## 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](mailto: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.

The NHS Commissioning Board (NHS CB) was established on 1 October 2012 as an executive non-departmental public body. Since 1 April 2013, the NHS Commissioning Board has used the name NHS England for operational purposes.

*This form has been extracted from, and should be used in accordance with, the NHS England Improving the Inputs to Medical Appraisal document, April 2016, Annex F: Examples of good practice in areas relating to appraisal inputs, available here:* [*https://www.england.nhs.uk/revalidation/appraisers/improving-the-inputs-to-medical-appraisal/*](https://www.england.nhs.uk/revalidation/appraisers/improving-the-inputs-to-medical-appraisal/)

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