

# Medical Appraisal and Revalidation Procedure

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# Medical Appraisal and Revalidation Procedure

## 1 Introduction

Revalidation is the process by which doctors will have to demonstrate to the General Medical Council (GMC) that they are up to date with continuing professional development (CPD), fit to practise and complying with the relevant professional standards. The medical Royal Colleges and Faculties have developed standards and defined essential specialty supporting information for the appraisal and revalidation of specialist doctors and GPs.

Appraisal is the cornerstone of revalidation. Revalidation will be based on systematic appraisal of the doctor's work on an annual basis with revalidation required every five years. Satisfactory appraisals over a five year period will enable a Responsible Officer to recommend revalidation to the GMC. All non-training grade medical staff (GPs, Consultants, SAS grades and any other non-training grade posts) are expected to go through revalidation every five years. The Deanery will be responsible for the revalidation of doctors in training.

The Royal College of Psychiatrists (2010a) has set out how psychiatrists will demonstrate that they meet the generic standards of *Good Medical Practice* (2006) and the specialist standards of *Good Psychiatric Practice* (2009). It will be through the annual appraisal process that psychiatrists will demonstrate that they are meeting these relevant standards.

This document sets out the way in which this requirement will be met by the Trust.

## 2 Purpose and Objectives

The purpose of this procedure is to set out the way in which the Trust will manage appraisal and revalidation recommendations for doctors working at the Trust.

The procedure defines the responsibilities of key staff involved in appraisal including medical staff, managers, HR etc. The aim of the procedure is to ensure that, through an effective appraisal mechanism, all medical staff are fit to practise and provide the highest standards of safe care to patients.

## **Objectives of appraisal**

The objectives of the appraisal scheme are to enable doctors to:

- review regularly an individual doctors 's work and performance, utilising relevant and appropriate comparative performance data from the Trust, regional and national sources (if these are available in a meaningful format)
- optimise the use of skills and resources in seeking to achieve the delivery of service opportunities
- consider the doctor's contribution to the quality and improvement of services and priorities delivered locally
- set out personal and professional development needs and agree plans for these to be met
- identify the need for the working environment to be adequately resourced to enable any service objectives in the agreed job plan review to be met
- provide an opportunity for doctors to discuss and seek support for their participation in activities for the wider NHS
- utilise the annual appraisal process and associated documentation to meet the requirements for GMC revalidation
- play a significant part in wider Trust issues such as clinical governance, risk management and the process for awarding discretionary points.

### **3 Scope**

This procedure applies to all non-training grade medical staff (GPs, Consultants, and all other non-training grades, and including substantive employees, employees with honorary contracts/joint contracts or temporarily employed) employed by the Trust.

It is not directly applicable to medical trainees, whose supervision, appraisal and revalidation will be managed by the Local education and Training Board (LETB).

### **4 Definition and Aims of Effective Appraisal**

#### **4.1 Definition of Appraisal**

Appraisal is defined as “a professional process of constructive dialogue, in which the doctor being appraised has a formal structured opportunity to reflect on his or her work and to consider how his or her effectiveness might be improved” (DoH, 2002).

Appraisal for doctors is a professional process of constructive dialogue, in which the doctor being appraised has a formal structured opportunity to reflect on his/her work and to consider how his/her effectiveness might be improved. It is intended to be a positive employer-led process to give doctors feed-back on their performance, to chart their continuing progress and to identify development needs. It is a forward-looking process that enables plans to be discussed and agreed for the educational and developmental needs of each individual.

The primary aim of appraisal is not to scrutinise doctors to see if they are performing poorly but rather to help them consolidate and improve on good performance, aiming towards excellence. However, it can help to recognise at an early stage developing poor performance or ill health which may be affecting clinical practice. It is important that appraisal is seen as a two-way process, which allows consultants to feed back issues to the organisation, as well as receiving feedback themselves.

The distinction is often made between summative and formative processes in appraisal. The summative component involves an assessment of what has happened whilst the formative part of appraisal involves identifying developmental needs and looking forward. A good appraisal involves both summative and formative components. The summative assessment of what has been achieved and what standards have been reached is necessary to inform the formative and developmental stage of the appraisal process.

## **5 Duties and responsibilities**

This section defines the key staff involved in the appraisal/revalidation process.

### **5.1 The Trust/ Chief Executive**

The Trust is the designated employing authority and through the Chief Executive is responsible for:

- ensuring that a suitable system of appraisal is operating in the Trust
- nominating the Responsible Officer
- ensuring effective governance arrangements are in place to maintain standards of appraisal

- allocating financial and administrative resources to support appraisal and revalidation

## 5.2 Responsible Officer/Medical Director

The Responsible Officer (RO) is a new statutory role which came into force on 1st January 2011 under *the Medical Profession (Responsible Officers) Regulations 2010*. The Trust has nominated the Medical Director to be the RO.

The RO is responsible for making recommendations to the GMC on revalidating doctors every five years based on the results of a doctor's annual appraisal and folder of information. The RO is responsible for:

- Ensuring that the Trust has an up to date Medical Appraisal and Revalidation Procedure documents.
- Maintaining a list of doctors for which the RO is responsible and securely retaining records of doctors' fitness to practise evaluations including appraisals and any other investigations or assessments.
- Ensuring all doctors working in the Trust participate in annual appraisal and that appropriate action is taken to remedy identified areas of weakness in doctors' performance.
- Making recommendations to the GMC about the fitness to practise of doctors employed by the Trust, and where a doctor employed by the Trust is subject to conditions imposed by or undertakings agreed with the GMC, to monitor compliance with those conditions.
- Establishing and implementing procedures to investigate concerns about a doctor's fitness to practise raised by patients or staff of the trust or arising from another source, in line with *Maintaining High Professional Standards in the NHS*.
- Providing an annual report on Revalidation to the Board of Directors.

**Note:** Where there is justified cause for concern about a doctor's fitness to practise which cannot be managed through remediation processes, the role of the Responsible Officer is limited to drawing the case to the attention of the GMC and to ensuring that the necessary supporting information is available. Final decisions which may affect the ability of the doctor to continue in practice will remain, as at present, the sole responsibility of the GMC.

## 5.3 Appraisal and Revalidation Lead/ Associate Medical Director

The Appraisal Lead is responsible to the RO and is responsible for:

- Overseeing a network of approved medical appraisers

- Assisting the RO in meeting his responsibilities as set out above
- Providing leadership and support to appraisers
- Auditing and quality assuring the appraisal process as set out in Appendix 16

## 5.4 Appraisers

All medical appraisers in the Trust are medical consultants of at least two years substantive appointment who have received formal appraisal training, and are accountable in their role of appraiser to the Appraisal Lead.

Responsibilities of the appraiser:

- To be formally trained in appraisal for revalidation.
- To ensure there is no conflict of interest between appraisee and appraiser (see Appendix 1)
- To obtain consent from the appraisee to collect information as part of the appraisal meeting.
- To agree an appraisal meeting with the appraisee normally 3 months ahead of the date and that relevant paperwork is submitted to the appraiser, at least 2 weeks before the appraisal.
- To assess the appraisee's supporting information being gathered for revalidation. The appraiser will be asked to check that the gathered supporting information is of the appropriate quality and quantity for the particular stage of the revalidation cycle that the appraisee is at. If the supporting information that is provided is insufficient to inform an evaluation of the doctors practice the appraiser in the first instance should discuss this with the appraisee. If this does not resolve the problem, the matter should be referred to the Appraisal Lead.
- To stop the appraisal process and refer the doctor to the RO if the appraisal suggests that a GPs health, conduct or performance poses a threat to patient safety.
- To ensure that any personal data recorded is accurate and is stored securely, and the appraisee is given adequate opportunity to check any information recorded.
- To have their own personal appraisal completed annually by another appraiser approved by the Appraisal Lead.
- To take part in a performance review, including feedback on performance in their role (see Section 11 below).

## 5.5 Appraisee

The appraisee is the doctor who is being appraised. All appraisers (as

defined above) will also become appraisees when they are being appraised themselves.

Responsibilities of the appraisee:

- To ensure that all email relating to appraisal will be sent via NHS mail or the Trust's email system
- To initiate and complete the annual appraisal in line with this procedure.
- The appraisee should make contact with their allocated appraiser and arrange an appraisal date. They should then log on to the appraisal toolkit (SARD) and enter the details of the appraiser and appointment time. This should be completed by the end of July at the latest (3 months into appraisal year).
- To ensure there is no conflict of interest between appraisee and appraiser (see Appendix 6)
- To consent for their appraiser to view and use their pre-appraisal paperwork by arranging an appraisal meeting and submitting his/her appraisal documentation via SARD for consideration.
- To set aside adequate time to prepare the documentation and supporting information for appraisal. It is acceptable for an appraisal to take place 6 months after the last appraisal has taken place to help facilitate moving appraisals earlier in to the appraisal year.
- To send a copy of the documentation and supporting information via SARD to the appraiser at least 2 weeks before the date of appraisal.
- To inform the appraiser of any complaints or disciplinary procedures made against them.
- To contribute to the governance and future development of consultant appraisal in the Trust by completing the feedback questionnaire and returning it within 4 weeks of the appraisal.
- To ensure that the appraisal summary and PDP produced as a result of their appraisal is a true reflection of the appraisal interview and satisfactory for the purposes of revalidation.

## **5.6 Medical HR Revalidation Lead**

The Medical HR Revalidation Lead will oversee the Revalidation Appraisal process in consultation with the Appraisal Lead and Responsible Officer and ensure that related procedures and practices are regularly reviewed in line with changes in legislation. The post holder will ensure that appropriate protocols, processes and records are developed and maintained to ensure that all medical staff undertake annual appraisal in line with national guidance.

## **5.7 Appraisal Facilitator**



The Appraisal Facilitator is responsible for providing administrative support to the appraisal process including:

- Maintaining the records/electronic data system and ensure that the systems in place are held securely.
- Maintaining a database of trained Appraisers, including proof of appraiser training
- Providing performance reports to Clinical Directorates of appraisal activity within their directorate.

## **6 The Appraisal Process**

The appraisal process is set out in detail at Appendix 1.

This appraisal process will include job planning, in which there is an opportunity to draw together information and data from which the job plan is shaped and reviewed (see p. 15)

## **7 Appraisal arrangements for clinical academics and doctors working in more than one designated body or in the private sector**

### **7.1 Doctors working in more than one NHS trust**

For doctors working in more than one designated body or trust, the trusts must agree on a 'lead' trust for the doctor's appraisal, which will normally be the employing trust where the doctor works most. Agreement will also include appropriate discussion prior to the appraisal between the RO and their equivalent in the other trust(s) to ensure that key issues are considered, including systems for accessing and sharing data and arrangements for action arising out of the appraisal. Feedback from the appraisal should also be given, on a confidential basis, to the other trust(s).

### **7.2 Appraisal for independent sector doctors employed by the NHS - whole practice appraisal**

Doctors practising in both the NHS and independent sectors need to undertake whole practice appraisal which will take account of their work in both sectors. The appraisal will usually take place in the sector within which they do the bulk of their work. Doctors employed by the NHS and who work privately are recommended to participate in whole practice appraisal within their NHS appraisal to cover all elements of their practice. Appraisal should take place in the NHS using NHS appraisal forms together with data provided in approved forms

available from the private hospitals. For further details see BMA guidance at:  
[www.bma.org.uk/employmentandcontracts/doctors\\_performance/1\\_appraisal/AppraisalIMPDocsNHS.jsp](http://www.bma.org.uk/employmentandcontracts/doctors_performance/1_appraisal/AppraisalIMPDocsNHS.jsp)

### 7.3 Clinical academics

Appraisal for clinical academics should be in line with Follett Principles. The Follett Review reported in September 2001 and made a number of recommendations regarding the appraisal, disciplinary and reporting arrangements for senior clinical academic staff. In regard to appraisal, the report recommended that Universities and NHS bodies should work together to develop a jointly agreed annual appraisal and performance review process based on that for NHS consultants, to meet the needs of both partners. The process should:

- Involve a decision on whether single or joint appraisal is appropriate for every senior NHS and university staff member with academic and clinical duties.
- Ensure joint appraisal for clinical academics holding honorary consultant contracts and for NHS staff undertaking substantial roles in universities.
- Define joint appraisal as two appraisers, one from the university and one from the NHS, working with one appraisee on a single occasion.
- Require a structured input from the other partner where a single appraiser acts.
- Be based on a single set of documents and start with a joint induction for those who will be jointly appraised.

## 8 Situations when deferral will be permitted

A deferral request process will normally be activated in the event that a scenario arises during the appraisal year that is outside the scope of normal operating processes e.g. long-term illness, maternity leave, suspension, sabbatical etc.

A deferral request form will need to be completed by the appraisee and agreed by the appraiser (see appendix 12).

### 8.1 Illness

If the appraiser considers that an appraisee should be excluded from any aspect of the appraisal scheme for any given year as a result of illness, they must ensure this is recorded on the database and inform

the Appraisal Lead.

## **8.2 Maternity, Adoption, Paternity**

Appraisals may be prepared for or undertaken during maternity, adoption and paternity leave with the agreement of the appraisee. Exception from the appraisal in any appraisal year will be considered in the event that there is absence from practice for more than 9 months in an appraisal year, resulting in insufficient time (either before the leave or following it) for an appraisal to take place. The appraisee must inform the appraiser and the decision must be recorded on the database (see appendix 13).

## **8.3 Suspension from practice**

Suspension from practice, pending either a trust or GMC investigation is an automatic exception, unless there are six clear months for the appraisee to recover their practice between their return to work and the end of the appraisal year.

## **8.4 Sabbatical**

Appraisal can take place where there are six clear months between the time when the appraisee has returned to work and the end of the appraisal year.

# **9 Governance arrangements for Medical Revalidation**

## **9.1 Record Keeping and Administration**

A live register will be kept by the RO's office, recording all information relating to each doctor on an annual basis. Previous records will be archived. All records will be kept in accordance with the data protection act and the register will be password protected. As a minimum, the register will include:

- Dates of previous appraisals.
- Date next appraisal is due.
- Date of return of completed appraisal forms.
- Date the appraisal actually took place.

## **9.2 Electronic appraisal toolkit**

It is expected that all appraisers and appraisees are trained in and use the online GMC approved accredited appraisal toolkit, the Strengthened Appraisal and Revalidation Database (SARD) to complete all appraisals, which has been purchased by the Trust. This provides a standard core content and electronic recording of supportive documentation.

### **9.3 Integration of appraisal with quality improvement, clinical governance and performance monitoring systems**

It is important that that key information such as specified complaints, SUIs and other significant events affecting patient safety, as well as outlying performance/clinical outcomes are included in the appraisal portfolio and have been discussed in the appraisal so that developmental needs are identified.

The Appraisal Lead in her role as Patient Safety and Clinical Risk Lead, and the Responsible Officer in his role as Chair of the Clinical Governance and Safety Committee, are routinely informed of all complaints, Serious Untoward Incidents and other clinical incidents, as well as clinical and performance outcomes in the Trust. The Appraisal Lead and RO will ensure that any such key information relating to an individual doctor will be discussed with the doctor concerned and communicated to the relevant appraiser to ensure that this will be included in the consultant's supporting information and discussed in the doctor's appraisal.

The Appraisal Lead will also ensure that information collated from appraisee feedback and audit of the appraisal process will be used to inform the Trust of educational needs and organizational development activity in an annual report of the quality and outcomes of appraisal (see Section 11).

### **9.4 Confidentiality, security and access arrangements**

Appraisal meetings will be conducted in private and the key points of the discussion and outcome will be fully documented, with copies held by the appraiser and appraisee. Both parties must complete and sign the appraisal summary document and PDP and send copies, in confidence, via SARD, to the RO. Both the Trust and the appraisee will need to retain copies of the appraisal documentation over a five year period. All records will be held on a secure basis by the RO and access/use must comply fully with the requirements of the Data Protection Act (1998). No information from the appraisal sessions will be disclosed unless agreed with the doctor, except under exceptional

circumstances where there are significant concerns about patient safety or issues that relate to fitness to practise.

No patient identifiable data is to be held in the appraisal records by either the appraisee or appraiser. If potentially identifiable information is used e.g. a complaint, it must be anonymised.

All staff must comply with the Trust's Information Governance Policy, and in particular, the Email Procedure when handling personal information.

## **10 Concerns and Complaints**

It is important that all complaints related to appraisal are dealt with in a timely and efficient way. Some concerns will be dealt with informally.

Appraisees may find it sufficient to raise minor concerns on their feedback questionnaire, after their appraisal interview, in the knowledge that this will be shared. Others may wish to raise issues directly with their appraiser. The Trust should ensure that appraisers report their handling of such problems to the Appraisal Lead. If the Appraisal Lead is unable to respond satisfactorily to the problem, he or she should refer the matter immediately to the RO.

If an appraisee has concerns regarding their appraisal these should be raised initially with the appraiser. If the consultant prefers not to approach his or her appraiser, or, because of the nature of the problem, considers it inappropriate to do so, the first point of contact should be the Appraisal Lead, who will attempt to resolve the problem through discussion and mediation involving others where appropriate. If the Appraisal Lead is unable to resolve the problem, he/she should refer the matter to the RO. In exceptional circumstances or when a concern cannot be resolved by these means, the RO will refer the matter to the Chief Executive.

In rare instances, where the concern or complaint is of a serious professional nature the Trust process for management of concerns raised about professional performance to protect patient safety will be followed.

## **11 Selection, Training and support of Medical Appraisers**

Procedures for the selection, training and support of medical appraisers are detailed in Appendix 2

## **12 Monitoring Compliance with the Procedure**

The Trust will undertake a review of the following organisational quality standards of the medical appraisal process and plan to work towards achieving these.

On an annual basis the following will be undertaken and co-ordinated by the Appraisal Lead/ Associate Medical Director:

### **12.1 Appraisee feedback**

Feedback questionnaires will be given to appraisees following completion of each appraisal (see appendix 14). These will be reviewed by the Appraisal Lead and RO and the information collated and included in the annual report to the Trust Board. Feedback will be given to appraisers on their performance. The Appraisal Lead will also use feedback from PDP's and questionnaires to inform the Trust of educational need.

### **12.2 Audit of the appraisal process**

The Trust will carry out regular self-assessment audits to make sure it is meeting quality standards in line with recommendations from the Revalidation Support Team. The Appraisal Lead will facilitate review of appraisal summaries and PDPs against revalidation requirements and quality criteria for appraisal and collate training needs to inform provision (Appendix 15). Appraisal summaries and PDPs will be audited and classified by appraiser. Routinely, 2 appraisals per appraiser will be examined annually to inform feedback to the appraiser and Trust and ensure appraisal provision is in line with this procedure and revalidation.

The Trust will facilitate external audit of the appraisal process in line with national guidelines.

### **12.3 Exception audit of missed or incomplete appraisals**

A missed or incomplete appraisal is an important occurrence which could indicate a problem with the appraisal system or a potential issue

with an individual doctor which needs to be addressed. Missed appraisals are those which were due within the appraisal year but are not performed. Incomplete appraisals are those where, for example, the appraisal discussion has not been completed or where the PDP or summary of appraisal discussion have not been signed off within 28 days of the appraisal meeting.

An exception audit (see Appendix 16) to identify the reasons for all missed or incomplete appraisals will be performed by the Appraisal Lead/Associate Medical Director at the end of each appraisal year and ensure that any recommendations and improvements are enacted within the following year.

#### **12.4 Annual report**

An annual report of the quality and outcomes of appraisal will be prepared by the Appraisal Lead and RO (Appendix 17) and presented to the Board of Directors.

### **13 Equality Impact Procedure**

The impact of this Procedure on staff and potential or prospective staff to the Trust has been fully assessed with neutral impacts identified.

### **14 References**

Department of Health (2001) *Appraisal Guidance for Consultants*

Department of Health (2006) *Good Doctors, Safer Patients*

Department of Health (2007) *Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century*

Department of Health (2008) *Medical Revalidation - Principles and Next Steps: the Report of the Chief Medical Officer for England's Working Group*

Department of Health (2010) *The Medical Profession (Responsible Officers) Regulations TSO*

Department of Health (2010) *The Role of the Responsible Officer: Closing the Gap in Medical Regulation – Responsible Officer Guidance.*

Follett, B. & Ellis, M.P. (2001) *A Review of Appraisal, Disciplinary and Reporting Arrangements for Senior NHS and University Staff with Academic and Clinical Duties. A report to the Secretary of State for*

### *Education and Skills*

General Medical Council (2006) *Good Medical Practice*. GMC ([http://www.gmc-uk.org/guidance/good\\_medical\\_practice.asp](http://www.gmc-uk.org/guidance/good_medical_practice.asp)).

General Medical Council (2009) *License to Practise*. GMC (<http://www.gmc-uk.org/doctors/licensing/practice.asp>).

General Medical Council (2010) *Revalidation: A Statement of Intent*

General Medical Council (2010) *Good Medical Practice Framework for Appraisal and Assessment*. GMC

General Medical Council (2011) *Supporting Evidence for Appraisal and Revalidation*. GMC

Mynors-Wallis, L. & Fearnley, D. (2010) *Good Practice Guidelines for Appraisal*. Royal College of Psychiatrists <http://www.rcpsych.ac.uk/pdf/Good%20Practice%20Guidelines%20for%20Appraisal.pdf>

NHS Clinical Governance Support Team (2007) *Assuring the Quality of Training for Medical Appraisers [AQTM]*

NHS Revalidation Support Team (2009) *Assuring the Quality of Medical Appraisal for Revalidation [AQMAR]*.

NHS Revalidation Support Team (2011) *Organisational Readiness Self-Assessment: End of Year Report 2010 11 v1.0*

Royal College of Psychiatrists (2009) *Good Psychiatric Practice (3rd edn) (CR154)*. Royal College of Psychiatrists.

Royal College of Psychiatrists (2010a) *Revalidation and Guidance for Psychiatrists (CR161)*. Royal College of Psychiatrists.

Royal College of Psychiatrists (2010b) *Good Psychiatric Practice: Continuing Professional Development (2nd edn) (CR157)*. Royal College of Psychiatrists.

UCEA (2002) *Joint University and NHS Appraisal Scheme for Clinical Academic Staff*.



## Appendix A : Appraisal process

### The Appraisal Process

#### 1. Standards underpinning the appraisal process

Appraisal should be:

- **Fair:** appraisal should be conducted fairly and consistently by competent and appropriately trained appraisers. It should be based on valid information and assessed against defined standards.
- **Supportive and developmental for doctors:** for the overwhelming majority of doctors who provide safe, effective and patient-centred care, appraisal should practice, develop skills, encourage doctors and improve the quality of professional practice.
- **Protective of patient safety:** appraisal should act as a safety net, identifying practice where development and change is needed. This should happen only in rare circumstances where clinical governance has failed to identify and address such practice.
- **Streamlined:** Appraisal systems should seek to minimise the time taken to prepare portfolios, complete documentation and participate in the appraisal.
- **Practicable:** NHS medical appraisal should support, not disrupt, the delivery of care to patients. Its implementation should take account of the pressures of the service and organizational needs, integrating with clinical governance and the complexity of the modern healthcare environment.
- **Valid and evidence based:** The ability of strengthened appraisal to meet the criteria set out above needs to be piloted and evaluated.

#### 2. Phases in the Appraisal Process:

Phase	Activity
1	Preparation work and information gathering by both appraiser and appraisee. Appraisals for revalidation are made up of whole practice appraisal and therefore appraisees must provide information from all organisations that employ them.
2	Appraisal discussion <i>including</i> a review of the previous year's PDP.
3	Notification & return of papers and agreement of a new PDP going forward.
4	Review & reporting by the Responsible Officer & Clinical Directors.
5	Issue of "Statement of satisfactory completion of appraisal" signed off by both parties within 28 days of the appraisal meeting, after this stage the appraisal process is complete.

#### Phase 1: Preparation for the appraisal meeting

Preparation for appraisal should be part of a consultant's Supporting Professional Activity (SPA). It is envisaged that between 2-4 hours a month is sufficient to prepare for appraisal.

#### NHS consultant appraisal documentation

The appraisee should start by completing or updating the consultant appraisal forms on SARD. These include sections on the following:

[Personal details](#)  
[Scope of Work](#)

Record of annual appraisals  
 Personal development plans and their review  
 Continuing Professional Development  
 Quality Improvement Activity  
 Significant Events  
 Feedback from colleagues and patients  
 Review of complaints  
 Achievements, challenges and aspirations  
 Probity and health statements  
 Additional Information  
 Personal development plan proposals  
 Supporting Information  
 Pre-appraisal preparation  
 The agreed personal development plan  
 Appraisal Summary  
 Appraiser Statement  
 Doctor Statement

### 3. Supporting Information

The appraisee is required to gather supporting information, referring to the standards in *Good Medical Practice* and *Good Psychiatric Practice*. This is recorded in the SARD Portfolio. The information collected should be from a number of areas of a doctor's practice and should include evidence of meeting clinical standards, including audits, outcomes and case based discussion, evidence of participating in Continuing Professional Development (CPD), feedback from colleagues and patients, and evidence of reflection on care provided. In *Revalidation and Guidance for Psychiatrists (CR161)* the Royal College of Psychiatrists (2010) has produced guidance for psychiatrists as to the types of evidence that they will be expected to collect in order to meet the requirements for revalidation, and how these map on to each of the attributes and domains of the GMC standards of Good Medical Practice (see below).

An important part of the appraisal process is not only collecting the supportive information, but providing evidence that the appraisee has reflected on it, including their role, participation and involvement in the activities, and evidence that their participation has led to demonstrable outcomes and changes in practice where necessary.

#### ***GMC standards of Good Medical Practice***

The General Medical Council has grouped the standards of Good Medical Practice into four domains, each with three attributes. The standards of Good Psychiatric Practice can also be considered in these twelve headings. The four domains and twelve attributes are:

#### ***Domain 1 Knowledge, skills and performance:***

- Attribute 1** Maintain your professional performance
- Attribute 2** Apply knowledge and experience to practice
- Attribute 3** Keep clear, accurate and legible records

#### ***Domain 2 Safety and quality:***

- Attribute 4** Put into effect systems to protect patients and improve care
- Attribute 5** Respond to risks to safety
- Attribute 6** Protect patients and colleagues from any risk posed by your health

#### ***Domain 3 Communication, partnership and teamwork:***

- Attribute 7** Communicate effectively
- Attribute 8** Work constructively with colleagues and delegate effectively

**Attribute 9** Establish and maintain partnerships with patients

**Domain 4 Maintaining trust:**

**Attribute 10** Show respect to patients

**Attribute 11** Treat patients and colleagues fairly and without discrimination

**Attribute 12** Act with honesty and integrity

The appraisee is expected to consider which out of the twelve attributes they wish to present supporting information for in the appraisal for each year. All twelve attributes are to be covered in a five-year appraisal cycle for revalidation. The choice may arise from the previous year's Personal Development Plan (PDP), which will have areas of development agreed and which will link to at least one of the attributes. Some information will be presented each year, whereas other information may only be required once in a five year cycle.

The appraisee should collect information that relates to all their professional roles. Appraisal must cover the whole scope of the doctor's work including management, research and teaching, and the provision of specialist advice in not only the employing organisation but also all other areas of medical practice.

#### **4. Essential supporting information requirements**

All psychiatrists in the Trust should follow the guidance produced by the Royal College of Psychiatrists (2010) in *Revalidation and Guidance for Psychiatrists (CR161)* and the GMC's *Supporting Evidence for Appraisal and Revalidation* (2011) as to the types of supporting information that they will be expected to collect and reflect on in order to meet the requirements for revalidation (Appendix 3).

A summary of the supportive information that will be essential for revalidation and considered at annual appraisal is as follows:

- Job role
- Work Place Based Assessments – 10 case-based discussions in 5 years
- Quality improvement activities – participation in 2 audits of significant areas of practice in each 5 year-cycle, as well as participation in an audit of record keeping
- Multi-source feedback (MSF) of colleagues every 5 years
- MSF of patients every 5 years
- Significant events - review and reflection on complaints, compliments and Serious Untoward Incidents

All psychiatrists in the Trust should currently follow the guidance in *Revalidation and Guidance for Psychiatrists* on case-based discussions (Appendix 4 and 5) and audit (Appendix 6), and use the structured reflective templates for multisource feedback from colleagues (Appendix 7), multisource feedback from patients (Appendix 8), complaint report (Appendix 9), and Serious Untoward Incident audit (Appendix 10) respectively, as well as the audit *pro forma* (Appendix 11).

#### **5. Multisource feedback**

The GMC has stipulated that participation in patient and colleague feedback will be necessary once in the five year revalidation cycle, as part of the supporting information for revalidation. This should be based on questionnaires that meet clear and robust criteria and that are approved by the GMC. The GMC intends colleague and patient feedback to be a developmental tool to help doctors to reflect on their performance, and are not proposing to use the feedback as a screening tool, although there is evidence that patient and colleague questionnaires can help to identify outliers in particular areas of practice.

All appraisees should use the multi-source feedback for colleagues which is available on SARD. Colleagues chosen should be familiar with the appraisee's practice, and should include a range of grades, including trainees where appropriate, and include administrative staff as well as clinicians, will be sent an online colleague questionnaire to complete. The recommended minimum number of peers required to complete the colleague questionnaire is 15.

There is recognition that obtaining meaningful feedback from psychiatric patients may pose particular difficulties, and any feedback questionnaire must be devised to take these into account. Moreover, the specialist field of psychotherapy poses additional questions regarding the role of patient feedback questionnaires, for example how their use might affect the course of the patient's treatment and the therapeutic relationship.

The Appraisal Lead and RO, in consultation with the medical consultants and the Human Resources Department in the Trust, are in the process of devising and piloting appropriate multi-source feedback questionnaires for patients that take these issues into account and are sensitive to our patient's needs. Once completed, this questionnaire will be available for use by appraisees via the electronic appraisal toolkit, SARD.

## **6. Choice of Appraiser**

The following guidelines will inform the choice of appraiser:

- All medical appraisers in the Trust must be appropriately trained in the standards for psychiatric appraisal and revalidation (see Appendix 2).
- Mechanisms must be in place to both support the appraiser and to quality assure the appraisal process.
- The majority of appraisals in each 5 year cycle should be done by a psychiatrist. It is not essential that each appraisal should be done by a psychiatrist from the same sub-specialty but appraisals should be undertaken by a colleague with a good understanding of the work being undertaken by the appraisee.
- Each appraisee should be appraised no more than four times in succession by the same appraiser, unless there are compelling indications that this would be beneficial, for example, the implementation of a complex and ongoing personal development plan.
- In order to ensure continuity appraisees should ensure that they do not frequently change their appraiser.
- The Appraisal Lead in conjunction with the RO and Clinical Directors will be responsible for allocating appraisers to appraisees.
- Appraisees should be involved in a choice about their appraiser. In circumstances where concerns are being raised about practice, agreement must be reached with the RO. If the appraisee is concerned about the choice of appraiser, this should be discussed with the RO. However, if issues are not resolved by this means, then an appraisee may request in writing to the Chief Executive, that he nominates a suitable alternative appraiser. The Chief Executive's decision on this matter will be final.
- The choice of appraiser should ensure that there are no conflicts of interest between appraiser and appraisee. The following situations should be avoided:
  - Where the appraiser and appraisee share personal or family relationships.
  - An appraiser and appraisee share close business or financial interests.
  - Reciprocal appraisal – where 2 doctors appraise each other.
  - An appraiser appraising a doctor who acts as their line manager in the same or a different organization.
  - A doctor's direct employer acting as their appraiser.

- An appraiser receiving direct payment from an appraisee for performing the appraisal.
- The risk of collusion or complacency between appraiser and appraisee may be minimised through appraiser training, ensuring two appraisers within the revalidation cycle, periodic joint appraisal, and qualitative evaluation of appraisal outputs.
- If a conflict of interest or appearance of bias is identified between appraisee and appraiser, the RO should be informed in writing, explaining the conflict and providing as much background information as is necessary and relevant. It may be appropriate for the RO to assign another appraiser.
- If a conflict of interest or appearance of bias exists between a doctor and the RO, the Trust should be informed in writing giving as much information as possible. It is important that every attempt is made to resolve the issue using the existing mediation procedures. If, after all processes are exhausted, a satisfactory resolution is not possible the evaluation of fitness to practise may be overseen by another Responsible Officer. In such circumstances, the designated body should seek advice from the Responsible Officer's own Responsible Officer (for example the appropriate SHA Medical Director in England, or in Wales the Medical Director of NHS Wales and in Scotland, the Chief Medical Officer) and the decision should be recorded in writing.

## **7. Pre-meeting**

The appraisee and appraiser should make contact before the meeting to discuss the agenda and raise any particular points e.g. the first appraisal for a new consultant, specialty doctor, any significant gaps etc. The appraiser should formally invite the appraisee to the meeting, usually allowing about 2 hours for the meeting itself. The portfolio of supporting information should be delivered to the appraiser at least two weeks before the appraisal meeting.

If any third party is to be present, e.g. a patient or another appraiser as an external validator, this must be agreed with the appraisee before the meeting.

Areas that may require further thought before the appraisal meeting include: teaching activity (possible outside the Trust), research, management and private practice. The appraisee may be asked to consider obtaining third party views as part of the supporting information e.g. feedback from trainees, academic head of department, line manager, clinical director, Chief Executive etc.

The appraiser should check all supporting information provided to help avoid unnecessary distraction in the appraisal interview itself. The appraiser should come to an opinion early on about whether there is sufficient supporting information to enable the appraisal interview to go ahead as planned, whether it should be adjourned, or whether a request for further information prior to the interview itself is necessary.

## **8. Phase 2: The appraisal meeting**

### **8.1 Practicalities**

Appraisal meetings are normally about 2 hours but this will vary depending upon the individual's circumstances.

Consideration needs to be given to the location of the appraisal meeting, convenient for both appraisee and appraiser but quiet and comfortable. A table should be available for any paper documents, and seating should allow ease of reference and note taking. Access to a computer will be necessary to access the electronic portfolio.

Appraisal meetings do not have to follow a rigid format, but generally the agenda should cover the following areas:

- Introductions and clarification of the appraisal process, progress so far and any particular issues to be considered. The appraisee should lead the discussion, systematically covering the portfolio and considering each domain and attribute. Whilst appraisal is both summative and formative, the move from summative towards formative discussion would be a logical sequence.
- The appraisee should discuss the PDP from the previous year. Attention to the success or otherwise of meeting the objectives in that PDP should be noted early on. Some may remain relevant objectives for the next year. Failure to achieve objectives should not automatically be seen as a concern, unless a very clear lack of regard or effort suggests otherwise. This should then be made very clear by the appraiser at the meeting e.g. "I see you have not met your objective to undertake...My view, from what you have told me is that this represents a lower standard than acceptable and therefore this must be met in the subsequent year, or the RO will become involved."
- Career advice and support are key aspects to the formative side of the appraisal process. It would be a natural part of the discussion to consider not only the next year but career aspirations beyond that. Doctors in career grade posts in particular may benefit from an opportunity to discuss this in the appraisal meeting.
- The GMP standards for note keeping are pertinent to the appraisal discussion. The record will be kept on the individual's personal file and is potentially disclosable to the RO and others. Decisions about revalidation may be based on these records and they are therefore very important.

## **8.2. Others at appraisal meeting**

The majority of appraisals will consist of meeting with two doctors, the appraisee and the appraiser. It may be helpful to consider bringing in a third party into one or more of the appraisal discussions over a 5 year period, for example:

- A lay person to provide a patient or carer perspective on the appraisal discussion.
- A sub-specialty colleague for individuals who practise in a very specialised area.
- A representative from a different organisation for doctors that work in two or more settings.
- Another trained appraiser to quality assure the appraiser.

## **8.3 Concerns**

The appraiser makes a judgement in each appraisal as to whether any concerns or issues that have come up in the appraisal are appropriately managed through the setting of objectives, as part of a personal development plan. This is the most likely outcome for most issues that arise in appraisal. The setting of such objectives is not an indicator of a poorly performing doctor but rather an understanding that there are areas in which training and practice can be strengthened.

If the appraiser identifies concerns that are not to be satisfactorily managed through agreement of a personal development plan, there are the following options:

- a. To adjourn the appraisal to reflect and seek advice from colleagues (e.g. the Appraisal Lead, the RO, the appropriate clinical lead, other medical appraisers) as to an appropriate way forward before setting another date with the appraisee.
- b. If necessary to raise issues through the Trust's clinical governance structures.
- c. If there are immediate concerns about fitness to practise, these should be discussed with the Appraisal Lead and RO, who may consider raising these with the General Medical Council.

Examples which would raise concerns about on-going practice would include the following:

- i. Concerns about multidisciplinary working that is having an adverse impact on patient care and not responding to appropriate remediation.
- ii. Repeated failure to appropriately reflect and learn from adverse incidents and complaints.
- iii. On-going audits which continue to show poor standards of care attributable to the individual doctor's practice.

Known concerns should usually be handled outside the appraisal process providing the opportunity for the doctor to demonstrate appropriate action to address the issues.

Doctors who are subject to performance or disciplinary procedures should continue to have an annual appraisal. This will be used to support the individual and identify any training or development needs.

#### 8.4. Outcome of meeting

A crucial aspect of appraisal is the judgement of the appraiser with regard to the quality of supporting information and performance. This is illustrated by the table below which aims to help guide the appraiser when facing one of four scenarios following an appraisal meeting.

***A matrix of relationship between quality of supporting information and associated judgement of performance***

	Good performance	Poor performance
Good quality supporting Information	a. Satisfactory appraisal	b. Satisfactory appraisal but performance concerns. Further actions needed e.g. PDP, Medical Manager, Responsible Officer, NCAS, GMC
Poor quality supporting Information	c. Unsatisfactory appraisal. Adjourn within 3 months with clear agreement about what information is required	d. Unsatisfactory appraisal. Adjourn and consult Medical Lead, Responsible Officer, NCAS, GMC.

**a. Satisfactory appraisal.**

This is the judgement that is made when good supporting information is presented and no concerns are raised throughout the appraisal meeting. This is likely to be the majority of doctors.

**b. Satisfactory appraisal process but significant performance issues.**

This is when the doctor has provided good supporting information but the information reveals concerns about performance or patient safety issues. The PDP must reflect this and have clear e.g. SMART (Specific, Measurable, Achievable, Relevant, Timed) objectives that set out how and when the performance will improve. The appraiser may refer to the consultant's line manager, the Appraisal Lead or Responsible Officer who may consider referral to the National Clinical Assessment Service (NCAS) and/or the GMC.

**c. Unsatisfactory appraisal – poor quality information.**

The psychiatrist has not provided enough supporting information to satisfy the appraiser that GMP and GPP standards have been met. There may be no performance concerns but the appraisal is adjourned for no longer than 3 months, to ensure that the required information is provided.

**d. Unsatisfactory appraisal and significant performance issues.**

The psychiatrist has not provided sufficient supporting information and there are concerns about performance. The appraisal is adjourned and the Responsible Officer should be notified, who may consider referring to NCAS or GMC may be notified. The appraiser should seek advice from the consultant's line manager/clinical lead, Appraisal Lead or RO before rescheduling a further appointment.

The appraisal meeting will end with a summary of the appraisal discussion and statement of agreed action, and the personal development plan (Form 4). There are four potential agreed statements:

- i. Presence or absence of immediate concerns about the doctor's fitness to practise. If concerns exist the statement will specify in which attribute(s) concern exists.
- ii. Whether there is sufficient supporting information recorded to demonstrate the doctor is making satisfactory progress towards revalidation
- iii. Whether there has been satisfactory progress with key elements in the previous year's Personal Development Plan.
- iv. Agreement with the Personal Development Plan that derives from the current year's appraisal discussion to demonstrate the doctor is making satisfactory progress towards revalidation and that key priorities for development have been included in the plan.

If these cannot be agreed, the appraisal is unsatisfactory and the process suggested in c and d above should be followed.

### **8.5 Content of a Professional Development Plan**

A Personal Development Plan (PDP) is the tool used to assist the appraisee in improving practice. The items in such a plan may include specific, educational or learning tasks, for example visiting another unit to learn from best practice, specific tasks linked to areas of potential concern, for example undertaking an audit in an area of clinical practice or agreement as to which aspects of appraisal need to be completed before the next appraisal cycle, for example obtaining formal feedback from users and carers.

The content of a PDP should be sufficiently challenging and ambitious to enable the doctor to improve practice but manageable within the context of the doctor's competing professional pressures.

### **8.6. Relationship of appraisal to the job planning process**

The appraisal will provide an opportunity to draw together information and data from which the job plan is shaped and reviewed. Any changes recommended in the job plan will need to be agreed at a subsequent separate meeting with the relevant clinical service manager, who should have been fully consulted on any relevant service issues as part of the appraisal preparation.

## **9. After the appraisal meeting (Phases 3-6)**

After the meeting the actions will relate to whether the appraisal was satisfactory (a or b) or unsatisfactory (c or d). A satisfactory appraisal will need to be confirmed in



writing by the appraiser to the appraisee, within two weeks of the appraisal meeting, with a summary of which attributes were satisfied and what actions were agreed in the PDP. A copy of the completed appraisal with a PDP signed by both parties within 28 days of the appraisal interview, should be submitted to the Responsible Officer as part of the on-going portfolio of supporting information for revalidation. The appraisee is responsible for keeping the appraisal portfolio and summary as part of revalidation supporting information. The appraisee is also responsible for submitting copies of their appraisal summary and PDP to the RO's office.

In cases of unsatisfactory appraisal there is a need to establish whether simply more time is required to allow the appraisee to collect supporting information (scenario c) or should this appraisal be put on hold to allow performance management. The appraiser will notify the RO and line manager of the appraisee, as well as the appraisee, as soon as reasonably practicable. The appraiser is not expected to performance manage the appraisee – referring to the line manager helps keep the two processes separate. A doctor in scenario d is clearly in need of performance management and/or remediation and whilst appraisal should be completed in good time e.g. 3 months, it may run parallel to a performance investigation, either internal or external.

## **Appendix B : Selection, training and support for Appraisers**

### **Selection Training and Support for Appraisers**

#### **1 Selection process for appraisers**

The Responsible Officer/Medical Director and Appraisal Lead/Associate Medical Director will be involved in the selection process of medical appraisers in conjunction with clinical/service leads. It is expected that all medical consultants in the trust of more than two years substantive employment should become appraisers. The role of appraiser may be a stand-alone role or an integral part of a broader medical management role (e.g clinical director, head of service). The core elements of the role of appraiser are described in the Job Description for Appraisers (Appendix 18)

All appraisers will be expected to meet the qualifications, experience, knowledge, expertise, skills and aptitude and associated competencies as identified by the Revalidation Support Team (Department of Health, 2010) and described in the Person Specification (Appendix 19).

The appraiser will have a probationary period of twelve months to ensure that he/she is competent and committed to the role. During this period, feedback will be obtained from appraisees and if practicable directly observed appraisal should occur.

## **2 Training and development of appraisers**

### **2.1 Initial training**

All appraisers in the Trust will participate in an initial one-day training course delivered by an approved trainer. The aims of the course will be in line with the recommended training objectives for medical appraiser in the Training Appraiser Training Curriculum Framework (*Assuring the Quality of Training for Medical Appraisers 2007*) (Appendix 20) and will include:

- Understanding the purpose of appraisal and its context in other structures for improving the quality of medical practice in both the local organisation and the wider context of the NHS
- Competency in assessing portfolios of supporting information that is submitted or informs the appraisal process
- Skills to conduct an effective appraisal discussion
- Ability to produce consistently high quality appraisal documentation

### **2.2 Support and on-going development**

All appraisers will meet regularly to discuss their work in the Appraiser Support and Development Group, led by the Appraisal Lead. The RO will also attend this group. This group will meet three to four times a year, and will provide a forum for the provision of peer support in the exchange of ideas and experience, review and development of appraisal practice and performance, mentoring specific to appraisal, identification of concerns, and identification of on-going training needs in an anonymised and confidential environment.

The appraisers will also have access to leadership and advice on all aspects of the appraisal process via the Appraisal Lead and RO.

Because of their role within the organisation and/or their relationship to the other appraisers, the RO and Appraisal Lead will also have access to external peer support, such as the NHS London Responsible Officer Support Network.

Appraisers will also participate in regular follow-up training and support to ensure consistency and development of appraiser skills.

### **2.3 Performance review**

Participation in performance review is a requirement of working as an appraiser in the Trust. The review process of appraisers within the Trust is the responsibility of the Appraisal Lead accountable to the RO.

To maintain their skills and knowledge all appraisers will undertake no fewer than 3 appraisals annually. Where an appraiser does not achieve this minimum number the Appraisal Lead will discuss the reasons for this with the appraiser and where appropriate agree further support.

Feedback will be given to appraisers on their performance, based on the information from the feedback questionnaires from their appraisees following completion of their appraisal (see Appendix 14, and Section 9.3).

### **3 Appraiser Fitness to Practice Concerns**

The Appraisal Lead will be informed by the RO of any investigation relating to the fitness to practice of an appraiser being undertaken by the Trust. The Appraisal Lead will establish the issues from the appraiser and the case investigator. In consultation with the RO, the Appraisal Lead will determine if a temporary cessation of the appraiser role is merited. Serious concerns will result in the immediate cessation of the appraiser role. All decisions to suspend appraiser functions will be reviewed by the RO.

## **Appendix C : Essential supporting information requirements**

### **Essential supporting information requirements**

Type of Information	Minimum required in 5 years	Comment
Case based discussion	10	Minimum 2 per year
Review of and reflection on complaints, compliments and serious untoward incidents	all	
Audit and other quality improvement activities	2 clinical audits 1 records audit	Complete 2 audits of significant clinical areas of practice over a 5 year cycle. Undertake at least
Patient feedback survey and review	1	To be presented no later than year 3
Colleague feedback and review	1	To be presented no later than year 3
New PDP and review of previous year's PDP	5	Annually
Meeting College CPD requirements	5	Annually
Clinical governance and other information (including outcomes) produced by the organisation and doctor	5	Annually
Teaching, research, management	5	Annually if part of role

## Appendix D : Case-based discussion – specialist doctor

### Case-based discussion – specialist doctor

Doctor's name ..... Date of discussion  
.....

Assessor's name ..... Assessor's registration number  
.....

Diagnosis  
.....

Focus of this discussion  
.....

**Good Psychiatric Practice standards**

Assessed (see overleaf)	Not assessed 0	Inconsistency in meeting standards 1	Meets standards and consistent with independent practice 2	Exceeds at standards 3	Excels at standards 4
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- 1 Assessment
- 2 Diagnosis
- 3 Risk assessment
- 4 Treatment plan and delivery
- 5 Knowledge of treatment options
- 6 Record keeping
- 7 Communication with professionals
- 8 Communication with patients

Good practice

Suggestions for development

Agreed action:

Assessor's signature:.....

**1 Assessment**

A psychiatrist must undertake competent assessments of patients with mental health problems and must:

- a. be competent in obtaining a full and relevant history that incorporates developmental, psychological, social, cultural and physical factors, and:
  - i. be able to gather this information in difficult or complicated situations
  - ii. in situations of urgency, prioritise what information is needed to achieve a safe and effective outcome for the patient
  - iii. seek and listen to the views and knowledge of the patient, their carers and family members and other professionals involved in the care of the patient
- b. have knowledge of:
  - i. human development and developmental psychopathology, and the influence of social factors and life experiences
  - ii. gender and age differences in the presentation and management of psychiatric disorders
  - iii. biological and organic factors present in many psychiatric disorders
  - iv. the impact of alcohol and substance misuse on physical and mental health
- c. be competent in undertaking a comprehensive mental state examination
- d. be competent in evaluating and documenting an assessment of clinical risk, considering harm to self, harm to others, harm from others, self-neglect and vulnerability
- e. be competent in determining the necessary physical examination and investigations required for a thorough assessment
- f. ensure that they are competent and trained, where appropriate, in the use of any assessment or rating tools used as part of the assessment.

## **2 Diagnosis**

In making the diagnosis and differential diagnosis, a psychiatrist should use a widely accepted diagnostic system.

## **3 Risk assessment**

A psychiatrist must appropriately assess situations where the level of disturbance is severe and risk of adverse events, such as injury to self or others, or harm from others, may be high, and take appropriate clinical action.

A psychiatrist must work with patients, carers and the multidisciplinary team to make management decisions that balance risks to the patient or the public with the desire to facilitate patient independence. This should involve consideration of positive therapeutic risk-taking.

## **4 Treatment plan and delivery**

A psychiatrist must ensure that treatment is planned and delivered effectively, and must:

- a. formulate a care plan that relates to the patient's goals, symptoms, diagnosis, risk, outcome of investigations and psychosocial context; this should be carried out in conjunction with, and should be agreed with, the patient, unless this is not feasible
- b. if the treatment proposed is outside existing clinical guidelines or the product licence of medication, discuss and obtain the patient's agreement, and where appropriate, the agreement of carers and family members
- c. involve detained patients in treatment decisions as much as possible, taking into account their mental health and the need to provide treatment in their best interests
- d. recognise the importance of family and carers in the care of patients, share information

and seek to fully involve them in the planning and implementation of care and treatment, having discussed this with the patient and considered their views.

## **5 Expert knowledge of treatment options**

A psychiatrist must have specialist knowledge of treatment options in the clinical areas within which they are working and, more generally, knowledge of treatment options within mental health. The psychiatrist must:

- a. ensure that treatments take account of clinical guidance available from relevant bodies/the College/scientific literature, and be able to justify clinical decisions outside accepted guidance
- b. have knowledge or, when needed, seek specialist advice in the prescribing of psychotropic medication; in so doing, the psychiatrist must have an understanding of the effects of prescription drugs, both beneficial and adverse
- c. understand the range of clinical interventions available within mental health services and arrange referrals where appropriate to the needs of the patient
- d. have sufficient knowledge and skills of psychiatric specialties other than their own in order to be able to provide emergency assessment, care and advice in situations where specialist cover is not immediately available.

## **6 Record keeping**

A psychiatrist must maintain a high standard of record-keeping:

- a. good psychiatric practice involves keeping complete and understandable records and adhering to the following:
  - i. handwritten notes must be legible, dated and signed with the doctor's name and title printed
  - ii. electronic records must be detailed, accurate and verified
  - iii. a record must be kept of all assessments and significant clinical decisions
  - iv. the reasoning behind clinical decisions must be explained and understandable in the record and, if appropriate, an account of alternative plans considered but not implemented must be recorded
  - v. the record should include information shared with or received from carers, family members or other professionals
  - vi. notes must not be tampered with, changed or added to once they have been signed or verified, without identifying the changes, dated and signed
- b. the psychiatrist should ensure that a process is in place to obtain and record in the clinical record patients' consent to share clinical information, and that this is completed for patients with whom they have direct contact and for whom they have clinical responsibility
- c. if the psychiatrist has agreed to provide a report, this must be completed in a timely fashion so that the patient is not disadvantaged by delay
- d. letters with details of the treatment plan should be provided to patients following a consultation.

## **7 Communication with professionals**

A psychiatrist must communicate treatment decisions, changes in treatment plans and other necessary information to all relevant professionals and agencies, as appropriate, verbally or in writing, with due regard to confidentiality.

## **8 Communication with patients**

A psychiatrist must provide information, both verbal and written, to support patients in maintaining their health. In particular, the psychiatrist must:

- a. provide information in understandable terms regarding diagnosis, treatment, prognosis and the support services available; this should recognise diversity of language, literacy and verbal skills
- b. if any medication is prescribed, provide information about side-effects and, where appropriate, dosage, as well as relevant information should an off-licence drug be recommended.



## Appendix E : Guidance for case-based discussion

### Guidance for case-based discussion

1 The psychiatrist being assessed should either identify a case for case-based discussion or provide the assessor with a list of anonymised case records (e.g. case numbers) from which the assessor can select two. The psychiatrist being assessed should then choose one of these two for the case-based discussion. The purpose of this is to have both a random component to the selection of cases and also the opportunity for the consultant being assessed to ensure the cases chosen reflect the broad mix of their caseload.

2 The assessor should have the opportunity to review the case notes in advance in order to pull out the key issues that they wish to discuss in the assessment.

3 A non-interrupted hour should be set aside for the case-based discussion.

4 Case-based discussion need not be solely a one-to-one meeting but can occur in a group setting. If the latter is the case, one consultant should lead the assessment.

5 The assessor should lead the discussion through the key areas of clinical practice being assessed. It is not expected that each of the areas will be assessed in the same level of detail. The areas to focus on depend on the clinical case and the psychiatrist's involvement.

6 Following the discussion, there should be a rating of each of the eight standards being assessed on the 0–4 scale.

7 It is expected that the most usual rating will be that of a 2 (consistent with independent practice). Areas in which there are suggestions for development should be rated as a 1. Areas of good practice should be rated as a 3 or 4.

8 The main purpose of case-based discussion is developmental. It is important that colleagues give constructive feedback to each other in order to facilitate a developmental process. It is not expected that psychiatrists would be exceeding or excelling in all areas of each case that is discussed.

9 Each psychiatrist is required to undertake ten case-based discussions over a 5-year cycle. No more than three should be done with one individual in order to have a minimum of four assessors commenting on cases over a 5-year cycle.

## Appendix F : Criteria and indicators of best practice in clinical audit

### Criteria and indicators of best practice in clinical audit

- 1 The topic for the audit is a priority.
- 2 The audit measures against standards.
- 3 The organisation enables the conduct of the audit.
- 4 The audit engages with clinical and non-clinical stakeholders.
- 5 Patients or their representatives are involved in the audit if appropriate.
- 6 The audit method is described in a written protocol.
- 7 The target sample should be appropriate to generate meaningful results.
- 8 The data collection process is robust.
- 9 The data are analysed and the results reported in a way that maximises the impact of the audit.
- 10 An action plan is developed to take forward any recommendations made.
- 11 The audit is a cyclical process that demonstrates that improvement has been achieved and sustained .

## Appendix G : Multisource feedback colleague structured reflective template

### Multisource feedback colleague structured reflective template

Requirement: one every 5 years

Date of feedback:

Feedback scheme used:

Number of colleagues giving feedback:

Name and designation of person who collated and gave feedback:

Main outcomes of feedback:

(Look at positive outcomes, as well as learning needs)

What learning might I undertake?

(It may help to separate learning from changing your behaviour. So, rather than 'I will show more respect to nursing colleagues', it might be more productive to undertake learning that develops your understanding of the benefits of the diversity of teams. Your ideas in this section can be discussed further with your appraiser.)

Final outcome after discussion at appraisal:

(Complete at appraisal, considering how your outcome will improve patient care)

## Appendix H : Multisource feedback patient structured reflective template

### Multisource feedback patient structured reflective template

Requirement: one every 5 years

Date of feedback:

Feedback scheme used:

Number of patients giving feedback:

Name and designation of person who collated and gave feedback:

Main outcomes of feedback:  
(Look at positive outcomes, as well as learning needs)

What learning might I undertake?

(It may help to separate learning from changing your behaviour. So, rather than 'I will show more respect to nursing colleagues', it might be more productive to undertake learning that develops your understanding of the benefits of the diversity of teams. Your ideas in this section can be discussed further with your appraiser.)

Final outcome after discussion at appraisal:  
(Complete at appraisal, considering how your outcome will improve patient care)

## Appendix I : Complaint report structured reflective template

### Complaint report structured reflective template

Requirement: one for each complaint you have received

Date of complaint:

Key issues of complaint:

Involvement of other bodies: responsible organisation/SHA/NCAS/GMC/other

If resolved, what were the findings:

What did I learn from this complaint?

How will my practice change?

Final outcome after discussion at appraisal:  
(Complete at appraisal, considering how your outcome will improve patient care)

## Appendix J : Serious untoward incident audit structured reflective template

### Serious untoward incident audit structured reflective template

Requirement: one annually

Date of incident:

Description of events:

What went well?

What could have been done better?

What changes have been agreed?

Personally:

For the team:

Final outcome after discussion at appraisal:

(Complete at appraisal, considering how your outcome will improve patient care)

## Appendix K : Audit Pro Forma

### *Audit pro forma*

Requirement: one annually

Measurement/audit title: Date of data collection/audit:

Reason for choice of measurement/audit:

Standards set:

Audit findings:

Learning outcome and changes made:

New audit target:

Final outcome after discussion at appraisal:

(Complete at appraisal, considering how your outcome will improve patient care)

*(Appendices 2-9 are from Royal College of Psychiatrists (2010b) Revalidation and Guidance for Psychiatrists (CR161).*





## Appendix M : Maternity Leave Guidance

### MATERNITY LEAVE GUIDANCE

1. If maternity leave is planned after completion of at least 6 months work in an appraisal year, then an appraisal should be planned prior to leave starting.
2. The PDP and appraisal discussion should consider how the appraisee will keep up-to-date and plan for their return to work after maternity leave.
3. If after returning to work from maternity leave there is 6 months, then an appraisal should take place.
4. If after returning to work from maternity leave there is less than 6 months, then an appraisal will not be necessary, but should be planned within 6 months of return to work, even though that will be in the next appraisal year.
5. If after returning to work from maternity leave, there is less than 6 months, but more than 3 months, an appraisal can be provided if desired to help with professional development needs planning.
6. An appraisal is not necessary during maternity leave, but can be arranged by special arrangement.

## Appendix N : Appraisee Feedback Questionnaire

**Appraisee Feedback Questionnaire** (see *NHS Revalidation Support Team (2011) Organisational Readiness Self Assessment: End of Year Report 2010 11 v1.0*)

Name of Organisation/Trust:						
Name of Appraisee		Date of Appraisal				
Name of Appraiser		Duration of appraisal meeting				
		Poor	Borderline	Average	Good	V good
The Organisation		1	2	3	4	5
The management of the appraisal system						
The access to the necessary supporting information						
Comment to help the organization improve the process						
The appraiser						
Their preparation for my appraisal						
Their skill in conducting my appraisal						
Their skill in reviewing progress against last year's PDP						
Their skill in providing challenge to help me review my practice						
Comments to help your appraiser improve their skills						
The appraisal discussion						
The new PDP reflects my main priorities for development						
The appraisal was useful for my professional development						
The appraisal was useful in preparation for revalidation						
Comments to help improve the appraisal discussion						

## Appendix O : Appraisal Summary and PDP Review Tool

Form 4 and PDP Review Tool

Source: *Sheffield GP appraisal policy*

Appraisal summary Criteria	Y / N	PDP Criteria	Y / N
Appraisal summary signed by both appraiser and appraisee (including GMC numbers)		PDP present	
Typed (legible)		Typed (legible)	
Evidence used to support statements is listed		There is a clear link between objectives in the PDP and the appraisal discussion on Form 4	
Significant absence of supporting information is noted		Learning needs reflect the needs of patients, practice, employer and GMC as well as own interests	
Reference to a review previous years Appraisal summary and PDP is made		Aims are converted into objectives	
Progress of PDP objectives is recorded		Objectives are SMART Especially Specific & Achievable	
Reasons for any changes to the PDP are noted and justified		Appropriate activities are stated	
Actions are agreed for the first 4 sections – not blanks “none” or “continue”		Appropriate outcomes are listed and will meet RCGP CPD credit requirements	

	COMMENT
Specificity: No blanks, vague or loose descriptions, e.g. fine / ok	
Objectivity: Relevant, factually correct, supporting information based when possible	
Freedom from bias and prejudice	
Acknowledgement of the Appraisee's achievements and developmental progress	
The appraisal discussion is challenging	
Challenging and actionable personal development plan	
<b>General Observations</b>	

## Appendix P : Exception Audit

Exception audit to identify reasons for all missed or incomplete appraisals

Results of exception audit to identify reasons for all missed or incomplete appraisals	Numbers
<b>Appraisee factors:</b>	
a. Absence of appraisee at the end of the appraisal year [so not possible to rearrange within year] eg maternity/sick leave	
b. Incomplete portfolio or supporting information	
c. PDP/summary not signed by appraisee within 28 days of the appraisal meeting	
d. Factors relating to lack of time of appraisee	
e. Lack of engagement of appraisee	
f. Other appraisee factors (description)	
<b>Appraiser factors:</b>	
a. Unforeseen absence of appraiser at the end of the appraisal year [so not possible to rearrange within year]	
b. PDP/summary not signed by appraiser within 28 days of the appraisal meeting	
c. Factors relating to lack of time of appraiser	
d. Other appraiser factors (description)	
<b>Organisational Factors</b>	
a. Administrative/management factors	
b. Factors relating to function or failure of electronic portfolio or information system	
c. insufficient numbers of trained appraisers	
d. other organizational factors (description)	
<b>Recommendations:</b>	

**Source:** NHS Revalidation Support Team (2011) *Organisational Readiness Self Assessment: End of Year Report 2010 11 v1.0*

## **Appendix Q : Annual appraisal and revalidation board report pro forma**

### **ANNUAL APPRAISAL AND REVALIDATION BOARD REPORT PROFORMA**

The annual appraisal and revalidation board report should be produced as a stand-alone document and should be structured so that the following information is clearly available:

#### **1) Management of Appraisal and Revalidation**

- a) Brief description of leadership and management structure
- b) Budget/Resource Summary including SPAs/funding for appraisers and appraisal leads

#### **2) Activity Levels**

- a) Total number of doctors for whom the organisation has responsibility for appraisal and revalidation, reported by grade and speciality. This should include part-time and temporary appointments (including locums), those on long term leave, career breaks, suspension, etc for whom the organisation has responsibility.
- b) Subset: Number of doctors who have had a completed appraisal in year, reported by grade and speciality, including the groups above.
- c) Subset: Number of appraised doctors for whom a PDP has been agreed, reported by grade and speciality, including the groups above.
- d) Exception audit, with reasons, for all missed or incomplete appraisals and all missing PDPs.
- e) Total numbers of doctors completing revalidation cycle and total numbers of recommendations completed.
- f) Total number of doctors in remediation, performance and disciplinary procedures.

#### **3) Quality Assurance**

- a) Outline of processes to assure quality of the appraisal system.
- b) Outline of work done to address previously identified areas for development.
- c) Summary of annual self assessment report with areas for development in the next year.
- d) Summary of the most recent Independent External Review.

#### **4) Development Needs**

- a) Summary of anonymised collated development needs [with special reference to those common to a number of doctors and those affecting patient safety].
- b) Summary of constraints and progress in addressing constraints previously identified.

#### **5) Performance Review, Support and Development of Appraisers**

- a) Summary of training provided, including feedback on training from appraisers.
- b) Compliance with guidance on curriculum for initial training.
- c) Arrangements for support and development of appraisers.
- d) Arrangements for performance review of appraisers.

#### **6) Clinical Governance**

Summary of organisation development needs in the systems supporting appraisal and revalidation:

- i) Clinical information systems
- ii) Clinical risk management/patient safety systems
- iii) Clinical audit systems
- iv) Reporting investigation and management of performance concerns
- v) Complaints management systems
- vi) Continuing Professional Development systems

#### **7) Access, security and confidentiality**

Results of audit of compliance with access, security and confidentiality protocol and reports of investigations of breaches.

**8) Summary and actions**

- a) Summary of important issues
- b) Recommended action

## Appendix R : Job description for appraisers

**Job Description for Appraisers** (need to write according to criteria in NHS Revalidation Support Team (2011) Organisational Readiness Self Assessment: End of Year Report 2010 11 v1.0)

*The role of appraiser may be a stand-alone role or an integral part of a broader medical management role (e.g. clinical director, head of service). To ensure quality and consistency the person specification of medical appraisers should include core elements relating to the role of appraiser. The following is an example.*

**The job description of the postholder includes the following core elements in relation to the appraiser role:**

1	Description of key accountabilities for the role which include accountability to the Responsible Officer
2	Description of role and key responsibilities of appraiser
3	Undertake pre-appraisal preparation and appraisal discussion in line with current local and national guidance and quality standards
4	Complete post appraisal documentation in line with current local and national guidance and quality standards
5	Duration of appointment as an appraiser (for example, description of arrangements for re-appointment or formal extension of contract every 3-5 years)
6	Maximum and minimum numbers of appraisal expected per year
7	Description of probationary period or provisional appointment subject to satisfactory evaluation/assessment after initial training
8	Requirement to attend initial training
9	Requirement to participate in on-going training and support to address development needs in the role of appraiser
10	Requirement to participate in performance review in the role of appraiser
11	Requirement to participate in the management and administration of the appraisal system
12	Requirement to participate in arrangements for quality assurance of the appraisal system
13	Description of confidentiality of appraisal process and specific circumstances in which confidentiality should be breached
	Indemnity arrangements for appraisers

## Appendix S : Person specification for appraisers

**Person Specification for Appraisers** (see *NHS Revalidation Support Team (2011) Organisational Readiness Self Assessment: End of Year Report 2010 11 v1.0*)

*The role of appraiser may be a stand-alone role or an integral part of a broader medical management role (e.g. clinical director, head of service). To ensure quality and consistency the person specification of medical appraisers should include core elements relating to the role of appraiser. The following is an example.*

<b>Core elements of a person specification for medical appraiser</b>	
No distinction has been made between 'essential' and 'desirable' as the importance of each of these qualities should be determined in relation to the local context Probationary periods or provisional appointment subject to satisfactory completion of training and/or demonstration of competence should be described in the job description	
<b>Qualifications</b>	Medical degree (plus any Postgraduate qualification required) GMC License to practice Where appropriate, entry on GMC Specialist
	Completion of Appraisal Training (this may not be a requirement prior to appointment but would need to be completed before appraisals are performed)
<b>Experience</b>	Has been subject to a minimum of 3 medical appraisals, not including those in training grades. (There may be unusual situations where this is not possible for example where medical appraisal has not occurred in the past in that organisation)
	Experience of managing own time to ensure deadlines are met
	Experience of applying principles of audit education or quality improvement
<b>Knowledge</b>	of the role of appraiser of the appraisal purpose and process and its links to revalidation of educational techniques relevant to appraisal
	of responsibilities of doctors as set out in Good Medical Practice of relevant Royal College specialty standards and CPD guidance Understanding of equality and diversity, and data protection and confidentiality legislation and guidance
	of the health sector in which appraisal duties are to be performed of local and national healthcare context of Evidence Based Medicine and clinical effectiveness
	Excellent integrity, personal effectiveness and self-awareness, with an ability to adapt behaviour to meet needs of an appraisee Excellent oral communication skills – including active listening skills, the ability to summarise a discussion, ask appropriate questions, provide constructive challenge and give effective feedback
	Excellent written communication skills – including the ability to summarise a discussion clearly and accurately
<b>Expertise, Skills and Aptitudes</b>	Objective evaluation skills
	Commitment to on-going personal education and development
	Good working relationship with professional colleagues and stakeholders
	Ability to work effectively in a team
	Motivating, influencing and negotiating skills
	Adequate IT skills for the role



## Appendix T : Appraiser training curriculum framework

**Appraiser Training Curriculum Framework** (see Appendix F, NHS Clinical Governance Support Team (2007) *Assuring the Quality of Training for Medical Appraisers* [AQTMA].)

Appraiser Training Curriculum Framework  
Recommended Training Objectives for Medical Appraiser Training

Training Objective – Demonstrate an understanding of the purpose of appraisal and its context in other structures for improving the quality of medical practice in both the local organisation and the wider context of the NHS			
Performance	Conditions	Standards	Assessment
Demonstrate an understanding of the purpose of appraisal	Given the current operative GMC and DoH appraisal policies	With accuracy	Verbal demonstration
Explain the professional responsibilities of an appraiser	Given the Host organisation's, GMC and DoH policies and an Appraiser Job Description	To an appropriate level in context with delivering an appraisal	Verbal demonstration
Demonstrate an understanding of the link from appraisal to the Personal Development Plan (PDP)	Given the operative GMC and DoH appraisal policies	To the understanding of an appraisee	Verbal demonstration
Explain the difference between formative appraisal and summative assessment in the appraisal context.	Given the definitions of 'formative' appraisal and 'summative' assessment within the appraisal context	Accurately differentiate between the two	Verbal demonstration
Demonstrate an understanding of the links between appraisal and revalidation	Given the GMC revalidation policy	To the understanding of an appraisee	Verbal demonstration

## Appendix U : Equality Impact Assessment

1. Does this Procedure, function or service development impact affect patients, staff and/or the public?

**YES**

**NO**

**If NO**, this is usually an indication that the Procedure, function or service development is not relevant to equality. Please explain that this is the case, or explain why it is relevant to equality even though it does not impact on people:

.....  
...  
.....  
...  
.....  
...

2. Is there reason to believe that the Procedure, function or service development could have an adverse impact on a particular group or groups?

**YES / NO**

**If YES**, which groups may be disadvantaged or experience adverse impact?

**Age** – especially younger and older people YES / NO

**Disability** – people with impairments YES / NO

**Gender** – women, men, transgender people YES / NO

**Race** – people of different ethnic groups YES / NO

**Religion and belief** – people of different faiths and beliefs YES / NO

**Sexuality** – especially lesbian, gay, and bisexual people YES / NO

**Other** .....YES / NO

3. If you answered **YES in section 2**, how have you reached that conclusion? (Please refer to the information you collected e.g., relevant research and reports, local monitoring data, results of consultations exercises, demographic data, professional knowledge and experience)

4.. Based on the initial screening process, now rate the level of impact on equality groups of the Procedure, function or service development:

**Negative / Adverse impact:**

**High** .....

(i.e. high risk of having, or does have, negative impact on equality of opportunity)

**Medium**.....

(i.e. some risk of having, or there is some evidence of, negative impact on equality of opportunity)

**Low**.....

(i.e. minimal risk of having, or does not have negative impact on equality)

**Positive impact:**

**High** .....

(i.e. highly likely to promote, or clearly does promote equality of opportunity)

**Medium**.....

(i.e. likely to promote, or does have some positive impact on equality of opportunity)

**Low**.....

(i.e. not likely to promote, or does not promote, equality of opportunity)

N.B. A rating of 'High' negative / adverse impact' means that a Full Equality Impact Assessment should be carried out (see Form Two)

A rating of 'Medium negative' or 'Low' positive impact may mean that further work has to take place, especially where the Procedure, function, service development is designed to promote equality of opportunity

Date completed .....

Name .....

Job Title .....