

# Annual appraisal

## Purpose and boundaries

Michael arrives at appraisal with a substantial collection of documents and an unexpectedly incomplete account of his year. His hospital work is well represented. His management responsibilities appear only in a job title, his teaching is represented by attendance certificates, and his external professional work is absent. Asked what he learned from a difficult service change, he searches for the presentation he gave afterwards. He can show that he was busy. It is harder to explain how his decisions developed, what others experienced and which arrangements need attention before the next year begins.

Michael is the composite Associate Specialist introduced elsewhere in this handbook. For this chapter, assume that he works in England, holds a longstanding substantive appointment and undertakes a separately agreed external educational role. His difficulty is common in established careers. Familiar work receives little explanation because the doctor understands it so well. Unfamiliar administrative requirements receive disproportionate attention because they threaten to delay completion. A useful appraisal reverses that imbalance. The records prepare a professional conversation about the actual work, its quality, the doctor's development and the conditions affecting both.

Annual appraisal is a structured opportunity to review professional practice with a trained appraiser. It contributes information to revalidation but is not itself the GMC's licensing decision. It is also distinct from the meeting that agrees the job plan and from a formal procedure investigating capability or conduct. NHS England's appraisal resources point to the Medical Appraisal Guide as an approach to this supported review; delivery arrangements must still be established with the relevant organisation. These distinctions protect the purpose of the discussion without making it detached from professional accountability. <sup>[16]</sup>

The practical question is not whether an awkward subject belongs in appraisal. A difficulty may affect learning, wellbeing or the safety of practice and deserve discussion. The question is what the appraisal can do about it. An appraiser can help Michael understand an unsupported responsibility, record its effect and identify a development or organisational

action. The appraiser cannot allocate a budget on the employer's behalf. An agreed PDP objective cannot quietly become approval for additional clinical duties. A concern needing urgent action must enter the appropriate governance route when it arises.

The six GMC supporting-information categories provide the evidence framework: continuing professional development, quality improvement activity, significant events, patient or service-user feedback, colleague feedback, and compliments and complaints. They are different ways of examining practice, not six independent competitions to accumulate documents. Their collection requirements are also different. Some relate to the year since the last appraisal; others require planned activity across the revalidation cycle. This chapter explains those differences before showing how to bring them into a proportionate annual account.<sup>[57]</sup>

Begin by writing three sentences before opening the portfolio. Describe the work undertaken, the most important learning or change, and the matter that needs help or a decision. Michael might explain that he maintained his clinical service, learned that an educational arrangement depended too heavily on his availability, and wants to plan a supported handover. That opening gives the appraiser a route through the material. It does not replace the required declarations; it stops them becoming the only visible purpose of the meeting.

An appraisal should leave an accurate account of the discussion and a realistic plan. It need not portray an exceptionally successful year. Illness, delayed projects, competing demands and a change of direction can all produce meaningful learning. Equally, a comfortable conversation is not sufficient if substantial roles or relevant concerns have been omitted. The reader's task is to make the professional picture intelligible, respond honestly to questions and distinguish what has been achieved from what remains proposed. The result should be useful both to the doctor who returns to it and to the authorised person who later considers its outputs.

## **Connection platform and timetable**

The first preparation task is administrative because an otherwise excellent appraisal can be undermined by being arranged through the wrong route. Confirm the designated body or other recognised revalidation connection in GMC Online, identify the appraisal office and establish how an appraiser is allocated. The GMC connection tool helps doctors determine their prescribed connection; a convenient colleague or familiar portfolio supplier does not determine it. Chapter 11 examines the connection rules in greater

detail. Here the immediate objective is to know who expects the appraisal and how its completion reaches the correct system. <sup>[9]</sup>

There is no single electronic appraisal platform for every UK doctor. In Wales, MARS is the all-Wales Medical Appraisal Revalidation System provided by HEIW. Its public entry page distinguishes medical and GP access and directs new users to appraisal and revalidation support. In Scotland, the Medical Appraisal Scotland service provides SOAR and associated guidance. England's organisations use their own approved arrangements, while Northern Ireland's Department of Health provides the national revalidation framework and employers supply operational instructions. A doctor moving between nations should obtain the receiving organisation's current process rather than assuming an existing login transfers the obligation. [17][18][19]

Separate three dates: the annual appraisal window, the deadline for submitting preparatory material, and the GMC revalidation submission date. They serve different purposes. A local portfolio deadline allows an appraiser to review information before meeting. The appraisal date marks the annual conversation. The revalidation submission date concerns the recommendation process. Put all three in the diary with their source and the responsible contact. If a date looks inconsistent, resolve it before deciding which one can safely be ignored.

An eight-week preparation plan is a useful working method, not a national requirement. At eight weeks, confirm the appointment and review the previous summary and PDP. At six weeks, request information that depends on others: external governance statements, feedback reports and confirmation of outstanding actions. At four weeks, select supporting information and draft reflections. At two weeks, check declarations, explain any gaps and submit within the actual local deadline. During the final week, prepare the questions worth discussing. After the meeting, check the summary and agreed actions promptly.

This sequence works because it separates collection delays from reflective work. Michael can write about a teaching improvement in an afternoon, but an external organisation may need several weeks to produce governance information. Aisha, preparing for her first appraisal in an NHS Specialty Doctor post, may need help identifying information held by a previous employer. Both should make those requests early. A short list recording the item, owner, request date and expected response is more useful than repeatedly opening the portfolio to see whether it feels complete.

Technical access deserves an early check too. Make sure that the account uses an address that will remain accessible throughout the process, that the

appraiser can see submitted material, and that attachments open correctly. Keep an authorised personal copy of final appraisal outputs where local policy permits, protected appropriately. Do not download confidential source records merely because a portfolio account may close. If access fails close to the deadline, notify the appraisal office with the error, time and attempted remedy; ask for an approved submission route and retain that correspondence.

Finally, tell the appraiser about any preparation need that could affect the meeting: additional time, accessible documents, a private remote location or an unfamiliar part of the scope. This is not an invitation to negotiate away substantive requirements. It allows the conversation to be arranged properly. If the allocated appraiser has a conflict or a relationship likely to inhibit a fair discussion, raise it through the appraisal office before sharing sensitive material. Early clarification is usually easier than trying to repair a disputed summary after an uncomfortable meeting.

## **Whole scope of practice**

The portfolio should describe the doctor's professional work, not merely the activity visible to the largest employer. The GMC expects declaration and supporting information across clinical and non-clinical roles, including NHS, independent, voluntary and private work. Educational, managerial, research and leadership responsibilities can therefore matter even when they occupy little time. Supporting information should normally arise from UK practice; overseas work needs early discussion with the responsible officer about acceptability. Evidence volume should be proportionate, with meaningful examples rather than repeated demonstrations of the same learning.<sup>[58]</sup>

Construct a scope map with one entry for each role. Record the organisation or setting, dates, nature of work, approximate commitment, level of responsibility, governance contact and evidence available. Include roles that ended during the year as well as those still active. The map is a working document, not an official substitute for the platform's declarations. Its value lies in making omissions visible. If the diary records regular teaching but the scope map contains only clinical work, something needs explanation before the evidence is assessed.

For Michael, four entries emerge. He provides inpatient and outpatient clinical care in his substantive employment. He leads a service improvement group under a separate responsibility within that organisation. He teaches on an externally organised professional course. He contributes to a professional committee with educational work. These activities overlap, but each

presents different questions. Clinical evidence may concern outcomes and communication. The improvement group requires an account of his contribution and what changed. External teaching calls for feedback and appropriate governance information. Committee work needs proportionate reflection on its professional relevance.

The map should not inflate every meeting into a separate job. A governance meeting within clinical employment can usually remain part of that role. The purpose is to distinguish work whose responsibilities, organisational oversight or evidence source differ materially. If a doctor undertakes occasional paid medical reports outside the NHS, that work is not automatically covered by a hospital complaints statement. If an external role is genuinely non-medical, explain its relevance rather than insisting that every hobby belongs in a regulated professional scope. Ambiguity is best resolved by describing the activity accurately.

Next, ask how concerns and feedback would become known. A statement from the principal employer may address incidents in its own systems but say nothing about another organisation. Request the appropriate governance information through the receiving appraisal or responsible-officer arrangements. A useful request identifies the period, role and information required, instead of asking vaguely for a reference. The doctor should distinguish a general endorsement from a governance confirmation. Someone may value Michael's contribution while having no authority to report whether a formal concern has been recorded.

Evidence should then be mapped against the questions each role raises. A teaching programme evaluation can inform quality improvement and service-user feedback, while a reflective account explains what Michael changed. A management role may draw on a reviewed process, stakeholder feedback and development undertaken for the responsibility. This does not mean that one favourable teaching evaluation answers every supporting-information category. The mapper should show both what an item supports and what it cannot establish. Chapter 12 develops this disciplined reuse of evidence across different professional purposes.

Consider an apparent gap: Michael has no individual patient feedback from an external educational role because that role has no patients. The gap is not resolved by attaching more hospital questionnaires. He needs an appropriate account of feedback from those receiving that professional service and agreement about the approach. A second gap is different: he has not sought any information about complaints in that role. Lack of direct patient contact does not make governance irrelevant. Distinguishing the two

prevents an exemption in one category being mistaken for exemption from the entire role.

Changes during the year deserve their own explanation. If Michael reduced clinical sessions to undertake leadership work, the evidence available may change before the portfolio's categories do. If Aisha started a new post halfway through the year, an appraisal should show the preceding employment period and the new responsibilities without implying twelve months of exposure to either. Give dates and describe what was possible. Where a role stopped, record any continuing action or unresolved concern and how information will remain available after access to its systems ends.

The final test is to read the scope map as someone who has never met the doctor. Can that reader identify where the work occurred, what the doctor did independently, where support existed and how its quality was reviewed? Can they see a reasonable connection between the declared work and the selected information? A portfolio may be concise and still answer those questions well. Conversely, a large portfolio can leave an entire professional role invisible. Completeness concerns the professional picture; it does not require indiscriminate uploading of every record generated within it.

Keep that map available between appraisals. When a new responsibility is accepted, add it while its boundaries are clear and identify the evidence contact then. Waiting until the annual meeting risks discovering that the only person able to describe the arrangement has moved on. A brief contemporary entry can preserve the agreement's meaning without creating another extensive portfolio task.

## **Continuing professional development**

Continuing professional development should start with a question arising from the work. What needs to be maintained, improved or learned for a forthcoming responsibility? The GMC requires CPD every year, across the whole scope, with reflection on its contribution to practice. It does not prescribe a universal number of CPD points for revalidation. College schemes and local expectations may provide additional structures, but a points total is not the regulator's substitute for relevance and learning. A doctor's plan should therefore make the connection between professional need, chosen activity and its intended use visible. <sup>[59]</sup>

A certificate answers a limited question: it may establish attendance or completion. It rarely explains the clinical uncertainty that prompted the activity or whether anything useful followed. Begin a CPD entry with that uncertainty. For example, Michael notices that he can describe the service's new referral process but cannot explain consistently which cases need a

different pathway. He reviews the approved guidance, discusses difficult examples with colleagues and tests his understanding against subsequent referrals. The learning is the clarified decision process; a course could contribute, but is not the only possible route.

Use four short elements in a learning record. Describe the need, what you did, what you understood differently and what followed. If nothing changed because the learning confirmed existing practice, explain what it confirmed and why that matters. If the activity was disappointing, identify the unresolved question and the next source. The entry need not turn every journal article into an essay. Group related reading around a coherent question, while retaining enough detail to identify the sources and distinguish genuine engagement from an unexamined bibliography.

The whole-scope map helps prevent clinical CPD from eclipsing other responsibilities. Michael's clinical updates do not necessarily prepare him to supervise a struggling learner or chair a difficult service meeting. Equally, attending several leadership events does not maintain competence in a changing clinical field. Allocate learning according to the demands of the work and the consequences of gaps. A low-frequency but high-consequence task may require deliberate rehearsal or supervised updating even though it contributes few entries to an activity log.

For Aisha, a learning need may combine clinical knowledge with the local application of an unfamiliar system. She might understand a condition well but need to learn the receiving organisation's escalation arrangements or documentation process. Her appraisal entry should not imply lack of medical competence simply because induction was necessary. It should describe the precise gap, how she addressed it and how she confirmed understanding. This distinction enables useful development without converting every difference between healthcare systems into a judgement about the doctor's overall capability.

Evidence of application should remain proportionate. A later peer discussion, an appropriately anonymised review or feedback on a changed explanation may be enough to show how learning informed practice. Do not invent an outcome measurement for a question it cannot answer. Attendance at a communication workshop cannot prove fewer complaints; a small review may show that explanations became clearer without establishing a causal effect on service outcomes. The appraisal discussion benefits from the doctor stating both the useful finding and its limits.

Professional development also requires resources. If an agreed objective depended on study leave, supervision or access to a course that was not available, record the request and outcome. Explain what alternative learning

was possible and what remains unresolved. The appraisal can identify the dependency and feed a practical request into job planning. It should not rewrite an unmet organisational commitment as a personal failure. At the same time, the doctor should consider reasonable alternatives rather than treating cancellation of one event as the end of the learning need.

At the annual review, choose the few CPD examples that best explain the year's professional development. Keep the wider record available, but guide the conversation towards learning that changed a decision, addressed a risk, maintained an important capability or prepared a new responsibility. Ask what is still uncertain and which future opportunity would make the greatest difference. A good CPD account turns the next year's plan into a response to actual practice rather than a shopping list of courses.

## **Quality improvement and significant events**

Quality improvement activity examines the quality of work and the effects of attempts to improve it. The GMC requires active participation in relevant activity at least once in the revalidation cycle, with the type, amount and frequency appropriate to scope and agreed through the responsible-officer arrangements. It also expects regular review and audit of work, including participation in national audit or outcome review conducted in the doctor's area of practice. Even where direct participation is impossible, the doctor must reflect on its outcomes. A relevant activity may include clinical audit, case review, evaluation of teaching or examination of management practice. Outcomes and subsequent actions should be discussed; an unevaluated change needs a plan for follow-up.<sup>[60]</sup>

For the SAS doctor, the first challenge is often recognising work already undertaken. A structured review of referral decisions, contribution to a prescribing audit or redesign followed by evaluation may provide useful evidence. Merely attending a governance meeting does not show active participation in improvement. State the question, the standard or intended outcome, the doctor's contribution, the findings and the response. Where the activity belongs to a team, describe the team achievement fairly and identify the individual role without appropriating work performed by others.

Take a composite example from Michael's educational responsibilities. Learners report that the course explains professional principles well but leaves uncertainty about applying them in unfamiliar situations. Michael and the faculty review the comments, introduce short decision exercises and repeat the evaluation. His appraisal account can explain the change in teaching design and what the subsequent responses suggest. It should also acknowledge that participant satisfaction is not the same as demonstrated

performance in practice. A useful next step might be a later assessment of application, if proportionate and feasible.

Clinical improvement needs similar precision. Suppose a team reviews whether follow-up responsibility is explicit in discharge communication. A baseline review finds that responsibility is often implied rather than recorded. The team changes the template, clarifies ownership and repeats the review. Michael should explain how cases were selected, what counted as an explicit allocation and whether the repeated sample was comparable. If compliance improved in a small sample, describe that result accurately. Do not infer that all communication failures have been prevented or that the change alone caused an improvement in patient outcomes.

An incomplete project can still support an honest appraisal discussion. The useful distinction is between no evaluation yet and a claim of success without evaluation. If the second review is delayed, record why, who owns it and when it will be revisited. If the change failed, describe what the failure revealed. Perhaps staff understood the new template but competing systems encouraged duplication; perhaps a standard was poorly defined. The appraisal should help translate that learning into the next action. It should not require a decorative success story to justify the time invested.

Significant events form a separate category. The GMC describes events that unexpectedly or unintentionally caused, or could have caused, patient harm. Doctors must declare and reflect on every relevant event in which they were involved since the previous appraisal, including involvement as part of the treating team. Discussion can concentrate on events that best demonstrate learning or change, while declaration remains complete. If none occurred, the doctor should declare that and consider the reporting process or preventive work. Local incident terminology may differ from the GMC category. <sup>[61]</sup>

This distinction matters when an organisation's label is narrower than the learning requirement. A near miss should not disappear merely because it was not classified locally as a serious incident. Equally, an appraisal entry should not imply that the doctor caused every event involving their team. Describe the nature of involvement accurately, separate established findings from matters still under review, and focus the reflective account on learning. The incident report, factual statement and clinical record perform other functions and should remain in their appropriate systems.

Consider a composite incident in which a follow-up action was not clearly handed over between services. Michael was one member of the treating team. His reflection can examine what he understood about ownership, how the ambiguity became apparent and what he now checks. It

can also identify a system problem: the handover process allowed an action to appear assigned without confirmation that the receiving team had accepted it. Personal learning and system analysis belong together. Neither the statement that the system failed nor a promise to be more careful is an adequate complete account.

Follow-through gives the reflection practical value. Record which action the doctor completed, which the team agreed and which needs organisational authority. If the employer is considering a wider redesign, do not claim it as implemented. At the next review, examine whether the immediate change persisted and whether the unresolved action was escalated appropriately. Learning may include recognising that a proposed safeguard creates a different burden or fails during out-of-hours work. The evidence should preserve that complexity while remaining clear enough to support a decision.

Quality improvement and incident learning can overlap without becoming interchangeable. A significant event may prompt an audit; the audit may reveal a wider pattern; a later review may test the response. Cross-reference the related material rather than duplicating an entire narrative under every category. The appraisal then follows one intelligible sequence: concern, investigation, learning, action and review. It remains essential that urgent concerns were handled through governance at the time. The annual conversation is a place to examine what followed, not the first destination for a patient-safety problem awaiting action.

## **Feedback complaints and compliments**

Feedback introduces perspectives that self-assessment cannot supply. The GMC requires a formal patient-feedback exercise at least once during each revalidation cycle and reflection on relevant other feedback at annual appraisal. Where there are no patients, feedback from recipients of the medical service may be appropriate; inability to collect it requires agreement with the responsible officer or suitable person. Collection should fit the population and setting, allow accessible participation and minimise selection bias. A separate formal survey for every role is not invariably required, but the approach must represent the scope meaningfully. <sup>[62]</sup>

Plan the exercise before the final revalidation year. Ask which approved mechanism is suitable, who will administer it and what practical support patients need. A clinic questionnaire may work poorly for people with communication difficulties, those receiving care during severe distress or patients seen only briefly. The response is to design a defensible approach with the relevant support, not to conclude that these patients have no

perspective worth hearing. Feedback from carers or representatives may help where appropriate, while remaining clearly identified as their perspective.

Colleague feedback is also required at least once per cycle. The GMC expects an impartial selection across the whole scope, including different professional roles. Validated questionnaires administered independently should be used wherever possible; alternatives need agreement. Numerical response recommendations belong to the chosen tool and circumstances, rather than a single universal GMC quota. The doctor should compare the findings with self-assessment and reflect on their significance for future practice. A group composed only of close medical colleagues is unlikely to illuminate the full experience of working with the doctor.<sup>[63]</sup>

Michael therefore includes colleagues who see different parts of his contribution, following the approved process. Some experience his clinical decisions, others his teaching or leadership. The point is not to secure equally favourable scores in every setting. It is to discover whether the same professional behaviour is experienced differently. A doctor who appears calm and decisive in clinical work may be perceived as hurried or inaccessible in a committee role. That difference can generate a specific question about preparation, availability or communication without becoming a verdict on personality.

Read feedback slowly enough to separate a pattern from an isolated comment. Ask what the respondent may have observed, whether other evidence supports the concern and what action would be proportionate. A defensive first response is understandable, but it is not a useful final interpretation. Neither should every adverse comment be accepted as fact. Discuss uncertainty with the appraiser, retain professionalism towards respondents and consider whether further information is needed. The practical objective is a tested understanding of the behaviour that can improve, not discovery of who wrote an unwelcome sentence.

Complaints require a distinct account. The GMC requires declaration and reflection on all formal complaints about the doctor or their practice since the previous appraisal; this includes relevant complaints involving the team. Informal complaints and compliments can also supply learning. At the meeting, selected examples may receive most attention because they demonstrate insight or change, but selection for discussion must not conceal the full declaration. Where no complaint names the doctor, relevant local feedback can still inform reflection.<sup>[64]</sup>

A complaint is an allegation or expression of dissatisfaction, not automatically a finding of wrongdoing. Record its status and outcome

accurately. If an investigation remains open, say so and distinguish learning already possible from conclusions not yet established. For example, a dispute about what was explained may prompt clearer checking of understanding without requiring the doctor to accept an inaccurate account of the original consultation. If formal proceedings are involved, obtain appropriate advice on statements and disclosure. Appraisal reflection should not become an improvised legal defence or substitute for the response required elsewhere.

Compliments deserve more than storage as reassurance. Ask what enabled the good experience and whether it can be sustained or shared. A family may value consistent communication between teams; a learner may value a supervisor explaining uncertainty openly. These comments can reveal effective habits that become invisible through familiarity. Bring patient, colleague and other feedback together at the level of learning: what should continue, what should change, and how will the doctor know whether the response helped? The next appraisal can then revisit a decision rather than repeat a score.

When discussing a survey, keep its limitations visible. A response rate may be low, the timing unusually difficult or a particular setting underrepresented. Explain the limitation without using it to dismiss an inconvenient result. Ask whether the comments still identify a reasonable question worth testing. If a report suggests that explanations are rushed, a modest observation exercise may be more useful than debating whether the score perfectly represents the entire year. The subsequent evidence can then support or modify the initial interpretation.

## **Health probity and constraints**

Professional assurance includes honesty about circumstances affecting safe work. Read the health and probity declarations actually required by the local appraisal process rather than answering from memory. Good medical practice requires doctors to take appropriate advice when health may affect their ability to practise safely and to act honestly in professional matters. Having an illness, disability or period of treatment is not equivalent to being unfit to practise. The relevant questions concern its effect on work, the advice obtained, necessary adjustments and whether arrangements protect patients and the doctor. <sup>[3]</sup>

Appraisal should create space to discuss wellbeing without turning the meeting into an occupational-health assessment. Michael may explain that sustained additional responsibilities have become difficult to combine with recovery time. The appraiser can help him identify the effect and the next

conversation, but cannot determine a medical restriction or rewrite the rota. A useful output records the relevant professional issue and action at an appropriate level of detail. Detailed medical information should be handled through the proper confidential route, not copied indiscriminately into a portfolio because a health field exists.

Distinguish an adjustment already agreed from one still requested. If a doctor says that night work is no longer appropriate, the appraisal should not leave readers uncertain whether this is personal preference, clinical advice or an established employment arrangement. The record can state that occupational-health advice has been sought and a job-plan discussion is pending. It should also explain any immediate arrangement required for safe practice. Waiting for an annual meeting is inappropriate when an urgent health or safety issue needs action sooner.

Probity preparation involves the same discipline. Review professional declarations, indemnity arrangements relevant to the scope and any formal matters requiring disclosure under the applicable process. Check whether an answer covers the whole year and every role. A declaration about the substantive employer may be incomplete if a separate professional activity generated a relevant concern. Where wording is unclear, seek clarification before submission. An uncertain question should prompt a documented enquiry, not an assumption that the least uncomfortable interpretation must be correct.

The portfolio must also distinguish personal conduct from organisational constraints. Lack of equipment, supervision, study leave or reliable data may affect what can be demonstrated or achieved. Describe the constraint specifically, the effect on the work, actions taken and the current position. Avoid two unhelpful extremes: an entirely blameless narrative in which the doctor has no agency, and an entirely personal narrative in which service failures become private development deficits. The useful account identifies what the doctor could reasonably do and what required another decision-maker.

Aisha might report that an agreed supervised opportunity repeatedly disappeared because of rota gaps. A realistic appraisal does not simply mark the objective completed through attendance elsewhere, nor label her unmotivated because it remains unfinished. It examines what experience she obtained, what competence still needs assessment and who can authorise the opportunity. The PDP can record a revised plan and an escalation date. The employer's resource decision remains visible as a dependency instead of being disguised as a promise Aisha cannot fulfil alone.

Finally, ask which constraints need action outside appraisal. Some belong in job planning, some with occupational health, some with a supervisor and some in a formal concern process. Agree who will make contact and what will be shared. This avoids the recurrent problem of a sensitive issue being sympathetically discussed but left without an owner. The appraisal's contribution is a truthful professional account and a sensible route forward. It should make support more accessible while keeping the authority and confidentiality of each process clear.

Be equally precise about recovery. A doctor returning to effective practice after treatment or adjustment should not remain described solely through the difficulty that prompted support. Explain the current arrangements and review point. This gives the reader a contemporary professional picture while preserving the relevant history, and avoids implying either permanent impairment or complete resolution without supporting information.

## **Reflection that demonstrates learning**

Reflection makes the difference between presenting evidence and understanding it. A useful account shows how the doctor interpreted an experience, what assumptions were tested and what follows. It can concern effective practice as well as difficulty. The joint reflective-practitioner guidance emphasises learning and future action, anonymisation and the distinction between reflection and incident reporting. It also explains that reflective notes do not have blanket legal privilege: a court may require relevant material, although the GMC does not request reflective notes to investigate concerns. Seek advice if disclosure is requested. <sup>[65]</sup>

A weak reflection says, 'I attended the meeting and learned a lot about communication.' It gives no indication of the question, insight or consequence. A more useful version might explain that the doctor had assumed silence meant agreement, recognised through feedback that a colleague felt unable to challenge the plan, and changed the closing question to invite unresolved concerns. The later review would ask whether colleagues now raise issues earlier. This account is brief, but it contains a movement in understanding and an action capable of being examined.

Use a simple sequence when a blank page makes reflection difficult. First identify the decision or experience, with only the context needed to understand the learning. Then explain what you initially thought and what information challenged or confirmed that view. Describe the alternative understanding, the action taken or planned, and the evidence that will help judge its effect. This is an authoring aid, not a mandatory GMC template.

Different events may need different emphasis; the essential feature is visible reasoning rather than completion of a formula.

Consider Michael's external teaching. His first note says that participants wanted more practical examples, so he added cases. A deeper account asks why the original approach had seemed sufficient. He realises that experienced faculty could supply the missing decision steps mentally, while participants could not. He therefore changes the exercise to reveal those steps explicitly and asks learners to explain their reasoning. The insight is about a mismatch between expert familiarity and the learner's starting point. That understanding can improve other teaching beyond the one revised session.

Reflection need not end in a change of position. Sometimes review confirms that a difficult decision was reasonable on the information available. The learning may concern explaining uncertainty, obtaining support earlier or recognising the limits of retrospective judgement. Avoid rewriting the past as though later information was known at the time. Distinguish what the doctor could reasonably infer then from what became clear afterwards. This makes the account more honest and more useful to future decisions made under similarly incomplete information.

Protect confidentiality by removing unnecessary identifying detail, not merely names. A rare event, precise date, distinctive role and location can identify someone in combination. Describe the professional problem at the level needed for learning and keep factual source records in their authorised systems. Do not include patient correspondence, colleague allegations or screenshots simply because they make the story feel more convincing. The appraiser needs to understand the evidence of learning; that does not normally require a replica of the underlying confidential file.

Avoid both excessive self-criticism and polished self-exoneration. Statements such as 'I must never make another mistake' offer no workable action, while 'the system was at fault' can prevent examination of the doctor's contribution. A balanced account identifies uncertainty, responsibility and context. It may say that a handover system was ambiguous and that the doctor will now verify acceptance of a critical task while seeking a system correction. The individual action is useful, but it does not pretend to solve a problem requiring organisational change.

Before submission, read the reflection without the attached evidence. Can a reader understand the learning and next action? Then read it alongside the evidence. Does it claim more than the material supports? Remove repeated chronology, generic declarations of commitment and unsupported outcomes. Keep the part that shows a changed question, a maintained good

practice or an informed decision. That disciplined editing makes a short reflection stronger and leaves room in appraisal for the discussion that written preparation cannot complete.

Where several reflections end with the same proposed action, examine the repetition. It may reveal a recurring difficulty that needs a stronger response than another promise to communicate better. Consider whether the shared cause is unclear ownership, missing time or an assumption about colleagues' knowledge, and choose an action that addresses it directly.

## **The appraisal conversation**

Begin the meeting by agreeing its priorities. The portfolio should allow the appraiser to identify questions in advance, but the doctor should also name what needs attention. Michael may want to discuss a sustainable transition from an external role, while the appraiser has noticed that its governance information is incomplete. Both matter. Agree an order that gives difficult or significant topics sufficient time rather than allowing a tour of attachments to consume the conversation. A prepared agenda is a guide, not a barrier to an important issue emerging.

Describe the year's work in ordinary language. Explain changes in scope, what went well, what was difficult and what the evidence cannot yet show. When the appraiser asks for clarification, try to identify the missing link rather than responding with another large document. Is the issue participation, learning, outcome, chronology or an absent role? Each calls for a different response. A precise question can often be answered with a short explanation and one relevant item, whereas indiscriminate additional material may make the uncertainty harder to resolve.

Appraisal can accommodate disagreement. The appraiser may interpret feedback differently or consider an objective insufficiently developed. Ask what evidence or reasoning supports that view and explain your own. Agreement is more likely when both distinguish the underlying observation from its possible meaning. If an issue cannot be resolved, the record should describe the difference accurately and identify the appropriate advice route. Signing an inaccurate summary merely to complete the process creates a problem that may be more difficult to explain later.

The meeting should also notice achievements without making praise its main output. Ask what enabled effective work and whether the conditions remain available. Michael's teaching may have succeeded because preparation time was protected; an expansion without that time could undermine the result. Aisha's early progress may depend on access to a reliable supervisor. Identifying those dependencies helps preserve good

practice. It also gives a development plan a firmer basis than assuming that successful outcomes can be repeated indefinitely through personal effort.

At the end, distinguish the appraisal summary from the next actions. Check that the account represents the whole scope, records relevant discussion fairly and does not imply that an unresolved issue has been settled. Identify which objectives belong in the PDP, which need a separate management or professional conversation and who will initiate them. An appraiser's recommendation to seek support is useful only if the doctor knows which service or person can provide it. Set a reasonable date for reviewing the written output through the local process.

Afterwards, correct factual errors promptly and preserve the final agreed version. Avoid quietly editing the underlying history when a later development changes the position; use a dated clarification through the appropriate system. The appraisal should be a trustworthy record of what was known and discussed at that time. Its value increases when the doctor can return months later and see the reasoning behind an objective, the support it required and the question the next review was intended to answer.

Before leaving, say aloud what you believe has been agreed. This simple check can reveal that an action the doctor heard as optional was understood by the appraiser as necessary, or that a request for clarification was mistaken for criticism. Resolving the difference immediately is easier than interpreting ambiguous wording later.

## **A workable personal development plan**

The PDP translates the appraisal into a manageable set of intentions. It should arise from actual learning needs, professional responsibilities and chosen development, rather than an obligation to populate every available field. A small number of meaningful objectives is usually easier to pursue than a long collection of aspirations. The appropriate number depends on the work and local process; this handbook does not impose a universal quota. Each objective should explain the intended improvement, the action, how progress will be recognised, the support needed and the review date.

Compare 'Improve teaching skills' with an objective grounded in Michael's appraisal: by the next scheduled course, redesign one session to make clinical reasoning explicit, obtain peer observation and compare learner feedback with the earlier format. This identifies a task and a source of evaluation without claiming that one session will transform educational practice. It also raises practical dependencies: faculty agreement, preparation time and a colleague able to observe. If those are not available, the objective needs revision or an action to obtain them.

A clinical objective can work similarly. Aisha identifies uncertainty about a particular decision within her agreed scope. Her plan is to review the relevant guidance, discuss a series of suitable examples with a supervisor and obtain feedback on her reasoning before the next development review. The objective should not invent a numerical quota unless an applicable assessment requirement supports one. What matters is sufficient evidence for the question being asked. If formal competence assessment is needed, name that requirement and the person authorised to undertake it.

Distinguish activity from completion. Booking a course completes an administrative step; attending completes an educational activity; applying and reviewing learning addresses the professional objective. Not every goal needs all three stages, but the wording should reveal what success means. A plan to understand pension options might appropriately end with obtaining scheme information and qualified advice, rather than a predetermined retirement decision. A plan to explore a leadership role may end in an informed choice not to pursue it. Development can clarify a direction without requiring promotion.

Add a contingency where the objective depends on another party. If supervised experience is not available by the agreed date, Aisha will discuss an alternative arrangement with the educational lead. If access to data is delayed, Michael will revise the evaluation timetable and record the limitation. This turns a foreseeable obstacle into a decision point. It also prevents a year-end judgement based solely on whether a box was completed, when the original plan relied on an organisational action that never occurred.

For each objective, write one sentence explaining why it deserves space in this year's plan. If the answer is only that it sounds professionally admirable, make it more specific or remove it. Ask what would remain difficult, uncertain or unsafe if the objective were not pursued. This test helps prioritise competing ambitions and distinguishes necessary maintenance from optional exploration. Both can be legitimate, but the doctor should know which demands prompt action and which can reasonably wait when circumstances change.

Review the PDP during the year, particularly after changes of role, health or service organisation. Record completed learning, explain abandoned objectives and revise those that no longer make sense. Do not retrospectively pretend that a changed goal was the original plan. At the next appraisal, the sequence should show what the doctor intended, what happened and why the response was reasonable. The final measure of a workable PDP is simple: the doctor can identify the next action without

reopening a complex portfolio, and the later reviewer can see how that action served professional practice.