This document has been agreed by the delegates of the National Conference on Appraisal, held in Leicester in February 2007, co-hosted by CGST and NAPCE. Its intention is to support the quality of appraisal in the context of the future requirements of re-licensing. It is not guaranteed that gathering the evidence listed will meet the eventual requirements for re-licensing.

Evidence for Medical Appraisal:

Essential / Optional

Statement of the NAPCE/CGST Conference February 2007

N A P C E
NATIONAL ASSOCIATION OF PRIMARY CARE EDUCATORS

NHS
Clinical Governance Support Team
Appraisal Support Group
www.appraisalsupport.nhs.uk

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Introduction

The evidence that can be supplied for appraisal is limitless. Indeed, it is inherent to the developmental ethos of appraisal that a doctor can introduce any evidence to his or her appraisal that he or she believes is relevant to their professional work, for discussion in confidence with their appraiser.

At the same time, to achieve consistency of appraisal, it helps to define some key evidence for every doctor to produce to show professional activity in the main areas of *Good Medical Practice*[1]. This point was made by the NHS Clinical Governance Support Team (CGST) in their framework document: *Assuring the Quality of Medical Appraisal*[2], which recommended that there should be a core of "valid and verifiable evidence" informing the appraisal discussion.

Furthermore, in *Good doctors, safer patients*[3], the Chief Medical Officer for England recommended that standards be set for UK medical re-licensing, which should be assessed in the appraisal process. This approach has now been further endorsed in the Government White Paper, *Trust, Assurance and Safety, the regulation of Health Professionals in the 21st Century*[4]

In February 2007 at a national conference hosted jointly by the NHS Clinical Governance Support Team (CGST) and the National Association of Primary Care Educators (NAPCE), delegates from all four countries of the UK, and from both primary and secondary care, debated the evidence that could constitute this core of evidence.

We set out this core of evidence in this paper. It is designed to be generic for all doctors in clinical practice, regardless of speciality, location or nature of employment. It distinguishes between that evidence which is:

- essential and personal,
- essential and organisational
- optional.

Evidence should be such that it provides confidence that the doctor's performance is satisfactory and that he or she is fit to practise safely.

Issues to consider

Principles relating to evidence:

In another publication: *Defining the evidence for revalidation*[5] CGST considered those factors which help to define meaningful evidence. These are:

1. Equivalent to that required of other disciplines
2. Level of relationship to the individual
3. The nature of the doctor's work
4. Face value credibility
5. Ease of production
6. Source of production
7. Level of objectivity
8. Level of verifiability
9. Whether "SMART"

These factors have informed the choice of evidence for this new document. Further explanation of each factor has been reproduced from *Defining the evidence for revalidation* in Appendix 1

Providing essential evidence or demonstrating excellence?

Appraisal is rightly an opportunity for a doctor to demonstrate the excellence of their practice, and have achievements recognised. The framework contained in this paper focuses however on the essential evidence which should be produced. *The CGST/NAPCE conference recommends that doctors should strive to continue to provide evidence over and above the essential requirement.* However, doctors should ensure that the essential evidence is present, before moving on to other evidence.

Structured reflective templates

A key ambition of the core evidence described in this paper is to ensure that it bridges the gap between the data, which in many instances relates to the organisation or team, and the behaviour and development needs of the individual doctor (point 2 above). The mechanism which we recommend to serve this purpose is the structured reflective template. Using such a template allows the doctor to take data relating to organisational or team behaviour, relate that information to his or her own behaviour, and thus identify personal learning.

Iterative process

The framework described in this paper is not a finished product. It is essential that the profession learns more about how to assess and verify the presence of good, safe medical practice. It is equally important not to expect more from a process than it is capable of delivering. Benchmarking in a normative (summative) sense remains some way off.

Incorporating assessment into appraisal.

Although appraisal is a formative process, if it is informed by valid and verifiable evidence, its quality is enhanced. The CGST/NAPCE conference supports the concept of incorporating explicit judgement against suitable agreed standards, as

proposed in *Good doctors, safer patients*. However, in order to protect the formative aspect of appraisal, the conference recommends that the assessment element be separated from the appraisal interview, in that the evidence should be validated prior to the appraisal discussion.

Setting the standards

Trust, Assurance and Safety, recommends that the standards for re-licensing should be set by the GMC, in consultation with others. The CGST/NAPCE conference recognises this, and offers this framework as a potential instrument to help inform this standard-setting process.

The Model

Essential evidence (personal) is that which should be produced by all doctors, and *without which an appraisal should be deferred* until the evidence is available. This evidence can be produced in isolation, without reference to any organisational input.

Essential evidence (organisational) is that which should be produced by all doctors unless there are clear reasons why it is not available. Where a doctor is unable to produce such evidence, this should be discussed with his or her host organisation, and if necessary at appraisal, to establish whether there are means by which it can be generated. The nature of this evidence is such that it should be locally agreed, through discussion between local doctors (and their representatives), and the organisation. It therefore follows that organisations are to be encouraged to be proactive in developing effective processes for clinical governance in order to support such measurement.

Optional evidence is other evidence that the doctor chooses to provide for appraisal, either because he or she wants to discuss issues that the evidence illustrates, or to show a level of excellence of professional activity. Clearly this category is limitless in its scope, and this paper seeks only to illustrate with examples the sort of evidence that might be relevant.

The Evidence

In addition to the evidence listed on pages 8 to 13, **completion of the appraisal preparatory paperwork is essential in order for the appraisal to proceed** (Forms 1, 2 and 3).

The forms must be:
- Legible (typed forms should be the norm)
- Coherently completed and adequately detailed
- Passed to the appraiser in good time (normally at least two weeks prior to the appraisal, to allow review before the appraisal)

We strongly suggest use of a secure facility such as the NHS Appraisal Toolkit, in England https://www.appraisals.nhs.uk as a vehicle to help doctors undertake their NHS appraisal.

This framework comes in the context of *Good doctors, safer patients*, the report by the Chief Medical Officer for England into the requirements for medical revalidation. It comes at a time when the General Medical Council are revising and refining their standards for good medical practice. We also expect that the professional colleges and faculties, through the Academy of Medical Royal Colleges, will soon develop guidance for their members relating to the evidence in the specific areas of:

- Maintaining good medical practice (through continuing professional development (CPD) arrangements)
- Probity and health.

This framework is intended to support these processes, and to be compatible with future Academy, GMC and NHS processes.

For other items we have provided templates to assist doctors in producing and presenting their evidence. The intent is that evidence will be presented in a consistent way which will also help the doctor in the process of self-reflection.

Feedback on this framework is welcome. Please contact:
maurice.conlon@ncgst.nhs.uk with your comments.

NHS Clinical Governance Support Team
www.cgsupport.nhs.uk and
National Association of Primary Care Educators
www.napce.net,
National Appraisal Conference
Leicester
February 2007

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Section of Good Medical Practice	Essential Evidence (Personal) (In the absence of any of the evidence listed in this column, the appraisal should be deferred until the evidence is available)	Essential Evidence (Organisational) (Evidence should normally be present for the large majority of doctors. If not presented, the reasons why should be discussed at appraisal)	Optional Evidence (Evidence which the doctor may choose to include for the purpose of discussion within the appraisal, and/or for the purpose of demonstrating his/her good practice. This list cannot be exhaustively defined; examples of evidence are listed for the purpose of illustration)
Relating to all sections	On-going PDP, with clear description in your new Form 3 of your successes and limitations in meeting each item. (Use the "Overview of development during the year" box near the end of form 3 for this)		
Good Clinical Care	Last year's Appraisal Summary (Form 4)	Key organisational audits, with structured reflective template(s)[2c] (These are audits generated by the organisation in which the doctor works, and which inform day to day performance. Examples include: Quality and Outcomes Framework data for GPs, Departmental audits, MRSA rates.) The doctor is not expected to generate these figures, but must complete a reflective piece describing his/her response to the data.	Personal data collection exercises/audits with reflection
	Two Case Review structured reflective templates[2a]	Significant event audit (SEA) structured reflective template[2b]. (Where the doctor works in an environment where there are mechanisms for significant event analysis, he/she should include evidence to indicate his/her participation in these. Where there have been no significant events relating directly to the doctor, he/she should still prepare at least one reflective template indicating how they have generated personal learning from the significant events of others in the team.	Personal Significant events with reflection
	One data collection exercise/audit with structured reflective template[2c]	Current Job Plan (Consultants only)	All previous PDPs
		Evidence of team reflection (Where such activity occurs)	Personal reflective diaries
			Plaudits
			Evidence of learning events relating to good clinical care

Section of Good Medical Practice	**Essential Evidence (Personal)** (Evidence without which the appraisal cannot continue)	**Essential Evidence (Organisational)** (Evidence should normally be present for the large majority of doctors. If not presented, the reasons why should be discussed at appraisal)	**Optional Evidence** (Evidence which the doctor may choose to include for the purpose of discussion within the appraisal, and/or for the purpose of demonstrating his/her good practice. This list cannot be exhaustively defined; examples of evidence are listed for the purpose of illustration)
Maintaining Good Medical Practice	Structured reflective template on the last year's personal learning[2d]	Evidence of having met the criteria set out by the relevant College/Faculty for Continuing Professional Development (CPD)	Practice/departmental development plan
			Evidence of participation in additional learning events to those of College/Faculty CPD requirements
			Evidence of membership of organisations where learning occurs
			Personal reflective diary
			Evidence of knowledge assessment. (e.g. Formal examination results, self-assessments etc)

Section of Good Medical Practice	**Essential Evidence (Personal)** (Evidence without which the appraisal cannot continue)	**Essential Evidence (Organisational)** (Evidence should normally be present for the large majority of doctors. If not presented, the reasons why should be discussed at appraisal)	**Optional Evidence** (Evidence which the doctor may choose to include for the purpose of discussion within the appraisal, and/or for the purpose of demonstrating his/her good practice. This list cannot be exhaustively defined; examples of evidence are listed for the purpose of illustration)
Relationships with Patients	The results of the most recent patient survey, with structured reflective template[2e] (This must have been carried out within the past 3 years, and must relate to the individual practice of the appraisee. Where the feedback exercise has been performed more that 1 year previously, a record of subsequent action must be included)	Additional patient feedback data. (Where the system within the doctor's organisation means that patient feedback is obtained more frequently than every three years, then these data should be included.)	Additional information for patients (e.g. Details of website, examples of leaflets and other formats of communication with patients.)
	Complaints structured reflective template(s)[2f], or declaration of no complaints[2g].	The organisation's complaints policy/protocol	Consent policy
		Information for patients about services (e.g. Practice/departmental leaflet)	Confidentiality policy
			Evidence of learning in the context of patient relationships (e.g. Communication skills workshops)
			Evidence relating to other aspects of patient relationships (e.g. involvement with patient participation groups)
Relationships with Colleagues	A record of the results of the most recent multi-source feedback exercise, with structured reflective template[13]. (The exercise: must have been carried out within the past 3 years, must relate to the individual practice of the appraisee, and must have been facilitated by a third party. Where the feedback exercise has been performed more than 1 year previously, a record of subsequent action must be included)	Additional multisource feedback data. (Where the system within the doctor's organisation means that patient feedback is obtained more frequently than every three years, then these data should be included.)	Evidence of learning in the context of colleague relationships (e.g. Team-building exercises, equal opportunities and diversity training)

Section of Good Medical Practice	**Essential Evidence (Personal)** (Evidence without which the appraisal cannot continue)	**Essential Evidence (Organisational)** (Evidence should normally be present for the large majority of doctors. If not presented, the reasons why should be discussed at appraisal)	**Optional Evidence** (Evidence which the doctor may choose to include for the purpose of discussion within the appraisal, and/or for the purpose of demonstrating his/her good practice. This list cannot be exhaustively defined; examples of evidence are listed for the purpose of illustration)
Other professional roles (to include Teaching, Research, Management, and any other clinical and non-clinical professional responsibilities	Full declaration of all such roles in the appraisal preparatory paperwork (Forms 2 and 3)	Evidence of on-going performance review in these contexts. (Where such review is coordinated by a discrete organisation, e.g., deanery, trust or PCT, through a formal performance review/process of reaccreditation, this evidence must be provided. Where the employing organisation has no structured process for reviewing the doctor's performance in the relevant context, this should be noted in the appraisal preparatory paperwork, and discussed at appraisal).	Evidence of learning in the relevant context (courses attended, learning modules completed, self-assessment tools used, etc)
	Structured reflective template on how other roles impact on your clinical practice[2i].		Evidence indicating performance in the relevant context (e.g. Publications, commendations, feedback from students, diplomas, degrees and other awards)

Section of Good Medical Practice	Essential Evidence (Personal) (Evidence without which the appraisal cannot continue)	Essential Evidence (Organisational) (Evidence should normally be present for the large majority of doctors. If not presented, the reasons why should be discussed at appraisal)	Optional Evidence (Evidence which the doctor may choose to include for the purpose of discussion within the appraisal, and/or for the purpose of demonstrating his/her good practice. This list cannot be exhaustively defined; examples of evidence are listed for the purpose of illustration)
Probity	Self-declaration of performance management status/disciplinary status within the host organisation	Evidence of probity in relation to funds managed on behalf of others.	Other evidence relating to probity which the appraisee chooses to present, to demonstrate good practice (e.g. Evidence of gift register)
	Self declaration of GMC Status, NCAA Status, Criminal Status	Completion of probity questionnaire, as defined by either GMC and Academy of Royal Medical Colleges (ARMC) or locally agreed.	Other evidence which the appraisee chooses to present, so as to discuss at the appraisal
	Completion of probity structured reflective template[2j]		Evidence of participation in learning activities relating to probity
Health	Completion of health structured reflective template[2k]	Self-declaration of health status, as defined by either GMC or ARMC, or locally agreed.	Other evidence relating to health which the appraisee chooses to present, to demonstrate good practice
			Evidence of participation in learning activities relating to health (e.g. Attending stress-reduction workshops)

Summary checklist of essential evidence for appraisal

Item	Requirement	Present (tick)
Completion of new forms 1,2,3	Annual Legible Coherent Provided in good time	
Provision of on-going PDP, with clear description in Form 3 of degree of attainment.	Annual	
Last year's appraisal summary (Form 4)	Annual	
Case review structured reflective template (SRT)	2 annually	
Data collection/audit with SRT	1 annually	
Significant event SRT	1 annually	
SRT on last year's learning	Annual	
Patient survey SRT	Within past three years	
Complaint SRT(s) or declaration of no complaints	At least one annually	
Multi-source feedback SRT	Within past 3 years	
Full declaration of all other professional roles	Annual	
Other professional roles SRT	Annual	
Probity SRT	Annual	
Health SRT	Annual	

References

(1): General Medical Council *Good Medical Practice* London, GMC, 2006.

(2): NHS Clinical Governance Support Team (2005) *Assuring the quality of medical appraisal* Available at: http://www.appraisalsupport.nhs.uk/files2/Assuring_the_Quality_of_Medical_Appraisal.pdf/ (accessed Feb 21 2007)

(3): Department of Health. *Good doctors, safer patients: Proposals to strengthen the system to assure and improve the performance of doctors and to protect the safety of patients. A report by the Chief Medical Officer.* London, Department of Health, 2006

(4): HM Government: *Trust, Assurance and Safety, the regulation of Health Professionals in the 21st Century* (CM7013) London, TSO, February 2007, available at: http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4143132&chk=gxBiUz. (accessed March 4, 2007)

(5): NHS Clinical Governance Support Team (2004) *Defining the evidence for revalidation: supporting the Royal College of General Practitioners* Available at: http://www.appraisalsupport.nhs.uk/files2/11092004090353defining_the_evidence_for_revalidation_pdf_late_edit.pdf

Appendix 1 - Factors to consider relating to evidence

There is no piece of evidence that has been identified, which meets all of the desirable attributes for the purpose. Any piece of evidence that may be useful, therefore, has its advantages and disadvantages. Those attributes, which might be considered to be of greatest importance when weighing a piece of evidence, are:

1. **Equivalent to that required of other disciplines.** Whilst each professional discipline will have items of evidence reflecting the specialised nature of the discipline, it is important to ensure that the overall burden of requirement for revalidation is the same for all.
2. **Level of relationship to the individual.** Generally speaking, more evidence currently exists, relating to organizational activity, than to the individual doctor. Ideally, revalidation requires data to be assessed, relevant to the individual. The disadvantages of much information that currently relates to the individual are that it may be less standardised, preventing comparisons, and it may be more difficult to verify.
3. **The nature of the doctor's work**. Despite the above limitations, much more information is available for stable senior doctors (Consultants, GP Principals) than for peripatetic doctors, e.g. locums, staff grade hospital doctors and non-principals GPs. In addition, the presence of a departmental or practice infrastructure makes it easier for Consultants and GP Principals to generate personally related data. The recommendations for "essential" evidence in this document include options that can be produced by peripatetic doctors.
4. **The level of "face-value" credibility.** An item that is perceived by the profession as lacking in value could be damaging to this new process at a critical early stage. It is worth acknowledging that for most of the items of evidence in this paper there is no substantive evidence base in terms of their impact on patient care. Indeed, for certain items of evidence, it is extremely difficult to move beyond face-validity. Nevertheless, where possible, establishing this evidence base is a key requirement for immediate development
5. **Ease of production**. Ideally, evidence should be produced as a by-product of another process. Hence, departmental data, or, in Primary Care, Quality and Outcomes Framework (QOF) data may be included, despite it being group-based. Also, evidence already being produced for appraisal, such as a description of the doctor's practice, or a significant event report, might be included to minimise duplication.
6. **Source of production**. Where possible, data should be collected with minimum disruption to the doctor. Hence, for example, Trusts and PCTs should provide data where possible. On the other hand, to a degree, involvement in the creation of evidence is important for ownership on the part of the doctor. A balance has therefore been sought in this regard, through the use of personal structured reflective templates, to ensure that the doctor provides a link between the organisation information and his or her individual practice.
7. **Level of objectivity**. Typically, a highly personal piece of evidence, e.g. personal audit, is difficult to standardise for the purposes of comparison.
8. **Level of verifiability**. Similarly, personally-produced data are less verifiable than, say, organisationally-produced data.
9. Whether "SMART" or not. Where possible, each item of evidence should be written in "SMART" terms, i.e. Specific/Measurable/Achievable/Realistic/Timely

Adapted from: NHS Clinical Governance Support Team (2004) Defining the evidence for revalidation – supporting the Royal College of General Practitioners. Full document available at: http://www.appraisalsupport.nhs.uk/files2/11092004090353defining_the_evidence_for_revalidation_pdf_late_edit.pdf (accessed July 12, 2006)

Appendix 2a - Case review structured reflective template

Name of doctor:	GMC No:
Date of clinical event:	Patient Identifier:
Description of clinical event: Hint: You may choose a single consultation at random, or you may prefer to choose a case in which you were involved over time. Either way, your involvement should have been significant. You should write from your personal perspective, and reflect on how your own professional behaviour can improve, not that of the organisation, or of others.	
Reflections relating to **Good Clinical Care**: Hints: This refers to the systems allowing effective care, and your place within them. Was all information to hand? Was there enough time for the consultation? Was the environment conducive to patient privacy and dignity? Were all required clinical facilities available? Were local guidelines available? What can I do to improve these factors?	
Reflections relating to **Maintaining Good Medical Practice** Hints: This refers to your level of knowledge. How do I judge my level of knowledge, or skill around this clinical topic? What unmet learning needs can I identify? How can I address them?	
Reflections relating to **Relationships with Patients** Hints: How well did I communicate with the patient? Did the patient feel respected? Did the patient have sufficient opportunity to tell their story? Did the patient feel a partner to the outcome of the consultation? How do I gauge these? What skills can I identify which will enhance these?	
Reflections relating to **Relationships with Colleagues** Hints: Did I take account of notes made by others prior to this event? Did I gather information appropriately from others? Did I make comprehensive, legible records for others who may see the patient subsequently? Did I appropriately respect the clinical approach of others, even if it differs from my own? What can I do to improve this area in the future?	
Outcome: For completion at your appraisal: Agreed potential learning needs for consideration for inclusion in your personal development plan, considering how your outcome will improve patient care.	

Appendix 2b - Significant event audit (SEA) structured reflective template

Name of doctor: GMC No:
SEA Title:
Date of incident:
Description of events:
What went well?
What could have been done better?
What changes have been agreed? Personally: For the team:
Final outcome after discussion at appraisal: (Complete at appraisal considering how your outcome will improve patient care)

Appendix 2c - Data collection/audit structured reflective template

Name of doctor: GMC No:
Measurement/audit title: Date of data collection/audit:
Reason for choice of measurement/audit:
Audit findings:
Learning outcome and changes made: New audit target:
Final outcome after discussion at appraisal: (Complete at appraisal considering how your outcome will improve patient care)

Appendix 2d - Personal learning structured reflective template

Name of doctor: GMC No:
Considering my comments under *Maintaining Good Medical Practice* (in form 3 of my appraisal paperwork), the following strategies may help improve how I keep up to date in the next year: Date of reflection:
Final outcome after discussion at appraisal: (To complete at appraisal considering how your approach will improve patient care)

Appendix 2e - Patient survey structured reflective template

Name of doctor:	GMC No:
Date of survey:	
Type of survey:	
What issues can I identify from the exercise? Hints: Look at your positive findings just as carefully as the most negative. Discuss and seek advice from colleagues both peer and senior, if possible. If you have difficulty identifying learning needs from the survey, be frank about this. Skills in interpreting such information can then be considered as your first learning need in this regard. What actions will I undertake? Hints: These might include: improving communication techniques, restructuring ward rounds to maximise dignity and privacy, negotiating changes to the consulting environment, developing skills with respect to specific cohorts of patients, learning more about how to learn from patient surveys (as above). Final outcome after discussion at appraisal: (Complete at appraisal considering how your outcome will improve patient care)	

Appendix 2f - Complaint report structured reflective template

Name of doctor:	GMC No:
Date of complaint:	
Nature of complaint:	
Status of complaint: On-going / resolved	
Involvement of other bodies: Responsible organisation / SHA / NCAA / GMC / Other	
If resolved, what were the findings?	
How will my practice change?	
Final outcome after discussion at appraisal: (Complete at appraisal considering how your outcome will improve patient care)	

Appendix 2g - Declaration of absence of complaints

Name of doctor:	GMC No:
I declare that, to the best of my knowledge, I have received no complaints relating to my professional practice since my last NHS Appraisal, on ___________ (insert date of last appraisal). I enclose details of my local complaints procedure.	
Signed:	Date:

Appendix 2h - Multi-source feedback structured reflective template

Name of doctor:	GMC No:
Date of exercise:	
Feedback scheme used (specify if self- or locally-designed):	
Number of colleagues giving feedback:	
Name of person who collated and gave feedback:	
Designation of person giving feedback: (e.g. Clinical Director, Professional Partner, Appraiser; Professional Facilitator)	
Main outcomes of feedback Hints: Look at your positive outcomes, as well as learning needs:	
What learning might I undertake? Hint: It may help to separate learning from changing your behaviour. So, rather than "I will show more respect to nursing colleagues", it might be more productive to undertake learning which develops your understanding of the benefits of the diversity of teams. Your ideas in this section can be discussed further with your appraiser.	
Final outcome after discussion at appraisal: (Complete at appraisal, considering how your outcome will improve patient care)	

Appendix 2i - Other roles structured reflective template

Name of doctor: GMC No:
Considering my other clinical and non-clinical roles as listed in Form 2 of my appraisal paperwork, these bring the following benefits to my main clinical role:
They also bring the following drawbacks to my main clinical role:
I could consider the following actions, to maximise the benefits and minimise the drawbacks: Date of reflection:
Final outcome after discussion at appraisal: (Complete at appraisal considering how your approach will improve patient care)

Appendix 2j - Probity structured reflective template

Probity structured reflective template*	
Name of doctor:	GMC No:
The following are situations where issues of probity are common: Ethics of working with drug reps (All doctors) Ethics of referring to alternative practitioners (All doctors). How/whether to tell patients which local pharmacy to visit (Primary Care clinicians). Doctors receiving gifts from patients (All doctors). Teaching issues e.g. having school children doing work experience, how much responsibility to give medical students (All doctors). Conflicts when interests of the PCT/Trust (or wider NHS) conflict with what is best for individual patient care (All doctors). Partnership issues e.g. cheque signing, salaried versus profit sharing (Primary Care clinicians). Sickness certification (All doctors). Applying for research funding (All doctors). Colleagues who are ill, underperforming or negligent. Patients who divulge information challenging principles of confidentiality (e.g. epileptic who is driving). Select an instance from this list or otherwise, where there has been a dilemma in terms of probity in the last year.	
Describe the dilemma:	
What did I do?	
What was good about the approach I took?	
What could I have done to have produced a better outcome?	
What changes will I make? Personally: For the team:	
Final outcome after discussion at appraisal: (Complete at appraisal considering how your approach will improve patient care)	

*Adapted from Whittet, Sally. *Health and probity in appraisal: what do you ask?* Available at: http://www.appraisalsupport.nhs.uk/files2/Health%20and%20Probity%20-%20Sally%20Whittet%20final%20pdf.pdf (accessed Feb 21, 2007)

Appendix 2k - Health structured reflective template

Name of doctor: GMC No:

The following are health issues which commonly apply to doctors:
• Are you registered with a GP?
• Have you attended your GP in the past year?
• Have you self-prescribed in the past year, or asked a colleague to prescribe?
• Have you bypassed the normal NHS referral process in the past year?
• Do you have a chronic illness?
• Are you in pain?
• Have you had a recent bereavement?
• Are you experiencing stress at work or elsewhere?
• What are your coping strategies for stress?
  ○ Do you actively self-care and consider work-life balance?
  ○ Do you have adequate holiday and study leave (and do you actually take this entitlement?)
  ○ What is your network of support at work and outside work? (Consider friends, colleagues, mentors, support groups)
• Are you concerned that you may have a dependency on alcohol or drugs?
• Are you involved in a complaint?
• Are you sleep-deprived?
Select an issue, from this list or otherwise, in terms of your health affecting your ability to provide clinical care in the last year.

What is/are the issues?
How have I approached this in the past?
What could I do in the next year to improve things?
Final outcome after discussion at appraisal: (Complete at appraisal considering how your approach will improve patient care)