



# **NHS England Medical Appraisal Logistics Handbook**

**NHS England INFORMATION READER BOX****Directorate**

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## **Equality and Health Inequalities Statement**

**Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:**

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.

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

# **NHS England Medical Appraisal Logistical Handbook**

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

## Contents

Contents .....	5
1 Introduction.....	7
General .....	7
Responsible officer regulations .....	7
Revalidation .....	7
Medical appraisal .....	7
Relevance of the guidance in this document.....	8
Information Governance.....	8
Statutory duty of the responsible officer, delegated authority, responsible officer autonomy and calibration of decisions .....	8
2 Topics with summary.....	9
Topic 1 - Achieving high medical appraisal uptake* .....	9
<i>(relevant for all designated bodies)</i> .....	9
Topic 2 - Scheduling medical appraisals* .....	9
<i>(relevant for all designated bodies, with specific details for NHS England)</i> .....	9
Topic 3 - Postponement of appraisal .....	9
<i>(relevant for all designated bodies)</i> .....	9
Topic 4 - Interrupting appraisal .....	9
<i>(relevant for all designated bodies)</i> .....	9
Topic 5 - Late sign off of appraisal .....	10
<i>(relevant for all designated bodies)</i> .....	10
Topic 6 - Appraisal of doctors who temporarily exit training.....	10
<i>(relevant for all designated bodies)</i> .....	10
Topic 7 - When to undertake additional patient feedback .....	10
<i>(relevant for all designated bodies)</i> .....	10
Topic 8 - Technology-assisted appraisal.....	10
<i>(relevant for all designated bodies)</i> .....	10
Topic 9 - Recognising professional time taken by appraisers* .....	10
<i>(relevant for all designated bodies, with specific details for NHS trusts)</i> .....	10
3 Topics in detail .....	11
Topic 1 - Achieving high medical appraisal uptake* .....	11
<i>(relevant for all designated bodies)</i> .....	11
Topic 2 - Scheduling medical appraisal* .....	13
<i>(relevant for all designated bodies, with specific details for NHS England)</i> .....	13
Topic 3 - Postponement of appraisal .....	17
<i>(relevant for all designated bodies)</i> .....	17
Topic 4 - Interrupting appraisal .....	18
<i>(relevant for all designated bodies)</i> .....	18
Topic 5 - Late sign off of appraisal .....	21
<i>(relevant for all designated bodies)</i> .....	21
Topic 6 - Appraisal of doctors who temporarily exit training.....	22

<i>(relevant for all designated bodies)</i> .....	22
Topic 7 - When to undertake additional patient feedback .....	23
<i>(relevant for all designated bodies)</i> .....	23
Topic 8 - Technology-assisted appraisal.....	25
<i>(relevant for all designated bodies)</i> .....	25
Topic 9 - Recognising professional time taken by appraisers* .....	29
<i>(relevant for all designated bodies, with specific details for NHS trusts)</i> .....	29
4 References .....	30

# 1 Introduction

## General

Medical appraisal has been a requirement for consultants since 2001 and for general practitioners (GPs) since 2002.

## Responsible officer regulations

The Medical Profession (Responsible Officers) regulations 2010 and the Medical Profession (Responsible Officers) (Amendment) regulations 2013 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 will participate in annual medical appraisal. On the basis of this and other information available to the responsible officer from local clinical governance systems, the responsible officer will make a recommendation to the GMC, normally 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 practice. 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*, which complies with the needs of revalidation. The *Medical Appraisal Guide* was reissued in 2014.

As the process of medical revalidation evolves, various practical considerations have emerged, the detail of which is not captured in existing guidance. It is important that these issues are captured and discussed, and a single approach identified, to ensure consistency across and within designated bodies.

To this end in 2014 the All England Appraisal Network drafted a series of NHS England medical appraisal position statements. Issues were passed to the All England Appraisal Network (National) group. The group developed an initial position statement which was then shared for wider discussion, depending on the nature of the issue.

The draft NHS England medical appraisal position statements have informed the content of this handbook, which provides advice on matters relating to the logistics of medical appraisal which are not addressed in existing guidance. It also is based on further discussion and feedback since the most recent drafting of the position statements. It therefore acts as an illustration of effective networking in action.

Responsible officers, appraisers and doctors may find this handbook 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.

## **Relevance of the guidance in this document**

NHS England has a dual function in relation to revalidation and appraisal: firstly as a designated body in its own right and secondly as Senior Responsible Owner for the implementation of the responsible officer regulations in England as a whole. Most of the content of this document is intended to be relevant to all designated bodies in England, and this is indicated under each topic heading. Topics which contain sections for specific designated bodies such as NHS England are denoted by a blue asterisk (\*) and the relevant sections are printed in blue.

## **Information Governance**

This document does not address matters relating to information governance, such as access to confidential patient or staff information for the purposes of the appraisal, and the management of individually identifiable data including any in the completed appraisal. Those issues are addressed in previously published guidance. The requirements of prevailing Information Governance law and good practice must be observed at all times.

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

Depending on the scale of a designated body and other factors, a responsible officer may delegate certain duties to others whilst retaining overall statutory responsibility as set out in the regulations. In this handbook therefore, where the term 'responsible officer' is used, this should be taken to mean 'responsible officer or other person with appropriately delegated authority'.

In many aspects of the revalidation process, including those set out in this handbook, the responsible officer necessarily holds discretion to make decisions based on their professional judgement. In making such decisions a responsible officer has the option of cross referencing their decision with other responsible officers and colleagues in the responsible officer network, and of seeking advice from their higher level responsible officer. Conferring in this way is a means to ensuring that decisions are based as much as possible on current national thinking, and are in step with decisions on similar matters made by other responsible officers. It also ensures that such issues are identified at an earlier stage. This in turn supports on-going calibration of decision-making throughout the revalidation system.

## 2 Topics with summary

The topic titles and summaries are listed below. Please click on a title to be taken to the detailed version of each topic. When in the detailed version of each topic, click **Summary** under the topic title to be taken back to this list.

### **Topic 1 - Achieving high medical appraisal uptake\*** ***(relevant for all designated bodies)***

- Annual medical appraisal is required for all doctors with a licence to practise.
- It assures a doctor's fitness to practise and simultaneously enhances individual practice and organisational clinical governance.
- Designated bodies must ensure availability of appraisal; the doctor has a duty to participate.

### **Topic 2 - Scheduling medical appraisals\*** ***(relevant for all designated bodies, with specific details for NHS England)***

- This section sets out a common approach for all designated bodies when scheduling medical appraisals, to support consistency, including for doctors moving around the service.
- It includes reference to doctors returning after a career break, and [specific details for NHS England about doctors who have just completed training](#).

### **Topic 3 - Postponement of appraisal** ***(relevant for all designated bodies)***

- Postponement of appraisal must be agreed with the responsible officer.
- The potential need to postpone must be communicated promptly to the responsible officer.
- A doctor doing any professional work must have an annual appraisal.
- In cases of suspension or illness individual circumstances must be considered before postponing appraisal.

### **Topic 4 - Interrupting appraisal** ***(relevant for all designated bodies)***

- Interruption should be an unusual event.
- Good preparation and communication reduces risk of interruption.
- The appraiser must judge whether to consult with the responsible officer.
- There should be mutual agreement to interrupt.
- The appraiser should record the interruption.
- The appraisal should be rescheduled at an appropriate interval.

**Topic 5 - Late sign off of appraisal**  
***(relevant for all designated bodies)***

- Medical appraisal is 'complete' when the appraisal outputs have been provided to the responsible officer within 28 days of the appraisal.
- Where delay is likely, the responsible officer should be informed in advance.
- The responsible officer has discretion to decide whether late provision has unacceptably compromised the appraisal.

**Topic 6 - Appraisal of doctors who temporarily exit training**  
***(relevant for all designated bodies)***

- Where a doctor's prescribed connection moves from a postgraduate dean to a service-based responsible officer but is likely to revert to the dean, the service-based responsible officer has discretion to modify the supervision of the doctor.

**Topic 7 - When to undertake additional patient feedback**  
***(relevant for all designated bodies)***

- All doctors, in particular when taking on a new role, should be open to undertaking additional patient feedback exercises, to increase insight about their practice.
- Where the results from these are not available in time for the doctor's recommendation, the responsible officer has discretion to recommend revalidation pending the outcomes.

**Topic 8 - Technology-assisted appraisal**  
***(relevant for all designated bodies)***

- Technology-assisted appraisal such as videoconferencing may be acceptable but must be approved by the responsible officer in advance.
- Technology-assistance is inappropriate when in fact it is a manoeuvre to circumvent the fact that the doctor does not have a legitimate connection to the organisation.

**Topic 9 - Recognising professional time taken by appraisers\***  
***(relevant for all designated bodies, with specific details for NHS trusts)***

- Designated bodies must facilitate sufficient time for appraisers to undertake appraisals.
- 0.25 SPA for 8 appraisals (40 hours per annum) is a reasonable benchmark to allocate to appraisers in NHS trusts.

### 3 Topics in detail

#### Topic 1 - Achieving high medical appraisal uptake\*

*(relevant for all designated bodies)*

##### Summary

- **Annual medical appraisal is required for all doctors with a licence.**
- **It assures a doctor's fitness to practise and simultaneously enhances individual practice and organisational clinical governance.**
- **Designated bodies ensure availability of appraisal; the doctor has a duty to participate.**

- 1) All doctors with a license to practise are expected to undertake an annual medical appraisal unless a postponement is agreed with their responsible officer.
- 2) [All doctors included on the NHS England performers list are required to undertake an annual appraisal to retain their inclusion as described in the National Health Service \(Performers list\) \(England\) Regulations 2013.](#) Designated bodies normally require employed doctors to undertake annual appraisal under the terms of their contract of employment.
- 3) Responsible officers require a robust medical appraisal programme which enables their doctors to engage in a personally relevant annual medical appraisal consistent with national guidance.
- 4) Responsible officers, supported by their Board, are expected to establish a culture of learning which maximises the potential benefits of medical appraisal on patient care. The objective is to support their doctors, enabling them to deliver consistent, high quality care in an environment which is professionally satisfying and stimulating.
- 5) Medical appraisal must be integrated within the wider clinical governance and development programmes of the designated body to include:
  - timely engagement of doctors in medical appraisal following the establishment of a prescribed connection;
  - the opportunity to engage in the organisational clinical governance programme to enable collection of relevant supporting information, including in circumstances such as short term employment that does not necessarily include an appraisal;
  - on-going communication with doctors to emphasise the benefits of engagement and the potential consequences of non-engagement.
- 6) The designated body must support a structure which enables:
  - training and support of appraisers, who are fundamental to the delivery and advocacy of medical appraisal. This includes their attendance at regular appraiser network meetings which adhere to a national blueprint;
  - access to a learning network ([including regional network programme](#)) for appraisal leaders which provides peer review and the opportunity to share good practice;
  - assurance and audit of appraisal quality and completion;

- communication and coordination including troubleshooting and a question and answer service;
  - efficient financial management including payments and invoicing of appraisers as appropriate.
- 7) Smaller designated bodies have all the same requirements in these respects as their larger counterparts. They may benefit from collaboration with peer organisations to ensure their systems are effective.
  - 8) Doctors employed on short term contracts or those working for a locum agency but within several different designated bodies require a specific focus to maximise their opportunity to gather their supporting information and engage in medical appraisal. A particular challenge exists for some locum agencies and other designated bodies, where appraisals are not always directly organised within the designated body, to ensure that appraisal undertaken in another designated body is of a suitable standard.
  - 9) A case review should be undertaken following the failure of a doctor to undertake a timely appraisal. Such analysis should review the doctor's personal circumstances and commitment to appraisal as well as the appraisal system and any aspect of this which is relevant to the engagement of the doctor.

## Topic 2 - Scheduling medical appraisal\*

*(relevant for all designated bodies, with specific details for NHS England)*

### Summary

- This section sets out a common approach for all designated bodies when scheduling medical appraisals, to support consistency, including for doctors moving around the service.
  - It includes reference to doctors returning after a career break, with **specific details for NHS England about doctors who have just completed training.**
- 1) All designated bodies must describe the local process for scheduling their medical appraisals in their medical appraisal policy.
  - 2) To facilitate the maintenance of an annual appraisal cycle for doctors who move between designated bodies, including doctors who complete training, and doctors who retain a prescribed connection to a designated body for a short period of time, it will be helpful to establish a shared approach between designated bodies as follows:
    - a) The appraisal year runs from 1 April to 31 March.
    - b) A doctor should have a set date by which their appraisal should normally take place every year (the 'appraisal due date')
    - c) The appraisal due date should remain the same each year unless changed by agreement with the doctor's responsible officer.
    - d) Where a doctor has a late appraisal, the subsequent appraisal should revert to the doctor's appraisal due date, except by agreement with the doctor's responsible officer.
    - e) Where a doctor does not have a clearly established appraisal due date, the next appraisal should take place by the last day of the twelfth month after the preceding appraisal. This should then by default become their appraisal due date from that point on.
    - f) In the case of a doctor who has completed training, this interval should be calculated from the date of completing training as this normally coincides with the doctor's final Annual Review of Competence Progression (ARCP)<sup>1</sup> as set out in the document *A Reference Guide for Postgraduate Specialty Training in the UK, 2014*
    - g) For a doctor who has not had a previous appraisal, or who has had a period of absence from practice exceeding six months, the date of their first appraisal should be agreed with their responsible officer, and this should subsequently be defined as their appraisal due date. Such a doctor may also require a re-entry process, as defined by agreement in discussion with the responsible officer, to ensure their safe and efficient re-entry into practice.
    - h) For a doctor who is likely to hold a prescribed connection to a designated body for only a short time, their appraisal due date should be confirmed to the

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<sup>1</sup> The ARCP is generally taken to be the broad equivalent, for doctors in training, of medical appraisal.

responsible officer immediately on engagement, and their appraisal undertaken within that designated body if their appraisal due date falls within the time that they remain connected to the designated body.

- i) Responsible officers have discretion to alter a doctor's appraisal due date. This may be appropriate for a variety of reasons, such as to ensure a manageable spread of appraisals throughout the year, avoid a bulge in appraisals at the end of the appraisal year, or accommodate individual circumstances on the part of the doctor. Such adjustments should be made after discussion and agreement with the doctor. In general, a doctor's appraisal due date should be amended by bringing it forward in time, rather than delaying it.

### **Specific considerations for doctors who do not begin work immediately after completing training**

- 3) A newly qualified doctor does not establish a prescribed connection to another designated body until they are engaged by that body [or in the case of a general practitioner they join the National Medical Performers List](#). A doctor who does not intend to begin work as a medical practitioner immediately on completing training but who knows where they are likely to begin work in due course should discuss their options with the relevant responsible officer .
- 4) [For a general practitioner planning a clearly defined period out of UK practice, with a pre-established date for commencing work within twelve months, the relevant responsible officer may advise them to join the Performers List before departure, and form a plan with them about the procedure that will apply when they return. If the period before commencing work under the Performers List is open-ended or greater than twelve months, the responsible officer should advise the doctor not to join the Performers List at that time, but make contact at such times as they can predict when they will commence practice under the Performers List.](#)
- 5) For a doctor who is likely to form a prescribed connection to a designated body other than NHS England, it will be uncommon for the prescribed connection to become established until formal engagement through employment or other mechanism begins. It may nevertheless be helpful, if a doctor knows in advance which designated body they are likely to connect with, to have a conversation with the responsible officer in advance, so that the first appraisal can be arranged, and suitable arrangements to facilitate the re-entry of the doctor into UK medical practice put in place.
- 6) It should be noted that a UK-trained doctor who travels abroad to work is subject to the medical regulatory requirements of the jurisdiction in which they are practising. As they are not working in the UK, they do not normally need a UK licence to practise and should consider whether to relinquish their licence to practise, with a view to reinstating this at such time as they return to practise in the UK. The process of relinquishing and reinstating their licence under these circumstances is purely administrative. If they choose to keep a licence they will have to revalidate, which in turn requires them to participate in appraisal.
- 7) A doctor practising abroad and who intends to return to practise in the UK should give thought to the means by which they can maintain their fitness to practise during the period of their absence from the UK. This may facilitate a simpler process of re-entry to UK medical practice.

- 8) A doctor who is seeking to return to practise after a period of absence should discuss their circumstances with their new responsible officer at the earliest opportunity. If they do not have a responsible officer they should consult the GMC for advice, and guidance is also available from their specialty body<sup>2</sup>. The timing of their first appraisal will be determined to some extent by their individual circumstances, including whether they can demonstrate that they have maintained fitness to practise in the relevant areas during their absence and hence whether a bespoke re-training programme or period of supervision is required prior to resuming practice. In general, the first appraisal should take place between 3 and 6 months after re-entry to professional practice. Where possible and practical, if the doctor had a previously agreed appraisal due date, this should be reinstated. Also, if the doctor has had an appraisal previously and circumstances permit, their first appraisal should be undertaken by the last day of the twelfth month after the preceding appraisal.

### Specific arrangements for NHS England responsible officers

- 9) NHS England responsible officers should operate in line with the above, in keeping with the NHS England Medical Appraisal Policy. The NHS England Medical Appraisal Policy also suggests the month of the doctor's birth as a default choice for a doctor's appraisal month, with their appraisal due date therefore being the last day of their month of birth. Using the month of birthday is favoured partly as a memorable month which doctors find easier to latch on to than others.
- 10) Following the 'month of birthday' rule creates problems for some newly qualified doctors, if their birth month is very soon after they emerge from training. In particular, newly qualified doctors whose birthday month falls less than 9 months from their exit from training will have too little time to accumulate sufficient supporting information for their first appraisal. Although an alternative would be to allocate a doctor's appraisal month as the month of the doctor's final Annual Review of Competence Progression (ARCP), this creates a different problem in that a bulge of appraisals would then build in August and February, when most doctors emerge from training programmes. In terms of maximising the quality of a doctor's appraisal, having a sensible interval between completion of training and a doctor's first appraisal is a greater priority than maintaining their birthday month as their appraisal month. The following approach will permit NHS England responsible officers to allocate appraisal months to doctors emerging from training in a manner that will be consistent across NHS England while also allowing the responsible officer to exert reasonable flexibility:
- a) Where the doctor's birthday month is 6 months or more after the month that they complete training, their allocated appraisal due date will be the last day of their birthday month.
  - b) Where the doctor's birthday month is less than 6 months after the month that they complete training, the responsible officer will agree an appraisal due date with the doctor such that the doctor's first appraisal takes place between the last day of the ninth month and the last day of the twelfth month from the

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<sup>2</sup> General Practitioners should contact the GP National Recruitment Office at: <http://gprecruitment.hee.nhs.uk/> so that they can apply for support and guidance via the Induction and Refresher scheme

month of completion of training. This will then become the doctor's appraisal month.

- 11) NHS England responsible officers have discretion to modify this approach on an individual basis, but the broad intention should be that the interval between the completion of training and a doctor's first medical appraisal should be not less than 6 months and not more than 12 months.

### **Topic 3 - Postponement of appraisal** ***(relevant for all designated bodies)***

#### **Summary**

- **Postponement of appraisal must be agreed with the responsible officer.**
  - **The potential need to postpone must be communicated promptly to the responsible officer.**
  - **A doctor doing *any* professional work must have an annual appraisal.**
  - **In cases of suspension or illness individual circumstances must be considered before postponing appraisal.**
- 
- 1) It is a doctor's responsibility to agree the date of their appraisal with their appraiser prior to their appraisal due date.
  - 2) Every designated body should have a process, set out in the medical appraisal policy, for requesting, assessing and agreeing the postponement of a doctor's medical appraisal.
  - 3) Postponement should be a planned event, agreed after discussion between a doctor and their responsible officer. A doctor must notify the potential need for postponement to the responsible officer as soon as this becomes apparent.
  - 4) The reasons for any agreed postponement should be recorded. Continued networking between responsible officers of the circumstances in which they agree postponement of appraisal will assist calibration.
  - 5) A doctor who is professionally active in any manner is expected to participate in their designated body's appraisal system. Absence from professional duties in the designated body does not therefore automatically imply that postponement of appraisal is appropriate.
  - 6) Postponement of appraisal may or may not be appropriate in cases of suspension or illness. Where a doctor is suspended or otherwise excluded from work, a decision on whether appraisal should proceed or not should be made, based on the circumstances of the case. If circumstances permit, the doctor should be party to this decision.

## **Topic 4 - Interrupting appraisal**

*(relevant for all designated bodies)*

### **Summary**

- **Interruption of appraisal should be unusual.**
- **Good preparation and communication reduces risk of interruption.**
- **The appraiser must judge whether to consult with the responsible officer.**
- **There should be mutual agreement to interrupt.**
- **The appraiser should record the interruption.**
- **The appraisal should be rescheduled at an appropriate interval.**

- 1) An interruption to appraisal occurs when the course of the meeting is disrupted in such a manner that completion of the discussion and/or mutual agreement of the appraisal outputs are not possible or appropriate. Interruption of an appraisal may be due to a number of reasons. In general it should be an unusual event.

### **Effective preparation minimises risk of interruption**

- 2) In the first instance ensuring the right setting for the appraisal is part of the preparation for a successful meeting. The appraisal should be in a private space, with adequate time allocated and be free of day to day working interruptions such as telephone calls and other professional duties. An appraisal should specifically not be scheduled at the same time as the doctor is required to be available for any other professional duties such as being on-call.
- 3) Both doctor and appraiser should have spent time preparing for the appraisal. The doctor should submit their appraisal documentation to the appraiser well in advance of the meeting, in accordance with the timescales set out in the local appraisal policy. This permits time for the appraiser to review the documentation and address issues prior to the appraisal through discussion and/or provision of further information by the doctor. It also allows time for the appraiser to communicate with the appraisal lead or responsible officer if necessary for advice about issues to be addressed in the appraisal.
- 4) Appraiser training will increase the skills of an appraiser in making decisions about which circumstances can be managed within the appraisal context and which require interruption.
- 5) In some circumstances careful allocation of an appropriately experienced and skilled appraiser may help to minimise the risk of interruption.
- 6) Open and transparent information sharing between the doctor, the appraiser and the responsible officer should minimise the risk of unexpected issues coming to light in the appraisal discussion which might necessitate interruption. For example, where the responsible officer is aware of a concern or issue relating to the doctor, there should be local mechanisms to ensure that the appraiser is aware of these.

### **Common situations that may precipitate interruption**

- 7) External reasons: There is an external interruption for either the appraiser or the doctor such as a very urgent contact e.g. family related crisis, building evacuation, failure of technology, unpredictable professional emergency.
- 8) Late provision of supporting information: The doctor may produce information on the day which needs more time to review by the appraiser. While it may be possible to review some such data during the appraisal meeting, more complex information may necessitate interruption to give the appraiser sufficient time to review it properly. Examples might include: the results or report of colleague and patient feedback, a doctor's review and reflection on a complicated significant event, or a complicated set of clinical outcomes data.
- 9) Unexpected serious concern about the fitness to practise of the doctor: Medical appraisal is not a forum for addressing significant concern about a doctor's practice. Such concerns must be referred to the responsible officer so that appropriate action can be taken. Very rarely, information provided or comment made by the doctor in the appraisal meeting is of such concern that the appraiser needs to interrupt the appraisal and make a referral to the responsible officer immediately, in order to protect patients, colleagues, other people or the doctor. All appraisers should be familiar with the GMC guidance *Raising and acting on concerns about patient safety* and be confident about applying this guidance in this situation. All appraisers should also be aware of the practicalities to be followed in such situations, including the appropriate contact details of the person from whom to seek immediate advice.
- 10) The doctor raises an unexpected serious concern about the fitness to practise of another person. Medical appraisal is not a forum for addressing concern about third parties to the discussion. Occasionally however a doctor may use the relatively private arena of an appraisal meeting to reveal a concern about another person. The appraiser should recognise when this is happening, and pause the appraisal conversation to clarify to their satisfaction whether interruption is immediately necessary in order to protect patients, colleagues, other people or the third party in question.

The appraiser should remind the doctor of their professional obligation to raise and act on concerns about patient safety and may consider offering support to the doctor to fulfil these obligations by way of signposting them to the appropriate authority.

Should the appraiser form the view that the doctor is not likely to raise this matter in any other way, the appraiser must consider whether the matter is of sufficient concern to warrant interrupting the appraisal to resolve the situation. This may include either or both of raising a concern about the third party in question and raising a concern about the doctor on the grounds of their failure to raise and take action on a concern about patient safety.

The appraiser should explain their intention to follow this course of action to the doctor; doing so will provide them with an opportunity to reconsider their own intended action in relation to the matter.
- 11) Dysfunctional doctor/appraiser relationship: Either the doctor or appraiser may perceive the approach of the other party as bullying, non-engaging, aggressive or otherwise professionally unacceptable.

If the doctor perceives unacceptable behaviour on the part of the appraiser, they should provide this in writing to the responsible officer in accordance with the complaint procedure set out in the relevant appraisal policy.

- 12) Unilateral departure of doctor or appraiser: The doctor or the appraiser may leave the appraisal without notice. The other party should inform the responsible officer so that the reasons can be fully clarified and appropriate action taken.

### **Managing the interruption**

- 13) If possible the decision to interrupt should be mutually agreed between the doctor and the appraiser. They should clarify the reason for the interruption between them, along with the actions that will follow.
- 14) A rescheduling should be arranged then and there if possible on at least a provisional basis. If the appraiser needs to seek clarity or guidance from the appraisal lead or responsible officer or if the appraiser is uncertain of the next steps in the process for that doctor, the provisional rescheduled date can be adjusted accordingly.
- 15) The appraiser must make a written note about the interruption. This should include:
- the fact of the interruption,
  - the reasons,
  - whether or not advice has been sought from the responsible officer,
  - the outcome.

This record should be made separately to the doctor's appraisal documentation. Reference to the interruption need only be made in the doctor's subsequent appraisal documentation if it is relevant to the appraisal discussion at that time. No third party identifiable information should ever be included in the doctor's appraisal documentation in this or any other circumstance.

- 16) Common outcomes of an interruption may include:
- simple rescheduling of the appraisal at a suitable interval,
  - a change in appraiser,
  - support for the doctor and intervention if needed,
  - a formal complaint by the doctor about the appraiser,
  - formal investigation as necessary by the responsible officer.
- Other outcomes may occur, dependent on the circumstances.
- 17) In the event that rescheduling of the appraisal is not deemed appropriate in the immediate future, the decision on when the appraisal process should be resumed rests with the responsible officer. Where circumstances dictate that the doctor's appraisal will not take place by their appraisal due date, or that an annual appraisal will be missed, this fact and the reasons why must be noted by the responsible officer.
- 18) The interruption of an appraisal should always be seen as a notable event by the doctor, their appraiser, and the appraisal office. It is therefore good practice that all parties record the event and reflect on its implications for future learning and practice, whether individually or as part of an organisational review, as appropriate to their role.

## **Topic 5 - Late sign off of appraisal** ***(relevant for all designated bodies)***

### **Summary**

- **Medical appraisal is ‘complete’ when the appraisal outputs have been provided to the responsible officer within 28 days of the appraisal.**
  - **Where delay is likely, the responsible officer should be informed in advance.**
  - **The responsible officer has discretion to decide whether late provision has unacceptably compromised the appraisal.**
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- 1) Completed medical appraisal is defined for all designated bodies in England within the Framework for Quality Assurance (NHS England, 2014). A completed appraisal comprises the following outputs: the doctors personal development plan, appraisal summary and appraiser statements, agreed, signed and dated by both parties and submitted to the responsible officer within a time frame that permits the conclusion that the appraisal has been satisfactorily completed to the standard required to support an effective revalidation recommendation. Compliance with this process is monitored through local quality assurance processes and national/regional quarterly and annual reporting.
  - 2) Provision of the appraisal outputs within 28 days means that the appraisal can normally be regarded as complete.
  - 3) Where appraisal outputs are provided to the responsible officer more than 28 days following the appraisal meeting, discretion rests with the responsible officer as to whether the conclusion can still be reached that the appraisal has been satisfactorily completed to the standard required to support an effective revalidation recommendation or whether the delay between the meeting and receipt of the outputs has unacceptably undermined this conclusion.
  - 4) There may be acceptable reasons for late sign off, and in many cases a delay likely to result in late provision of outputs can be predicted. Where a delay is predicted the responsible officer should be informed so that a reasonable adjustment to the time frame can be agreed.

## Topic 6 - Appraisal of doctors who temporarily exit training (relevant for all designated bodies)

### Summary

- **Where a doctor's prescribed connection moves from a postgraduate dean to a service-based responsible officer but is likely to revert to the dean, the service-based responsible officer has discretion to modify the supervision of the doctor.**
- 1) The prescribed connection of any doctor is set out in the responsible officer regulations and is not negotiable on an individual basis.
  - 2) For all doctors the standard for the doctor's practice is that described in the GMC guidance *GMP Framework for appraisal and revalidation*.
  - 3) The default process of review of any doctor whose prescribed connection is to a service-based responsible officer (i.e. a responsible officer who is not a postgraduate dean), is appraisal, in keeping with the NHS Revalidation Support Team *Medical Appraisal Guide* (MAG). For trainees, whose responsible officer is the dean of their Local Education and Training Board (LETB), the process of review is the *Annual Review of Competency Progression* (ARCP). Both of these processes are well-established, with support from a wide base of stakeholders including the GMC, and are underpinned by quality assurance processes to monitor their effectiveness.
  - 4) For some individual doctors or groups of doctors the responsible officer may find it appropriate to exert discretion in terms of the form of review applied to the doctor. An example of this is a when a doctor in training transfers to a service-based responsible officer from a postgraduate dean due to a temporary pause in the doctor's postgraduate training.
  - 5) For such doctors, the responsible officer may find it appropriate to adapt the approach in the MAG and blend it with aspects of the ARCP process. An example of this would be by appointing a suitably trained educational supervisor instead of an appraiser to supervise and support the doctor.
  - 6) The responsible officer may also find it appropriate to modify the local approach to the supporting information, such as arrangements for continuing professional development activity, and patient and colleague feedback.
  - 7) Where a period of time greater than twelve months has elapsed from the doctor exiting their training programme, or where it cannot be said that it is likely that a doctor will re-enter training within twelve months of exiting their training programme (whichever occurs sooner), the process should revert to the standard approach described in the MAG.
  - 8) The prime driver for modifying the approach taken for an individual doctor or a group of doctors must be to apply that process which demonstrates the fitness to practise of the doctor in question most effectively.
  - 9) The final responsibility for ensuring that the process applied demonstrates that a doctor is meeting the requirements of the GMC GMP Framework for appraisal and revalidation rests with their responsible officer. A responsible officer using an approach which is modified from either the ARCP or MAG based processes therefore needs to be able to demonstrate that the resulting approach is at least as effective as these processes.

## Topic 7 - When to undertake additional patient feedback (relevant for all designated bodies)

### Summary:

- All doctors, in particular when taking on a new role, should be open to undertaking additional patient feedback exercises, to increase professional insight.
  - Where the results are not available in time for the doctor's recommendation, the responsible officer has discretion to recommend revalidation pending the outcomes.
- 1) Current GMC guidance indicates that a doctor must submit a patient feedback questionnaire consistent with GMC guidelines once in a revalidation cycle<sup>3</sup>. This should be viewed as a minimum specification. All doctors should value patient feedback as a core element of their work, improving patient care by enabling reflection and change in practice to take place. Developing this reflective approach to improving patient care engages patients and confirms their opinion is valued. It encourages doctors and organisations to put the patient at the centre of their care and ultimately improve patient outcomes.
  - 2) A doctor should proactively make their own judgement about when it is appropriate to undertake a fresh patient feedback and should seek advice from their appraiser and/or responsible officer if they are uncertain.
  - 3) A doctor whose role changes in a significant fashion should consider undertaking a fresh patient feedback exercise relatively sooner after the change in role. This change may be in the nature of the clinical work, for example a surgeon transferring into general practice. The role could also change in context, for example a physician who moves to a different hospital, or a general practitioner who takes up new work in an out of hours centre.
  - 4) Where a change in role is of a lesser degree and a fresh exercise is not thought likely to lead to a significant change in the doctor's professional development it may be legitimate to default to the GMC stipulation of completing one feedback exercise per revalidation cycle.
  - 5) Where any concern arises which in the view of the responsible officer would be assisted by the completion of a fresh patient feedback exercise, this can be undertaken at any time.
  - 6) Where there is agreement that a fresh exercise is appropriate for whatever reason, but there is insufficient time for it to be undertaken in time for a doctor's revalidation recommendation or the results are not likely to be obtained in time, the responsible officer has discretion to make a recommendation before the fresh exercise is undertaken or the results received, with agreement between the doctor and the responsible officer that the exercise be completed within an agreed interval. The responsible officer may define whether the outcomes of the exercise must be presented to the appraisal office before the next appraisal, or simply included as supporting information at the doctor's next appraisal.

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<sup>3</sup> In a doctor's first revalidation cycle, the GMC have stipulated that patient feedback that is not entirely consistent with GMC guidelines may be considered, provided it has been undertaken in the five years prior to the doctor's revalidation date, and provided it remains relevant to the doctor's current practice.

- 7) Where the responsible officer has reason to believe that the outcome of the patient feedback exercise may have a bearing on the doctor's fitness to practise and the revalidation recommendation is due then they should request a deferral of the recommendation so that the information from the feedback exercise is available in order to inform the recommendation.
- 8) Where there is disagreement between the doctor and the responsible officer about whether sufficient patient feedback has been presented to support a revalidation recommendation, final authority rests with the responsible officer, who can only make a recommendation to revalidate when assured that the supporting information presented by the doctor is sufficient.

## Topic 8 - Technology-assisted appraisal

*(relevant for all designated bodies)*

### Summary

- **Use of technology-assistance in appraisal such as videoconferencing, may be acceptable but must be approved by the responsible officer in advance.**
- **Technology-assistance is inappropriate when in fact it is a manoeuvre to circumvent the fact that the doctor does not have a legitimate connection to the organisation.**
- **Any technology-assistance to appraisal will need approval by the organisation to ensure that it meets the organisation's security and governance standards as well as maintain confidentiality. Speak to the relevant Information Technology or Information Governance function.**

- 1) Medical appraisal must always be conducted in a professional and proper manner, in order to produce meaningful outputs that will give the responsible officer the assurance required to support a revalidation recommendation. In almost all cases, this necessitates a face-to-face meeting between the doctor and their appraiser. On rare occasions, circumstances may present insurmountable obstacles to a face-to-face meeting. In individual circumstances, there may therefore be a role for the appropriate use of technology, for example internet-based videoconferencing facilities, in supporting the undertaking of appraisal to the required standard. The GMC, in their document *A guide for doctors to the General Medical Council Regulations 2012*, indicate that technology-assisted appraisals may be acceptable but that at least the first appraisal should be carried out in person.
- 2) This decision is entirely at the discretion of the responsible officer, in the context of the individual circumstances. It should be noted that GMC acceptance of the principle of the acceptability of technology-assisted appraisal does not over-ride the prerogative of the responsible officer to decline this option. By the same token, if a responsible officer can assure that their systems are robust, then they are at liberty to deploy this option more freely.
- 3) In the final analysis a technology-assisted appraisal should only be undertaken if in the view of the responsible officer a postponement would cause more harm than good.
- 4) All of the following should apply before a responsible officer approves a technology-assisted appraisal:
  - both doctor and appraiser must have all the supporting information at hand during the interview;
  - the technology must function sufficiently well to permit a meaningful appraisal on the day;
  - the technology chosen must be compliant with existing information governance rules. See <http://systems.hscic.gov.uk/qipp/library/remcon.pdf> for guidance on this.
  - the appraiser must be skilled in undertaking the appraisal in the context of the technology;

- the appraiser must record that the appraisal was undertaken using technology assistance in the free text space associated with the Appraiser's Statements in the appraisal outputs;
- there must be no known significant issue in relation to the doctor's fitness to practise which would necessitate an appraisal in person;
- there should be a readiness to abort the appraisal meeting and arrange a meeting in person should any significant issue come to light which cannot be properly addressed because of the technology-assisted nature of the meeting;
- all other requirements in relation to the appraisal in terms of compliance with the prevailing guidance will apply, in the same way that they would if technology were not being used to support the meeting.

It should be extremely uncommon for a doctor's first appraisal with a new appraiser to be carried out in a technology-assisted appraisal.

- 5) As technology improves and testing and piloting lead to better understanding of how to make it work reliably, both technically and in the sense of supporting high quality appraisal, it is conceivable that use of technology may increase in the future.
- 6) It is imperative that the use of technology to overcome practical difficulties is not employed in circumstances where the difficulties have arisen because the doctor does not in fact hold a legitimate prescribed connection to the designated body in question. To illustrate this, three scenarios are given below, two where technology-assisted appraisal is a legitimate approach and one where it is not.

### **Scenario A**

#### ***In which technology-assisted appraisal may be appropriate***

Dr A works as a consultant in Emergency Medicine in England, and is also a Territorial Army reservist. She contacts her responsible officer just before her appraisal is due, to explain she has been called up for military service abroad at short notice. She has prepared all her supporting information. Her appraisal due date falls during her tour of duty, and her revalidation due date is shortly afterwards. An effective video link is available between her base camp abroad and the appraiser in England, and it will be possible to provide separate copies of the appraisal documentation in both places on the day. She was appraised by the same appraiser last year and there are no active concerns about her practice.

In this circumstance the doctor is out of the country for a period which covers her appraisal month. She will provide all the required elements of supporting information and is being proactive in her communication with the responsible officer. Although one option is to postpone her appraisal until after her sabbatical, this would also entail a need to defer her revalidation recommendation. Although this is also an option it would also be acceptable and practical for a technology assisted appraisal to be performed during the doctor's period of work abroad.

Note: In this example, military regulations mean the doctor will still be subject to GMC regulation whilst abroad, as if she were practising in the UK. In a non-military scenario it is important to note that the doctor will need to ensure that she complies with the requirements of the appropriate regulator in that location during her time abroad.

## **Scenario B**

### ***In which technology-assisted appraisal may be appropriate***

Dr B spends one month in the UK as locum every year. He spends the rest of year in full practice abroad, of a similar nature to his work in the UK. He had an appraisal in the UK last year at which he presented a full portfolio in keeping with GMC guidelines, drawn from both his UK and overseas practice, and which the responsible officer was able to assure as valid and verifiable<sup>4</sup>. He contacts his responsible officer to explain that he will be overseas on the due date of this year's appraisal. He confirms that he will be able to present a similarly complete portfolio at his appraisal, and requests that this appraisal is carried out using internet-based video conferencing. His appraiser has experience in undertaking technology-assisted appraisal and is willing to do so on this occasion.

Because Dr B has been proactive and organised, and because the responsible officer is in a position to be assured that the appraisal will be based on good supporting information and undertaken by an appraiser experienced in technology-assisted appraisal, the responsible officer can be confident that the appraisal will be effective, and so could reasonably approve the use of technology-assisted appraisal on this occasion.

## **Scenario C**

### ***In which technology-assisted appraisal is not appropriate:***

Dr C completed Foundation Training but did not enter a training programme immediately because she was deliberating on her career choice. She completed some locum attachments, which established a prescribed connection to a locum agency. Some months after undertaking her last locum placement the doctor contacts the responsible officer by phone from Australia. She explains that she moved to Australia three months previously and is not sure how long she is likely to remain there before deciding on her career plan. She wants to retain her GMC licence to practise, and requests an appraisal using internet-based videoconferencing technology to help her do so. She is vague about the amount and nature of the professional work she is undertaking in Australia, and the supporting information she may have available to present for appraisal.

Because Dr C is out of the country for an indefinite period it may not be appropriate for her to have a revalidation-related appraisal whether technology assisted or not. More significantly, an appraisal cannot proceed unless the responsible officer is satisfied that Dr C can present a full portfolio of supporting information, valid and verifiable in the context of her UK practise. The use of technology does not replace the requirement to bring to the appraisal information demonstrating competence in UK practice.

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<sup>4</sup> The decision as to whether supporting information gathered outside the UK is acceptable for presentation at appraisal in the UK is a matter for the responsible officer. This decision will rest on a number of factors, including the validity of the information in relation to the doctor's work in the UK, and whether the responsible officer can be satisfied as to its verifiability.

This doctor does not need a GMC licence to practice to support work outside the UK. If working abroad she should practice in a manner consistent with the requirements of that jurisdiction. This is a matter between her and that jurisdiction. She should be encouraged to relinquish her GMC licence for the duration of her absence from the UK, with a view to re-establishing her licence when she returns.

## Topic 9 - Recognising professional time taken by appraisers\*

*(relevant for all designated bodies, with specific details for NHS trusts)*

### Summary

- **Designated bodies must facilitate sufficient time for appraisers to undertake appraisals.**
  - **0.25 SPA for 8 appraisals (40 hours per annum) is a reasonable benchmark to allocate to appraisers in NHS trusts.**
1. Medical appraisal is an important professional activity requiring careful selection, training and continual development of appraisers, as set out in the guidance *Quality Assurance of Medical Appraisers: Engagement, training and assurance of medical appraisers in England*, version 5 (NHS Revalidation Support Team, 2014). The vast majority of medical appraisers are themselves doctors.
  2. There are two main approaches to facilitating appraisers in undertaking their duties:
    - The appraiser undertakes appraisals as part of their overall professional duties within the organisation. They receive no added remuneration for this but there is allowance for the time spent preparing, undertaking and writing up their appraisals. The time and costs of their training and development requirements are provided by the employing organisation.
    - The appraiser undertakes appraisals as an independent contractor. They are paid for their time in preparing, undertaking and completing each appraisal, and are expected to make provision for finding the required time themselves. Independent contractors are also expected to meet their own costs in terms of professional development in their appraiser role.
  3. Whatever approach is taken, it is important, in order to encourage appraisers to take the responsibility seriously and to maintain their skills, that the appraiser is appropriately remunerated either in time or money for undertaking this work. Sufficient time must also be available initial and ongoing training and for them to complete the work to a suitable standard, whether through adjustment of workload in the case of an appraiser in an employed role or through personal time management in the case of an appraiser working as independent contractor.

### Specific advice for NHS Trusts operating a process of Supporting Professional Activities (SPA)

4. The current BMA recommendations are that a consultant job plan should be a 7.5 DCC (Direct Clinical Care)/2.5 SPA (Supporting Professional Activities) split. Increasingly, NHS trusts are looking to doctors to justify the SPA allocation.
5. In many trusts, all doctors are entitled to one SPA for CPD and all other SPA activity has to be allocated to a particular role. NHS England, in its Senior Responsible Owner (SRO) role, takes the view that designated bodies operating a SPA based job planning scheme should recognise the appraiser role by allocating SPA time. A suitable benchmark for this, assuming an estimated 4 hours per appraisal and 8 hours per annum for training and development in the role, would be at the level of 0.25 SPA for 8 appraisals (40 hours per annum).

## 4 References

A Framework of Quality Assurance for Responsible Officers and Revalidation (Department of Health, NHS England, 2014) <http://www.england.nhs.uk/revalidation/qa/>

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](http://www.gmc-uk.org/Revalidation_guidance_for_doctors.pdf_54232703.pdf)

A Reference Guide for Postgraduate Specialty Training in the UK (The Gold Guide, 5th edition) (Conference of Postgraduate Medical Deans of the United Kingdom, 2014) <http://www.copmed.org.uk/publications/the-gold-guide>

An introduction to revalidation (GMC) <http://www.gmc-uk.org/doctors/revalidation/9627.asp>

Good Medical Practice (GMC 2013) [http://www.gmc-uk.org/guidance/good\\_medical\\_practice.asp](http://www.gmc-uk.org/guidance/good_medical_practice.asp)

Medical Appraisal Guide: A guide to medical appraisal for revalidation in England, version 4 (NHS Revalidation Support Team, 2013 (reissued with updated hyperlinks September 2014)) <http://www.england.nhs.uk/revalidation/appraisers/med-app-guide/>

Medical Appraisal Position Statements (NHS England) Available on request from: [england.revalidation-pmo@nhs.net](mailto:england.revalidation-pmo@nhs.net).

*Quality Assurance of Medical Appraisers: Engagement, training and assurance of medical appraisers in England*, version 5 (NHS Revalidation Support Team, 2014) <http://www.england.nhs.uk/revalidation/ro/app-syst/>

Raising and acting on concerns about patient safety (GMC, 2012) [http://www.gmc-uk.org/guidance/ethical\\_guidance/raising\\_concerns.asp](http://www.gmc-uk.org/guidance/ethical_guidance/raising_concerns.asp)

Specialty Guidance for Appraisal and Revalidation (Academy of Medical Royal Colleges) <http://www.aomrc.org.uk/revalidation/speciality-frameworks-and-speciality-guidance.html>

Supporting information for appraisal and revalidation (GMC, 2012) [www.gmc-uk.org/doctors/revalidation/revalidation\\_information.asp](http://www.gmc-uk.org/doctors/revalidation/revalidation_information.asp).

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