RCGP Example Portfolio: Academic GP

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Introduction

The RCGP has developed a range of example portfolios to demonstrate how GPs in a variety of professional contexts can demonstrate that they are meeting revalidation standards set by the GMC. The portfolios have been authored by RCGP Specialty Advisers, clinical experts on revalidation with specialist areas of knowledge. The documents should be treated as 'hypothetical' portfolios in that the supporting information contained, the GP and the GP's working environment are fictional.

These are not full portfolios, but instead contain samples of supporting information, with emphasis on items which are of particular relevance to the GP's role. Neither are they 'exemplar' portfolios. The Specialty Adviser, who provides commentary throughout, identifies where there is opportunity for the GP to develop their supporting information. The portfolios take a 'snapshot' of a portfolio at the end of the fourth year in a five-year cycle, enabling the Specialty Adviser to suggest any areas for the GP to concentrate on in the final year of their cycle.

Although the portfolios have been written by the RCGP Specialty Advisers, they do not represent the method by which advisers will give advice to Responsible Officers and others. Advisers will not comment on individual portfolios, and requests for advice will be made through the RCGP central helpdesk.

If there are specialty elements to the role, the RCGP would strongly advise that the GP refers to the guidance produced by the relevant College or Faculty.

General information

This area is blank unless there is information specifically relevant to the subject GP.

1. Personal details

Title: First name: Surname:

GMC Reference Number:

2. Qualifications

Primary medical degree:

Qualifications:

Specialty Adviser comments:

Background to academic careers in universities:

Substantive academic careers may start from CCT, and be described by titles such as post-Doctoral Clinical Fellow, Lecturer, Senior Lecturer, Reader, Associate Professor and Professor. For most academic appointments, the primary employer will be a university, and the GP will hold an honorary contract with a local NHS body and/or a practice for clinical sessions. It is possible, though less common, that the GP will be both a GP principal and an academic. An academic GP would usually hold an MD or PhD, often as well as a Masters degree.

The appraisal of an academic would usually show that both an academic appraiser AND a GP appraiser, plus possibly an NHS representative, had seen and commented on the appraisal material. It is important for assessing the overall responsibilities of the doctor that the employment status and overall sessional commitments of both posts are clearly stated. Most academics are now required to have joint appraisals, or at least to exchange documentation and agree common sign-off: this is because of the need to ensure that the overall portfolio is manageable, and to look at any development goals or professional needs that may have implications for both sides of the portfolio.

3. Scope of your work

This area is blank unless there is information specifically relevant to the subject GP.

Please list the organisations and locations where you have undertaken work as a doctor.

Organisation	*Location*
University	
Practice	
NHS local employers	(Honorary Contracts)
	*might include other roles e.g. appraiser, consultancy

Please provide a comprehensive description of the scope and nature of your practice.

Dr X is a lecturer in general practice at the local medical school. S/he has completed the RCGP Revalidation ePortfolio, and has been on the local Performers' List and practised locally for five years with annual appraisals. S/he notes that they have submitted the RST form, also a full current CV, and a downloaded zip file of the RCGP Revalidation ePortfolio as evidence. The scope of work sheet shows:

Area of work Details Qualifications Duration

Clinical – regular (two half days a week).
Two sessions a week at xxx – routine surgeries and visits.
Clinical – ad hoc. None – no out of hours.

Educational (four half days a week)
Lead for Masters in Health Science.
Five lectures per year to MB BS.
S/he is a PBL group tutor, has five medical students for pastoral care, and participates in ~ 20 hours of clinical exams a year for the MB BS.

Managerial (one half day a week)
S/he is the Deputy Student Advisor for the Medical School.
S/he leads for the Department of Primary Care for liaison with the regional NIHR Primary Care Network.

Other roles (four half days a week)
Research portfolio – currently three funded grants, of which s/he is principal / lead applicant for one.
Writing and speaking re research is part of this commitment.
S/he has published four peer reviewed papers in the last year.

Specialty Adviser comments:

The usual job plan for clinical academics is 11 sessions, with 2 or 3 in clinical work, and the rest divided across teaching, administration and research.

More senior staff may have less frontline teaching and more admin/national roles. Academic portfolios are very diverse, and it should not be the role of the RCGP to give guidance on the appropriateness of any particular commitment – this rests with the primary employer. Academics are generally judged by their outputs, and the academic part of their portfolio may therefore include:

1. Research – grant funding, publications, conference contributions, and lead roles.
2. Teaching – undergraduate and postgraduate student input, examiner roles, institutional roles (e.g. module leads, course provider, authorship of educational resources).
3. Enterprise and engagement – roles where there are academic partnerships and outreach work, stand-alone commercial enterprises or cost centres, regional contributions such as membership of LETBs.
4. National and international esteem – Clinical Excellence Awards, work for the National Institute for Health Research, NICE, journals, or the RCGP.

All these should be visible in any description of the academic's role or job plan: many academics will model this on the 11-session NHS consultant contract, showing roles with direct and indirect commitment to the NHS as well as 'pure' academic functions.

External consultancies or secondments may also be listed – need to be clear who the employer is and whether the academic employer or another body scrutinises these – for example if the GP was also an appraiser.

4. Record of annual appraisals

This area is blank unless there is information specifically relevant to the subject GP.

Appraisal Year	*Appraisal status*
2012 - 2013	Submitted
--select--	Submitted

5. Probity declaration

This area is blank unless there is information specifically relevant to the subject GP.

I have met the probity requirements as defined by either the GMC or the Academy of Medical Royal Colleges.		Date
I have met the health requirements as defined by either the GMC or the Academy of Medical Royal Colleges.		Date
I have met the insurance requirements as defined by either the GMC or the Academy of Medical Royal Colleges.		Date

Pre-appraisal documentation

One example of a pre-appraisal document is provided.

In preparation for your appraisal you should consider how you are meeting the requirements of the domains of Good Medical Practice. *This reflection will help you and your appraiser to prepare for your appraisal and will help your appraiser summarise the appraisal discussion. Sections 1–4 and the declaration at the bottom are mandatory and sections 5–8 can be optional.*

General background/context

[For the clinical it should be as any other GP or portfolio. For an academic it will be under the scrutiny of the university.]

The doctor should set out details appropriate to their roles here – too diverse to take one example.

For any and all aspects of the academic portfolio, the types of evidence listed for appraisal should be available. This would usually include:

- *a current CV with an emphasis on recent achievements (papers, grants, etc.) and a clear summary of the roles they play*
- *feedback from colleagues: the usual MSFs should be useable for colleagues, although the clinical sections may be incomplete; peer review of teaching many also be available*
- *feedback from students: for undergraduates this may be collated by institutional methods; for postgraduates, it is usually by supervision records, and by deliverables such as achievement of Masters and PhDs*
- *quality assurance – course evaluation and development materials should be available.*

Aspirations/achievements/challenges

Will be career- and portfolio specific but should show evidence of GP as well as academic priorities.

Specific areas for discussion with your appraiser

Key issue for academics is 'How do you fit it all in?' To fulfil the criteria for clinical revalidation, be an active researcher, a member of a research group, a teacher who delivers frontline teaching and contributes to routine university educational development processes, who will have some specific students for whom they have pastoral and/or academic responsibilities, may have some specific institutional lead responsibilities, and who has to do CPD and collegial networking to perform their job, is a tall order even for very intelligent and well organised people. The GP appraisers should have been able to contribute by ensuring the usual questions about workload, time management, health and support are probed in detail, as well as checking any concerns about probity which can surface in academic as well as clinical work.

Have you been requested to bring specific information to your appraisal by your organisation or RO?

No.

Knowledge, skills and performance

I have special research areas (e.g. mental health, patient empowerment, quality indicators, team climate …) and have in-depth knowledge in these including methodological approaches relevant to my discipline and research needs.

As a teacher doing regular group work for problem-based learning, and as a clinical examiner in OSCEs, I get useful reminders from the students and their assessments about clinical areas, though this depends on what I am teaching. As a clinician, I routinely try to keep up to date using reading and specific training modalities, but also do a lot of 'PUNS and DENs' – each clinic must generate at least two! All documentation has been submitted in my appraisal via the RCGP Revalidation ePortfolio and the RST (www.revalidationsupport.nhs.uk/CubeCore/.uploads/documents/pdf/MAGmodelappraisalformv3.pdf).

Safety and quality

My work with peers as a researcher, teacher and academic is more closely scrutinised than GP as it all works in the public domain, and grants/data/ethics all have institutional systems. (Note: this would not apply if the doctor was doing research for a company or 'own account' research.)

Communication, partnership and teamwork

Individual specific but may relate to both practice and academic team settings.

Maintaining trust

Specialty Adviser comments:

Again note overall balance of roles.

It is always hard for part-time doctors to demonstrate the quality of their clinical work and they need to work with GP appraiser to find ways of doing relevant audits, together with patient and colleague feedback on clinical as well as academic work.

There can be no compromises even though this doctor does only ~ 80 clinical sessions a year.

The usual roles about adequacy of information and apparent insight/self challenge apply.

Keeping up to date

Continuing Professional Development (CPD)

Some key points about the RCGP credit-based system for CPD:

- The expectation is that GPs will collect at least 50 credits per year covering the full scope of their practice.
- Credits are self assessed and verified at appraisal.
- At its simplest, each recorded hour spent on a CPD activity, which can include planning, accompanied by a reflective record will count as a credit.
- A GP can double their points if they can demonstrate impact, i.e. that learning has resulted in positive change for patients, the service or others e.g. NHS locally or nationally.
- The RCGP Impact Toolkit describes the ways in which impact can be evidenced.
- The RCGP Revalidation ePortfolio contains a field in which GPs are required to record a comment if they have claimed impact credits. If no impact comments have been claimed in the examples below, this field will be marked N/A.
- A common query around conferences is whether these should be recorded as a single learning episode. We would suggest that GPs record the parts of the conference that they consider useful learning separately with the appropriate time factor, reflections and evidence. This will enable them to allocate impact credits to the relevant CPD entries.

Four or five examples of key learning activities are provided in each year (Years 1 to 4).

The likely headings included in one complete cycle of appraisal are shown below. Some brief examples of CPD activities are included, but obviously the complete learning log would be much more extensive. The other sections would be as for any GP.

Reading (journals/books)

Date(s): 01/12/2011 to 23/03/2012
Usual quarterly reading update: new journals, books, reading BMJ, BJGP, MPS, DTB, local prescribing bulleting and online reading for PUNs and DENs. Articles retained include: functional assessment in older people (BMJ series), ADHD assessment (NICE guidelines), clinical prediction rules, NICE guideline on stable angina, home oxygen, sarcoma diagnosis/prognosis.
Credits claimed: 6 **Time**: 6 hour(s) **Impact**: 0
Impact comments: have used questionnaires more for assessment in older people (function) and kids (diagnosis of ADHD).

Date(s): 01/06/2012 to 01/09/2012
Quarterly summary: key articles retained on errors in prescriptions (Avery), pregnancy and contact with children with rashes (BMJ), autistic spectrum disorders, restless legs, sleep disorders, overactive bladder syndrome, proteinuria, and a host of others on policy and educational issues.
Credits claimed: 10 **Time**: 10 hour(s) **Impact**: 0
Impact comments: Standard refreshers really but useful.

Date(s): 19/10/2012 to 1/12/2012
Quarterly catch up on journals (9–5pm) – BMJ, BJGP, MPS ARC, BHF. Also research papers from the RCGP Research Papers of the Year Awards. Those retained have specific next steps to update practice – please see attachment for full details.
Credits claimed: 16 **Time**: 8 hour(s) **Impact**: 2

Clinical learning

E-learning:
RCGP Kidney Health in General Practice: Session: The Role of General Practice in Managing Kidney Health.
MHRA – learning module on SSRIs.
Monthly clinical meetings in practice – team based, notes provided.
Quarterly 1:1 practice mentoring meetings – notes provided in log.
PUNs and DENS, SEAs, case reviews – details given in log.
Safeguarding – three items included: e-learning and background reading, attendance at a practice meeting, attendance at a local Grand Round (all with supporting documentation and comments on impact).

Research-related learning

(This would be in depth, relating to new projects, but might impact on clinical learning.) Papers and presentations are included. My uploaded CV shows evidence for this.

Development of new roles

These may be clinical or academic, evidence should be provided.

Personal development plans

An example of a PDP objective is provided.

Current PDP objective	*Learning / development need*	*Anticipated outcome*	*Achievement method*	*Anticipated achievement date*	*Achievement evidence*
Keep up to date clinically	To continue to be safe to practice	Continue submitting evidence in RCGP Revalidation ePortfolio	SEAs, CPD and impacts, peer review etc	01/01/2002	see RCGP and RST

Specialty Adviser comments:

These will be highly context specific – a professor chairing the Medical Schools Council will have different challenges from an early years lecturer.

Again the key issue is whether they have enough evidence of support for clinical activity and whether their other commitments have full professional scrutiny.

Review of practice

Significant Event Audits

These would be as for any other GP.

Clinical audit (or equivalent quality improvement activity)

Projects from academic sources, e.g. quality improvement of a teaching course, may be impressive and interesting, but the GP should focus on the clinical side of their role – so again the submissions here would not be different from other part time clinicians.

Feedback on practice

Colleague feedback

Acceptable evidence for revalidation would have been agreed (or not) by academic and GP appraisers. The issue of patient safety should be considered primary.

Patient feedback

One example of patient feedback is provided. Fields are blank unless there is information specifically relevant to the subject GP.

Patient feedback (PSQ) 1

Start date: 01/02/12 **End date:** 01/03/12

Brief description of the activity

Undertook patient survey in the practice I work in – covering 50 questionnaires.

I had to upload these myself as was not included in the local survey.

Time: 4 hours **Impact:** No **Credit claimed:** 4

Impact comment

N/A.

Learning need addressed

Need to know whether I am meeting patient's expectations.

Method used

Outcome of activity

Satisfactory – no major complaints except about my availability!

Outline any further learning or development needs highlighted by the activity

I have discussed more effective forward booking and need to clarify why availability is limited with others in the practice to get clear messages to patients.

Additional details to be entered for each patient feedback entry

Patient feedback ref

What were the key points arising from the patient survey?

Supportive, good listener, knowledgeable and competent. One patient out of 40 replies said that I did not listen to her adequately and that she was dissatisfied with the consultation.

With whom and when did you discuss the patient survey results?

Practice manager, senior partner, locum group.

What was the focus of the discussion?

What changed as a result of this feedback? Were there any outcomes/actions?

I will actively listen to patients and try to check that everything is satisfactory before they leave the consultation room.

Record your personal key learning points

Confidence that I am doing ok. Attention brought to seek out the patient's agenda.

How has this affected patient care in practice

I think that I am trying to establish their agenda more.

Record your next steps in this area

Will continue to seek informal feedback from clinical colleagues and staff.

Specialty Adviser comments:

This demonstrates appropriate reflective behaviour.