

**Faculty of Public Health
Quality Assurance Report
2023**

Wessex Appraisal Service Ltd.



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Introduction

Thank you for commissioning Wessex Appraisal Service Ltd. to provide a comprehensive external quality assurance review of the Faculty of Public Health (FPH) Revalidation and Medical Appraisal Service.

The aims of the independent review as provided in the FPH specification are to:

- check compliance
- provide a benchmark and basis on which to further enhance the quality of appraisals as well as revalidation processes
- identify areas to further develop infrastructure to support revalidation and appraisal
- recognise areas of risks
- provide steers to strengthen links with Clinical Governance as a non-employing designated body
- offer feedback and recommendations

To complete the quality assurance process Wessex Appraisal Service agreed to:

- review 20 appraisal portfolios
- facilitate 7 interviews with the core revalidation team
- facilitate 2 interviews with FPH appraisers
- complete a comprehensive policy review
- present findings in a pre-report video conference to allow for clarification and discussion
- provide a formal written report of all quality assurance processes and findings

This final written report includes an overview of the services provided with observations and insights. More information is available upon request and in separate documents. This will enable the report to be shared easily with all relevant stakeholders, while maintaining the confidentiality of individual portfolios and interviews.

Executive Summary

Quality Assurance

Wessex Appraisal Service is pleased to report that:

- The extensive FPH policy review mapped against current core revalidation standards and national documentation revealed a strong focus on clarity of process for all appraisees and a positive appraisal ethos.
- The policies were up to date and comprehensive, and available on the FPH website with good transparency and accessibility.
- The twenty appraisal portfolios reviewed were of high quality with appraisal outputs that were consistently well-written, all scoring above the minimum satisfactory score of 16/20 (range 16.5-18, mean 17.275).
- Nine semi-structured interviews with the CEO, Deputy CEO, FPH Registrar, FPH Lay Board Member, Revalidation and Workforce Administrator, FPH Responsible Officer (RO), Lead Appraiser and two FPH appraisers took place between August and November 2023.
- Thematic analysis of the interviews was very positive, and revealed a cohesive and efficient team, with clear lines of responsibility and high levels of communication and trust.
- The external QA, and additional observations from the video conference, which was well attended from the most senior levels of the FPH, demonstrate that continuous quality improvement (CQI) is central to the FPH Revalidation and Appraisal Service methodology. This is an example of best practice.

Executive Summary

Areas for consideration

These suggestions are put forward for consideration and internal discussion:

- Formalise the review process for Policies and Procedures with an increased consistency of style and structure and clarity about lines of responsibility considering recent changes in personnel.
- Ensure that links in policies are regularly checked and kept up to date.
- Create Plain English Summaries, particularly for the longer Policies.
- Strengthen / make clear the encouragement for Faculty appraisees who are in a process of responding to concerns or remediation to bring someone as a support to meetings, whether the meetings are formal or informal.
- Create a peer-to-peer communication method / community of practice / support group for the appraisers to share experiences, ideas and examples of good practice.
- Facilitate specific appraiser update training regarding best practice in appraisal summaries, especially due to the regular updates in the FPH SUPPORTS QI tool, and the implementation of the GMC Good Medical Practice 2024.
- Promote appraiser use of coaching techniques to support the development of empowering PDP goals and ensure that the impact of achieving the goal on the appraisee's practice is discussed.
- Continue to develop areas for lay advisor input, as having a lay member is an example of best practice, and a valuable resource for quality improvement.
- Consider adopting the aim of working towards equivalence with the NHS standard appraisal fee payable to the appraiser, due to the current vulnerability created by the lower FPH payment to appraisers.

Policy Review

Overview

The detailed Policy review, including all tracked changes and comments, can be made available upon request (Appendix 1). The full list of Policies reviewed is:

- FPH Clinical Governance policy
- FPH Revalidation Service User Agreement
- FPH Appraisal Guide
- FPH Appraisal and Revalidation policy
- FPH Data Protection policy
- Remediation procedure
- Sub-engagement and non-engagement procedure
- Responding to Concerns procedure
- Approved Practice Setting procedure
- Return to Practice Principles
- Appraiser Agreement
- Registration Form
- Guidance for Medical (Crematorium) Referees

Observations

The FPH policies and procedures reviewed were extensive and well managed. They are available on the FPH website for all members of the Faculty. The policies are clear and well written and cover the core revalidation standards, as laid out in national documentation, as well as additional areas of particular focus for the FPH.

Insights

Ensuring all policies are available online and links are up to date.

Within any process of regular policy review, it is important to ensure that all policies are available on the website and that any links are checked. We discovered that the Sub-engagement and non-engagement procedure was not available. In discussion, it was clear that this was an oversight, and we were assured that it will be remedied as soon as possible. Some links in policies were no longer active. These will undoubtedly be brought up to date in the current policy review.

Consistency of recording of policy review process.

Although the policies and procedures are comprehensive, it is best practice to have consistency across all documents, including visual style and format. The policies are already reviewed at regular intervals. We were told that historically this has been done annually, which is best practice, but there should be a consistent way of tracking this with a short policy review statement at the end of each policy. This statement should include the date the policy was reviewed, the expected date (month and year) of the next review and the person responsible for the review. During the video conference, we were made aware that there is a policy review currently underway which offers an opportunity for increasing standardisation.

Creating consistency of process between medical and non-medical registrants.

We understand that the FPH has made the conscious decision that the guidance provided within the Appraisal and Revalidation policies should be broad and inclusive. The intention is that the documentation should be appropriate regardless of regulatory background and the policies should be accessible by both the medical and non-medical specialists requiring appraisal. Currently the policies remain skewed towards the medical doctors. In this context, different specialities do not normally have specific guidance, with the exception of the Guidance for Medical (Crematorium) Referees. They are felt to be a special case due to the unique nature of the role.

Accessibility and Plain English summaries.

To ensure the accessibility of the policy documents, they are currently made available online on the FPH website. For the longer documents it may be helpful to include Plain English summaries of the content. These usually have a maximum length of one page and contain a short description of the document. As a minimum, the FPH Appraisal and Revalidation Policy, Revalidation Service User Agreement and Sub-engagement and non-engagement procedure could benefit from such a summary. These policies are the most relevant to the users of the FPH Revalidation and Medical Appraisal Service and a 'Too Long Didn't Read' (TLDR) option could capture key information from the longer documents as straightforward highlights. This short form would make policies more approachable, and the summaries could be drafted using Artificial Intelligence (AI) technology to ensure that the process is not too costly or time consuming.

Providing support to individuals undergoing investigation.

Within the Remediation and Responding to Concerns policies there are specific mentions of the 'case conference' or a review of the investigation undertaken if the concerns are classified as 'higher level (Red)'. In these situations, where there might be a difficult conversation that the individual needs to hear, it is best practice to allow the individual responding to the procedure to be accompanied by a colleague or representative during these meetings. The FPH should consider strengthening or clarifying the guidance around these policies to encourage the use of this additional support. We understand that the FPH is a non-employing designated body which may make it more complicated to properly express this concept within the relevant policies. As discussed during the video conference, it is important that the wording is carefully considered and appropriate.

Appraisal Outputs Quality Assurance

Overview

Wessex Appraisal Service Ltd. were commissioned to review twenty portfolios that were randomly selected by the FPH. The portfolios were taken from appraisals completed between August 2022 and June 2023. We understand that this is a sample size of roughly 15%, which reflects NHS England recommendations to review 10-20% of outputs annually and makes the findings from the review appropriately representative. The portfolios were reviewed in full, comprising the entire appraisal inputs and outputs.

The randomisation procedure yielded portfolios for review from appraisals facilitated by nine different appraisers. This does not represent all the appraisers engaged by the FPH. The suggestion that some appraisals for the appraisers not represented should be selected, to replace those from an appraiser represented more than twice, was not agreed, on the basis that it would be hard to randomise. Those appraisers who were not represented should still have some of their appraisal outputs reviewed internally for completeness.

Although originally the FPH suggested that the appraisal portfolios would be anonymised, as part of commissioning, we recommended that they should be shared in a non-anonymised form. Anonymisation of the outputs typically reduces the ability to quality assure the appraisal summary effectively, for example around scope of work. To satisfy data protection requirements for portfolios containing personal and potentially sensitive information, the appraisal portfolios were shared via a secure electronic platform (SharePoint) and were never downloaded or taken outside the secure FPH environment. All members of the Wessex team who viewed the portfolios to QA them were individually named. They have had appropriate IG and GDPR training and their contracts have specific provisions about maintaining confidentiality. They are experienced in the QA of appraisals and perform the same function for the appraisers engaged by Wessex Appraisal Service Ltd. on a regular basis. For this commission, they also held regular calibration sessions, using FPH data, to ensure that the intra- and inter- rater consistency could be maximised.

Wessex Appraisal Service Ltd. was commissioned to review ten appraisal portfolios using the Academy of Medical Royal Colleges' SUPPORTS QI tool (as refined in 2022 to reflect the Medical Appraisal Guide 2022) and ten appraisal portfolios using the EXCELLENCE quality assurance tool (for comparison against the previous external review). Using these separate tools allowed us to highlight differences in nuance and emphasis between tools, as well as providing a platform for comparison with the results of the previous review. Learning from the evaluation of the SUPPORTS QI and EXCELLENCE tools can be found in Appendix 2. The details of the twenty quality assurance reviews can also be made available upon request (Appendix 3).

In the post review video conference, the Lead Appraiser said that, as part of the FPH ethos of continuous quality improvement, the FPH have been using a unique version of SUPPORTS QI tool since 1st April 2021, updated in September 2023 to version 3a, for internal QA/QI. This continuous quality improvement (CQI) is an example of good practice, and, in the videoconference, the Lead Appraiser reported an improvement in the quality of appraisal summaries over time. For completeness, this review has compared all three quality assurance tools and found that there are some subtle differences between them. This will have affected the ability of appraisers to achieve maximum scores on the SUPPORTS and EXCELLENCE tools used in the review as the assessment criteria is slightly different. Nevertheless, the appraisal portfolios received satisfactory ratings that are maintained while using the new version '3a' of the FPH SUPPORTS QI tool. Comparisons which highlight the similarities and differences can be found in Appendix 4a and 4b.

Assessment drives performance and it is essential to give appraisers access to the tools that will be used and against which they will be assessed. Each version of the FPH SUPPORTS tool has been shared with the FPH appraisers and training in how the appraisal outputs should be presented has been provided at the appraiser development days. As the FPH appraisers become more familiar with the new FPH SUPPORTS QI tool, it is likely that their scores will continue to increase.

GMC Good Medical Practice 2024

The update of the GMC Good Medical Practice 2013 guidance which comes into effect at the end of January 2024, will significantly impact the way in which appraisers document the appraisal outputs. The appraisal portfolio is designed so that doctors

can demonstrate that they are working in line with Good Medical Practice and so the changes in the four domains and underlying attributes will require a new format for

the portfolio and especially the appraisal summary. We anticipate that the electronic platform providers, including L2P, will incorporate the changes from 1st April 2024, although they have until April 2025 for full implementation. Appraisers will need specific update training to enable them to complete the appraisal outputs in the format with confidence. It is likely that the assessment tools, such as the FPH SUPPORTS QI tool, will also require some revision to reflect the new domains and focus.

Observations

All the FPH portfolios reviewed, without exception, were of a high standard and consistency. The appraisal portfolio scores ranged from 16.5 - 18/20 (mean 17.275)/20.

- The range for SUPPORTS QI tool scores was 17-18/20 (mean 17.4/20)
- The range for EXCELLENCE tool scores was 16.5-18/20 (mean 17.05/20)

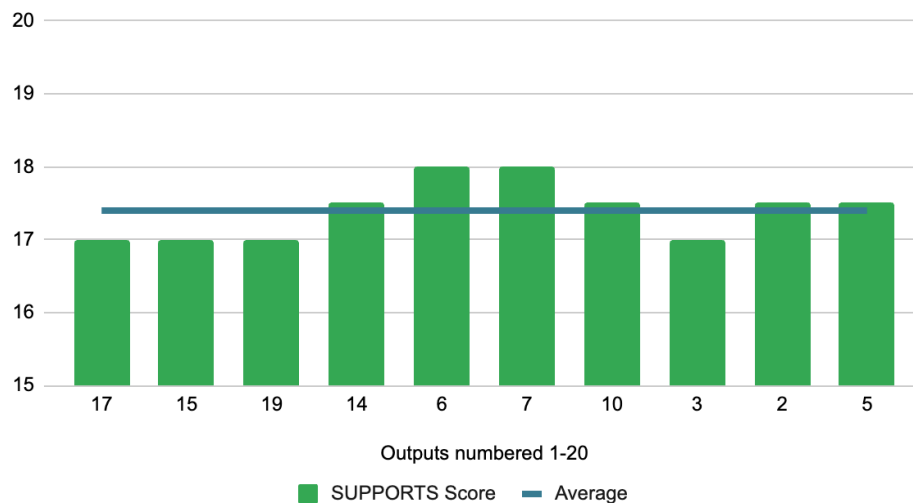
It is important to recognise that 16/20 is a satisfactory quality assurance outcome, for both the tools used. The scores demonstrate a good level of consistency across both tools and across the appraisers, which is a credit to the FPH Appraisal and Revalidation Service training and support of appraisers. Where there is a small discrepancy in the scores, with those from EXCELLENCE being slightly lower overall, this appears to be due to SUPPORTS QI only allocating 4 marks for PDP review and the new PDP, whereas EXCELLENCE allocates 6 marks. It is recognised that ownership of the PDP by the doctor can create variability in how well it is documented.

The appraisal portfolios were well written, with clear and concise language and high-quality outputs. The summaries are all in a typed professional format and appear free from prejudice or bias, with all statements based on evidence from the discussion or supporting information. The raters were deliberately discriminating, looking to highlight small areas for improvement. The points that have been missed are subtle but would enhance the usefulness of the summary to the appraisee and RO, by making transparent aspects such as recording gaps in revalidation requirements. The appraisal portfolio can only ever be a proxy marker for the quality of the appraisal discussion. Nevertheless, this QA exercise suggests that these appraisers are facilitating high quality appraisal discussions.

The graphs below show the consistency of outputs across the appraisal portfolios reviewed, and the high average score found using both the SUPPORTS and EXCELLENCE tools.

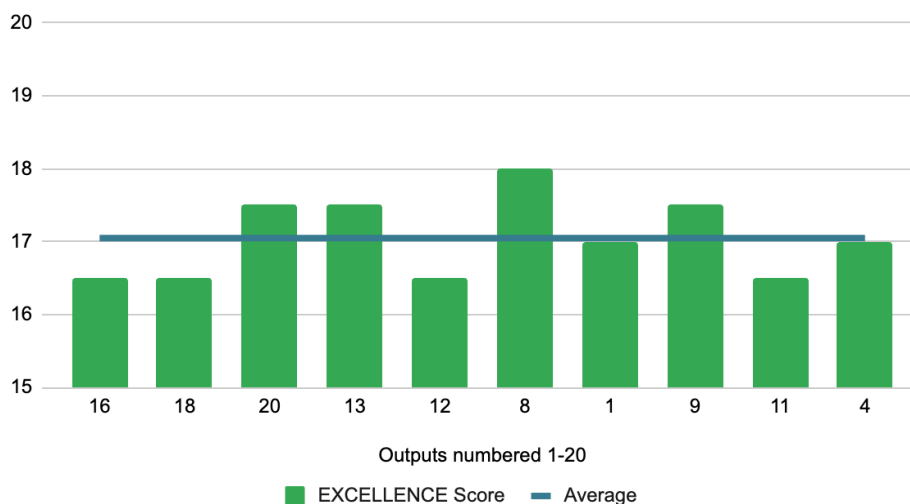
SUPPORTS QI

FPH SUPPORTS Score and Average



EXCELLENCE

FPH EXCELLENCE Score and Average



The twenty portfolios were randomly assigned a number 1-20 across both tools, and the scores are shown above. Where there was more than one appraisal portfolio from the same appraiser the QA was split between SUPPORTS and EXCELLENCE and between the raters, as part of the calibration method.

Insights

The appraisal summaries reviewed demonstrated an awareness that key information is required to support the demonstration of appraisees' skills and reflection, so this was generally very well done. Overall, the tone was warm and supportive.

Unsurprisingly, the most common areas where scores were reduced came from a lack of awareness of the assessment tools and specific information that is explicitly required for each.

Explain appraisee's qualifications for scope of work.

The pen portraits of the appraisees were usually well written and described the whole scope of work for the appraisee but the historic qualifications and experience equipping appraisees for their current scope of work was often not explained. Although these details are typically captured in the pre-appraisal portfolio, the QA tools used encourage each summary to make the connections showing how the appraisee is equipped for their whole scope of work. In addition, ensuring these details are in the summary makes them easy for the RO to find.

Explain the appraiser's background and qualifications.

Most appraisers did not include any comment about how they were qualified to undertake the role of medical appraiser. This information is most relevant to appraisers appraising appraisees who have no prescribed connection and are revalidating directly with the GMC, but it is easy to add as a standard sentence. This forms a useful ongoing record of the appraiser's qualifications and route to calibrating their professional judgements.

Other specific information required by SUPPORTS and EXCELLENCE QA/QI tools.

Summaries were not necessarily clear about the revalidation or appraisal specifics. It is expected by both QA tools that the revalidation date and position of appraisal in terms of both appraisal and revalidation cycles is recorded, any gaps in requirements for revalidation are made clear, or, if there are no remaining gaps, that this too is recorded explicitly. This is a very important way of highlighting to the appraisee and the RO what supporting information is still required before a recommendation to revalidate can be made.

There is an expectation that every appraisal will be held in an appropriate place, with privacy and freedom from interruptions, whether they are held in person or remotely, and that the duration of the appraisal will be recorded. Most appraisers included some of these details, but they were not necessarily consistent. Not all appraisers commented on the information governance required and ensuring that there was no patient identifiable information in the portfolio. This is included in the tools to serve as a reminder to check that anonymisation is done carefully. One way to ensure that these items are always included is for appraisers to be provided with a consistent prompt paragraph, that captures the appraisal and revalidation specifics. This reduces the work required for the appraiser and encourages good practice.

We recommend creating reproducible templates for the following topics:

- Appraisal specifics, including appraisal date, length of time, venue, privacy etc.
- Revalidation specifics, including revalidation date, which appraisal it is in the cycle, how many with the same appraiser, and any gaps that could prevent revalidation, for example a missing Multi Source Feedback survey.
- Health and probity specifics, including a summary of the doctor's responses to the health statement and probity statement, and a quick sentence on indemnity and insurance if necessary.

Examples can be found in Appendix 5.

Increase the focus on impact of lessons learned and changes made.

Information around good medical practice, safety and quality is generally well covered with quality improvement activities being recorded and discussed. In most cases reviewing professional and personal experiences in the period since the last appraisal was a strong element of the summaries. Where marks were lost, it was most often due to a lack of clarity about the direct impact of lessons learned or quality improvements made. These should be explicitly stated. There was also a tendency towards minimising the personal aspects of impact in the summaries reviewed. Although this did not affect the scoring, it is something appraisers may wish to consider.

Remember the importance of written affirmation/validation.

Both SUPPORTS QI and EXCELLENCE explicitly look for the 'praise' in appraisal e.g. 'encourages excellence'. An affirming appraisal document can boost morale and increase retention. Comments such as '... is an example of good practice'; '... was a significant achievement', etc. can be evidence based and objective as well as validating the hard work of the appraisee.

Ensuring the appraisal discussion is appraisee centred and appropriately challenging.

It is difficult with the setup of the L2P tool and how it is formatted for the summaries to tell if the appraisee led the discussion/was able to set the agenda. In addition, challenge can be misunderstood, and some appraisers appear to find it harder to demonstrate in the context of an appraisal that is clearly supportive. It may be helpful to consider challenge in terms of stretch, development, and encouragement. Demonstrating questions asked and the targeted reflection of the appraisee can provide evidence of appropriate challenge and the impact on the personal and professional development of the appraisee.

Documentation around the PDP.

This is typically the weakest area of the appraisal outputs in all organisations, including Wessex Appraisal Service Ltd., partly because of the requirement to ensure that the new PDP is 'owned' by the appraisee, who is unlikely to have had any training in writing an effective PDP goal. The FPH is no exception. This is why the QI/QA tools place such emphasis on the review of progress against the previous PDP goals and where new PDP goals arise from the appraisal documentation and discussion. In the outputs reviewed, prior PDP goals were commented upon in general terms, although sometimes the actual progress made against each goal was not reviewed in detail. This seems to link our finding that PDP goals in general were not written in a sufficiently SMART(ER) way, especially in terms of being Specific, Measurable and Reflecting on impact / what success looks like.

In the case of the summary where they stated there were no prior PDP goals, one option might have been to review the informal goals the appraisee had worked towards and the challenges arising from their change in context as if they were the previous PDP items.

We all recognise that the PDP goals are and should remain owned by the appraisee, but that discussing them at appraisal and for support to be provided ensures they are formulated in a SMART(ER) way. In most cases the goals needed to include the expected impact, further consideration of how the progress would be demonstrated/measured and details linking them to an expected timeline. PDP goals should also be signposted in the write up of the appraisal discussion, as this helps link them back to the appraisee's agenda and demonstrate their specific relevance. If the goals were written up in greater detail the links could also be shown that way.

Our recommendation would always be for the appraisers to have a dedicated skills update in this area. As we understand it, this may have already been included in the FPH appraiser training in September 2023, which occurred well after the outputs provided were written.

Please find a copy of the Academy of Medical Royal Colleges (AoMRC) PDP template in Appendix 6. This highlights some questions which can be used as useful prompts when co-creating a PDP goal.

Documenting aspirations.

Aspirations often have a timescale of over one year. We agreed that these medium-term goals can be very important and yet they are not always well documented in the appraisal portfolio. In relation to the PDP goals, which are almost always written to be achievable within the appraisal period, aspirations can potentially be missed in the appraisal outputs. One strategy to avoid this, is to break a longer-term aspiration into a series of more timebound steps towards the ultimate goal. Another is to be entirely explicit that achieving the goal as defined will take longer than a year.

Semi-Structured Interviews

Overview

The interviews of the core revalidation team were conducted virtually and scheduled to take no longer than thirty minutes. The interviews were semi-structured and based around common topics and conversational themes rather than a specific question set. The seven common topics included: communication, best practice, potential changes or improvements, training, support, quality processes and escalation of concerns. This style of interview allowed for a greater freedom of response and the ability to have an open discussion led by the interviewee. The interviews were then analysed thematically to draw out common themes and create our observations and insights. The thematic analysis can be found in Appendix 7.

As planned, the Wessex Appraisal Service Ltd. interview team conducted nine interviews with the CEO, Deputy CEO, FPH Registrar, FPH Lay Board Member, Revalidation and Workforce Administrator, FPH Responsible Officer (RO), Lead Appraiser and two FPH appraisers. The interviews were recorded and transcribed for analysis purposes, but interviewees were given the assurance that they would not be made available as part of the final reporting, so that they felt they could speak in confidence.

Observations

There was an exceptional shared appraisal ethos found across all the FPH interviews, which indicated the supportive and formative nature of the appraisal process. The importance of appraisal for maintaining professionalism and ensuring safe practice was brought up alongside the importance of appraisees maintaining high well-being and having time to reflect on their practice. Appraisal within the FPH is seen as valuable and there was a good level of awareness concerning the Revalidation and Appraisal Service at all levels of the organisation.

The FPH revalidation team is a cohesive unit who were highly rated as being supportive and responsive. There are clear roles and responsibilities with good relationships between the team members. There are regular meetings to ensure all relevant topics are discussed and shared as well as creating a space to ask for help or advice. This supportive developmental environment allows for support and feedback

to be given in all directions. The close-knit nature of the team means that the pathways for advice and escalation are open, preventing potential issues.

The L2P appraisal management system is regarded as straightforward and easy to use, however it does not currently synchronise with the member's portal leading to occasional duplication of effort. However, this was felt to be a small price for a good tool. During the Covid 19 pandemic the FPH allowed for remote appraisals to be held. This practice now continues in some cases where it is easier for both the appraiser and doctor. Views vary regarding virtual meetings, with some liking them so much that there is some challenge to the suggestion that at least one appraisal in three years should be facilitated in person, now that everyone is so used to doing things by Zoom or Teams, but there is also an acceptance that it can be quite nice to get back to face to face again. Overall, whether the appraisal takes place in person or remotely should be decided by the doctor's preference if the appraiser has capacity to do both.

There is great engagement with the Revalidation Service across the FPH with appraisers reporting that their queries are dealt with quickly and efficiently. Cross referencing between the appraisers and the revalidation team shows that the regular training and updates for appraisers are well received and productive. The new appraisers are trained externally but have a period of close supervision by the appraisal lead which allows them to develop their skills in a safe environment. Alongside the regular training, the quality processes of the FPH Revalidation Service include direct feedback from the Appraisal Lead on appraisal portfolios and summaries and annual reviews of appraisee feedback. These help to ensure consistency and continuous quality improvement for the whole Revalidation Service, which is appreciated by the appraisers and the wider team.

Insights

The revalidation team has good links between each other and directly to the appraisers and appraisees, however, there was some disconnect between the appraisers themselves. A peer-to-peer support group would create a community of practice and be a good way to ensure that the FPH appraisers can share best practice and ask for feedback. An instant message app shared by the whole group could be helpful for non-confidential enquiries due to the speed of response achievable and the ability to use the wisdom of the group and share learning. There is an explicit

process of continuous quality improvement within the FPH, such that some of our recommendations and matters arising from the interviews have already been acted on. The interviews of appraisers took place early in our review and through the video conference it is our understanding that this has already been put in place in the form of a WhatsApp group. We cannot know whether the quality assurance process and interviews themselves fed into this, but it is a lovely example of good practice that is common in the FPH.

Due to a change in personnel and some restructuring of the revalidation team it will be important to maintain the continuity of function. It can be easy to lose oversight during periods of change, and a part of the success of the Revalidation Service stems from clear responsibilities and job roles. We recommend that as the restructuring continues there are regular updates and any alterations in job role or function are widely reviewed. This must also consider the evolution of appraisal as a whole, following the announcement of Good Medical Practice 2024, which could lead to other subtle changes in appraisal processes and emphasis.

Lay involvement.

It is considered best practice to have lay involvement in appraisal and revalidation teams and we commend the FPH for recognising the importance of hearing the patient and public voice. There are a variety of stages in the appraisal and revalidation process where the diversity of a lay viewpoint can be useful. In our experience, to maximise the insights arising from this role, it is important that all team members are clear about the scope of the role and support needed by lay members. It may be helpful to facilitate a conversation with the whole revalidation team to understand where the potential focus of the lay member would be most beneficial.

Induction.

As the revalidation team is small it is important to ensure that the handover between roles is consistent and robust. Creating Standard Operating Procedures (SOP) provides resilience in the event of any unexpected absence and particularly at points of handover. Strengthening the induction processes for each role and continuing to offer support will facilitate smooth transitions. In particular, it is important to be clear

about the boundaries around responsibilities so that new team members have clarity about their roles.

Appraiser remuneration.

There were interesting comments from several interviewees about the low fees paid to appraisers. These were mitigated by the fact that those who commented also spoke about how this is driven by keeping the fees for appraisees lower, which was seen as desirable. The current NHS England recommended appraisal fee is £584 per appraisal, which is significantly higher than the fee paid by the FPH. The FPH is therefore currently relying on the goodwill of their appraisers, who are clearly highly skilled and committed, to continue to appraise, when they could be better remunerated elsewhere.

While it is beyond the remit of this commission to look at the pay to appraisers, or the cost of the service to the registrants, paying below the NHS rate is a potential risk that makes the organisation vulnerable. When discussing the fees paid to the appraisers as part of the video conference, it was revealed that there has already been a very significant move to improve appraiser remuneration, indicating that the team were already aware of the risk. We understand the FPH will be increasing the fee paid to appraisers from £400 to £500 from 1 April 2024. This will be within the existing fee window that they charge connected members (currently £1300). We recommend that the FPH considers further an explicit process that aims to bring the payments to their appraisers in line with the NHS rate over time, as this will help to future proof their supply of appraisers.

Conclusion

Wessex Appraisal Service Ltd. was delighted to win the commission to perform an external quality assurance exercise for the Faculty of Public Health. It was a pleasure to review a Revalidation and Medical Appraisal Service that is working so well. Our observations and insights are based on drilling into small details because the big picture is of a highly regarded, approachable and effective team with an excellent ethos of supportive appraisal. We anticipate that our comments will feed into the process of internal continuous quality improvement which is such a strength of the team. Although it is a time of transition internally, following the retirement of one key team member, structures are already in place to ensure that historic high standards can be maintained and improved.

The biggest challenge on the horizon is the implementation of the updated GMC Good Medical Practice at the end of January 2024. This will impact on doctors and appraisers alike, and further training and support will be needed for the appraisers, in particular. The FPH has very good structures in place to address any changes required in a timely way, once the new L2P format is revealed.

We wish you well over the next stage of development of appraisal and revalidation. Do keep in touch if there are any areas where you feel we could work productively together in future.

Appendices

Appendix 1

The policy reviews are available upon request with all comments and changes tracked.

Appendix 2

Overall, the random summaries provided are all very good and score above the minimum standard required. The EXCELLENCE scores are generally a little lower than those using the SUPPORTS tool. We believe this is due to the wording of the criteria and the differences in emphasis. EXCELLENCE is an older tool and is therefore also perhaps less in line with up-to-date good practice. The points that have been missed are subtle but would enhance the usefulness of the summary to the doctor and the RO by making things like gaps in the progress towards revalidation totally transparent.

Learning from the evaluation of SUPPORTS QI of appraisal outputs.

Overview

Provides a good description of the doctor, and the context(s) in which they work (1) including their background qualifications, and experience relevant to the scope of work (1) and their whole scope of work (1)

This was generally well done with a pen-portrait of the doctor and their whole scope of work well described and typically at the beginning of the appraisal summary, which situates the doctor at the heart of the summary. If any marks were lost it was usually in failing to note the doctors background qualifications that equip them for their scope of work. Although these are included in the pre-appraisal portfolio, capturing them in the summary makes them easy for the RO to find.

Specifics and Sign-offs

Professionally written – typewritten, objective, suitably succinct, free from bias or prejudice (1)

All summaries were professionally written and appeared free from bias or prejudice.

Gives revalidation specifics - recommendation due date, point in revalidation cycle, number of appraisals within this cycle / with this appraiser, appraiser qualifications (1)

Many appraisers lost 0.5 marks for not being clear about the revalidation specifics in every case. Most appraisers did not include any comment about how they were qualified to undertake the role of medical appraiser. While this is most relevant to doctors appraising directly with the GMC who have no other prescribed connection, it is easy to add as a standard sentence and forms a useful record of the appraiser's qualifications and route to calibrating their professional judgements.

Describes a professional appraisal - venue/remote appraisal provider, duration, information governance and appropriate anonymisation. Demonstrates an audit trail if exceptional circumstances apply (period in work since last appraisal not 12 months / approval for unusual arrangements or postponement etc.) (1)

Some appraisers lost 0.5 marks for not being clear about the appraisal specifics in every case. Not all appraisers commented on the information governance and ensuring that there was no patient identifiable information in the portfolio.

Summarises the responses to input and output statements, including health and probity. Comments on anything the doctor was asked to bring to discuss at the appraisal meeting or review e.g. Factors for Consideration (FfC) SRT (if applicable). Comments on medical indemnity. Where appropriate, circumstances commented on and explanation made to RO (1)

Some appraisers lost 0.5 marks for not being clear about the portfolio input specifics in every case. Although these inputs are in the pre-appraisal portfolio, it is useful to the RO to summarise them all in one place and this is easy to do with a standard section for every summary.

An example summary for specifics and sign-offs is given in Appendix 5.

Tracks GMC Supporting Information (SI) requirements

Reviews SI in relation to *Good Medical Practice* and whole scope of work, including commenting on any SI supplied or discussed and how this demonstrates the ability to work safely and make quality improvements in their practice (1)

Comments on any gaps identified in the requirements for revalidation, or covering whole scope of practice and how they will be addressed, including them in PDP if appropriate (or stating if no gaps) (1)

Information around good medical practice, safety and quality is generally well covered with quality improvement activities recorded and discussed. Some appraisers do not explicitly state whether there are any gaps in the portfolio for revalidation or not. A standard statement can be helpful in the general comment at the end of the appraisal summary, as suggested in Appendix 5.

Understanding impact

Reviews the personal and professional impact of the period since the last appraisal. (1) Considers lessons learned and any changes made in terms of quality of practice and improving patient care (1)

In most cases this was a strong element of the summaries, however where 0.5 marks were lost it is due to a lack of clarity about the direct impacts of changes made or quality improvement change not being explicitly stated. There was also a tendency towards minimising the personal aspects of impact in the summaries which although it didn't affect the scoring is something appraisers may wish to consider as appraisal should reflect the individual as human as well as a medical professional.

Support

Focuses on the agenda and needs of the doctor (1)

It is difficult with the setup of the tool and format of the summaries to tell if the doctor led the discussion or was able to follow their agenda in the appraisal discussion.

Considers health, wellbeing and work/leisure balance, including response to the 'How are you?' rating scale. Offers support / signposts to resources for support (if applicable) (1)

In some cases, 0.5 marks were removed due to Work life balance/ "How are you? score" not being mentioned. If it is not included or only the 'score is given without reflection, then an opportunity is missed for using it as a tool for addressing strategies linked to wellbeing or signposting resources if necessary.

Reflection

Encourages reflective practice and stimulates the doctor to consider their personal and professional development in the context of their work and any challenges they face (1)

To greater or lesser extent all the summaries demonstrated that the appraisee had reflected and most demonstrated that the reflective practice occurred pre-appraisal and during the discussion with the appraiser. Although all contained sufficient evidence of reflection, those that did it best include not just statements that the appraisee had reflected, but what the reflection was and why it was relevant.

Praises excellence

– affirms good practice (with examples), celebrates achievements (1) and records aspirations (some may have a timescale over one year) (1)

Where 0.5 marks are removed it is usually due to the lack or limited inclusion of aspirations, especially where the PDP is also less clear about why a goal has arisen. Stylistically some appraisers are more subtle with affirming / validating the appraisee,

and celebrating achievements, but they have not been marked down for this as long as the tone is warm and supportive.

PDP

Reviews and comments on progress with last year's PDP objectives. (1) Indicates how new PDP objectives arise from appraisal and Good Medical Practice. (1)

New goals are SMARTER (Specific, Measurable, Achievable, Relevant, Time-bound, Economic and Reflect Impact). (1) Makes explicit how achievement will impact on quality / safety or patient care (1)

The PDP is the area where we most often find room for improvement, and it does have to be owned by the doctor so the wording may not always be as polished as it could be. We recommend using the AoMRC PDP template (Appendix 6) and answering the questions it asks as a useful technique for improving the detail about where the goal arises in the appraisal and discussion and what the impact of achieving it will be.

Learning from the evaluation of EXCELLENCE QI of appraisal outputs

Overall

Encompass all? does the summary comment on context, including stage of revalidation cycle, and reflection on the whole of the scope of work?

Where revalidation details or background qualifications or changes in practice of the doctor did not appear to have been covered this led to a lowered score. This may be due to the appraiser knowing they are included in the pre-appraisal information but including it in the summary is advisable.

Exclude bias and prejudice? are all statements objective, free from bias and prejudice and based on evidence? Is it a typed, professional document?

The summaries are all in a typed professional format and appear free from prejudice or bias. All statements appear based on evidence from the discussion or supporting information.

Challenge, support and encourage? Does the summary demonstrate that the appraisal was challenging, supportive and focussed on the needs of the doctor?

The setup of the tool and format of the summaries (as also noticed in the SUPPORTS review) makes it difficult to tell if the doctor set the agenda and whether they led the appraisal discussion. Challenge is a tricky aspect to get right in a summary as the

appraisal should also be shown to be supportive. Therefore, this is an area where appraisers may benefit from additional training, including recording evidence of any necessary signposting.

Similarly demonstrating questions asked and the targeted reflection of the appraisee can support this element.

Explain why any statements (including health and probity) have not been agreed? does appropriate commentary explain any 'no' or 'disagree' answers?

(Score 2 if N/A)

No marks were taken away, despite one summary containing a disagreement as the reasoning was appropriately explained. This case shows why making sure that the health, probity and indemnity statements are appropriately reviewed in the summary is important.

Reviewing

Look at supporting information, lessons learned and changes made? does the summary drive quality improvements by reflecting what has been learned and what needs to be changed as a result?

The most common issue here was that whilst discussion of practice clearly took place, links were not made to the doctors' learning or to the impact on their practice. Nor did these summaries include specific reflection on quality improvement activities and the changes made as a result, missing an opportunity to empower the appraisees to take the next step in a CQI process.

Look at last year's PDP and reflect on each objective? if any objectives have not been achieved, have the reasons been discussed and documented?

Typically, the prior PDP's were commented upon, although sometimes the actual progress made was not reviewed in detail, this seems to link to the fact PDP goals in general were not sufficiently SMARTER. In the case of the summary where they stated there were no prior PDP's it would have been appropriate to instead review the informal goals the appraisee had worked towards and the challenges in their change in context as if they were the previous PDP items.

Encourage excellence, celebrate accomplishments and record aspirations? does the summary capture examples of good practice and record aspirations (some of which may have a timescale over one year)?

It was a running theme that aspirations, especially any which may take longer than a year, were not explicitly stated and that the accomplishments could have been celebrated and used as learning points, especially where they related to overcoming challenges in the appraisee's scope of work.

Planning Ahead

Note any gaps/no gaps in the requirements for revalidation and how they will be addressed? what supporting information is outstanding for each role?

Revalidation specifics were often not laid out clearly, therefore colleague feedback, or other revalidation requirements were left out of the summaries. Neither was the need to complete them or when/how the appraisee might do so included in the summary or the PDP. We recommend that patient and colleague feedback should be included in the PDP process so that they can be carefully discussed and planned.

Contain SMART PDP Objectives? Are they Specific, Measurable, Achievable, Relevant and Timely? Do they challenge the doctor to make quality improvements?

In general PDP's require the most improvement, yes these are owned by the appraisee, but they should still be discussed at appraisal and formulated in a SMART way (this is what the tool asks for) or even better in a SMARTER way. In most cases the goals needed to include the expected impact, further consideration of how the progress would be demonstrated/measured and details linking them to an expected timeline. See Appendix 6.

Explain the new PDP items? does the summary show how the PDP objectives are relevant and derive from the supporting information and appraisal discussion?

PDP goals were not always signposted in the write up of the appraisal discussion, which would help link them back to the appraisee's agenda and demonstrate why they were relevant. If the goals were written up in greater detail the links could also be shown that way.

Appendix 3

The 20 SUPPORTS and EXCELLENCE QA reports are available upon request as a separate document.

Appendix 4

During the video conference, the FPH mentioned that they had developed an updated quality assurance tool to use internally for appraisal outputs, SUPPORTS version 3a. In addition to the commissioned work, for interest, we undertook a comparison between the tools to highlight key areas of similarity and difference. This makes transparent the reasons why elements required by the QA/QI tools chosen for the review may not have been included by the appraisers as the emphasis in the FPH SUPPORTS tool is slightly different.

KEY for Appendix 4a and Appendix 4b:

Green highlight - concept in both tools, with minimal or no difference in implied meaning/emphasis.

Orange highlight - concept in both tools with marked difference in wording due to emphasis.

No highlight - concept only in one tool so unable to compare.

Appendix 4a

SUPPORTS QI	FPH SUPPORTS Tool
<p>Overview: Provides a good description of the doctor, and the context(s) in which they work (1) including their background qualifications, and experience relevant to the scope of work (1) and their whole scope of work (1)</p>	<p>OVERVIEW: 1a=Summary describes all roles carried out as a doctor/Registrant (including wte, if possible). (1) 1b=Summary paints a picture of how the doctor practices medicine and explains any breaks in employment. (1)</p>
<p>Specifics and Sign off: Professionally written – typewritten, objective, suitably succinct, free from bias or prejudice (1) Gives revalidation specifics - recommendation due date, point in revalidation cycle, number of appraisals within this cycle / with this appraiser, appraiser qualifications (1) Describes a professional appraisal - venue/remote appraisal provider, duration, information governance and appropriate anonymisation. Demonstrates an audit trail if exceptional circumstances apply (period in work since last appraisal not 12 months / approval for unusual arrangements or postponement etc.) (1) Summarises the responses to input and output statements, including health and probity. Comments on anything the doctor was asked to bring to discuss at the appraisal meeting or review e.g. Factors for Consideration (FfC) SRT (if applicable). Comments on medical indemnity. Where appropriate, circumstances commented on and explanation made to RO (1)</p>	<p>SPECIFICS AND MANDATORY STATEMENTS: 2a=No 3rd party information in uploaded evidence and no obvious biases in summary. (1) 2b=Summary paints a picture of how this appraisal fits into the revalidation cycle. (1) 2c=Summary describes appraisal meeting & (if necessary) explains why not 12 months since last appraisal. (1) 2d=Summary explains any 'no' or 'disagree' answers in health and probity statements, and comments on indemnity arrangements. (1)</p>
<p>Tracks GMC Supporting Information (SI) Requirements: Reviews SI in relation to <i>Good Medical Practice</i> and whole scope of work, including commenting on any SI supplied or discussed and how this demonstrates the ability to work safely and make quality improvements in their practice (1) Comments on any gaps identified in the requirements for revalidation, or covering whole scope of practice and how they will be addressed, including them in PDP if appropriate (or stating if no gaps) (1)</p>	<p>TRACKS GMC SUPPORTING INFORMATION REQUIREMENTS: 3a=Supporting information presented is summarised by the appraiser. (1) 3b=Summary identifies any gaps in the supporting information (eg MSF), and notes in particular any areas of work which have not yet been evidenced this cycle. (1)</p>
<p>Understanding Impact: Reviews the personal and professional impact of the period since the last appraisal. (1) Considers lessons learned and any changes made in terms of quality of practice and improving patient care (1)</p>	<p>PROFESSIONAL WELL-BEING: 4a=Summary comments on occupational stressors, support mechanisms and ability to work effectively. (1) 4b=If appropriate, summary describes what the appraisee has done/could do as a result of identifying workplace stressors. (1)</p>
<p>Support Focuses on the agenda and needs of the doctor (1) Considers health, wellbeing and work/leisure balance, including response to the 'How are you?' rating scale. Offers support / signposts to resources for support (if applicable) (1)</p>	<p>PERSONAL WELL-BEING: 5a=Summary describes how the appraiser provided support or guidance during the appraisal discussion. (1) 5b=Summary comments on the doctor's health, well-being and work/life balance. (1)</p>
<p>Reflection: Encourages reflective practice and stimulates the doctor to consider their personal and professional</p>	<p>REFLECTION: 6a=Summary describes how the appraiser promoted reflective practice and encouraged the appraisee to</p>

<p>development in the context of their work and any challenges they face (1)</p>	<p>consider their personal and professional development. (1) 6b=Summary demonstrates how the appraiser encouraged the appraisee to demonstrate how they work safely and make quality improvements in their practice. (1)</p>
<p><i>Praises Excellence – affirms good practice (with examples), celebrates achievements (1) and records aspirations (some may have a timescale over one year) (1)</i></p>	<p>PRAISES EXCELLENCE: 7a=Summary records achievements (incl good practice). (1) 7b=Summary records short/medium-term aspirations. (1)</p>
<p><i>PDP: Reviews and comments on progress with last year's PDP objectives. (1) Indicates how new PDP objectives arise from appraisal and Good Medical Practice. (1)</i> <i>New goals are SMARTER (Specific, Measurable, Achievable, Relevant, Time-bound, Economic and Reflect Impact). (1) Makes explicit how achievement will impact on quality / safety or patient care. (1)</i></p>	<p>PDP: 8a=Summary comments on completion (or otherwise) of the previous PDP and explains any objectives not yet met. (1) 8b=New PDP includes 3-6 objectives, which are SMART. (1) 8c=Summary describes how at least one new PDP objective was derived from the supporting information and discussion. (1) 8d=Summary describes why at least one of the new PDP objectives is important to the appraisee. (1)</p>

Appendix 4b

EXCELLENCE	FPH SUPPORTS Tool
<p>Encompass all? Does the summary comment on context, including stage of revalidation cycle, and reflection on the whole of the scope of work? (2)</p>	<p>OVERVIEW: 1a=Summary describes all roles carried out as a doctor/Registrant (including wte, if possible). (1) 1b=Summary paints a picture of how the doctor practices medicine and explains any breaks in employment. (1)</p>
<p>Exclude bias and prejudice? Are all statements objective, free from bias and prejudice and based on evidence? Is it a typed, professional document? (2)</p>	<p>SPECIFICS AND MANDATORY STATEMENTS: 2a=No 3rd party information in uploaded evidence and no obvious biases in summary. (1) 2b=Summary paints a picture of how this appraisal fits into the revalidation cycle. (1) 2c=Summary describes appraisal meeting & (if necessary) explains why not 12 months since last appraisal. (1) 2d=Summary explains any 'no' or 'disagree' answers in health and probity statements, and comments on indemnity arrangements. (1)</p>
<p>Challenge, support and encourage? Does the summary demonstrate that the appraisal was challenging, supportive and focussed on the needs of the doctor? (2)</p>	<p>TRACKS GMC SUPPORTING INFORMATION REQUIREMENTS: 3a=Supporting information presented is summarised by the appraiser. (1) 3b=Summary identifies any gaps in the supporting information (eg MSF), and notes in particular any areas of work which have not yet been evidenced this cycle. (1)</p>
<p>Explain why any statements (including health and probity) have not been agreed? does appropriate commentary explain any 'no' or 'disagree' answers? (Score 2 if N/A) (2)</p>	<p>PROFESSIONAL WELL-BEING: 4a=Summary comments on occupational stressors, support mechanisms and ability to work effectively. (1) 4b=If appropriate, summary describes what the appraisee has done/could do as a result of identifying workplace stressors. (1)</p>
<p>Look at supporting information, lessons learned and changes made? does the summary drive quality improvements by reflecting what has been learned and what needs to be changed as a result? (2)</p>	<p>PERSONAL WELL-BEING: 5a=Summary describes how the appraiser provided support or guidance during the appraisal discussion. (1) 5b=Summary comments on the doctor's health, well-being and work/life balance. (1)</p>
<p>Look at last year's PDP and reflect on each objective? if any objectives have not been achieved, have the reasons been discussed and documented? (2)</p>	<p>REFLECTION: 6a=Summary describes how the appraiser promoted reflective practice and encouraged the appraisee to consider their personal and professional development. (1) 6b=Summary demonstrates how the appraiser encouraged the appraisee to demonstrate how they work safely and make quality improvements in their practice. (1)</p>
<p>Encourage excellence, celebrate accomplishments and record aspirations? does the summary capture examples</p>	<p>PRAISES EXCELLENCE:</p>

<p>of good practice and record aspirations (some of which may have a timescale over one year)? (2)</p>	<p>7a=Summary records achievements (incl good practice). (1) 7b=Summary records short/medium-term aspirations. (1)</p>
<p>Note any gaps/no gaps in the requirements for revalidation and how they will be addressed? what supporting information is outstanding for each role? (2)</p>	<p>PDP: 8a=Summary comments on completion (or otherwise) of the previous PDP and explains any objectives not yet met. (1) 8b=New PDP includes 3-6 objectives, which are SMART. (1) 8c=Summary describes how at least one new PDP objective was derived from the supporting information and discussion. (1) 8d=Summary describes why at least one of the new PDP objectives is important to the appraisee. (1)</p>
<p>Contain SMART PDP Objectives? Are they Specific, Measurable, Achievable, Relevant and Timely? Do they challenge the doctor to make quality improvements? (2)</p>	
<p>Explain the new PDP items? does the summary show how the PDP objectives are relevant and derive from the supporting information and appraisal discussion? (2)</p>	

We note that the new FPH tool is explicit about expecting 3-6 PDP objectives but only requires the rationale for at least one to be explained. Specifying 3-6 objectives is an interesting choice as most literature is in agreement that the number of PDP goals does not matter, as one major goal could be broken down into several smaller actions agreed, or a person with a larger scope of work might want to record more goals because they want to cover their whole scope of work. At the same time, explaining where each goal has arisen from the documentation and discussion and why they are important to the appraisee for the next appraisal period seems to us to be important for every PDP objective.

After reviewing the draft report, the Lead appraiser made it known to us that the 3-6 PDP objectives was the lynchpin for the change from requiring 50 CPD points in the new CPD policy. The standard of 3-6 objectives arises from the NHS England standard (as expressed in ASPAT) that a good quality PDP will have between 3-6 objectives. The Lead Appraiser also expressed that now might be the time to update the SUPPORTS version 3a to include the rationale for all PDP objectives, rather than the initial developmental approach of at least one which was used to introduce the skill to appraisers as it appears this is already being met.

Appendix 5

Suggested prompt paragraphs for appraisal and revalidation specifics.

For he/him

Dr XY has a revalidation due date of ... which means this is the first / second/ third / fourth / last appraisal in this revalidation cycle. It is the first / second / third appraisal with this medical appraiser. I am fully trained and up to date to facilitate medical appraisals for revalidation and my CPD and quality assurance is provided by ... It is twelve / other months since the previous appraisal and the supporting information provided was proportionate for twelve / other months in practice and the Medical Appraisal Guide 2022 process and covered the whole of the doctor's scope of work.

The appraisal took place by remote videoconferencing on MS Teams / Zoom / Google meets / in person with both parties in an appropriate venue with privacy, freedom from interruptions and appropriate access to the internet and other facilities. It took ... hours (excluding breaks and writing up). There was no identifiable third-party information included in the appraisal summary and good information governance was followed throughout. There was no supporting information provided separately OR Some sensitive supporting information that could not be anonymised adequately, including the original complaint documentation / SEA documentation / compliments was provided separately so that it could be summarised appropriately without forming part of the portfolio. The previous appraisal PDP, summary and outputs were available to me as the appraiser in the EMIS/FourteenFish / Agilo/Clarity / L2P portfolio. They were shared in good time before the appraisal.

Dr XY signed the health statement and declared that he accepts the professional obligations placed on him in Good Medical Practice about his personal health. He said that there was nothing currently affecting his health that he was aware of that could have an adverse impact on patient care or need specific adjustments to his practice. OR He declared an ongoing health condition and we discussed the specific adjustments that he has agreed to look after himself appropriately so he can continue to work safely and effectively.

We talked about how he looks after his health. He remains up to date with his vaccinations, including COVID-19, in order to protect patients and colleagues.

Dr XY signed the probity statement, declaring his acceptance of the professional obligations placed on him in Good Medical Practice in relation to probity, including the statutory obligation to ensure that he has adequate professional indemnity for all his professional roles and the professional obligation to manage his interests appropriately. He has appropriate indemnity when practising for his current scope of work with the MPS / MDU / MDDUS / NHS state-backed indemnity etc., and has no conflicts of interest to declare / declares his conflicts of interest openly and transparently in the online register of interests.

Dr XY declared no suspensions or restrictions to his practice and that he had not been subject to an investigation of any kind since his last appraisal. OR Dr X declared the following suspensions or restrictions to his practice ... AND/OR Dr X declared that he had been subject to an investigation by ... since his last appraisal, which we discussed and is summarised under ...

He stated that he had not been requested to bring any specific information to the appraisal by his organisation or responsible officer. OR He stated that he had been requested to bring ... to their appraisal by his ... which we discussed and is summarised under

Dr XY does no private practice and no medico-legal work. OR Dr X does some private practice / medico-legal work which is described in the whole scope of work. The annual review documentation is / is not included.

Dr XY completed the Academy of Medical Royal Colleges (AoMRC) 'Factors for consideration template for doctors wishing to reassure themselves that they are competent across the whole scope of their work' to reflect on his low volume of ... / unusual or limited range of practice in ... / return to work after a longer break, which we discussed and is summarised as a quality improvement activity.

For she/her

Dr XX has a revalidation due date of ... which means this is the first / second/ third / fourth / last appraisal in this revalidation cycle. It is the first / second / third appraisal with this medical appraiser. I am fully trained and up to date to facilitate medical appraisals for revalidation and my CPD and quality assurance is provided by ... It is twelve / other months since the previous appraisal and the supporting information provided was proportionate for twelve / other months in practice and

the Medical Appraisal Guide 2022 process and covered the whole of the doctor's scope of work.

The appraisal took place by remote videoconferencing on MS Teams / Zoom / Google meets / in person with both parties in an appropriate venue with privacy, freedom from interruptions and appropriate access to the internet and other facilities. It took ... hours (excluding breaks and writing up). There was no identifiable third-party information included in the appraisal summary and good information governance was followed throughout. There was no supporting information provided separately OR Some sensitive supporting information that could not be anonymised adequately, including the original complaint documentation / SEA documentation / compliments was provided separately so that it could be summarised appropriately without forming part of the portfolio. The previous appraisal PDP, summary and outputs were available to me as the appraiser in the EMIS/FourteenFish / Agilo/Clarity / L2P portfolio. They were shared in good time before the appraisal.

Dr XX signed the health statement and declared that she accepts the professional obligations placed on her in Good Medical Practice about her personal health. She said that there was nothing currently affecting her health that she was aware of that could have an adverse impact on patient care or need specific adjustments to her practice. OR She declared an ongoing health condition and we discussed the specific adjustments that she has agreed to look after herself appropriately so she can continue to work safely and effectively.

We talked about how she looks after her health. She remains up to date with her vaccinations, including COVID-19, in order to protect patients and colleagues.

Dr XX signed the probity statement, declaring her acceptance of the professional obligations placed on her in Good Medical Practice in relation to probity, including the statutory obligation to ensure that she has adequate professional indemnity for all her professional roles and the professional obligation to manage her interests appropriately. She has appropriate indemnity when practising for her current scope of work with the MPS / MDU / MDDUS / NHS state-backed indemnity etc. and has no conflicts of interest to declare / declares her conflicts of interest openly and transparently in the online register of interests.

Dr XX declared no suspensions or restrictions to her practice and that she had not been subject to an investigation of any kind since her last appraisal. OR Dr XX declared the following suspensions or restrictions to her practice ... AND/OR Dr XX declared that she had been subject to an investigation by ... since her last appraisal, which we discussed and is summarised under ...

She stated that she had not been requested to bring any specific information to the appraisal by her organisation or responsible officer. OR She stated that she had been requested to bring ... to the appraisal by her ... which we discussed and is summarised under

Dr XX does no private practice and no medico-legal work. OR Dr XX does some private practice / medico-legal work which is described in the whole scope of work. The annual review documentation is / is not included.

Dr XX completed the Academy of Medical Royal Colleges (AoMRC) 'Factors for consideration template for doctors wishing to reassure themselves that they are competent across the whole scope of their work' to reflect on her low volume of ... / unusual or limited range of practice in ... / return to work after a longer break, which we discussed and is summarised as a quality improvement activity.

Progress towards revalidation prompt

For he/him

Dr XY presented a verbal and written portfolio of supporting information with no gaps for this stage of the revalidation cycle, although he is aware that he will need to complete appropriate formal colleague and patient feedback at least once in the five-year cycle.

OR

Dr XY presented a complete verbal and written portfolio of supporting information with no remaining gaps for this revalidation cycle. He has completed appropriate GMC compliant formal colleague and patient feedback and discussed the results at appraisal.

We have discussed how he keeps up to date across his whole scope of work, with a spread of CPD and opportunities to calibrate his practice, his quality improvement activities including learning from events, including significant events and serious

incidents, and how he seeks and acts on informal feedback as well as his learning from complaints and compliments.

For She/her

Dr XX presented a verbal and written portfolio of supporting information with no gaps for this stage of the revalidation cycle, although she is aware that she will need to complete appropriate formal colleague and patient feedback at least once in the five-year cycle.

OR

Dr XX presented a complete verbal and written portfolio of supporting information with no remaining gaps for this revalidation cycle. She has completed appropriate GMC compliant formal colleague and patient feedback and discussed the results at appraisal.

We have discussed how she keeps up to date across her whole scope of work, with a spread of CPD and opportunities to calibrate her practice, her quality improvement activities including learning from events, including significant events and serious incidents, and how she seeks and acts on informal feedback as well as her learning from complaints and compliments.

Appendix 6

AoMRC PDP template

Available to download from: <https://www.aomrc.org.uk/revalidation/medical-appraisal-revalidation/>



Personal Development Plan (PDP) Template 2022

What are your top priorities for the period till your next appraisal? Think about the things that are important to you. What will make the most positive difference to your personal and professional development, or the team/system that you work in, and have the biggest impact?

During your appraisal, use your appraiser's coaching skills and support to refine your goals and create a plan to help you achieve them.

Learning and/or development need <i>What do you want to change, or achieve, and why is it a priority now?</i>	Agreed action(s) or goal(s) <i>How might you do this? What options do you have? Describe the actions or steps you plan to take...</i>	Timescale for completion <i>By when will you have done this? Do intermediate steps have their own timescales that are worth recording?</i>	How I intend to demonstrate success <i>How will you know that you have achieved your goal? Describe what success will look and feel like. What will be the impact on you, your colleagues/teams and/or patients?</i>

Appendix 7

Thematic analysis from interviews:

Overview

There are about a dozen very well-trained appraisers who provide an annual medical appraisal for the c.120 people who are connected to the FPH. The responsible officer makes appropriate revalidation recommendations to the GMC, and is supported by the Deputy CEO, the Lead appraiser, and the appraisal administrator, and latterly a lay person.

Despite being a non-employing designated body, the revalidation service feel that they are small enough to know people by name and to have a good idea of what everyone connected to the service is up to, and an ability to make informed and empathetic decisions about their revalidation.

To hear a senior leader remark "As organisation I / we take our revalidation very seriously" is a very important underpinning to the culture of taking appraisal and revalidation that has been a consistent theme of our interviews. The ethos can clearly be seen in the comments below:

"I think we get pretty good engagement and people are happy to work with the Faculty".

"I think the doctors actually really enjoy their appraisal... they do find it beneficial"

"I think it's a great system, the whole revalidation appraisal system to keep doctors up to date."

[The] "role of the appraiser is to make them think differently, things that they wouldn't normally think and also it's meant to be a mutual pleasant experience that you both learn from as well."

"I honestly believe this, that they have very robust processes in place and they take revalidation very seriously"

"We have tended towards more supportive ... approach to appraisal"

Administrative feedback

Personnel were clear about their roles and responsibilities and enthusiastic about being part of a successful process that gets good feedback. The administrative burden is seen as far less than it was, partly due to the use of the L2P appraisal management system. L2P is seen as better than other toolkits that appraisers have used elsewhere. It is also seen as providing a secure place to store appraisal

information online so that it can be easily accessed without the risk of it being emailed around. At the same time, it is considered to be somewhat hospital focused but that is felt to be OK as there would not be the money to get it modified to be more focused on Public Health and the interviewees were not aware of anything better.

"L2P works really well and the feedback we get on that is really good."

Once every six weeks there is the equivalent of a Responsible Officer Advisory Group (ROAG) which includes the appraisal administrator, the RO, the lead appraiser and, more recently, a lay member. This is seen as an opportunity to discuss policy issues if they come up as well as deal with appraisee issues and to debate and calibrate opinions. These meetings are supported by good communication via email with the other team members and an open-door policy held by the Lead appraiser and Deputy CEO.

The policy review process was described as historically done annually led by a manager who has recently left, although people at a variety of levels contributed through their different lenses. The CEO is aware of the policy review process and the responsibility has been taken up at the time of review by the Deputy CEO. The awareness of policies was good across all levels of the service with the understanding that they could be found both on the server and on the Faculty website.

"I know there are policies. In fact recently we renewed our contracts and things like that"

Support from the Faculty Office is highlighted as a standout feature of the FPH system. There is a clear intention to present a successful value proposition for the members and the administration is a key part of these efforts.

"our revalidation administrator, she's absolutely fantastic"

The revalidation administrator "...is amazing – so people keep throwing more work at her"

Leadership feedback

The CEO feels confident in the appraisal and revalidation team and the policies and processes that underpin the revalidation recommendations that are made. They are comfortable that they have enough oversight and line manage the Deputy CEO who

is more directly involved. The Board has 5 ordinary meetings a year and are seen as generally supportive, although there is little need to have a great deal of input or relationship with the Board. In interviews with more senior members the awareness and relationship with the Board is higher.

"we have an incredibly supportive board [and] we have an incredibly supportive group of officers who act as a sort of informal sounding group."

"I'm very proud of our revalidation service. I think it is an efficient well-run service with good people and policies behind it. It is treated with equal if not more importance than all the other things the faculty does."

In general, the leadership of the revalidation team is considered to be strong and supportive.

"[The Lead appraiser and RO] are amazing. They are so supportive and good and they're patient, always have answers to all my questions"

Lead appraiser feedback

The Lead appraiser is clearly very experienced and is recognised as being very dedicated and experienced "we have a lead appraiser who is very on it and very steeped in appraisal and appraisal practice". They see themselves as the go between the RO and the revalidation team and the appraisers and make a point of being available by email, checking their emails almost daily. The shift in focus in the rebalanced appraisal processes post-Covid is seen as something that was probably going to happen anyway because the FPH was already heading in the direction of a more supportive appraisal process.

The Lead Appraiser takes the lead on the QA of the appraisal outputs and reviewing the feedback to share with the appraisers annually. They also collate any themes that indicate areas for improvement to cover at the development days.

The Lead Appraiser attends the RO and Appraisal Lead network meetings for the SouthWest because that is where they live, while the RO attends the NHS England London ones. This clearly brings a breadth of view and source of calibration to the team.

"I do like the fact that [the Lead Appraiser] is very accessible and also gives us good feedback one way or the other."

"So I find it helpful and supportive and then also rigorous in that, they come back to us and say, yeah, you could do a wee bit more on this or leave it on that"

Appraiser feedback

We heard from appraisers who facilitate 10-12 appraisals annually for the FPH. Some also do appraisals elsewhere. They get annual feedback with anonymised / aggregated feedback from their appraisees and feedback from the lead appraiser on the QA of their appraisal outputs which is appreciated. They feel that the amount of appraiser CPD and training and updates is about right. It is seen as valuable, so it is generally well-received and although not mandatory they try to attend. One commented on supporting doctors doing a first appraisal with a call before the appraisal to make it easier for them. Appraisers are confident to raise concerns and know where to find the FPH policies or who to ask for help when needed.

Those appraisers who also have experience of appraising elsewhere compare the system at the FPH very favourably with other organisations. The appraisers we interviewed are also appraised themselves within the Faculty and feel that this gives them insights that enable them to be better appraisers. One commented on a negative appraisal experience with an appraiser elsewhere, and on using an inferior appraisal toolkit, and reflected on how much better L2P is. It was lovely to hear the degree of positivity about appraising.

"I think the standard of appraisal we offer is very good ...the appraisers, and the appraisal service".

"Appraisal is absolutely fantastic, the appraisers are all highly rated, people recognise that there's a very good service and they are robust and fair. People feel like they've been through genuine proper appraisal".

"I love being an appraiser."

"we get very positive feedback from our users and they do think our appraisers support them very well."

Training and Support

We heard about a half-day online refresher training in the Spring and a whole day in person training day in the Autumn. There were comments about the advantages of meeting in person in terms of being able to have 'coffee conversations', and the RO and Lead appraiser making themselves available if anyone wants a private

conversation. The dangers of isolation in a virtual world, and the exceptional pressures on Public Health during Covid meant that the support was seen as vital and appreciated. There was also a sense that the training has improved over the years. The training is not compulsory, but it is seen as valuable and that appraisers try to attend if they can. The Lead appraiser makes the effort to catch up with appraisers who have not been able to attend which is an example of good practice.

“the training has improved over the years considerably because I think there is face-to-face contact. And also working through real life scenarios has been really useful because it's done in a very safe environment.”

It was also made clear that the RO and Lead appraiser are very approachable and supportive. As well as able to provide appropriate challenge, which is appreciated. One appraiser commented that this is something that does not happen to the same extent in other organisations where they have appraised.

“Through the year, we would get emails from [the Lead Appraiser]. If there's any issues we need to pick up he keeps us in touch, which is which is good. So I don't feel alone or anything.”