



Improving the inputs to medical appraisal

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Improving the inputs to medical appraisal

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Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and

Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

Contents

1	Purpose and relevance of this paper	5
2	Executive summary	5
3	Background	7
	General.....	7
	Responsible officer regulations.....	7
	Revalidation.....	7
	Medical appraisal.....	7
	Appraisal inputs	8
4	Appraisal inputs: general considerations	9
	4.1 Appraisal and clinical governance: synergies and distinctions	9
	4.2 Shared responsibility for information gathering.....	11
	4.3 Agreeing expected supporting information locally.....	14
	4.4 Assessing the appraisal inputs: responsibilities and escalation.....	15
5	Areas for special consideration.....	17
	5.1 Concerns about practice	17
	5.2 Varied scope of work	17
	5.3 Information shared about a doctor's practice	19
	5.4 The nature of the doctor's work	19
	5.5 Supporting information gathered outside the UK	20
	5.6 Designing local quality initiatives to support appraisal.....	20
	5.7 Volume of work.....	21
	5.8 Doctors in postgraduate training.....	22
6	Conclusion.....	22
7	References	22
8	Appendices.....	24
	Appendix A: Doctor's medical appraisal checklist	25
	Appendix B: Generic medical in-post review template	38
	Appendix C: Assessing supporting information in context of volume of work.....	42
	Appendix D: Template for agreed expected information at appraisal	45
	Appendix E: Obtaining patient feedback in non-standard situations.....	46
	Appendix F: Examples of good practice in areas relating to appraisal inputs.....	47
9	Working group	49

1 Purpose and relevance of this paper

This paper aims to promote improvements to the inputs to medical appraisal by:

- describing the current understanding and providing principles
- reviewing the different categories of appraisal inputs in the light of these
- providing useful tools and examples of good practice

This paper is set in the context of the model of medical appraisal as described in the NHS Revalidation Support Team document '[Medical Appraisal Guide: a guide to medical appraisal for revalidation in England \(MAG\)](#)'.

This paper is relevant to all designated bodies in England. It is of particular importance to responsible officers, appraisers, human resource, clinical governance, information governance departments and doctors. It will also be of interest to patient and public representatives and other groups and bodies with an interest in the quality of healthcare.

2 Executive summary

Appraisal and clinical governance: synergies and distinctions

Appraisal and clinical governance are distinct processes that work in synergy to demonstrate a doctor's fitness to practise and promote quality in the provision of patient care. Primarily, the clinical governance process is where a doctor's professional actions are assessed; appraisal is the forum where the doctor demonstrates that they are keeping up to date and reflecting on what they do.

All information relevant to a doctor's fitness to practise from across their full scope of work should be available in both the doctor's appraisal and the designated body's clinical governance system.

Shared responsibility for information gathering

The doctor and the organisation share responsibility for gathering information about the doctor's practice for overlapping reasons. Doctors and organisations should work constructively to achieve this in the interests of transparency and improving patient care, and of reducing the burden of documentation for doctors.

All organisations need to consider how they achieve this, bearing in mind that the relevant regulations apply regardless of organisational scale or capacity, or the contractual relationship that exists between either the doctor or their organisation and the designated body. Other factors, such as where the population of doctors is largely peripatetic, need to be taken into account. In these situations, networking and discussion are helpful in finding solutions.

Agreeing expected supporting information locally

Doctors and their responsible officers should agree the expected supporting information, supplementing the doctor's own information, on which the doctors will reflect at their appraisal. The agreed expected information should take into account GMC requirements, College guidance, local factors and factors specific to the doctor.

Assessing the appraisal inputs: responsibilities and escalation

A doctor must ensure that their appraisal inputs demonstrate fitness to practise across their scope of work. The responsible officer must be assured that the doctor's appraisal inputs support a recommendation of fitness to practise. The appraiser provides this assurance via the appraisal outputs.

GMC requirements are the primary reference, supported by Academy, College and other professional body guidance, and local agreements about supporting information. Where there is uncertainty, the doctor, their appraiser and the responsible officer must strive for agreement, with input from other sources of expertise if appropriate. This discussion should occur prior to the appraisal meeting.

Special considerations:

- **Concerns about a doctor's practice** must be included for reflection at appraisal. However the prime purpose of doing so is to prompt reflection rather than judgement. The local management of a concern (including whether to involve the GMC) is the remit of the responsible officer.

A doctor should be provided by their organisation(s) with details of any concerns for presentation and reflection at appraisal.

- Under certain circumstances a doctor with a **varied scope of work** may present evidence from the governance framework from individual areas of work, provided this is verifiable and in keeping with GMC requirements, rather than a full suite of supporting information for each area. Where the governance processes within an individual role do not provide such evidence, the doctor should provide self-review with reflection as a minimum.
- Processes for **sharing information about a doctor's practice** are the remit of clinical governance and are outside the scope of this paper. However, the information shared is relevant to doctors as a prompt for reflection at appraisal.
A doctor should therefore be provided by their organisation(s) with such information for presentation and reflection at appraisal.
- Where **the nature of a doctor's work** means that GMC requirements and other relevant guidance on appraisal inputs do not immediately seem relevant, the doctor should: assume that they are expected to gather the information in question, think broadly about how to gather the information, take advice on how they might gather the information or a modified version and seek agreement from their responsible officer before deciding on the most appropriate course of action.
- **Supporting information gathered outside the UK** may be acceptable as part of a doctor's appraisal submission, provided the responsible officer is satisfied that the information is in keeping with GMC requirements, can be verified and is relevant to the context of the doctor's scope of work in the UK.
- The designing of **local quality initiatives to help doctors generate evidence for appraisal** and vice versa is to be encouraged as beneficial to doctors, designated bodies and patient care. Examples of such initiatives should be shared between organisations.
- Depending on the nature of the work, a doctor undertaking a **lesser volume of work** in an area should take increasing care that their appraisal inputs are sufficient to demonstrate fitness to practise in that area.

- A **doctor in postgraduate training** who undertakes any professional role outside their training programme must declare this and submit information about it as set out in their Annual Review of Competence Progression (ARCP) scheme.

A range of tools to support improvements to appraisal inputs is presented in the [appendices](#) for use by doctors, their appraisers and their responsible officers. These include an appraisal inputs [checklist](#) for doctors, an [in-post review template](#), a template to support the communication between a responsible officer and a doctor of the [agreed expected information for appraisal](#), and existing [examples of good practice](#).

3 Background

General

Medical appraisal has been a requirement for consultants since 2001 and for general practitioners (GPs) since 2002. All doctors have been required to undergo annual appraisal since the commencement of revalidation in December 2012.

Responsible officer regulations

The Medical Profession (Responsible Officers) Regulations 2010 and the Medical Profession (Responsible Officers) (Amendment) Regulations 2013 (“the regulations”) require each body designated under the regulations to appoint a responsible officer who must monitor and evaluate the fitness to practise of doctors with whom the designated body has a prescribed link.

Revalidation

Revalidation is the process by which licensed doctors demonstrate to the General Medical Council (GMC) that they are up to date and fit to practise. One cornerstone of the revalidation process is that doctors participate in an annual medical appraisal. On the basis of this and other information available to the responsible officer from local clinical governance systems, the responsible officer makes a recommendation to the GMC, normally once every five years, about the doctor’s revalidation. The GMC will consider the responsible officer’s recommendation and decide whether to continue the doctor’s licence to practise.

Medical appraisal

Medical appraisal is the appraisal of a doctor by a trained appraiser, informed by supporting information defined by the GMC, in which the doctor demonstrates that they are practising in accordance with the GMC guidance ‘Good Medical Practice’ across the whole of their scope of work. In 2012 the GMC also published ‘Supporting information for appraisal and revalidation’ followed in 2013 by ‘the Good Medical Practice framework for appraisal and revalidation’, to support the process. The Academy of Medical Royal Colleges also assisted by coordinating the publication of specialty guidance on supporting information. In 2013 the NHS Revalidation Support Team published a piloted and tested model of medical appraisal, the ‘Medical Appraisal Guide (MAG)’, which complies with the needs of revalidation. The [‘Medical Appraisal Guide’](#) was reissued in 2014.

Appraisal inputs

Figure 1: The stages of medical appraisal



The 'Medical Appraisal Guide' describes appraisal in three stages: inputs, the appraisal meeting and outputs (Figure 1). Each of these stages lends itself to the development of standards of quality to assure that it contributes to the fulfilment of the purposes of an appraisal (Figure 2).

As the process of revalidation evolves, so too does the understanding of appraisal. The appraisal inputs stage (the doctor's appraisal submission) is now recognised as the foundation on which the discussion and the outputs depend.

Various considerations have emerged in relation to the appraisal inputs since revalidation began, the detail of which is not captured in existing guidance.

The All England Appraisal Network therefore drafted a series of medical appraisal position statements in 2014.

This paper is informed by these position statements, and the discussions which they have triggered. It sets out the situation on matters relating to the appraisal inputs not addressed in existing guidance, and describes how the quality of these can be improved. In this way it acts as an illustration of effective networking in action.

Responsible officers, appraisers and doctors may find this paper useful for reference when faced with a situation not fully addressed in local policies and procedures. It will also be of value when writing or revising local policies and procedures.

Figure 2: Purposes of medical appraisal

- 1) To enable doctors to discuss their practice and performance with their appraiser in order to demonstrate that they continue to meet the principles and values set out in the GMC document 'Good Medical Practice' and thus to inform the responsible officer's revalidation recommendation to the GMC.
- 2) To enable doctors to enhance the quality of their professional work by planning their professional development.
- 3) To enable doctors to consider their own needs in planning their professional development, and may also be used
- 4) To enable doctors to ensure that they are working productively and in line with the priorities and requirements of the organisation they practise in.

'NHS Revalidation Support Team -Medical Appraisal Guide v4', March 2013 (re-issued with updated hyperlinks September 2014)

Statutory duty of the responsible officer, delegated authority, responsible officer autonomy and calibration of decisions

A responsible officer may delegate certain duties to others whilst retaining overall statutory responsibility as set out in the regulations. This may include, for example, delegating an associate director to manage day-to-day revalidation activity, or delegating relevant activities to effective human resource departments.

Additionally, some doctors do not hold a prescribed connection to a designated body, and therefore do not have a responsible officer. Such doctors may, with the agreement of the GMC, have their revalidation managed by a GMC-approved 'suitable person'.

A small number of doctors have neither a responsible officer nor a 'suitable person'. These doctors have their revalidation managed directly by the GMC.

In this document, therefore, where the term 'responsible officer' is used, this should be taken to mean 'responsible officer or other person with appropriately delegated authority', GMC-approved 'suitable person' or relevant GMC personnel.

In many aspects of the revalidation process, including those set out in this paper, the responsible officer holds discretion to make decisions based on their professional judgement. In doing so a responsible officer may confer with other responsible officers and colleagues in the responsible officer network, and their higher level responsible officer. They may also take advice from other resources such as the local GMC Employer Liaison Adviser and other experts such as persons from Colleges and other professional bodies. Conferring in this way helps ensure that decisions are based on current national thinking, and are in step with other responsible officers.

[\[Back to Executive Summary\]](#)

4 Appraisal inputs: general considerations

4.1 Appraisal and clinical governance: synergies and distinctions

Key points: Appraisal and clinical governance are distinct processes that work in synergy to demonstrate a doctor's fitness to practise and promote quality in the provision of patient care. Broadly, the clinical governance process is where a doctor's professional actions are assessed as adequate; appraisal is the forum where the doctor demonstrates that they are keeping up to date and reflecting on what they do.

All information relevant to a doctor's fitness to practise from across their full scope of work should be available in both the doctor's appraisal and the designated body's clinical governance system.

The central debate on the relationship between appraisal and revalidation relates to the primarily summative nature of revalidation and the primarily formative nature of appraisal. The '[Medical Appraisal Guide](#)' resolves this by setting out the distinct purposes of medical appraisal (Figure 2). Thus, the summative purpose of supporting a revalidation recommendation (Purpose 1), sits alongside the more formative purposes of supporting the doctor (Purposes 2 and 3) in the context of their place of work (Purpose 4). Each is valid in its own right. In addition, each supports the others in the

central purpose of both appraisal and revalidation, namely to lead to higher quality patient care.

There is also a related debate about the relationship between appraisal and clinical governance. Again, setting the purposes of appraisal (Figure 2) against the definition of clinical governance (Figure 3) can help resolve this.

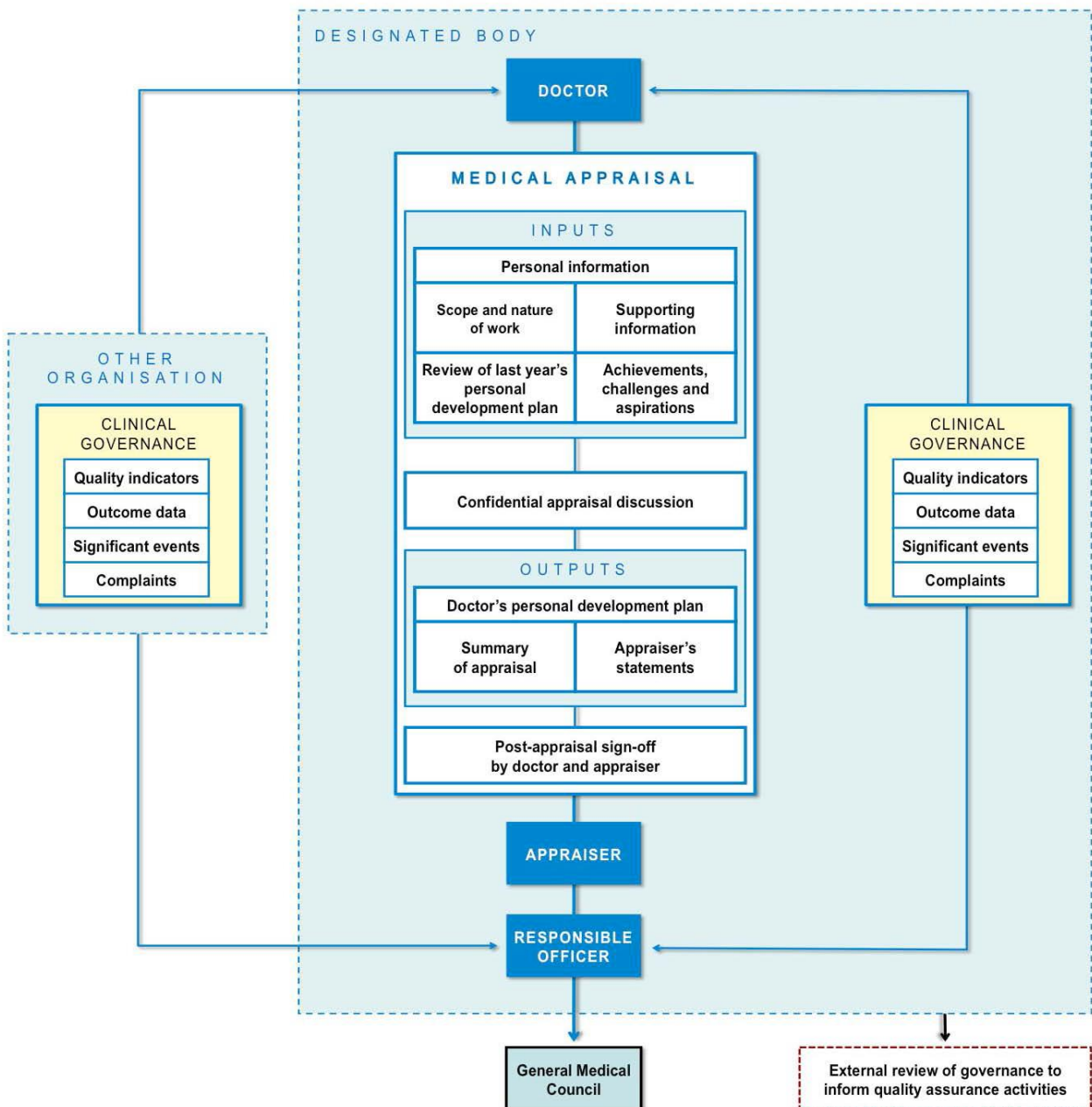
Figure 3: Definition of clinical governance

‘Clinical governance is a framework through which healthcare organisations are accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.’

G. Scally and L. J. Donaldson,

‘Clinical governance and the drive for quality improvement in the new NHS in England’
 BMJ (4 July 1998): 61-65

Figure 4: The relationship between appraisal and clinical governance



Appraisal should be seen as part of the clinical governance framework, not the framework in itself. The outputs of a local clinical governance framework should form a significant component of the inputs to an appraisal. If appraisal forms the greater component of the clinical governance framework a risk arises of displacing the supportive aspects of appraisal, whilst at the same time never fully developing the scrutiny required for effective governance.

This paper promotes the development of clinical governance to reinforce appraisal, and thereby further strengthen governance in a virtuous circle. Broadly, scrutiny occurs through governance; support at appraisal. If the scrutiny is robust and objective, the support will be more effective and vice versa. The two processes are synergistic and most productive when the boundary between them is recognised and observed.

Figure 4 illustrates the relationship between clinical governance and appraisal within the overall context of revalidation. Examples of current practice where clinical governance and appraisal are functioning synergistically in this way are presented at [Appendix F](#).

[\[Back to Executive Summary\]](#)

4.2 Shared responsibility for information gathering

Key points: The doctor and the organisation share responsibility for gathering information about the doctor's practice for overlapping reasons. Doctors and organisations should work constructively to achieve this in the interests of transparency and improving patient care, and of reducing the burden of documentation for doctors.

All organisations need to consider how they achieve this, bearing in mind that the relevant regulations apply regardless of organisational scale or capacity, or the contractual relationship that exists between either the doctor or their organisation and the designated body. Other factors, such as where the population of doctors is largely peripatetic, need to be taken into account. In these situations, networking and discussion are helpful in finding solutions.

The GMC has defined six categories of supporting information which a doctor should present to demonstrate that they are up to date and fit to practise (Figure 5). Specialty organisations have augmented GMC requirements with guidance relevant for their members. A doctor is professionally responsible for presenting all such relevant information at their appraisal, the agreed process for which is described in the ['Medical Appraisal Guide'](#).

Figure 5: GMC categories of supporting information

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

The responsible officer regulations require responsible officers to monitor the professional practice of their doctors. Additionally, any organisation engaging or contracting with a doctor must be able to assure the doctor's fitness to practise in that role. Information is central to this requirement, as Figure 4 indicates.

There are, therefore, both organisational and individual obligations to gather information about a doctor's practice. The categories of information defined by the GMC for revalidation have a strong read-across value in meeting the governance requirements of responsible officers and healthcare organisations. There are, therefore, several advantages to all parties if these processes can be sensibly aligned. These include, but are not limited to:

- A reduction in the burden of documentation on doctors
- Greater objectivity, verifiability and consistency of information leading to better quality appraisal
- A new and valuable perspective on the quality of care for organisations, achieved by the alignment of their information processes to support the generation of information about doctors' practice
- Helping doctors and their organisations to ensure that they are working productively and in line with each other, achieved through discussion about the nature of information to include locally, and then review of the information itself. This advantage can be realised primarily because healthcare organisations and doctors share the common goal of high quality patient care

It may be beyond the remit of the organisation to gather certain types of information for the doctor (for example the doctor's organisation is unlikely to be in a position to gather all of a doctor's continuing professional development activities). However it makes good sense to align the information processes where possible, and in many organisations it should be possible to help compile organisational information on organisation-led continuing professional development, significant events and complaints/compliments; in time, the same should be possible for patient and colleague feedback.

The principle of organisational information being submitted at appraisal is not new. In 2007, a national conference on appraisal proposed a framework using 'Personal' and 'Organisational' information. The GMC guidance on supporting information also makes it clear that team based information is acceptable, provided the doctor reflects on its relevance to their personal practice.

Examples of current practice where clinical governance information is fed into appraisal by the doctor's organisation in this way are presented at [Appendix F](#).

Two additional aspects are worth consideration in relation to these matters:

The nature of the designated body

A wide variety of designated bodies exists in England. Most 'standard' NHS bodies have connections to 100-500 doctors. Designated bodies in the independent sector vary widely in size. Many designated bodies have small numbers of doctors with a prescribed connection. Some of these are themselves small organisations while others are large, but have a small number of doctors within a large work force.

Other designated bodies have large number of doctors working in the organisation, but most of these hold their prescribed connection elsewhere and only a small number hold their prescribed connection with that organisation.

OFFICIAL

One designated body (NHS England) is particularly large, with prescribed connections to around 45,000 doctors. NHS England is unusual in that it is the only designated body with more than one responsible officer. The challenge of consistency is of particular note here, as there is especial need for the NHS England responsible officers to remain in step with each other in terms of agreed expected information.

A similar situation exists in Health Education England, where, although comprising a number of Local Education and Training Boards (LETBs) which individually are designated bodies, there is a particular need for consistency in the approach taken towards all doctors in postgraduate training.

Depending on the scale and nature of the designated body, as well as the contractual arrangements that may or may not exist between the doctor and/or the organisation(s) in which they work and their designated body, the responsible officer may have more or less direct oversight of the clinical governance processes that apply to the doctor. Where this link is less direct, for example in NHS England where the responsible officer is relying on clinical governance processes within practices and Clinical Commissioning Groups, there is a challenge for the responsible officer to have sufficient oversight of the clinical governance process to be confident of discharging their duties under the regulations. Correspondingly there is a requirement on the doctor and those responsible for their supervision at intermediate levels to cooperate with the responsible officer in the discharge of their statutory duties. This situation also exists in the small number of designated bodies which are membership organisations, where the connected doctors tend to work in a geographically dispersed manner, with varying degrees of professional supervision.

While these factors influence the capacity of the designated body to manage medical revalidation and develop its approach to the appraisal inputs line with the principles of this paper, all designated bodies have the same statutory duties. Where a designated body finds that these factors are influencing their ability to deliver their responsibilities, they need to consider how to address this through actions such as networking and working collaboratively with other similar designated bodies.

Examples of current practice where responsible officers and their designated bodies are networking in this way are presented at [Appendix F](#).

The working patterns of the doctors

Doctors' working patterns also have an impact on the challenge faced by the designated body in discharging their statutory duties, in particular where doctors are peripatetic, for example where the designated body is a locum agency.

The challenges for peripatetic doctors and their designated bodies include:

- logistics around appraisal and clinical governance, where the timescale of these processes is out of step with the period of time that the doctor is working in the organisation
- accumulating supporting information is commonly perceived as a greater challenge for a peripatetic doctor
- gathering governance information from the places where a peripatetic doctor has worked to support the doctor's responsible officer's duties requires cooperation between organisations. This is particularly challenging where a doctor is connected

to a designated body, but their practice is largely undertaken in other organisations. For example, a doctor whose prescribed connection is to a locum agency and whose work takes place in a number of other organisations for very short placements

Designated bodies with peripatetic doctors therefore need to consider carefully how they discharge their statutory duties and in keeping with the principles of this paper, how they support doctors in gathering and presenting their appraisal inputs. Again, networking and collaboration are important factors in solving these challenges.

The responsible officer network in England and the All England Appraisal Network are key resources for the challenges that exist in both of these aspects.

An example of current practice where these challenges are being successfully addressed is presented at [Appendix F](#).

[\[Back to Executive Summary\]](#)

4.3 Agreeing expected supporting information locally

Key points: Doctors and their responsible officers should agree the expected supporting information, supplementing the doctor's own information, for presentation and reflection at appraisal. The agreed expected information should take into account GMC requirements, College guidance, local factors and factors specific to the doctor.

Whilst the GMC is clear about the six types of supporting information a doctor must provide at appraisal (Figure 5), the specific information that a doctor will bring varies significantly for several reasons:

- The nature of the doctor's work (e.g. different feedback information applies to a histopathologist and an elderly care physician)
- The doctor's organisation (e.g. different audit information may be available for two gastroenterologists doing similar work, where one is working in a NHS Trust, and one in a private provider unit)
- The logistics of the doctor's work (e.g. different information is available to a full time general practitioner working only in one practice and a peripatetic general practitioner working in several different practices in any one week)
- The structure of the doctor's scope of work (e.g. different CPD information will apply to a doctor working only in one clinical role and a doctor who has a clinical role and is also a responsible officer and medical advisor to a pharmaceutical company)

This creates a challenge of establishing what information a particular doctor is expected to present. Currently the whole responsibility for identifying the content of the appraisal submission rests with the doctor. Advantages to this include that the submission is well-customised to the circumstances of the doctor and the doctor retains control of the appraisal agenda. Disadvantages include that a doctor may fail to appreciate or be aware of relevant information about their practice or, for a variety of reasons, may omit relevant information. Another disadvantage is the burden of documentation on a doctor having to assemble all their supporting information when the essential behaviour being reviewed is their ability to reflect on, not gather, the data. It is therefore desirable to move to a situation where designated bodies support their doctors in gathering and providing information for their appraisal.

The principle of agreement is important in this. A responsible officer should not unilaterally specify requirements for appraisal inputs for a doctor or group of doctors. Nor should a doctor or group of doctors reject sensible proposals without good reason. It is therefore important that this is a shared activity between a responsible officer and their doctors. The mechanism by which such expected supporting information is agreed will vary according to the designated body in question.

The agreed expected information should be in line with GMC and College guidance, and in keeping with local circumstances. These include key local quality initiatives and circumstances individual to the doctor, such as the presence of a concern about the doctor's practice. The discussions should also address whether the doctor or organisation is expected to assemble the information. Once agreed, the designated body should provide individual doctors with a list of the expected information (and, where agreed, the information itself) in a timely manner before each doctor's appraisal. The doctor's role is then purely to review the information and provide their reflection on it, or if they do not submit it, provide an explanation as to why not.

The template at Appendix D (Section 8) is a suitable format within which a responsible officer can notify a doctor of their agreed expected items of information. The doctor should present this list under the 'Additional Information' section of their appraisal submission and reflect on the items it contains in their appraisal submission. This can be either in the 'Additional Information' section, or in the section of the appraisal paperwork to which each item relates, as appropriate.

It should be noted that such reflection may comprise a review by the doctor and a comment on why the information is not relevant to their practice.

[\[Back to Executive Summary\]](#)

4.4 Assessing the appraisal inputs: responsibilities and escalation

Key points: A doctor must ensure that their appraisal inputs demonstrate fitness to practise across their scope of work. Their responsible officer must be assured that the doctor's appraisal inputs support a recommendation of fitness to practise. The appraiser provides this assurance via the appraisal outputs.

GMC requirements are the primary reference, supported by Academy, College and other professional body guidance, and local agreements about supporting information. Where there is uncertainty, the doctor, appraiser and responsible officer must strive for agreement, with input from other sources of expertise if appropriate. This discussion should occur prior to the appraisal meeting.

As indicated above, defining specific expectations of supporting information beyond what is already set out in existing guidance is difficult. This leads to a subsequent challenge in developing reliable methods of assessment of doctors' appraisal inputs, given that this is more a qualitative than a quantitative assessment. The decision about whether the appraisal inputs are sufficient to demonstrate fitness to practise across a doctor's scope of work falls to three key people: the doctor, their appraiser and the responsible officer.

Doctors, appraisers and their responsible officers should adopt the following principles-based approach to assessing a doctor's appraisal inputs, using the escalation set out

OFFICIAL

when there is uncertainty about whether or not the information provided is sufficient to demonstrate fitness to practise:

- The GMC guidance is the foundation of the assessment as to whether a doctor's appraisal inputs are sufficient to demonstrate fitness to practise. The assessment may also be informed by College and other professional body guidance and local agreement about expected information.
- The doctor must make a personal professional judgement about whether their appraisal inputs are sufficient to demonstrate their fitness to practise in all areas of their scope of work, before submitting them for their appraisal. The doctor should be capable of justifying their reasoning.
- In the absence of a formal statement to this effect on the appraisal form, submission of the appraisal paperwork to the appraiser is to be taken as indicating that the doctor is of the view that their appraisal inputs are sufficient.
- A doctor who is not able to state with confidence that their appraisal inputs are sufficient should discuss this, initially with the person with clinical governance responsibility in the relevant area, then with their appraiser, and/or with their responsible officer, prior to submitting it for their appraisal.
- The appraiser should assess whether a doctor's appraisal inputs appear to be sufficient before the appraisal discussion.
- An appraiser who is not able to state with confidence that the doctor's appraisal inputs are sufficient should raise this with the doctor before the appraisal and not as part of the appraisal discussion. They must articulate the reasons for their judgement and may offer advice on how the doctor can address this. It may be appropriate to postpone the appraisal to facilitate this.
- After discussion with the doctor an appraiser who remains unable to state that the appraisal inputs are sufficient should raise the matter with the responsible officer before the appraisal.
- A responsible officer who, after discussion with the doctor, remains unable to state that the appraisal inputs are sufficient may raise the matter with the person responsible for clinical governance in the relevant area of the doctor's scope of work. This is to establish the governance arrangements that apply to the doctor in that setting and thus whether there are means whereby the doctor can be supported appropriately to assemble sufficient information. If the matter remains unresolved after this, the responsible officer should take advice on the next steps from a variety of sources, depending on the circumstances. Possible sources of such advice include other responsible officers in the responsible officer network, the local GMC Employer Liaison Advisor and the regional responsible officer.
- It may be necessary to postpone the appraisal if a doctor and their responsible officer are not able to reach agreement on whether the doctor's appraisal inputs are sufficient. If a revalidation recommendation is pending, it may also be necessary to arrange a deferral in order to resolve the matter.

An example of current practice where doctors' appraisal inputs are assessed in this way is presented at [Appendix F](#).

[\[Back to Executive Summary\]](#)

5 Areas for special consideration

5.1 Concerns about practice

Key points: Concerns about a doctor's practice must be included for reflection at appraisal. However the prime purpose of doing so is to prompt reflection rather than judgement. The local management of a concern (including whether to involve the GMC) is the remit of the responsible officer.

A doctor should be provided with details of any concerns for presentation and reflection at appraisal by their organisation(s).

Individual information about a doctor's practice will range from that indicating excellence to that relating to concerns. Every doctor must include any concerns about their practice for reflection and discussion at appraisal. Failure to do so may in itself constitute a concern about probity on the part of a doctor.

As described in Section 4.1, given that the proper mechanism for addressing a concern is via the governance mechanisms of an organisation, appraisal represents an opportunity to reflect on the matter from a developmental perspective, turning it into a valuable trigger for reflection, learning and improvements to practice. Therefore, the inclusion of a concern in the appraisal submission has a formative focus, distinct from the governance process around the concern itself.

As an early step in developing agreed expected information, responsible officers and those with clinical governance responsibility in places where a doctor is working should develop systems to provide the doctor with details of their complaints in a timely manner prior to their appraisal.

Examples of current practice where complaints data are provided to doctors in this way are presented at [Appendix F](#).

[\[Back to Executive Summary\]](#)

5.2 Varied scope of work

Key points: Under certain circumstances a doctor with a varied scope of work may present evidence from the governance framework from individual areas of work, provided this is verifiable and in keeping with GMC requirements, rather than a full suite of supporting information for each area. Where the governance processes within an individual role do not provide any such evidence, the doctor should provide self-review with reflection as a minimum.

Annual medical appraisal must cover the full scope of a doctor's work. It is increasingly the norm for a doctor to describe several professional roles in their scope of work. As mentioned in Section 4.4, a layer of complexity is created when a doctor has a varied scope of work, in terms of providing sufficient supporting information in a manner that is not excessively onerous, and yet permits them to demonstrate that they are up to date and fit to practise in each role.

If a doctor has several areas in their scope of work, this could be interpreted by some as increasing the requirement for the number of items of supporting information that they must provide. It would soon become unmanageable if a doctor is expected to

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produce evidence from each of the six GMC categories of supporting information (Figure 5) in each of their separate professional roles at each appraisal.

As already stated in Section 4.2 an organisation engaging a doctor also has a duty to provide a clinical governance framework around that doctor. The person responsible for clinical governance in an individual area of a doctor's scope of work should be able to describe the governance framework within which the doctor works. Therefore, in some situations, rather than a doctor accruing a complete set of supporting information in every role, it may be sufficient to provide evidence of compliance with the governance processes at each engaging organisation as evidence of keeping up to date and fit to practise in that role. Such a framework of governance must cover the domains of Good Medical Practice and the GMC guidance 'Supporting Information for Appraisal and Revalidation', in the context of the work the doctor is doing. The template in-role review form in Appendix B (Section 8) provides a suitable format for this summary.

Evidence of such compliance with local governance processes is primarily a clinical governance matter. At the same time, presentation of the evidence is legitimate in terms of its providing the basis of reflection by the doctor. In keeping with the principles in Section 4.1, in the absence of the evidence indicating a concern about the doctor's fitness to practise, a responsible officer may regard submission of such evidence at appraisal as sufficient in terms of clinical governance assurance of the doctor's fitness to practise in that role.

This approach will not always be suitable and should generally only be used for subsidiary non-clinical roles. A balance needs to be struck between the need to provide assurance of fitness to undertake a role, based primarily on the level of risk associated with the role, and the burden of documentation on the doctor. For roles with very low associated risk, it may be acceptable for a less structured process of review in that role to be agreed between the doctor and their responsible officer. It is appropriate, however, for a doctor will need to provide a full suite of supporting information at appraisal for every clinical and significant non-clinical role, unless the evidence of their compliance with the clinical governance framework in that role is particularly comprehensive and detailed. If in doubt the doctor should discuss the matter with their responsible officer before submitting their appraisal inputs.

Where a doctor works in a setting where such assurance is not available, then they need to consider how to provide assurance at their medical appraisal of their fitness to undertake that role. As a minimum this may take the form of a self-review by the doctor on whether they are sufficiently up to date and fit to practise in that role, for discussion at their appraisal. The template in-role review form in Appendix B (Section 8) again provides a suitable format for such a self-review when completed alone by a doctor. It is also suitable for use in an informal peer-review context which may provide an added level of objectivity to the process.

An example of current practice where the clinical governance processes in other organisations where a doctor is working produce a report suitable for the doctor to present at their appraisal in this way is presented at [Appendix F](#).

[\[Back to Executive Summary\]](#)

5.3 Information shared about a doctor's practice

Key points: Processes for sharing information about a doctor's practice are the remit of clinical governance and are outside the scope of this paper. However, the information shared is relevant to doctors as a prompt for reflection at appraisal. A doctor should therefore be provided by their organisation(s) with such information for presentation and reflection at appraisal.

The matter of appropriate sharing of information about a doctor's practice to and from their responsible officer is increasingly recognised as important. Such required information must be carefully defined, flow effectively along the correct pathways, and issues of patient safety must be properly balanced with data protection and information governance rules and regulations.

These flows and the rules which govern them are the remit of clinical governance processes and are not within the scope of this paper. However, the information shared is highly relevant to appraisal in that it commonly constitutes valuable material for reflection on the part of the doctor.

Sharing such information is consistent with the principle of human resource management that a doctor should be closely involved in any discussions relating to their practice. In the vast majority of cases the doctor has the legal right of access to the information. For these reasons making such information routinely available for reflection at appraisal as part of the agreed expected information is to be encouraged.

[\[Back to Executive Summary\]](#)

5.4 The nature of the doctor's work

Key points: Where the nature of a doctor's work means that GMC requirements and other relevant guidance on appraisal inputs do not immediately seem relevant, the doctor should: assume that they are expected to gather the information in question, think broadly about how to gather the information, take advice on how they might gather the information or a modified version and seek agreement from their responsible officer before deciding on the most appropriate course of action.

As mentioned in Section 4.3, the nature of a doctor's work will influence the nature of their appraisal inputs. For obvious reasons, GMC requirements and most specialist body guidance focuses on a doctor's clinical work, and are written accordingly. This creates a challenge for doctors who either have no clinical role or who have non-clinical roles, to present appraisal inputs which are consistent with the guidance. GMC guidance does refer to this under the topic of feedback from patients (Figure 6).

Figure 6: GMC comments on patient feedback for doctors that do not see patients, or cannot collect feedback from their patients

You should assume that you do have to collect patient feedback, and consider how you can do so. We recommend that you think broadly about who can give you this sort of feedback. ... If you believe that you cannot collect feedback from your patients, you should discuss this (as well as any alternative ways to engage with your patients) with your appraiser.

Supporting information for appraisal and revalidation, GMC 2013

The principles behind this passage of GMC guidance are helpful in relation to any aspect of the appraisal inputs. These are that the doctor should:

- assume that they should gather the information in question
- think broadly about how to gather the information
- take advice on how to gather the information
- seek agreement from their responsible officer (commonly via their appraiser) before deciding that on the appropriate course of action

For example, considering significant events, while the GMC guidance on significant events refers to events which ‘...could or did lead to harm of one or more patients.’ a doctor in a wholly managerial role who sees no patients may think more broadly about the subject and include events in which a proportionately significant negative outcome occurred as a result of their actions, even though patients were not directly harmed.

With respect to feedback from patients, Appendix E (Section 8) contains an algorithm to assist doctors, appraisers and responsible officers in terms of considering how to obtain feedback from patients by doctors for whom this is a challenge.

[\[Back to Executive Summary\]](#)

5.5 Supporting information gathered outside the UK

Key points: supporting information gathered outside the UK may be acceptable as part of a doctor’s appraisal submission, provided the responsible officer is satisfied that the information is in keeping with GMC requirements, can be verified and is relevant to the context of the doctor’s scope of work in the UK.

A doctor’s appraisal submission is normally compiled from supporting information relating to the doctor’s practice in the UK, in the context of their GMC licence to practise. Some doctors undertake only a small amount of practice in the UK, and as a result may have difficulty in gathering sufficient supporting information to support assurance of their fitness to practice.

The responsible officer must be confident that the doctor is presenting as much supporting information from their UK practice as is possible. They will also need to be satisfied that any supporting information based on non-UK practice is in keeping with GMC requirements, verifiable and relevant to the context of the doctor’s UK practice, before giving approval to its inclusion in the doctor’s appraisal inputs.

[\[Back to Executive Summary\]](#)

5.6 Designing local quality initiatives to support appraisal

Key points: The designing of local quality initiatives to help doctors generate evidence for appraisal and vice versa is to be encouraged as beneficial to doctors, designated bodies and patient care. Examples of such initiatives should be shared between organisations.

This paper has discussed how clinical governance processes may enhance appraisal by providing the base material to support reflection by a doctor. It is possible that a

reciprocal benefit may be achieved, where local clinical governance harnesses the outputs of reflective activity by doctors to inform local quality improvement activities.

Where initiatives such as systematised quality improvement programmes, continuing professional development, case review, significant event analysis, patient/colleague feedback exercises, complaints and compliments are developed in agreement between local organisations and their doctors, these can generate benefits to the service, doctors and the patients for whose care they share responsibility. They can also assist doctors in respect of their appraisal and personal development by imparting skills in effective reflection.

Inviting doctors to participate in locally defined clinical review processes, in which the outputs are made available to the doctor in a suitable format to present and reflect upon at their medical appraisal, is therefore a positive proposition. Similarly, the concept of doctors being invited to share their appraisal reflections with locally defined service review projects is equally positive.

Participation in such initiatives should be by consent, with discussion and consensus helping to shape the nature and content of such processes in a way that reaps the greatest benefits to patients, doctors and the organisation.

It should be noted that there is no role for the extraction of information from appraisal documentation held by a designated body, for any purpose other than discharge of the responsible officer's duties under the responsible officer regulations, without the consent of the doctor in question.

An example of current practice where the local responsible officer and doctors have agreed to participate in local quality initiatives, the outputs from which are suitable for the doctors to use at appraisal is presented at [Appendix F](#).

[\[Back to Executive Summary\]](#)

5.7 Volume of work

Key points: Depending on the nature of the work, a doctor undertaking a lesser volume of work in an area may need to take increasing care that their appraisal inputs are sufficient to demonstrate fitness to practise in that area.

Consideration of whether a doctor's volume of work is sufficient for them to maintain fitness to practise in an area should be part of every doctor's governance process in each area of their scope of work. A doctor who is undertaking a smaller volume of work in an area should take increasing care to describe why in their judgement they remain up to date and fit to practise in that role. This applies whether the role in question is a doctor's only professional activity or is one role in a portfolio of other roles. It is also likely to apply more particularly when the role in question is clinical. The framework in Appendix C (Section 8) is intended to assist with making judgements about whether a doctor's supporting information is sufficient, when taken into context with the volume of work the doctor is undertaking in that role.

[\[Back to Executive Summary\]](#)

5.8 Doctors in postgraduate training

Key points: A doctor in postgraduate training who undertakes any professional role outside their training programme must declare this and submit information about it as set out in their Annual Review of Competence Progression (ARCP) scheme.

The supervision and support of a doctor in postgraduate training is managed within the Annual Review of Competence Progression (ARCP) process, and not the medical appraisal process.

The ARCP review process requires a doctor to declare if they are undertaking any work outside the remit of their training programme, such as locum work.

It follows that an organisation engaging a doctor in training in this way must include them in their overall governance framework and be prepared to provide information about this to the doctor and/or their responsible officer (in this case the dean) in a manner consistent with the principles described in this document.

[\[Back to Executive Summary\]](#)

6 Conclusion

Medical appraisal is now a universal process for the profession, supporting accountability, professional development and patient care. The quality of a doctor's appraisal inputs is fundamental to the quality of their appraisal. Organisations and doctors share the responsibility for gathering information about practice to support appraisal and clinical governance processes. Doctors and their organisations should agree items of information to support these needs. To minimise the burden of documentation and increase objectivity organisations should, where feasible and appropriate, provide this information to their doctors. Examples of good practice exist in these areas and some of these are listed in [Appendix F](#). Doctors and their organisations can make progress in improving the quality of appraisal inputs by learning from these examples and using the tools contained within this paper.

[\[Back to Executive Summary\]](#)

7 References

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A guide for doctors to the General Medical Council (Licence to Practise and Revalidation) Regulations 2012 (GMC, 2012) http://www.gmc-uk.org/Revalidation_guidance_for_doctors.pdf 54232703.pdf

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www.gmc-uk.org/doctors/revalidation/revalidation_information.asp.

The good medical practice framework for appraisal and revalidation (GMC, 2013)

www.gmc-uk.org/doctors/revalidation/revalidation_gmp_framework.asp.

The Medical Profession (Responsible Officers) Regulations 2010 (Her Majesty's Stationery Office, 2010) www.legislation.gov.uk/id/ukdsi/2010/9780111500286.

The National Health Service (Performers Lists) (England) Regulations 2013

<http://www.legislation.gov.uk/uksi/2013/335/contents/made>.

8 Appendices

In this section are provided tools designed to help doctors and responsible officers make operational the principles of this paper. Many designated bodies have already developed similar tools. Due to the networking aspects of revalidation, it is highly desirable that all designated bodies use similar approaches and documentation where possible. Responsible officers are therefore strongly encouraged to adopt the tools provided here where possible. Where the adoption of a tool would be disruptive to local processes, it would be very helpful for this to be communicated upwards in the responsible officer network, so that the matter can be debated and resolved.

[Appendix A Doctor's medical appraisal checklist](#)

[Appendix B Generic in-post review template](#)

[Appendix C Assessing supporting information in context of volume of work](#)

[Appendix D Template for agreed expected information at appraisal](#)

[Appendix E Obtaining patient feedback in non-standard situations](#)

[Appendix F Examples of existing good practice in relation to appraisal inputs](#)





















[\[Back to Executive Summary\]](#)

Appendix A: Doctor's medical appraisal checklist

This appendix presents a distillation of existing guidance on supporting information, with additional clarification where this has emerged over time, in the format of a checklist for use by doctors prior to submitting their appraisal inputs. It should also be useful to appraisers, appraisal leads and responsible officers as a convenient reference tool.

This checklist is also available as a [standalone interactive document](#), which takes the form of a single page PDF, with the detailed guidance on each item hidden behind the relevant help button. The checklist also forms a new section of the updated [MAG form \(NHS England 2016\)](#).

Doctor's medical appraisal checklist

General		
	What this checklist is for – background	
<input type="checkbox"/>	Previous appraisal record – submitted	
<input type="checkbox"/>	Scope of work – completed, with reflection, including governance arrangements and conflicts of interest	
<input type="checkbox"/>	Reflection – present throughout submission	
<input type="checkbox"/>	Confidentiality – identifiable information removed/redacted	
Supporting information		
<input type="checkbox"/>	Personal details – completed and up to date	
<input type="checkbox"/>	Overall – supporting information matches my scope of work	
<input type="checkbox"/>	Review of last year's PDP – present	
<input type="checkbox"/>	CPD – listed, compliant with guidance, with reflection	
<input type="checkbox"/>	Quality improvement activities – listed, compliant with guidance, with reflection	
<input type="checkbox"/>	Significant events (also known as an untoward or critical incidents): all unintended or unexpected events, which could have or did lead to harm of one or more patients – listed, with reflection, or confirmed none to include	
<input type="checkbox"/>	Feedback from colleagues – submitted, with reflection, or date last submitted	
<input type="checkbox"/>	Feedback from patients – submitted, with reflection or date last submitted or confirmation not necessary (agreed by responsible officer)	
<input type="checkbox"/>	Complaints and compliments – all complaints listed, with reflection, or confirmed none to include. Compliments listed (optional), with reflection	
<input type="checkbox"/>	Achievements, challenges and aspirations – completed (optional – may be raised verbally at appraisal)	
<input type="checkbox"/>	Probity declaration – completed; suspensions, restrictions or investigations listed if present, with reflection	
<input type="checkbox"/>	Health declaration – completed	
<input type="checkbox"/>	Additional information – listed, or confirmed none expected, or explanation why absent	
<input type="checkbox"/>	Review of GMC 'Good Medical Practice' domains – completed	
<input type="checkbox"/>	New PDP ideas – listed (optional – may be raised verbally at appraisal)	

(Ctrl +) click  for explanatory notes on an item

Doctor's medical appraisal checklist**Appendix A: Explanatory notes for the doctor's medical appraisal checklist****What this checklist is for**

Medical appraisal has four purposes¹:

1. To allow you to demonstrate your fitness to practise for revalidation
2. To help you enhance the quality of your work by planning your professional development
3. To help you consider your own needs
4. To help you work productively and in line with your organisation.

By submitting your appraisal portfolio two weeks in advance, the first and fourth purposes can largely be completed before the appraisal, creating greater scope to focus on personal and professional developments to improve your practice when you meet your appraiser.

Revalidation has been designed in such a way that, as a professional, you provide the first level of assurance of your fitness to practise in the form of your appraisal submission. You should therefore only finalise your submission to your appraiser when you are confident that it provides this assurance.

The checklist to which these explanatory notes refer aims to help you with this. Founded on GMC guidance², it addresses the essential requirements of a satisfactory appraisal portfolio. It also indicates where College and other professional body guidance are relevant^{3, 4}, as well as where local processes might also define certain expected aspects of your submission.

The information which comprises the appraisal inputs falls into five headings:

1. Personal information
2. Scope and nature of work
3. Supporting information
4. Review of previous personal development plan
5. Achievements, challenges and aspirations

This checklist helps you to consider each category based on existing guidance and current thinking since that guidance was written.

You should find it helpful to review your appraisal submission using this checklist as a final step before submitting it for review by your appraiser.

Where you are uncertain about any of the parameters listed, you can refer to these explanatory notes by using the help symbol to the right of the item on the checklist. If you remain uncertain, you should contact your appraiser for advice before you finalise your submission.

1, 2, 3, 4 [Further information can be found here](#)

[Return to checklist](#)

Explanatory notes for the doctor's medical appraisal checklist:**General****Previous appraisal record** – submitted

Tick if:

I have provided my last appraisal summary.

[Return to checklist](#)**Scope of work** – completed, with reflection, including governance arrangements and conflicts of interest

Tick if:

I have listed the organisations and locations where I have undertaken work as a licensed medical practitioner in the interval since my last appraisal, and provided a comprehensive description of the scope and nature of my practice.

(GMC and Academy^{2, 4} guidance states that you should record the scope and nature of all of your professional work. This should include all roles and positions for which a licence to practise is required, and should include work for voluntary organisations, work in private or independent practice and managerial, educational, research and academic roles.

Full and accurate declaration of their full scope of work has become recognised as a vital factor in supporting the rest of the process. This is because assessment of the rest of the doctor's supporting information requires the appraiser to be fully informed about all the work the doctor is doing in order to judge that, in the round, the doctor's supporting information reflects that the doctor is keeping up to date and fit to practise in all of their professional roles.

Types of work may be categorised into:

- Clinical commitments
- Educational roles, including academic and research
- Managerial and leadership roles
- Any other roles.

As well as listing each your roles you should describe the nature of your work in that role, and the governance arrangements within which you work in each role. You should upload any supportive information relating to your governance in a role such as in-post reviews/appraisals and personal objectives, under 'Additional Information' in your appraisal submission. If there is no formal governance in a role, you should make note of this fact, and comment on how you ensure your fitness to practise in that role, for example through activities such as self-review, peer review, self-directed learning and quality improvement.

You should reflect on your overall scope of work, and in particular make reference to whether any conflicts exists within it which would require action on your part.

^{2, 4} [Further information can be found here](#)

[Return to checklist](#)

Reflection – present throughout submission

Tick if:

I have reflected adequately on all the sections of my preparation.

(The GMC requires you to reflect on your supporting information and this is supported by Academy guidance⁴ (Figure 1).

Put simply you are expected to explain the relevance of the presented information to your practice and describe the actions you have taken or plan to take as a result.

In greater depth it may include a description of how you have shared, or plan to share, the learning with colleagues or changed, or plan to change, relevant systems).

Figure 1: Academy guidance on reflection

‘Reflection is a common theme running through the supporting information and the appraisal discussion. It should not be a complex or time-consuming process, and essentially involves considering each element of the supporting information, thinking about what you have learned and documenting how this learning has influenced your current and future practice.’⁴

⁴ [Further information can be found here](#)

[Return to checklist](#)

Confidentiality – identifiable information removed/redacted

Tick if:

I have removed or redacted all patient and staff personal identifiable information or there is no such information to remove or redact⁵.

(You must take care to ensure that your whole appraisal submission is free from patient and staff personal identifiable information. In particular, due to data protection issues, the attaching of original material from significant events, complaints and compliments to your appraisal submission is not encouraged. It is recommended that you refer to them and provide your reflection on them in your appraisal submission but provide any supporting documentation separately to your appraiser.)

⁵ [Further information can be found here](#)

[Return to checklist](#)

Explanatory notes for the doctor’s medical appraisal checklist:**Supporting information****Personal details** – completed and up to date

Tick if you have, as a minimum, provided:

- your name
- your GMC number
- your medical and professional qualifications
- your contact details. In practice this means:
 - a working postal address
 - a working e-mail address
 - a working telephone number, whether land line or mobile.

In this context ‘working’ means one from which you will respond in a timely manner to correspondence or calls received. Your personal details must be updated as they change, and reviewed no less frequently than at each appraisal.

[Return to checklist](#)

Overall – supporting information matches my scope of work

Tick if:

I am confident that there is a good breadth to my supporting information and this allows me to assure my fitness to practise in all areas in which I am professionally active. Where there may be gaps I have highlighted these in my submission for discussion at my appraisal.

(Whilst you may not always present a full suite of supporting information for every role that you do at every appraisal (Figure 2), you should be able to make the case that your supporting information gives sufficient broad assurance of your fitness to practise, over a revalidation cycle.

This may require some consideration and professional judgement. For example if you are active in front line clinical service, you would be expected to include a significant amount of clinical CPD in your appraisal submission every year, but if your scope of work includes being a referee for a medical journal, you may undertake a lesser volume of CPD in that role over a longer than annual cycle. For some roles it may be legitimate to provide more supporting information in some years and less in another, and you might refer to this in your commentary on that role.

It is good practice to refer to this issue in each appraisal, and to review your supporting information across your full scope of work

with your appraiser as your revalidation cycle progresses. This will help ensure that you do not suddenly find that you need to provide a large amount of supporting information across several roles in the year prior to your revalidation.

If this is your last appraisal prior to your revalidation date and you are in any doubt that your supporting information gives broad assurance of this nature it is advisable that you discuss this with your appraiser prior to finalising your submission.)

Figure 2: Academy of Medical Royal Colleges on matching supporting information to scope of work

‘Although the supporting information brought to appraisal for revalidation should cover the whole scope of a doctor’s practice, this coverage does not have to take place every year of the five year cycle. It is permissible for a doctor to concentrate on specific areas of practice each year, and then to discuss with their appraiser how and when the remaining areas will be covered during the five-year cycle.’⁴

⁴ [Further information can be found here](#)

[Return to checklist](#)

Review of last year’s PDP - present

Tick if:

I have provided my PDP from my last appraisal and commented on my progress with each item.

(You do not have to have achieved all your planned items, but if you have not completed one or more it is important that you describe why this has occurred. It will be helpful to indicate if you wish to carry forward to next year’s PDP any items you have not completed.)

[Return to checklist](#)

CPD – listed, compliant with guidance, with reflection

Tick if:

My listed Continuing Professional Development (CPD) meets the GMC requirements, it takes into account College and other relevant guidance and it

covers my whole scope of work (see advice under 'Overall – supporting information matches my scope of work', above). I have reflected on my CPD.

(Your CPD must meet the GMC requirements, take into account College and other relevant guidance and cover the doctor's whole scope of work.

It is important to reflect on individual activities of CPD as you do each one, and most CPD recording vehicles include this as standard. It is also important that, in preparation for your appraisal, you review your CPD 'in the round', and comment on how effective it has been in helping you remain up to date and fit to practise in all your professional roles.

Doctors should approach their training requirements proactively. Initiatives to facilitate this are welcome and the sharing of good practice in this area is to be encouraged. While prime responsibility for your personal learning rests with you, bearing in mind the shared responsibilities described in Section 4, the organisation also has a role in supporting your learning. Such activities might include, but are not restricted to:

- providing relevant structured training for new doctors
- providing vehicles such as e-learning
- facilitating team protected training
- supporting learning based on case discussions, complaints and significant events
- developing benchmarking data/audits etc. to prompt individual and team peer review
- nurturing champions for appropriate clinical areas
- analysing learning needs identified via appraisal and other means, and providing suitable training as a result.

It should therefore be clear that a broad and imaginative approach to CPD is to be encouraged. Volume, content, format (be it externally provided or self-directed) or indeed timing of CPD is not specified in the GMC guidance. Specialty guidance offers a degree of detail additional to GMC guidance and if you are a doctor practising within the remit of a College or other appropriate professional body you should take note of this. In practise the volume, content, type of delivery and timing of CPD activity must be individually tailored to your specific needs and interests in the context of your scope of work. As noted in the GMC's guidance, CPD should focus on outcomes or outputs rather than on inputs and a 'time-served' approach.

In addition to the above, how you meet your learning needs will depend on your preferred ways of learning, the objectives of the learning and the opportunities available.

If you are planning to undertake 'non-traditional' learning activities you may find it helpful to discuss this with the person with clinical governance responsibility in your place of work, your appraiser or your responsible officer, to ensure that the planned activity is legitimate and as effective for you as possible.

Mandatory training

An organisation may specify training activities for its employees. These are commonly referred to as 'mandatory training' and may include, while not being limited to: equality and diversity training, information governance, fire training and manual handling. Such activities are commonly contractually specified. While they may or may not relate directly to your professional duties, the activities usually fall

under the umbrella of CPD, and completion can be seen broadly in the context of the GMC domains of ‘Good Medical Practice’.

You should therefore undertake any mandatory training to which you are contractually committed, unless you obtain exemption from the organisation. Whilst items of mandatory training may therefore be part of the agreed expected information for appraisal it should be recognised that the purpose of including them is primarily to prompt your reflection. The function of confirming that the activities have been completed rests with the governance processes of the organisation.)

[Return to checklist](#)

Quality improvement activities – listed, compliant with guidance, with reflection

Tick if:

My listed quality improvement activities meet the GMC requirements, take into account College and other relevant guidance and cover my whole scope of work (see advice under ‘Overall – supporting information matches my scope of work’, above). I have reflected on my quality improvement activities.

(The quality improvement activities listed by a doctor must meet these GMC requirements (Figure 3). A doctor should also take into account College and other relevant guidance and consider the quality improvement activities they are presenting in the context of their whole scope of work (as described above). The doctor must reflect on their quality improvement activities.

It is important that, in preparation for their appraisal, the doctor reviews their quality improvement activities ‘in the round’, and comments on how effective they have been in helping the doctor remain up to date and fit to practise in all their professional roles.

For the purpose of illustration, examples of activities which are acceptable within this category include but are not limited to:

- Case reviews
- Clinical data collection exercises
- Reviews of clinical outcomes
- A quality improvement data exercise or audit (group or personal)

Whilst there is clear benefit to undertaking personal activities in this area, the GMC does not require quality improvement activities to be individually driven by the doctor. Activities undertaken within a team, practice, department, organisation or nationally may all qualify for reflection in this category. In all examples, the consistent requirements are that the doctor is able to analyse the data presented, identify its relevance to their practice and indicate actions which they have taken or plan to take as a result.)

Figure 3: GMC requirements on quality improvement activities

‘You will have to demonstrate that you regularly participate in activities that review and evaluate the quality of your work. Quality improvement activities should be robust, systematic and relevant to your work. They should include an element of evaluation and action, and where possible, demonstrate an outcome or change.

Quality improvement activities could take many forms depending on the role you undertake and the work that you do. If you work in a non-clinical environment, you should participate in quality improvement activities relevant to your work.’²

² [Further information can be found here](#)

[Return to checklist](#)

Significant events (also known as untoward or critical incidents): all unintended or unexpected events, which could have or did lead to harm of one or more patients – listed, with reflection or confirmed none to include

Tick if:

I have included all such events in which I have been involved since my last appraisal submission.

(You must present all events meeting the GMC definition (Figure 4), with reflection, or confirm that there are none to include, as part of your appraisal submission.

In many well led services there are processes for capturing events of this nature. At a more formal level these include Serious Untoward Incidents (SUI) or Serious Incidents Requiring Investigation (SIRI); at a more local level they include

Figure 4: GMC definition of significant events

'all unintended or unexpected events, which could have or did lead to harm of one or more patients'²

untoward or critical incidents. Other sources also exist, such as Coroner reports. In locations where there are well developed systems, you may need to make a judgement about which events to present in this section, depending on the degree of harm/potential for harm and whether your involvement was central or peripheral. While it is good practice to present reviews of events from which you have derived learning but which may not meet the GMC definition or in which your involvement was peripheral, it is more appropriate to place these in the Quality Improvement Activities section. The Quality Improvement Activities section is also the more suitable section to submit events with a positive outcome.

If you work in an environment in which the capturing and analysis of such events are not part of local procedures, you must still note and include all events which meet the GMC definition above, whether or not this has been addressed in an official capacity.

It is acceptable for you not to list any events in this section if none meeting the GMC definition have occurred since your last appraisal, but if this is the case you should positively indicate that there are none, in the interests of clarity. Your appraiser may also explore with you the effectiveness of your processes for identifying significant events.

If you have managerial responsibility for significant events in your organisation, you should present this, along with your reflection on your effectiveness in this regard, within the Quality Improvement Activities section of your appraisal submission.

The direct attaching of original material from significant events to your appraisal submission is not encouraged as the nature of such material often makes true anonymisation difficult. It is recommended that you refer to them and provide your reflection in your appraisal submission but provide any supporting material separately to your appraiser.)

² [Further information can be found here](#)

[Return to checklist](#)

Feedback from colleagues – submitted, with reflection, or date last submitted

Tick if:

I have included a formal colleague feedback exercise in keeping with GMC and relevant College or other guidance and reflected on the results,

or

I have already presented a formal colleague feedback exercise in this revalidation

cycle and recorded the date that this was completed in this appraisal submission,
or

I have not yet completed a formal colleague feedback exercise in this revalidation cycle, but have pointed this out in my appraisal submission for discussion with my appraiser⁵.

(GMC guidance² is for a minimum of one colleague survey, compliant with GMC requirements⁶, about the individual doctor to be completed during each five-year revalidation cycle². You are expected to reflect on the results of these surveys individually and with your appraiser and to identify lessons learned and changes to be made as a result.

If you have several different positions and roles in your scope of work, it may be appropriate for you to undertake separate colleague feedback exercises in more than one of these roles. This is partly because the design of one survey is typically structured towards a particular type of role, for example questionnaires designed for clinical and management settings may differ. You should also consider whether the survey(s) you are using ensure you have obtained feedback from sufficient numbers and categories of colleagues across your full scope of work.)

2, 5, 6 [Further information can be found here](#)

[Return to checklist](#)

Feedback from patients – Submitted, with reflection, or date last submitted or confirmation not necessary (agreed by responsible officer)

Tick if:

I have included a formal patient feedback exercise in keeping with GMC and relevant College or other guidance and reflected on the results,

or

I have already presented a formal patient feedback exercise in this revalidation cycle and recorded the date that this was completed in this appraisal submission,

or

I have not yet completed a formal patient feedback exercise in this revalidation cycle, but have pointed this out in my appraisal submission for discussion with my appraiser⁷,

or

I have agreed with my responsible officer that patient feedback is not appropriate in the context of my scope of work, and have noted this in my appraisal submission.

(GMC guidance is for a minimum of one patient survey, compliant with GMC requirements, about the individual doctor to be completed during each five-year revalidation cycle². You are expected to reflect on the results of these surveys individually and with their appraiser and to identify lessons learned and changes to be made as a result.

In keeping with views expressed by patients, this should be viewed as a minimum, and you may wish to present patient feedback, both formal and informal more frequently than this, in order to ensure you obtain feedback from sufficient numbers and categories of patients across your full scope of work, and to support your personal learning about improving your practice most effectively.

For doctors who have no patient contact, the GMC comments: 'You should assume that you do have to collect patient feedback, and consider how you can do so. We recommend that you think broadly about who can give you this sort of

feedback. For instance, you might want to collect views from people who are not conventional patients but have a similar role, like families and carers, students, or even suppliers or customers’.

If you believe that patient feedback may not be necessary in your case but have not formally agreed this with your responsible officer, you should contact your appraiser to discuss this before you finalise your submission.)

^{2,7} [Further information can be found here](#)

[Return to checklist](#)

Complaints and compliments – all complaints listed, with reflection, or confirmed none to include. Compliments listed (optional), with reflection

Tick if:

[I have included all complaints in which I have been involved, with reflection. I have listed any compliments which I wish to present, with reflection.](#)

(GMC guidance encourages doctors to view complaints as a form of valuable patient feedback, from which learning and improvements to practice can be derived². You must present all complaints in which you have been involved and which have been addressed at an organisational level (practice, departmental or higher). Academy guidance encourages the presentation of compliments at appraisal, as they too provide a source of learning and reinforcement.

Where you have not been involved in any complaints at an organisational level it may be acceptable for this section to be blank. However if you work in an environment in which there are no effective complaints procedures, you must remember that you have a professional duty to be receptive to complaints and to respond appropriately, and to present all complaints about your professional practice within this section.

Bear in mind that the purpose of presenting a complaint at your appraisal is not to adjudicate on the substance of the complaint, but to provide an opportunity to reflect and develop insight and learning for your future practice.

If you have managerial responsibility for complaints in your organisation, you should present this, along with your reflection on your effectiveness in this regard within the Quality Improvement Activity section of your appraisal submission.

The attaching of original material from complaints and compliments to your appraisal submission is not encouraged as the nature of such material often makes true anonymisation difficult. It is recommended that you refer to them and provide your reflection in your appraisal submission but provide any supporting material separately to your appraiser.)

² [Further information can be found here](#)

[Return to checklist](#)

Achievements, challenges and aspirations - completed (optional – may be raised verbally at appraisal)

Tick if:

[I have reflected on my professional achievements, challenges and aspirations and considered whether I wish to discuss any of these with my appraiser.](#)

(You are encouraged to reflect on your professional achievements, challenges and aspirations and consider whether you wish to discuss any of these with your appraiser at each appraisal.

It is not required for you to write anything down in this section of your appraisal submission, but you should expect your appraiser to raise the subject with you and

you have the option of a private conversation on these matters. This section arguably provides one of the clearest opportunities to ensure that the appraisal addresses the personal and professional needs of the doctor.

Having assembled and commented on your appraisal information to date it can help to pause in your preparation and organise your thoughts before making an entry in this section.)

[Return to checklist](#)

Probity declaration - completed; suspensions, restrictions or investigations listed if present, with reflection

Tick if:

I have made a declaration that I accept the professional obligations placed on me in 'Good Medical Practice' in relation to probity and considered whether there are any matters in relation to probity which I wish to discuss with my appraiser. This includes recognition that I accept the statutory obligation to ensure that I have adequate and appropriate medical insurance or indemnity covering my full scope of work in the UK⁸, and the professional obligation to manage my interests appropriately.

I have confirmed whether I have any suspensions, restrictions or investigations to declare and given details of these if they are present, with my reflection for discussion at appraisal.

(You must also confirm whether you have any suspensions, restrictions or investigations to declare and give details of these if they are present, with your reflection for discussion at appraisal.

Bear in mind that the purpose of presenting these at your appraisal is not to adjudicate on them, but to provide an opportunity to reflect and develop insight and learning for your future practice.

If you are subject to any suspensions, restrictions or investigations, or if you have been asked to include specific information in your appraisal, but you are not including this in your appraisal submission, it is vital that you discuss this with your appraiser or responsible officer before finalising your appraisal submission. Failure to include such information without prior discussion could constitute a failure of probity which could call into question your fitness to practise.)

⁸ [Further information can be found here](#)

[Return to checklist](#)

Health declaration - completed

Tick if:

I have made a health declaration that I accept the professional obligations placed on me in 'Good Medical Practice' about my personal health and considered whether there are any matters in relation to my health which I wish to discuss with my appraiser.

(Academy guidance⁴ indicates that, when making a health declaration, you accept your professional obligations in this way, it is appropriate to consider any relevant specialty guidance, as certain specialties may have specific requirements in relation to health, such as immunisation and infection control procedures.)

⁴ [Further information can be found here](#)

[Return to checklist](#)

Additional information – listed, or confirmed none expected, or explanation why absent

Tick if:

I have indicated whether I have been asked to present any specific information in my appraisal submission.

Where I have, I have included this information in my submission, with my reflection for discussion at appraisal.

or

I have not been asked to present any specific information in my appraisal submission.

(In many settings there are specific items which the responsible officer may agree with doctors are expected, and should be presented at appraisal, with reflection. Where such items are defined, they should be listed in this section. The information itself should then be set out in the relevant section to which it pertains.

You should indicate in this section whether or not you have been specifically asked to present any information in your appraisal submission, with your reflection on these or an explanation of why you have not presented them.

These specific items may relate to the clinical specialty and originate from, for example, College specialty guidance³. Alternatively they may originate from local priorities identified by the responsible officer or elsewhere in the system. They may include any of the categories of supporting information (CPD, quality improvement, significant events, complaints, feedback from colleagues and patients). They may also relate to matters of health and probity as well as other professional matters. They may be defined as expected for groups of doctors, or they may be agreed individually between a doctor and their responsible officer.)

³ [Further information can be found here](#)

[Return to checklist](#)

Review of GMC 'Good Medical Practice' domains - completed

Tick if:

I have reviewed all of my supporting information in the context of the GMC Good Medical Practice domains⁹ and provided written reflection for discussion at my appraisal.

⁹ [Further information can be found here](#)

[Return to checklist](#)

New PDP ideas - listed (optional – may be raised verbally at appraisal)

Tick if:

I have considered whether to record some ideas for my PDP for discussion at my appraisal.

(It is not required for you to do this but it can be helpful; evidence indicates that a doctor who takes control of their PDP is more likely to make progress with fulfilling it.)

[Return to checklist](#)

Appendix B: Generic medical in-post review template

Using this template

It is good practice for the person with clinical governance responsibility for a doctor in a particular role to hold a periodic review meeting with the doctor. This template is intended to guide this process and provide a record of the meeting for the doctor and their engaging organisation. It is intended for use where a suitable in-post review process does not already exist.

When considering whether to use this template to review a role which a doctor is undertaking, a balance needs to be struck between the need to provide assurance of fitness to undertake a role, based primarily on the level of risk associated with the role, and the burden of documentation on the doctor. For roles with very low associated risk, it may be acceptable to present a less structured form of review in that role to be agreed between the doctor and their responsible officer, for example by way of a comment in the scope of work section of the doctor's appraisal form. The periodicity of the agreed level of review might also be the subject of discussion and agreement between the doctor and their responsible officer, again depending on the nature of the role and its associated level of risk.

Whilst primarily designed to support a review meeting between a doctor and the person with clinical governance responsibility for their work, this template can also be used alone by a doctor as a self-review tool, or by doctor and a colleague as a peer-facilitated review tool, in a networking or buddying context.

The intended procedure is as follows:

1. The reviewer or organisation part-populates the template, and prepares any organisationally-generated records of CPD, quality improvement activity, feedback, complaints/compliments and any other relevant information relating to the doctor, as available.
2. The doctor completes remaining items in Section A.
3. The doctor and reviewer hold the review meeting, structured along the lines of the information in the template.
4. The doctor and reviewer agree the content of Section B, and complete the sign-off in Section C.
5. The doctor and the organisation each retain a copy of the final template.

Note: The doctor should present a copy of the completed template at their own medical appraisal, as supporting information indicating their participation in effective governance processes in relation to the role being reviewed.

Section A

Doctor's name: Click here to enter text.
Doctor's GMC number: Click here to enter text.
Reviewer's name (enter 'None' if self-review): Click here to enter text.
Reviewer's role: Click here to enter text.
Date of review: Click here to enter a date.

General

What role does this review relate to: Click here to enter text.
Start date in this role: Click here to enter text.
Have you signed a contract? Choose an item.
Date of signature of contract: Click here to enter a date.

Other professional roles that you have: Click here to enter text.
--

Headlines

Description of this role and the work you have undertaken in the last year: Click here to enter text.
Looking at your last review's development themes/objectives in relation to this role, to what extent did you get to fulfil these? Click here to enter text.
What do you consider you did well in the last year? Click here to enter text.
What difficulties/ barriers have you come across? Click here to enter text.
How well does your role work fit in with your other professional duties? Click here to enter text.
How would you like your work in this role to develop? Click here to enter text.

CPD in relation to this role

(If your organisation arranges any CPD activities for you in relation to this role, you should describe these here)

Comments on CPD arranged by your organisation, and any other CPD activities you have undertaken that are relevant to this role; possible development plans: Click here to enter text.
--

Quality improvement activity in relation to this role

(Your organisation should provide relevant data if available)

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Comments on data provided by your organisation and any other quality improvement activity relating to this role; possible development plans:

[Click here to enter text.](#)

Significant events in relation to this role

(Your organisation may define with you what might constitute a significant event in the context of your role)

Comments; possible development plans:

[Click here to enter text.](#)

Maintaining professional relationships with those you deliver this service to

(Engaging organisation to provide feedback if available,)

Comments on feedback provided by the organisation and any other feedback from those you deliver the service to; possible development plans:

[Click here to enter text.](#)

Maintaining professional relationships with colleagues in relation to this role

Comments; possible development plans:

[Click here to enter text.](#)

Your health in relation to this role

Comments; possible development plans:

[Click here to enter text.](#)

Maintaining probity in relation to this role

(Your organisation may define with you what might constitute suitable probity considerations in the context of your role)

Comments, possible development plans:

[Click here to enter text.](#)

Complaints and compliments in relation to this role

(Engaging organisation to provide information about complaints if available)

Comments; possible development plans:

[Click here to enter text.](#)

Any other comments before the discussion

Reviewer: [Click here to enter text.](#)

Doctor: [Click here to enter text.](#)

Section B

Comments/summary following discussion, or self-reflection comments by doctor

Reviewer: Click here to enter text.

Doctor: Click here to enter text.

Personal development themes in relation to this role

Click here to enter text.

Actions by reviewer

Click here to enter text.

Section C

Sign-off

We/I confirm that the above is an accurate summary of the review process and personal development themes/actions.

Signature (if required):

Click here to enter text.

Date of sign-off: Click here to enter a date.

[\[Back to Appendices list\]](#)

Appendix C:

Assessing supporting information in context of volume of work

Function of this appendix

This appendix sets out advice about the considerations a doctor, their appraiser and their responsible officer* may make in respect of assessing a doctor's supporting information in the context of the volume of the doctor's work.

There is a generally recognised perspective that for many roles, the greater volume of work a doctor does in the role the easier it is for them to gather sufficient supporting information to demonstrate fitness to practise, and conversely the lower their volume of work the more challenging this is.

It is therefore appropriate to make some degree of assessment in respect of a doctor's volume of work in a role and whether as a result their supporting information is sufficient to permit a revalidation recommendation by the responsible officer.

It is not possible to define a generic minimum volume of work applicable to all roles. These matters must be considered on the basis of a spectrum of safety, and so clearly delineated universal categories are neither definable nor appropriate. For many roles an apparently low volume of work is compatible with fitness to practise in that role and will still permit the gathering of an acceptable portfolio of supporting information. Conversely in other roles an apparently greater volume of work may not be compatible with fitness to practise in that role and the gathering of sufficient information to demonstrate this.

The professional judgements of the doctor, their appraiser and the responsible officer are key components in each individual circumstance.

In the interests of clarity, this appendix provides advice to a doctor, their appraiser and their responsible officer primarily on assessing whether the doctor's volume of work permits them to gather sufficient supporting information, not whether their volume of work indicates fitness to practice or otherwise.

In all situations:

- A full suite of supporting information covering the doctor's full scope of work is expected, including all six types of information as defined by the GMC (Box 1).
- It should not be assumed that a high volume of work in a role automatically implies that the supporting information will be sufficient.
- Some crossover of supporting information between areas of scope of work might be appropriate, e.g. a patient and colleague feedback exercise in one area might be sufficient to cover another area.
- The local checklist of agreed expected information should be applied if there is one.
- The doctor must assess their supporting information as being sufficient to

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demonstrate fitness to practice in line with GMC requirements, College guidelines and any local requirements prior to submitting their documentation to the appraiser.

- It is good practice for the doctor to consider their fitness to practice in the context of the volume of their work in each of their roles, and note this for discussion with their appraiser if appropriate.
- If the doctor is unable to state with confidence that their supporting information is sufficient they should seek advice from the person with clinical governance responsibility in that area of work, and/or their appraiser, prior to submitting their documentation for appraisal.
- The appraiser must make an assessment that the doctor's supporting information appears to be sufficient before the appraisal meeting takes place, taking into account GMC requirements, College guidance and any local requirements.
- The appraiser may communicate with the doctor and if necessary with the responsible officer prior to appraisal if unable to state with confidence that the supporting information is sufficient.
- The appraisal may need to be postponed until a sufficient portfolio of supporting information is presented by the doctor.
- Factors to consider include:
 - The likelihood of risk to patient safety, direct or indirect
 - The quality of the information presented by the doctor and the quality of their reflection on it
 - The potential relevance of supporting information presented in relation to other areas of work
 - The degree to which the doctor has successfully compensated for a low volume of work, for example by increasing their level of CPD activity
 - Whether the doctor's volume of work in the area in question is in keeping with that of other doctors working in the same area
 - Whether, if relevant guidance on the matter exists, for example from a College, the doctor has shown that they are acting in compliance with this or explained why it is not relevant
 - The level of proactivity exhibited by the doctor in terms of seeking out help and advice on how to demonstrate their fitness to practise
 - Whether previous discussions at appraisal and elsewhere have addressed the issue, and whether the doctor has acted in accordance with the agreed approach.

Communication to the responsible officer:

- It may be appropriate to include a comment on the impact of the doctor's volume of work in one or more areas of their scope of work in the appraisal outputs.
- The appraiser may on occasion find it helpful to discuss the matter with the responsible officer, prior to and/or after the appraisal meeting, before signing off the appraisal outputs.

When a doctor's volume of work is low

Suggested approach:

- In many professional roles a doctor whose volume of work is low will still find it straightforward to gather a portfolio of supporting information, which the appraiser can confirm is sufficient to demonstrate fitness to practise in line with GMC requirements.
- However, as the volume of work diminishes a doctor and their appraiser should to start to bear the potential implications of this in mind. As the doctor's volume of work continues to drop they may find it increasingly challenging to gather sufficient supporting evidence, perhaps particularly in respect of quality improvement activities and feedback from patients and colleagues. Increasing care will be required to ensure that their supporting information is sufficient to demonstrate fitness to practice. This may include the presentation of sufficient CPD activities to counterbalance reduced professional exposure in that area.
- The doctor should be increasingly prepared to refer to the implications of their volume of work in their appraisal submission using the factors above to frame the discussion.
- The appraiser should be increasingly ready to raise the matter on review of the doctor's portfolio prior to the appraisal or at the appraisal meeting, whether or not the doctor has referred to it in the submission.
- Both doctor and appraiser should be increasingly proactive about discussing the matter at appraisal.
- It will become progressively more important to refer to the possible implications of the doctor's volume of work in the appraisal outputs, especially when the volume of work diminishes to very low levels.

Communication to the responsible officer:

- Communication via the appraisal outputs will be sufficient in many cases.
- The appraiser will find it increasingly appropriate to discuss the matter with the responsible officer, prior to and/or after the appraisal meeting, before signing off the appraisal outputs, especially when the volume of work diminishes to very low levels.

*The term 'responsible officer' includes the responsible officer or other person with delegated responsibility (this may include a revalidation or appraisal lead, or a senior appraiser), or GMC-approved 'suitable person' or other appropriate GMC personnel (where the doctor's revalidation is directly managed by the GMC).

[\[Back to Appendices list\]](#)

Appendix D: Template for agreed expected information at appraisal

Doctor's appraisal checklist Additional Information for reflection at appraisal

Doctor: Click here to enter text.

GMC Number: Click here to enter text.

The following items are supplementary to the doctor's medical appraisal checklist. Please present this list as additional information at your appraisal and reflect on each item in your preparatory documentation. Please also submit any relevant supporting information as specified.

The items listed should be relevant to your practice as understood by your responsible officer. However, if any are not, then it is acceptable reflection for you to indicate this in your preparatory documentation, and discuss this with your appraiser when you meet.

<input type="checkbox"/>	Click here to enter text.	
<input type="checkbox"/>	Click here to enter text.	
<input type="checkbox"/>	Click here to enter text.	
<input type="checkbox"/>	Click here to enter text.	

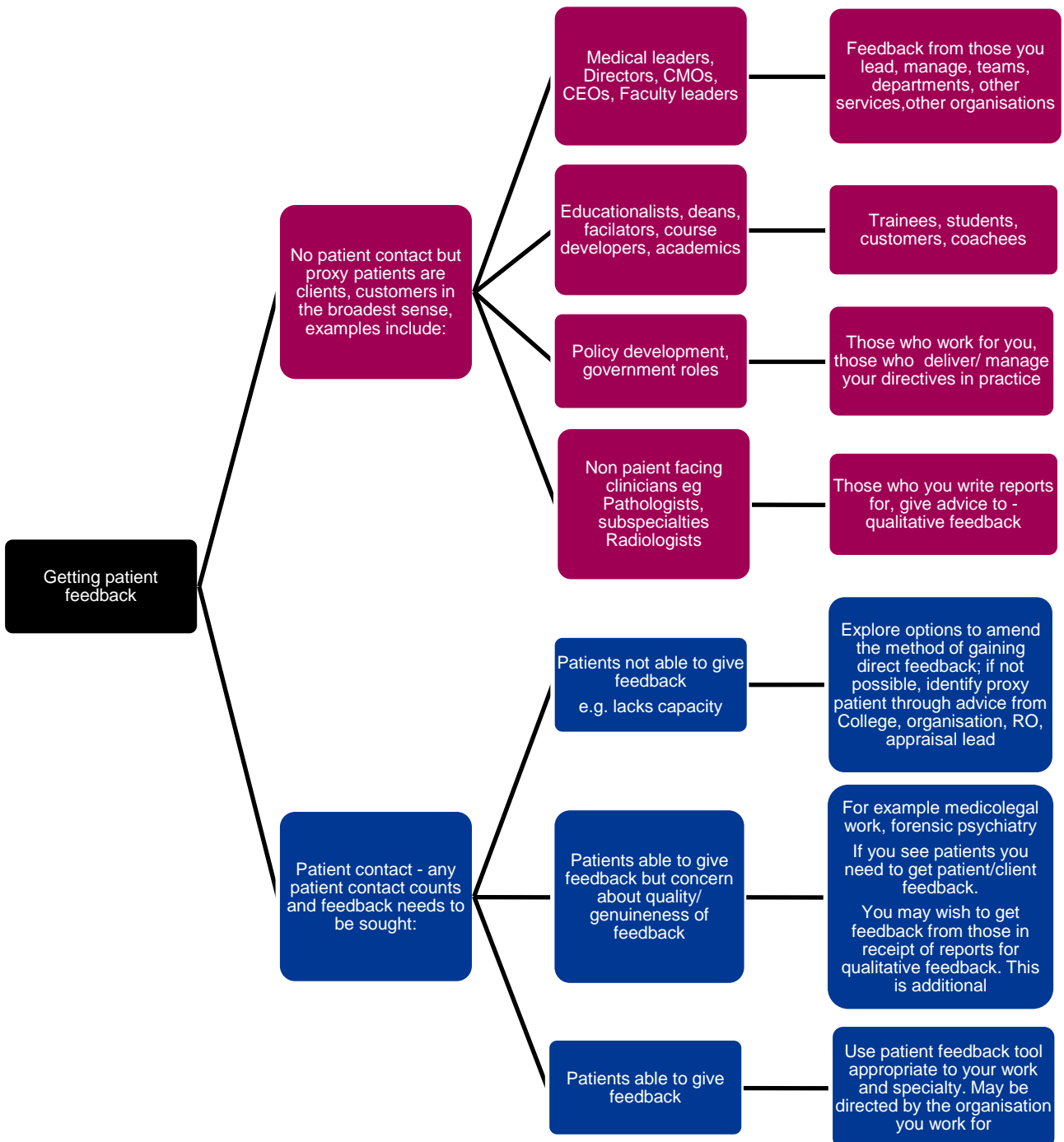
By way of illustration, the following list of additional items applies to doctors who have listed the role of responsible officer as part of their scope of work. Different items will apply to groups of/or individual doctors, as discussed in the main body of this paper.

Additional information for presentation and reflection at appraisal for a doctor who lists the role of responsible officer in their scope of work:

<input type="checkbox"/>	Evidence of appointment to the role of responsible officer – presented, (or date previously submitted)	
<input type="checkbox"/>	Evidence of training in the role of responsible officer – presented, with reflection, or confirmation of the year this took place or explanation of why not undertaken	
<input type="checkbox"/>	Evidence of reflection on the Annual Organisational Audit (AOA), the annual Board report (or equivalent), and AOA action plan – presented, with reflection, or explanation of the reasons why these are not present	
<input type="checkbox"/>	Evidence of attendance at a minimum of three responsible officer network meetings – presented, with reflection, or explanation of why not attended	

[\[Back to Appendices list\]](#)

Appendix E: Obtaining patient feedback in non-standard situations



Additional resource: The GMC have published case studies of how some doctors in atypical circumstances have obtained patient feedback at: http://www.gmc-uk.org/doctors/revalidation/colleague_patient_feedback.asp

[\[Back to Appendices list\]](#)

Appendix F: Examples of good practice in areas relating to appraisal inputs

The anonymised examples in this appendix illustrate known examples where the process or principle described in this document are already being put into action. For more details on individual examples, or to be put into contact with those involved with each example, please contact england.revalidation-pmo@nhs.net.

As progress is made across England further examples will be identified and may be added to this list.

Example 1

Synergy between clinical governance and appraisal (Section 4.1)

Organisations who help their doctors gather supporting information (Section 5.1)

Places where clinical governance information is fed into appraisal (Section 4.2)

In a NHS Foundation Trust in the north of England data is provided annually to each appraisee to assist with the appraisal process. The DATIX incident reporting system provides basic information relating to serious incidents, complaints and claims where the doctor is named. The Health Informatics department also provide information relating to activity data, benchmarking data (Dr Foster) and attendance at audit.

The aim is to discuss such matters in a formative context with the output being that the issue has been considered and reflected on.

Example 2

Synergy between clinical governance and appraisal (Section 4.1)

Organisations who help their doctors gather supporting information (Section 5.1)

Places where clinical governance information is fed into appraisal (Section 4.2)

A large FT in the North West has developed a mechanism for sharing all of a doctor's SUI's SIRI's and Complaints with them three months before their appraisal, for them to reflect on at their appraisal rather than having to record these themselves. In addition if a doctor is recommended any support following a concern e.g. coaching details or any communication about this such as a letter from the medical director to the doctor, this is automatically uploaded on the doctor's appraisal folder so they can reflect on it at appraisal.

The medical director says: We find that this is an effective way of being confident that our doctors include these important events in their appraisal.

Example 3

Designated bodies where there is a clear process for assessing appraisal inputs and resolving the matter when there is uncertainty about whether these are sufficient (Section 4.4)

One secondary care provider arranges for the appraisal lead to screen all appraisal submissions before the appraisals proceed.

Example 4

Places where the local responsible officer and doctors have agreed to participate in local quality initiatives, the outputs from which are suitable for the doctors to use at appraisal (Section 5.6)

In London, an initiative between cancer leads and the local appraisal teams has led to general practitioners being invited to complete a review template following a diagnosis of cancer in one of their patients. They can then reflect on the matter at their appraisal for their own professional development and share insights gleaned with the initiative to improve cancer diagnosis within the local system.

Example 5

Networking in action between responsible officers (Section 4.2)

In addition to the established responsible officer network meetings, several responsible officers in the north of England participate in a 'buddying' arrangement whereby the responsible officers work in pairs to provide advice and calibration to each other.

Example 6

Networking in action between responsible officers (Section 4.2)

Also in the north of England, and also in addition to the established responsible officer network meetings, a group of six responsible officers meet regularly to liaise on common issues.

Example 7

Places where clinical governance information is shared from places where the doctor is working into their medical appraisal (Section 5.2)

Organisations which support peripatetic doctors in accruing supporting information for their appraisal (Section 4.2)

In a moderate-sized General Practice in the Midlands all doctors have an annual in-house review with the practice clinical governance lead, the outputs of which are presented to the doctor in a format which they can then present for reflection at their medical appraisal. This helps them discuss their practice objectives and their personal objectives together with their appraiser, and provided assurance to their NHS England responsible officer that they are being effectively supervised and supported by their practice.

In the same practice, temporary doctors are encouraged to participate in the significant events processes even if they have moved on by the time the event comes to light. This is facilitated by a template notification form to the doctor, informing them of the event and requesting input from them according to the risk stratification of the event. This template can be included by the doctor for reflection at appraisal.

In this way the practice improves its inputs to significant event reviews, and integrates the temporary doctor more effectively within the team. Equally the temporary doctor feels included in the team activities in a supportive and measured manner, and accrues information for reflection at appraisal from their day to day work.

[\[Back to Appendices list\]](#)

9 Working group

As described in Section 3, this paper has arisen from a series of position statements drafted by the All England Appraisal Network in 2014. These provided a means by which issues pertinent to consistency and quality were captured, discussed and developed, so as to develop an agreed approach across all relevant parties. Issues were passed to the All England Appraisal Network (National) group in the first instance. The network developed an initial position statement based on preliminary discussion. This statement was shared for wider discussion as appropriate, then re-drafted and re-circulated. Depending on the nature of the issue, input and approval was sought from various bodies or relevant individuals. The degree to which a position statement was shared and/or approved was recorded within each document.

A working group was convened in March 2015 to develop the draft position statements relating to appraisal inputs into this paper. The membership of this group is detailed below:

Core working group	
Name	Organisation
Alistair Baker	Consultant Paediatric Hepatologist, King's College Hospital and Responsible Officer, MAAR Gateway Ltd and Responsible Officer Appraiser, NHS London
Vicky Banks	Regional Appraisal Lead, NHS England (South)
Susi Caesar	Associate Dean, Appraisal and Revalidation Service, Health Education Wessex
Ruth Chapman	Regional Appraisal Lead, NHS England (London)
Liz Clarke	Appraisal Lead, NHS Trafford CCG
Maurice Conlon (Chair)	National Appraisal Lead, NHS England
Jack Cornish	Responsible Officer Support Officer, Health Education England
Alex Crowe	Consultant nephrologist and Clinical Service Lead for Appraisal and Revalidation, Wirral University Teaching Hospital NHS Trust
Jean-Jaques de Gorter	Group Medical Director (Responsible Officer), Spire Healthcare
Ian Gell	Regional Appraisal Lead, NHS England (Midlands and East)
Nathan Jones	Nathan Jones, Head of Assessment and Revalidation, Health Education England – East Midlands Office

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Tom Kane	Consultant in radiology & nuclear medicine, Blackpool Teaching Hospitals NHSFT and Alliance Medical PETCT Centre, Preston
Debra King	Consultant Physician and Associate Medical Director for Appraisal and Revalidation, Wirral University Teaching Hospital
Yvonne Livesey	Revalidation and CPD Programme Manager, Academy of Medical Royal Colleges
David Macdonald	Appraisal Lead, Spire Healthcare
Sol Mead	Patient/Public Representative
Ian McKay	Chair, Independent Sector Responsible Officer Committee (ISROC)
Helena McKeown	Revalidation and Appraisal Lead, GP Committee - Education Training and Workforce Subcommittee, British Medical Association
Alexander Ottley	Senior Policy Executive, NHS Primary Care Division, Policy Directorate, British Medical Association
Sarah Parsons	Medical Workforce Manager, NHS Employers
Ian Starke	Chair, Revalidation and Professional Development Committee, Academy of Medical Royal Colleges
Kate Tansley	Policy and Projects Manager, Academy of Medical Royal Colleges
Paul Twomey	Joint Medical Director, NHS England-North (Yorkshire and the Humber)
Julia Whiteman	Lead Dean for Revalidation, Health Education England
Support	
Kate Archer	Programme Manager, NHS England Professional Standards Team
Mark Cohen	Project Manager, NHS England Professional Standards Team
Jenny Kirk	Project Manager, NHS England Professional Standards Team