



Association for
Palliative Medicine
Of Great Britain and Ireland

Appraisal Guidance for Consultants and SAS Doctors in Palliative Medicine

Updated October 2025

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Introduction

This document has been developed in response to challenges relating to medical appraisal inherent within Palliative Medicine. It has been updated by the Clinical Quality Committee of the Association for Palliative Medicine (APM).

The challenges are firstly, “success” in palliative and end of life care is not easily measured by quantifiable data. This guidance suggests ways in which palliative medicine doctors might demonstrate the quality and effectiveness of their service. Secondly, patients receiving palliative and end of life care are less able to provide feedback on the service because of frailty. In an inpatient palliative care settings for instance, a proportion of patients cannot provide written feedback, and towards end of life, obtaining feedback becomes even more difficult. Thirdly, a significant part of the impact of palliative and end of life care is indirect, with palliative medicine doctors working to support other colleagues in the delivery of palliative and end of life care, through professional support and through education. Fourthly, palliative and end of life care attends 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 medicine doctors work exclusively in the third-sector which may have limited infrastructure to support collection of evidence for appraisal.

This specialty-specific guidance is based on the GMC “[Guidance on Supporting Information for Appraisal and Revalidation](#)” and the [Reflective Practitioner](#); a toolkit developed by the Academy of Medical Royal Colleges (AoMRC), the UK Conference of Postgraduate Medical Deans (COPMeD), the General Medical Council (GMC), and the Medical Schools Council. Revalidation requires all licensed doctors to participate in regular appraisals that consider information drawn from the doctor’s whole practice. Reflection on supporting evidence is a core requirement for revalidation. The information within this document is aimed at consultants, specialty, specialist and associate specialist (SAS) doctors who provide palliative care and end of life care to patients over 18. The document will also be valuable to appraisers and Responsible Officers who may not be familiar with the specialty, nor the particular constraints that may influence collection of evidence about the practice of an individual doctor.

In the subsequent sections outlined below there is a non-exhaustive list of examples of supporting information that could be included in a doctor’s portfolio of evidence for appraisal.

1. Continuing professional development (CPD)
2. Quality improvement activity including teaching, management and research
3. Significant events
4. Feedback from colleagues
5. Feedback from patients
6. Complaints and compliments

It should be noted that often a piece of supporting information may be applicable to more than one section. This guidance highlights the importance of providing information in relation to the entire scope

of practice, including private work and non-clinical roles activities such as education, research and management.

The information should be mapped to the four domains defined by [Good Medical Practice](#), which form the basis of the appraisal summary:

- Domain 1: Knowledge, skills and development
- Domain 2: Patients, partnership and communication
- Domain 3: Colleagues, culture and safety
- Domain 4: Trust and professionalism

Most Trusts or charities now use an electronic system for capturing appraisals. Doctors should follow local policy or instruction from their Responsible Officer (RO) and Designated Body. In the absence of clear instruction from your RO, NHS England provides a free of charge [Medical appraisal template 0622.docx](#) (MAGMAF 4.2 form) which is a dynamic interactive PDF. It can only be opened (with full functionality) in Adobe Reader (this is not sufficient to be an appraisal platform). Doctors in Scotland can use [the Scottish Online Appraisal Resource](#) (SOAR), which also facilitates a multisource feedback. For colleagues working in Wales, there is the [MARS system](#) for appraisal and revalidation. The Royal Collage of General Practice (RCGP) has partnered with Clarity Informatics to provide a [revalidation ePortfolio](#) toolkit for GPs.

1. Continuing Professional Development

Continuing Professional Development (CPD) is an ongoing process that enables individual doctors to maintain and improve standards of medical practice through the development of knowledge, skills, attitudes and behaviour. CPD should also support specific changes in practice. Over each revalidation cycle, CPD should support all professional roles whether clinical, managerial, academic or educational.

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. There are many approaches to reflection. The “What? So what? Now what?” framework is one example of a simple way to structure reflections and is recommended by the [Academy of Medical Royal Colleges](#) et al in their [Reflective Practitioner](#) guidance additional support and guidance can be found in the [AoMRC Reflective Practice Toolkit AoMRC CoPMED 0818.pdf](#).

The [Association of Palliative Medicine](#) (APM) recommends enrolment in the [CPD system](#) from the Royal College of Physicians (RCP). Whilst not mandatory from the GMC, doctors working as a physician are required by the RCP to achieve the following CPD

- Minimum of 50 CPD credits per year, 250 credits over a 5-year cycle (1 hour of learning activity = 1 credit)
- 25 ‘external’ credits (through activities outside the place of work) and 10 ‘personal’ credits obtained through self-directed learning
- Complete an annual reflection- answer 3 reflective questions on the last 12 months of your CPD
- There should be a range of CPD activities undertaken that reflect development of 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.

Appraisal Portfolio Supporting Evidence (non-exhaustive list):

- Attendance at major palliative medicine conferences and general internal medicine (GIM) conferences with reflection and/or sharing of knowledge gain relating to key learning and application to own and organisations practice.
- Attendance at core palliative medicine and core GIM seminars, courses and workshops It can include broader topics for example clinical governance/root cause analysis training or ethics
- Self-directed learning: journal reading, e-learning, learning in response to a clinical problem with demonstration of reflection or peer review
- Peer discussion and reflection including case reviews and Schwartz rounds
- Core palliative medicine skills (e.g. advanced communication skills)
- Refreshing GIM skills where appropriate e.g. paracentesis (courses, e-learning, workshops)
- Extension or acquiring new skills with adoption into practice e.g. media training; practical use of ultrasound; mentorship
- Reviewer of original articles in preparation of publication

- Preparation for talks as an invited speaker at regional and national level
- CPD for specific roles e.g. skills trainer, educational/clinical supervisor to trainees, medical appraiser, RO, medical director etc.
- Targeted CPD for leadership/management development
- Log of work based place assessments (WBPA) undertaken
- Non clinical skills training e.g. IT skills/Excel training

2. Quality Improvement Activity (QIA)

It is anticipated that doctors will engage in QIA continuously and provide evidence at each appraisal. Supporting information should reflect activities in all places of practice.

With respect to **service evaluations, audits** and similar projects the doctor's portfolio of evidence should include a brief summary with details of the role the doctor carried out - for example as lead, or as supervisor, designer or data analyst, how the outcomes were shared and/or reviewed within a peer group or in comparison to local and national benchmarking and the actions and implementation of change following this. Data from **outcome or experience measures** is worthy of inclusion in this section. It is useful to be clear about definitions of each

- An outcome measure is "a change in health status which can be attributed to preceding healthcare intervention"
- An experience measure captures "a patient and their family's perception about their experience of the healthcare they have received"

Case studies, morbidity and mortality reviews etc. should include individual and team reflections and be anonymised appropriately to protect confidentiality of patients and staff. The RCP provide a template that has been designed to enable clinicians to record significant learning experiences in their day to day practice.

Teaching and training is core to palliative medicine practice and occupies a large proportion of our workload. In its broadest sense it may encompass education of patients, carers, non-clinicians and lay people. This activity represents the indirect clinical care we deliver through others facilitated by our multi-professional teaching and training. It is important not just to collate a list of teaching events but to show evaluation with reflection and learning to continually improve teaching. .

Postgraduate medical trainer – The [Promoting excellence - GMC](#) identified 2 groups of postgraduate trainer, Educational Supervisor and Clinical Supervisor. These roles should be appraised against the [5 themes](#) ([Promoting excellence: standards for medical education and training](#) set out by the GMC. The educational and clinical supervisor accreditation is should be part of the NHS whole scope of practice appraisal but there are local generic processes for this which doctors are recommend to refer to and complete

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 (budget or staff); recruitment and selection; strategy development, as chair/lead of a working group or Committee, or rota management. Each of these requires leadership skills and through reflection on achievements, objectives for personal development can be identified.

Appraisal Portfolio Supporting Evidence (non-exhaustive list):

- Aggregated, population or patient level palliative care team or provider experience measures e.g. of care rated by the patient or their proxy. (Note the higher the level of aggregation of data, the more difficult it is to attribute improved outcomes to any one specific intervention or team/doctor.)
- Aggregate outcome data including patient-centred outcome measures” (PCOMs) and patient-reported outcome measures (PROMs) such as in the [Outcome & Assessment Measures | Cicely Saunders Institute of Palliative Care, Policy & Rehabilitation | King's College London](#)
- Evidence of the introduction of an outcome or experience measure into clinical practice.
- 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 or modify team practices and processes
- Other reviews of clinical outcomes e.g. mortality and morbidity meetings or demonstration of effectiveness such as impact on admissions, rapid discharge, place of care,
- Contribution to regional or national initiatives such as the national dataset and outcomes work, etc.
- Local and national improvement schemes e.g. [FAMCARE](#), [National Audit of Care at End of Life](#) , [Hospice UK](#) audit tools for pressure ulcers and infection control plus clinical audit or service evaluation.
- Case review or peer group debriefs/discussions that have resulted in reflection and change in practice/impact
- Demonstrable improvement in patient safety, care or experience
- Service innovation projects including local or national CQUIN projects
- Impact of new or updated health policy/management practice
- Development of evidence based protocols/guidelines
- External quality review; Peer review, Care Quality Commission (CQC) inspection reports (especially if lead clinician, Medical Director/Responsible Officer roles) with reflection and action plans.
- Formal teaching of undergraduates doctors and the MDT with specific examples. The brief write up should include what need it was meeting, details of the sessions delivered plus reflections on evaluations
- Group teaching evaluations and tutee feedback received
- Supporting trainees in difficulty with reflection on specific examples
- Activities in specific roles e.g. mentor, trainer and educational/clinical supervisor to trainees, medical appraiser, RO
- Managerial appraisal or performance reports eg for roles such as medical director, clinical director or clinical lead for a service

- Educational appraisal report to summarise roles, responsibilities and teaching organised and delivered
- Contributions to tutoring MSc and PhD students, with reflections
- Grant income – lead applicant or co-applicant, and details including funder, duration and amount of award.
- Dissemination and or translation of research to quality improvement Peer-reviewed research papers, commentaries, editorials, letters, book chapters
- Annual reports/quality accounts
- Work undertaken for regional network, national or College committees and working groups
- Development of a business plan and outcome and anticipated change/improvement

3. Significant Events

The GMC define a significant event in this context as any unintended or unexpected event which could or did lead to harm. 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) which they are linked to and that have happened since their last appraisal took place. Within their supporting evidence there should be a reflective piece demonstrating key learning or changes in practice as a consequence of the event, as well as a review of what happened. It is comprehensive to demonstrate peer discussion has taken place and include subsequent actions to improve the service to patients and families. One such example template <https://www.rcplondon.ac.uk/file/517/download?token=JScBf5uL> is that offered by the RCP.

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 is a positive aspect of the doctor's development and practice. All supporting information, including reflections, should be anonymised appropriately to protect confidentiality of patients and staff.

Appraisal Portfolio Supporting Evidence (non-exhaustive list):

- Reportable clinical incident
- Serious Untoward Incidents
- Reduction in service levels e.g. bed closures. How it was managed to create the least negative impact on patient care
- The Organisation being placed in CQC's special measures
- GMC imposed restrictions on a doctor's practice
- Unexpected or serious complication to treatment e.g. bowel perforation during paracentesis
- Controlled drug incidents and other serious drug errors
- Administration of naloxone during titration of opioids
- Yellow card reportable side effects relating to the prescribing and administration of drugs
- Significant safeguarding events
- Use of sedation to manage prolonged distress associated with intractable symptoms
- Failed discharge from inpatient setting or an inappropriate hospital admissions
- Significant harm to carers in bereavement eg suicide or attempted self-harm

- Doctors who have been involved with a case[s] referred under the Patient Safety and Incident Reporting Framework(PSIRF) should include a summary of outcomes and learning points from any PSIRF with their appraisal documentation.

4. Feedback From Colleagues

At least once per revalidation cycle colleague feedback should be gathered about individual's practice. It should reflect the multidisciplinary nature of palliative and end of life care. The sample of colleagues should include feedback from the whole scope of work, both clinical and non-clinical roles such as education, research or management roles and also include private practice. It is also important to capture feedback from professional colleagues who are supported by the palliative medicine specialists to delivery of palliative or end of life care. This indirect patient care can be a significant proportion of Palliative Medicine doctors work load. This feedback may be captured via individual colleague feedback but also through team feedback, service evaluations or professional service user surveys.

In some organisations the list of colleagues may need approving by the medical director or RO. Collection must be anonymous; usually by a third party, for example administrative staff, appraiser, or the revalidation team. The feedback should be received prior to the doctor's appraisal so that they have the opportunity to reflect on it and discuss it in their appraisal.

The GMC does not prescribe how many responses make the feedback robust and valid. This will depend on the tool being used and it is set by the questionnaire provider.

Appraisal Portfolio Supporting Evidence (non-exhaustive list):

- Informal feedback: positive and negative from individual colleagues including the multidisciplinary team, trainees, and professionals other than palliative care specialists. It can be in the form of emails, letters or verbal comments etc.
- Formal feedback using a standardised questionnaire that reflects the values and principles of Good medical practice. See below for examples
- Details and outcomes of the changes that have been made based on prior colleague feedback
- Role-specific feedback especially if holding a senior position: evidence of discussion with appraiser or manager; reflection e.g. leadership 360

Examples of Colleague Feedback Templates:

- [Colleague feedback - GMCRCF MSF](#)
- [360 Equiniti](#)
- [Feedback and Surveys - FourteenFish](#)

5. Feedback From Patients

At least once per revalidation cycle patient feedback should be gathered about individual's practice. Patient feedback for the purposes of appraisal and revalidation focuses on the doctor's communication and interpersonal skills, behaviours and attitudes. Ultimately the process will identify areas of strengths, areas for development, and highlight changes the doctor can make to improve the care they provide. Patient reported outcomes and experiences are discussed as QIA in section 2.

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 engage with the process. Considerable time may therefore be required to accrue feedback from the 15 or 20 patients recommended. It is perfectly acceptable to use the patient's family and friends as proxies for their views if the patient is not able to do this themselves. The feedback must come from across the whole scope of practice and be representative of the patients cared for

A validated questionnaire that is consistent with the principles, values and responsibilities set out in [Good Medical Practice](#) should be used. Designated Bodies may have systems and processes in place for collating patient or proxy feedback. The main requirement is to ensure that the administration, collection and collation of this feedback are conducted independently of the doctor, to maintain objectivity and anonymity.

After the feedback is collated the doctor must reflect on what the feedback means for their current and future practice. These reflections should then be included within the doctor's appraisal for discussion.

Examples of Patient Feedback Questionnaires

- RCP Patient feedback questionnaire
<https://www.rcplondon.ac.uk/file/549/download?token=5NcD1BRB>
- [Fourteen Fish](#)

6. Complaints and Compliments

All NHS and independent organisations should have systems for handling complaints so that they are reported, investigated and actions taken to improve care when received about a clinician or service

Examples of compliments include letters and cards emails etc. These apply also to positive comments from colleagues as well. Compliments may be made through informal PALS feedback in hospitals.

Appraisal Portfolio Supporting Evidence (non-exhaustive list):

- Any formal complaint directed towards the individual doctor, team or organisation. An anonymised account that shows reflection, the efforts taken to resolve complaint and implementation of any learning.
- Medical leads involvement with resolving organisational complaints
- External reviews of complaints e.g. Ombudsmen reviews
- A selection of compliment e.g. thank you cards, emails, letters etc. especially where the doctor or team is mentioned specifically.

References

1. [Revalidation - GMC](#)
2. [Guidance on supporting information for revalidation guide - GMC](#)
3. [NHS England » Doctors](#)
4. Royal College of Physicians Guidance; [Education and professional development | RCP](#)
5. [Medical appraisal - AOMRC](#)