# Appraisal Support Pack
# Practice evidence

## Appraisal support packs

This pack is one in a series of educational resources, which have been designed to help doctors prepare for their appraisal. It has been developed by HEIW.

The pack is designed to give doctors ideas about how they might review their practice and learning in specific practical areas. The pack provides guidelines on the types of issues doctors might wish to consider in relation to these areas, and about how they might collect, record and structure this information. The pack includes templates, which will help doctors structure this information in a format that can meaningfully be included in the appraisal process.

It is hoped that the pack will help doctors to collect information based on their day-today practice without necessitating a large amount of additional work. Some of this information may already be available to doctors, including for example through clinical governance activities managed by the Local Health Board, significant event and complaints meetings, projects within consortia, prescribing advisory meetings, progress reports on QOF activities including Quality and Productivity (QP) areas and the peer and patient questionnaires now mandatory for revalidation. It should be noted that while the information may be the same, the purposes of the activities are separate and distinct. These packs are designed to help doctors reflect on the implications of this information for their personal learning and development and do not form part of any clinical governance or performance management process.

### Using the materials for appraisal

It is not compulsory that doctors use these packs; they are available as an additional resource for those who wish to make use of them. It is not suggested that an individual completes all the sections every year; rather it may be used as a guide to produce information for appraisal in a structured format. This should enable the appraisal discussion to become more focussed.

The templates encourage and promote written reflection on the subject areas, and if followed will produce an entry that may be copied and pasted into the appraisal web site boxes under 'My Appraisal Information' and then using the 'New Practice Evidence' template rather than the 'New Personal Evidence' default template. Or, simply uploaded to the web site with just the title field completed to aid the appraiser in understanding the content of the file. Doctors should use these materials in the way they feel is most appropriate to them and meaningful to their appraisal, and avoid duplication of work or information.

**Practice Evidence - What is appropriate?**

The practice evidence support document has been designed to help doctors prepare evidence about the functioning of their practice. Appraisal quite rightly focuses on individual development. It is relevant however, how that development is used within the team and also relevant that development takes place according to team priorities. It may also help you demonstrate your role in an environment that is safe and effective in delivering patient care.

Quality improvement templates are already available on the appraisal web site under the Revalidation Template tab when entering information under 'My Appraisal Information' and will not be duplicated here. These are for **individual** activity rather than practice activity and are listed below:

1. Audit/Monitoring of a teaching programme
2. Case Review or discussion
3. Clinical Audit
4. Evaluation of Impact of a Health Initiative
5. Review of Clinical Outcomes
6. Significant Event analysis

When considering **practice evidence** however, the templates included in this support pack will provide the doctor with a structure in which to provide evidence of the common situation where you may be involved in the work of others, perhaps in the activities one to five above, or in other practice based activities where you work as a member of a team or in support of another colleague. In these situations, you will not be the lead individual for the activity but will nevertheless play a significant role and this should be recognised at appraisal. The following templates may be used to aid you in recording and analysing your involvement.

The list is by no means exhaustive and the templates do not cover for example, areas such as contributing to the Quality and productivity (QP) domain of QOF, practice meetings, consortia projects, establishing a new enhanced service etc.

**Contents**

**Examples of "practice work" that would be appropriate to use in your appraisal folder**

- Much of the work we do as GPs involves a team approach. We work with others to deliver healthcare to our patients, this team approach is sometimes difficult to document for the purposes of appraisal. An example would be a colleague in the practice is auditing lithium monitoring, the initial data collection show only 40% of patients on lithium have a blood level within therapeutic range in the last 6 months. You sit down with your colleague and work out a strategy to improve this; you then work to that plan. Your colleague finishes the audit there is an improvement in patient care however it is difficult for you to include that audit in your appraisal folder, as it was not you that "did" the audit.

- Significant event audit does not always directly involve an individual, it is imperative that a practice has a significant event system in place and this should be demonstrated at appraisal. An individual's contribution to SEA can be demonstrated and a template and example is included in this document.

- Practice skill mix is an important factor when considering personal development. If there are 4 GPs within the practice providing minor surgery then another individual may consider it as a low developmental priority however if no other GPs in the practice are trained then the priority obviously changes. A template for examining the skills mix of the practice is included.

- Practice development – a practice may be planning to move premises, become a training practice, take on medical students or to change appointments system. Large developments could affect an individual's development plan for that appraisal year. A template (and example) is included in this document that may be used to highlight the impact of developments and highlight an individual's role within that change.

- QOF – many practices are achieving high QOF points, the goalposts are ever shifting. An individual may like to highlight how they have contributed to the practice in this area and either identify learning needs falling out of this or highlight development or teamwork that has helped in achieving success.

- Patient and colleague satisfaction surveys

**Section 1: Contribution to audit**

This section offers a template for an individual to demonstrate their role within an audit(s) where they are not necessarily the prime instigator. It does not remove the revalidation requirements for an individual's responsibilities under the quality improvement domain (i.e. within a 5 year cycle either a personal audit, case reviews, review of a teaching programme or the evaluation of the impact of a health initiative)

| | |
|---|---|
| **Title of audit** | |
| **Why was this audit performed** | |
| **Main outcomes** | |
| **Personal role within the audit** | |
| **Change in personal practice?** | |
| **Any developmental needs identified** | |
| **What has this process meant for me?** | |

**Example**

| | |
|---|---|
| **Title of audit** | *Co-prescribing of folic acid with Methotrexate* |
| **Why was this audit performed** | *A patient saw one of my partners with nausea and vomiting. She was taking Methotrexate for her RA but not taking folic acid supplementation – he brought this up in a practice meeting and I must admit that I was not aware of the evidence to support the co-prescribing* |
| **Main outcomes** | *My partner originally found that only 62% of our patients were co-prescribed folic acid with Methotrexate.* |
| **Personal role within the audit** | *I was involved in seeing 3 of the patients who were not on a coprescription – all of whom had at least some symptoms of gastric upset or sore mucous membranes* |
| **Change in personal practice?** | *I will endeavour to ensure that whenever I sign a repeat prescription for Methotrexate that I check that the patient is taking folic acid.* |

| | |
|---|---|
| **Any developmental needs identified** | *This has brought home to me that I really am a little rusty around all of the DMARDs and their monitoring. We have local shared care protocols that the practice has a system in place to monitor these. I think I could do with updating my knowledge in this area and I will note this down in my PDP* |
| **What has this process meant for me?** | *I really am someone who is a bit reluctant to become involved in audit myself. This audit however has shown me that real improvements in patient care can be made through this process. The three patients I was personally involved in were showing signs of Methotrexate toxicity and I know that at least one of them is feeling much better after the co-prescription. I think that as well as learning more about the DMARDs I will audit the blood and urine monitoring of our patients on these potentially toxic agents.* |

## Section 2a: Significant event analysis

The first part of this section gives examples of how to do an individual significant event analysis where **you** are the reporting clinician and so this is for information only. This template exists already on the appraisal web site under Revalidation Templates or you may have a practice-based template that you use to inform the LHB. The second part gives a reflective tool that an individual can use to examine their role within the significant event monitoring system of their practice where they are not the reporting clinician.

Significant event analysis if carried out correctly can be a powerful learning tool acting as a catalyst for change. A significant event may be defined as *"Any event thought by anyone in the team to be significant in the care of patients or the conduct of the practice"* (Pringle et al 1995).

Significant events can be an event where something has gone wrong, where a less correct course of action has been taken or may be an example of where the system or an individual has worked well and the event is analysed in an attempt to ensure that the system will perform equally well should the same situation arise again.

Significant events should not be used to apportion blame, rather, to foster an environment of openness and a willingness to examine practice and systems to improve services and safety.

**Significant Event Template (also available on appraisal web site)**

| |
|---|
| **Title of event** |
| |
| **Date of event** |
| |
| **Date of SEA meeting** |
| |
| **Personnel present and role** |
| |
| **Description of event** |
| |
| **What went well?** |
| |
| **What could have been done better?** |
| |
| **Reflections on the event** (consider Knowledge skills and performance· Safety and quality· Communication partnership and teamwork· Maintaining trust) |
| |
| **What changes have been agreed?** (Personal or Team) |
| |
| **Changes carried out and their effect** |
| |

**Example**

| **Title of event** |
|---|
| Child with meningitis |
| **Date of event** |
| 3/1/14 |
| **Date of SEA meeting** |
| 9/1/14 |
| **Personnel present and role** |
| Drs A, B and C, practice manager, senior practice nurse |
| **Description of event** |
| *At 8am on a Monday morning a mother rang the practice and requested a house call for her 8 year old child. The receptionist was alarmed by the symptoms described (headache and light hurting his eyes) and advised the mother to immediately bring the child to surgery. The child arrived 5 minutes later and was brought into my room immediately. A quick assessment showed this child to have meningism, in the meantime the receptionist alerted another doctor in the practice and the practice nurse. Penicillin arrived with the nurse and my partner made arrangements for hospitalisation, the nurse drew up the penicillin and I continued my clinical assessment.* |
| **What went well?** |
| • *Receptionist training and experience, the receptionist was able to spot potentially serious symptoms and advise the mother of the best and quickest action*<br>• *The immediate availability of two doctors to attend an emergency – this is mainly a reflection of working as a team*<br>• *The receptionist summoning help including the penicillin*<br>• *The availability of in date penicillin without having to search for it*<br>• *Further evidence of teamwork in the multi tasking* |
| **What could have been done better?** |
| *This is a very positive significant event – everything went well. We need to learn from this and ensure up to date resuscitation training for all staff. Of particular note the availability of emergency medication needs examination* |
| **Reflections on the event** (consider Knowledge skills and performance· Safety and quality·<br>Communication partnership and teamwork· Maintaining trust)<br>I was pleased that my clinical skills in spotting a case of meningitis had not degraded since hospital days and that I was able to give the recognised first line treatment at the correct dose (600mg of phenoxymethylpenicillin). The child had definite<br>photophobia, was irritated, had a positive Kernig's sign and at least one petechiae on the upper left chest, also a CRT of > 2 seconds. I contacted the ward later that day and the child was stable on HDU. |
| |
| **What changes have been agreed?** (Personal or Team) |
| *The practice nurse now has a list of emergency medication expected to be on site and up to date this is checked monthly as per a protocol.. The doctor's bags are checked and restocked monthly.* |
| **Changes carried out and their effect** |
| *The changes have been implemented in full. Monthly audits show that emergency medication is being checked and maintained as per the protocol as are the doctors' bags.* |

**Section 2b: Reflective tool re significant event monitoring in practice.** For use if not directly involved in a significant event.

| | |
|---|---|
| **Describe the significant event policy in your practice – you may wish to include your template in supporting documentation** | |
| **When are significant events discussed and who is present at the meeting?** | |
| **Describe one or more examples of your involvement in significant event analysis** | |
| **Describe one or more changes made to your practice as a result of a significant event (either one you were personally involved with or something that happened to someone else that has affected you)** | |
| **What do you think about significant event analysis** | |

**Example**

| | |
|---|---|
| **Describe the significant event policy in your practice – you may wish to include your template in supporting documentation** | *Significant event reporting is encouraged from all members of the team. We encourage both good and "bad" reporting, we have a template (available in supporting documentation) that allows reporting of the circumstances, identifies the issues and makes the solutions explicit. It is a confidential process* |
| | *but in a small organisation such as ours the personnel involved are easily identifiable – we get around this by fostering a no blame culture and the "there by the grace of God go I" attitude.* |
| **When are significant events discussed and who is present at the meeting?** | *They are discussed at our monthly multidisciplinary meeting to which all members of the team are invited. Any event involving a serious issue of patient safety would be discussed immediately by partners present at the end of morning surgery that day or the next day – any action taken would then still be reported to the monthly team meeting* |

| | |
|---|---|
| **Describe an example of your involvement in significant event analysis** | *I have been fortunate this year not to have been involved in a significant event. I am however an active participant in the process. We had one event this year with a "near miss" – one of our partners prescribed a beta blocker for an asthmatic – fortunately this was picked up by the pharmacist – this was discussed at the team meeting. It was obvious which partner had done this by their reaction. After the meeting I was able to have a personal talk with the partner involved who's confidence had been shaken by this – I think he valued my support.* |
| **Describe a change made to your practice as a result of a significant event (either one you were personally involved with or something that happened to someone else that has affected you)** | *We have had a number of abnormal results go "astray" this year this has been discussed on 3 occasions at our team meetings. We now have a system in place to ensure all results are seen, action indicated and that the action is carried out. It has meant that I take longer reading the mail but it seems (so far) to have eliminated mistakes* |
| **What do you think about significant event analysis?** | *Initially I was a bit wary about washing dirty linen in public. It is however now a valuable part of our practice leading to minor changes to improve the practice and patient safety* |

## Section 3: Practice skill mix

All practices have individuals with skills; the mix of these skills contributes to the efficient running of the practice. It is not feasible for every GP to be highly skilled in all areas and as such it may be useful to plan the mix of skills within the practice. This skill mix may put a greater or lesser emphasis on an individual's PDP. The template below allows the practice to look at skills it may need to provide a good/better service and the reflective template allows the individual an opportunity to examine their individual skills and needs for the future. The template is not exhaustive and the practice should identify skills required in their own area (e.g. dispensing does not apply to all practices)

| Skill | Who possesses it? | Is this enough provision? | Training needs (for whom?) |
|---|---|---|---|
| **Child health surveillance** | | | |
| **Minor Surgery** | | | |
| **Dermatology / Dermoscopy** | | | |
| **IUD fitting** | | | |
| **Cytology** | | | |
| **Contraceptive implant fitting** | | | |
| **Diabetic annual check** | | | |
| **Respiratory lead** | | | |
| **GP trainer** | | | |
| **Medical student tutor** | | | |
| **Substance misuse** | | | |
| **Finance lead** | | | |
| **Add other skills below** | | | |

**Practice training needs overview**

| Need | How need will be filled | Completed | Any change to practice? |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**Example**

| Skill | Who possesses it? | Is this enough provision? | Training needs (for whom?) |
|---|---|---|---|
| **Child health surveillance** | *Dr A, Dr B and 2 health visitors* | *Yes the clinic alternates between the two doctors and the health visitors only once have we needed to cancel a clinic due to absence of both partners.* | *Dr A did a course 18 months ago. Dr B needs to do an update course. Both health visitors receive annual training from the trust* |
| **Minor Surgery** | *Dr C and to some extent Dr D* | *Probably not Dr C is doing the vast majority of minor surgery and as a consequence has a 2 month wait for non urgent cases. The procedures (payment) is capped by the LHB so extending our provision would not increase income* | *Dr C is up to date with training Dr D would like to extend her skills and is to attend an update course in 2 months and will have some in house training from Dr C* |
| **IUD fitting** | *Dr D and Dr A* | *Yes probably more than enough – each partner insert 1012 per year which is just about enough to maintain skills* | *No not at present* |
| **Cytology** | *Sister A Sister B Drs A, C ,D and E* | *Yes probably enough Dr B used to perform smears but has not undertaken liquid cytology training* | *No Dr B is happy not to take cytology* |
| **Diabetic annual check** | *Dr E sister B* | *Not enough to cope with the volume. Sister B is overwhelmed with annual checks and Dr E cannot possibly see all the patients himself* | *The structure of the diabetic care in the practice needs evaluating and Dr E Sister B and Dr A have agreed to look at this and identify structural changes and training needs* |
| **Add other skills below** | | | |

**Practice training needs overview**

| Need | How need will be filled | Completed | Any change to practice? |
|---|---|---|---|
| **Dr B needs to do an update course in Child health** | *Local course runs annually (next course booked but not for another 4 months)* | | |
| **Dr D is to attend an update course in Minor Surgery** | *Update in minor surgery at local postgrad centre* | *Completed 23rd June* | *Dr D now to have 3 or 4 supervised sessions with Dr C and will take a bigger role in the practice* |
| **Diabetes care** | *Under examination at present by Dr E, A and sister B* | | |

## Section 4: Reflection on practice skill mix

If your practice has completed the template above you may wish to examine your role and possible training priorities for the future by using the template below.

| | |
|---|---|
| **Do I possess specific skills or am I responsible for a specific area of the work of the practice?** | |
| **Are there gaps in the skill mix of the practice that I need training in order to fill?** | |
| **What are those training needs and what are the ways in which to meet them?** | |
| **Are there any areas you would like to develop (even if its not an area that the practice needs more provision)** | |

**Example**

| | |
|---|---|
| **Do I possess specific skills or am I responsible for a specific area of the work of the practice?** | *I run child health clinics once a fortnight and have received training within last 18 months. I fit IUDs and take cytology I have an interest in cardiology but do not perform a specific role within the practice. I am just about to become involved with diabetic care.* |
| **Are there gaps in the skill mix of the practice that I need training in order to fill?** | *I will need to update my diabetic care when I move in to helping run the annual review clinic. I am confident with the cardiac prevention side of things but am less confident on the physical examination – particularly the eyes. I am also less familiar with the newer oral glycaemic agents* |
| **What are those training needs and what are the ways in which to meet them?** | *I think I need to look at the elements of an annual check and which examinations I will perform and if there are others in the (extended) team better placed – for instance I am rusty on examining fundii but all diabetics now have annual retinal photography – so do I need this skill? I certainly need to update my knowledge on oral glycaemic agents and insulin. I will do this in a number of ways – there is a diabetic course that runs fairly regularly locally and there will be an* |
| | *element of personal reading but I also intend to write up a couple of case histories and discuss them with Dr E* |

| | |
|---|---|
| **Are there any areas you would like to develop (even if its not an area that the practice needs more provision)** | *I would like to do a little minor surgery and I will attend a practical course, I will probably confine myself to smaller procedures but it does interest me (perhaps next year)* |

## Section 5: Practice developments

If there are changes being made in the fabric or structure of the practice that affect your personal development, you may wish to highlight them using the following template.

| | |
|---|---|
| **Nature of change** | |
| **How will this affect the practice and/or me?** | |
| **Personal developmental issues** | |
| **How I feel about impending (or complete) changes** | |

**Example**

| | |
|---|---|
| **Nature of change** | *Retirement of senior partner* |
| **How will this affect the practice and/or me?** | *The senior partner is due to retire in 6 months – she has taken the lead in dealing with the practice accountancy for the past 12 years. She is also one of only 2 people in the practice currently fitting IUDs. She runs the diabetic annual reviews. Recruitment is not an issue as we have a long term locum who is going to step in but it leaves me as the only partner fitting IUDs and someone is going to need to take over both diabetic clinic and the accountancy* |
| **Personal developmental issues** | *I have been identified as the person to take over dealing with the accountant. This concerns me slightly as I have difficulty in understanding the accounts as presented. The practice manager understands them better than I do – it's something I will need to learn.* |
| **How I feel about impending (or complete) changes** | *I am sorry to see my colleague retire, she has promised to fill locum posts at least for the next year or so. It does leave some problems in the practice but as we are planning well in advance it should be fairly smooth. I do not envisage being the only doctor to fit IUDs to be an issue and indeed will lead to me gaining more experience. Thank goodness it's not me that's going to take over diabetic care!* |

**Section 6: QOF**

Many individuals make a contribution to QOF targets you may wish to highlight in your appraisal your contributions, your development and your future developmental needs using the following template

| | |
|---|---|
| **Describe areas of QOF responsibility** | |
| **Describe other areas to which you contribute** | |
| **Describe the impact of QOF on the way you practice** | |
| **Describe the impact of QOF on the way your practice functions** | |
| **Describe the impact of QOF on your patients** | |
| **Do any learning needs fall out of your roles in QOF?** | |

**Example**

| | |
|---|---|
| **Describe areas of QOF responsibility** | *I am responsible for the Asthma and COPD sections of QOF* |
| **Describe other areas to which you contribute** | *I have a role in supporting the practice manager in the organisational areas of QOF* |
| **Describe the impact of QOF on the way you practice** | *Wow – have you got all day! There are many good things about QOF however I feel that I am constantly hounding patients to perform better, to re-attend, to take more drugs and to diet and exercise. Treating to target is all well and good but what about that last blood pressure reading of the year being 151/91 when you know the patient has had a very busy day and has rushed to make his appointment time? The cholesterol of 5.01? The computer driven "rewards" system sometimes takes common sense out of the equation. I would hope I have maintained my role as a patients advocate and have used skills to allow patients to make informed choices (e.g. I have a patient aged 93 who is on the IHD register by virtue of angina some 10 years earlier confirmed by a cardiologist. He takes no medication as now he has an almost totally sedentary lifestyle as his knees and hips will not allow him to get around much – he struggles up to the surgery! He was* |

| | |
|---|---|
| | *picked up in our call recall system and had his annual bloods. His cholesterol is 5.6 what do we do? I had a discussion with him about why we check cholesterol and explained that he would be called for tests etc and that his cholesterol was too high. His response was "well it has done me no harm so far") There are so many examples along this line perhaps it is something that should be discussed at appraisal* |

| | |
|---|---|
| **Describe the impact of QOF on the way your practice functions** | *We are a training practice and as such our medical records have been summarised. We had disease registers in place. However on closer scrutiny the data was far from perfect with many patients appearing on registers they shouldn't and many patients missed off registers. Despite QOF being with us for some time I am still having to verify patients into asthma/COPD/neither my partners are doing similar exercises in their domains. Read coding has been part of the problem with codes entered many years ago popping up in inappropriate categories. I don't really understand the Read code system and perhaps this could be a learning need. The practice is now much more organised from the point of view of data capture. We have also developed some staff into different roles and I have been involved in some training of our nursing assistants.*<br>*Is the practice a happier place? – no I feel that some of the team search for points to the exclusion of other things, on the positive side I think we are more of a team than we ever were. All partners have worked well on their own domains without exception there is however an undercurrent developing with regard to the amount of work that generates. I wonder how long it will take to either change the system (which of course the domains have already changed) or prove that this really does improve patient outcomes.* |

| | |
|---|---|
| **Describe the impact of QOF on your patients** | *More patients are receiving monitored, evidence-based healthcare. There is little doubt that there has been an improvement in the preventative care given to our patients with DM or IHD this has been achieved through a more effective call recall system and by treating to target.*<br>*I think that patients now receive more recalls to the practice and perhaps they are more heath conscious (or heath neurotic). They appreciate the opportunity to feed back to the practice about the care they receive (see general patient satisfaction survey and specific survey regarding the minor surgery treatment).*<br>*Has it impacted on informed choice? I hope not – this is something that worries me perhaps we could discuss this at appraisal* |
| **Do any learning needs fall out of your roles in QOF?** | *Obviously I need to keep up to date in the areas of Asthma and COPD – please see courses attended in other evidence presented. I have also attended a short course on practice organisational points (see certificate) this was worse than useless – but I tried.*<br>*Re reading the tirade above I realise that I am concerned that QOF has changed the way that I practice – I think I will video my consultations and analyse them possibly with my partner who is the practice trainer.* |

## Section 7: Patient and colleague Satisfaction surveys

Patient satisfaction surveys are no longer required for QOF, however, patient and colleague feedback still needs to be completed at least once per revalidation cycle.


Orbit360 has been developed by the Revalidation Support Unit (RSU) to facilitate both patient and colleague feedback for all doctors with a prescribed connection to an NHS designated body in Wales. This is free of charge to doctors and has been developed to satisfy all requirements of revalidation (please note that Orbit360 is not currently available to doctors in training grade posts or locums employed through locum agencies). Information on how to access this service is provided below.

Find out what information you need to include to satisfy the requirements of revalidation. You can access the Orbit360 homepage to register and initiate your patient and colleague feedback and further information can be found on the Frequently Asked Questions site.

If you decide to embark on this exercise you must be prepared for some less than excellent comments. It is also vital this is totally anonymous otherwise you are not likely to receive true responses.

You'll nominate a Supporting Medical Colleague (SMC) at the start of the Orbit360 process, part of their role will be to help you make sense of and interpret the responses. It is important that you reflect upon the feedback you have received and include this at one of your annual appraisals prior to revalidation. The reflection is the most important aspect of the feedback process which can help identify development needs and plan for change in your practice.

Once you receive the minimum number of patient (34) and colleague (15) responses, your SMC will be notified and have the opportunity to provide feedback on your completed report. You should then add this, along with your reflections, to MARS. You should select 'Feedback' in the category box and then either 'Patient', 'Colleague' or 'Patient and Colleague' depending on which you have undertaken. Orbit360 offers functionality for you to complete your patient and colleague feedback at the same time or independently of each other. Where possible you should complete them at the same time to minimise the work for the SMC in the process.

All completed patient and colleague feedback surveys are anonymous and it is likely that the practice and the individual will receive some negative feedback. Overall ratings of doctors by patients may not match the doctor's expectation and a lower rating than expected could lead to a demoralised individual. It is for this reason that your nominated 'supporting medical colleague' receives the survey information first and releases it to you.

**Patient survey, template for doctor:**

| | |
|---|---|
| You have now received a summary of responses from your patients and had the opportunity to discuss it with your nominated Supportive medical Colleague (SMC). You may wish to consider the following when reading through the results and also consider the feedback from your SMC. You may then upload this template to MARS. | |
| Are the responses in line with my own self-rating? | |
| If better than I was expecting, what areas in particular exceeded my own selfrating? Why might this be? | |
| If some areas were lower than my selfrating, what were these and why might this be? | |
| What (if any) text entries were helpful in explaining the responses? | |
| Are there any development opportunities suggested by the results? | |
| Were there any further insights and / or development opportunities arising from discussion with my SMC? | |

**Example:**

| | |
|---|---|
| You have now received a summary of responses from your patients and had the opportunity to discuss it with your nominated Supportive medical Colleague (SMC). You may wish to consider the following when reading through the results and also consider the feedback from your SMC. | |
| Are the responses in line with my own self-rating? | *Mostly they exceeded my own view, with the time pressures we are under and knowing that issues beyond our control make getting an appointment so difficult, I was delighted and heartened to see so many patients rating me as 'outstanding' whereas I had rated myself as 'good'* |
| If better than I was expecting, what areas in particular exceeded my own selfrating? Why might this be? | *'Listening' and 'assessing the medical condition' were better than expected as I feel rushed so much of the time, I feel that the patient centred skills I developed on the VTS are often not allowed to come to the surface. I find this reassuring that patients feel that I do listen and then go on to make a good medical assessment. I can only assume these skills are now innate.* |

| | |
|---|---|
| If some areas were lower than my selfrating, what were these and why might this be? | *Given the above, I was then disappointed that not all of the responses for explaining about the 'condition and management' and also for 'involving the patient in decisions' were not as highly rated. Some had marked me as 'good' and there was one' satisfactory'. I feel that in an effort to finish the consultation within 10 minutes, I rush the last bit and become more doctor centred. I will try to remember that explaining more to patients about their condition and management ultimately will save time as there will be greater compliance and less revisits, also, there are different phrases I could use when discussing treatment options that will quickly enable the patient feel become involved. Discussing this further with my appraiser may help.* |
| What (if any) text entries were helpful in explaining the responses? | *There were no negative comments so I feel better about the lower scores as discussed above, I feel that anything really significant would have been mentioned here, also, there were many comments such as 'great doctor', 'always makes me feel at ease' 'listened to' etc.* |
| Are there any development opportunities suggested by the results? | *I will revisit my consulting skills as discussed above and be more patient centred at the end of the consultation as well as at the start* |
| Were there any further insights and / or development opportunities arising from discussion with my SMC? | *My colleague did not consider the slightly lower ratings in any way significant and stated that he would feel very happy to have the same response. He did agree with my suggestions on consultations skills however as this is always good practice.* |

**Patient survey, template for supportive medical colleague**

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| You have been nominated by your colleague to be their Supportive medical Colleague (SMC) and have the role of providing your colleague with feedback on the responses contained within. You may wish to consider the following when discussing the results with them. | |
| Are the participants' responses at the level you would expect? If not, why not? | |
| Are there any responses that you feel your colleague may find challenging or harmful? If so, why? | |
| Are there any text comments that you feel are worth highlighting to the doctor, either positive or negative? You could enter them here | |
| Do you have any further comments that will aid your colleague in making use of this survey? | |

**<u>Example</u>**

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| You have been nominated by your colleague to be their Supportive medical Colleague (SMC) and have the role of providing your colleague with feedback on the responses contained within. You may wish to consider the following when discussing the results with them. | |
| Are the participants' responses at the level you would expect? If not, why not? | *I know the doctor to be a caring and diligent doctor so was not surprised to* |
| | *see high ratings, also, I am aware that doctors often underestimate their own competence.* |
| Are there any responses that you feel your colleague may find challenging or harmful? If so, why? | *I would be happy with all of the results but knowing my colleague and also doctors in general, I expect she will feel the slightly lower scores for explaining about the condition and sharing management options is something to analyse further. We will discuss whether she feels this is a true reflection of her consultation skills or whether, as is often the case with surveys, there are some responses that appear out of step with the others.* |
| Are there any text comments that you feel are worth highlighting to the doctor, either positive or negative? You could enter them here | *Further to the above, all of the comments are positive and there are no negative responses. This should help the doctor put the few lower scores into perspective.* |

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| Do you have any further comments that will aid your colleague in making use of this survey? | *If the doctor feels that there are aspects of the consultation that she feels could be improved, then I will be happy to share my own experience and perspective.* |

**Colleague survey, template for doctor**

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| You have now received a summary of your colleagues' responses and had the opportunity to discuss it with your nominated Supportive medical Colleague (SMC). You may wish to consider the following when reading through the results and also consider the feedback from your SMC. | |
| Are the responses in line with my own self-rating? | |
| If better than I was expecting, what areas in particular exceeded my own selfrating? Why might this be? | |
| If some areas were lower than my selfrating, what were these and why might this be? | |
| What (if any) text entries were helpful in explaining the responses? | |
| Are there any development opportunities suggested by the results? | |
| Were there any further insights and / or development opportunities arising from discussion with my SMC? | |

**<u>Example</u>**

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|---|---|
| You have now received a summary of your colleagues' responses and had the opportunity to discuss it with your nominated Supportive medical Colleague (SMC). You may wish to consider the following when reading through the results and also consider the feedback from your SMC. | |
| Are the responses in line with my own self-rating? | *Mostly I was pleased and relieved, all of the average scores were above my predictions.* |
| If better than I was expecting, what areas in particular exceeded my own selfrating? Why might this be? | *The questions that relate to my skills as a doctor were interesting as I really wasn't sure what the view was of this core part of my work as we work effectively in isolation. I guess they pick up on views expressed by others or through reading my medical record entries. We don't have much of a barometer by which to measure the quality of our clinical expertise, the high score given suggesting that colleagues would approach me for advice is encouraging.* |

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| If some areas were lower than my selfrating, what were these and why might this be? | *I was disappointed and puzzled by some of the scores though. Despite the overall score in some areas being higher than those given for the average doctor, there were within those scores some lower ratings for 'Time management', 'Commitment to improve quality of service' and 'contributes to the education and supervision of students and junior colleagues'. For a start, we don't even have students and though I am senior partner, I wouldn't say any of my colleagues were junior. Time management! I arrive first, get all my paperwork done before surgery and finish on time with all work finished before leaving. I don't understand what 'Commitment to improve quality of service' even means! I can only think its contributing to practice meetings and discussing the future of the practice and services. I chair the meetings as senior partner and offer an experienced view on new proposals so that people don't get carried away – most things have been tried in the past already. My SMC couldn't shed any light on these comments either though did point out that almost all other ratings were 'outstanding'. Perhaps discussing this further with my appraiser will help.* |
| What (if any) text entries were helpful in explaining the responses? | *There were very many uplifting responses but one comment was 'it may be helpful to let the practice manager chair the meetings as this would allow the doctor to participate more in the meetings rather than get sidetracked by facilitating and them and recording the minutes'. I had considered my role an important one in ensuring that proper process was followed but perhaps others may perceive this as being less involved in the discussion. Discussing this further with my SMC confirmed that although he had not written the comment, he suggested that most other practices use their practice manager for this role as it frees up all the clinical personnel to have a more involved discussion. I will consider this further and discuss with my appraiser also.* |
| Are there any development opportunities suggested by the results? | *The lower score for 'Time management' continues to confuse me. I think it may be worth exploring this further at a practice meeting – in a non-judgemental way of course! It could be an open-ended discussion about* |

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| | *perceived work load and whether any redistribution is needed.* |
| Were there any further insights and / or development opportunities arising from discussion with my SMC? | *We discussed and agreed as above* |

**Colleague survey, template for supportive medical colleague**

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| You have been nominated by your colleague to be their Supportive medical Colleague (SMC) and have the role of providing your colleague with feedback on the responses contained within. You may wish to consider the following when discussing the results with them. | |
| Are the participants' responses at the level you would expect? If not, why not? | |
| Are there any responses that you feel your colleague may find challenging or harmful? If so, why? | |
| Are there any text comments that you feel are worth highlighting to the doctor, either positive or negative? You could enter them here | |
| Do you have any further comments that will aid your colleague in making use of this survey? | |

**<u>Example</u>**

| | |
|---|---|
| You have been nominated by your colleague to be their Supportive medical Colleague (SMC) and have the role of providing your colleague with feedback on the responses contained within. You may wish to consider the following when discussing the results with them. | |
| Are the participants' responses at the level you would expect? If not, why not? | *They are high scores as I would expect* |
| Are there any responses that you feel your colleague may find challenging or harmful? If so, why? | *We all like to get perfect scores so I doubt she will be happy that some of the areas were scored lower by just a few respondents. These were 'Time management', 'Commitment to improve quality of service' and 'contributes to the education and supervision of students and junior colleagues'.* |
| Are there any text comments that you feel are worth highlighting to the doctor, either positive or negative? You could enter them here | *I will discuss the overwhelming number of positive responses, for example:*<br>*"Helpful, pleasant, approachable and friendly"*<br>*" Pleasure to work with."*<br>*"Excellent doctor, professional, competent, caring with patients"*<br><br>*There was one negative / constructive* |

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| | *advice comment: "it may be helpful to let the practice manager chair the meetings as this would allow the doctor to participate more in the meetings rather than get sidetracked by facilitating and them and recording the minutes". This may relate to the common position in most other practices I know, where the chair persona and minute taker is not a partner, usually the practice manager. The doctor can at times be outside of our discussions as he gets on with the demands of recording the discussion and keeping the agenda running.* |
| Do you have any further comments that will aid your colleague in making use of this survey? | *In the main, to focus on the overwhelming positive response from colleagues who clearly like and respect him, to keep the apparent lower scores from a few in perspective (time keeping may just be because she finishes on time and goes home quite appropriately, whereas the slower colleagues are always left last to leave, and teaching junior colleagues?– I have no idea what that's about!) and if you're struggling to squeeze some developmental opportunity out of it – well then you can't be doing too badly. I agree on her suggestions of dropping the chairperson role and it's timely to explore workload distribution.* |