NHS
Clinical Governance Support Team

Assuring the Quality of Medical Appraisal

Report of the
NHS Clinical Governance Support Team
Expert Group

July 2005

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Appendices

1. Foreword

The only effective knowledge that allows each of us to develop and continually improve is self-knowledge. Appraisal, properly implemented and trusted by the profession, allows that crucial learning in an era where more than ever before the medical profession needs to be seen to promote professional standards and not just protect professional status.

Appraisal is now an annual milestone in the lives of UK doctors. In many UK organisations, both primary and secondary, high quality medical appraisal is bringing real benefits to on-the-ground healthcare provision.

Because measuring the quality of appraisal is key in demonstrating these benefits, the NHS Appraisal Steering Group commissioned the NHS Clinical Governance Support Team (CGST) to work with experts in appraisal, throughout the NHS, to devise the quality assurance framework described in this paper.

We set out ***four high level indicators*** of quality in appraisal, and ***items of evidence*** for each. The appendices include ***self-assessment tools*** for use by organisations. We have respected differences between appraisal systems in different places and sectors, but offer a challenge to ensure that the core attributes of healthy appraisal are met, whatever the setting.

I am delighted that the CGST has led this project. If clinical governance seeks to cultivate the environment in which excellence can flourish, then appraisal is a valuable means of achieving this, by addressing the needs of the individual, in the context of their organisation.

This framework is an early step in an on-going journey, and should be seen as such. I believe it offers something to stretch organisations doing appraisal well, as well as sensible objectives to those that need guidance. Vitally, it will help ensure that appraisal adds to the culture of clinical governance that is core to the future success of the NHS.

Professor Aidan Halligan
Director of Clinical Governance for the NHS

2. Executive Summary

2.1. Appraisal was introduced for hospital consultants in 2001 and for general practitioners the following year. There is significant variation between the models of appraisal that have arisen in different geographical areas and in different healthcare settings. The suggested link with revalidation has brought this variation into sharp relief, and has led to many of the criticisms contained in the Fifth Shipman Report.

2.2. The NHS Appraisal Steering Group [ASG] commissioned a project from the NHS Clinical Governance Support Team [CGST] to devise a suitable framework for the Quality Assurance of appraisal for all doctors in the UK.

2.3. The CGST set up an Expert Group to devise the framework. The resulting framework describes four recommended high level indicators of quality for appraisal schemes, with detailed supporting evidence for each indicator:

2.3.1. Organisational Ethos

There is unequivocal commitment from the highest levels of the host organisation* to deliver a quality assured system of appraisal that is fully integrated with other systems of quality improvement.

2.3.2. Appraiser Selection, Skills and Training

The host organisation has a process for selection of appraisers, and appraiser skills are continually reviewed and developed.

* **Host Organisation**

The term is used in this document to indicate the organisation to which the doctor is linked for the purpose of appraisal. This is usually the doctor's main employing or contracting organisation. NHS host organisations have a statutory responsibility to provide appraisal for doctors, but as appraisal is not only an NHS requirement we extend the term to include certain private sector employers and other organisations providing appraisal for the purpose of revalidation.

2.3.3. Appraisal Discussion

The appraisal discussion is challenging and effective; it is informed by valid and verifiable supporting evidence that reflects the breadth of the individual doctor's practice and results in a Personal Development Plan [PDP] prioritising the doctor's development needs for the coming year.

2.3.4. Systems and Infrastructure

The supporting systems and infrastructure are effective and ensure that all doctors linked to the host organisation are supported and appraised annually.

2.4. The indicators and supporting information are derived from a wide range of source materials [see Appendix 6] and provide a framework for quality achievable by the majority of NHS organisations.

2.5. The Expert Group has also identified a number of issues that require addressing in order to improve quality and it has made a number of specific recommendations:

2.5.1. Appraisal systems in Primary Care should be coordinated at Regional/Deanery level. Similar collegiate arrangements may be possible in some hospital Trusts.

2.5.2. The self-assessment audit [Appendix 1] should be routinely used by host organisations to assess their progress. The audit tool should be further developed and refined.

2.5.3. All doctors should be linked to a host organisation for the purposes of appraisal and revalidation.

2.5.4. Organisations employing or contracting appraisers should provide explicit assurance of indemnity for the appraiser.

2.5.5. The appraisal summary document and the PDP should both be shared with the host organisation; but strictly for viewing only by the Chief Executive [CEO] and Clinical Governance Lead. [Where host organisations choose to delegate this access, for example, as is the case in

Wales, it must be subject to written agreement covering access to specified anonymised information and any circumstances when access to individual information by the Trust is appropriate, and in recognition that final responsibility resides with the CEO and Clinical Governance Lead.]

2.5.6. There should be a consistent framework for annual reporting on appraisal.

2.5.7. Appraisers should be appointed on the basis of the desirable competencies for the role.

2.5.8. Training programmes for appraisers should be designed and commissioned using regional expertise, e.g. for GPs by Postgraduate Deaneries or equivalent, and mechanisms for sharing curriculum design nationally should be encouraged.

2.5.9. Appropriate means of generating public and lay involvement in the appraisal process for doctors should be explored and developed.

2.5.10. A "Statement of satisfactory completion of appraisal" should be developed and incorporated into the standard NHS appraisal paperwork, and the NHS Appraisal Toolkit [or equivalent].

2.5.11. A UK-wide group, with representation from all NHS sectors and a clearly defined remit, should be established:

- To oversee the development, sharing and dissemination of quality practice and expertise in medical appraisal; including further refinement of the quality assurance framework, developing the self assessment audit and improving lay involvement.
- To encourage the convergence of curriculum design for appraiser training programmes.
- To assure the evidence considered within appraisal is of a sufficiently high and consistent standard.
- To determine whether accreditation for medical appraisers is practical or desirable.

3. Introduction

3.1. Appraisal was introduced for hospital consultants in 2001 and for general practitioners [GPs] the following year. There is significant variation between the models of appraisal that have arisen in different geographical areas and in different healthcare settings. The suggested link with revalidation has brought this variation into sharp relief, and has led to many of the criticisms contained in the Fifth Shipman Report[1].

3.2. The Department of Health NHS Appraisal Steering Group [ASG] commissioned the NHS Clinical Governance Support Team [CGST] to undertake a project to design a framework for the quality assurance of appraisal for doctors.

3.3. The overall purpose of this project is to promote quality and consistency in appraisal systems for doctors throughout the NHS; and hence to satisfy the various needs of the individual, their host organisation, and the central authorities that monitor and assure the acceptable performance of both.

3.4. The aims of the project are:

- **To develop a framework for quality assurance of appraisal systems for medical practitioners.**
- **To identify a number of high-level indicators of quality common to all settings.**
- **To identify more detailed indicators of quality and examples of good practice.**

3.5. The CGST chose to develop the framework by establishing an Expert Group. The membership of the Group was drawn from the four countries of the UK and covered all sectors of the NHS. A smaller Task Group met on two occasions to discuss the detail of the proposed framework, and the full Expert Group communicated regularly by e-mail and telephone.

3.6. This report describes good practice in medical appraisal systems and should be used in conjunction with Department of Health policy documents and guidance on appraisal systems[2].

4. Background

4.1. Appraisal should be understood to have a central role in the integration of systems for quality improvement. It is a process that links the systems of:

- **Continuing professional development and training**
- **Regulation and revalidation of doctors**
- **Clinical governance**
- **Performance development and the management of impaired clinical performance**
- **Complaints**
- **Workforce Planning and Human Resources**
- **Risk management**
- **Service development**

It allows doctors to effectively prioritise the limited time available for learning and development, and it is the means by which the needs of the individual and the needs of the service are aligned[3].

4.2. The Fifth Shipman Report[1] contained a number of criticisms of appraisal. It found that there was a lack of clarity regarding the purpose of appraisal and a lack of uniformity in appraisal systems nationally. The report highlighted the need for further development of quality assurance of the appraisal process.

4.3. The General Medical Council [GMC] refers to the need for quality assurance of appraisal systems in its guidance on revalidation[4]. Whilst the eventual model of revalidation is uncertain at this time it is important to consider the requirements of the GMC, as the link between appraisal and revalidation is likely to remain in some form.

4.4. There is continuing debate, especially in Primary Care, about the balance between summative and formative processes within appraisal, and between the needs of the individual and those of the organisation. In attempting to include these themes within the same process there is a risk that some benefits may be lost. The Expert Group did not seek to resolve this debate definitively, but has made its recommendations on the assumption that appraisal is a broadly formative process.

4.5. Some issues are particular to Primary Care, in that Primary Care Trusts [PCTs] do not have a line-management relationship with the majority of GPs working within the Trust. The model of appraisal that has developed in Primary Care is one of peer appraisal and formative professional development. It is a widely held view that there would be considerable difficulty recruiting appraisers in PCTs if appraisal for GPs included a significant summative element.

4.6. By contrast, in secondary care, it is not uncommon for appraisal discussions to be dominated by detailed negotiations relating to the Job Plan of the individual consultant. While discussions relating to Job Plan adherence and constraints are a legitimate part of the appraisal discussion, overemphasis on job planning can distract from the important process of personal development planning.

4.7. The Healthcare Commission has the responsibility for monitoring standards in healthcare organisations in England, with parallel arrangements in Scotland, Wales and Northern Ireland. The Expert Group understands that routine detailed assessment of medical appraisal systems will not be feasible and will only be performed where there are signs of dysfunction. Some form of standardised self-assessment by responsible organisations against clear standards is therefore required.

4.8. There are a number of groups of doctors that require special consideration to ensure that the quality of their appraisal systems is consistent. Such groups include: locums/freelance doctors, GPs with a Special Clinical Interest [GPwSI], doctors with non-clinical roles and doctors working wholly in private practice. We have sought to ensure that indicators and recommendations are transferable to these situations wherever possible.

4.9. It is important to recognise that host organisations have a responsibility to provide timely appraisal of acceptable quality for their doctors. A doctor should not be disadvantaged when the responsibility for omission, delay or substandard appraisal lies with the host organisation.

4.10. The evidence considered at the appraisal discussion must be valid, verifiable and conform to national, GMC and Royal College guidance. There is ongoing work to develop standards against which the evidence can be assessed[5]. The Expert Group strongly supports this work, and took the view that it was beyond the remit of this project to define these standards.

4.11. It is generally agreed that in order to be effective the appraisal process must be sufficiently challenging. The presence of challenge is difficult to assess and has as much to do with the clinical governance and other systems within the organisation, as it has to do with the skills of the appraiser and the attitude of the appraisee. It is beyond the scope of this project to consider these supporting systems in detail.

4.12. Whilst we believe that this paper may have implications for the appraisal of other professional groups, we have limited our remit to the consideration of appraisal systems for doctors.

4.13. The cost implications of improving quality and implementing recommendations was considered to be crucially important by the Expert Group and much of this framework can be put in place at minimal or no cost. We also suggest, bearing in mind evidence suggesting a link between good human resource practice and positive clinical outcomes, that using this framework to develop effective appraisal systems could lead to significant cost benefits for healthcare organisations[6].

5. Recommended High Level Indicators

The Expert Group defined the following four High Level Indicators . The pretext was simple: What aspects of an appraisal scheme will provide valid indications that high quality appraisals are being indertaken?

5.1.1. High Level Indicator 1: Organisational Ethos

There is unequivocal commitment from the highest levels of the host organisation to deliver a quality assured system of appraisal that is fully integrated with other systems of quality improvement.

5.1.2. High Level Indicator 2: Appraiser Selection, Skills and Training

The host organisation has a process for selection of appraisers, and appraiser skills are continually reviewed and developed.

5.1.3. High Level Indicator 3: Appraisal Discussion

The appraisal discussion is challenging and effective; it is informed by valid and verifiable supporting evidence that reflects the breadth of the individual doctor's practice and results in a Personal Development Plan [PDP] prioritising the doctor's development needs for the coming year.

5.1.4. High Level Indicator 4: Systems and Infrastructure

The supporting systems and infrastructure are effective and ensure that all doctors linked to the host organisation are supported and appraised annually.

6. Supporting evidence

Within each of the four High Level Indicators, the following may be used as supporting evidence:

6.1. Organisational Ethos

There is unequivocal commitment from the highest levels of the host organisation to deliver a quality assured system of appraisal that is fully integrated with other systems of quality improvement.

6.1.1. Evidence of commitment

- The host organisation has identified financial and administrative resources to support appraisal
- There is a clear description of the host organisation's appraisal system
- There is medical leadership and clear accountability for appraisal
- An annual report with a standard core content [Appendix 2] is presented to a public Board meeting
- Actions recommended in the annual report are addressed by the Board
- Opportunities exist for individuals to fulfil their development needs.

6.1.2. Evidence of quality assurance

- The host organisation can demonstrate compliance with national guidance and standards and those set within the organisation
- There is evidence of lay involvement in the quality assurance of appraisal

- Quality assurance procedures include:
  - An annual self-assessment audit [Appendix 1] with a standard core content
  - A three-yearly objective assessment of the appraisal system by an appropriate independent group [either within or outside the host organisation]
  - Review of feedback questionnaires from appraisees
  - The annual report to the Board includes the results of the self-assessment audit and, when available, the independent report and recommendations.

6.1.3. Evidence of integration

- The appraisal system is integrated with other quality improvement systems in the host organisation [e.g. continuing professional development and training, clinical governance, management of impaired clinical performance, workforce planning and human resources, risk management, service development, complaints]
- Evidence that appraisal is seen by the host organisation as integral to the delivery of continuing professional development
- Evidence that the annual report of collected development needs informs organisational strategies
- Clear policies on the management of situations where a doctor's fitness to practise is impaired, including guidance on referral to National Clinical Assessment Service [NCAS] and GMC
- Clear guidance on suspending appraisal when fitness to practise issues make it inappropriate to proceed

- Agreement with other organisations when joint or additional appraisal is needed for doctors with other professional roles.

6.2. Appraiser Selection, Skills and Training

The organisation has a process for selection of appraisers, and appraiser skills are continually reviewed and developed.

6.2.1. Evidence of selection of appraisers

- Recruitment of appraisers uses a defined person specification [Appendix 3] and job description [which are included in a wider person specification/job description if appraisal is part of a broader role]
- There is lay involvement in selection of appraisers
- The appraiser must participate in initial appraiser training which addresses
  - Core skills
  - Giving constructive feedback – including use of 360 degree surveys for feedback
  - Confidentiality
  - Assessing satisfactory participation by the appraisee in the appraisal discussion
  - When and how to halt the appraisal discussion
- There are systems to ensure that initial training effectively addresses appraiser needs

6.2.2. Evidence of review and development of skills

- There are systems in place for appraisal and performance management of appraisers
- There are systems to ensure that appraisers participate in on-going training and development and that training is effectively addressing appraiser needs
- There is guidance about the minimum and maximum numbers of appraisals per appraiser per year

- Appraisal Sumary forms, and Personal Development Plans [PDPs] are reviewed anonymously by the Appraisal Lead at least annually and feedback on their quality is given to the individual appraiser [see Appendix 4]

- The views of appraisees are routinely gathered and fed back to the individual appraiser. A sample appraisee feedback questionnaire is attached [Appendix 5]

- There is a process for periodically assessing appraiser skills, e.g. anonymous review of Appraisal Summary Forms and PDPs, observation of appraisal interview/video recording with appropriate consent, observation of role play.

6.3. Appraisal discussion

The appraisal discussion is challenging and effective; it is informed by valid and verifiable supporting evidence that reflects the breadth of the individual doctor's practice and results in a Personal Development Plan [PDP] prioritising the doctor's development needs for the coming year.

6.3.1. Evidence that the appraisal interview is challenging and effective

- The previous year's PDP is reviewed

- A new PDP is produced

- Colleague and patient feedback is discussed

- There is evidence of a change of appraiser after a maximum of three appraisals

- Performance management and development systems address challenge within the appraisal discussion, e.g. through appraisee feedback questionnaires, anonymous review of Appraisal Summary Forms and PDPs, observation of appraisal interview/ video recording with appropriate consent, observation of role play.

6.3.2. Evidence of valid and verifiable supporting evidence

- There is a core portfolio of supporting evidence which reflects the breadth of the doctor's practice [including private practice] and conforms to national, GMC and Royal College standards and guidance

- The portfolio of supporting evidence is verifiable
- Clinical governance systems within the host organisation which produce evidence relating to performance are quality assured
- The supporting evidence includes feedback from patients and colleagues
- There is guidance and training for appraisers for situations when evidence is insufficient

6.4. Systems and Infrastructure

The supporting systems and infrastructure are effective and ensure that all doctors linked to the host organisation are supported and appraised annually.

6.4.1. Evidence of effective supporting systems and infrastructure

- There is dedicated administrative support for the appraisal system
- There is clearly identified managerial responsibility for the appraisal process
- There is evidence of compliance with NHS guidance on the conduct of appraisal
- Adequate notice is given to prepare for the appraisal discussion
- There is protected time for the appraisal discussion
- There is access to effective information systems for the production and holding of evidence
- There is evidence of choice of appraiser for the appraisee
- There is guidance on potential conflicts of interest between appraisee and

appraiser

- There is guidance on the environment within which the appraisal discussion takes place
- All Appraisal Summary Forms and PDPs are agreed by appraisee and appraiser
- Appraisal Summary Forms and PDPs are securely stored in accordance with national guidance. Access is limited to the nominated persons
- There is a system for handling complaints about appraisal
- The host organisation offers training in the use of an appraisal support system e.g. the electronic NHS Appraisal Toolkit
- The appraiser is indemnified for their actions in the role of appraiser unless they have acted with negligence or neglect

6.4.2. Evidence that <u>all doctors are appraised annually</u>

- The number of completed appraisals and total number of doctors to be appraised in year are recorded
- Exception audit is performed by the host organisation to determine reasons for all missed or incomplete appraisals
- The appraisal system includes arrangements for sessional, part-time and temporary appointments
- Standard information obtained by the host organisation from doctors includes certificate of satisfactory completion of appraisal and appraisal due date.

7. Recommendations

7.1. The above framework contains indicators that the Expert Group decided were reasonable, achievable and appropriately challenging to the large majority of host organisations. There are several additional important areas that need to be addressed. These are listed below, with appropriate recommendations:

7.2. It was agreed by the group that the best examples of appraisal systems occurred where they were organised over a wide geographical area. This allowed expertise, coordination and consistency to develop and made effective use of administrative support and clinical leadership. Examples of single appraisal systems covering Wales, Scotland, Northern Ireland, and Essex were considered. Within these areas, the host organisation retains statutory responsibility for the appraisal system, but pools resources with other organisations to develop a system over a wider area. Consistent local interpretation of guidance appears to be an important factor in the development of these high quality systems.

Recommendation:

Appraisal systems in Primary Care should be coordinated at Regional/Deanery level. Similar collegiate arrangements may be possible in some hospital Trusts.

7.3. Self Assessment Audit [see Appendix 1]. We have adapted an audit initially proposed by the National Association of Primary Care Educators [NAPCE][7] for use by host organisations. This encompasses the best examples from a number of systems examined. The selected indicators are intended to be developmental rather than mandatory.

Recommendation:

The self-assessment audit [Appendix 1] should be routinely used by host organisations to assess their progress. The audit tool should be further developed and refined.

7.4. In Primary Care all doctors including locums and freelance GPs are linked to an individual PCT. There are a number of groups of doctors, most notably hospital

locums but including doctors with non-clinical roles and doctors working wholly in the private sector, that are not currently linked to host organisations. To ensure consistency it would be desirable for all doctors to be linked to a host organisation for the purposes of appraisal and revalidation. For example, in England, "NHS Professionals" is already providing a function for many hospital locums; this role could be extended to include other doctors. Some professional bodies may also take on this responsibility.

Recommendation:

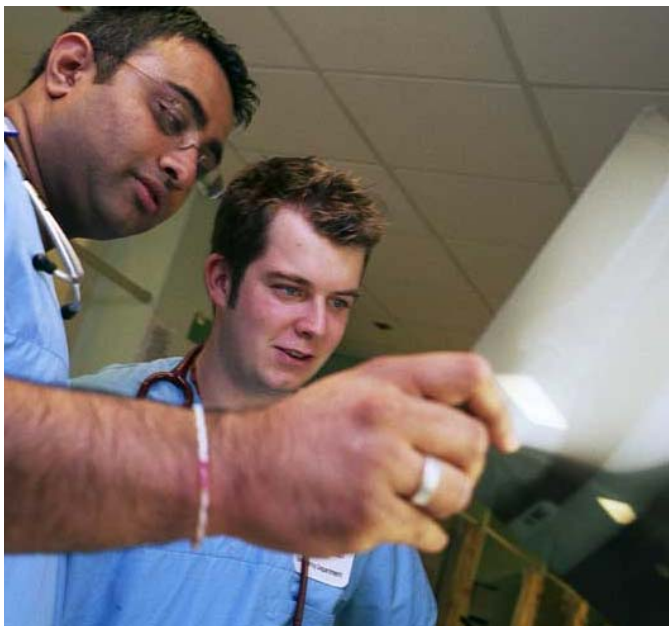
All doctors should be linked to a host organisation for the purposes of appraisal and revalidation.

7.5. It appears that the issue of indemnity for employed or contracted appraisers may not be clear. It seems appropriate for appraisers who are not acting negligently to be indemnified for their actions by the host organisation.

Recommendation:

Organisations employing or contracting appraisers should provide explicit assurance of indemnity for the appraiser.

7.6. There is widespread concern about the confidentiality of the appraisal process and the related documentation. This is a particular problem in Primary Care where there is wide variation in the interpretation of central guidance. In some Trusts, Chief Executives and Clinical Governance Leads do not have access to completed appraisal summary documents or PDPs. We believe it is desirable for the host organisation to have access to this individualised information, within precisely defined limits, as they retain responsibility for the quality of the appraisal process and the quality of service delivered. Delegation of this access may be appropriate but must be subject



to written agreement covering access to specified anonymised information and any circumstances when access to individual information by the Trust is appropriate. Central clarification of the NHS guidance on this point would be welcome.

Recommendation:

The appraisal summary document and the PDP should both be shared with the host organisation; but strictly for viewing only by the Chief Executive [CEO] and Clinical Governance Lead. [Where host organisations choose to delegate this access, it must be subject to written agreement covering access to specified anonymised information and any circumstances when access to individual information by the Trust is appropriate. Final responsibility resides with the CEO and Clinical Governance Lead.]

7.7. There is a need for consistency in the Board level annual reporting arrangements. A sample annual Board report is attached [Appendix 2].

Recommendation:

A consistent framework for annual reporting on appraisal should be used.

7.8. Recruitment and appointment of appraisers should be based on the identified competencies required for the role. When the role of appraiser is essential to a wider role e.g. clinical director, the competencies of an appraiser should be considered essential to the appointment. There is some experience of hospital Trusts appointing specialist appraisers separate from the clinical director role. There are potential advantages to this approach but benefits will depend on local circumstances. A sample Person Specification is attached [Appendix 3].

Recommendation:

Appraisers should be appointed on the basis of the desirable competencies for the role.

7.9. Initial and ongoing training for appraisers is variable in quality, frequency and duration. It would be difficult to standardise training programmes at this time, but the training should be aligned to the required set of skills and the effectiveness of the training programmes to develop these skills should be regularly monitored by the host organisation. Eventually the accreditation of appraisers may be desirable and therefore training programmes should be encouraged to converge on an agreed national curriculum.

Recommendation:

Training programmes for appraisers should be designed and commissioned using regional expertise, e.g. for GPs by Postgraduate Deaneries or equivalent, and mechanisms for sharing curriculum design nationally should be encouraged.

7.10. It is clear that meaningful public and lay involvement in medical appraisal is underdeveloped. The most obvious areas for involvement are in the recruitment of appraisers and in the quality assurance and reporting arrangements.

Recommendation:

Appropriate means of generating public and lay involvement in the appraisal process for doctors should be explored and developed.

7.11. The current appraisal output form contains the Appraisal Summary Document as well as the PDP. There is a need for documentary 'Proof of Appraisal' without needing to provide detailed information relating to learning needs. We suggest that a separate "Statement of satisfactory completion of appraisal" would allow doctors [particularly peripatetic locums] to show employing organisations other than their host organisation that appraisal has occurred, along with their appraisal due date. We believe the learning needs stated in the appraisal summary and PDP should remain confidential and privileged [as in paragraph 7.6 above].

Recommendation:

A "Statement of satisfactory completion of appraisal" should be developed and incorporated into the standard NHS appraisal paperwork, and the NHS Appraisal Toolkit [or equivalent].

7.12. Recognising the differences that have emerged, particularly between primary and secondary care, we support on-going dialogue between the different sectors and regions, so that learning and good practice can be shared. There is also a potential need for an agency to lead on accreditation of appraisers and encouraging convergence of evidence and appraisal training programmes.

Recommendation:

A UK-wide group, with representation from all NHS sectors and a clearly defined remit, should be established:

- To oversee the development, sharing and dissemination of quality practice and expertise in medical appraisal; including further refinement of the quality assurance framework, developing the self assessment audit and improving lay involvement.
- To encourage the convergence of curriculum design for appraiser training programmes.
- To assure the evidence considered within appraisal is of a sufficiently high and consistent standard
- To determine whether accreditation for medical appraisers is practical or desirable.

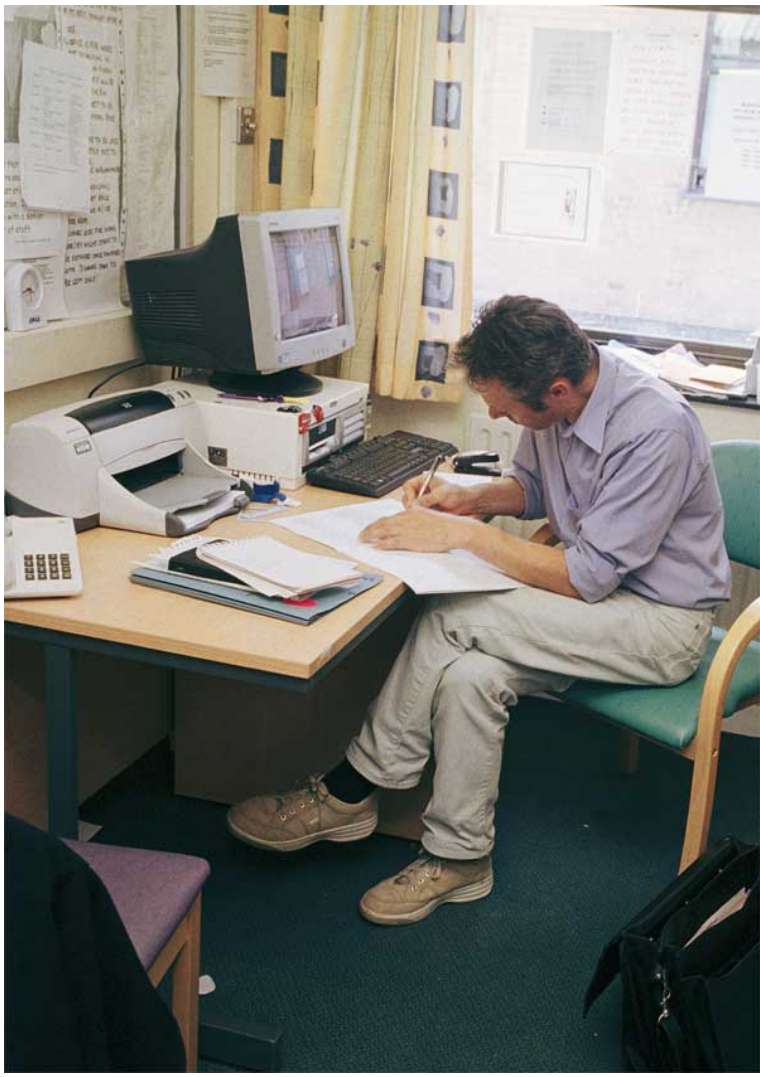
8. Conclusion

8.1. It is not possible, or indeed desirable, for all variation in medical appraisal systems in the UK to be eliminated. The framework for quality that this report proposes will improve quality and raise standards by providing a stimulus towards increased convergence and consistency.

8.2. This framework seeks to establish general measures that all appraisal systems should be able to fulfil, whilst allowing local flexibility for how that is achieved.

8.3. We believe this framework strikes a reasonable balance between that which is achievable now, and that which is aspirational, in order to stimulate quality improvement. Further development of the framework will be required as knowledge and experience grows.

8.4. Appraisal for doctors is generally regarded as a positive process[8]. We strongly support the on-going development of appraisal systems, and believe this framework for quality assurance marks an important milestone in the evolution of the process.



Appendix 1

Suggested baseline self-assessment checklist for host organisations

	1 Practice does not follow standards that should reasonably be expected.	2 Practice in this area is sound, although progress can still be made	3 Practice in this area is excellent
The organisational ethos and commitment to appraisal			
The organisation has clearly identified resources to support appraisal	The allocation of resources is unclear and evaluations identify problems with resources supporting appraisal	There is a clear allocation of resources to support appraisal and this appears to be adequate	Evaluations demonstrate that the appraisal process is resourced well
A named doctor is responsible for leadership and development of the appraisal process	There is no defined leadership	An individual has the responsibility but does not have the time or resources to lead the appraisal process	The appraisal leadership is committed, informed and is able to lead the process effectively
An annual report is produced for the board	No annual report is produced	The annual report is incomplete or does give clear information to the board	A well produced annual report gives information to the board to allow individuals and the organisation to respond to appraisal
Appraisal is integrated with other processes for Continuing Professional Development and Clinical Governance	It is not clear what place appraisal has in the organisational structure	Links exist between appraisal and CPD and clinical governance but it is not clear how effective these links are	Appraisal is part of an integrated process for CPD and clinical governance that is shown to work effectively
The organisation responds to needs identified in appraisal	It is unclear how the organisation responds to needs identified in appraisal	The Trust has some processes to support individuals in addressing educational and/or developmental needs and also considers implications for the development of the Trust.	There is a clear process to ensure that individuals are effectively supported in their development, barriers to development are addressed and the Trust has clear planning and delivery of changes to address organisational developmental needs
Quality Assurance	There is no clear process for Quality Assuring Appraisal	The Trust has processes to Quality assure appraisal but these are not always effective	The Trust has clear processes for monitoring the QA of appraisal and responds to needs identified
There is evidence of lay and public involvement in the appraisal system	There is no lay or public involvement in the appraisal system	There is some evidence of lay or public involvement	Lay and public involvement is actively sought, with evidence of participation at a number of levels
The confidentiality of the appraisal process is robust and trusted	It is unclear how effective any processes for confidentiality work	There is a clear policy that protects the confidentiality of the appraisal process	The confidentiality process is effective and, as evidence in evaluations, trusted by individuals
Actions to improve quality in these areas:			

Appraiser Skills and Training			
A defined person specification is used when selecting appraisers	There is no evidence that a clear person specification is used	A person specification exists and is used	A person specification is used, it is reviewed regularly and applied well
Appraisers are properly selected	It is not clear how appraisers are selected	Appraisers are selected at interview and a job description is available	There is a clear selection procedure at interview, including lay representation, that enjoys the confidence of individuals in the organisation
Appointment as an appraiser depends on successful completion of training	Appraisers are not trained or it unclear how they are trained	Appraisal training occurs	High quality appraiser training is undertaken by all appraisers. This is provided by skilled trainers and feedback is given to appraisers on their strengths and weaknesses
There is a clear job description for appraisers	There is no job description	A job description exists	There is a job description that is regularly reviewed and accurately reflects the role of appraisers in the organisation
Appraisers are supported in their role	It is unclear what support, if any, exists for appraisers	Appraisers are supported by the Appraisal Lead and some links exist between appraisers	There is appraisers group that is resourced and meets regularly, offering support to appraisers and developing appraisers skills
Appraisers carry out an appropriate number of appraisals	It is unclear how many appraisals individual appraisers complete each year	There is a defined minimum and maximum number of appraisals completed by each appraiser annually	The number of appraisals completed by an appraiser complies with the Trust's policy and reflects the needs of their own development
Assessment of appraisers skills	Appraisers skills are not assessed	Some assessment is made and feedback occurs to appraisers	Evaluation forms, the quality of Forms 4 and observation inform feedback to the appraiser. Reappointment as an appraiser depends on satisfactory performance and ongoing development of skills
Anonymised review of Appraisal Summary Forms and PDPs is undertaken as a developmental tool for appraisers	Appraisal Summary Forms and PDPs are not reviewed	A process exists but it is not consistently applied	Regular review of anonymised Forms 4 by the Appraisal lead takes place at least annually, with feedback to the appraiser
Ongoing training of appraisers	It is unclear what further training appraisers undergo	Appraisers attend periodic retraining	Appraisers are actively involved in a developmental appraisers group; address needs identified in review of their performance and attend external training relevant to their needs on an annual basis. There is independent assessment of their skills on a 3 yearly basis
Actions to improve quality in these areas:			

The Appraisal Discussion			
The appraisal reviews the progress against the previous year's development plan	It is unclear how PDPs are reviewed	Appraisers review progress against development plans	Appraisers review progress against development plans as evidenced in Form 4s and in evaluations and this progress informs the subsequent year' development
The appraisal discussion is challenging	It is unclear whether the interview is challenging	Appraisal appears to be appropriately challenging in most cases	Evaluation demonstrates that appraisers are able to challenge whilst remaining supportive to the appraiser
There is a clearly defined portfolio of evidence that informs appraisal	It is unclear how evidence is chosen to inform appraisal	An agreed evidence set is brought to the appraisal discussion	Evidence considered is valid, verifiable, conforms to national guidance and includes feedback from patients and colleagues
There are clearly understood actions when the evidence informing appraisal in incomplete	It is unclear to appraisee and appraisers what should be done if information is incomplete	There is a written policy that outlines individuals' and the organisation's responsibilities if the evidence folder is incomplete	There is a written policy that is understood by all and mechanisms exist to support individuals in completing the evidence
The development plans are of a high standard and accurately reflect the appraisal discussion	It is unclear whether the development plan reflects priorities identified in appraisal	The development plans appear to be well produced and considered	The development plans are excellent and evaluation shows they reflect individuals' needs
Appraisal takes place in an appropriate environment	There is no guidance on where appraisal takes place	There is guidance to ensure appraisal takes place in an appropriate environment	Guidance is effectively followed
Actions to improve quality in these areas:			

Systems and Infrastructure - Supporting Appraisal			
There is sufficient administrative support for appraisal	There is no clearly identified administrative support and/or problems are identified in evaluations	There is dedicated administrative support that appears reasonably effective	Evaluations confirm the presence of effective administrative support for appraisal
Sufficient notice is given for appraisal	Insufficient time is available to prepare for appraisal	Sufficient time appears to be available	Sufficient time is available for appraiser and appraisee to prepare for appraisal and this is confirmed in evaluations of appraisal
Matching of appraiser and appraisee is well managed	It is unclear how matching occurs and/or problems are evident in the process	There is a process to match appraiser and appraisee	There is a clearly understood process to match appraiser and appraisee and a process exists for choice if a problem or conflict of interest is identified
There is a complaints process should problems arise within the appraisal process	There does not appear to be a complaints process	A complaints process exists	A complaints process is produced, reviewed and is readily accessible to doctors in the organisation. Complaints are audited
Appraisal Summary Forms and PDPs are signed by appraiser and appraisee	Appraisal Summary Forms and PDPs are not always signed	Appraisal Summary Forms and PDPs are signed	Appraisal Summary Forms and PDPs are legibly signed and GMC numbers appended to signatures
Appraisal Summary Forms and PDPs are securely stored	Appraisal Summary Forms and PDPs are not securely stored	Appraisal Summary Forms and PDPs are securely stored	Appraisal Summary Forms and PDPs are securely stored and there is evidence that access to the Forms is strictly controlled and monitored
Doctors are appraised annually	It is unclear how many doctors are appraised or more than 5% of doctors are not appraised	At least 95% of doctors appraised are and an exception audit has taken place for incomplete or missed appraisals with actions to address any problems produced	All doctors are appraised
Locums have been appraised	It is not known whether locums working in the organisation have been appraised	Locums working in the organisation have been appraised	Locums have been appraised and the date of their last appraisal recorded
Doctors working across organisations	The responsibility for carrying out appraisals for doctors working across organisations is not clear	There is a policy to clarify where appraisal is done for doctors working within several organisations	There is a clear policy and a robust and confidential process for ensuring appraisal has occurred is in place that is understood by those doctors
Actions to improve quality in these areas:			

General Comments and priorities identified		
Date	Name	Signature Position

Appendix 2

Annual appraisal report for Board

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

1. Individuals responsible

   The section should clearly identify individuals with responsibility for appraisal within the organisation, including the medical and managerial leadership

2. Activity Levels

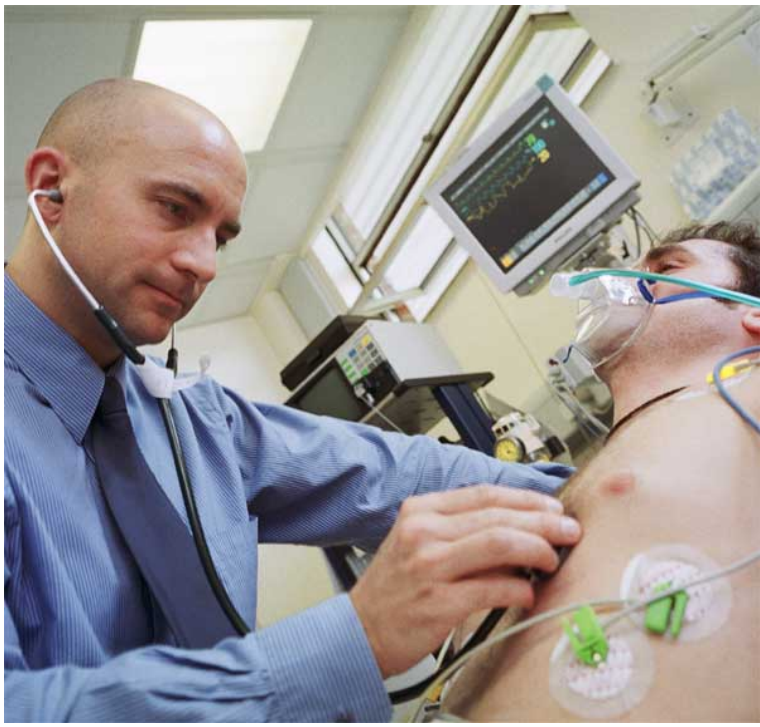
   The numbers of doctors who have been appraised and the total due for appraisal in the reporting year. There should be an exception audit of all missed or incomplete appraisals included in the report.

3. Quality assurance of the appraisal process

   The report should outline the processes in place to assure quality of the appraisal process, including work done to address previously identified areas for development and areas to develop in the next year. A summary of the evaluations produced should inform this section as should progress against the self-assessment audit [Appendix 1]. The results of the last three yearly external assessments should also be included.

4. The learning needs of individual doctors

   There should be a summary of anonymised learning needs identified by individual doctors. There should be particular attention paid to needs common to a number of individuals and needs that affect patient safety. Barriers to individuals realising needs, identified in previous appraisal cycles, should also be outlined and progress in addressing these barriers included in the report.



5. Other developmental needs of individual doctors

Appraisal may identify non-educational needs of doctors, such as stress management, and difficulties in career progression. These should be carefully anonymised and summarised in the report.

6. Organisational development

Issues that should be addressed by the organisation, rather than the individual, should be identified. A plan to deal with areas of concern should be outlined and progress against the previous year's plan should be reported. Specific issues relating to the selection and training for appraisers should be reported

7. Summary

The report should include a summary of important issues arising from appraisal.

Appendix 3

Person specification for appraisers

This generic person specification is proposed as a foundation for selection of appraisers of doctors in all NHS organisations. It is based on work done by Chambers at al[9], and NAPCE and NATPACT[10].

Person Specification for Appraiser	**E**ssential/**D**esirable
Education	
Medical Degree	E
GMC registration	E
Completion of Appraisal Training before appointment	E
Experience	
3 years since completion of specialist or GP training	E
Involvement in medical education or training	D
Skills, aptitudes and knowledge	
Interpersonal and communication skills	E
Understanding of the appraisal process	E
Understanding of equality and diversity best practice	E
Understanding of learning needs assessment	D
Knowledge of local professional development and education structures	D
Personal Qualities	
Motivated and conscientious	E
Enjoying respect of colleagues	E
Health and Physical abilities	
Psychologically capable of work as an appraiser	E

Appendix 4

Anonymous Appraisal Summary Document and PDP Review

Qualitative analysis of the Appraisal Summary Documents and Personal Development Plans by Appraisal Lead with feedback to individual appraisers.

Assessment:

1. Unsatisfactory
2. Satisfactory
3. Excellent

Anonymised appraisal forms assessed for the following criteria:

- Legibility
- Specificity: no blanks, no vague or loose descriptions e.g. 'fine' 'OK'
- Objectivity: relevant, factually correct, evidence based when possible
- Freedom from bias and prejudice
- Contains no identifiable third party information
- Acknowledgement of the appraisee's achievements and developmental progress
- Challenging and actionable educational plan
- Acceptance by the appraisee i.e. signed

Based on: A Rughani 2004 and D Young 2004[11,12]

Appendix 5

Sample appraisee feedback questionnaire

The appraisee questionnaire is an important part of the quality assurance process. It may also be useful to use an appraiser feedback tool to view the same appraisal interview from 2 perspectives.

1 Very poor/ly	2 Poor/ly	3 Average/ly	4 Good/Well	5 Very good/Well

The Trust's approach to appraisal	1	2	3	4	5
The Trust's approach to appraisal is					
The Trust support of me in addressing and realising my developmental needs					
My ability to complete the development plan in last year's appraisal					
The Trust's response to general issues arising out of appraisal					

My appraiser's skills	1	2	3	4	5
The appraiser's skill in conducting my appraisal					
My preparation for appraisal was					
The appraiser's preparation for the appraisal was					
My appraiser's ability to listen to me					
The appraiser was supportive					
The appraiser's feedback was constructive and helpful					
The appraiser made me think about new areas for development					
My overall rating of my appraiser in their role as an appraiser					

The appraisal interview	1	2	3	4	5
Usefulness of the appraisal in my professional development					
The appraiser reviewed progress against last year's development plan					
How challenging was the appraisal in making me think about my practise					
The development plan reflects my main priorities for development					
My appraisal was worthwhile					

The administration of appraisal	1	2	3	4	5
Forms and material to prepare for appraisal were available					
I was given adequate notice of my appraisal					
The process for allocation of my appraiser allowed me an element of choice					
My confidence in the confidentiality of the appraisal					
Time available to prepare for the appraisal interview					
My overall rating of the administration supporting appraisal in the Trust					

Comments of how the Trust could improve its approach to appraisal

Comments to help your appraiser improve their skills

How could you or your appraiser have made the appraisal interview more successful?

How could the administration of appraisal and support of appraisal be improved?

Appendix 6

Source Materials and Documents

A Quality Assurance Framework for Appraisal of Doctors

Dr Nick Bishop, Assistant Medical Director, Commission for Health Improvement. 2003

Quality Assurance Assessment Table for Appraisal of Doctors

Dr Nick Bishop, Assistant Medical Director, Commission for Health Improvement. 2003

Developing the Quality of the Appraisal Process for Doctors in the United Kingdom

Dr Nick Lyons, National Association of Primary Care Educators and NHS Clinical Governance Support Team, December 2004

Appraisal and Local Certification – A Discussion Paper on the Roles of process, Guidance and Quality Assurance,

Amanda Watson, Director of Education and Registration, General Medical Council. 30.9.04

The Policy Framework for Revalidation: A Position Paper

General Medical Council. July 2004

Revalidation – Evidence and Quality Assurance. Council Paper

General Medical Council. 25 November 2003.

GP Appraisal in Wales Annual Report 2003-4

Katie Evans, GP Appraisal and CPD Manager, GP Appraisal and CPD Unit, Cardiff University. September 2004

Developments in GP Appraisal in Wales

Katie Evans, GP Appraisal and CPD Manager, GP Appraisal and CPD Unit, Cardiff University. January 2005

GP Appraisal in Wales – External Quality Assurance

Katie Evans, GP Appraisal and CPD Manager, GP Appraisal and CPD Unit, Cardiff University. February 2005

GP Appraisal in Wales – Quality Assurance Strategy

Katie Evans, GP Appraisal and CPD Manager, GP Appraisal and CPD Unit, Cardiff University. February 2005

There's a baby in the bath water! The value of appraisal [draft]

Malcolm Lewis, Katie Evans, GP Appraisal and CPD Unit, Cardiff University. March 2005

GP Appraisal in Essex: The Essex Scheme

Madeline Kenny, GP Appraisal Administrator, EQUIP. January 2005

The Critical Success Factors in Delivering GP Appraisal: A review of the first year in Northumberland and Tyne & Wear

Adams R, J Illing, D Jelley, C Walker & T van Zwanenberg. December 2004

Consultant Appraisal in Wales: Moving Forward. Briefing Paper 6.

Prof Siobhan McClelland, Brenda Houston, David Salt, Dr Iain Robbe, Mags Rees, Centre for Health Leadership Wales. January 2004

Quality Assurance of Appraisal.

Dr T Bradley, Northern Ireland Medical and Dental Training Agency. 2005

Appraisal and revalidation for doctors: complement or conflict?

Keith Judkins MB ChB FRCA. Clinician in Management (2004) 12: 00–00 2004 Radcliffe Publishing

ABC of GP Appraisal. How to write an annual appraisal report.

Dr Nick Lyons. Sheet 12, NAPCE/NATPACT Oct 2004

ABC of GP Appraisal. GP Appraisal: The PCOs responsibility.

Dr Nick Lyons Sheet 13, NAPCE/NATPACT Oct 2004

Quality Assurance of GP Appraisal in Southern Derbyshire and Nottingham City PCTs.

Sheona MacLeod, CME Tutor. January 2005

GP Appraisal in Scotland: Quality Assurance of the GP Appraisal Scheme in Scotland.

Cath Denholm, Education & Development Manger [Primary Care], NHS Education for Scotland. March 2005

COGPED. Quality assurance of service provision through continuing professional development for Non-Principals in General Practice.

Dr. Pat Lane, Director of Postgraduate General Practice Education, North Trent. October 2000

Quality Assuring GP Appraisal. Report of Exploratory Workshop

A Jamieson, Associate Director London Deanery, GP Department. 26th April 2004

QA of GP Appraisal Questionnaire responses

A Jamieson, Associate Director London Deanery, GP Department. Oct 2004

Guide to Independent Sector Appraisal for doctors. Doctors employed by the NHS and who have practising privileges at independent hospitals (Whole Practice Appraisal). An agreement between the British Medical Association and the Independent Healthcare Forum. Oct 2004

North West Wales NHS Trust, Medical Appraisal Scheme – Full Supporting Documentation.

Jean Williams, Education Centre Manager, North West Wales NHS Trust. 2004

Appendix 7

Expert Group membership

Chair

Dr Martin Shelly

Associate Director of Primary Care, NHS Clinical Governance Support Team, and GP Principal

Deputy Co-chairs

Dr Maurice Conlon

Appraisal Lead, NHS Clinical Governance Support Team, and GP Principal

Dr Nick Lyons

GP associate, NHS Clinical Governance Support Team; Associate Director, Wessex Deanery, and GP Principal

Expert Group Membership

Dr Tina Ambury

Appraisal Lead RCGP, and Portfolio GP

Dr Gill Bailey*

Medical Director & Clinical Governance Lead, South Birmingham PCT, and GP Principal

Dr Nick Bishop*

Senior Medical Advisor & Chairman Clinical Advisory Team, Healthcare Commission

Dr Maura Briscoe*

DHSSPS Northern Ireland

Mr Terry Brown*

SCHIN Project Manager

Mr John Cowles*

Portfolio Manager, Post-Registration Learning & Development, Department of Health

Ms Cath Denholm*

Education & Development Manager (Primary Care) for NHS Education for Scotland, and Project Lead for the GP Appraisal Scheme in Scotland

*denotes Task Group Member

Dr Vinod Diwakar

Consultant Paediatrician, Birmingham Children's' NHS Hospital Trust

Miss Katie Evans*

GP Appraisal and CPD Manager, Wales

Dr Clare Gerada

Director of Primary Care, NHS Clinical Governance Support Team, and GP Principal

Dr David Graham

Director of Appraisal for the NHS, and Postgraduate Dean, Mersey Deanery

Mr Scott Hayward*

Project Manager for NHS Appraisal Toolkit

Dr Diana Jelley*

GP Appraisal Advisor, Northern Deanery, and GP Principal

Ms Julie Jones*

Head of Workforce Development, East Yorkshire PCT

Dr Keith Judkins*

Former Medical Director (PGH)/Consultant Anaesthetist

Ms Madeleine Kenny*

GP Appraisal Administrator EQUIP

Dr Philip Leech

Former Principal Medical Officer for Primary Care, Department of Health

Dr Malcolm Lewis*

Sub-Dean & Director, Postgraduate Education for General Practice School of Postgraduate Medical & Dental Education (Wales)

Dr Kwee Matheson*

Regional Clinical Director, NHS Professionals (Doctors)

Dr Kay Mohanna

Principal Lecturer in Medical Education, Staffordshire University; Education Convenor of the Midland Faculty RCGP, and GP Principal

*denotes Task Group Member

Prof. Ed Peile

Head of Division of Medical Education and Associate Dean (Teaching), Warwick Medical School, The University of Warwick

Dr Umesh Prabhu

Consultant Paediatrician, Fairfield NHS Hospital Trust

Dr Rodger Thornham

Executive Committee Chair, North Tees Teaching PCT; Associate Director of Post Graduate GP Education of Northern Deanery, and GP Principal

Prof Tim van Zwanenberg*

Professor of Postgraduate General Practice, Postgraduate Institute for Medicine and Dentistry, University of Newcastle, and GP non-Principal

Dr Anne Vulpe

Psychiatrist in Learning Disability, New Forest Community Learning Disabilities Health Team

Ms Amanda Watson*

Director of Education and Registration, General Medical Council

Ms Jean Williams*

Education Centre Manager, North West Wales NHS Trust

*denotes Task Group Member

Appendix 8

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[10] NAPCE and NATPACT (2004) *ABC of Appraisal* Bury, NAPCE

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