

# Appraisal Metrics for Consultants and SSAS doctors in Specialist Palliative Care

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## *Introduction*

This document presents guidance on appraisal metrics for specialist palliative care physicians. It has been produced by a group of specialist palliative care doctors and is endorsed by the Royal College of Physicians and the Association of Palliative Medicine. It has been developed in response to changes in medical appraisal associated with revalidation in the UK and reflects current systems in all countries within the United Kingdom. The guidance is based upon the areas of work identified by the GMC guidance on 'Supporting Information for appraisal and revalidation'.

Specialist palliative care teams are those with palliative care as their core daily work. They are multidisciplinary teams, have specialist skills and experience, and deliver palliative care both directly and indirectly; directly by providing care to patients and families, and indirectly by supporting other professionals to deliver such care (1).

Guidance specific to specialist palliative care physicians is needed as a result of the particular challenges they experience in producing evidence to reflect their work.

Firstly, "success" in specialist palliative care is not easily measured by quantifiable metrics. This guidance suggests ways in which specialist palliative care doctors might demonstrate the quality and effectiveness of their service. Secondly, patients receiving specialist palliative care are less able to give feedback on the service because of their frailty. In inpatient palliative care settings for instance, up to 60% of patients cannot provide written feedback (2), and towards end of life, obtaining feedback becomes even more difficult. Thirdly, a significant part of the impact of specialist palliative care is indirect, with specialist palliative care doctors working to support other professional colleagues in delivery of palliative and end of life care, through professional support and through education. Fourthly, specialist palliative care aims to attend to the needs of those around the patient, as well as the patient themselves. It specifically focuses on families as part of care, and information about this component of professional activity needs to feed into doctors' appraisals. Lastly, many palliative care doctors work exclusively in third-sector organisations which may have limited infrastructure to support collection of appraisal metrics.

This guidance is aimed at consultants and SSAS doctors who provide specialist palliative care to patients over 18. The document will also be valuable to appraisers and Responsible Officers who may not be familiar with the speciality, nor the particular constraints that may influence collection of evidence about the practice of an individual doctor. It was informed by an online survey of appraisal and revalidation experience in specialist palliative medicine doctors. A total of 167 responses were received about the types of appraisal metrics currently being collected. These will be referred to in subsequent sections and full details are provided in Appendix 1.

The document is arranged in the following sections and within each, examples are given of supporting information with an indication of minimum evidence and what might be considered best practice. Examples described under 'Minimum' are those which the specialty considers all doctors working within palliative medicine should try to include in their portfolios; appraisers may question why these are not provided within each cycle, if not each year. Those denoted as 'Best Practice' provide examples that physicians should strive towards but this may be dependent upon both context of work and available resources.

1. Continuing Professional Development (CPD)
2. Activity, audit and quality improvement
3. Significant events
4. Feedback from colleagues
5. Feedback from patients
6. Complaints and compliments
7. Teaching and training
8. Research
9. Management

The information is mapped to the four domains defined by Good Medical Practice, which form the basis of the appraisal summary:

- Domain 1: Knowledge, skills and performance
- Domain 2: Safety and quality
- Domain 3: Communication, partnership and teamwork
- Domain 4: Maintaining trust

It should be noted that often a piece of supporting information may be applicable to more than one domain. This guidance highlights the importance of providing some information in relation to the entire scope of practice, including private work and non-clinical roles activities such as education, research and management.

Whether the contents are organised within a paper based or electronic portfolio is usually subject to guidance by the local Responsible Officer and Designated Body. Members and Fellows of the College of Physicians or General Practitioners can utilise an electronic portfolio such as the CPD diary or CPD credits scheme. Alternatively, The Medical Appraisal Guide provides a free of charge electronic portfolio (known as the 'MAG form' which is an electronic platform for organisation of supporting information and the appraisal outputs). Doctors in Scotland can use the Scottish Online Appraisal Resource (SOAR), which also facilitates a multisource feedback and those in Wales, the MARS system for appraisal and revalidation.

## Useful Resources:

GMC Guidance 'Supporting Information for Appraisal and Revalidation': [http://www.gmc-uk.org/doctors/revalidation/revalidation\\_information.asp](http://www.gmc-uk.org/doctors/revalidation/revalidation_information.asp)

RCGP portfolio for GPs: <https://appraisals.clarity.co.uk>

RCP portfolio for physicians: <https://www.rcplondon.ac.uk/cpd/revalidation/revalidation-portfolio>

RCGP revalidation e portfolio: <https://gpeportfolio.rcgp.org.uk/>

NHS revalidation The Medical Appraisal Guide, and electronic appraisal form: <http://www.england.nhs.uk/revalidation/appraisers/med-app-guide/>

Medical Appraisal and Revalidation System (MARS) for all doctors in Wales: <http://marswales.org/>

Revalidation in Wales: <http://revalidation.walesdeanery.org/>

Revalidation in Scotland: <http://www.appraisal.nes.scot.nhs.uk>

## *1. Continuing Professional Development*

This section covers keeping knowledge and skills up to date in palliative medicine to maintain competence and performance. CPD should, over each revalidation cycle, support all professional roles whether clinical, managerial, academic or as a trainer.

CPD activities should also be accompanied by demonstration of reflection, which indicates the learning that was gained and its impact on professional development, and not simply be a list of courses attended. The RCP CPD website provides a tool that can be used for reflection and these are also included within electronic portfolios.

The Association of Palliative Medicine (APM) recommends enrolment in the CPD system from the Royal College of Physicians (RCP). This is not mandatory, however you would need to show evidence of comparable activities and credits if it is not used.

- Minimum of 50 CPD credits per year, 250 credits over a 5-year cycle (1 hour of learning activity = 1 credit)
- The RCP recommend 25 'external' credits (through activities outside the place of work) and 10 'personal' credits obtained through self-directed learning
- There should be a range of CPD activity activities undertaken that can reflect development in relation to the different roles undertaken by a doctor.

For doctors who work in Wales, CPD information can be recorded on the MARS system and is transferable.

|  | <b>Minimum</b>  | <b>Best practice</b>   | <b>Appraisal summary domain</b>   |
|--|---|--|---|
| Attendance at a major palliative medicine conference   | Once every five years: attendance and reflection about key learning and application to own practice | Every two years  | Domain 1: Knowledge, skills and performance plus other depending on topic   |
| Other external events: attendance at seminars and workshops  | Core palliative medicine topics   | Includes some broader topics in other relevant clinical subjects; clinical governance/root cause analysis training; ethics | Domain 1: Knowledge, skills and performance plus other depending on topic   |
| Self-directed learning: journal reading, e-learning; learning in response to a clinical problem              | Documentation with demonstration of reflection  | Peer discussion and reflection   | Domain 1: Knowledge, skills and performance plus other depending on topic   |
| Refreshing and development of skills through interactive learning  | Core palliative medicine skills (e.g. communication skills)   | Extended /new skills with adoption in practice e.g. media training; practical use of ultrasound; mentorship                | Domain 1: Knowledge, skills and performance plus other depending on topic<br>e.g: Domain 2- Safety and Quality<br>Domain 3: Communication, Teamwork |
| Reviewer of original articles<br>Preparation for talks as invited speaker                                    |   | Ad hoc   | Domain 1: Knowledge, skills and performance plus other depending on topic   |
| Demonstration of CPD as an expectation of specific roles: trainer/supervisor of doctors<br>medical appraiser | GMC requires annual supporting information in respect of educational roles                          | Where no minimum requirement, some related CPD every 2-3 years   | Domain 1: Knowledge, skills and performance plus other depending on topic   |

## Useful Resources

Royal College of Physicians detailed guidance on CPD credits

<https://www.rcplondon.ac.uk/education-practice/advice/guidelines-cpd-diary>

Royal College of Physicians CPD Diary

<https://cpd.rcplondon.ac.uk/Login.aspx>

### *2. Quality improvement, activity and audit*

It is recommended that data collection such as the Palliative Care Clinical Data Set (PCCDS) be reported as a measure of activity of specialist palliative care services. Compliance with collection of this data can be used in supporting information about clinical activity for appraisal and revalidation, acknowledging that often there is shared team approach. It is anticipated that doctors would be engaging in audit or other quality improvement (QI) activities continuously with evidence provided at each appraisal. It is considered good practice to take part in national audits and evaluations such as FAMCARE where available.

The portfolio contents for QI/audit work should, as far as possible, include a brief summary with details of how the outcomes were shared, presented, reviewed within a peer group or in comparison to local and national benchmarking and the actions and implementation of change following this. The role of the individual doctor should be described - for example as lead, or as supervisor of a trainee undertaking the audit.

Supporting information should reflect activities in all places of work; wherever possible an annual statement of assurance of good practice should be obtained via the RO or clinical governance lead of individual organisations.

All supporting information, including reflections, should be anonymised appropriately to protect confidentiality of patients and staff.

|  | <b>Minimum</b>   | <b>Best practice</b>   | <b>Appraisal summary domain</b>   |
|--|--|--|---|
| Activity (new patient and follow up referrals, outpatient consultations, home visits; MDT attendance; on call activities and telephone advice<br>Specific procedures if applicable | Provision of individual level activity if available<br><br>PCCDS records for the team/service if required locally, or as applicable to Scotland, Wales and N Ireland   | Review of activity e.g. peer review discussion of telephone advice given   | Domain 1: Knowledge, skills and performance<br>Domain 2: Safety and quality |
| Audit: List of audit activities completed and on going   | Demonstration of engagement of some audit activity each year, whether led or supervised<br>Report of a completed audit, recommendations and action plan every 2 years<br>One complete cycle (includes implementation and re-audit) with some benchmarking of practice every five years | Benchmarking of practice by participation in loco-regional and national audits such as FAMCARE 2, national end of life care audit, those initiated by Hospice UK | Domain 1: Knowledge, skills and performance<br>Domain 2: Safety and quality |
| External quality review; Peer review , CQC inspection reports<br>(especially if lead clinician, medical director/Responsible Officer roles)  | Last CQC report (if lead for EOL care)   | Include with reflection and action plan  | Domain 2: Safety and quality  |

|  | <b>Minimum</b>   | <b>Best practice</b>   | <b>Appraisal summary domain</b> |
|--|--|--|---------------------------------|
| Quality improvement audit and other activities: specific projects which might be supported by third sector or commissioners (CQUINS) | Demonstration of engagement in some QI activity every year | Demonstrable improvement in patient safety, care or experience embedded in practice:<br>Development of evidence based protocols (formally approved)<br>Service innovation leading to improved care pathway | Domain 2: Safety and quality    |
| Clinical outcomes  | See section 5  |  |                                 |

### *3. Significant events*

All NHS and independent organisations should have systems for clinical governance through which clinical incidents are reported, investigated and actions taken to improve care.

A doctor should include in his/her portfolio, and discuss at appraisal, any significant events or serious untoward incidents (SUIs) within the past year which have related to them as an individual. This should include evidence of reflection and learning from these where appropriate. These may not be the prime or sole responsibility of the clinician but there is also responsibility to support the investigation and actions to improve the service to patients and families. While being responsible for a significant incident is distressing to a doctor, demonstration of their response and efforts to resolve the situation and make improvements for the future should be seen as positive aspects of one's development and practice. All supporting information, including reflections, should be anonymised appropriately to protect confidentiality of patients and staff.

Morbidity and mortality data, while important for other specialties, is less transferrable as a quality or outcome indicator in relation to palliative care practice. An alternative approach would be to consider use of peer-review and discussion of clinical events. These may relate to difficult clinical situations in which specialist palliative care teams and the physician may be directly involved in a specific care setting, and these provide possible topics for peer review and discussion, or local audit with comparison of practice between comparable teams and services.

The following are examples of clinical events that could be used in such a way:



- Episodes requiring administration of naloxone during titration of opioids in a specific care setting
- Peer view of practice where relatively high 24-hour doses of opioids are used
- Planned withdrawal of assisted ventilation
- Complications of steroid administration including hyperglycaemia
- Use of sedation to manage prolonged distress associated with intractable symptoms
- Episodes where there are safeguarding and DOLS processes
- Failed discharge from inpatient setting or an inappropriate hospital admissions
- Suicide or attempted self-harm in a patient or carer

|  | <b>Minimum</b>  | <b>Best practice</b>  | <b>Appraisal summary domain</b>   |
|--|---|---|---|
| Clinical incidents (specific events where there has been recognised harm or a near miss) | Examples of incidents reported by doctor with reflection and learning   | Detailed review and action plan implemented to prevent recurrence | Domain 2: Safety and quality  |
|  | Examples of incidents directly relating to care provided by self or team with reflection<br>SUI: include evidence of participation in investigatory process and outcome; reflection of learning<br>Evidence of being open with patient and families | Demonstration of peer discussion, actions taken                   | Domain 2: Safety and quality<br><br>Domain 4: maintain trust (duty of candour examples) |

|  | <b>Minimum</b>                          | <b>Best practice</b>  | <b>Appraisal summary domain</b>  |
|--|---|---|--|
| Clinical events relevant to palliative care (see examples above) | Personal reflection on a specific event | Formal audit or peer review of a cluster of cases in past year<br>Reflection and any change in practice | Domain 2: Safety and quality<br>Possible domain 3: Communication, teamwork |

#### **4. Feedback from colleagues.**

Feedback from colleagues should include feedback on the individual doctor as well as feedback on the whole team or service.

Individual feedback should reflect the multidisciplinary nature of Palliative Medicine and include a range of clinical and non-clinical colleague from different disciplines. The sample of colleagues should reflect the whole scope of work, both clinical and non-clinical roles such as education, research or management roles and also include private practice. In some organisations the list of colleagues may need approving by the medical lead. Collection must be anonymous; usually by a third party, for example administrative staff, appraiser, or the revalidation team. You should receive the feedback prior to your appraisal so that you have opportunity to reflect on it and discuss in your appraisal.

Further guidance is available from the GMC and the RCP at:

<https://www.rcplondon.ac.uk/education-practice/advice/feedback-revalidation>

The GMC does not prescribe the numbers of responses but the RCP recommends 15 colleague raters.

In Palliative Medicine practice, it is also important to capture feedback from professional colleagues who are supported in delivery of palliative or end of life care. This indirect patient care can be a significant proportion of Palliative Medicine doctors work load and the influence on other professionals will extend beyond the care of individual patients. This feedback may be captured via individual colleague feedback but also through team feedback, service evaluations or professional service user surveys.

|  | <b>Minimum</b>  | <b>Best practice</b>   | <b>Appraisal summary domain</b>                                      |
|--|---|--|--|
| Informal feedback: positive and negative from individual colleagues including the multidisciplinary team, trainees, professionals other than palliative care | Examples of any received in year with reflective note on any significant communications   | Inclusion of all informal feedback received, whether positive or negative.   | Domain 3: Communication, teamwork<br><br>Domain 4: maintaining trust |
| Formal feedback  | Once in every 5 year cycle, within first 3 years<br><br>Demonstration of discussion with appraiser or manager; reflection and where appropriate CPD or personal development goals to improve practice | Role-specific feedback especially if holding a senior position: evidence of discussion with appraiser or manager; reflection and where appropriate CPD goals | Domain 3: Communication, teamwork<br><br>Domain 4: maintaining trust |

| <b>Feedback from Colleagues</b> |                             | <b>Examples</b>  |
|---------------------------------|-----------------------------|--|
|                                 | Individual                  | GMC MSF <a href="http://www.gmc-uk.org/colleague_questionnaire.pdf_48212261.pdf">http://www.gmc-uk.org/colleague_questionnaire.pdf_48212261.pdf</a><br>RCP MSF <a href="https://www.rcplondon.ac.uk/cpd/revalidation/supporting-information-tools-and-templates/feedback-and-revalidation">https://www.rcplondon.ac.uk/cpd/revalidation/supporting-information-tools-and-templates/feedback-and-revalidation</a><br>360 Equiniti <a href="http://www.equiniti360clinical.com/">http://www.equiniti360clinical.com/</a> |
|                                 | Service                     | Service Evaluation<br>Staff User Survey  |
|                                 | Other Indirect Patient Care | Impact of advice line or other service innovation.<br>Report/Service Evaluation/Audit  |

## 5. Feedback from patients.

This section overlaps heavily with section 2 (Activity, audit and quality improvement), since audit or quality improvement often depends on patient feedback to assess and improve the standards or quality of care being delivered.

The three main forms of feedback from patients will be:

- Outcome measures
- Experience measures
- Direct feedback from patients about the specific interaction with a particular doctor (a specific type of experience feedback required for revalidation)

Data from outcome or experience measures can readily be used for appraisal and revalidation purposes. It is useful to be clear about definitions:

- An outcome measure is “a change in health status which can be attributed to preceding healthcare intervention” (3)
- An experience measure captures “a patient and their family’s perception about their experience of the healthcare they have received” (4)

It is also worth considering *who* has collected the data.

All supporting information, including reflections, should be anonymised appropriately to protect confidentiality of patients and staff.

### Outcome measures

Outcome measures may be reported by patients themselves, by patients with help from family or professionals, or by professionals. Ideally, patient-reported outcome measures (PROMs) are preferred, since this is less subject to bias in reporting, but this is problematic in palliative care because patients may simply be too ill or lack capacity to complete. The extent of inability to complete PROMs varies by setting: up to 60% of hospice patients need help completing outcome measures and about 15-25% of community patients need help (5).

Focusing on patient-reported measures alone therefore runs the risk of excluding a high proportion of patients; the use of “patient- or person-centred outcome measures” (PCOMs) has been proposed instead (5). PCOMs refer to measures which focus on the domains known to be prioritized by patients with advanced illness (hence they are person-centred), yet they may be reported by proxies (families or professionals) on the patient’s behalf as the patient is often too frail or sick to report for themselves. Proxy report has been shown to be both necessary and useful in palliative care (6), and it is therefore appropriate to use proxy measures for appraisal and revalidation purposes.

## Experience measures

Experience measures cannot so readily be reported by proxies, since it is really only the individual themselves who can experience care and then report that experience. However, in palliative care, the family view on the experience of care is sometimes sought. It is important to distinguish whether it is: i) the family perspective on the patient's experience of care, ii) the family's own experience of care of themselves, or iii) the family's reporting of outcomes, which is sought. Sometimes these are combined within measures, and even within single items.

Data from outcome and experience measures can be reported at individual patient level, or may be aggregated to group or population level. The level of aggregation may vary from being grouped at a specific palliative care team or service level (for example, all community patients seen in a geographical patch), to an organisation level (such as all patients seen within a hospice). Clearly, the higher the level of aggregation of data, the more difficult it becomes to attribute improved (or sustained<sup>1</sup>) improved outcomes to any one specific intervention or team.

### Direct feedback from patients about the specific interaction with a particular doctor

Direct feedback from patients about their experience of specific consultations or other interactions with a particular doctor is difficult to accrue from palliative care patients because of their frailty. However, it has proved possible to achieve feedback from consecutive patients, provided there is awareness that only a small proportion of patients are likely to be well enough to complete, and considerable time may therefore be required to accrue feedback from the 15 or 20 patients recommended. This proportion obviously varies according to palliative care setting, but may need several months to achieve in inpatient (hospice and hospital) contexts.

In Appendix 2, there is an adapted version of the General Medical Council patient questionnaire which can be used for this purpose, together with an outline covering letter. The main requirement is to ensure that the collection and collation of this feedback is conducted independently of the doctor, usually by an independent administrator or revalidation support staff.

### Use of outcome and experience measures in appraisal and revalidation

The use of outcomes and experience measures can be used in a variety of ways to support appraisal and revalidation:

- Evidence of the introduction of an outcome or experience measure into clinical practice
- Use of outcome or experience measures in audit, service evaluation or research
- Patient-level data which relates to interventions of a specific professional (this may be more difficult to obtain, since most of palliative care is underpinned by multi-disciplinary team working)

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<sup>1</sup> Since palliative care patients are often deteriorating in health, outcomes may show that **deterioration is prevented**, rather than any improvement made. For example, functional status may be maintained rather than allowed to deteriorate, or breathlessness may be prevented from worsening rather than resolved.

- Use of feedback from outcome or experience measures for yourself and/or other team members to directly influence the care of individual patients and families
- Documentation of the use of feedback from outcome or experience measures to directly modify team practices and processes
- Contribution to regional or national initiatives requiring outcomes and experience measures, such as regional outcomes initiatives, the national data and outcomes work, etc.

|   | <b>Minimum</b>    | <b>Best practice</b>   | <b>Appraisal Summary Domain</b>  |
|---|-------------------|--|--|
| Team outcome data (gathered about team)               | No minimum agreed | Reporting of outcome measures e.g. OACC suite<br><br>Demonstration of effectiveness such as impact on admissions, rapid discharge, place of care, etc. | Domain 1: Knowledge, skills and performance<br>Domain 2: Safety and quality<br><br>Domain 3: Communication, partnership and teamwork |
| Individual outcome data (gathered about own practice) | No minimum agreed | Reporting of outcome measures e.g. OACC suite in relation to specific contacts.  | Domain 1: Knowledge, skills and performance<br>Domain 2: Safety and quality  |
| National audits                                       | No minimum agreed | National end of life care audit; audits applicable to Scotland, Wales and N Ireland .  | Domain 2: Safety and quality   |

|  | <b>Minimum</b>                          | <b>Best practice</b>  | <b>Appraisal Summary Domain</b>  |
|--|---|---|--|
| Local audits   | At least one audit yearly               | For example:<br>Drug prescribing<br><br>Blood sugar monitoring (steroids), antibiotic use<br><br>Procedures and complication rates<br><br>Regional trainee/ organisational audits: application of clinical policies | Domain 1: Knowledge, skills and performance<br><br>Domain 2: Safety and quality<br><br>Possibly also:<br><br>Domain 3: Communication, partnership and teamwork |
| Patient-reported experience of care                                  | Patient feedback at least every 5 years | Patient multisource feedback survey <sup>2</sup><br><br>Patient satisfaction survey   | Domain 3: Communication, teamwork<br><br>Domain 4: Maintaining trust   |
| Carer-reported experience  | Post-bereavement survey                 | FAMCARE2<br><br>Post bereavement survey at least every 2 years  | Domain 3: Communication, teamwork<br><br>Domain 4: Maintaining trust   |
| Other 'client' outcomes e.g other professionals who refer to service | No minimum agreed                       | User satisfaction surveys   | Domain 3: Communication, teamwork<br><br>Domain 4: Maintaining trust   |

<sup>2</sup> May be adapted locally based upon GMC example – see Appendix 2.

|   | <b>Minimum</b>   | <b>Best practice</b>   | <b>Appraisal Summary Domain</b> |
|---|--|--|---------------------------------|
| Quality improvement work (beyond audit) | No minimum agreed, although governance and safeguarding activities and review should be regular and continuous | Clinical governance - review, learning and actions<br><br>Safeguarding activities<br><br>Hospital CQUIN projects (e.g. documentation of advance care planning) |                                 |

## ***6. Complaints and compliments***

All NHS and independent organisations should have systems for clinical governance through which complaints received about a clinician or service are reported, investigated and actions taken to improve care. In addition, the clinician may have assisted in the process to investigate or resolve a complaint, or provide a peer opinion.

Examples of compliments have always been letters and cards but may also be captured in emails; these apply also to positive comments from colleagues. Compliments may be made through informal PALs feedback in hospitals. The formal 360 feedback exercises with both colleagues and patients/carers provide important supporting information, especially through any specific comments made within these.

Whenever possible these should be captured but anonymised; both positive and negative comments warrant reflection when included in the portfolio.

|            | <b>Minimum</b>   | <b>Best practice</b>  | <b>Appraisal summary domain</b> |
|------------|--|---|---------------------------------|
| Complaints | Must include any formal complaint directed towards the individual clinician and reflection | Demonstration of efforts to resolve complaint and/or implementation of any learning |                                 |



## 7. Teaching and Training

Strengthened medical appraisal covers “whole scope of work” so all educational roles must be included and considered. Teaching and Training is core to palliative medicine practice and occupies a large proportion of our workload. This activity represents the indirect clinical care we deliver through others facilitated by our multi-professional teaching and training. The quality of palliative care training to all staff groups dictates the quality of palliative care both now and in the future.

It is important not just to collate lists of teaching but to show evaluation, reflection on evaluation, and learning to continually improve teaching. Education may also encompass education of patients, carers, non-clinicians and lay people.

Postgraduate medical trainer – The GMC Standards for Trainers identified 2 groups of postgraduate trainer, Educational Supervisor and Clinical Supervisor. These roles should be appraised against some or all of the 7 domains set out by academy of medical educators. <http://www.gmc-uk.org/education/10264.asp>.

- 1) ensuring safe and effective patient care through training. ES and CS
- 2) establishing and maintaining an environment for learning ES and CS
- 3) teaching and facilitating learning ES and CS
- 4) enhancing learning through assessment ES and CS
- 5) supporting and monitoring educational process ES
- 6) guiding personal and professional development ES
- 7) continuing professional development(CPD) as an educator ES and CS

Local processes will be in place, full national guidance available at

[http://www.gmc-uk.org/education/postgraduate/standards\\_and\\_guidance.asp](http://www.gmc-uk.org/education/postgraduate/standards_and_guidance.asp)

Education Organisers e.g. undergraduate or postgraduate dean, sub-dean roles will have a review of their work undertaken by their supervisors that is then discussed at medical appraisal.

### Supporting Information

Teaching and training is likely to be extensive so using a local template for Educational Appraisal to summarise roles, responsibilities and teaching organised and delivered may be helpful to your appraiser. NACT provide an example Appendix 8 Review of Educator Roles. Within this document there are also examples of Supporting Information under the 4 GMC Domains

<http://www.nact.org.uk/documents/national-documents/>

There is overlap with other sections

- Educational Roles should be recorded under Scope of Work.
- Educational CPD recorded in CPD section
- Include Education colleagues in Colleague feedback (MSF)
- PDP should contain Educational Role learning and development needs

|  | <b>Minimum</b>  | <b>Best practice</b>  | <b>Appraisal summary domain</b>   |
|--|---|---|---|
| <b>Teaching</b><br>Undergraduate<br>Postgraduate<br>Medics<br>Multi-professional | Description of roles undertaken and any specific examples – e.g Course Lead, Tutor, sessional teaching<br><br>Session evaluation<br>Tutee feedback<br>Course evaluation | <ul style="list-style-type: none"> <li>• Peer observation and feedback</li> <li>• Reflection on Teaching/ Teaching Role example in AOME Guidance) <a href="http://www.gmc-uk.org/AOME_Essential_User_Guide_Nov_2013.pdf">http://www.gmc-uk.org/AOME_Essential_User_Guide_Nov_2013.pdf</a></li> <li>• <a href="http://www.oxforddeanery.nhs.uk/pdf/AOME%20Essential%20User%20Guide%20Nov%202013.pdf">http://www.oxforddeanery.nhs.uk/pdf/AOME%20Essential%20User%20Guide%20Nov%202013.pdf</a></li> <li>• Kirkpatrick Model of levels of training Evaluation- Reaction, Learning, Behaviour, Results <a href="http://www.kirkpatrickpartners.com/OurPhilosophy/TheKirkpatrickModel/tabid/302/Default.aspx">http://www.kirkpatrickpartners.com/OurPhilosophy/TheKirkpatrickModel/tabid/302/Default.aspx</a></li> </ul> | Domain 1 skills and performance<br>Domain 2: Safety and quality<br>Domain 3 Communication, teamwork |
| <b>Training</b><br>Educational Supervisor<br>Clinical Supervisor                 | Annual Trainee feedback on ES/CS  | <ul style="list-style-type: none"> <li>• Peer observation of supervision and feedback</li> <li>• Log of supervision meetings (e-portfolio)</li> <li>• Log of WBPA undertaken (e-portfolio)</li> <li>• Training Site feedback</li> </ul>   | Domain 1 skills and performance   |

|                                   |  |   |  |
|-----------------------------------|--|---|--|
| ARCP Panel member                 |  | <ul style="list-style-type: none"> <li>• ARCP panel ES Report feedback</li> </ul>                                   |  |
| Informal teaching                 |  | <ul style="list-style-type: none"> <li>• Visitor Feedback</li> </ul>  |  |
| Supporting trainees in difficulty |  | <ul style="list-style-type: none"> <li>• Reflection on specific examples</li> <li>• Activities as mentor</li> </ul> | Domain 1<br>skills and performance<br>Domain 2:<br>Safety and quality<br>Domain 3<br>Communication, teamwork |

## 8. Research

Metrics for research can readily be provided according to the standard academic requirements:

- Grant income – lead applicant or co-applicant, and details including funder, duration and amount of award.
- Publications – peer-reviewed research papers, commentaries, editorials, letters, book chapters.
- Citation and other metrics, either in relation to individual publications (such as number of cites, impact factor of journal, and percentile in field) or aggregated (such as H index).
- Academic esteem indicators (awards, positions, keynote and other presentations).
- Contributions to teaching, such as tutoring MSc and PhD students, teaching hours (see Section 7 Teaching and Training for more details).

## 9. Management

Evidence would be expected in relation to formal roles such as those of medical director, clinical director or clinical lead for a service. However all doctors, whether or not consultants, may engage in a range of non-clinical activities where they are taking responsibility to plan, co-ordinate and lead specific activities within their organisation or beyond. For example, responsibilities for effective use of resources whether a budget or staff; recruitment and selection; strategy development or as chair/lead of a working group or Committee. Each of these require leadership skills and through reflection on achievements, objectives for personal development can be identified.

Outcomes should relate to the key responsibilities, specific objectives and what has been accomplished in the past year. Supporting information may also include 360 colleague feedback using tools developed for clinical leadership assessment.

|  | <b>Minimum</b>   | <b>Best practice</b>  | <b>Appraisal summary domain</b>   |
|--|--|---|---|
| Clinical leadership  | Description of roles undertaken and any specific examples – chairing effectively, managing conflict; lead of a projector task group; role in clinical governance | Description of service development or project; objectives and achievements in year<br><br>Annual reports<br><br>Targeted CPD for leadership development   | Domain 1 skills and performance)<br><br>Domain 2: Safety and quality<br><br>Domain 3<br>Communication, teamwork |
| Chair or member of regional network, national or College committees and working groups |  | Terms of reference, key objectives and evidence of achievements;<br>personal reflection   | Domain 1 skills and performance)<br><br>Domain 2: Safety and quality<br><br>Domain 3<br>Communication, teamwork |
| Clinical director/senior medical manager role  | Job description, key outcome areas and achievements with reflection  | Portfolio includes annual review in role by as senior such as medical director/executive<br><br>Personal reflection<br><br>CPD evidence of development in role<br><br>Colleague feedback in relation to role (once in each cycle) | Any or all  |
| Financial/business responsibility  |  | Development of a business plan and outcome<br><br>Responsibility for  | Domain 1 Knowledge, skills and performance;<br><br>Domain 4 maintaining   |

|                               |  |  |   |
|-------------------------------|--|--|---|
|                               |  | budget and how this is managed; probity  | trust   |
| Achieving clinical efficiency |  | Evidence of resource benefits though a specific initiative /project (reduce length of stay, avoidable hospital admissions, fewer deaths in hospital) | Domain 1 Knowledge, skills and performance;<br><br>Domain 3 Communication, teamwork |

### *APM/JSC Palliative Medicine Working Group members*

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 Rachel Quibell  
 Rob George  
 Annabel Howell  
 Clare Spencer

Reviewed and amended by JSC March 2017

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## Appendix 1

### Survey of APM members 2014

A short on-line survey was sent to all APM members and collated in July 2014. 207 responses were received, of whom 167 said they were currently working within palliative medicine. There were 143 consultant responders; 42 replies from SSAS and hospice doctors, plus a small number of trainees.

The questions asked about what evidence was currently being used in portfolios; if there were specific tools used and about any problems in the process.

182 answered the question about specific tools, providing a useful snapshot of current practice:

| Category                                    | Currently used as evidence |
|---|----------------------------|
| Local audit activity                        | 93%                        |
| Case review discussions                     | 68%                        |
| Effectiveness of teaching                   | 61%                        |
| Quality improvement activity                | 42%                        |
| Participation in national audits            | 37%                        |
| PROMS                                       | 34%                        |
| Clinical outcome data                       | 25%                        |
| Impact of health policy/management practice | 17%                        |

Examples of specific data collection tools that were given included MDS data, NCDAM, FAMCARE, VOICES, SKIPP, PaCA, HtH nutrition and hydration tool, All Wales audit of individual care pathways for last days of life.

'Other' information collected included 360 feedback (patient and staff); patient and carer satisfaction surveys; patient identified goals and whether these were met; baseline activity including OP and domiciliary visits; mention of levels of complexity; bereaved carer surveys; complaint investigation and significant event analysis.

Of particular significance were the replies to what resources were available to support data collections (170 responses):

| Available resource  | Response |
|---|----------|
| There are organisational resources to support data collection | 25%      |
| There are limited resources within the team                   | 19%      |
| I have to collect data myself                                 | 44%      |
| Other   | 12%      |

‘In the trust this is well supported, the hospice component is not’; ‘Resource is nowhere near what is required’

A number of comments reflected concern about capturing outcome, including feedback from distressed and unwell patients and carers.

#### Key messages

- Wide range of measures are being used
- Some confusion between PROMs and PREMs
- Challenge of individual outcome data due to team work approach and sick and distressed patients and carers.
- Organisational resources limited for data collection (only 25% had organisational support), better in hospitals
- Appreciation that this piece of work was being done

## Appendix 2

This is an adapted version of the General Medical Council Patient Feedback questionnaire which can be used by palliative care physicians. This is based on that provided by the GMC at

[http://www.gmc-uk.org/patient\\_questionnaire.pdf](http://www.gmc-uk.org/patient_questionnaire.pdf) 48210488.pdf

but it excludes question 2:

|                          |  |                          |                               |                          |   |  |
|--------------------------|--|--------------------------|-------------------------------|--------------------------|---|--|
| <b>2</b>                 | <b>Which of the following best describes the reason you saw the doctor today? (Please tick all the boxes that apply)</b> |                          |                               |                          |   |  |
| <input type="checkbox"/> | To ask for advice  | <input type="checkbox"/> | Because of an ongoing problem | <input type="checkbox"/> | For treatment (including prescriptions) |  |
| <input type="checkbox"/> | Because of a one-off problem   | <input type="checkbox"/> | For a routine check           | <input type="checkbox"/> | Other (please give details)             |  |

and question 3:

|                          |  |                          |   |                          |                |                          |   |                          |   |
|--------------------------|--|--------------------------|---|--------------------------|----------------|--------------------------|---|--------------------------|---|
| <b>3</b>                 | <b>On a scale of 1 to 5, how important to your health and wellbeing was your reason for visiting the doctor today?</b> |                          |   |                          |                |                          |   |                          |   |
|                          | Not very important   |                          |   |                          | Very important |                          |   |                          |   |
| <input type="checkbox"/> | 1  | <input type="checkbox"/> | 2 | <input type="checkbox"/> | 3              | <input type="checkbox"/> | 4 | <input type="checkbox"/> | 5 |

neither of which are readily applicable for palliative care patients. In all other respects it is unchanged. It also includes a suggested cover letter.

### Suggested cover letter

*(Address of team)*

Dear

### **Feedback Questionnaire**

Every doctor needs feedback in order to provide excellent care. We would therefore like to ask you about the consultation you have had with Dr *(name)*.

Please could you help us by filling out this short questionnaire? This relates to your meeting today with Dr *(name)*, and not with other areas of your care.

This should only take a few minutes of your time, and will not impact in any way on the care you are receiving.

Your answers will be kept confidential, and the questionnaire is anonymous. This means that the doctor will see your answers but will not know who gave them. The answers you give will not affect your care in any way.



Please return your completed questionnaire in the Freepost envelope enclosed (no stamp required). A member of staff not involved in your care will come to collect this from you in the next couple of days or alternatively you can post it if you prefer.

If you have any questions or wish to discuss any aspects of your care in more detail then please contact the palliative care team on (*telephone number*).

Thank you for your help.

Yours sincerely,

*Signed by both*

Clinical Lead for Palliative Care team

Clinical or Medical Director (or  
other appropriate senior lead)

## Feedback Questionnaire

### For Dr.

Licensed doctors are expected to seek feedback from colleagues and patients and to review and act upon that feedback where appropriate.

The purpose of this exercise is to provide doctors with information about their work through the eyes of those they work with and treat, and is intended to help inform their further development.

Please do not write your name on this questionnaire.

Please base your answers only on the consultation you have had today with Dr. \_\_\_\_\_

Please mark the box like this  with a ball point pen. If you change your mind, just cross out your old response and make your new choice.

If you are filling this in for someone else, please answer the following questions from the patient's point of view.

**Please write today's date here:** \_\_\_\_\_

|    |   |                        |              |                        |              |                |           |                |
|----|---|------------------------|--------------|------------------------|--------------|----------------|-----------|----------------|
| 1. | Are you filling in this questionnaire for:<br><input type="checkbox"/> Yourself <input type="checkbox"/> Your child <input type="checkbox"/> Your spouse or partner <input type="checkbox"/> Another relative or friend   |                        |              |                        |              |                |           |                |
| 2. | How good was your doctor today at each of the following? (Please tick one box in each line)   |                        |              |                        |              |                |           |                |
|    | <table border="0" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%;"></td> <td style="width: 15%; text-align: center;">Poor</td> <td style="width: 15%; text-align: center;">Less than Satisfactory</td> <td style="width: 15%; text-align: center;">Satisfactory</td> <td style="width: 15%; text-align: center;">Good</td> <td style="width: 15%; text-align: center;">Very Good</td> <td style="width: 15%; text-align: center;">Does Not Apply</td> </tr> </table> |                        | Poor         | Less than Satisfactory | Satisfactory | Good           | Very Good | Does Not Apply |
|    | Poor  | Less than Satisfactory | Satisfactory | Good                   | Very Good    | Does Not Apply |           |                |
| a. | Being polite <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>   |                        |              |                        |              |                |           |                |
| b. | Making you feel at ease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>  |                        |              |                        |              |                |           |                |
| c. | Listening to you <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>   |                        |              |                        |              |                |           |                |
| d. | Assessing your medical condition <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>   |                        |              |                        |              |                |           |                |
| e. | Explaining your condition and treatment <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>  |                        |              |                        |              |                |           |                |
| f. | Involving you in decisions About your treatment <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>  |                        |              |                        |              |                |           |                |
| g. | Providing or arranging Treatment for you <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>   |                        |              |                        |              |                |           |                |

|    |   |                          |                          |                              |                             |                          |                          |
|----|---|--------------------------|--------------------------|------------------------------|-----------------------------|--------------------------|--------------------------|
| 3. | Please decide how strongly you agree or disagree with the following statements by ticking one box in each line.   |                          |                          |                              |                             |                          |                          |
|    |   | Strongly Disagree        | Disagree                 | Neutral                      | Agree                       | Strongly Agree           | Does Not Apply           |
| a. | This doctor will keep information about me confidential   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>     | <input type="checkbox"/>    | <input type="checkbox"/> | <input type="checkbox"/> |
| b. | This doctor is honest and trustworthy   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>     | <input type="checkbox"/>    | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. | I am confident about this doctor's ability to provide care  |                          |                          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |                          |                          |
| 5. | I would be completely happy to see this doctor again  |                          |                          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |                          |                          |
| 6. | Please add any other comments you wish to make about this doctor<br>Please note: no patients will be identified when this information is given to the doctor. |                          |                          |                              |                             |                          |                          |

The next questions will provide the doctor with some basic information about who took part in the survey. If you are filling this in on behalf of someone else, please provide details about the patient.

|    |   |  |                                      |                                    |  |                                     |
|----|---|--|--------------------------------------|------------------------------------|--|-------------------------------------|
| 7. | Are you:  | <input type="checkbox"/> Female                    | <input type="checkbox"/> Male        |                                    |  |                                     |
| 8. | Age:  | <input type="checkbox"/> Under 15                  | <input type="checkbox"/> 15-20       | <input type="checkbox"/> 21-40     | <input type="checkbox"/> 41-60         | <input type="checkbox"/> 60 or over |
| 9. | What is your ethnic group? Please choose one section from A to E, and then tick the appropriate box to indicate your cultural background. |  |                                      |                                    |  |                                     |
|    | <b>A White</b>  | <b>B Mixed</b>                                     | <b>C Asian or Asian British</b>      | <b>D Black or Black British</b>    | <b>E Chinese or other ethnic group</b> |                                     |
|    | <input type="checkbox"/> British  | <input type="checkbox"/> White and Black Caribbean | <input type="checkbox"/> Indian      | <input type="checkbox"/> Caribbean | <input type="checkbox"/> Chinese       |                                     |
|    | <input type="checkbox"/> Irish  | <input type="checkbox"/> White and Black African   | <input type="checkbox"/> Pakistani   | <input type="checkbox"/> African   |  |                                     |
|    |   | <input type="checkbox"/> White and Asian           | <input type="checkbox"/> Bangladeshi |                                    |  |                                     |
|    | <input type="checkbox"/> Any other  | <input type="checkbox"/> Any other                 | <input type="checkbox"/> Any other   | <input type="checkbox"/> Any other | <input type="checkbox"/> Any other:    |                                     |
|    | White background:   |  | Mixed background:                    |                                    | Asian background: Black background:    |                                     |
|    | _____   |  | _____                                |                                    | _____                                  |                                     |