# NHS EnglandNHS England All England Appraisal Network

# Medical Appraisal Position Statement

## Reference: MAPS A1

## Routine appraiser assurance

### Relevance:

This statement is relevant to all designated bodies in England.

### Position statement:

It is important that medical appraisers in England maintain and develop their skills on an ongoing basis. This is primarily the responsibility of the appraiser, but the designated body has a share in this responsibility.

There are a variety of means by which medical appraisers can maintain and develop their skills, but core activities include:

1. CPD: Attendance at local update and appraisal network meetings, in addition to other types of continuing professional development, including peer review
2. Quality improvement activity: Review of appraisal outputs, in particular the appraisal summary and PDP that are recorded in the appraisals they carry out
3. Significant events: noting and recording for reflections events from their appraisal work from which learning and development can be derived
4. Feedback: Obtaining and reflecting on feedback from doctors whom they appraise, and from colleagues in their appraisal role
5. Appraiser assurance review meetings with a senior appraiser or appraisal lead.

Using a simple framework to review a doctor’s appraisal submission is another means of supporting appraiser consistency, especially in situations where appraisers are faced with a variety of appraisal formats used by doctors.

This document supplements the *Quality assurance of medical appraisers* guidance (QAMA) issued by the NHS Revalidation Support Team in setting out further detail and providing useful tools around the on-going process of appraiser assurance.

This position is underpinned by the following principles:

1. The patient safety benefits of revalidation and the professional development benefits of appraisal depend on all doctors receiving a consistently good quality appraisal experience.
2. Medical appraisers have a professional responsibility to maintain and develop their appraisal skills.
3. Designated bodies have a responsibility to support their appraisers in the maintenance and development of their skills, and to assure the quality of medical appraisals.
4. Attendance at network meetings and other forms of shared learning interactions is a key component of appraisers maintaining and developing their skills and of calibrating their behaviours and decisions.
5. Quality assurance audit of appraisal outputs and feedback from doctors helps to identify individual and group appraiser learning needs.
6. Periodic assurance review meetings with a senior appraiser or appraisal lead, or with a peer appraiser is of benefit to all appraisers, and in particular new appraisers and appraisers requiring additional development.
7. There is also a role for self-review, although the involvement of a second person in the process adds to assurance and objectivity.

### Rationale for position statement

#### *Description and background*

Consistency of medical appraisal across all sectors is important to ensure that all doctors receive a good quality appraisal. Good quality appraisal outputs, in which the appraiser has documented that the doctor has demonstrated that they are keeping up to date and fit to practice, are necessary to help the responsible officer decide whether to recommend a doctor for revalidation. This in turn helps ensure patient safety.

The NHS Revalidation Support Team (RST) guidance document *Assuring the quality of medical appraisers* (QAMA) describes the principles behind the selection, training and supervision of medical appraisers, and the NHS England revalidation web page contains example training materials to support their initial training, with the expectation that all new appraisers undergo two days of basic appraiser training. However there is not yet a standardised approach towards the on-going assurance of appraisers across England, and not all currently benefit from on-going appraiser development or further training. Some appraisal groups meet regularly for educational and developmental purposes but others do not. In some areas, senior appraisers/appraisal leads are carrying out quality assurance audit of appraisal outputs (summary of appraisals and PDPs). This auditing helps to bench mark and inform individual appraiser development via their PDP. Some senior appraisers meet for 1:1s with individual appraisers to discuss their quality assurance audit results, feedback from doctors and developmental needs.

#### *Current approach and associated risks*

All new appraisers should continue to be appointed after a standardised interview process and should have written terms of engagement in the role, as set out in QAMA.

Appraisers should undergo standard induction and training (see the training materials on the NHS England revalidation website pages).

This paper reinforces the principles in QAMA that medical appraisers should have effective on-going assurance/review, and presents suitable tools to support this process (Appendices 1-4). This is in keeping with QAMA, which suggests that:

* assessment of the competence of appraisers may also be used as part of routine organisational quality assurance procedures
* prior to commencing the provision of medical appraisals
* at the point of contract renewal
* once in each revalidation cycle as a part of a local accreditation process.
* Assessment of competence may also be used in exceptional circumstances as a valuable exercise where there are concerns about the performance of a medical appraiser.

(If appraisers are unable to maintain the required standard despite remedial input, they should not continue in the appraiser role).

It is helpful to structure the approach to routine appraiser assurance according to the types of supporting information described in *Supporting information for Appraisal and Revalidation* by the GMC, as meeting the needs of their guidance: *Good Medical Practice.* The six types of supporting information are:

1. CPD
2. Quality improvement activity
3. Significant events
4. Feedback from patients
5. Feedback from colleagues
6. Complaints and compliments

#### *CPD (To include participation in appraisal network meetings and other shared learning):*

Maintenance of CPD related to the appraiser role is the individual’s responsibility but attendance at appraiser network meetings is an important means of achieving this, and it is commonly appropriate for designated bodies to facilitate this. It is expected good practice that appraisers working independently or in small groups in small designated bodies should access wider appraiser peer groups and networks. Those commissioning the services of appraisers should ensure that this is made possible to promote consistency. The importance of local appraisal networks is emphasised in QAMA and a buddying system for appraisers is also suggested as another way of ensuring benchmarking.

Appraiser network meetings should link into the national appraisal network so that there will be sharing of information, standards and resources across England to aid benchmarking and calibration of approach.

#### *Quality improvement activity (To include appraisal summary and PDP audit tool):*

Appraisal outputs should be audited using an audit tool for the purposes of benchmarking and identifying individual and group learning needs. A recommended appraisal summary and PDP audit tool (ASPAT) is attached in the Appendix 1.

The ASPAT has been developed by doctors from the primary, secondary and independent sector and is a generic tool that may be used to audit the appraisal summary and PDP of all doctors in England. It may also be useful as a reference for appraisers as they write their appraisal summaries.

The ASPAT has been written after reviewing other available appraisal audit tools such as *PROGRESS*, *EXCELLENCE*, the *East Midlands tool* and the *Oxford tool*. This audit tool covers many similar areas to its predecessors and offers further development in certain areas. Whilst the ASPAT is not specifically intended to replace other tools where these are being used to good effect, it may act as a suitable standard tool in places where no such process has been in place before.

It is envisaged that senior appraisers might initially audit a random anonymised sample of appraisal summaries and PDPs from each appraiser to gain an overview of the quality of the individual’s and the overall appraiser group’s outputs. In the absence of firm parameters around quantity and periodicity, a suitable minimum number to review on an annual basis is two sets of appraisal outputs. To some extent the proportion requiring review depends on the confidence of the responsible officer in the reliability of the appraisal outputs, reducing in circumstances where the confidence is high, and increasing if confidence is challenged.

It is clear that scoring using the tool will be subjective to some extent. It offers a chance to give quantitative and qualitative feedback (the latter in the form of comments from the senior appraiser).

The results of audit should be presented as a subjective snap shot of the appraiser’s performance and should be used to identify areas for development in a supportive non-judgemental way.

1. ***Significant events:***

In a parallel fashion to clinical professional roles, appraisers should be alert to incidents and events which are worthy of capture from which learning and development can be derived. Whilst events equivalent to serious untoward incidents are likely to be uncommon in an appraisal setting, events suitable for consideration include but are not limited to: an unexpected concern which comes to light in an appraisal, an interrupted appraisal, failure to agree the appraisal outputs with the doctor. There are many suitable templates for supporting significant event and incident capture and review; the key component of the process is the inclusion of reflection and identification of personal development.

1. ***Feedback from doctors being appraised:***

In the context of appraisal duties, the doctors that they are appraising can be viewed by the appraiser as ‘patients’ or ‘clients’. Regardless of this semantic point, feedback from the doctors they appraise is a valuable source of information for an appraiser. Several of the commercially available appraisal formats have inbuilt tools to support this. Where such tools are not available, the appendices of *Quality assuring medical appraisers* provides a suitable format. A form derived from this can be found in Appendix 2.

1. ***Feedback from colleagues in the appraisal arena:***

Appraisers should also be open to receiving feedback, whether formal or informal, from their colleagues in their appraisal work, for the purpose of learning and development. This includes their fellow appraisers, senior appraiser, lead appraiser, the responsible officer, and management and administrative support staff in the revalidation and appraisal office.

1. ***Complaints (Appendix 2):***

Complaints about their appraisals, most commonly from the doctor being appraised, are also a valuable source of information for an appraiser. Designated bodies should have processes to manage complaints about appraiser performance, and of feeding information about these back to the appraiser. The appraiser in turn should use such information to reflect on their performance and identify appropriate learning and development.

#### *Appraiser assurance review meetings (Appendix 3):*

On-going appraiser development should be guided by learning needs identified through quality assurance of appraisal outputs and feedback, and should form part of the appraiser’s overall professional PDP. This will be largely self-directed for most appraisers. The senior appraiser may also signpost areas for development at an assurance review meeting, at which all the strands listed above can be considered in the round. It is good practice to hold an assurance review meeting between an appraiser and their senior appraiser on a periodic basis. Where an appraiser is participating in local appraiser update and networking sessions, and their appraisal output audit and appraiser feedback information is satisfactory it may not be necessary to hold an appraiser assurance review meeting annually, and a general standard of one assurance review every five years should be sufficient in such cases. However, an assurance review meeting can be particularly helpful in some contexts, for example, for new or recently appointed appraisers, or appraisers where there are indications that additional development may be required. A template suitable for undertaking appraiser assurance review can be found in Appendix 3. This template is also suitable for independent use by an appraiser as a self-review tool, and for use by an appraiser and a peer, as a peer review tool in a networking or buddying context as described in the CPD section above.

***Appraisal summary preparatory notes template (Appendix 4):***

Appraisers are commonly faced with more than one format of appraisal by their doctors, especially appraisers who undertake appraisals in primary care, or for doctors working in different designated bodies. The template in Appendix 4 provides a structure for reviewing a doctor’s appraisal submission in a consistent way, regardless of the format presented by the doctor. Completed roughly, it can act as a useful aide-memoire in the discussion. Completed carefully, it can have the added benefit of improving the appraiser’s efficiency by providing the basis of the final signed-off appraisal summary.

### Appendices

### Appraisal summary and PDP audit tool (ASPAT)

1. Appraiser feedback from doctors (From QAMA)

### Appraiser assurance review template

### Appraisal summary preparatory notes template

### References

*Quality Assurance of Medical Appraisers Engagement, training and assurance of medical appraisers in England* (NHS Revalidation Support Team 2014)

[*http://www.rcpath.org/Resources/RCPath/Migrated%20Resources/Documents/Q/Quality\_assurance\_medical\_appraisers\_main\_document\_v5.pdf*](http://www.rcpath.org/Resources/RCPath/Migrated%20Resources/Documents/Q/Quality_assurance_medical_appraisers_main_document_v5.pdf)

*NHS England Medical Appraisal Policy* (NHS England Oct 2013): <http://www.england.nhs.uk/revalidation/wp-content/uploads/sites/10/2014/04/med-app-policy-1013.pdf>

*Medical Appraisal Guide* (NHS Revalidation Support Team, 2013) <http://www.england.nhs.uk/revalidation/ro/info-docs/>

*Medical Appraisal Guide Model Appraisal Form* (NHS Revalidation Support Team, 2012) <http://www.england.nhs.uk/revalidation/ro/info-docs/>

*Good medical practice framework for appraisal and revalidation* (GMC, March 2013) <http://www.gmc-uk.org/static/documents/content/GMC_Revalidation_A4_Guidance_GMP_Framework_04.pdf>

*Supporting information for appraisal and revalidation* (GMC, March 2012) <http://www.gmc-uk.org/static/documents/content/RT_-_Supporting_information_for_appraisal_and_revalidation_-_DC5485.pdf>

*Appraiser training and support* (NHS England revalidation website, April 2014) <http://www.england.nhs.uk/revalidation/appraisers/app-train-sup/>

### NHS England medical appraisal position statements

NHS England medical appraisal position statements are a means by which issues pertinent to consistency and quality are captured, discussed and developed, so as to develop an agreed approach across all relevant parties. Issues are passed to the All England Appraisal Network (National) group in the first instance. The network develops an initial position statement based on preliminary discussion. This statement is shared for wider discussion as appropriate, then re-drafted and re-circulated. Depending on the nature of the issue, formal approval may be obtained from various bodies or relevant individuals. The degree to which a position statement has been shared and/or approved is detailed in the governance table at the end of the document.

A position statement should be seen as a fluid document to facilitate discussion and debate. It aims to capture current thinking on an issue and describe the best agreed approach available at the time. Incremental levels of sign off and approval occur after appropriate consensus-building efforts have occurred. A position statement may therefore eventually be consolidated as policy, but while it remains a position statement it remains a vehicle for debate and discussion.

### NHS England medical appraisal position statement relevance

NHS England has a dual function in relation to revalidation and appraisal: firstly as a designated body in its own right, and secondly as Senior Responsible Owner for the revalidation programme in England as a whole. A NHS England medical appraisal position statement may therefore be relevant to NHS England only or to all designated bodies in England. The relevance of an individual position statement is indicated in the title of the statement. Position statements which are NHS England-only may still be of interest to other designated bodies.

**Governance table**

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| Document narrative | 19/09/2014 (RC): First draft  07/10/2014: Maurice Conlon amended title  15/12/2014 (JK): Shared with ROCON on 11/12/14 for comment.  16/12/2014 (RC) Re-drafting  31/12/2014 (JK): Re-formatted in NHS England style by Jenny Kirk  31/12/2014 (MC) Re-drafting  31/12/2014 (JK): Distributed to responsible officers and appraisal leads via regional offices for comment  06/01/2015 (JK): Discussed MAPS and appendices in depth at AN(N); further revisions to be made  19/01/2015 (JK): Re-drafting by JK  29/01/2015 (JK): Further re-drafting by JK  30/01/2015 (MC): Significant re-write by MC; shared with JK and RC  12/02/2015 (MC): Minor re-drafting following feedback from RC  17/02/2015 (JK): Minor re-formatting by JK |