The Royal College of Ophthalmologists
17 Cornwall Terrace, London. NW1 4QW.
Telephone: 020-7935 0702
Facsimile: 020-7935 9838

Website: WWW.RCOPHTH.AC.UK

PATRON HRH THE DUKE OF YORK, KG, KCVO, ADC

The Royal College of Ophthalmologists "Orphan Groups" Revalidation Pilot Project 2010

Project Report

Richard Smith
Beth Barnes
Bill Aylward

Executive Summary

1) **Description of project**
   Forty two ophthalmologists working outside the hospital eye service in a variety of settings underwent appraisal between September and December 2010 using a modified version of the "Strengthened Medical Appraisal" format currently being evaluated in revalidation pathfinder pilot projects in England. The format incorporated existing draft specialty standards for the revalidation of ophthalmologists. A single appraiser conducted all appraisals and the appraisal summaries were reviewed by a former NHS Medical Director who acted as a Responsible Officer for the purpose of the project. The appraiser and appraisees completed evaluation forms (as used in the national Pathfinder Pilots) following appraisal.

2) **Principal findings**
   a) Providing that requirements for supporting information remain sufficiently flexible to reflect the diversity of medical practice, it is not likely to be unduly difficult for doctors working in unusual or "portfolio" careers to achieve revalidation.
   b) Many doctors working outside the NHS hospital environment or general practice have no previous experience of appraisal and limited IT skills and may need significant help in preparing for appraisal and revalidation, particularly in the first year that revalidation "goes live".
   c) Explicit mapping of supporting information to the attributes of Good Medical Practice is achievable, but does not appear to add any value to the process of appraisal
   d) Only 4 of 42 volunteers currently have access to appraisal in their workplace setting.
   e) A general requirement for doctors to undertake the equivalent of 50 hours of CPD per year appears to be reasonable and achievable
   f) Routine incorporation of structured patient feedback and review of complaints and critical incidents into appraisal requires the active involvement of healthcare organizations which employ or contract with doctors. This does not currently happen consistently, although there were some notable instances of exemplary practice (a refractive surgery provider and a primary care trust).
   g) With some safeguards to verify authenticity of documentation, supporting information relating to practice abroad can be suitable for appraisal for revalidation.
   h) There appears to be a perception amongst doctors on the UK Medical Register who are currently working abroad that their prospects for future employment in the UK may be compromised if they cannot maintain a Licence to Practise.
   i) Of 42 appraisals, 3 raised concerns for the appraiser resulting in specific recommendations in the Personal Development Plan, though none of these were sufficiently serious to warrant restriction of practice.
   j) The Responsible Officer made positive recommendations following evaluation of 37 (88%) appraisals. Four recommendations (10%) were deferred because of insufficient information and one appraisee (2%) could not be recommended for revalidation because of extremely limited and occasional clinical practice.
   k) Median time expenditure per appraisal on the appraisal process was 10 hours for appraisees, and 5 hours for the appraiser.

3) **Principal Recommendations**
   a) Requirements for supporting information should pay due regard to the diversity of medical practice and should not be more prescriptive in terms of content and quantity than can be justified by evidence of its importance and relevance to a particular field of medical practice.
   b) Training of appraisers should cover the appraisal of doctors with unusual careers and should recognize that a significant number of doctors still have no previous experience of appraisal
   c) The requirement for explicit mapping of items of supporting information to attributes of Good Medical Practice appears to be unnecessary and should be removed
   d) Although it may be reasonable to expect a basic level of IT literacy from doctors preparing for revalidation, there should always be an option to complete appraisal documentation “off-line”.
   e) Further work needs to be undertaken to ascertain the resources required to provide appraisals for doctors not employed by NHS trusts or working in general practice
   f) Requirements for CPD should accommodate the educational needs of doctors in unusual careers and should recognize the needs of doctors on limited incomes
   g) Healthcare organizations should have a responsibility to maintain suitable questionnaires for structured patient feedback, and should provide doctors with structured information about complaints, clinical incidents etc which involve them (or provide a statement confirming their absence).
   h) Supporting information derived from practice abroad should be admissible for the purpose of revalidation where relevant.
   i) Doctors currently on the UK Medical Register who work abroad but are likely to return to the UK need more detailed guidance on the process of retaining or reapplying for a Licence to Practise.

INDEX

PART A: METHODS, RESULTS AND CONCLUSIONS

1 Background to project

The medical scandals and mishaps which fuelled public demand for a regulatory process to ensure that doctors remain fit to practise throughout their careers have been extensively documented elsewhere. A report by the Chief Medical Officer for England, Sir Liam Donaldson in 2006 (*Good Doctors, Safer Patients)* and the government white paper (*Trust, Assurance and Safety, 2007)* which followed it envisaged twin-track processes referred to as relicensure and recertification to ensure that doctors continued to practise at a level consistent with remaining on the medical register and the specialist or GP register respectively. The General Medical Council (GMC) was charged with the responsibility of setting the standards for relicensure and the Medical Royal Colleges and specialist societies were asked to set specialty standards for recertification.

For a number of practical reasons, it became necessary to merge the elements of relicensure and recertification into a single process which is referred to as revalidation. The GMC is the competent body in law to make the final decision to renew a doctor's licence to practise (LTP) or not. This decision will be informed by a recommendation from a senior doctor known as a Responsible Officer (RO) with which the doctor has a prescribed relationship (defined in legislation), which in turn is based on a review of annual appraisals of the doctor's practice over a five year cycle. Doctors will be revalidated on the basis of their actual scope of practice.

"Strengthened Medical Appraisal" contains both formative and summative elements and requires the doctor to produce positive supporting information to demonstrate that his / her practice conforms to twelve attributes of *Good Medical Practice* as defined by the GMC in its *Framework for Appraisal and Assessment*. The outcome of each appraisal is a personal development plan which is reviewed at the following appraisal and may be reviewed at any stage in the revalidation cycle by the RO.

The Medical Royal Colleges, faculties and specialist societies, via the Academy of Medical Royal Colleges (AoMRC) submitted plans for specialty standards for revalidation to the GMC in Autumn 2009. These set out the types of supporting information which should be presented at appraisal for each specialty.

The process of strengthened medical appraisal is currently being put to the test in a number of pathfinder pilot projects in the UK and revalidation is expected to begin in 2012, by which time the pilot projects will have concluded and reported.

The GMC has also required the AoMRC and its constituent colleges and faculties to ensure that, in setting specialist standards for revalidation, doctors who practise outside the "mainstream" of each specialty are not unfairly disadvantaged. The AoMRC has therefore commissioned a number of pilot projects to test strengthened medical appraisal with "orphan groups" of doctors, of which this project is one.

2 The Royal College of Ophthalmologists' approach to specialty requirements for supporting information

Ophthalmology is a diverse specialty with varying degrees of sub-specialisation. Some ophthalmologists have a substantial surgical component to their work whilst others perform no surgery. When considering the specialty detail which might be inserted into the GMC's general template for revalidation, the College applied the following principles:

1. Supporting information for appraisal should accurately reflect the scope and breadth of the ophthalmologist's practice, though it is only appropriate to require specific items of supporting information where there is currently evidence of their validity and importance to clinical care. In a number of areas of ophthalmological practice, measures of process or outcome are already in common use and are validated by large-scale audit or widespread professional consensus. Where such measures exist, supporting information for ophthalmologists who practise in these areas should reference them.

2. Supporting information should, as far as possible be derived from information which is already being collected as part of routine practice. In some fields of ophthalmological practice, supporting information will primarily reflect the quality of a service as a whole rather than directly measuring the performance of the individuals who contribute to that service. Providing that such data is capable of estimating the consistency of quality or outcomes within the service, it is still a legitimate source of supporting information for revalidation of an individual doctor.

3. Specialist standards should pay due regard to the inevitability that medical care in the UK is moving towards universal adoption of electronic medical records (EMR) systems and should create a stimulus for the rate of adoption of EMR to accelerate. However, specialist standards should be framed in a way that doctors whose healthcare organizations have not yet implemented EMR systems can collate supporting information manually and are not personally disadvantaged in so doing.

4. Specialist standards should pay due regard to areas of known risk. These include areas of practice which have previously resulted in the College being asked for professional standards advice by healthcare organisations (eg cataract surgery), areas of practice which have previously been a source of public concern (eg laser refractive surgery), areas of innovative or emerging practice where protocols are still in development and areas of occasional or low-volume practice.

5. Specialty detail should only be added to the generic core standards for supporting information for revalidation where it clearly "adds value". The College did not consider it necessary therefore to recommend specialty specific questions in patient or peer feedback instruments, for example.

It will in any case be necessary to review specialist standards periodically as practice within the specialty evolves, and the College will aim to make standards as objective as possible in the light of evidence emerging from research, clinical audit and the increasingly widespread use of EMR.

3 Characteristics of "Orphan Groups"

The AoMRC has identified approximately 30 groups of doctors who for various reasons work outside the "mainstream" of clinical practice. Some groupings are in the process of evolving into specialties and already have societies or networks for sharing good practice, whilst others have natural or historical links to existing specialties but tend to be physically or professionally isolated by virtue of their degree of specialisation, working environment or terms and conditions of service. Doctors in orphan groups may or may not be members of colleges or specialist societies and this makes it difficult to estimate the numbers of doctors in these groups.

There are three potential problems in planning for revalidation of doctors in these groups:

1. Many will not have an immediately apparent link to a Responsible Officer through employment or contractor status.
2. It may be difficult for doctors to find a peer to conduct their appraisal
3. The setting of specialist standards could create an unintended barrier to their successful revalidation either by making it difficult for doctors to assemble supporting information or by making it difficult for appraisers to assess supporting information against specialty standards.

Within ophthalmology, the following orphan groups were identified, and potential areas of difficulty with revalidation were considered:

Group	Characteristics
Ophthalmic Medical Practitioners	Doctors who do OMP work exclusively usually have little day to day contact with other ophthalmologists. They are usually self employed and have no access to paid study leave. Scope for systematic audit is often limited.
Ophthalmologists working for organizations which provide refractive surgery service	Usually self-employed. Some organizations have well-developed governance structures and may provide training, though not all do so. Day to day contact with other ophthalmologists may be limited. Opportunities to maintain general ophthalmological skills may be limited
Ophthalmologists who continue in private practice after retirement from the NHS	May have practising privileges at independent hospitals and retain links with NHS colleagues. De-skilling may be a potential issue for ophthalmologists who continue intraocular surgery as surgical volume diminishes.
Ophthalmologists who undertake clinical work entirely in the independent sector (not covered in other categories)	This is a diverse group. Some will have had a full specialist training in the UK and have previously been appointed to a NHS consultant post. They are likely to be recognized by private medical insurers and work in independent hospitals. Others may never have held a NHS consultant post and may not be recognized by private medical

	insurers or have practising privileges in independent hospitals. The latter group may not currently have regular appraisal and may practise in relative isolation. The scope of practice of ophthalmologists in this group is varied and may include surgical procedures, some of which may not normally be available on the NHS (eg cosmetic procedures).
Ophthalmologists whose practice consists mainly of the provision of medico-legal reports	Ophthalmologists in this group may not have any direct clinical responsibility for patients, although they will usually conduct examinations prior to producing reports. They may have limited professional links with other ophthalmologists and may not have easy access to appraisal.
Locums	Some ophthalmologists who work mainly in a locum capacity are resident in the UK and may have previously undertaken training posts in the UK. Other ophthalmologists may be based mainly abroad but undertake periodic locums in the UK, usually for short periods. Ophthalmologists who undertake locums in the same organization continuously for significant periods will probably be able to arrange appraisal within that organization, but ophthalmologists who undertake short term locums are likely to find it difficult to arrange appraisal and to participate in clinical audit. Ophthalmologists who have a substantive appointment or private practice abroad but undertake locums in the UK, however, may be able to supply useful supporting information for appraisal from their work abroad.
Ophthalmologists who undertake work abroad in a humanitarian capacity	Ophthalmologists in this group are often working in developing countries in challenging circumstances and in relative isolation. Regular access to educational events may be difficult to organize and access to the internet may be intermittent and expensive. Appraisal may only be possible by telephone and supporting information for appraisal may need to take account of local culture (eg structured patient feedback). Opportunities to follow patients up after surgery may be very limited.
Ophthalmologists in independent sector organizations undertaking NHS work	Ophthalmologists in this group usually undertake primary care ophthalmology in settings such as community hospitals,

	clinics and GP surgeries. They are sometimes involved in the triage of referrals from optometrists or GPs to the hospital eye service. They often work in relative isolation. They may be employed or self employed. They may or may not have access to paid study leave. It may be difficult to arrange appraisal.
Ophthalmologists in full time non-clinical research	Most ophthalmologists in this category are likely to be in training, working towards a higher degree. As such, they will be accountable to the governance structure of the institution under which their research is taking place. However, if they do not have a training number in a deanery, they may experience difficulty in assembling supporting information and arranging appraisal for revalidation.
Ophthalmologists working in senior NHS management posts or non-clinical positions in industry or regulatory bodies	Ophthalmologists in these positions may hold very senior positions with indirect responsibility for the welfare of patients via other doctors for whom they have oversight. They may need to maintain a licence to practise either because they undertake limited amounts of clinical work, or to maintain professional credibility. They are likely to be part of a governance structure and to have regular appraisal, though their appraiser will probably not be another ophthalmologist. It may be difficult to maintain clinical skills and undertake clinical CPD because of competing work pressures. Opportunities for clinical audit may be limited, though it should not generally be difficult to assemble supporting information covering general professional attributes.
Ophthalmologists not currently working, but planning to return to clinical work (maternity leave and other planned career breaks, illness, suspension etc)	Depending on the length of time out of clinical practice, clinical skills may suffer attrition (skills in intraocular surgery seem to be particularly vulnerable). Usually no opportunity to participate in clinical audit. Reduced financial circumstances may limit access to CPD – particularly conferences.

The project did not recruit general practitioners with a specialist interest in ophthalmology because it is expected that they will seek revalidation using specialist standards set out by the Royal College of General Practitioners (RCGP), although their numbers are small and they may have difficulty maintaining regular contact with other ophthalmologists. It will be necessary to reach agreement on how the ophthalmology element of their work should be appraised.

4 Aims of project

1. To recruit a representative sample of ophthalmologists who wish to maintain a licence to practise whose practice falls within an “orphan group” as defined in the previous section.

2. To provide strengthened medical appraisal for doctors volunteering to take part in the project, based on the GMC Framework for Appraisal and Assessment, but also incorporating the specialist standards for ophthalmology.

3. To identify any areas where the GMC Framework or the specialist standards for ophthalmology might need to be adapted to accommodate the scope of practice of doctors in “orphan groups”.

4. To provide an estimate of any resources that the RCOphth may need to put in place to assist doctors in these groups with strengthened medical appraisal. This might include the provision of appraisal, training of appraisers and training of appraisees in the preparation of supporting information for appraisal.

5. To provide feedback to the AoMRC, the NHS Revalidation Support Team and the GMC on the operation of the appraisal process.

5 Governance and accountability

The project was funded by the Academy of Medical Royal Colleges and as a requirement of the grant, detailed quarterly updates on progress have been provided to the Academy’s Revalidation Project Governance Committee since the start of the project.

The projected was hosted by the Royal College of Ophthalmologists and regular updates on progress have been provided to the Council of the RCOphth via the Professional Standards Committee.

6 Project Design and Milestones

One of the requirements of the AoMRC was that the project design should mirror that of the national pathfinder revalidation pilot projects as far as possible. The pathfinder pilot projects have been taking place in England in a variety of NHS organizations between April 2010 and March 2011 under the supervision of the NHS Revalidation Support Team, with input from one or more Medical Royal Colleges.

The pathfinder pilots generally require participating doctors to use a secure web-based program (the Revalidation Pilot Toolkit - RPT) to upload supporting information for appraisal. The doctor’s appraiser reviews the supporting information prior to appraisal and makes a judgement about its completeness and quality. The purpose of the appraisal discussion is therefore to clarify points raised by the supporting information, to provide a basis for the formative element of appraisal, and to agree a personal development plan (PDP). Following the appraisal discussion, the appraiser and appraisee agree a written summary of the appraisal and PDP which will in due course be considered by the Responsible Officer (RO) in making a recommendation regarding revalidation. It is also possible for the RO to view the appraisee’s supporting information following a completed appraisal.

A structured evaluation of the pathfinder pilot projects is being undertaken by Frontline, with input from appraisees, appraisers, ROs and participating NHS organizations.

Although this project broadly followed the design of the pathfinder pilot projects, it proved necessary to make the following variations:

1. The NHS Revalidation Support Team was unable to provide access to the RPT for this project. The content of the RPT was therefore recreated as a series of Microsoft Word forms which could be either be printed and completed by hand, or completed off-line on a personal computer and saved as a Word file. A few minor modifications were made to the order of the sections of the appraisal template and a few modifications were made to the questions asked of appraisees where, in the pilot lead's judgement, the wording was ambiguous or obscure. The RCOphth specialty standards were inserted into the template, as all participating doctors were ophthalmologists.

2. As the project was small in scale compared to the national pathfinder pilots, it was decided that a single experienced appraiser (RS) would conduct all appraisals, rather than training a faculty of appraisers, in order to ensure a consistent approach to appraisal and to minimize the risk of slippage of the schedule of the project.

3. As most participating doctors did not have an immediately obvious link to a RO, a senior doctor (Bill Aylward) who had previous experience as a medical director of Moorfields Eye Hospital was recruited to the project as the pilot RO.

4. As Frontline was not funded to include pilot projects other than the national pathfinder pilots in the scope of its evaluation, the RCOphth provided administrative support for an evaluation of this project using the same forms that have been used in the national pathfinder projects.

Following confirmation of funding for the project in March 2010, a schedule for the project was agreed:

Recruitment of appraisees	April – July 2010
Pre-appraisal preparation	June – August 2010
Appraisals scheduled and appraisal summaries agreed	September – December 2010
Responsible Officer evaluations	November-December 2010
Project evaluation and preparation of written summary	December 2010

7 Recruitment

The project was advertised via a letter of invitation in an email-shot of members and affiliate members on the RCOphth membership database. An article was posted on the RCOphth website and a notice was placed in *College News*, a quarterly bulletin distributed by post to all College members, affiliate members and senior members. The RCOphth Annual Congress in May 2010 provided an opportunity for members of the Professional Standards Committee to discuss the project informally with delegates. The Congress programme included an academic session on the subject of revalidation. Informal feedback from volunteers suggested that in addition to these methods of communication, information passed on by word of mouth had also resulted in recruitment.

A locum agency, Medacs Healthcare also kindly agreed to publicize the pilot project to the ophthalmologists on its register. Initially, recruitment was due to close at the end of May 2010, but a steady trickle of further expressions of interest resulted in the deadline being extended until mid-August 2010.

The aims of the project outlined above were explained and it was made clear that volunteers would be offered a free appraisal by an experienced appraiser (RS) and that there would also be an opportunity for the appraisal to be reviewed by an individual acting as a Responsible Officer for the duration of the project.

Potential recruits were deemed to be eligible if:

- they had trained as an ophthalmologist in the UK or abroad
- they had been issued with a Licence to Practise by the GMC
- they worked outside the NHS Hospital Eye Service in one of the groups mentioned above or in similar circumstances where they did not currently have access to NHS annual peer appraisal.

The eligibility criteria were sometimes stretched a little for potential recruits who were borderline.

8 Pre-appraisal planning

Following the initial expression of interest, volunteers were asked to complete a short questionnaire giving the following details:

- Name
- Address for correspondence
- Email address
- Telephone number
- GMC number
- Whether Licence to Practise issued
- Current scope of practice
- Preferred venue for appraisal (with the option of a telephone / Skype appraisal for volunteers who were abroad).

Following receipt of these details, volunteers were sent the appraisal documentation with a covering document explaining how to prepare for appraisal (Appendix 1). The Professional Standards Department then contacted volunteers individually by phone or email to schedule appraisals.

Approximately 50 initial expressions of interest were received, of which 42 resulted in completed appraisals. Of the doctors who withdrew, most did not respond to further attempts to contact them. Three gave formal notice of withdrawal (one decided to retire, one felt on reflection that the work of preparing for appraisal would be too much and the third did not give a reason). One volunteer scheduled his appraisal on the last available day, then was unable to take part because of clinical commitments.

Volunteers were asked to give written consent for their appraisal summary and supporting documentation to be reviewed by the pilot RO. None declined to do so.

9 Appraisal process and documentation

The volunteers were provided with the appraisal template shown in Appendix 2. The template was provided as a series of Microsoft Word forms rather than as a single document. This allowed them to select or print only the forms that were relevant to their scope of practice. Volunteers were recommended to open, complete and save the forms in Microsoft Word, then email the forms with any supporting documentation as file attachments to Beth Barnes, ensuring that no patient-identifiable data was included. They were asked to send completed forms and any supporting documentation at least a week before the appraisal date.

The volunteers' familiarity with information technology (IT) was variable. However, even those who admitted an aversion to IT were able to compose a basic email, receive an email and print an attached file (or were able to find someone who could do this for them).

In the event, most volunteers completed the appraisal template electronically and sent it by email, though several completed it electronically then printed it and sent it by post. Two printed the blank forms, completed them by hand, then sent them by post.

A strict interpretation of the rules for strengthened medical appraisal set out in the Revalidation Pilot Toolkit requires that the appraisal does not go ahead unless the appraiser has received the completed appraisal template and supporting information in advance of the appraisal.

However, the decision to use a single appraiser meant that the time window during which appraisals could be scheduled was fixed and the number of appraisals which could be scheduled in each week was limited, so a pragmatic decision was made that appraisals would go ahead at the agreed time whatever the state of readiness of the supporting information. An appraisal conducted "on the hoof" is far from ideal, but it is better than no appraisal. It would not have been possible to complete a meaningful appraisal by telephone without appraisal documentation having been sent in advance, but in the event, all doctors whose appraisals had to be conducted by telephone sent their appraisal documentation by email in good time.

Predictably, the degree of preparedness varied considerably. One individual sent a completed appraisal template and copious quantities of supporting information, meticulously filed and indexed, two months in advance of the appraisal. At the opposite end of the spectrum, a small number of doctors provided no supporting information in advance of the appraisal, had not completed the appraisal template and brought a sparse quantity of supporting information which appeared to have been gathered in some haste.

Very few of the volunteers were able to provide all of their supporting information in electronic form, even those who had taken part in appraisal regularly for several years. Most of those who provided supporting information electronically also brought additional supporting information in paper form to the appraisal. There were two main reasons for this: firstly, it was time-consuming and impractical to scan large quantities of paper records; secondly, many doctors lacked the facilities or the knowledge to convert native electronic file formats into portable document files or JPEG files.

In advance of the appraisal, the appraiser viewed the completed appraisal template and supporting information (where available) and made notes of specific areas for discussion. This documentation was available in printed form (if it had been sent by post) or on a laptop screen (if it had been sent electronically) during the appraisal.

The appraiser started each appraisal with a brief explanation of the purpose and process of appraisal and revalidation, followed by a review of the aims of the pilot project. The appraisee was encouraged to ask questions and to raise any issues which were of particular concern to them. The appraiser then clarified details of the appraisee's previous professional experience and current scope of practice before moving on to a review of supporting information and discussion of a personal development plan.

The appraiser took contemporaneous notes of the appraisal by hand, then wrote a formal summary as a Microsoft Word file within a few days of the appraisal taking place. The file was sent to the appraisee in draft with a request that the appraisee should notify any errors of fact or significant omissions. At this stage, the appraisee was also provided with a copy of the post-appraisal evaluation form MR6 used in the national pathfinder pilots and asked to complete this and return it to Beth Barnes. Once any corrections had been agreed, a copy of the final version of the appraisal summary was sent as a portable document file with the appraiser's electronic signature appended. A copy of the final version of the appraisal summary was also made available to the pilot RO (written consent having been obtained from the appraisee).

Within a week of each appraisal taking place, the appraiser also completed an evaluation form MR7.

10 Evaluation by Pilot Responsible Officer

Following completion of the appraisals, appraisal summaries were forwarded to the Pilot Responsible Officer who could either made a recommendation on the basis of the appraisal summary alone or request the supporting information which was provided at appraisal. In a small number of cases, the Pilot Responsible Officer contacted the appraiser to ask for clarification on matters of fact from the appraisal summary or supporting information. Although it would in theory have been possible for the Pilot Responsible Officer to contact appraisees directly to request further information where there was insufficient supporting information to make a recommendation, the limited time scale of this pilot project made it impractical to do so.

11 Pilot Volunteer Group

The pilot volunteer group comprised 7 women and 35 men. Their ages ranged from 31 to 79.

The scope of practice of the ophthalmologists who completed the appraisal process is set out in the following table. Where an ophthalmologist's practice covered more than one category, the category which defines the principal part of their work is used.

Scope of practice	Number
Ophthalmic medical practitioner	7
Primary care ophthalmology – working for independent provider	5
Medicolegal or tribunal work	4
Full time independent practice (not retired from NHS)	4
Independent practice abroad ± occasional locums in UK	4
Laser refractive surgery	3
Independent practice – retired from NHS	3
Employed abroad ± occasional locums in UK	3
UK graduates working abroad in humanitarian capacity	3*
Unemployed	2
Full time locum	1
Full time independent practice, part UK, part abroad	1
Retired, occasional prescriber	1
Pharmaceutical industry	1

*one is primarily an academic with a part time clinical commitment.

12 Appraisal setting

The setting for the appraisal is summarised in the table below

Location	Number
The Royal College of Ophthalmologists	24
Hospital Postgraduate Centre or office	8
Phone conference	4
Private consulting rooms or private hospital	3
GP surgery	2
Deanery premises	1

Four appraisals took place by phone. In three cases, the doctor was abroad (one in Tanzania, one in Dubai and one in New Zealand). In the fourth case, a face to face meeting had been scheduled in the UK but could not take place because of adverse weather conditions.

No significant difficulties were encountered with the appraisals conducted by telephone. An initial attempt was made to use Skype for one of these, but the video link failed and the audio quality was poor, so telephone was used instead.

13 Appraiser's findings

a) Completion of appraisal template

In the instructions for preparing for appraisal (Appendix 1), volunteers were asked to use forms 1 (demographic details), 2 (work details), 10 (declaration of probity), 11 (declaration of health), 14 (matrix for mapping supporting information to attributes of *Good Medical Practice*), 15 (self-appraisal against the domains of *Good Medical Practice*) and 16 (draft personal development plan) as a minimum, and to use as many of any of the other forms as were relevant to the supporting information being brought to appraisal.

It was anticipated that volunteers would not find the process of mapping supporting information to the attributes of *Good Medical Practice* easy or intuitive, so an additional document was provided which explained the process. Because Microsoft Word forms were used instead of the RPT, it was necessary to map the supporting information under each form to the attributes manually, then transfer this information manually to a summary matrix (Form 14).

33 of 42 volunteers used the pilot appraisal template as the basis for their appraisal documentation. Three volunteers used the NHS template used in their previous appraisals and 6 produced supporting information but did not attempt to use the pilot template. Thirty volunteers provided information (the completed template or supporting information or both) in advance of the appraisal, and 12 provided information on the day of the appraisal.

Of the 33 volunteers who used the pilot appraisal template, all completed Forms 1,2 10 and 11. However, forms 14, 15 and 16 were completed by 15, 16 and 17 volunteers respectively.

b) Quality and scope of supporting information

As expected from the diverse range of careers represented in the pilot group, the scope of supporting information provided varied greatly. Volunteers who saw small numbers of patients or whose practice was limited to narrow categories of patients tended to be more constrained in terms of the range of supporting information it was possible to provide than volunteers with busy, full time or varied clinical practices.

This does not imply, however, that the quality of supporting information provided was necessarily limited by the doctor's scope of practice. Some volunteers who saw quite small numbers of patients (because of working part time, or because of the specialized nature of their practice) brought supporting information of excellent quality. Conversely, some volunteers with busy and varied clinical practices with potential access to a considerable range of supporting information produced information of sparse quantity and rather poor quality.

The two most important determinants of the quality of supporting information appeared to be the volunteer's previous exposure to appraisal and the time taken to prepare for appraisal.

c) Audit, clinical outcomes and case reviews

Most of the specialty detail which was added to the general appraisal template fell into the audit and clinical outcomes section (See appendix 2, forms 3(a) – 3(l)). Specific items of supporting information were requested of ophthalmologists whose practice included cataract surgery (form 3c), corneal transplantation (form 3d), glaucoma surgery (form 3e), strabismus surgery (form 3f), retinal detachment surgery (form 3g), treatment for age-related maculopathy (form 3h) or refractive surgery (form 3j). Volunteers were also asked to review any areas of work where they were engaged in novel or emerging areas of practice (form 3k) or occasional / low volume practice (form 3l).

Recognizing that the scope of practice of some ophthalmologists would not include any of these areas, volunteers were invited to contribute other audit information relevant to their scope of practice (form 3b).

Form 7 (Case review or significant event) was amended slightly from the RPT to give volunteers an opportunity to contribute not just cases which were recorded as clinical incidents, but also cases which presented ethical or diagnostic dilemmas.

Of 42 volunteers, 27 provided supporting information which consisted of formal clinical audit or measurement of outcomes, or case reviews. The volunteers who produced the most comprehensive audit information were generally those who had previously experienced NHS appraisal and those with a full time clinical practice.

Three ophthalmologists whose practice consists primarily of medico-legal work brought to appraisal (under form 7) anonymised examples of their medicolegal reports, all of which were of very good quality and provided good supporting information covering many of the attributes of *Good Medical Practice*. The scope for formal audit within medico-legal practice is very limited because the number of new or concluded cases per year is usually relatively small, cases often take a long time to reach a conclusion and the ophthalmologist who provided the report is frequently not informed of the outcome.

Two ophthalmologists who performed refractive surgery for the same company brought very comprehensive audit data, including patient feedback data which was provided routinely by the company to all its surgeons as part of annual appraisal. This was an example of excellent practice.

Ophthalmic medical practitioners (OMPs) often see substantial numbers of patients who attend for sight testing for spectacles and contact lenses. Most have no ophthalmic pathology apart from a refractive error, but a minority will have pathology which the OMP is expected to detect and, if necessary, refer to the hospital eye service. The scope for clinical audit may be limited to audits of referrals, requests by patients for re-tests and record-keeping, but two OMPs who were managing partners in the practice where they worked also brought to their appraisal data from external audit of the practice by the local Primary Care Trust (PCT). This provided very useful supporting information which demonstrated their probity in financial matters, their commitment to safeguarding the safety of patients and staff and their communication skills.

Independent sector organizations which contract with PCTs to provide NHS services are usually required to provide a wide range of information as part of the contract monitoring process. As well as demographic and diagnostic information, this normally includes patient feedback and patient reported outcomes. Three of five ophthalmologists who worked for this type of organization were able to use this type of data as part of their supporting information for appraisal.

Of 11 volunteers whose work took place mainly or completely outside the UK, all provided supporting information in the clinical audit and outcomes section. The supporting information was of moderately good quality in 6 of these and excellent quality in 5. The scope of clinical audit was sometimes constrained by difficulty in maintaining good clinical records and limited opportunity for follow up of patients (particularly for ophthalmologists working in rural settings in developing countries), but the volunteers showed considerable resourcefulness and a commitment to the principles of clinical audit.

Of four ophthalmologists engaged in full time independent practice in the UK (not including those who were beyond retirement age), three provided supporting information on clinical audit and outcomes of very high quality indeed. This was helped by the fact that, as sole practitioners, they had complete control over their record keeping systems. The fourth would almost certainly have been able to do so with a modest investment of time in preparation for appraisal.

Altogether, 15 volunteers did not come to appraisal with any supporting information in the audit / clinical outcomes (forms 3) or case review / significant event sections (form 7). In two cases, lack of planning for appraisal appeared to be the main reason for this. In one case, the volunteer had been out of clinical practice for four years because of illness. One volunteer had recently taken up a post with a pharmaceutical company and did not have any direct patient contact, though he was likely to acquire responsibility for the progress of clinical trials and anticipated that he would be able to provide audit information to support his next appraisal.

The remaining 11 volunteers had little or no previous experience of appraisal and felt that they needed more guidance on choosing and preparing supporting information. In this situation, the appraisal discussion focused what might be the most appropriate and accessible forms of supporting information to include for the next appraisal.

d) CPD

Thirty five of 42 volunteers provided supporting information about their CPD for appraisal. The remaining 7 were all engaged in regular CPD and gave a verbal description during the appraisal discussion.

Twenty six volunteers were registered with the RCOphth for CPD and one further volunteer had been registered in the past but had allowed his membership to lapse. One volunteer who resided in New Zealand was registered for CPD with the Royal Australasian and New Zealand College of Ophthalmologists (RANZCO).

Only 5 of 42 volunteers included in their supporting information about CPD a reflective record of the CPD activities undertaken and what was learned from them, though several others had included in their self-appraisal an analysis of their CPD

needs and aims. One volunteer who had a post in the pharmaceutical industry was required to maintain a detailed record of educational events he attended as a condition of employment. Two volunteers provided supporting information about CPD including a reflective record of exemplary quality. Both were full-time OMPs.

Thirty one volunteers were self-employed, 9 were employed and 2 were not currently employed. All those who were employed and 6 who were self-employed had some access free of charge to "face-to-face" CPD activities within working hours without loss of earnings. In most cases, the organization which employed or contracted them provided its own programme of educational activities. All three ophthalmologists who worked abroad in a humanitarian capacity had access to paid study leave via their employers and one ophthalmologist working in the pharmaceutical industry had access to paid study leave with expenses.

The CPD resources used varied depending on work circumstances and personal preference. The cost of national and international conferences is a deterrent to attendance by some self-employed individuals, particularly those working part time, those not in employment or those working beyond retirement from the NHS. Several volunteers maintained links with a local hospital eye unit and felt welcome to attend teaching or audit meetings. Regional ophthalmological societies frequently provide half-day or one-day meetings with good educational content at a modest cost. On-line educational resources are becoming increasingly popular and a number now incorporate assessments which attract CPD points. Several volunteers made extensive use of such websites.

Four volunteers whose work included a significant component of medico-legal work all devoted a proportion of their CPD to activities which maintained their legal knowledge and skills. Two had obtained a legal qualification at master's degree level.

e) Patient and peer feedback

For the purpose of the pilot project, arrangements were made to give the volunteers access to an electronic peer feedback questionnaire from Edgecumbe Consulting. Although this was not made an absolute requirement for participation in the pilot project, volunteers were encouraged to undertake a peer feedback survey prior to the appraisal discussion because it is usually possible to complete it in a fairly short time and the only requirement on the volunteer is to provide email addresses of the peers who will be asked to provide feedback.

The questionnaire asks 30 questions covering the four domains of the GMC Framework for Appraisal and Assessment using a 6-point Likert scale (answers range from "not effectively" to "extremely effectively") with a seventh option of "cannot comment". In addition, there are two binary questions which asks whether the person providing feedback has any concerns about the professional integrity or health of the doctor to whom feedback is being given.

For the purpose of feedback, the individuals from whom feedback is requested are divided into "peers" and "junior / support staff" and the collated responses for the two groups are analysed separately. The doctor requesting feedback is also asked

to complete a self-appraisal using the same questions. Free text comments are invited from respondents.

The main body of the collated results is sent to appraisee and appraiser and is displayed as a series of bar graphs showing the median response to each of the first 30 questions with a line showing the range of responses. The self-appraisal, results from peers and results from junior / support staff are displayed separately for each question. Answers to the two binary questions are displayed in a table as the number of peers and junior/ support staff who answered yes or no.

Free text comments are collated separately and sent to the appraiser only, so that any sensitive issues can be addressed during the appraisal discussion.

Edgecumbe Consulting has also developed a patient feedback questionnaire. This is a paper-based questionnaire and the forms are returned to Edgecumbe after completion and are collated into a report which is sent to the appraiser and appraisee. This contained 18 questions and responses were recorded using the same 6-point Likert scale as in the peer feedback questionnaire.

In view of the fact that volunteers had at the most a few weeks to prepare for appraisal, they were not asked to undertake a patient feedback exercise (which can be time-consuming to perform), although the Edgecumbe patient feedback questionnaire was made available for those who wished to use it.

In total, 16 volunteers completed the Edgecumbe peer feedback exercise in advance of the appraisal discussion. One volunteer had recently completed Peninsula Medical School's peer feedback exercise. A further volunteer had recently completed what appeared to be a Deanery peer feedback exercise for use with doctors in training (although the volunteer was a locum consultant in a NHS trust at the time). The feedback from each reviewer in this case was open and attributable. One volunteer brought a number of written testimonials from a range of eminent peers to appraisal in lieu of a structured peer feedback exercise. Of the remaining 23 volunteers, the reasons given for not undertaking a peer feedback exercise were either lack of time, or uncertainty about whether a large enough group of peers could be found to make the exercise valid.

A number of volunteers were under the misapprehension that only medically qualified peers could give feedback. Had this been the case, it would certainly have been problematic for volunteers who have few close medical colleagues, but on reflection, nearly all volunteers agreed that they could identify at least 6 individuals who knew them reasonably well in a professional capacity and would be able to provide informed feedback on most of the questions in the Edgecumbe questionnaire.

For 18 volunteers for whom some form of structured peer feedback was available, there was generally good agreement between ratings on the 6 point Likert scale and free text comments which related to the same professional attributes. Free text comments appeared to be perceptive and not overly deferential. In a number of cases, they included suggestions for development (for instance, improved time management or more tactful delivery of feedback in the teaching situation). However, in no case was there negative feedback to a level which would warrant a recorded concern at appraisal.

In this series of appraisals, peer feedback was the only external source of supporting information on attribute 2c ("Protect patients and colleagues from any risk posed by your health"). Three volunteers provided information about health problems they have suffered, but in all cases, peers who contributed to the Edgecumbe questionnaire were unanimous in the opinion that the doctor's health did not impact adversely on patients or colleagues.

Four of the volunteers who completed the Edgecumbe peer feedback exercise were working outside the UK (one in Pakistan, one in West Africa, one in United Arab Emirates and one in New Zealand). The first two commented that, to their knowledge, this was the first time that such an exercise had been attempted in their workplace. Despite this, the feedback suggested that the reviewers understood what was being asked of them and felt comfortable to contribute honest opinions. It would appear therefore from this limited sample, that peer feedback can be used across national and cultural boundaries without major problems. However, this requires further research.

Two volunteers undertook Edgecumbe's patient feedback survey (one with 3 patients and the other with 12 patients), and one volunteer had recently completed Peninsula Medical School's patient feedback survey. Feedback was very positive in all cases, although the sample size in the Edgecumbe survey was less than ideal for statistical validity.

Two volunteers work for a company which provides refractive surgery facilities. The company routinely solicits feedback from patients on all aspects of their experience from the initial assessment through to the postoperative visits, and this includes perceptions about the clinical care, communication skills and general professionalism of the surgeon. This feedback is collated by the company (including free-text comments) and forms part of the surgeon's annual appraisal. The surgeon's "score" on each question is compared with the average score for the company's surgeons. It should be noted that clients requesting refractive surgery usually have very high expectations of treatment, and it may therefore be difficult to disaggregate their perceptions of the surgeon's professionalism from the extent to which their expectations of treatment were realised. Nevertheless, the data is undoubtedly of value and it is highly commendable that the company has taken such a positive initiative to incorporate patient feedback into its service standards.

Five volunteers undertake work for independent companies which have contracts with PCTs to provide primary care ophthalmology services. As a condition of the contract, the PCT either expects the organization to gather patient feedback data or, in some cases, will undertake data gathering itself. However, with one exception, the questions concentrated almost exclusively on aspects of process, such as waiting times. Three volunteers brought patient feedback information gained in this way to appraisal but in only one case did it include any direct feedback on the professional attributes of the doctor (which was very positive).

One volunteer is an OMP and a managing partner in an optometric practice which holds a franchise for a major national chain. The company conducts periodic surveys of clients and also uses "mystery shoppers" to provide feedback on the service provided by optometrists and OMPs. However, the feedback includes commercial data (eg rate of conversion of sight tests into spectacle or contact lens

sales) as well as information about standards of clinical care, so is probably of limited use for appraisal.

Two volunteers said that they were aware that the organizations with which they contract solicit feedback from patients, but that information is not shared with them unless there has been negative feedback which relates to them personally.

The majority of volunteers brought to appraisal written accolades from patients, some of which provided useful feedback on particular attributes of the doctor which had been appreciated. Most volunteers who had regular contact with patients for whom they had clinical responsibility felt that they would not encounter any major difficulties in undertaking a structured patient feedback exercise in the future. However, those who did not have direct clinical responsibility for patients (for instance those whose practice consists mainly of medico-legal reports) felt that it would be difficult for them to do so.

There are a number of practical difficulties in obtaining structured patient feedback whilst working abroad. In non-English speaking countries, questionnaires would require translation. In a number of cultures, patients are traditionally very deferential towards doctors and would not feel comfortable with the concept of providing feedback on a doctor's performance. Some cultures are unfamiliar with the use of multiple choice questions. Further research in this area will have to start with an understanding of how patients express satisfaction or dissatisfaction with medical care in particular cultural settings or in particular types of clinical practice. One doctor who works mostly in private practice in southern Europe commented that in his culture, dissatisfied patients are extremely reluctant to complain (even if there are good grounds for doing so) and simply take their custom elsewhere. Accolades, however tend to be measured in litres of olive oil!

f) Complaints

Thirty four volunteers stated that they were not aware of any recent or unresolved complaints involving them personally. Three volunteers who were OMPs and partners in an optometric practice stated that they were responsible for dealing with complaints that came to the practice, though in all cases these related to dissatisfaction with spectacles that had been dispensed, rather than to any aspect of clinical care. One volunteer had received two complaints which related to dissatisfaction with outcomes of refractive surgery, though these were resolved promptly and appeared to relate to unrealistic expectations of treatment. One volunteer was the subject of a complaint to the GMC from a relative of a deceased patient relating to the conduct of an eye test. The GMC found the complaint to be without merit and the case was closed promptly without action.

One volunteer had conditions placed on his registration by the GMC pending a Fitness to Practise hearing and was not employed at the time of the appraisal. Supporting documentation relating to the complaint was legally privileged and was therefore excluded from the appraisal discussion, but the appraisal discussion was able to cover all other aspects of the doctor's practice.

In general, there was little external documentation to corroborate information given by the volunteers about absence of complaints, but one volunteer had taken the

initiative to write to all the units at which he had practising privileges to obtain confirmation that there were no outstanding complaints against him.

g) Probity and health

All 36 volunteers who used the pilot appraisal template or the NHS appraisal template signed the declarations on probity and health. Additional supporting information came from peer feedback as noted above.

One volunteer whose practice was based abroad provided additional supporting information about his probity. He had taken firm action to counter an instance of dishonest and unethical practice in his institution and to put measures in place to prevent a recurrence.

One volunteer has not undertaken clinical work for a considerable period because of a health problem which has now resolved, and hopes to return to clinical practice.

h) Other supporting information

Eight volunteers contributed substantial additional supporting information from responsibilities outside their main area of clinical practice. Two had significant research responsibilities, one is a clinical reviewer for the NHS Ombudsman's office, one is a postgraduate tutor, one is the president of a national professional organization and two have significant managerial responsibilities. One volunteer has a limited clinical practice following retirement from the NHS, but has developed a successful career as an author in a field related to medicine. The supporting information from these sources covered mainly domains 2, 3 and 4 of the GMC framework.

i) Mapping of supporting information to attributes of Good Medical Practice

Twelve volunteers attempted to map their supporting information to the twelve attributes of *Good Medical Practice* and to complete the matrix (form 14). Most found the process tedious and felt that it complicated the process of preparing for appraisal. When writing the appraisal summary, evaluation of the supporting information was summarised under the headings of the supporting information. A further evaluation of supporting information under the headings of the twelve attributes of *Good Medical Practice* was included in the appraisal summary, but added no new information.

From the appraiser's perspective, the explicit mapping of supporting information to the twelve attributes was not particularly difficult, but added nothing of value to the appraisal process and possibly detracted from the clarity of the process by making the appraisal summary rather long and repetitious.

Provided that the supporting information was of reasonably good quality and included a detailed description of the appraisee's scope of practice, a review of clinical activity (audit, clinical outcomes or case reviews, as appropriate to the scope of practice), a review of CPD, peer and patient feedback and documentation of any complaints and critical incidents, it could reliably be assumed that all twelve

attributes would be covered by at least one piece (usually more than one) of supporting information. Conversely, in all cases where there was no supporting information covering one or more of the 12 attributes, the reason was immediately apparent in terms of gaps in supporting information which was obviously relevant and required in the context of the doctor's scope of practice

The appraisee's self-appraisal against the twelve attributes (Form 15) was completed in a similar number of appraisals but also added little of value and tended to repeat material that had already been presented elsewhere in the appraisal documentation.

j) Formulation of personal development plans (PDP)

Seventeen volunteers completed a draft PDP (Form 16) in advance of the appraisal discussion. In general, the suggested goals were reasonable and achievable. There were no major disagreements between the appraiser and appraisee about the content or priority of PDP goals. Unsurprisingly, the most comprehensive and best articulated draft PDPs were produced by volunteers who had previous experience of NHS appraisal. Broadly, PDP goals consisted of two categories: activity to address gaps in supporting information for future appraisal and personal career goals.

There were three appraisals where the supporting information presented suggested some cause for concern to a level where a specific recommendation for action was made in the PDP. All of these related to surgical complication rates for ophthalmologists who were undertaking cataract surgery relatively infrequently. In no case was the concern serious enough in the appraiser's view to warrant immediate cessation of cataract surgery or referral to the GMC and it should be possible to monitor action on the recommendations within local clinical governance and appraisal mechanisms.

14 Responsible Officer's findings

The appraisal summaries were sent to the Pilot RO for evaluation. The summaries were read by the RO and categorised into three groups. The following table indicates the numbers within each group following the initial evaluation:

Positive recommendation	34 (81%)
Insufficient information – decision deferred	7 (17%)
Concerns – unable to make positive recommendation	1 (2%)

There was one case for which it was felt that revalidation could not be recommended. The doctor in this case had ceased regular clinical practice, and practice was so limited in scope and occasional that it would not be possible to recommend revalidation. For those in the second group, the supporting information which had been brought to appraisal was requested and reviewed. Clarification was also sought from the appraiser in these cases. As a result of that process, a positive recommendation was made in an additional three cases bringing the final totals to;

Positive recommendation	37 (88%)
Insufficient information – decision deferred	4 (10%)
Concerns – unable to make positive recommendation	1 (2%)

In the four cases where a positive recommendation could still not be made, the reasons were entirely due to lack of information. For a real 5 year revalidation cycle it is likely that there would be much greater opportunity for the appropriate information to be collected, and also for the appraiser to set and review PDP objectives to ensure that sufficient supporting information was available by the end of the cycle.

The approximate time required of the RO for the process was recorded, so that this may be useful in resource planning. The average time required to read an appraisal summary and come to a decision was 15 minutes, and the average time required to read supplementary information where necessary was 35 minutes. In addition discussion with the appraiser accounted for an additional 30 minutes. However, these times are likely to be proportionately greater with documentation for a full five year cycle.

15 Conclusions and Recommendations

1. Data from this pilot project suggests that it will be possible for doctors working in unusual or "portfolio" careers to achieve revalidation without undue difficulty providing that the requirements for supporting information are made sufficiently flexible to reflect the diversity of medical practice. The categories of supporting information where a degree of flexibility is particularly necessary are: Review of Practice (eg clinical audit, clinical outcomes, case review, review of clinical incidents) and Patient Feedback. For example, it may not be reasonable to require all ophthalmologists to produce a fixed number of audits every 5 years because an ophthalmologist whose work consists entirely of writing medicolegal reports would not be able to comply with the requirement in any meaningful way. However, it is justifiable to ask all ophthalmologists who perform cataract surgery, however infrequently, to keep a record of their visual and refractive outcomes of cataract surgery and significant complications because there is good evidence for the validity and importance of such information.

   Recommendations: Generic requirements for supporting information should be cautious about setting universal minimum standards unless it is clear that it will be possible for all categories of doctor to achieve them. More detailed requirements appropriate to particular specialties, sub-specialties, or "orphan groups" should be provided in specialty guidance for appraisal but should not be more prescriptive than is justifiable.

2. Many doctors working outside the NHS hospital environment or general practice have no previous experience of appraisal and will need a considerable amount of help in preparing for revalidation. Although this may be partially achievable with written information and training courses, it is likely that many doctors will bring to their first appraisal limited supporting information and a major task for appraisers during the first round of appraisals under the new system will be to provide appraisees with advice about preparing for the following year's appraisal.

Recommendation: The training of appraisers should cover situations where the appraisee has an unusual career or scope of practice and should take account of the fact that many doctors still have no previous experience of appraisal.

3. Explicit mapping of items of supporting information to the twelve attributes of the GMC *Framework for assessment and appraisal* is not particularly difficult, but it is time-consuming, tends to distract from the task of evaluating supporting information, contributes no additional information and makes the documentation of appraisal unnecessarily complicated. Data from this pilot project suggests that this requirement could be safely omitted without introducing a risk of failure to detect areas of concern about a doctor's practice.

   Recommendation: The requirement at appraisal for explicit mapping of items of supporting information to the twelve attributes should be removed.

4. The level of IT literacy amongst doctors in "non-standard" careers is very variable. It is unlikely that more than half of the doctors in this pilot project would have completed the appraisal process had there been a requirement to complete appraisal documentation on-line and to upload supporting information in electronic format.

   Recommendation: Any national requirements for medical appraisal should allow appraisal documentation and supporting information to be assembled without the requirement for a live internet connection.

5. Only 4 of the 42 volunteers in this pilot currently have access to appraisal in their workplace setting. A further 6 volunteers have been able to schedule appraisals by prevailing on the good will of colleagues in the NHS. The ability to obtain future appraisals is a significant source of anxiety for these doctors. Although the RCOphth is willing to facilitate the provision of appraisals for ophthalmologists who do not have access to appraisal in their workplace, the number of doctors who will need to avail themselves of this service is not known with any accuracy. Realistically, it is likely that most appraisers of these doctors will have to be recruited from amongst NHS consultants and perhaps senior specialty doctors. Even if it is possible to provide an appraisal service on a non profit-making basis, the cost of an appraisal will be significant and at present, it appears that, for doctors who are self-employed, the cost will be borne by the appraisee. Unless it is possible to subsidise the cost somehow, there is a danger that doctors on relatively low incomes will be placed at a disadvantage.

   Recommendation: Further work needs to be undertaken to ascertain the resources required to provide appraisals for doctors who are not employed by the NHS.

6. The data from this study suggests that doctors in "orphan groups" are able to gain access to a reasonable range of CPD activities and that a requirement of 50 hours of accredited CPD activity per year is achievable, providing that there is a facility to grant recognition flexibly for educational activities outside the "main stream" where these are clearly relevant to the doctor's scope of practice. For instance, an ophthalmologist who undertakes medicolegal work will need to maintain and update his / her knowledge of the law as well as knowledge of clinical ophthalmology. It should, however, be recognized that cost (both expenses and lost earnings) places significant constraints on attendance at educational events for some doctors,

particularly those working part time in a self-employed capacity and those trying to maintain skills during a career break. Local and regional educational activities are available at modest cost and generally welcome doctors from outside the hospital eye service, although they are not always well publicized. The increasing availability and quality of on-line CPD resources is a welcome development. The practice of maintaining a reflective personal record of CPD does not yet seem to have become widely embedded in ophthalmology, although there were two volunteers in this study who maintained exemplary CPD diaries.

Recommendations: Systems for accreditation of CPD activity should be reviewed periodically to ensure that recognition is not weighted excessively in favour of expensive conferences and that "peripheral" activities can receive recognition where they are clearly relevant to a doctor's scope of practice. Good quality local and regional educational events, and on-line CPD resources are important sources of CPD for doctors on limited incomes and should be encouraged. Aids for encouraging reflection on CPD activities may need to be developed further.

7. For doctors who provide clinical care for patients on a reasonably regular basis in the UK, obtaining structured feedback from patients appears to be feasible for most, although this study suggests that it is the type of supporting information with which doctors are least familiar and least comfortable, particularly those who have no previous experience of appraisal. Although 8 of 42 volunteers in this study worked in settings where patient feedback was solicited routinely, only 3 volunteers received any structured feedback on their own professional attributes as a result, and none of the patient survey instruments would meet the standards set out by the GMC. Until IT literacy amongst adults of all ages approaches 100%, structured patient feedback will remain a paper-based activity and requires the active involvement of persons other than the doctor being assessed. This study suggests that significant organizational changes need to be made before structured patient feedback of the type envisaged for the revalidation of doctors becomes a routine part of healthcare.

   Recommendations: Structured patient feedback is only likely to become embedded in the appraisal of doctors and into managed care environments generally if healthcare organizations are made responsible for introducing and maintaining suitable feedback instruments. It is probably only reasonable to regard this as a responsibility of the individual doctor where the doctor is a sole practitioner working entirely outside a managed care environment. Consideration needs to be given to the design of valid methods for obtaining feedback where a doctor sees small numbers of patients.

8. The study suggests that structured peer feedback does not present too many difficulties for doctors in "orphan groups" and that it works well in many cultures where English is not the first language. Most doctors will be able to identify the 10-12 peers usually required for statistical validity, but a small proportion may have a peer group of less than this size.

9. Doctors who work in any type of managed care environment are heavily reliant on the organization which employs them or with which they contract for accurate information about complaints or critical incidents which involve them. This study suggests that healthcare organizations are not always diligent about feeding back clinical governance information to doctors which tends to encourage a "no news is

good news" philosophy. There are, however notable examples of good practice. Examples in this study are a refractive surgery organization which routinely feeds detailed clinical governance information back to its surgeons as part of annual appraisal and a PCT which provides detailed feedback to doctors working for an independent sector provider with which the PCT contracts.

Recommendation: Healthcare organizations should provide standardized clinical governance information to doctors they employ or contract with for the purposes of appraisal, including (where appropriate) a statement to indicate the doctor is not the subject of any complaints or serious incidents.

10. With appropriate safeguards to verify identity and the authenticity of supporting information, it is quite feasible to appraise doctors who work abroad and even to conduct the appraisal discussion remotely using a telephone or live internet link. The only area of supporting information which is inherently problematic in an international setting is structured patient feedback, because of language and cultural differences. The study suggests that many doctors who are on the UK Medical Register are keen not only to maintain their entry on the register, but also to maintain a Licence to Practise.

    Doctors who are based abroad but undertake clinical practice in the UK with reasonable regularity will need to maintain a licence to practise, and it seems entirely appropriate to include supporting information relating to their work abroad in their appraisal.

    Doctors who are based in the UK but are undertaking work abroad for finite terms (for instance those undertaking humanitarian work with non-governmental organizations) are normally required to maintain registration with the GMC to work in the host country, but in areas of political instability, they may find themselves needing to resume work in the UK at very short notice and may wish to maintain a licence to practise for this reason. The three doctors in this situation in this study all provided supporting information of very good quality.

    The keenness of some international doctors to maintain a licence to practise appears to originate from a perception that registration without a current Licence to Practise is a lower status of registration, or that it will present a barrier to employment should they wish to work in the UK in the future. Since the abolition of the permit-free training visa, it has become much more difficult for doctors from outside the European Union to gain employment in the UK and the introduction of the licence to practise may be viewed as an attempt to introduce a further barrier. Although the GMC has stated that the process of applying for a Licence to Practise (or reapplying for one which has lapsed) will be quick and simple, this message will need to be communicated more strongly.

    Recommendation: Supporting information relating to work undertaken outside the UK should be admissible for medical appraisal subject to any necessary verification of authenticity. It may be necessary to communicate more clearly how international doctors already on the GMC register will be able to apply for, or reinstate a Licence to Practise should they wish to work in the UK in the future, and that they will not be disadvantaged in terms of future employment should the LTP be allowed to lapse.

11. Of 42 appraisals, 3 raised concerns from the appraiser's perspective that resulted in a specific point for action in the PDP, although none were sufficiently serious in the appraiser's judgement to recommend formal restriction of practice or referral to the GMC and all could be handled satisfactorily within the context of appraisal and local clinical governance frameworks. Although it is not possible to comment on whether the incidence of concerns in this study reflect the anticipated prevalence of concerns in a wider population of doctors, it is interesting to note that the concerns all arose in an area of known risk (low-volume cataract surgery).

    The Pilot RO made a positive recommendation in 37 cases (88%), deferred making a recommendation in 4 cases (10%) because of insufficient supporting information and felt unable to make a positive recommendation in one case (2%) because the doctor concerned had effectively retired from clinical practice.

12. The median time taken by volunteers to prepare for appraisal was 10 hours (range 2-96 hours). As noted above, some volunteers had no previous experience of appraisal and the level of preparedness was variable, so no firm conclusions can be drawn about whether this finding is representative of a wider group of doctors. The median time spent by the appraiser on each appraisal was 5 hours (1.5 hours to review supporting information, 1.5 hours for the appraisal discussion and 2hours writing up the appraisal summary). The median time taken for the RO to review an appraisal summary was 15 minutes, but if a detailed review of supporting information was required in order to make a recommendation or if additional information had to be sought from the appraiser, this would typically add another 30-60 minutes to the process.

13. Volunteers who completed evaluation forms generally held positive views about the appraisal process and felt that the benefits were likely to outweigh the costs. However, some scepticism was expressed by volunteers with previous experience of NHS appraisal that the new appraisal format conferred any additional benefit in relation to the additional preparation required.

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17 The Project Team

Richard Smith is a consultant ophthalmologist at Buckinghamshire Healthcare NHS Trust and chairs the Revalidation Subcommittee of the Royal College of Ophthalmologists.

Beth Barnes is Head of the Professional Standards Department at the Royal College of Ophthalmologists

Bill Aylward is a consultant vitreo-retinal surgeon and former Medical Director of Moorfields Eye Hospital NHS Foundation Trust.

PART B – SUMMARY OF EVALUATION FORMS COMPLETED BY APPRAISER AND APPRAISEES

The pilot project was evaluated using forms designed by Frontline for evaluation of the national pathfinder pilot projects at the request of the Academy of Medical Royal Colleges. The project was conducted by a single organisation (the RCOphth) and used a single appraiser and Responsible Officer. The RCOphth was also responsible for collation of the evaluation forms.

The following forms were not relevant to this project and were not used:

MR1 Initial Questionnaire for All Participants
MR2 Initial Questionnaire for Organisations
MR3 Initial Questionnaire for all Appraisees
MR4 Initial Appraiser Questionnaire
MR5 Quarterly Questionnaire for Responsible Officers
MR8 Final questionnaire for Appraisers
MR9 Final questionnaire for Responsible Officers
MR10 Final Questionnaire for Organisations

MR7 Post-Appraisal Questionnaire for Appraisers

42 appraisals were undertaken and 42 MR7 Post-Appraisal Questionnaires for Appraisers were completed. One individual undertook all of the 42 appraisals.

The first question was to provide a unique identifier for the questionnaire, the second asked for the date of completion of the questionnaire. The question numbers 1.3 etc. correspond with the question numbers on the Frontline version of the MR7 form. Any question numbers in graphs should be disregarded.

1.3 Was the appraisee from the same specialty as you?

In all cases the appraisee and the appraiser were from the same specialty.

1.4 On which NHS organisation's behalf did you carry out this appraisal?
For all 42 Appraisals this was answered as the Academy of Medical Royal Colleges.

2.1 How long did it take you to prepare for the strengthened appraisal discussion (in hours)?
The mean average time to prepare for appraisals was an hour and a half and ranged between no time to 3 hours for the appraisals. However some of the appraisees did not supply appraisal documentation in advance of the appraisal so it is probably reliable to take the mean of 1.5 hours.

2.2. If you encountered any specific difficulties before the appraisal please explain briefly the nature of these difficulties and how they were resolved (this includes preparation for the appraisal, for example arranging the appraisal, and receiving and understanding the supporting information).

The comments noted by the appraiser covered 5 main areas:

- Geographical distance – 3 of the appraisees live and work outside of the UK and were not able to travel to the UK solely for the purpose of appraisal. 3 appraisals were carried out via teleconference for this reason. One appraisal planned to take place in Edinburgh was carried out via teleconference rather than face-to-face due to adverse weather conditions affecting travel arrangements. A further 6 appraisees work live and work outside the UK but were able to combine the appraisal with a visit to the UK.

- Limited or no supporting information in advance of the appraisal (9 appraisals) – the appraisals went ahead as it was felt that it was better to undertake the appraisal than not to have one. For some appraisees in this category additional information was requested after the appraisal and included in the appraisal summary. In 3 further appraisals, supporting information was not provided in advance of appraisals but was provided in paper form at the appraisal discussion.

- No, or limited previous experience of appraisal (4 appraisals). Volunteers with previous experience of NHS appraisal tended to be better prepared for appraisal than those with none.

- Limited IT familiarity of appraisee. Two appraisees printed out the forms and completed them by hand. These were scanned at the RCOphth and forwarded to the appraiser electronically. This did not cause significant problems

- One appraisee required significant help in preparing for appraisal which was given by email.

- One appraisee has conditions placed on registration by the GMC pending the outcome of a fitness to practise investigation, so it was agreed that legally privileged information would be excluded from the supporting information for appraisal. This probably did not diminish the value of the appraisal, but could present some issues for evaluation of the appraisal by the Responsible Officer.

- In one case, the supporting information was limited in scope because the appraisee only saw patients occasionally. This difficulty was addressed by requesting additional supporting information at appraisal.

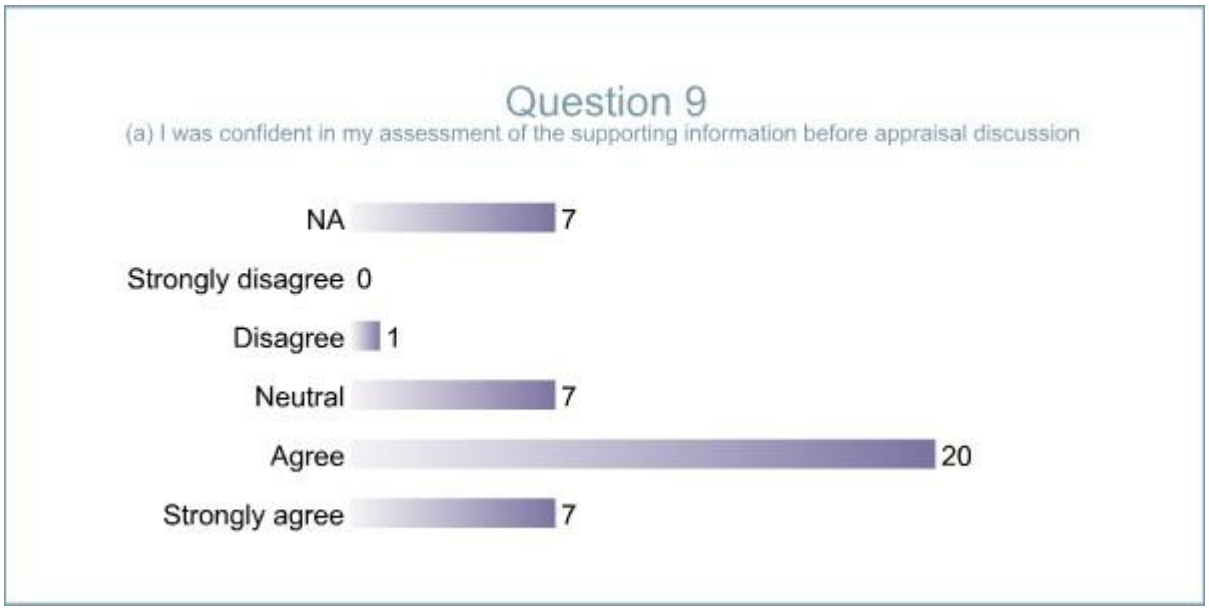
2.3 If you requested any further supporting information before the appraisal discussion please state what information you required and why?

Notes were made in this section in 5 feedback forms

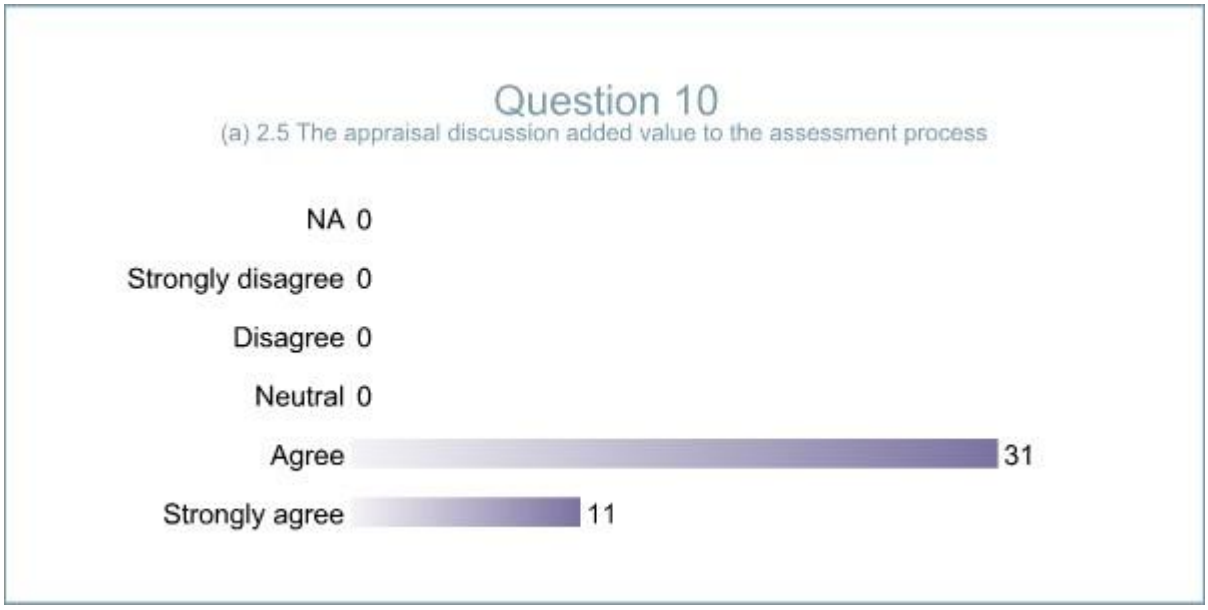
- Some additional supporting information would have been available for the appraisal but this was not possible with a phone conference. It was agreed that a summary of a non-clinical appraisal would be forwarded following the meeting
- None sent despite reminder
- Requested but not brought until day of appraisal
- Requested but not brought until day of appraisal-
- Peer feedback - this doctor has retired from the NHS and has a limited number of people from whom feedback can be requested

2.4 To what extent would you agree or disagree with the following statement? I was confident in my assessment of the supporting information before appraisal discussion

Where this was answered “not applicable”, supporting information was not provided in advance of the appraisal discussion



2.5 To what extent would you agree of disagree with the following statement: The appraisal discussion added value to the assessment process?



2.6 If you requested any further supporting information during the appraisal discussion please state what information you required and why.

This question was answered where significant pieces of supporting information could reasonably have been expected for this appraisal but were not provided. This was addressed by making them PDP objectives for the next appraisal

Supporting information requested	Incidents
Case report	1
Peer Review (MSF)	13
Patient feedback	8
Audit	5
CPD	5

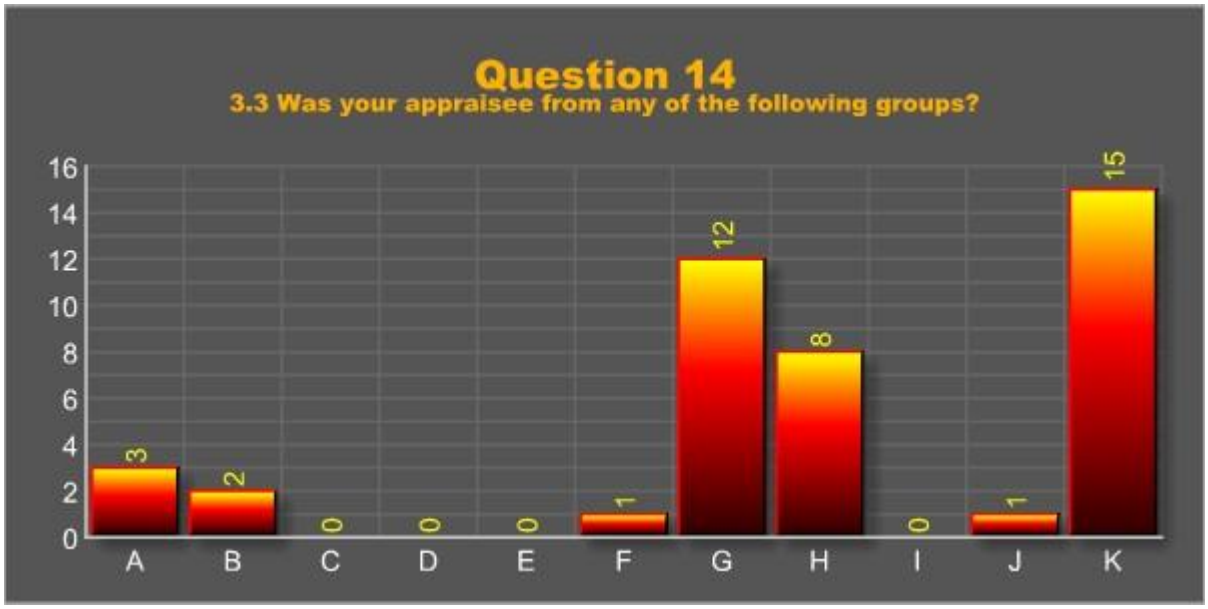
3.1 How long was the appraisal (in hours)?

Mean: 1.57 hours
Range: 1.25<=>2.5

3.2 How long did it take you to write up the report of the strengthened appraisal discussion (in hours)?

Mean: 2.02 hours
Range: 1<=>8

3.3 Was your appraisee from any of the following groups?



A) Part-time doctors
B) Locum
C) GP with special interest
D) GP with other extended roles
E) Disabled
F) Returners from sabbatical/sick leave/maternity
G) Doctors working outside the NHS in private practice
H) Doctors working overseas
I) Academic medicine
J) Pharmaceutical industry
K) Other

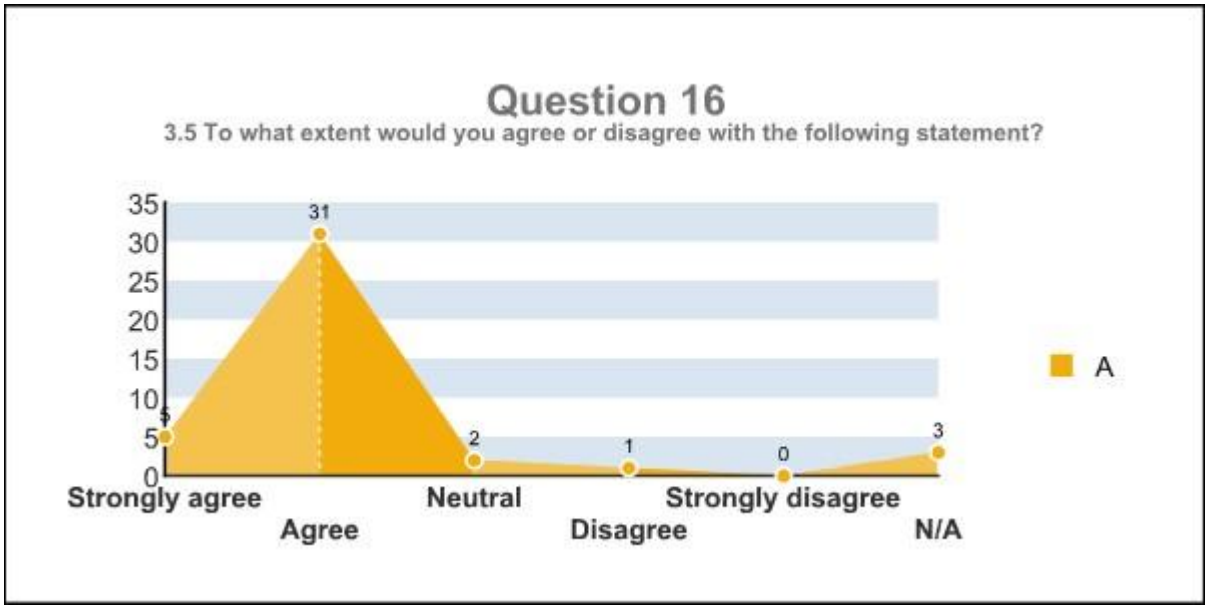
K = See page 15

3.4 For any of the groups above, did this give rise to any particular challenges, and how were they resolved?

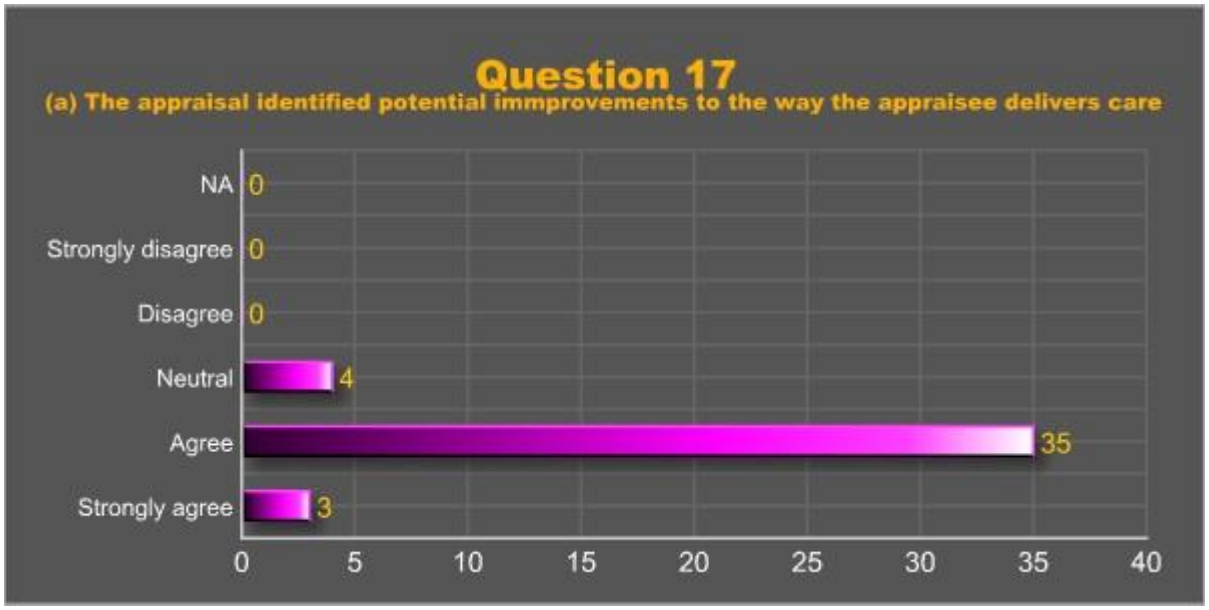
This question was answered positively in 19 cases:

- Appraisee works partly or wholly abroad. Supporting information will need to be drawn from practice abroad (11 appraisees)
- Appraisee not currently working following health problem (1 appraisee)
- Patient feedback problematic because of specialised nature of work (3 appraisees).
- Limited clinical practice. Supporting information drawn mostly from non-clinical work (1 appraisee)
- Legally privileged information excluded from appraisal (1 appraisal)
- Audit data collected by employer but not made available to appraisee (2 appraisees)

3.5 To what extent would you agree or disagree with the following statement: The appraisee self-assessment of supporting information showed agreement with my assessment of the supporting information?



3.6 To what extent would you agree or disagree with the following statement: The appraisal identified potential improvements to the way the appraisee delivers care?



3.7 As a result of the appraisal, did you have any concerns, which suggested that this appraisee should be subject to formal restriction of practice, supervision of practice or compulsory remediation?

There was only one appraisee for which the answer to the question was yes and three others where a lower level of concern resulted in a comment in the following question

3.8 If yes please indicate the nature of the issue, and please describe how you handled your concerns

- Recommended a period of refamiliarisation with intraocular surgery under the supervision of a colleague with audit of all cases undertaken

- There was a discussion about viability of continuing to perform cataract surgery in view of declining numbers, but it was agreed that this should be subject to continuing audit

- The doctor already has restrictions on registration, but the appraisal did not suggest that there should be any additional restrictions.

- The appraisee shows good awareness of limitations and will request supervision voluntarily, having been out of clinical practice for three years with a health problem which has now resolved

3.9 Please comment on any opportunities to improve the appraisal discussion

Comments feel into the following categories:

- The appraisee would have benefited from training in preparation for appraisal: 4
- Earlier presentation of supporting information and pre-appraisal discussion: 13
- More detail required in some aspects of supporting information: 1

MR6 Post Appraisal Questionnaire for Appraisees

30 of 42 post appraisal questionnaires were received but not all questions had been completed by each respondent. When considering the results of the questionnaires summarised below it is worth noting that some of the questions were not relevant to this specific pilot e.g. 1.5 and 1.6 and a number of the questions were answered by some respondents without following the instructions on the questionnaire e.g. the matrix questions for sections 5 and 6.

The question numbers 1.3 etc. correspond with the question numbers on the Frontline version of the MR7 form. Any question numbers in graphs should be disregarded.

Question 1.3 and 1.4 - All of the respondents agreed the appraiser was from the same specialty as them; ophthalmology. 70% of the respondents did not know the appraiser in advance of the appraisal.
Section 2 of the MR6 questionnaire asked respondents to qualify the extent to which they agreed with a series of statements. **NB in all of the tables below the % refers to the % of responses for that particular question.**

To what extent would you agree or disagree with the following statements?	Strongly Agree	Agree	Neutral	Disagree	Strongly Agree	N/A
2.1 My strengthened appraisal was well structured (i.e. there was a clear and appropriate agenda which was followed)	23 (76.67%)	7 (23.33%)	0	0	0	0
2.2 My strengthened appraisal gave me worthwhile opportunities to review my practice that I would not otherwise have had	17 (56.67%)	9 (30%)	4 (13.33%)	0	0	0
2.3 My strengthened appraisal helped me to understand my practice as a doctor	12 (40%)	10 (33.33%)	7 (23.33%)	1 (3.33%)	0	0
2.4 My strengthened appraisal helped me to understand how my colleagues perceive me as a doctor	11 (36.67%)	8 (26.67%)	6 (20%)	1 (3.33%)	0	4 (13.33%)
2.5 My strengthened appraisal helped me to understand how my patients perceive me as a doctor	7 (23.33%)	8 (26.67%)	6 (20%)	3 (10%)	0	6 (20%)
2.6 If I was aware of any problems with the organisation that might be a danger to patients, the strengthened appraisal process would have identified them	6 (20%)	12 (40%)	4 (13.33%)	2 (6.67%)	1 (3.33%)	5 (16.67%)
2.7 If there had been any issues with my own practice that might be a danger to the care of my patients, the strengthened appraisal process would have identified them	7 (23.33%)	16 (53.33%)	2 (6.67%)	2 (6.67%)	0	3 (10%)
2.8 I intend improving the way I deliver care as a result of my strengthened appraisal	8 (26.67%)	13 (43.33%)	4 (13.33%)	2 (6.67%)	0	3 (10%)
2.9 My appraiser performed the appraisal well (only received 29 answers to this section)	26 (89.66%)	3 (10.34%)	0	0	0	0
2.10 My appraiser was objective	24 80%)	6 (20%)	0	0	0	0
2.11 Appraisals are a good way of improving an individual's practice	15 (50%)	9 (30%)	4 (13.33%)	0	1 (3.33%)	1 (3.33%)
2.12 The strengthened appraisal led to more opportunities to improve practice	8 (26.67%)	12 (40%)	8 (26.67%)	0	1 (3.33%)	1 (3.33%)

3.1 How many hours in total did you spend on collating information and preparing for your strengthened appraisal discussion?

Average 15.21
Range 2<=>96
Median 10
Total responses: 29

3.2 Did you have access to any administrative support when preparing for your appraisal

Yes =13/30 or 43%
No =17/30 or 57%

When considering the responses to this question it should be remembered that the participants in this pilot were not NHS consultants.

3.3 If Yes, what support was available?

There were 13 responses to this question summarised below however the text responses did reveal a number of different interpretations to the question

N/A =1
The Royal College of Ophthalmologists = 5
MSF site used for the pilot = 1
Paramedical staff = 1
Local administration team = 3
Secretary = 1
Previous completion of NHS style appraisal = 1

3.4 If no, what support would you like to have had?

There were 14 responses to this question summarised below:

I do not think administrative support would have been helpful/None = 7
Data collection for audit/more data from my employers about clinical outcomes = 3
More guidance on filling in the forms = 2
Time in my contract to help with preparation = 1
Secretarial, audit staff, patient record system = 1

3.5 How could the systems for collecting and collating information be improved?

When considering the answers to this question it is worth noting that this pilot did not require electronic submission of documents and did not have access to the revalidation pathfinder pilot online toolkit. Consideration should also be given to the fact that participants in this pilot were not substantive NHS employees.

There were 14 responses to this question summarised below

Proper record keeping and regular auditing = 1
Simplification of the paperwork = 3
I found the present system satisfactory = 4
Online real time statistics availability/easy it access = 2
Electronic patient record system which work and are used effectively = 4

4.1 How long was strengthened appraisal discussion (in hours)?

Average: 1.61
Range: 1<=>2.50
Median: 1.50
Total Responses: 30

4.2 If the appraiser requested any further supporting information before the appraisal discussion please state what information was required and why

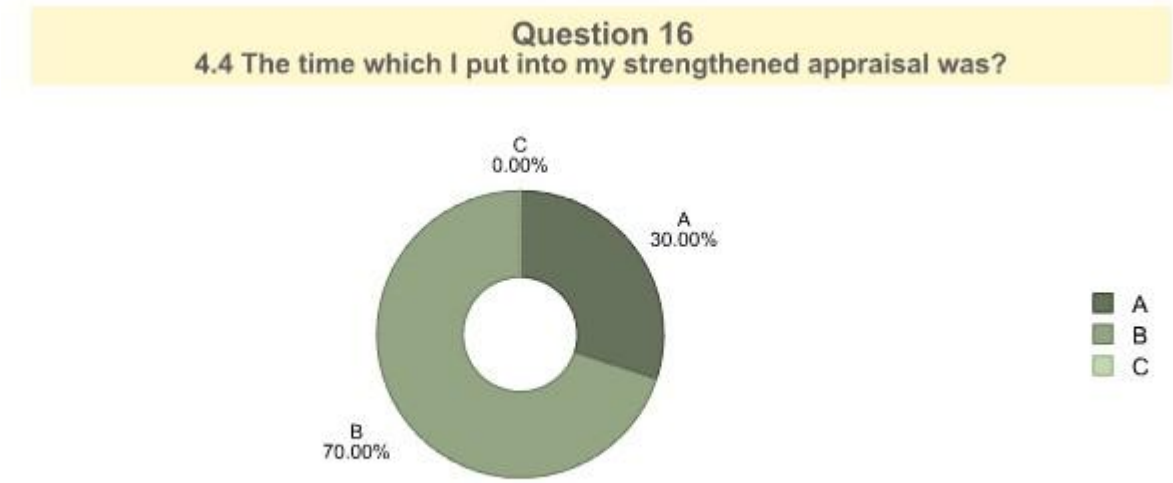
8 responses to this question were received and covered specimen medical legal reports, audits, peer and patient review, evidence of CPD, critical incident reporting, complaints, statements on probity and health, and a request for a CV.

The College requested appraisal information to be submitted at least 1 week in advance of the appraisal date but this did not prove possible for all participants.

4.3 If the appraiser requested any further supporting information during the appraisal discussion please state what information was required and why

7 responses to this question were received and covered data to expand the work required in my research, colleague feedback, audit, case report, and CPD.

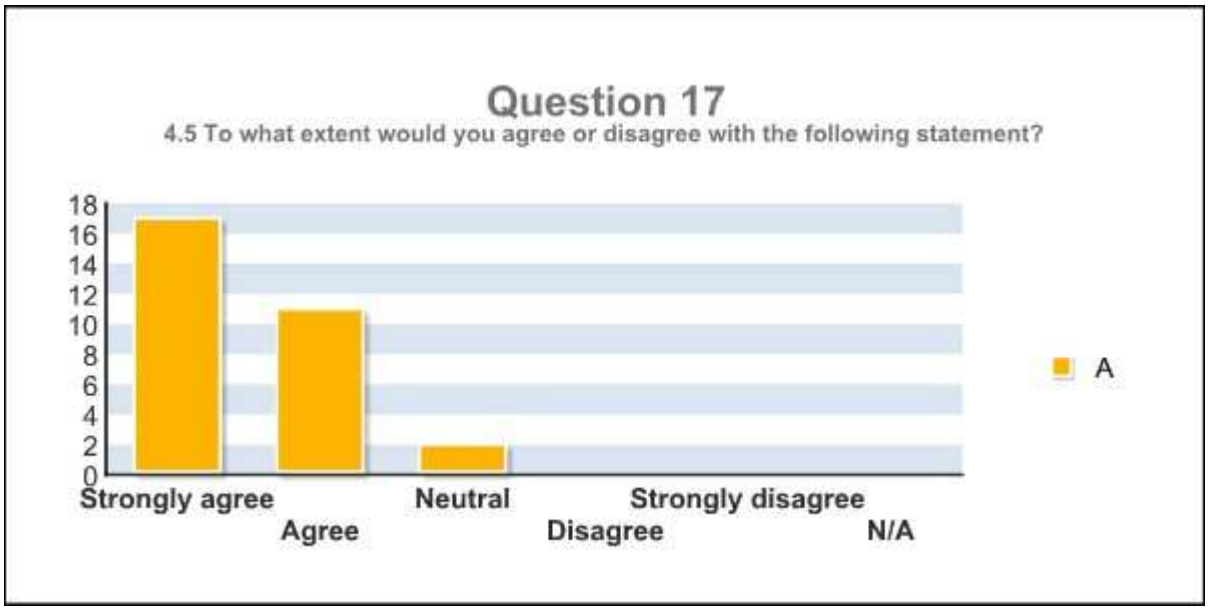
4.4 The time which I put into my strengthened appraisal was?



A = Too much, 9 responses
B = About Right, 21 responses
C = Too little, 0 responses

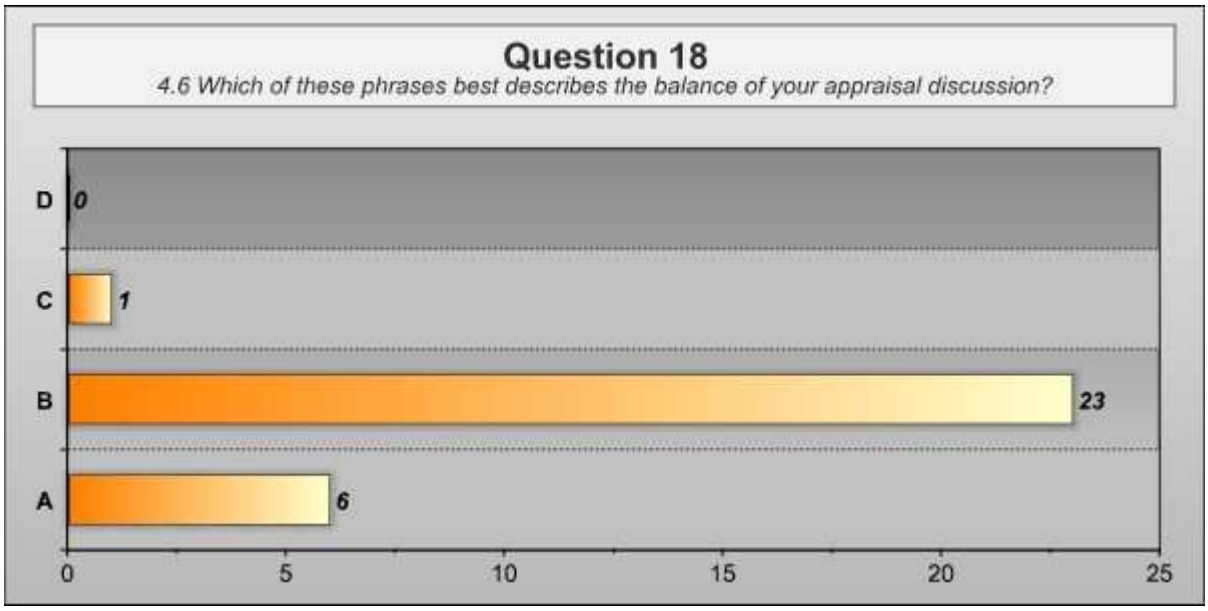
4.5 To what extent would you agree or disagree with the following statement?

A= An appraisal should primarily consider your practice and professional development. The priorities of your employer (for example, waiting list reduction) may sometimes be discussed, but they should be identified and kept separate: The appraisal discussion focused on my practice and professional development needs.



56.67% of respondents strongly agreed with the statement, 36.67 agreed and 6.67% were neutral.

4.6 Which of these phrases best describes the balance of your appraisal discussion?



A) Mainly reviewing against GMC requirements 20%
B) A balance between reviewing against GMC requirements and developing my practice 76.7%
C) Mainly focused on developing my practice 3.3%
D) N/A

4.7 Please comment on any opportunities to improve the appraisal discussion

There were 10 responses to this question and 7 of the 10 in fact had positive comments about the appraisal and did not comment on opportunities for improvement. The remaining 3 comments were ‘include more space for details about post and circumstances of job into the document. I had to explain this all in the discussion’, ‘This was my first such appraisal since finishing SpR training - subsequent appraisals might be focussed on the PDP objectives. It would also be useful to discuss a 3 year plan and perhaps a 10 year plan of professional / clinical development to help me/other clinicians take a longer term perspective in goal setting and achieving.’ and ‘To be able to see all of the 360 degree (MSF) appraisal to prepare.’

4.8 If this appraisal had contributed to a formal revalidation recommendation, would you have wanted to appeal or challenge any aspects of the process?

Only 2 respondents answered yes to this question and gave reasons in question 4.9 below. The remaining 28 respondents answered no to this question.

4.9 If yes, please describe your concerns

There were 2 answers to this question

- 'This was the first appraisal and may have required better preparation'
- 'The open discussion was satisfactory for any type of ophthalmic practice '

Section 5 of the questionnaire was presented in a matrix format for respondents to answer. However the results to each section of the matrix are presented separately. Please note that it appears from the individual responses that respondents often did not follow the specific instructions of this part of the questionnaire and the results therefore may not be as intended by the questionnaire designer(s).

5. Thinking of your strengthened appraisal did you undertake this activity during this year?

	Yes	**No**	**Responses**
5.1 CPD	29 (96.67%)	1 (3.33%)	30
5.2 Audits and informal data review	19 (67.86%)	9 (32.14%)	28
5.3 Review of complaints	13 (52%)	12 (48%)	25
5.4 Significant event/case reviews	14 (53.85%)	12 (46.15%)	26
5.5 Multi-source Feedback from colleagues	18 (64.29%)	10 (35.71%)	28
5.6 Patient Feedback	15 (51.72%)	14 (48.28%)	29
5.7 Clinical governance information provided by your organisation	11 (42.31%)	15 (57.69%)	26
5.8 Clinical governance information generated by you	12 (48%)	13 (52%)	25
5.9 Probity/self declaration	27 (93.1%)	2 (6.9%)	29
5.10 Other	4 (57.14%)	3 (42.86%)	7

Section 5 Thinking of your strengthened appraisal, did you discuss this activity in your appraisal?

	Yes	No	Responses
5.1 CPD	30 (100%)	0	30
5.2 Audits and informal data review	28 (100%)	0	28
5.3 Review of complaints	22 (91.67%)	2 (8.33%)	24
5.4 Significant event/case reviews	17 (81%)	4 (19.00%)	21
5.5 Multi-source Feedback from colleagues	24 (100%)	0	0
5.6 Patient Feedback	26 (92.86%)	2 (7.14%)	28
5.7 Clinical governance information provided by your organisation	14 (60.87%)	9 (39.13%)	23
5.8 Clinical governance information generated by you	14 (63.64%)	8 (36.36%)	22
5.9 Probity/self declaration	22 (100%)	0	22
5.10 Other	2 (66.67%)	1 (33.33%)	3

Thinking of your strengthened appraisal do you feel the amount of discussion of this activity was?

	Too Much	About Right	Too Little	Responses
5.1 CPD	0	29 (96.67%)	1 (3.33%)	30
5.2 Audits and informal data review	0	28 (100%)	0	28
5.3 Review of complaints	0	25 (100%)	0	25
5.4 Significant event/case reviews	0	20 (100%)	0	20
5.5 Multi-source Feedback from colleagues	0	22 (95.65%)	1 (4.35%)	23
5.6 Patient Feedback	0	25 (92.59%)	2 (7.14%)	27
5.7 Clinical governance information provided by your organisation	0	17 (94.44%)	1 (5.56%)	18
5.8 Clinical governance information generated by you	0	18 (100%)	0	10
5.9 Probity/self declaration	0	24 (100%)	0	24
5.10 Other	0	2 (100%)	0	2

Section 6 of the questionnaire was presented in a matrix format for respondents to answer. However the results to each section of the matrix are presented separately below. Please note that it appears from the individual responses that respondents often did not follow the specific instructions of this part of the questionnaire choosing less than or more than the requested 3 activities. The results therefore may not be as intended by the questionnaire designer(s).

Section 6 Where you carried out the listed activity in the last year - for questions A, B and C below, identify 3 activities in the 'simplest' or 'most valuable' column and 3 from the 'most difficult' or 'least valuable' column

Question A: Ease of collating the piece of information to your portfolio?

	Simplest	Most Difficult	Responses
6.1 CPD	18 (78.26%)	5 (21.74%)	23
6.2 Audits and informal data review	5 (26.32%)	14 (73.68%)	19
6.3 Review of complaints	12 (85.32%)	2 (14.49%)	14
6.4 Significant event/case reviews	6 (42.86%)	8 (57.14%)	14
6.5 Multi-source Feedback from colleagues	11 (64.71%)	6 (35.29%)	17
6.6 Patient Feedback	8 (50%)	8 (50%)	16
6.7 Review of previous year's appraisal	5 (62.50%)	3 (37.5%)	8
6.8 Clinical governance information provided by your organisation	6 (50%)	6 (50%)	12
6.9 Clinical governance information generated by you	5 (45.45%)	6 (54.55%)	11
6.10 Probity/self declaration	16 (88.89%)	2 (11.11%)	18

From the above information we can see that the respondents felt that CPD information was the simplest to provide, followed by probity/self declaration and review of complaints. Audits and informal data reviews were felt to be the most difficult to collate for the portfolio, then significant event/case reviews and patient feedback.

Question B: How valuable this piece of information was in evaluating your own standards of practice?

	Most valuable	Least valuable	Responses
6.1 CPD	20 (83.33%)	4 (16.67%)	24
6.2 Audits and informal data review	13 (72.22%)	5 (27.78%)	18
6.3 Review of complaints	6 (54.55%)	5 (45.45%)	11
6.4 Significant event/case reviews	8 (66.67%)	4 (33.33%)	12
6.5 Multi-source Feedback from colleagues	11 (73.33%)	4 (26.67%)	15
6.6 Patient Feedback	8 (72.73%)	3 (27.27%)	11
6.7 Review of previous year's appraisal	4 (40%)	6 (60%)	10
6.8 Clinical governance information provided by your organisation	6 (50%)	6 (50%)	12
6.9 Clinical governance information generated by you	7 (58.33%)	5 (41.67%)	12
6.10 Probity/self declaration	8 (44.44%)	10 (55.56%)	18

The majority of respondents felt that CPD was the most valuable piece of information for evaluation their own standard of practice with audits and informal data reviews and MSF from colleagues also felt to add value. Least valuable was statement of probity although it was one of the easiest pieces of information to provide for the appraisal portfolio, followed by a review of last year's appraisal and clinical governance information provided by the appraisees organisation. It is unclear how many of the appraisees in the pilot had previously had an appraisal in the last year so this may devalue the result in this area.

Question C: How valuable this activity was in planning how to improve patient care?

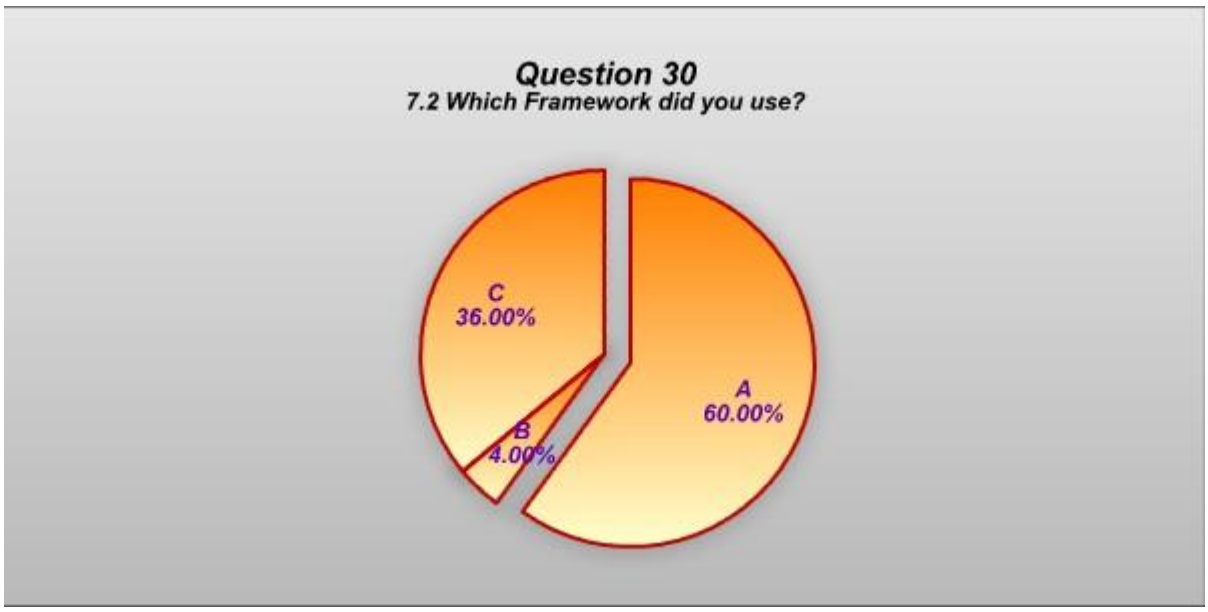
	Most valuable	Least valuable	Responses
6.1 CPD	17 (77.27%)	5 (22.73%)	22
6.2 Audits and informal data review	14 (82.35%)	3 (17.65%)	17
6.3 Review of complaints	6 (54.55%)	5 (45.45%)	11
6.4 Significant event/case reviews	7 (53.85%)	6 (46.15%)	13
6.5 Multi-source Feedback from colleagues	8 (47%)	9 (53%)	117
6.6 Patient Feedback	10 (71.43%)	4 (28.57%)	14
6.7 Review of previous year's appraisal	4 (40%)	6 (60%)	10
6.8 Clinical governance information provided by your organisation	6 (50%)	6 (50%)	12
6.9 Clinical governance information generated by you	6 (46.15%)	7 (53.85%)	13
6.10 Probity/self declaration	8 (40%)	12 (60%)	20

The majority of respondents felt that CPD was the most valuable piece of information improving patient care with audits and informal data reviews and patient also felt to add value. Again the least valuable was statement of probity followed by MSF feedback from colleagues and clinical governance information provided by the appraisees organisation.

7.1 To achieve revalidation, over 5 years the GMC expects doctors to demonstrate compliance with the twelve 'Attributes' of Good Medical Practice Framework. The medical Royal Colleges and Faculties have prepared specialty-specific frameworks to indicate how doctors in each specialty may satisfy each Attribute, and to set the standards expected. Were you aware of the relevant College framework?

Yes = 24 out of 30 respondents or 80% of respondents
No = 6 out of 30 respondents of 20% of respondents

7.2 Which Framework did you use?



A) Ophthalmology = 15/30
B) None = 4/30
C) Other = 9/30

The only specialty framework provided to all participants by The Royal College of Ophthalmologists was the Specialty Framework for Revalidation - ophthalmology

7.3 Please provide any suggestions you have for improving the specialty framework(s)

There were only 7 responses to this question 3 of which endorsed the current specialty frameworks. The other 3 responses can be summarised as requests to provide more detail for very specific areas of the respondent's practice. The last response requested the specialty framework to be available on line; it has been on the RCOphth website since March 2010.

7.4 Did you need any specialty (College of Faculty support)?

Yes =13/29 responses (13%)
No = 16 out of 29 responses (16%)

7.5 If yes, please describe the circumstances which lead to you requiring this support.

Of the 12 responses 2 of the respondents noted they practised outside of the UK and had queries relating to this; 7 related to questions about the process of appraisal and revalidation for the pilot and the remaining comment was 'The college sent me all the relevant forms to complete'.

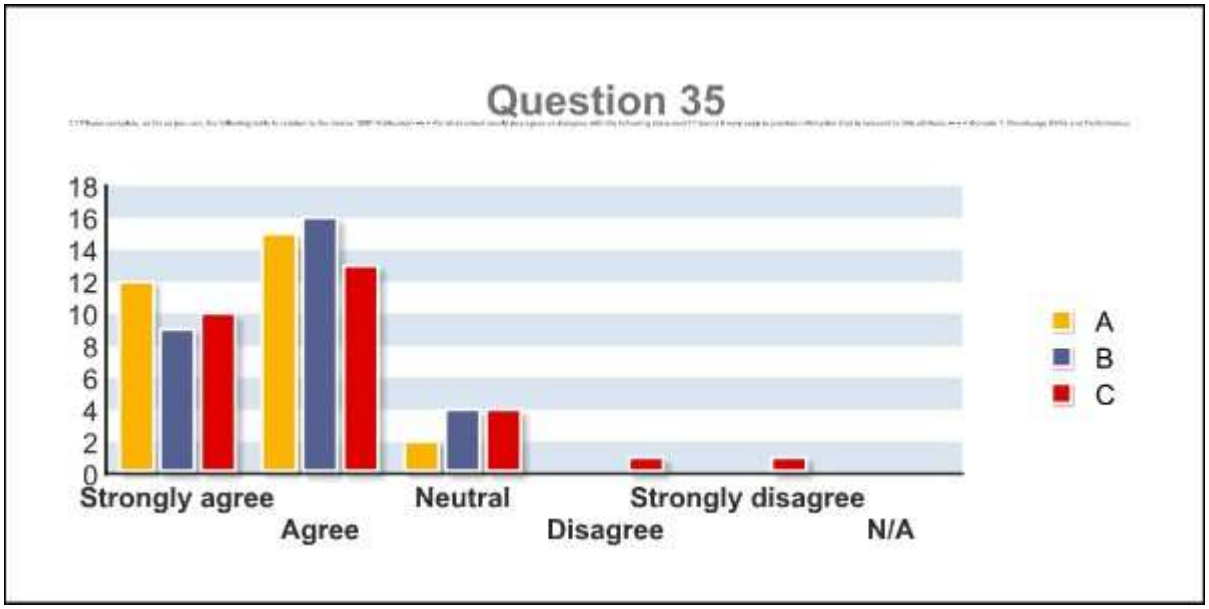
7.6 If yes, please comment on the ease of obtaining the support and the helpfulness of the support received.

There were 13 responses to this question. 11 respondents commented that it was easy to contact the College for support and that the quality of advice given was excellent. The other 2 responses were slightly more mysterious ‘not clear what this support entails’ and ‘We shall see’.

7.7 Please complete, as far as you can, the following table in relation to the twelve 'GMP Attributes'

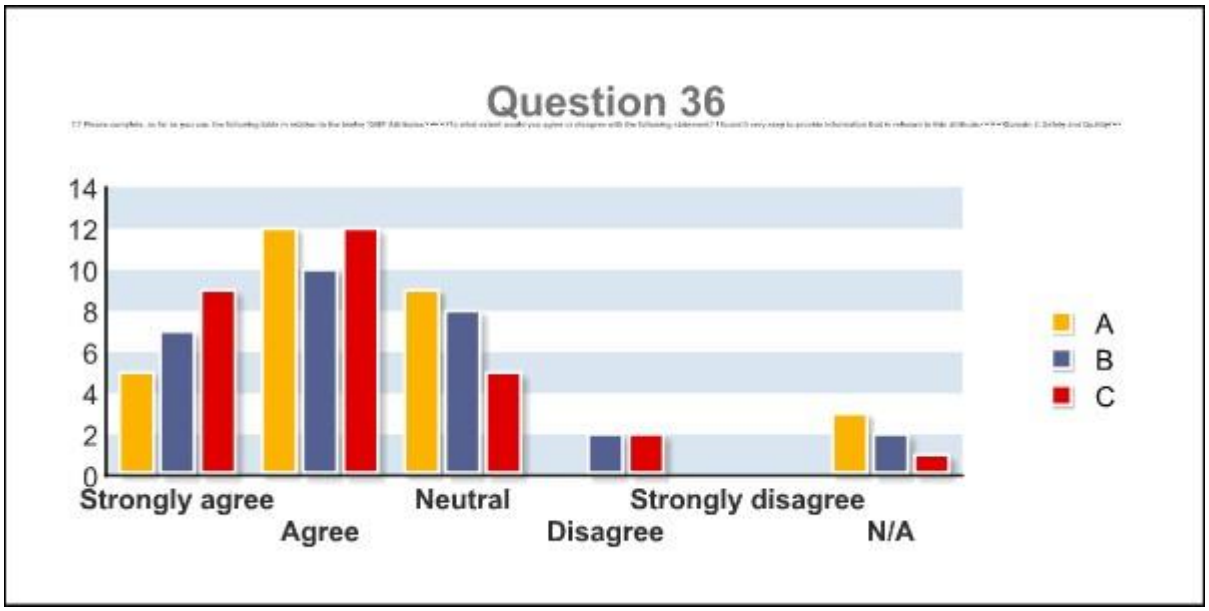
Domain 1: Knowledge Skills and Performance
To what extent would you agree or disagree with the following statement? I found it very easy to provide information that is relevant to this attribute.

A) Maintain your professional performance
B) Apply knowledge and experience to practice
C) Keep clear, accurate and legible records



Domain 2: Safety and Quality
To what extent would you agree or disagree with the following statement? I found it very easy to provide information that is relevant to this attribute.

A) Put into effect systems to protect patients and improve care
B) Respond to risks to safety
C) Protect patients from any risk posed by your health

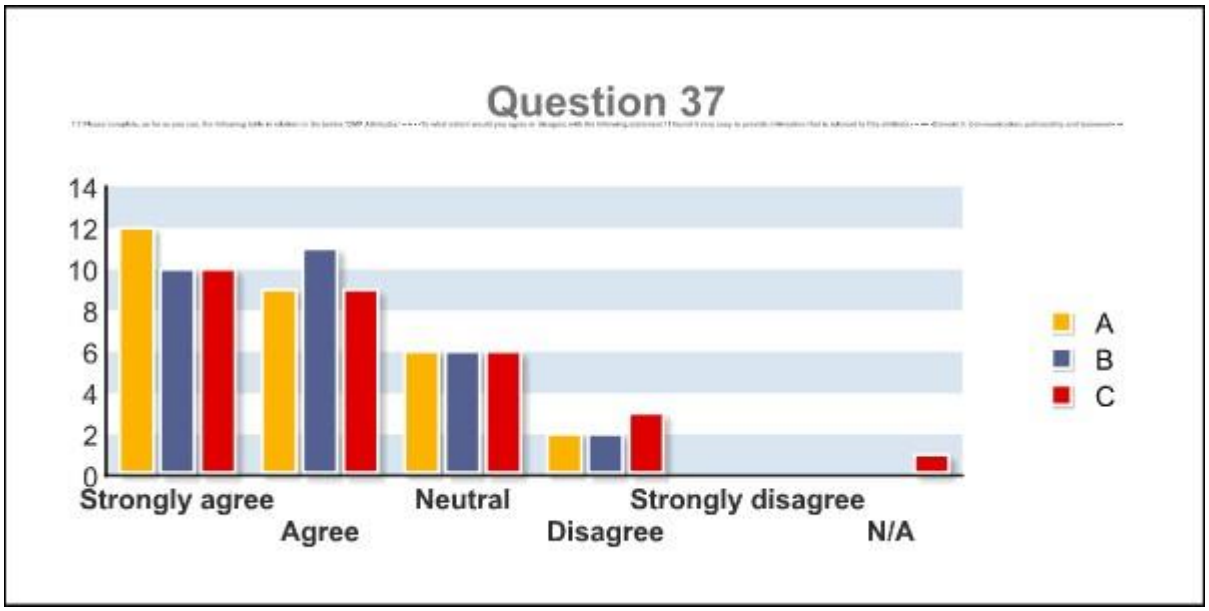


Comments from respondents:

- 'Difficult to quantify beyond a specific area that an audit covers - so quite limited evidence base'
- 'With a self reporting system, this is going to be flawed, 360 appraisal with specific questions on health is required to provide information in this domain'

Domain 3: Communication, partnership and teamwork
To what extent would you agree or disagree with the following statement? I found it very easy to provide information that is relevant to this attribute.

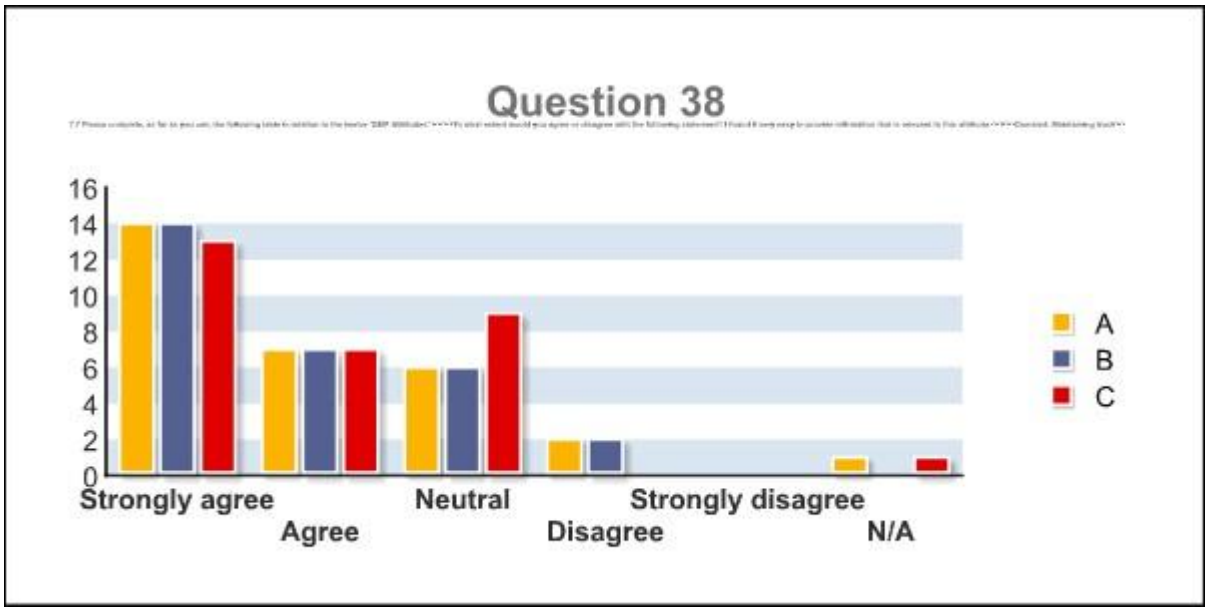
A) Communicate effectively
B) Work constructively with colleagues and delegate efficiently
C) Establish and maintain partnerships with patients



Comment from respondent ‘Easy if 360 degree feedback has been performed, otherwise difficult’

Domain 4: Maintaining trust
To what extent would you agree or disagree with the following statement? I found it very easy to provide information that is relevant to this attribute.

A) Show respect for patients
B) Treat patients and colleagues fairly and without discrimination
C) Act with honesty and integrity



Summary of comments from respondents is that it is difficult to provide supporting info on this that is objective, but easier if 360 degree feedback (Colleague MSF) has been sought and received.

8.1 Did you receive training in preparation for the strengthened appraisal process; including collecting, self assessing and submitting your supporting information?

Yes 3
No 27

8.2 If yes, approximately how long did the training take (in hours)?

The 3 responses to this question varied from ½ reading the material supplied by the College for this pilot, 2 hours and 4 hours.

8.4 Did you feel the training was effective?

Despite the answer to question 8.1 5 people responded that they felt the training was effective. There were no other responses to this question.

8.5 If no, please comment

There were 5 responses to this question, 3 indicated that the respondent felt training for this appraisal was not necessary. 1 respondent felt the guidance forms given to participants were useful but did not provide enough information about what would be involved. The final response stated that the participant worked outside the UK and had felt this was the reason training had not been provided.

8.6 Please provide any suggestions you may have for changing the training provided

The only response to this question noted that online training would be useful.

9.1 Did you identify any problems with data confidentiality (patient data or your own)?

Only 1 of the 30 respondents answered yes to this question. 'YES, EMPLOYER MYSTERY SHOPPER FILMS IN TESTING ROOM AND PUBLIC AREAS'

9.2 Do you have any suggestions for improving quality assurance of the appraisal process?

There were 8 responses to this question; 7 answered no they did not have any suggestions for improving quality assurance of the appraisal process. The remaining more detailed answers was' I think there are problems with some of the 12 areas being assessed in finding ways of providing hard / generalisable / checkable data. Ultimately I think there will need to be a degree of professional trust between the doctor and the revalidating body in some of these areas that what is said reflects the general pattern of practice of the individual. I think that probably the most reliable way to assess some of these things is through the assessment of peers. Other areas such as CPD, Audit are more readily assessed through verifiable data. To really get hard data on quality the system as a whole will need to invest much more in collecting information about outcomes and patient experience. This would require a massive investment - and cannot (I believe) be simply put on the shoulders of the individual doctor.'

9.3 Please provide any suggestions you may have for improving the appraisal process

Of the 7 responses to this question 3 were not suggestions for improvement but support for the process used in the pilot. The 4 remaining suggestions were:

- 'I regret to say, that despite the very professional approach of my appraiser, I remain very sceptical that the process either does or can be a useful exercise; as a medical practitioner of 37 years, who has constantly tried to improve his delivery of care and maintain professional standards for my patients despite a variety of Government initiatives which interfered with that process, I do not accept that 'appraisal' has anything specific to offer me. The process is unlikely to detect failures in practice which would not be otherwise apparent.'

- 'It may help if we can provide audits data to college regularly'

- 'Appraisal is very time consuming. A new appraisal technique such as this, adds much effort compared to the previous appraisal. I am not convinced that there has been a huge gain. What is important in the appraisal process is the people doing it- appraiser and appraisee. The paper work required should be as simple as possible, not increasingly complicated. My suggestion is to keep the paper work simple'

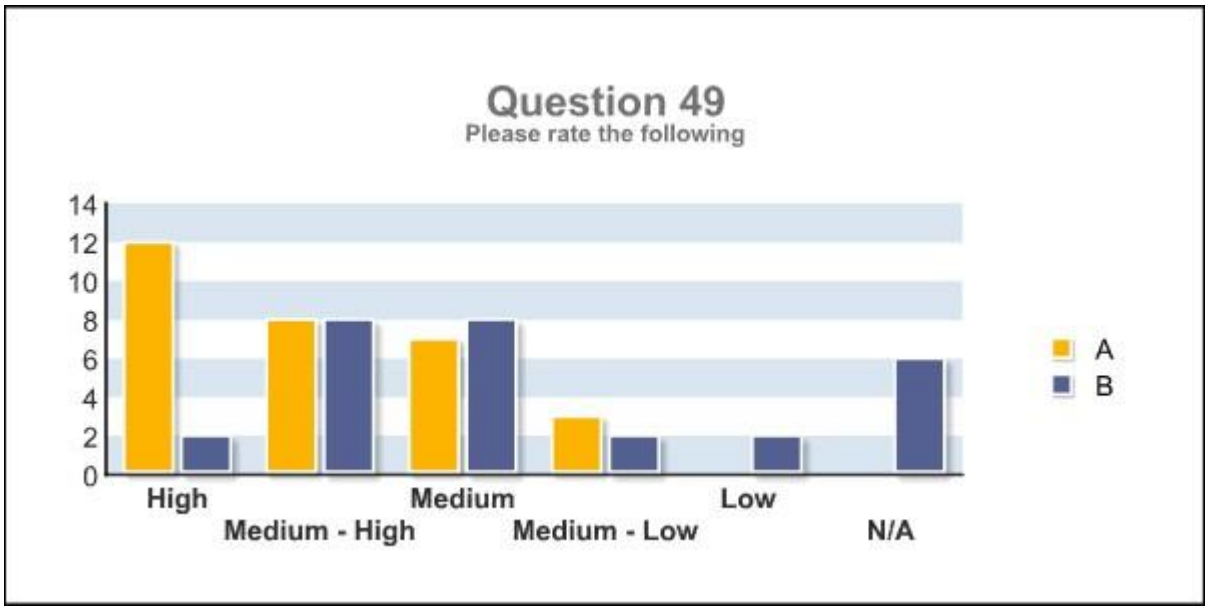
- 'training, access to feedback'

9.4 What have you learnt from this process?

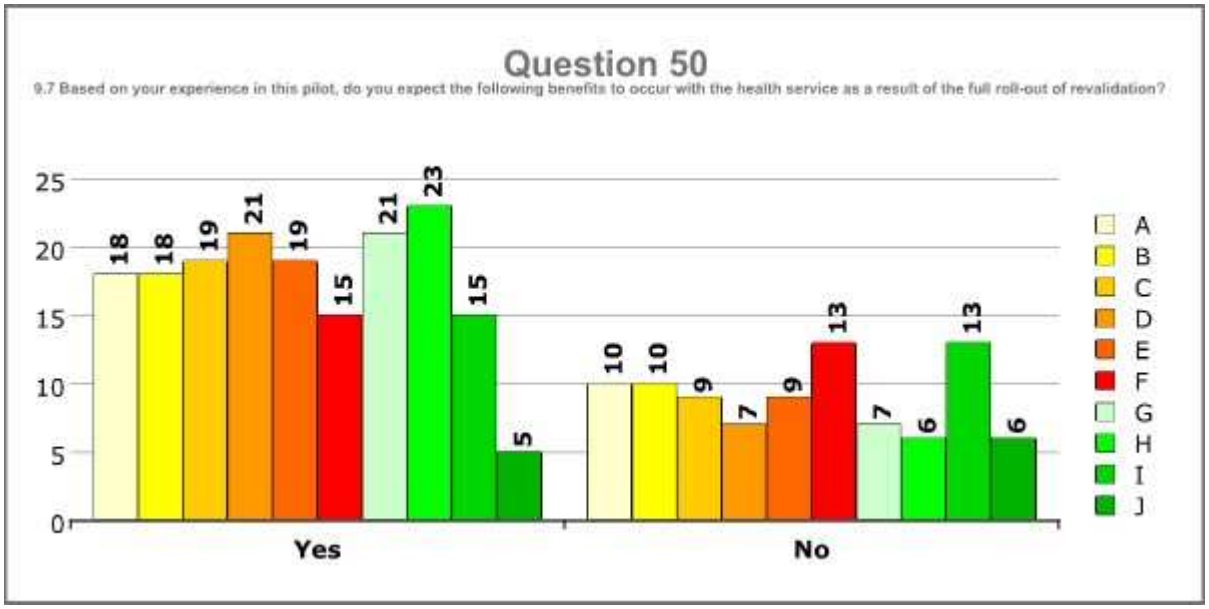
There were 23 responses to this question and the general themes were that respondents had a better understanding of the revalidation requirements and appraisal process. A number of respondents also commented on the importance of self-evaluation, systematic record keeping and audit, systematic patient feedback and the opportunity to reflect on their practice.

9.5 and 9.6 Please rate the following

A) 9.5 How do you rate the benefits of the strengthened appraisal system?
B) 9.6 How do you rate the costs of the strengthened appraisal system?



9.7 Based on your experience in this pilot, do you expect the following benefits to occur with the health service as a result of the full roll-out of revalidation?



A) Improvement in patient experience
B) Improved patient safety
C) Improved quality of care
D) Improved patient trust
E) Improvement in quality of clinical information
F) Reductions in clinical negligence claims
G) Reductions in fitness to practice cases
H) Reductions in the amount of time it takes to identify and rectify poor practice
I) Reduction in complaints received
J) Other benefits

PART C: APPENDICES

Appendix 1: Pilot appraisal project for Revalidation – guidance on preparing for appraisal

Dear < >

The General Medical Council has placed on the medical royal colleges, and faculties two specific responsibilities:

1. To specify how the general standards required of doctors for revalidation can be satisfied in the context of the specialties and sub-specialties of medical practice

2. To ensure that specialty standards do not disadvantage unfairly any groups of doctors who wish to maintain a licence to practice in that specialty.

A number of pilot projects are under way across the UK to ensure that the specialty standards for revalidation are appropriate and workable for doctors in "conventional" careers in each specialty.

The purpose of this project is to ensure that the specialist standards for ophthalmology are also appropriate and workable for ophthalmologists whose careers are based mostly or wholly outside the NHS hospital eye service.

You have kindly volunteered to take part in this project. Your main task is to prepare for and to attend an appraisal which will be based on the format designed by NHS (England)'s Revalidation Support Team (RST), which is referred to as "Strengthened Medical Appraisal". Scotland, Wales and Northern Ireland will be using different appraisal formats, although these will be similar in scope and the supporting information you provide for this appraisal should translate into the formats used by the three countries without difficulty.

Some participants in this project will be very familiar with appraisal, whereas others may have very limited previous experience of appraisal. The appraisal aims to be as faithful as possible to the principles of Strengthened Medical Appraisal and therefore to provide the best possible preparation for annual appraisal and revalidation once revalidation "goes live". Even if your scope of professional practice is very limited or very specialised, we believe that it will be possible for you to provide supporting information for appraisal which will cover all 4 domains and 12 attributes of Good Medical Practice set out in the Specialty Framework for Ophthalmology (a copy of which will accompany this document).

The outcome of the appraisal will not be a pass or fail. Rather, it will be structured feedback from the appraiser and from the pilot project's "Responsible Officer" which will assist you in preparing for future appraisals leading to revalidation.

In the limited time you have to prepare for this appraisal, it is very unlikely that you will be able to provide supporting information covering all aspects of the specialty framework for appraisal. **We are not therefore specifying a minimum amount of supporting information that you should provide for the appraisal**. However, the more supporting information you are able to provide, the more value you are likely to gain from the appraisal.

We are currently in negotiation with a company to provide access to an on-line peer feedback package which will allow you to conduct a multi-source feedback exercise and we will provide further details of this shortly. Unfortunately, within this project it is unlikely to be possible for us to be able to give you access to a commercially available patient feedback package, though this need not prevent you from conducting your own patient feedback survey.

The English pilot projects are using an on-line appraisal programme (the "Revalidation Pilot Toolkit" (RPT)) which requires users to enter all appraisal documentation and supporting information electronically. The Department of Health is unable to give us access to the RPT for this project, so we have recreated most of the structure of the RPT in a series of Microsoft Word documents which contain tables into which you can enter information. We have also incorporated the specialist standards for ophthalmology into the forms. There are 26 forms altogether, but you only need to use the ones which are relevant to the supporting information you are submitting for appraisal. However, all users will need to complete forms 1,2,10,11,14,15 and 16.

The forms will be emailed to you and are designed to be completed on a computer. **Please be careful to save your work at regular intervals as you complete the forms to avoid loss of data.** You may either print out the forms and send them, and any attached documents by post to Beth Barnes in advance of the appraisal, or alternatively, you can send the forms and any other associated documents electronically as email attachments. Either way, it is wise to keep a backup copy.

Please be careful not to send information which might identify patients directly or confidential information about work colleagues. There are strict rules about sending patient identifiable data by post or email and it is unlikely that you would be able to comply with them. If your supporting information contains data derived from patient records, we suggest that you use a numbering system of your own for patients and keep a separate secure record which allows you to match your numbering system back to the original patient records if necessary.

We will be asking you to complete a questionnaire just before your appraisal which will ask about how easy or otherwise you found it to prepare for the appraisal and another questionnaire just after the appraisal to ask how useful you found the appraisal. If you encounter any difficulties in preparing for appraisal, or if any aspect of the guidance is unclear, Beth Barnes and I will be happy to give advice in advance of the appraisal. It is particularly important that you inform us if, during the process of preparing for the appraisal, any aspects of the specialty framework for ophthalmology is causing you particular difficulty because of the nature of your work.

Finally, as you have volunteered for the project, you are free to withdraw at any stage if you wish. However, we hope that you will see it through to completion and that you will find it valuable in preparing for revalidation for the future.

Please direct enquiries to Beth Barnes, Head of Professional Standards Department at the Royal College of Ophthalmologists (beth.barnes@rcophth.ac.uk) – address and telephone number as on the letter-head . Beth will forward enquiries to me and in her absence, messages will be picked up by another member of the College staff.

Beth will be in contact with you to ascertain your availability for appraisal during September, October and November. The appraisal itself is likely to take about 90 minutes. I am happy to travel to a mutually convenient venue in the UK. For participants who are normally based outside the UK, we will either try to schedule an appraisal at a time when you are in the UK, or to arrange to conduct the appraisal via the internet using Skype.

Yours sincerely,

Richard Smith FRCS FRCOphth
Project lead and Chairman of Revalidation Subcommittee

Appendix 2: Appraisal template forms

Note: where a field on a form contains a default entry, this denotes an option box in the original form.

Appraisal Form 1 – Personal details and Professional Qualifications

Title	
First name	
Surname	
E-mail address	
Preferred telephone no.	
Address Line 1	
Address Line 2	
Address Line 3	
City / Town	
Post code / ZIP	
Country	
GMC Number	
Date of last appraisal (if any)	
Name of Responsible Officer (if known)	
Licence to practice issued?	Yes

Primary medical qualification	
University / Awarding institution	
Year awarded	
Diploma / qualification 2	
Awarding institution	
Year awarded	
Diploma / qualification 3	
Awarding institution	
Year awarded	
Diploma / qualification 4	
Awarding institution	
Year awarded	

Pilot Appraisal Form 2

Posts / Roles

Use this section to describe the clinical or non-clinical roles you perform.

Please use more than one copy of this form if you undertake separate roles with differing lines of professional accountability (for instance, if you spend part of your working week undertaking ophthalmic medical practitioner work for a PCT and part of the your working week working for a company which undertakes laser refractive surgery).

Start date	
Title of post / role	
End date (if known)	
Average time commitment	
Post / role type	Employed
Name of employer or responsible body	
Key responsibilities	
Is a formal performance review undertaken?	Yes
Development needs identified by last performance review	
Please note any issues from this role that you wish to discuss at appraisal	

Pilot Appraisal Form 3a

Summary of supporting information on audit

Form	Description	Number attached
3b	Summary of non-prescribed audit or service review	
3c	Prescribed audit – cataract	
3d	Prescribed audit – corneal graft	
3e	Prescribed audit – glaucoma drainage surgery	
3f	Prescribed audit – strabismus surgery	
3g	Prescribed audit – retinal reattachment surgery	
3h	Prescribed audit – treatment for ARMD	
3j	Prescribed audit – refractive surgery	
3k	Summary of work in new / emerging areas of practice	
3l	Review of occasionally used clinical skills	

Reviewing the audit information summarised on the forms you have attached:

Please note any significant areas of your practice for which no audit information has yet been accumulated	
Please note any constraints which have limited your ability to audit any areas of your practice	
What went well, and what could be improved in terms of outcomes of audit?	
Learning / development points	
Please note any items you wish to add to your personal development plan	

Pilot Appraisal Form 3b
Summary of "non-prescribed" audit or service review

Definition: This form is designed to be used to summarise clinical audits or service reviews in areas of ophthalmology which are not covered by "prescribed" audit (see forms 3c-3j).

For the purposes of this pilot, please do not include information which might identify individual patients directly (eg a name or date of birth)

Area of practice audited	
Time period of audit	
What questions did you hope to answer?	
Audit method	
Main conclusions	
What changes will / did you make as a result?	
What went well?	
What could have been done better?	
Supporting documents attached:	

Examples of supporting documentation include:

Copy of a report of a quality assurance report undertaken by an external body
Audit protocol
Copy of audit presentation
Publication resulting from audit
Patient reported outcome measures

This supporting information demonstrates the following attributes

1a	**1b**	**1c**	**2a**	2b	2c	**3a**	3b	**3c**	4a	4b	4c
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Pilot Appraisal Form 3c
Cataract "prescribed" audit

Please note: The information below is the minimum that should be provided over a five year revalidation cycle by an ophthalmologist who performs cataract surgery. Many cataract surgeons will be in a position to provide more detailed information about the outcomes of their cataract surgery than this.

For the purpose of this pilot, please do not attach information which may identify individual patients directly (eg a name or date of birth).

Total number of cataract operations performed as the primary surgeon in current revalidation cycle	
Number of cases of posterior capsule rupture in current revalidation cycle	
Number of cases of postoperative endophthalmitis in current revalidation cycle	

Attached: an audit of at least 50 consecutive cataract operations performed in the current revalidation cycle including: preoperative and postoperative visual acuity, intended refractive outcome and actual refractive outcome	Yes

It is accepted that it can be difficult to obtain complete data on all patients, but data should be of sufficient quality to allow a valid assessment of the visual and refractive outcome of cataract surgery.

This supporting information demonstrates the following attributes

1a	**1b**	**1c**	**2a**	2b	2c	**3a**	3b	**3c**	4a	4b	4c
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Pilot Appraisal Form 3d
Corneal graft "prescribed" audit

Please note: The information below is the minimum that should be provided over a five year revalidation cycle by an ophthalmologist who performs corneal graft surgery. Many corneal surgeons will be in a position to provide more detailed information about the outcomes of their corneal graft surgery than this.

For the purpose of this pilot, please do not attach information which may identify individual patients directly (eg a name or date of birth).

Total number of corneal graft operations performed as the primary surgeon in current revalidation cycle	

Attached: an audit of 50 consecutive corneal graft operations performed in the current revalidation cycle (or an audit of all corneal graft procedures performed if less than 50 have been performed) which includes: clinical indication for surgery, preoperative and postoperative best corrected visual acuity, postoperative refractive error and significant complications	Yes
Attached: an audit of corneal graft survival and reasons for graft failure , which may be a continuous audit spanning more than one revalidation cycle.	Yes

It is accepted that it can be difficult to obtain complete data on all patients, but data should be of sufficient quality to allow a valid assessment of the visual and refractive outcomes of corneal graft surgery.

It is acceptable to attach a standard corneal graft outcome report produced by NHS Blood and Transplant for the unit in which the appraisee performs corneal graft surgery in lieu of a personal surgical audit (even if the data relates to more than one surgeon) **providing that** the data includes the current revalidation cycle, includes data from the doctor being appraised, and the unit has a data return rate to NHSBT of **at least 85%**

This supporting information demonstrates the following attributes

1a	**1b**	**1c**	**2a**	2b	2c	**3a**	3b	**3c**	4a	4b	4c
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Pilot Appraisal Form 3e
Glaucoma drainage surgery "prescribed" audit

Please note: The information below is the minimum that should be provided over a five year revalidation cycle by an ophthalmologist who performs glaucoma drainage surgery. Many glaucoma surgeons will be in a position to provide more detailed information about the outcomes of their glaucoma drainage surgery than this.

For the purpose of this pilot, please do not attach information which may identify individual patients directly (eg a name or date of birth).

Total number of glaucoma drainage operations performed as the primary surgeon in current revalidation cycle	

Attached: an audit of 50 consecutive glaucoma drainage operations performed in the current revalidation cycle (or an audit of all glaucoma drainage procedures performed if less than 50 have been performed) which includes: glaucoma type, preoperative intraocular pressure, use of antimetabolites, significant complications, further interventions and achievement of target intraocular pressure.	Yes

It is accepted that it can be difficult to obtain complete data on all patients, but data should be of sufficient quality to allow a valid assessment of the main outcomes of glaucoma drainage surgery.

This supporting information demonstrates the following attributes

1a	**1b**	**1c**	**2a**	2b	2c	**3a**	3b	**3c**	4a	4b	4c
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Pilot Appraisal Form 3f
Strabismus surgery "prescribed" audit

Please note: The information below is the minimum that should be provided over a five year revalidation cycle by an ophthalmologist who performs strabismus surgery. Many surgeons will be in a position to provide more detailed information about the outcomes of their strabismus surgery than this.

For the purpose of this pilot, please do not attach information which may identify individual patients directly (eg a name or date of birth).

Total number of strabismus operations performed as the primary surgeon in current revalidation cycle	

Attached: an audit of 50 consecutive strabismus operations performed in the current revalidation cycle (or an audit of all strabismus procedures performed if less than 50 have been performed) which includes: diagnosis, preoperative visual acuity, preoperative and postoperative prism cover test measurements, and significant complications	Yes

It is accepted that it can be difficult to obtain complete data on all patients, but data should be of sufficient quality to allow a valid assessment of the main outcomes of strabismus surgery.

This supporting information demonstrates the following attributes

1a	**1b**	**1c**	**2a**	2b	2c	**3a**	3b	**3c**	4a	4b	4c
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Pilot Appraisal Form 3g
Retinal reattachment surgery "prescribed" audit

Please note: The information below is the minimum that should be provided over a five year revalidation cycle by an ophthalmologist who performs retinal reattachment surgery. Many surgeons will be in a position to provide more detailed information about the outcomes of their retinal reattachment surgery than this.

For the purpose of this pilot, please do not attach information which may identify individual patients directly (eg a name or date of birth).

Total number of primary retinal reattachment operations performed as the primary surgeon in current revalidation cycle	

Attached: an audit of 50 consecutive primary retinal reattachment operations performed in the current revalidation cycle (or an audit of all primary retinal reattachment procedures performed if less than 50 have been performed) which includes: diagnosis, duration of retinal detachment, preoperative status of the retina, preoperative visual acuity, whether primary reattachment of the retina was achieved, significant complications and visual outcome.	Yes

It is accepted that it can be difficult to obtain complete data on all patients, but data should be of sufficient quality to allow a valid assessment of the main outcomes of retinal reattachment surgery.

This supporting information demonstrates the following attributes

1a	**1b**	**1c**	**2a**	2b	2c	**3a**	3b	**3c**	4a	4b	4c
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Pilot Appraisal Form 3h
Age-related Maculopathy (ARM) treatment "prescribed" audit

Please note: The information below is the minimum that should be provided over a five year revalidation cycle by an ophthalmologist who undertakes treatment for ARM using intravitreal injections, photodynamic therapy or laser.

For the purpose of this pilot, please do not attach information which may identify individual patients directly (eg a name or date of birth).

Total number of treatments given or supervised in current revalidation cycle	

Attached: an audit of 50 consecutive treatments for ARM in the current revalidation cycle (or an audit of all treatments for ARM performed if less than 50 have been performed) which includes: angiographic diagnosis, pre-treatment visual acuity, treatment schedule, post-treatment visual acuities for at least one year.	Yes

It is accepted that it can be difficult to obtain complete data on all patients, but data should be of sufficient quality to allow a valid assessment of the main outcomes of treatment for ARM.

This supporting information demonstrates the following attributes

1a	**1b**	**1c**	**2a**	2b	2c	**3a**	3b	**3c**	4a	4b	4c
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Pilot Appraisal Form 3j
Refractive surgery "prescribed" audit

Please note: The information below is the minimum that should be provided over a five year revalidation cycle by an ophthalmologist who undertakes laser or surgical treatment with the primary aim of correcting refractive error. Many refractive surgeons will routinely collect data on refractive surgical procedures they have performed in considerably greater detail.

For the purpose of this pilot, please do not attach information which may identify individual patients directly (eg a name or date of birth).

Total number of patients treated as the primary surgeon where the primary aim of the procedure is to correct refractive error	

Attached: an audit of 50 consecutive refractive surgical procedures undertaken in the current revalidation cycle. Please refer to the RCOphth requirements for the Certificate in Laser Refractive Surgery for guidance (www.rcophth.ac.uk/exams/application-packs/2009_Laser_Refractive_Surgery_Application_Pack_%282%29.doc)	Yes

It is accepted that it can be difficult to obtain complete data on all patients, but data should be of sufficient quality to allow a valid assessment of the main outcomes of refractive surgical procedures.

This supporting information demonstrates the following attributes

1a	**1b**	**1c**	**2a**	2b	2c	**3a**	3b	**3c**	4a	4b	4c
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Pilot Appraisal Form 3k
Review of work in new and emerging areas of practice

Definition: This form is intended for use by ophthalmologists who are engaged in clinical research or clinical practice which involves the use of novel treatments or novel uses of existing treatments, particularly where optimal treatment protocols are yet to be established or where NICE has advised that such work should only be undertaken as part of research trials or that special approval needs to be sought for it from the local clinical governance committee.

Please use more than one copy of this form if you are engaged in more than one area of practice which is covered by the definition above. **This section should be reviewed and updated in each year of the revalidation cycle**

For the purpose of this pilot, please do not attach information which may identify individual patients directly (eg a name or date of birth).

Please describe the area of new or emerging clinical practice	
Please outline your role in this area of practice	
Approximately how many patients in this category do you treat per year?	
Please outline the methods you use for sharing information about this area of practice with peers working in a similar field	
Please describe how you audit outcomes and adverse events and safeguard patient safety in this area of practice	
Please outline any ways in which your practice in this area has been modified in response to audit or risks to patient safety	
Please outline any research studies into this area of practice in which you are engaged	
Ethics committee approval has been given for my work in this area of practice	Yes
Clinical governance committee approval has been sought and granted for this area of practice	Yes

Examples of supporting documentation which may accompany this form:

Treatment protocols
Patient information leaflets / dedicated consent forms
Copy of ethics committee / clinical governance committee approval
Research study protocols
Audit studies
Analysis of adverse events associated with this area of practice
Publications resulting from your involvement in this area of practice

This supporting information demonstrates the following attributes

1a	**1b**	**1c**	**2a**	**2b**	2c	**3a**	**3b**	**3c**	**4a**	**4b**	**4c**
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Pilot Appraisal Form 3l
Review of occasionally used clinical skills

Definition: Ophthalmologists may sometimes need to maintain or develop clinical skills that will only be used occasionally, for instance in emergency situations, or to maintain a service in a remote area, without which patients would have difficulty in accessing appropriate or timely care.

This section should be reviewed and updated in each year of the revalidation cycle.

For the purpose of this pilot, please do not attach information which may identify individual patients directly (eg a name or date of birth).

Please describe any areas of clinical practice in which you are involved on an occasional basis	
Approximately how many patients in these categories do you treat per year?	
What would the consequences for patient safety or access to treatment be if you ceased practice in these areas?	
Please describe how you audit outcomes and adverse events and safeguard patient safety in this area of practice	
Please outline any ways in which your practice in this area has been modified in response to audit or risks to patient safety	
Please outline any steps you have taken or plan to take to maintain your clinical skills at a safe level in these areas of practice	

Examples of supporting documentation which may accompany this form:

Treatment protocols
Patient information leaflets / dedicated consent forms
Audit studies
Analysis of adverse events associated with this area of practice

This supporting information demonstrates the following attributes

1a	**1b**	**1c**	**2a**	**2b**	2c	**3a**	**3b**	**3c**	**4a**	**4b**	**4c**
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Pilot Appraisal Form 4

Summary of Continuing Professional Development

Specialty CPD requirements

You should complete this section each year. If you are registered with the RCOphth for CPD and have entered your CPD events on the RCOphth on-line CPD system, you can attach data from your personal CPD diary to your appraisal record either as a file attachment or in printed form, as follows:

From the RCOphth website home page, click the CPD tab and enter your membership number and password. To display your CPD diary for any month, select the "My diary" tab and enter the month you wish to display. To display your notes of a previously entered CPD activity, select the event on the diary and click "review".

To print a diary page or a CPD activity you have displayed on screen (Windows XP or Vista or Windows 7), place the cursor on the web page and right click the mouse. Select "Print".

To copy a diary page or CPD activity you have displayed to Microsoft Word, place the cursor on the web page and right click the mouse. Select "Select All". Right click again and select "Copy". Open a document in Word, right click and select "Paste". Save your document.

Please attach (electronically or as a printed document) your most recent College CPD certificate (Click the Points Report tab and click "show certificate", once you are satisfied that your CPD record is accurate and up to date (see on-screen warning).

If you are not registered with the RCOphth or any other CPD software system, please attach a summary of your CPD activities for the year under review at appraisal showing the date, venue, and name of activity all local or regional CPD events, external academic meetings, self-directed CPD activities, and training activities in management / teaching etc.

Checklist (for users registered for CPD with the RCOphth)

RCOphth CPD certificate for the year under review	☐
Copy of CPD diary for each month of the year under review	☐
Copy of review of each CPD activity in category B,C and D	☐

Checklist (for users not registered with the RCOphth)

Summary of CPD events for the year under review (date, venue, description of activity)	☐

Local mandatory training requirements

Please summarise the local mandatory training events that you were required to attend during the year under review and attach any certificates of attendance / completion:

Mandatory training event	Attendance date	Certificate attached
		☐
		☐
		☐
		☐
		☐
		☐
		☐
		☐
		☐
		☐
		☐

Attendance at local audit / clinical governance meetings

Record of attendance at local audit / clinical governance meetings attached	☐

Reflection on CPD activity for the year under review

Please summarise the most important learning points from your CPD activity during the year under review. What could be improved?

Please note any items you wish to take forward to your personal development plan:
List any documents attached:

The supporting information in this section demonstrates the following attributes

1a	**1b**	1c	**2a**	2b	2c	**3a**	**3b**	**3c**	**4a**	**4b**	**4c**
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Pilot Appraisal Form 5

Patient Feedback

For the purpose of this pilot, please do not attach information which might identify a patient directly (eg name, date of birth, address). If you attach accolades received from patients, please black out the patient's name and address.

You will not be required to complete this section each year, but you are required to provide information in this section by **Year 3** of the revalidation cycle.

Types of document which may be attached in this section include:

- Results of a survey of the opinions of patients on your professional skills
- Results of a survey of the opinions of patients on a clinical service to which you contribute.
- Spontaneous accolades from patients on the care they have received from you or your team.

However, spontaneous accolades from patients should not form the sum total of supporting information in this section. Questionnaire surveys of patients on your professional skills or performance should be administered and the results collated by someone other than yourself to ensure that patients feel free to express opinions honestly.

Description of patient feedback document	Time period to which feedback relates

Reflection on Patient Feedback

Please reflect on the patient feedback you have received. What aspects of your professional skills received particular praise? What could have been done better?

Items to take forward to your Personal Development Plan

Please note any items you wish to discuss at appraisal or to include in your Personal Development Plan

This supporting information demonstrates the following attributes

1a	1b	1c	**2a**	**2b**	2c	**3a**	**3b**	**3c**	**4a**	**4b**	**4c**
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Pilot Appraisal Form 6

Colleague Feedback

For the purpose of this pilot, please do not attach information which might identify a patient directly (eg name, date of birth, address).

You will not be required to complete this section each year, but you are required to provide information in this section by **Year 3** of the revalidation cycle.

Types of document which may be attached in this section include:

- Results of a survey of the opinions of colleagues on your professional skills. This is often referred to as "multi-source feedback" (MSF) or "360 degree appraisal"
- Spontaneous accolades from colleagues.

However, spontaneous accolades from colleagues should not form the sum total of supporting information in this section. Questionnaire surveys of colleagues on your professional skills or performance should be administered and the results collated by someone other than yourself to ensure that those surveyed feel free to express opinions honestly. It is also important that the survey should be representative of the range of professional groups with which you work closely. In general, responses from 10-12 colleagues are required to provide valid and reliable results. Your organization may provide a MSF survey tool for your use. There are a number of MSF software packages which are commercially available.

Description of colleague feedback document	Time period to which feedback relates

Reflection on Colleague Feedback

Please reflect on the colleague feedback you have received. What aspects of your professional skills received particular praise? What needs to change in response to the feedback you have received?

Items to take forward to your Personal Development Plan

Please note any items you wish to discuss at appraisal or to include in your Personal Development Plan

This supporting information demonstrates the following attributes

1a	1b	1c	**2a**	**2b**	2c	**3a**	**3b**	**3c**	**4a**	**4b**	**4c**
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Pilot Appraisal Form 7
Significant event or case review

In the English NHS Revalidation Pilot Toolkit, there is a requirement to produce a minimum of two items of supporting information in these categories for each year of the revalidation cycle.The aim of this section is to encourage reflection on what was learned from these cases or events. It is not necessary that case reviews should be of patients with rare or exotic diagnoses, but they should be cases in which you have had some personal involvement. A significant event may be defined as an event which has had a significant impact on your professional practice. It may be a patient-related event such as a critical incident or a near-miss, or it may be a non-clinical situation that you have been involved in working through.

In providing supporting information in this section, please be careful not to include data which may allow individual patients to be identified or data which may breach rights to confidentiality of other staff members. This section should not be used to raise concerns about professional colleagues or employers – there are other more appropriate ways to do that.

Please use a separate form for each significant event or case review you wish to include.

To what time period does this significant event or case review relate?
Please describe the significant event or clinical case
Please describe any ethical issues or dilemmas raised by this significant event or clinical case and how these were resolved
Please highlight ways in which your involvement in this event or case demonstrates any of the 12 attributes of Good Medical Practice
What could have been done better?
Please list any documents or references you wish to attach to this form
Please note any items that you wish to add to your personal development plan

This supporting information demonstrates the following attributes

1a	**1b**	**1c**	**2a**	**2b**	2c	**3a**	**3b**	**3c**	**4a**	**4b**	**4c**
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Pilot Appraisal Form 8

Complaints

Receiving a complaint is never a pleasant experience, but most doctors will at some time be involved in handling or responding to a complaint. The purpose of this section is to encourage the recording of any complaints which have been lodged since your last appraisal in which you have been involved. This is to allow reflection on what was learned from complaints, not to apportion blame.

In providing supporting information in this section, please be careful not to include data which may allow individual patients to be identified or data which may breach rights to confidentiality of other staff members. This section should not be used to raise concerns about professional colleagues or employers – there are other more appropriate ways to do that.

Please use a separate form for each complaint you wish to include.

To what time period does this complaint relate?

Please describe the circumstances that led to the complaint being made, the nature of the complaint and what steps have been taken to resolve it.

What aspects of the case were handled well?

What could have been done better?

Please note any changes you or your team have made as a result of this complaint

Please note any items you wish to take forward to your personal development plan:
List any documents attached:

This supporting information demonstrates the following attributes

1a	1b	1c	2a	2b	2c	3a	3b	3c	4a	4b	4c
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Pilot Appraisal Form 9

Teamwork and leadership

There is no requirement to enter information in this section in the English NHS Revalidation Pilot Toolkit. However, doctors whose work includes a significant component of clinical leadership, management or non-clinical work may find that this area provides good opportunities to demonstrate the attributes of Good Medical Practice.

Examples of supporting information which may be included in this section are reports of meetings where team performance and quality is discussed, eg clinical audit meetings, multi-disciplinary team meetings, training meetings etc.

Please do not include information which may allow individual patients to be identified or data which might breach the rights to confidentiality of other staff members.

Please describe the supporting information which demonstrates your involvement in teamwork or leadership, including your role or title

Please outline any ethical dilemmas or problems which have arisen in this role and how these are being addressed

What has gone well?

What could be have been done better?

Please list any documents or references you wish to attach to this form

Please note any items which you wish to carry forward to your personal development plan

This supporting information demonstrates the following attributes

1a	1b	1c	2a	2b	2c	3a	3b	3c	4a	4b	4c
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Pilot Appraisal Form 10

Statement on Probity

The General Medical Council requires that doctors who are preparing for revalidation should provide details of their medical indemnity cover, declare any criminal charges against them and make a declaration to confirm that they comply with the the principles relating to professional and probity set out in *Good Medical Practice*.

Appraisal Year End:

Medical Indemnity cover provider	
Medical Indemnity membership number	

Details of any criminal charges that you have been, or are currently subject to:

Please confirm that the following two statements are accurate, or identify where they do not apply:

1. I am aware of the principles and values on which good practice is founded as outlined in the GMC publication *Good Medical Practice* and of the responsibilities on me as a doctor to comply with these standards and the supporting ethical guidance particularly in respect of professional and personal probity.

2. I confirm that no concern has been expressed about my compliance with these principles and values.

I confirm that I comply with the two statements above	Yes
Further information:	

Please note any items you wish to take forward to your personal development plan:
List any documents attached:

This supporting information demonstrates the following attributes

1a	1b	1c	**2a**	**2b**	**2c**	3a	3b	3c	**4a**	**4b**	**4c**
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Pilot Appraisal Form 11

Statement on Health

The General Medical Council requires that doctors who are preparing for revalidation should confirm that they are registered with a General Practitioner every year and make a declaration to confirm that they comply with the the principles relating to health set out in *Good Medical Practice*.

Appraisal Year End:

I confirm that I am currently registered with a General Practitioner	Yes

Please confirm that the following two statements are accurate, or identify where they do not apply:

1. I am not suffering from, or aware of any siginificant health issues, or such health issues are being appropriately managed.

2. I can confirm that health issues do not adversely affect, nor are likely to affect my ability to care safely for patients.

I confirm that I comply with the two statements above	Yes
Further information:	

Please note any items you wish to take forward to your personal development plan:
List any documents attached:

This supporting information demonstrates the following attributes

1a	1b	1c	2a	2b	2c	3a	3b	3c	4a	4b	4c
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Pilot Appraisal Form 12

Supporting Information relating to other roles

Your appraisal, in the main should focus on your main clinical role which, for most doctors will be a clinical one. However, increasingly doctors have portfolio careers combining clinical, teaching, managerial, research and other roles.

You should already have detailed any subsidiary roles to your main professional role in Appraisal Form 2.

This form provides space for you to attach supporting information relating to these roles so that you can discuss with your appraiser how these roles relate to your main professional roles and how they might be developed.

Title	
Description of role	

What has gone well in this role and what could have been done better?
How do you wish this role to develop in the future?

Please note any items you wish to take forward to your personal development plan:
List any documents attached:

This supporting information demonstrates the following attributes

1a	1b	1c	2a	2b	2c	3a	3b	3c	4a	4b	4c
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Pilot Appraisal Form 13

Additional Supporting Information

This section allows you to include any additional supporting information which validates your professional standing. For instance, you may wish to include papers in peer-reviewed journals, chapters in textbooks on scientific or professional matters, work undertaken for regulatory bodies etc.

Summary of information in this section:

Please note any items you wish to take forward to your personal development plan:
List any documents attached:

This supporting information demonstrates the following attributes

1a	1b	1c	2a	2b	2c	3a	3b	3c	4a	4b	4c
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Pilot Appraisal Form 14

Mapping Supporting Information to the 12 Attributes of "Good Medical Practice"

At the bottom of each form 3b-l and 4– 13, there is a grid which asks you to indicate which of the 12 attributes of GMP are demonstrated by the supporting information summarised on that form. If you copy each grid onto this table, it will allow you to see easily the number of pieces of supporting information which relate to each attribute.

|---------- Attributes of GMP----------|

Form	Number of forms	1a	1b	1c	2a	2b	2c	3a	3b	3c	4a	4b	4c
3b		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
3c		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
3d		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
3e		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
3f		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
3g		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
3h		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
3j		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
3k		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
3l		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
4		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
5		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
6		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
7		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
8		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
9		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
10		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
11		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
12		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
13		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Pilot Appraisal Form 15

Review of GMP Domains and Attributes

This section allows you to review the supporting information that you have provided in relation to the domains and attributes of *Good Medical Practice* and to record any issues that you wish to discuss at appraisal. The matrix on Form 14 will help you to locate the items of supporting information that relate to each domain and attribute of GMP.

DOMAIN 1 – KNOWLEDGE, SKILLS AND PERFORMANCE

Attribute 1a: Maintain your professional performance
Attribute 1b: Apply knowledge and experience to practice
Attribute 1c: Keep clear, accurate and legible records

What are your main strengths and weaknesses in this domain?
How does your supporting information demonstrate my effectiveness in this area?
What do you need / wish to do to improve your effectiveness in this domain in the next year?
Are there any issues relating to this domain that you wish to raise at this appraisal?

DOMAIN 2 – SAFETY AND QUALITY

Attribute 2a: Put into effect systems to protect patients and improve care
Attribute 2b: Respond to risks to safety
Attribute 2c: Protect patients and colleagues from any risk posed by your health

What are your main strengths and weaknesses in this domain?
How does your supporting information demonstrate my effectiveness in this area?
What do you need / wish to do to improve your effectiveness in this domain in the next year?
Are there any issues relating to this domain that you wish to raise at this appraisal?

DOMAIN 3 – COMMUNICATION, PARTNERSHIP AND TEAMWORK

Attribute 3a: Communicate effectively
Attribute 3b: Work constructively with colleagues and delegate effectively
Attribute 3c: Establish and maintain partnerships with patients

What are your main strengths and weaknesses in this domain?
How does your supporting information demonstrate my effectiveness in this area?
What do you need / wish to do to improve your effectiveness in this domain in the next year?
Are there any issues relating to this domain that you wish to raise at this appraisal?

DOMAIN 4 – MAINTAINING TRUST

Attribute 4a: Show respect for patients
Attribute 4b: Treat patients and colleagues fairly and without discrimination
Attribute 4c: Act with honesty and integrity

What are your main strengths and weaknesses in this domain?
How does your supporting information demonstrate my effectiveness in this area?
What do you need / wish to do to improve your effectiveness in this domain in the next year?
Are there any issues relating to this domain that you wish to raise at this appraisal?

Pilot Appraisal Form 16

Draft Personal Development Plan and items for discussion at appraisal

Please use this form to summarise items you have noted on other forms which may form part of your Personal Development Plan (PDP) for the coming year, and also to summarise items which you have noted on other forms which you wish to discuss at appraisal.

One of the main objectives of appraisal is to agree a PDP with your appraiser. In general, it is better to refine the list of PDP objectives down to a fairly small number (probably not more than 4-6), and to ensure that they are measurable and achievable.

Draft PDP objectives for discussion at appraisal:

Summary of other matters you wish to discuss with your appraiser: