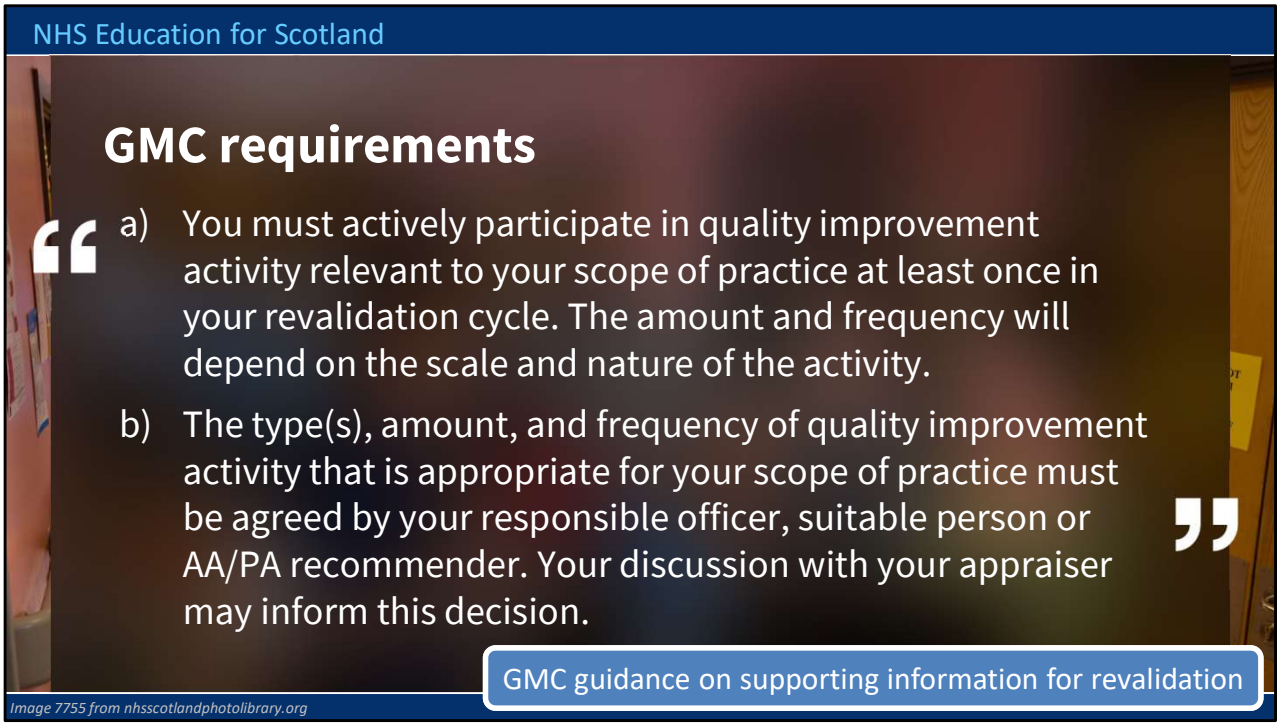
Now let's move on to Quality Improvement Activity which is part of Domain 2.



When looking at Quality Improvement Activity it is useful to go back to the reason for doing this. It should be a review of performance against local, regional and national benchmark data, where this is robust and available. It could, for example, include morbidity and mortality statistics and complication rates compared to that doctors practice.

Clinical audit is frequently used as evidence here and this may be national or departmental audit results. In this case it is important that the reflection includes what this means for **this** specific doctors practice and what they have changed as a result of the outcome of the audit.

As the list shows there are various other areas that would be completely suitable to include as part of the discussion of quality improvement.

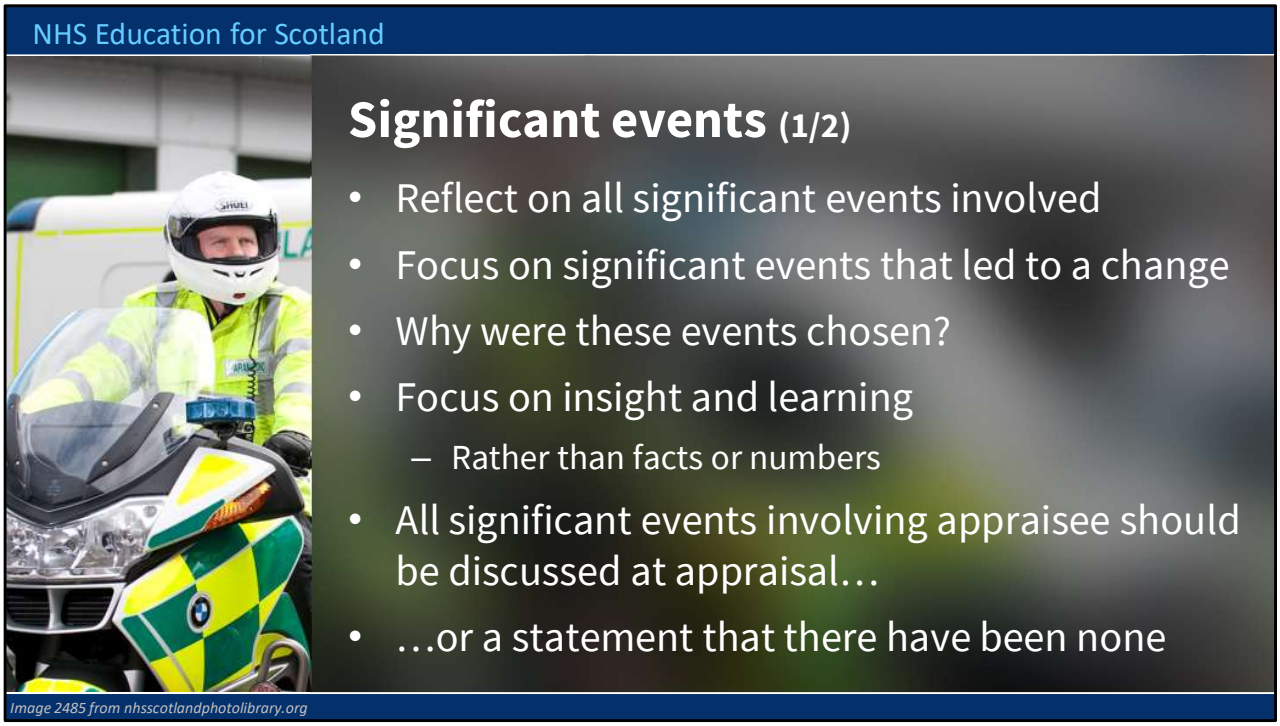


As outlined by the GMC guidance on supporting information for revalidation*, QIA is expected once every revalidation cycle. However, you are advised to check with your employing health board on QIA requirement for appraisal, which may differ. Regardless of frequency, the QIA should be relevant to the appraisee's work.

As part of the discussion, you could inquire why the appraisee chose the particular piece of work and how it is relevant to what they do in their day-to-day practice. It should also include a reflection of the results and the impact from any lessons learnt. It may also contribute to the personal development plan going forward.

** https://www.gmc-uk.org/registration-and-licensing/managing-your-registration/revalidation/guidance-on-supporting-information-for-revalidation*

Another piece of supporting information relevant for Domain 2 is the review of any significant or learning events.



Under GMC guidance, significant events are described as unintended or unexpected events which could or did lead to harm of one or more patients. Under the guidance it **also** includes incidents which did *not* cause harm but could have done, or events that should have been prevented.

In general practice, serious event analyses are seen more like case reviews or learning events. This is different to secondary care where this category is usually termed serious event incidents. These are examined in depth, and all secondary care doctors aspire to prevent them, wherever possible.

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Significant events (2/2)

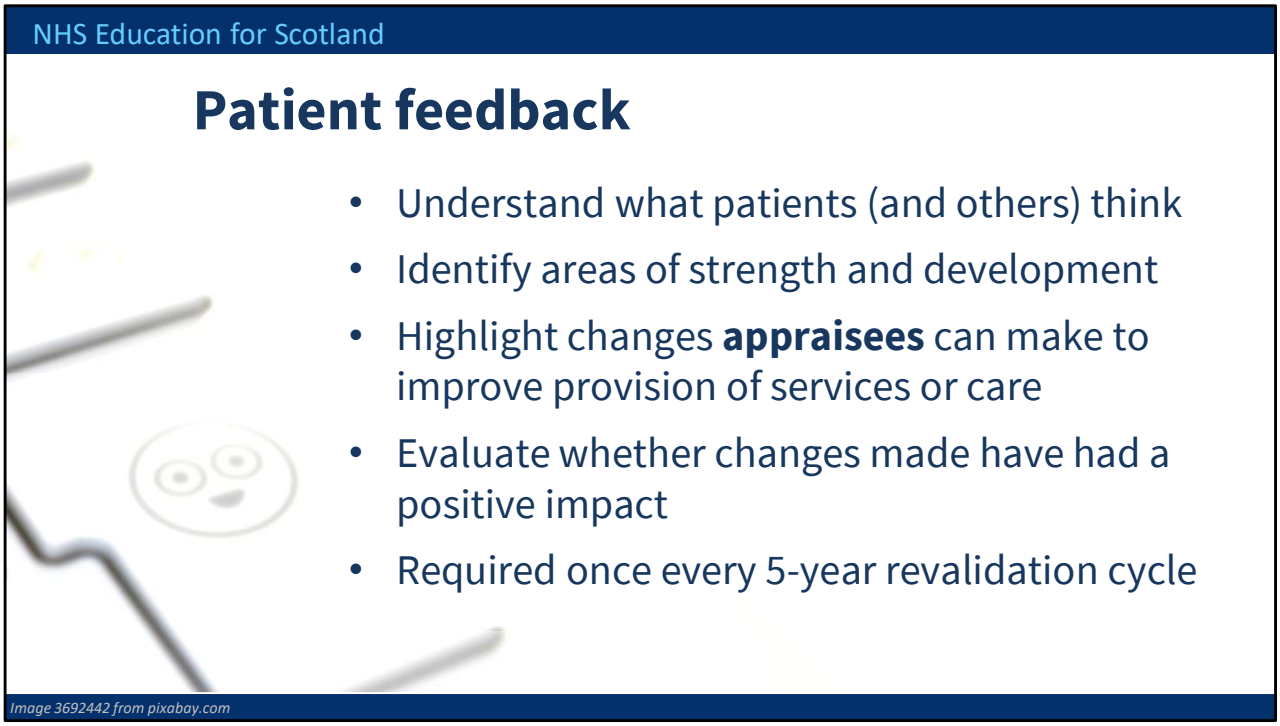
- Be familiar with employing organisations' processes and thresholds for recording incidents
  - Secondary care tend to refer to SUIs – serious untoward incidents
- Other 'significant events' may be quality improvement activities

Image 2485 from nhsscotlandphotolibrary.org

All healthcare professionals have a duty of candour; a professional responsibility to be honest with patients when things go wrong. This is something that should be discussed as part of the appraisal if a doctor has been involved in an incident that did cause harm to patients. The discussion should focus on the learning from this and also be supportive to the doctor who will generally be very upset themselves by what has happened.

The learning may well be reflected in the Personal Development Plan going forward and it may also be necessary to discuss with the doctor if they need to access any psychological support or any further training themselves.

Domains 2 and 3 covers any feedback that the doctor has received from patients and colleagues respectively.



Feedback is a useful tool to look at, evaluate and develop behaviours, teamwork, professionalism, communication and interpersonal skills.

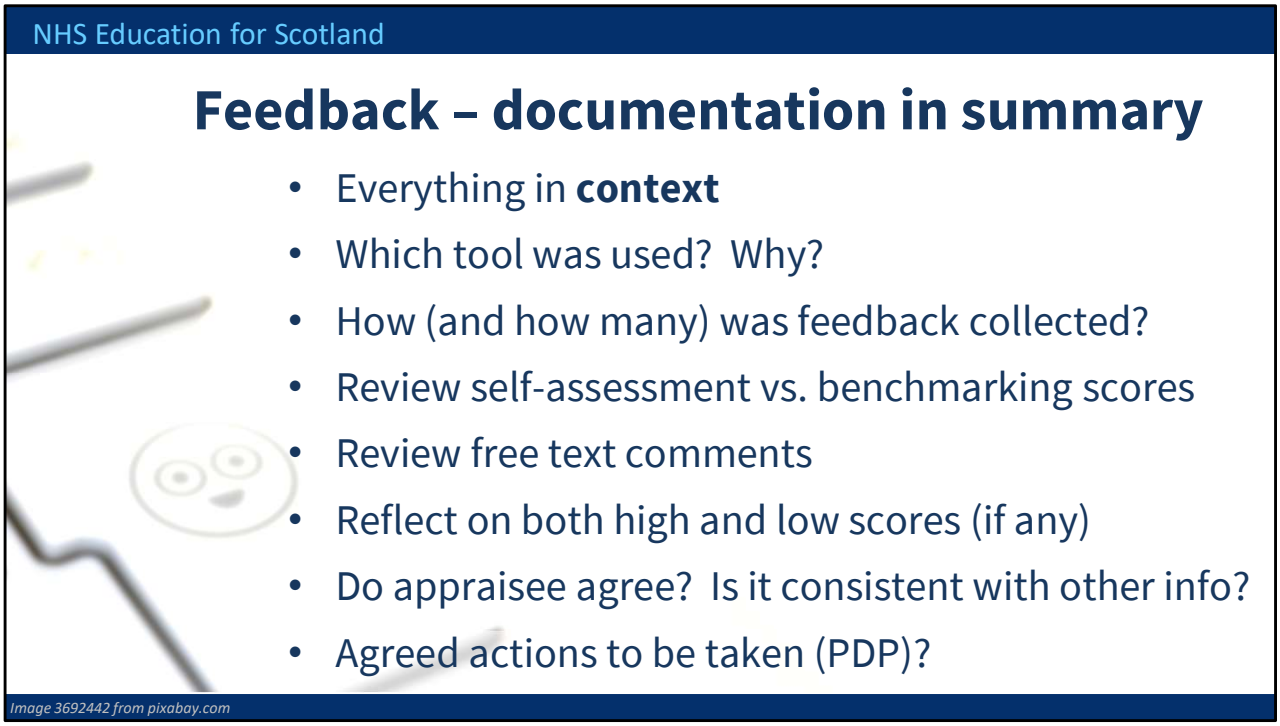
Patient feedback specifically helps the doctor understand **how** they come across in their interactions with patients. At least once in every revalidation cycle this must be independently administered and collected using a validated standard questionnaire.

In the other years, discussion would be based on any other feedback they have received - for example, thank you cards or messages or as part of complaints.

Colleague feedback helps doctors understand how their practice is viewed by people they work with; and it needs to include a representation of the whole multidisciplinary team and not just consultant colleagues. Doctors should be able to explain why they have selected these colleagues and show how their feedback reflects the whole scope of their work.

For example, as an appraiser, you should consider the inclusion of Feedback Form 6 on SOAR, where your appraisees are asked for their reflections on the appraisal and your performance as an appraiser.

Under GMC guidance, a standardised questionnaire needs to be used once in the 5-year revalidation cycle to obtain formal feedback.



When reflecting on the feedback with the doctor it is important to see this in context. For example, somebody working as a psychiatrist may well receive lower average scores than somebody working in other specialties.

It is also important to be mindful that somebody who does not see patients regularly or who works in a very specific scope of work may not be able to use a standard questionnaire you would normally expect to see. For example, those working mainly in leadership roles would find it more appropriate to upload a leadership specific 360 instead.

It is important to consider both the self-assessment and the average scores to see what level of self-awareness the doctor has. Reflect on the area where the doctor scored highly or has very positive comments; as well as those with lower scores and discuss if the doctor agrees with the feedback… Does it correlate with other supporting information that is part of their appraisal? Do not let the appraisee dwell on outlying lower scores if the vast majority of responses were positive.

If appropriate, document agreed outcomes as PDP.

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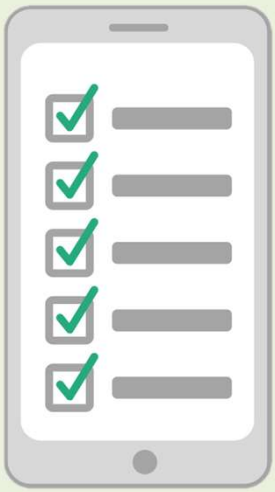

Self-declaration statements

Let’s take a look at the self-declaration statements that appraisees are expected to complete as part of the appraisal process.

NHS Education for Scotland

Compliments and Complaints

- Is a form of feedback
- Identify areas of good practice and strengths
- Explore areas for improvement & lessons learned
- Demonstrate they value patients' and others' concerns and comments about their work…
- …by making changes according to the feedback received.

Image 6587736 from pixabay.com

Compliments and complaints should be seen as another type of feedback.

The important thing to discuss with the doctor is **how** they have dealt with the complaint **rather** than focusing on numbers. For example, **what** have they learned from it? **How** has it influenced their practice? **What** have they found that they are doing really well in, and that they are going to continue doing? And **what** have they changed? **What** should they change?

If somebody has not been involved in any complaints, you would expect them to make a statement that there have not been any - either about them or their team in the given appraisal period.

You could expand and include in the discussions on how they are practising in order to try and avoid complaints in the first place. Or, are they aware of the protocols if they are involved in a complaint?

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Probity statement

- *…is a declaration that they accept the professional obligations placed on them in the Good Medical Practice in relation to probity*
- Required for each appraisal
- Probity is at the heart of medical professionalism
- Honest and trustworthy and acting with integrity
- Manage any potential conflicts of interests

Image 6587736 from pixabay.com

A probity statement is required for each appraisal. The Good Medical Practice provides many details around probity; but for the purposes of appraisal, the kind of things that a doctor might discuss could include their approach to research; or how they manage the legal requirement for insurance or indemnity.

Also consider in what ways they are honest and trustworthy… have they provided honest references for other doctors? Did they write appropriate and accurate information in any reports? They should also reflect on any financial and commercial dealings, and ensure they manage any potential conflicts of interests.

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Health statement

- *… is a declaration that the doctor accepts their professional obligations about their personal health under Good Medical Practice.*
- Registration with GP outside their family
- Seek medical assistance when needed
- Not self-medicating
- Consider immunisation

Image 6587736 from pixabay.com

In each appraisal a health statement is also required, in which the doctor accepts their professional obligation under the Good Medical Practice regarding their own health.

These discussions would include whether the doctor is registered with a GP **outside** their family; and perhaps more importantly, should any personal health problems arise – for example, a serious condition that could pose a risk to patients or otherwise - they would consult their GP, or any other suitably qualified colleague, rather than self-medicating.

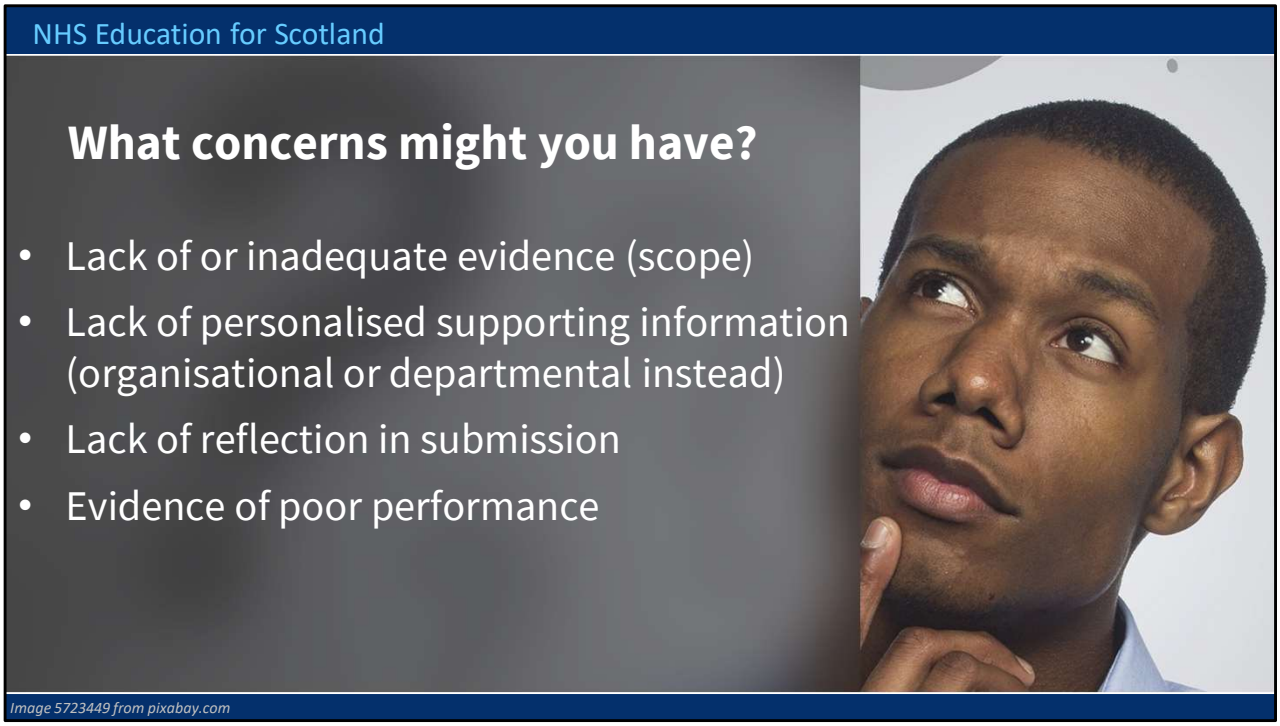
You may also want to discuss the requirement for having regular immunisations, for example, regular flu jabs and Hepatitis B injections.

Supporting information for appraisal and revalidation	Domain 1	Domain 2	Domain 3	Domain 4
Continuing professional development	x			
Quality improvement activity	x			
Significant events			x	
Feedback from patients		x		
Feedback from colleagues			x	
Compliments and complaints		x		
PDP and PDP review	x			
Health statement			x	
Probity statement				x
Recognition of Trainer (RoT)			x	

This table highlights which GMC Domain each supporting information should go under.

Please note for the purposes of **revalidation**, QIA, Feedback from Patients, and Feedback from Colleagues are expected once in a 5-year cycle. The others are expected annually at appraisal.

Now let us look at how you would assess the quality of any supporting information a doctor has submitted.



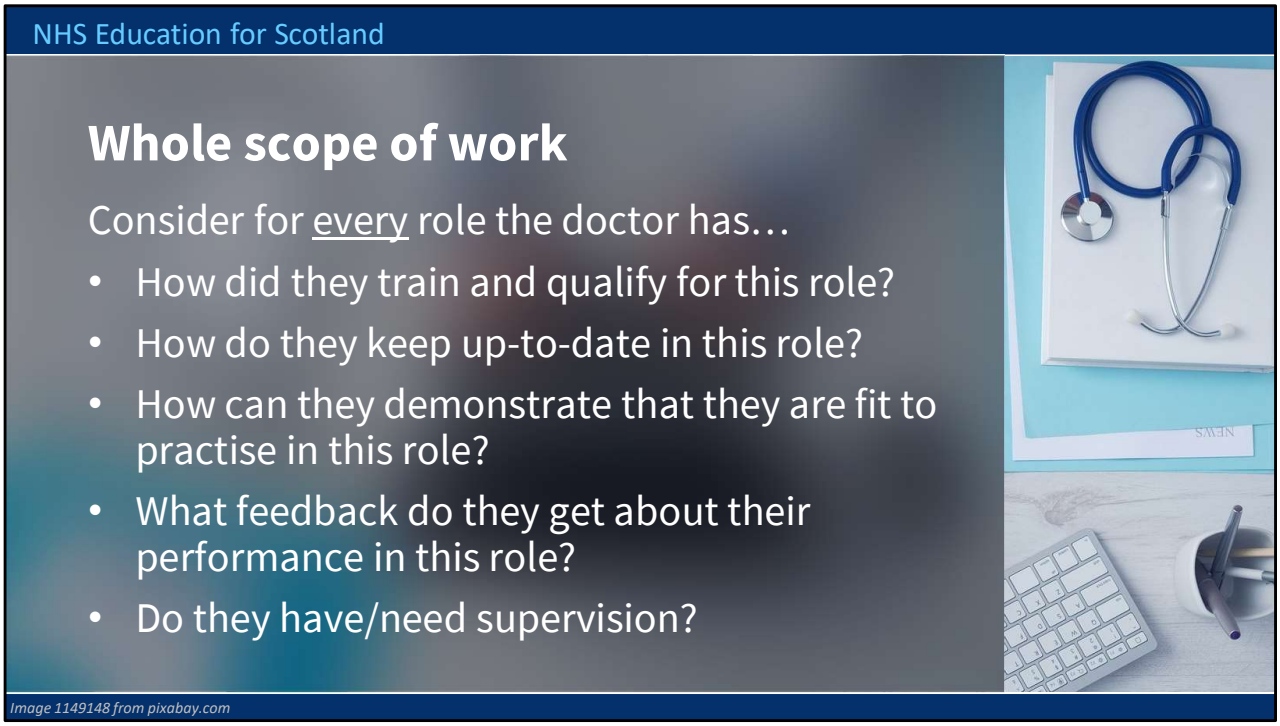
As an appraiser, what are your concerns when it comes to supporting information?

There may be areas where there is limited or no evidence submitted, or the evidence is not in keeping with the doctor's scope of work. Sometimes you may also come across evidence that is not personal to the doctor, for example, departmental or organisational information. This might be appropriate if there is good reflection on how this impacts the doctor's practice and their response to it.

Any information submitted **without** any reflection would be inadequate, although you may choose to discuss this as part of the appraisal and have a joint general reflection with them.

Some appraisees may find it quite difficult to do this in advance of the appraisal meeting, and you may improve their reflection as part of an appraisal portfolio stretching over a number of years.

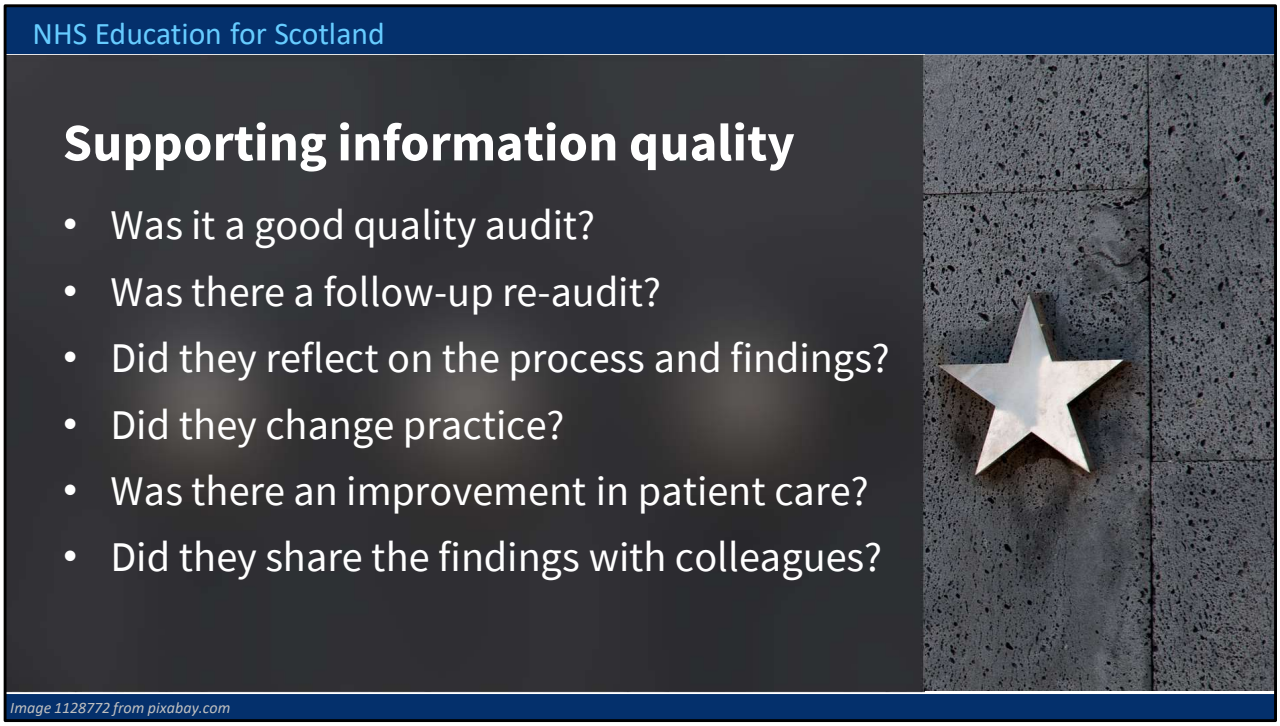
Another area of concern might be where the supporting information highlights potentially poor or inadequate performance, so you might want to carefully consider prior to the appraisal how you could bring this up in the meeting.



Here are a few questions that can guide you in the assessment of the adequacy of supporting information.

Many doctors will have more than just their main clinical role,.. for example, some of them will be clinical or educational supervisors. And if you think of your own scope of work going forward, this will include the appraiser role. It is important to be mindful that the supporting information needs to be proportionate and that you don't expect a huge amount of different kinds of information for each and every role.

Overall, the supporting information should demonstrate that the appraisee has remained up-to-date and is fit to practice in any of the roles, and that they show how they receive feedback **and** considered their reflections and response to it.



In the appraisal discussion you will want to reflect on the **quality** of the supporting information. If you consider somebody just submitting a baseline audit with no evidence of any changes in practice, and no re-audit showing that there has been an improvement in patient care, that would be fairly weak evidence.

For all pieces of supporting information, you should be looking for reflections in both on the process they used to identify their information, **and** how they responded to the findings or the information provided.

You may also look at a wider organisational improvement impact the doctor has by discussing and sharing findings with colleagues, rather than just including them in their own portfolio.

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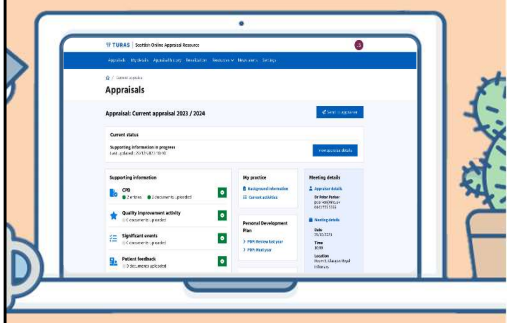
Uploading to SOAR



- Beware of Patient/Person Identifiable Information
- Sensitive information on appraisee's health
- Do **not** sign off Form 4
- Anonymise and re-submit
- Contact SOAR helpdesk

Image 2298286 from pixabay.com

Guidance is issued to appraisees already reminding them not to include any patient identifiable information in their submissions. This is typically done by accident in the complaints and compliments sections. Your appraisees may also share sensitive information regarding their own health… again they will have been advised not to include the specifics of this in their submission but to focus on the reflections instead.

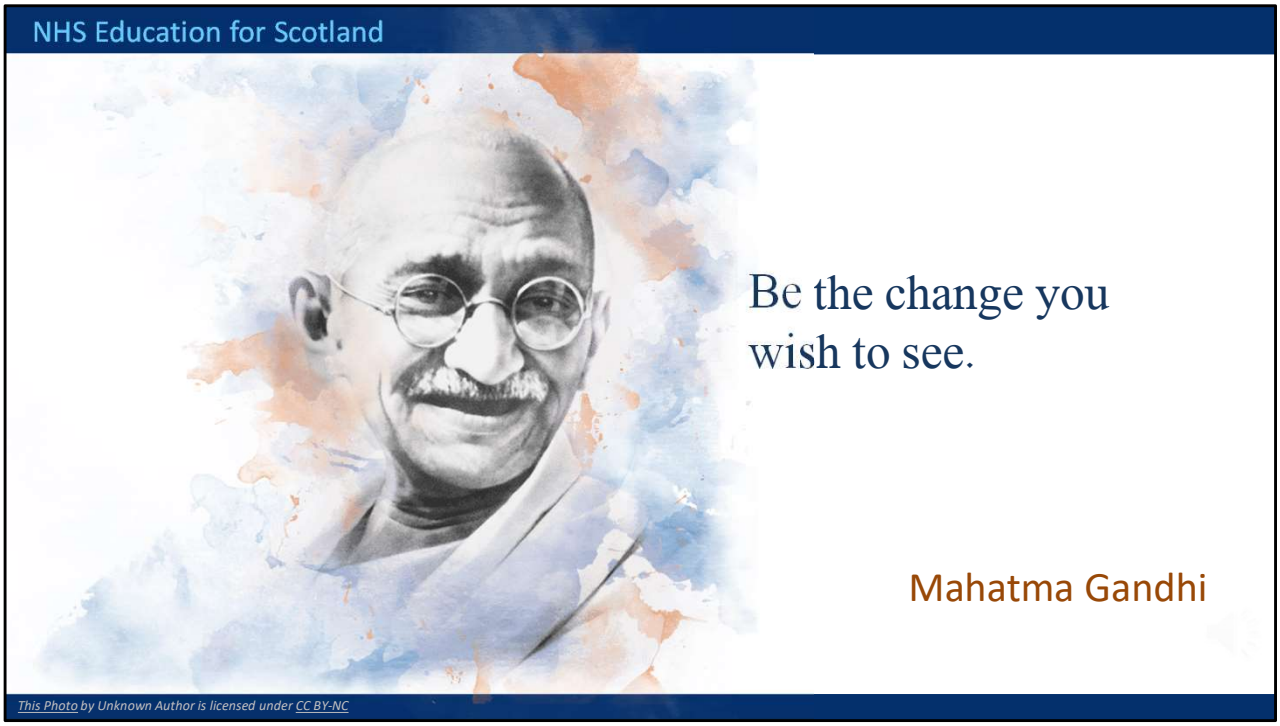
If you come across any supporting information that has patient or person identifiable information in it, make sure you do NOT forward or sign off the Form 4 on SOAR. Once Form 4 is approved, all supporting information is archived and can't be changed. Alert the appraisee to this and ask them to anonymise the relevant documents and re-submit. Alternatively , since you will have seen the document by this stage, you can ask the appraisee to remove it from their submission and resubmit, and you just document accordingly on the Form 4.

Should you encounter any issues, please contact the SOAR helpdesk for further assistance.

In the workbook provided, please consider how we can encourage doctors to produce good quality supporting information. Part of the discussion could include how the employing organisations are helping - by regularly producing outcome data, or by supporting good quality audits on an ongoing basis.

Also think about how you would approach the consideration of scope of work and appropriate supporting information for each element.

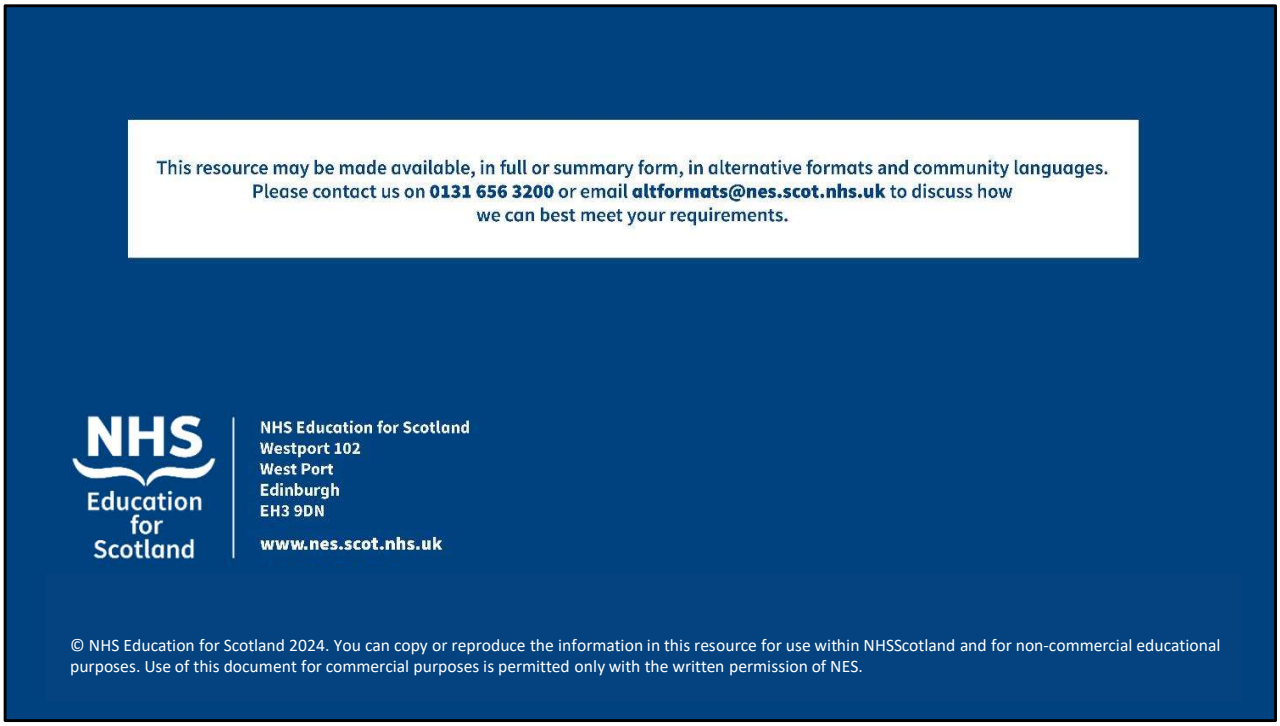
These will form part of the discussions at the New Appraiser training.



We hope you enjoyed this module, and now feel more confident when assessing supporting information submissions and encouraging reflections.

If you are planning to attend the New Appraiser training and this is supported by your employing health board's Appraisal Lead, please complete the other modules from the Medical Appraisal Scotland website. When you are ready, send in your training course application form and remember to copy in your Appraisal Lead. We will be in touch from there.

https://www.appraisal.nes.scot.nhs.uk/appraiser-training/new-appraiser/



[End of module 2]

Audio by:
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