**Medical Appraisal 2020 - guidance for appraisers**

**Context**

In recognition of the exceptional stresses that the COVID-19 pandemic is placing on all healthcare workers, there is widespread agreement that appraisal should offer doctors a confidential professional discussion about their experience of the pandemic and provide a chance for them to reflect on their development, and maintaining their health and wellbeing as essential for high standards of professional practice. The administrative burdens involved in preparing for appraisals should be minimised to free up time for clinical care.

* The Covid-19 pandemic will have affected every doctor in some way – including a change in the type and volume of work they have been doing, the widespread use of new technology such as video consulting, and the unprecedented impact of the virus on daily lives, and on the health and well-being of relatives, friends and colleagues.
* Many doctors will have had an extremely exhausting and challenging period on the ‘frontline’ of service delivery. Others may have been suddenly shifted to working in a new field, or ended up doing less work than usual or working remotely and away from colleagues, and some may have wanted to work but been unable to do so because of their own health or other constraints
* Some doctors are at increased risk of a poor outcome from COVID-19 because of their individual risk factors such as a pre-existing health condition, increasing age or pregnancy. These doctors will have been under additional stress.
* Additionally, the disproportionally high death rate of NHS staff from a Black, Asian or Minority Ethnic (BAME) background in the UK has considerably increased the stress being experienced by these colleagues, both in terms of their own health and safety and that of their families.
* The purposes of appraisal remain the same:
  + To support a doctor’s professional development
  + To support a doctor’s personal development
  + To help a doctor work productively within their organisation
  + To help assure a positive revalidation decision
* But as appraisal restarts following the pause caused by the pandemic, there is a rebalancing of emphasis. For the doctor, there is a focus on their wellbeing and development, with a more flexible approach to supporting information. Verbal rather than written reflection is acceptable – so only the basic reflection based on the new Medical Appraisal 2020 template needs to be submitted, with no additional evidence uploaded, and other supporting information can be discussed during the appraisal. For the appraiser, there is an emphasis on enhanced use of their core skills in facilitating the appraisal discussion and producing a summary more based on the appraisal discussion and minimised documentation.
* So, the appraisal after the restart is principally a chance to reflect on the doctor’s work, not to add to it. There is a basic level of input to the process, although doctors who have collected more information can submit this if it is of value to them. The professionalism of doctors has been clearly shown in their response to the pandemic and they need a chance to reflect on the impact on them as doctors and as human beings. The six types of GMC required supporting information remain the same but the pre-appraisal documentation has been minimised.
* This change in focus and content of these appraisals has implications for you as an appraiser in terms of preparing for the appraisal, conducting the appraisal discussion, signposting support and completing the output documents.
* Your skills as an appraiser have never been more important and are absolutely essential for the success of the medical appraisal 2020 process
* This guidance should be read in conjunction with the Frequently Asked Questions (FAQs), and the Medical Appraisal 2020 Training power point presentation published alongside it.

**Confidentiality**

Please be aware that the guidance on confidentiality that has always applied to the content of the appraisal discussion is particularly relevant to appraisal in the context of the pandemic. Doctors must be reassured that the discussion is confidential and that the appraisal is a safe space to explore ideas and concerns (within the normal provisions about moving beyond the appraisal process if any over-riding patient or self-harm safety concerns were disclosed). It is appropriate to reassure doctors that the appraisal summary is not a verbatim account of the discussion but a summary of the elements relevant to demonstrating continued competence as a doctor in order to revalidate successfully. A discussion which focuses at least in part on maintaining health and well-being may raise sensitive issues. As an appraiser you are well placed to discuss such issues, to the extent that this is helpful for your appraisee, and to signpost to further support as appropriate. However, you do not need to record the details of this conversation in your appraisal summary. In most cases, you will just record that the discussion has taken place, with any relevant action points (if this is helpful to the doctor). It is important to make this clear at the start of the appraisal.

**Preparation**

* The first thing you need to do is to establish from your appraisee how the appraisal will take place. Within NHS England and Improvement, the default expectation is that this will be via a videoconferencing tool such as Microsoft Teams. In other designated bodies different arrangements may apply. In all situations the Covid-secure policy of the location in question must be observed. Beyond this decision should be based on your mutual needs, and any difficulties or discordance discussed with the appraisal team.
* Doctors are being asked to be proportionate and mindful of the time they spend preparing for this appraisal. The Medical Appraisal 2020 template [used alone and then uploaded to the MAG4.2 Form, or newly embedded within the on-line toolkits] provides the guidance for the information expected.

* The focus in this appraisal is on the doctor’s personal and professional development, their well-being and their achievements, challenges and aspirations at this time. The doctor’s preparatory documentation will include:
  + A summary of their current scope of work and any recent changes
  + A review of their previous PDP and what items [if any] they have managed to make progress with, or complete.
  + Brief reflective notes on their challenges, achievements and aspirations
  + Brief reflective notes on how they are and how they have maintained their health and wellbeing
  + An indication of any CPD, QIA or feedback, including compliments, they wish to focus on at the meeting
  + The inclusion of any complaints or significant events that need to be discussed at the meeting, or anything that they were specifically asked to bring to the appraisal, in the usual way
  + Ideas for their future development
  + All pre-appraisal sign-offs, including probity and health

* Please note, you should NOT be asking for any additional documentary evidence in addition to that outlined above and summarised in the Medical Appraisal 2020 Template. In particular, there is no need for the doctor to upload certificates to confirm that training or CPD requirements have been met. The doctor is encouraged to submit brief reflective notes only. Even if these are not forthcoming, the appraisal should go ahead regardless, and you should use your skills to sensitively draw out in the discussion the doctor’s learning and future personal and professional development goals in the context of their response to the epidemic.
* Your preparation for the appraisal meeting will be a process of identifying the key issues highlighted by the doctor in their pre-appraisal submission, and considering how to approach these issues, including whether sign-posting towards additional help might be appropriate.
* It will be very important to seek to understand the context of the doctor’s work during the pandemic and to recognise where individuals have been at particular risk due to pre-existing health conditions, increasing age or pregnancy, or coming from a Black, Asian or Minority Ethnic (BAME) background.
* All appraisers should be aware of the specific additional risks that are still being faced by doctors from BAME backgrounds and their families. 44% of doctors in England are from BAME backgrounds but they represent 95% of the deaths of doctors [(HSJ, April 2020)](https://www.hsj.co.uk/exclusive-deaths-of-nhs-staff-from-covid-19-analysed/7027471.article). Specific advice and guidance for doctors from BAME backgrounds is included in the list of support contacts and resources provided.

**The appraisal meeting**

* This should be no different from the best medical appraisals, which already focus on supporting the personal and professional development of the doctor in the context within which they work, and already take maintaining the health and wellbeing of doctors as a serious professional responsibility. However, you will have less documentary evidence in most cases and will have to facilitate the verbal self-reflection and insights of the doctor correspondingly more carefully. By the end of the discussion you need to be able to have identified, discussed and be ready to record, the key issues for the doctor since their last appraisal, and particularly during the pandemic, and their learning, to support their future development.
* Asking the doctor what areas they wish to focus on during the appraisal discussion is the most important first step. How you decide to structure the appraisal meeting will depend on the agenda set by your appraisee. ***The core message is to allow the appraisal to be led by your appraisee – what are their core issues, concerns, challenges, achievements and aspirations?***
* The discussion should cover the following areas in whatever order seems to be appropriate:
  + A discussion of the doctor’s current scope of work and what changes [if any] have occurred during the pandemic, and whether these are on-going.
  + A review of progress with last year’s PDP and any professional development – it is quite possible that none of the aims were achieved – if this is so, it is important to identify whether any aims need to be carried forward into the new PDP, whether they should now be appropriately ‘dropped’.
  + Challenges, achievements and aspirations –discuss what have been the biggest difficulties and constraints and the external factors that have influenced the doctor personally and professionally over this period, and also consider what they have achieved, how barriers have been overcome, new ways of working embraced etc. Aspirations for the future can be discussed in general terms, which may also help to establish some PDP aims for the coming year.
  + A discussion of any complaints or Significant Events (SEs) with a focus on those that have led to learning, reflection and/or a change in practice
  + Personal and professional well-being – a discussion about how the doctor is, and what they have done to maintain their health and wellbeing, including any support they have accessed during the pandemic should cover:
    - Mental and physical wellbeing
    - Risk assessment at work
    - Support at work
    - Opportunities to voice concerns, if any
    - Resources for appropriate support
  + There are likely to be additional specific issues and health concerns for doctors who have been at increased risk from COVID-19, particularly doctors from BAME backgrounds, who have been shown to find it more difficult to seek support or to whistleblow about lack of PPE etc. and who may have additional concerns about their families or communities.
* Other elements of the appraisal: CPD, QIA, feedback from patients and colleagues, including compliments] also need to be discussed, through verbal rather than through written reflection. A positive revalidation recommendation will still be based on the same six types of GMC required supporting information and the doctor demonstrating that they are working in line with Good Medical Practice (GMP) across the whole of their scope of work.
* Questions could focus on how learning about COVID-19 took place, what sources of information were the most accessible, helpful and reliable, and how learning was shared and applied to practice. How did the changes in working practice affect relationships with patients and the confidence of individual doctors?
* You might also want to discuss how individual doctors and the team[s] they are working with responded to the challenges that arose in terms of other necessary system changes, and how relationships with colleagues and wider teams adapted to change.
* You can also discuss any informal or formal feedback that the appraisee has received either as an individual or to the service they work for
* ***Overall, the most important role of this appraisal is to provide space for a supportive focused discussion of all aspects of what for many doctors may have been the most challenging few months of their working lives.***

**The output documents**

* The appraisal summary may need to be written up slightly differently in order to capture sufficient examples of high quality (not quantity) supporting information to demonstrate working in line with GMP. The aim will be to capture the essence of the discussion and summarise the core learning and development for the individual doctor.
* You should write up the summary under the four domain headings of Good Medical Practice as normal, focusing on the key elements of maintaining health and well-being, and reviewing the achievements, challenges and aspirations of the doctor.
* Verbal reflection, on CPD and QI activities that have not been written up by the doctor, can be facilitated in the discussion and captured in the appraisal summary.
* A new PDP needs to be agreed and written up. It is particularly important that the goals are owned by the doctor and written in a SMARTER way. Defining a new PDP with a couple of PDP aims is fine, in line with on-going workload and stress.
* The five output statements should be agreed/disagreed in the usual way. If a ‘disagree’ statement is made, it is important, as always, to put an explanation in the comment to the RO and to remind the doctor that they have the opportunity to comment too.
* Doctors whose revalidation recommendation will fall before their next appraisal will need to make sure that they have provided all the six types of supporting information required by the GMC for revalidation, taking into account all appraisals in their current cycle. This must include collection of patient and colleague feedback, and QIA, if this has not yet been done, as a revalidation recommendation cannot be made without this supporting information having been collected, reflected upon and discussed at appraisal.
* If it is impossible to collect all the required supporting information for revalidation prior to this appraisal, the missing supporting information should be detailed in the appraisal summary, as well as a plan for how to collect it before the next appraisal. Guidance may vary locally as to how this should be recorded by the appraiser in order to alert the responsible officer and their team that the doctor is not yet revalidation ready. This may include marking Statement 2 as a ‘disagree’ and making an appropriate explanation in the box to the responsible officer. It would be wise to seek advice from the appraisal and revalidation team so that the doctor can be supported in collecting the supporting information that they need.
* Doctors who are not able to provide this information, in the context of the pandemic, will need a deferral recommendation from their responsible officer so they can complete a further appraisal before a revalidation recommendation is submitted to the GMC.
* The GMC has agreed that appraisals in the context of the COVID-19 pandemic should focus on the health, wellbeing and development of the doctor. This is consistent with existing GMC guidance for appraisal and revalidation.
* Engaging with Medical Appraisal 2020 will satisfy the GMC revalidation requirements in terms of engaging with the annual medical appraisal process.

**Appendix 1 Example documentation**

This appendix contains examples of two hypothetical appraisal templates [the first a GP, the second a hospital doctor] and the output summaries that could have been written after their appraisals.

**Example 1 – Primary care**

**Appraisal inputs:**

An example of a medical appraisal 2020 template completed by a hypothetical GP [Doctor C] who is now due to be revalidated in Dec 2021:

## **Personal details**

Name: Doctor C

GMC Number: 1234567

## 

## **Scope of work**

*Describe your core roles and any significant changes since your last appraisal.*

I work 6 sessions a week as a salaried GP in a large city practice where I did some of my GP training. I have been there for 5 years. I also have a one session a week role at our local CCG. Until COVID-19 this focused on referrals management, but for the last few months I have been working with the team responsible for setting up the ‘hot hub’ for COVID-19 patients and managing our clinical input to care homes. I have also done a few 111 triage sessions but the need for extra help was less than predicted

## **Personal Development Plan (PDP) review:**

*What progress, if any, have you made with last year’s PDP? What goals would you like to carry forward to next year*

I completed my planned update of contraceptive skills [including Implanon fitting] before COVID-19 started but the other two items, a comparative review of 2WW referrals with practice colleagues and looking towards becoming a GP trainer have been put on hold. I would hope to carry both forward to my next PDP if circumstances permit.

1. **Challenges, achievements and aspirations:**

*What personal and professional challenges or constraints have you faced? How did they affect your plans?*

For me, the biggest professional challenges have been around the switch to remote working [with both colleagues and patients] and maintaining the best possible quality of care for care home patients, and ensuring their advanced wishes were known and respected

In personal terms, I did get anxious about the personal risk of infection, especially as the hot hub did not always have full PPE available. I was unable to visit my elderly parents who live 200 miles away for 4 months and I was constantly worried about them, although fortunately neither of them became ill. Two close family members who work in the care sector did get the virus but fortunately neither required hospital care. I spent quite a lot of time counselling worried friends and relatives

*What have been your greatest achievements since your last appraisal? What do you most want to highlight?*

Survival through a really difficult period in which the world of work and home was turned upside down creating massive challenges. I feel that I responded well to many new demands and I am very proud of the anticipatory work we did in care homes making sure that new HCPs were discussed with all residents and their families. I have done all I can to support family and friends and I have struggled, but kept going, living alone and not being able to maintain my usual regime of frequent meeting friends, eating out, visiting my parents etc

*What do you hope to achieve in the future, personally and professionally?*

I think we have all learnt a lot about ourselves these past months and about how society responds to such a massive new challenge. I think we have to review with patients how the service we offer is best reconfigured in a ‘post COVID-19’ world, and to understand how to deliver the best possible care in a changed context, especially around remote triage and consulting

1. **Personal and professional wellbeing:**

*On a scale of 1 (most negative) to 10 (most positive), how are you?*

6 to 7 now but I have felt quite low earlier in the pandemic when there was absolute social isolation (apart from solitary working at the practice and zoom meetings) which really took its toll. I found myself becoming quite emotional even filling in parts of this template…

*Consider:*

*- How has this this phase of your professional life been for you?*

*- How do you maintain your health and wellbeing, and what do you need to do differently, if anything?*

*- Have you needed any support since your last appraisal, and was the help you needed available?*

This has been a tough professional challenge as stated above and I have missed the close working that comes in a well-established team-especially being able to share worries and questions about patients with colleagues informally on a day to day basis

I have enjoyed the discipline of doing some regular exercise everyday [mostly walking and cycling] and I hope to keep this up as it wasn’t part of my regular routine before

I have missed my self-directed learning group and really want to start this again if we can work out how to do it. I know that HEE provides some free mentoring sessions and I feel I would like to take the opportunity to debrief in this way if I can.

1. **CPD, quality improvement activity, feedback from colleagues and patients**

*Include any aspects of these that you particularly wish to discuss at your appraisal.*

I have done loads of COVID-19 related learning but I have documented very little of it. The biggest challenge was determining what information was most relevant and finding a way to store it. I have also watched some podcasts and joined a couple of local GP WhatsApp groups which helped with sharing ideas and concerns. No formal QI but I would like to discuss the issue of remote video consulting which is a massive change for most of us. My MSF is still outstanding from last year

1. **Significant events or complaints since your last appraisal:**

*Please include if any. You will be able to describe and discuss them in more detail with your appraiser:*

Complaint: I have had one complaint in the last year from a patient who upset because I didn’t visit her mother during height of our COVID-19 peak. Review of the case by the practice governance lead confirmed a visit would not have added to clinical care so the risk of a visit was not justified. It was resolved by explanation to the daughter – in fact I have now had 2 consultations by video with this lady in her late 80’s!’

Significant Event: I have also had a significant event which related to a patient I triaged by phone with abdominal pain and treated observantly but I felt with good safety-netting. The patient subsequently presented to A&E and was diagnosed with volvulus, requiring surgery. I phoned to explain and apologise, also reviewed the case within the team for learning. Although there were no obvious cues that I missed in the consultation, and safety netting was appropriate [to attend A&E if no better], and ultimately no harm came to the patient, I still feel bad and wish I had been able to examine the patient as I would have done in a ‘pre-COVID-19’ face-to-face appointment. The patient was very understanding and appreciative that I called. Feeling from the team was that this illustrates the tightened margin of safety within which we are having to function in the context of the pandemic and the need to minimise face to face contact with patients.

1. **Items you have been asked to bring to your appraisal:**

*Please include if any. You will be able to describe and discuss them in more detail with your appraiser:*

None

1. **Your Personal Development Plan themes:**

*What are your goals for the coming year?*

Complete MSF for my revalidation next year, plus 2WW review and possibly becoming a trainer as above - maybe also some more work on patient experience of video consulting

**Appraisal outputs**

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| **SUMMARY**  This is my second appraisal with Dr C and it took place remotely [using Zoom] by mutual consent and took 2.5 hours (including a break). No confidential third party information was included and appropriate information governance was followed throughout. Dr C works as a salaried GP 6 sessions a week in a large urban practice. She also works one session a week for her local CCG previously setting clinical standards for secondary care referrals, but during the COVID-19 crisis she has been part of the CCG team setting up the shared response to COVID-19 for all local practices, including the establishment and staffing of a COVID-19 ‘hot hub’, and managing the clinical input to all local care homes. She has also taken on some additional sessions helping the 111 service with telephone triage of possible COVID-19 patients. She lives alone and has no health concerns that prevented her from undertaking face-to-face patient care.  Dr C is due to be revalidated in Dec 2021 [postponed from Dec 2020 by the GMC response to the COVID-19 crisis] Her October 2019 appraisal was fully revalidation ready except for her MSF, which she had just started to collect when the COVID-19 crisis developed. Completing this forms part of her new PDP and once reflected on at her next appraisal Dr C will be fully revalidation ready from an appraisal point of view. |

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| **Domain 1: Knowledge, skills and performance**  We spent some time discussing how Dr C and her practice had responded to the complex educational demands of the COVID-19 crisis and how they had divided and shared the workload of reading and processing multiple information and guidance. Her learning had come from a range of written sources, but also with a wider use of other media including podcasts, WhatsApp groups with colleagues and Zoom meetings with her self-directed learning group. Pressure of work meant that she has not recorded much of this learning in writing, but she was able to describe how a great deal of learning and timely reflection had taken place so that she stayed up to date with rapidly changing information. She cited her increasing confidence in handling enquiries from patients with possible COVID-19 symptoms as evidence of her most important learning impacting on the quality of her patient care. There was also plenty of evidence of the application of learning to practice, with examples from the practice of changes that had been made to triage and telephone access arrangements following local CCG guidance and team discussions.. Dr C also reflected on how her own telephone consulting style had changed following her training for her 111 role, and how she had further adapted these skills for video consultations, with additional learning from a webinar on COVID-19 triage skills.  Dr C also completed an online BLS in the context of COVID-19 course, and a further online safeguarding update because she was becoming anxious about media reports of increasing levels of abuse during lockdown. She described the impact of the learning in changes to her practice in checking whether someone else is in the room with a patient on the phone, or in a video consultation.  We discussed Dr C’s PDP from last year. She had completed her planned update of contraceptive skills but the other two items, applying for the intending trainers’ course and a comparative review of 2WW referrals with practice colleagues had not been started due to her changing priorities during the pandemic. Dr C has decided to postpone the intended trainers’ course application for now – she has added the 2WW review to next year’s PDP. In context, Dr C has done well to make progress with her previous PDP, and we have agreed a new PDP that arises from this discussion and her review of her needs now.  **Domain 2: Safety and quality**  Dr C described the difficulty in maintaining the normal practice routines of coffee time and corridor discussions about patients, with much less informal contact with colleagues as a result of social distancing and working across different sites and the ‘hot hub’. She felt this could have a detrimental effect on safety systems, with less opportunity to share early concerns or discuss options with colleagues. The frequency of practice and self-directed learning group meetings had also decreased over the six month period dominated by COVID-19, and all had taken place remotely, and Dr C felt strongly that this reduction in face to face peer support made her feel more isolated and less able to discuss clinical issues with colleagues at a time when such support was most needed. Her use of social media addressed this gap to some extent but did not fully mitigate the impact of social distancing on relationships within the practice. We discussed one significant event related to a patient who had a telephone consultation for abdominal pain with Dr C and who subsequently presented with a twisted volvulus needing surgery. The team reviewed the case and felt the telephone management was appropriate, and the patient had no concerns after the event. Dr C was pleased that no harm came to the patient but feels that things are currently (inevitably) less safe for patients than they were with fewer face-to-face consultations and less opportunity to discuss challenging cases face-to-face informally with colleagues in the practice. She is also concerned about the non-COVID-19 work that has not been presenting in primary care as early as it should have done.  Dr C felt that another very significant safety issue to emerge from the COVID-19 crisis was the management of patients in care homes. The need for care home patients to have a clear advance statement of their [or their legal guardian’s] wishes in the context of hospital admission and active treatment in the face of COVID-19 infection was brought home repeatedly-some care facilities were much better prepared than others. One of her responsibilities at the CCG was to support her ANP colleagues in making sure all residents had a COVID-19 specific HCP in place, and this was a very demanding and emotionally stressful task. She discussed the harrowing work of reviewing care home patients remotely by video consultation, and recognising that some were unwell with likely COVID-19, but unable [in the early days] to have their diagnosis confirmed or have their relatives visit them.  In terms of her own health, Dr C felt very lucky that she did not develop any COVID-19 symptoms, but she worried a great deal about two close family members working in the care sector with little protective equipment, both of whom contracted the virus but did not need hospital admission. She was very stressed being unable to visit her own elderly parents for several months as they live in another city, and she had to keep in touch through regular phone and Facetime calls. Increasing her regular exercise and ensuring she prioritised human connections, albeit remotely, helped and she will carry what she has learned about self-care forwards.  Overall, Dr C feels that the last 6 months have definitely been the most difficult of her career to date and she will seek some personal mentoring or counselling in the coming months to help her process the anxieties and stresses she experienced, and this forms part of her new PDP. Information was shared on how to access available local services.  **Domain 3: Communication, partnership and teamwork**  We discussed many issues around communication with colleagues and the impact the COVID-19 crisis had had on team working and colleague support. Dr C felt that at times the volume of information sent to health care teams about COVID-19 was overwhelming, and sorting out what were essential communications was often quite difficult. She felt that she had worked hard to communicate has effectively as possible with her colleagues, but the lack of face to face contact altered and reduced the supportive role of colleague working. Dr C felt there was still some important work to be done within the practice reviewing how the crisis had been managed, what had worked well and what might be done differently should a similar situation arise again.  We also talked about the impact of COVID-19 on relationships with patients and especially the impact of remote consulting. We discussed her one complaint which occurred during the peak ‘COVID-19’ period, which was related to this issue, and has been resolved. The complaint was from the daughter of an elderly patient who was concerned that her mother should have been visited at home. The case was reviewed and an explanation provided for the patient and her daughter that was accepted and Dr C has had two subsequent video consultations with the patient which have worked well. Dr C feels that although there are convenience issues on both sides related to remote consulting in terms of ease of access etc, but she feels that for many patients with several problems or complex issues, video or telephone consultations do not address their needs as fully as a face-to-face interaction. She would not welcome a wholesale shift to remote consulting as the default option, and feels that patients should be involved in any debate about how GP care is best delivered in a ‘post COVID-19’ world.  At a personal level Dr C had received some positive feedback from several patients about the speed of her response to their queries and the thoroughness of her follow up.  **Domain 4: Maintaining trust**  There was much evidence from this appraisal discussion that Dr C has high respect and regard for her patients and has held their concerns as the highest priority when reflecting on quality of care during this very difficult period. Her reflections suggest that Dr C treats her patients and colleagues with the very highest standards of honesty, integrity and respect, and without discrimination.  General Summary  Dr C presented a thoughtful account of the impact of the COVID-19 pandemic on her and her practice and we agreed an appropriately supportive PDP for the coming year. Her MSF remains a gap in her revalidation portfolio but she had already started to collect feedback pre-COVID-19 and has made plans to finish this for her final appraisal next year, before her revalidation is due in Dec 2021.  Dr C impressed me with her commitment to her patients over this difficult time and her professionalism, which justifies the trust they have placed in her.  . |

**Example 2 – Secondary care**

**Appraisal inputs**

An example of a medical appraisal 2020 template completed by a hypothetical Hospital doctor [Doctor D]

## **Personal details**

Name: Doctor D

GMC Number: 3456789

## **Scope of work**

*Describe your core roles and any significant changes since your last appraisal.*

Clinical: Consultant Rheumatologist - working in this large NHS Foundation Trust for the last 15 years. I have three outpatient clinics a week and also oversee in-patient beds and our day unit for specialized IV treatment regimes. I also (usually) work two sessions a week in a local private hospital. Clinical Director for Rheumatology for 5 years Educational: Clinical appraisal lead for the hospital. Changes: Routine work reduced in volume. Most out-patient reviews moved to remote consultations, using remote dial in facilities. With full PPE, a few acutely ill NP seen for assessment and day patient treatments offered to those who wanted/needed. For the first weeks of ‘lockdown’ I worked in A&E to manage suspected COVID-19 cases, and to provide triage and assessment pathways. As COVID-19 cases have reduced, working with the medical directorate and l PCN networks to restart some face-to-face clinic sessions and manage the backlog of routine referrals. Appraisal and appraisal lead work suspended but now working on the restart and rolling out nationally provided training materials for the Trust

## **PDP review:**

*What progress, if any, have you made with last year’s PDP? Are there goals you want to carry forward?*

My PDP was partially completed. The excellent two-day conference on rheumatoid arthritis included new medical treatments, and management of systemic complications. With our revalidation manager, I improved QA of our appraisal outputs. Other aims were superseded by COVID-19 and will need to be carried forward.

1. **Challenges, achievements and aspirations:**

*What personal and professional challenges or constraints have you faced?*

A major challenge was stopping our normal working patterns while knowing there would be new cases of inflammatory arthritis needing urgent treatment but not being seen. I found the shift back to seeing acutely ill patients in A&E exciting and challenging. I worked initially with experienced colleagues, or doctors doing A&E training, and read as much as I could on diagnosis and acute management of COVID-19 patients. I rapidly became less anxious about my rusty triage skills, but my personal anxiety as a Sudanese doctor increased as it became clear that doctors of BAME origin were making up most of the COVID-19 deaths amongst UK doctors. I also helped my wife to provide home schooling to our children

*What have been your greatest achievements?*

To have survived the last six months and to have made a positive contribution to the care of COVID-19 patients and the planning for new working practices across the Trust. To have a better relationship with my children having spent more time with them

*What do you hope to achieve in the future, personally and professionally?*

To develop the diagnosis and management of inflammatory arthritis and its complications in young adults in our Trust in the context of COVID-19.

1. **Personal and professional wellbeing:**

*On a scale of 1 (most negative) to 10 (most positive), how are you?*

At present an 8-there were times during the pandemic when fears about personal safety would have made that a 3-4

*Consider:*

*- How has the Covid-19 pandemic impacted on you?*

*- How do you maintain your health and wellbeing, and what do you need to do differently, if anything?*

*- Have you needed any support, and was the help you needed available?*

The first UK doctor to die from COVID-19 was a compatriot of mine and as health worker deaths rose it became clear that those of us from BAME backgrounds are disproportionately at risk of a poor outcome from COVID-19. It is still not clear exactly why this is, but I have been concerned about my personal risk. I have started exercising every day and have lost a few kilos and I intend to keep this up. I have been worried for my family and some of my friends and colleagues for the same reasons-fortunately none have been significantly affected by COVID-19 so far. We have formed a local WhatsApp group so we can share thoughts and encourage each other but I have not had any formal support from the Trust

1. **CPD, QIA, feedback from colleagues and patients, including compliments**

*Include any aspects of these that you particularly wish to discuss at your appraisal.*

My CPD log on the Trust appraisal portfolio includes CPD prior to March 2020 and some of the reading I have done on COVID-19, although much of this has not been recorded. I found podcasts and webinars very useful and listened to quite a lot when driving to work.

I haven’t written up any formal QIA, but I was pleased to put in place a robust QA system for our appraisers which I hope will improve standards once appraisal restarts

I was revalidated in 2018 so I haven’t collected any recent formal personal feedback .We have asked a sample of our outpatients about their experience of remote video review, and most have been quite satisfied, but I miss the face to face contact and the opportunity to examine patients

1. **Significant events or complaints since your last appraisal:**

*Please include if any. You will be able to describe and discuss them in more detail with your appraiser:*

I have not had a personal significant event in the last year but as Clinical Director I have to review all serious incidents and disseminate lessons learned to all clinical teams. The most challenging occurred at the beginning of COVID-19, when the hospital discharged one of our in-patients to her Care Home, as part of freeing up capacity, where the patient, and others, including one staff member, subsequently died of COVID\_19. A full enquiry is on-going and this was very traumatic for me and my team. My only complaint was made early in the year by a patient who had waited more than two hours for her clinic appointment to see me on a day when all the IT system was down and delays were inevitable-I wrote to apologise and no further action has occurred

1. **Items you have been asked to bring to your appraisal:**

*Please include if any. You will be able to describe and discuss them in more detail with your appraiser:*

None

1. **Your Personal Development Plan themes:**

*What are your goals for the coming year?*

To bring forward the two aims not addressed last year-namely to review management of inflammatory arthritis in young people and to audit the outcomes of our new one stop diagnostic clinic. To look at how best to deliver rheumatology care for young adults. To review our new scheme to QA the performance of our appraisers

**Appraisal outputs**

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| **SUMMARY**  This was my third appraisal with Dr D, whom I have known since he was appointed as a Consultant Rheumatologist 15 years ago and took two hours excluding writing up. No confidential third party information was included and appropriate information governance was followed throughout. Dr D works full time with 4.5 PAs set aside for his work as Clinical Director in his speciality and as appraisal lead for the Trust. He also does two clinics a week at the local private hospital and he submitted a written sign off for his work at this hospital. We carried out the appraisal face to face but socially distanced in the Trust boardroom. Dr D was revalidated in 2018. His appraisal fulfilled all the requirements of the 2020 Medical appraisal guidance. |

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| **Domain 1: Knowledge, skills and performance**  Dr D is an experienced consultant who performs a full range of NHS services in his speciality and works as a clinical director and as Trust appraisal lead. He has met the challenge of work in the COVID-19 pandemic by offering his skills alongside his colleagues in A&E and developing his knowledge through reading, podcasts etc. Little of this learning was recorded in his electronic portfolio due to pressure of workload but we discussed how he built up his confidence and applied his learning to his day to day work as the pandemic progressed. This included monitoring the range of symptoms displayed by COVID-19 patients who became unwell and identifying some poor prognostic indicators. Dr D remains concerned about the number of new rheumatology patients who could not be seen during the first three months of COVID-19 and the delay in diagnosis and initiation of their treatment. As clinical director, Dr D has been part of the Trust medical directorate seeking to re-establish some level of normal working with appropriate COVID-19 restrictions - there is a significant backlog of clinic appointments, postponed operations and overdue treatments and ongoing concern about how to deal with the surge in new referrals as patients return to see their GPs. He also wants to develop services such as the new one stop diagnostic clinic for new cases and a specialised teenage clinic for inflammatory arthritis, but these plans have had to be put on hold for now, which he finds very frustrating.  We also discussed Dr D’s QIA related to his role as clinical lead for appraisal and the considerable amount of work he had put into this prior to COVID-19 to ensure higher standards and better consistency amongst the Trust’s medical appraisers. Evaluation of outcomes will be a PDP aim for this year.  **Domain 2: Safety and quality**  Dr D works for a Trust with a strong reputation for a quick and thorough response to concerns, especially those that relate in any way to patient safety. One of his roles as clinical director is to review serious events, investigate the causes if necessary and to highlight any significant learning from any incident and share any broad principles throughout the Trust. We discussed a recent incident in which Dr D had involvement, although not in terms of personal responsibility. The patient had been coming for regular in-patient treatment for her crippling Rheumatoid arthritis. She was discharged back to her Care Home without testing as part of the move to increase capacity and was the likely cause of COVID-19 in the Care Home, dying herself, along with several other residents and one staff member. Dr D was very sad and felt this had impacted significantly on his team. The review of this event is on going although Dr D accepts that this was not an isolated problem.  We discussed Dr D’s own health and what he had donealready to mitigate any risk factors for having a poorer outcome from COVID-19. We talked at length about the personal fear of frontline working as the death toll of health care workers and then doctors increased. He had met two of the Sudanese doctors who died early in the pandemic and lived in fear that he or his close family would also become victims, although this eased somewhat once the PPE supplies felt more secure.  **Domain 3: Communication, partnership and teamwork**  We discussed how Dr D had switched from some of his rheumatology work to an acute triage role with Covid patients in A&E. He felt that he coped well with acquiring new skills and knowledge and with needing initial mentoring sometimes by junior doctors training in A&E. This was backed up by informal feedback and appreciation from A&E colleagues. We also discussed Dr D’s work within the medical directorate in reshaping service provision in the wake of the first wave of COVID-19, and the difficulties in planning with such an uncertain future.  Dr D also discussed doing some remote clinic consulting from home when his children were off school, and the difficulties of working in that environment, plus his concerns about ‘seeing’ rheumatology patients but not being able to examine them. Dr D had had one complaint about poor timekeeping in his clinic, which had been resolved with an apology and an explanation  **Domain 4: Maintaining trust**  Dr D provided plenty of evidence in our discussion that he respects patients and does all he can to work in partnership with them and to act with honesty and integrity and without discrimination. We discussed his feelings about being part of a vulnerable minority racial group in relation to COVID-19, and the personal health risks involved.  General Summary  Dr D provided thoughtful reflection on his practice and the impact of COVID-19 on himself, his colleagues and patients.  There are no gaps in his revalidation portfolio for this stage of the cycle, and the probity and health statements were signed. He is aware he will need to seek formal patient and colleague feedback before his appraisal in 2023. We agreed a PDP that addresses his need to maintain his new healthy habits of self-care and looks at the system redesign implications of COVID-19 for his patients.  Our discussion provided a picture of a very committed and hardworking doctor who put considerable personal risk aside to do everything possible to make sure patients were provided with the best possible care through a very challenging period. |