NHS
Sheffield Health and Social Care
NHS Foundation Trust

# Policy:

## MD 012 - Appraisal Policy for Medical Staff

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**Summary of policy**
This policy is to ensure the Trust's requirements for appraisal are clear, understood and implemented fairly. Medical appraisal differs fundamentally from appraisal in other settings due to its direct link with external professional regulation and revalidation.
As summarised at Appendix A (amendment log) the policy has been amended to include additional guidance from the NHS England regarding the doctor appraisal process and to accommodate changes in the Trusts internal management structure.

**Policy Version and advice on document history, availability and storage**
This is version 4 and replaces version 3 – November 2016.

This policy will be available to all staff via the SHSC Intranet and website. The previous version will be removed from the Intranet and website and archived. Word and pdf copies of the current and the previous version of this policy are available via the Director of

| Corporate Governance. Any printed copies of previous versions should be destroyed and if a hard copy is required, it should be replaced with this version. |
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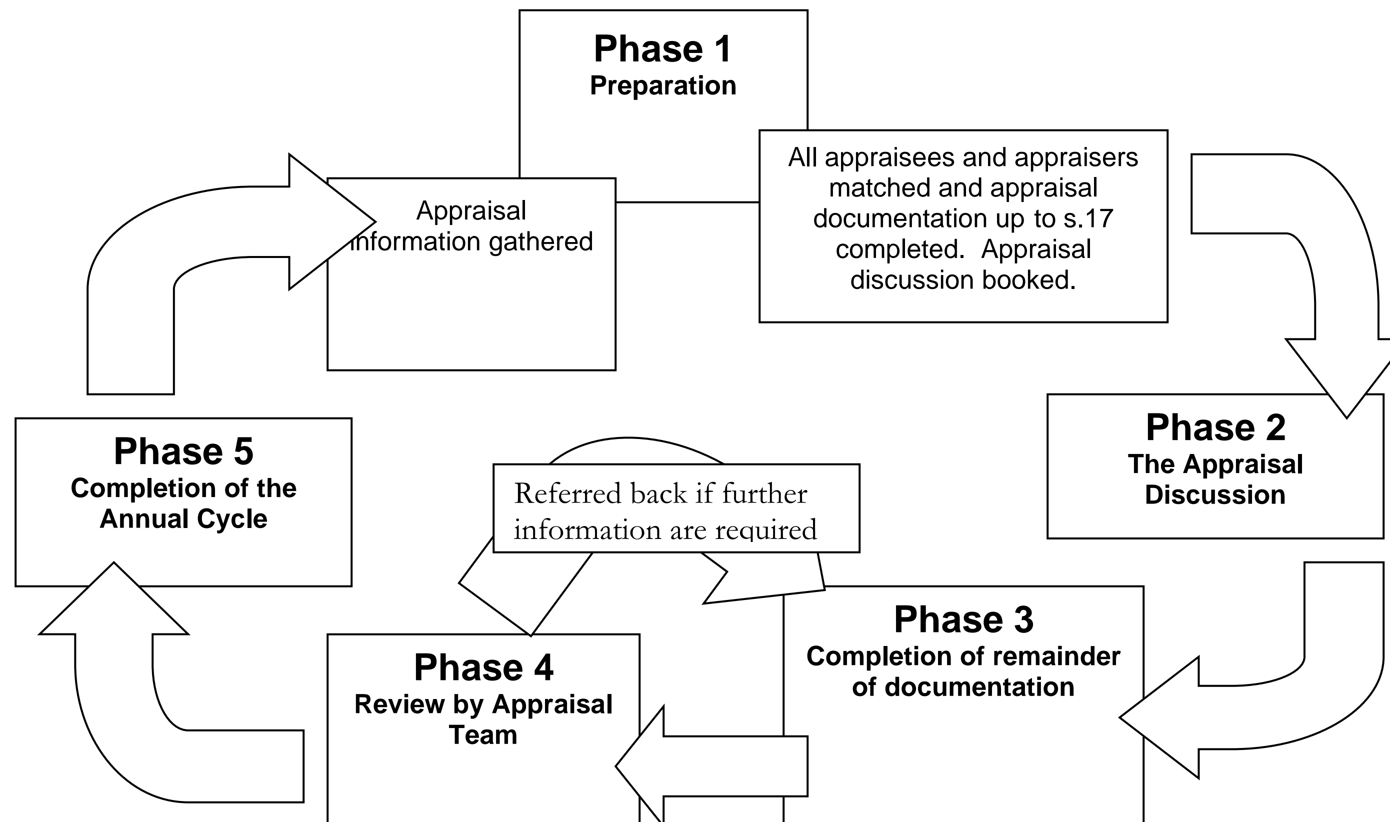
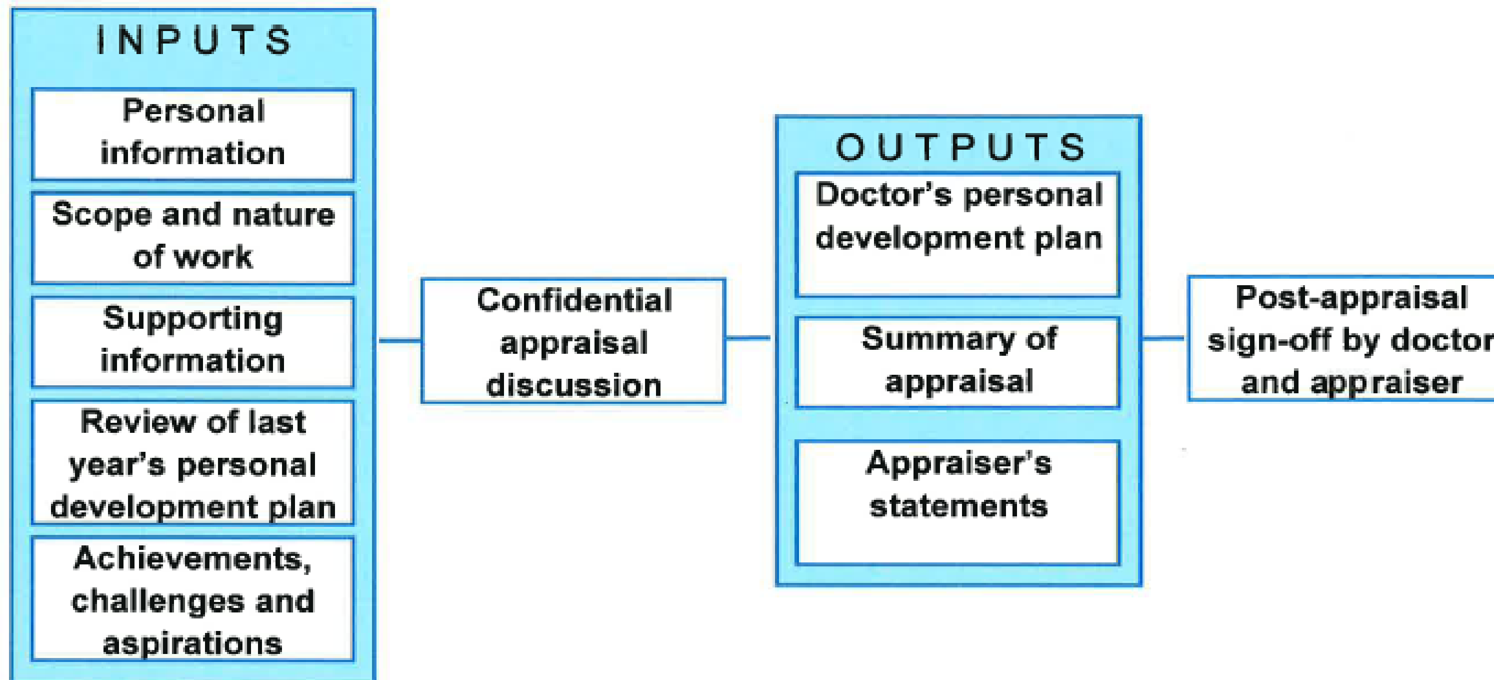
## FLOWCHART 1 – Appraisal Process

The Appraisal process is comprised of five phases:

- Phase 1: Preparation work and information gathering by both appraiser and appraisee. Appraisals for revalidation are made up of whole practice appraisal and therefore appraisees must provide information from all organisations that employ them as well as any voluntary or private practice work.
- Phase 2: Appraisal discussion *including* a review of the previous year's PDP.
- Phase 3: Completion of documents and agreement of a new PDP going forward.
- Phase 4: Review of feedback forms by the Revalidation Steering Group
- Phase 5: Annual appraisal completed.



**Flowchart 2 – Appraisal Inputs and Outputs**



## 1. Introduction

This policy is to ensure the Trust's requirements for appraisal are clear, understood and implemented fairly. Medical appraisal differs fundamentally from appraisal in other settings due to its direct link with external professional regulation and revalidation.

The Trust believes that appraisal is a positive process to enable constructive dialogue to occur and in which the doctor being appraised has a formal structured opportunity to reflect on their performance and how it might be improved to enhance quality of care and the effectiveness of the Trust

This policy and associated documentation will be overseen and monitored by the Revalidation Steering Group. In addition advice and guidance will be available from the Associate Medical Director for Revalidation. All information provided under this process will be treated with full regard to confidentiality and will be used for purposes appropriate to appraisal and revalidation. Should any serious concerns emerge then they will be considered in line with the appropriate Trust policies and GMC guidance.

This policy will also be applied with full regard for the Trust's policy on Equal Opportunities and Dignity at Work. Any reasonable adjustments will be made, where appropriate. This document may change and be reviewed as updated guidance is released from NHS England, RCPsych & the GMC.

## 2. Scope

The policy applies to all non-training medical staff employed by the Trust including those who work with honorary contracts where they relate to the Responsible Officer of the Trust. The Deanery will be responsible for the appraisal and revalidation of doctors in training. NHS England appoints the Responsible Officer for Salaried GPs. Locums directly employed by the Trust will be the responsibility of the Responsible Officer including any doctors engaged under a LAS post (Locum Appointment for Service) where this is not the responsibility of the Deanery. For locums employed via an agency, the Responsible Officer will be within the locum agency. However arrangements will be made to provide formal assessment on their work within the Trust before they leave (see section 6.19).

Appropriate arrangements will be made for the appraisal of the Responsible Officer (see 6.3).
The Trust will make arrangements for seamless appraisal for any doctors who have been on maternity leave in any five year period, and for any doctors who have had a break in service for whatever reason.

## 3. Definitions

**Responsible Officer (RO) -** is the primary role in the successful application of this policy. It is currently incorporated into the Associate Medical Director for Revalidation's role..

**Associate Medical Director for Revalidation** (AMDR) will support the revalidation process including providing guidance and support to appraisers in carrying out their r responsibilities.

Medical Director (MD) – is the senior medical professional within the organisation and will support the revalidation process including ensuring there are sufficient resources for the Responsible Officer and leading on any disciplinary aspects relating to appraisal and/or revalidation.

Medical Managers- are the clinicians other than those roles specified above who are responsible for the management of other doctors within the Trust (This would typically be a Clinical Director).

**Revalidation -** is the process by which doctors will have to demonstrate to the General Medical Council, normally every 5 years, that they are up to date and fit to practice. It is based on local evaluation of doctor's performance against national standards approved by the GMC. It is based on a doctor's whole practice.

**Remediation -** is the overall process to redress identified aspects of underperformance. Remediation is a broad concept varying from informal agreements to carry out some reskilling, to more formal supervised programmes of remediation or rehabilitation

**The Revalidation Steering Group (RSG)** will comprise the RO, the Medical Director, the AMDR and the appraisers appointed from within the Trust.

The Appraisal Team will comprise the RO, AMDR and their staff responsible for the administration of the appraisal system

The appraisal window is the period during which an annual appraisal should occur. Each doctor should have an appraisal month and the appraisal meeting should happen in the three months preceding the end of the designated appraisal month e.g. if the appraisal month is September then the meeting should be in July, August or up to 30 September. The document must then be completed within 28 days of the appraisal meeting.

**External Responsible Officer –** this will be a person appointed by the Trust to have the responsibility for revalidation in the following circumstances:

a) Where there are such small numbers of doctors within the Trust that by virtue of line management and/or other working arrangements it would be difficult to avoid general conflicts of interest or appearance of bias.

b) Where there is a conflict of interest or appearance of bias between the main Responsible Officer and one of the doctors requiring the appointment of a second Responsible Officer.

c) Where the Trust wishes to outsource the expertise required.

## 4. Purpose

This policy is intended to support all those involved with the appraisal process within the Trust. The aim is to ensure that through effective appraisal, medical staff are fit to practice and provide the highest standards of safe care to patients.

Appraisal is underpinned by continuing professional development and used properly can help to develop a reflective culture within service and training. It is expected that regular successful annual appraisal will provide the foundation stone upon which a positive affirmation of continued fitness to practice can be made every five years by the doctor's Responsible Officer.

Medical appraisal is a process of facilitated self-review supported by information gathered from the full scope of a doctor's work.

Medical appraisal can be used for four purposes:

1. To enable doctors to discuss their practice and performance with their appraiser in order to demonstrate that they continue to meet the principles and values set out in *Good Medical Practice* and thus to inform the Responsible Officer's revalidation recommendation to the GMC.

2. To enable doctors to enhance the quality of their professional work by planning their professional development.

3. To enable doctors to consider their own needs in planning their professional development.

and may also be used:

4. To enable doctors to ensure that they are working productively and in line with the priorities and requirements of the organisation they practise in.

Job planning, rather than appraisal, will normally be the primary means by which doctors ensure that they work productively and in line with the priorities and requirements of the Trust. However, the outputs from each process may be used to inform the other e.g. if a doctor was unable to meet Trust objectives through a lack of training or skills then it would be appropriate for these matters to be considered as part of the appraisal process.

Whilst appraisal is not the forum to address specific clinical governance or performance issues, there may be instances where a RO may wish to ensure that certain key elements of supporting information are included in the doctor's portfolio and discussed at appraisal. In such instances the RO may stipulate to the doctor that the information should be included and subsequently check in the appraisal summary that discussion has taken place.

## 5. Duties

**Medical Director -** will, on behalf of the Trust, be responsible for ensuring that the Responsible Officer is provided with appropriate resources to allow him/her to discharge their duties.

**Board of Directors -** are responsible for monitoring and approving a framework to support the appraisal and revalidation of consultant and other career grade doctors that is compliant with all relevant legislation, guidelines and NHS best practise standards.

**Responsible Officer -** is accountable to the Chief Executive for the appraisal process. He/she will be responsible for appointing appraisers and ensuring that: all relevant medical staff are appraised; that any follow up action is taken; that comprehensive records are kept of all appraisals; and for making recommendations for revalidation to the General Medical Council. In so doing, the Responsible Officer is responsible for ensuring that the appraisal policy and processes comply with the relevant national guidance and legislation that appraisers are properly trained to carry out this role and are in a position to undertake appraisal of clinical performance, service delivery and management roles. The Responsible Officer will also be responsible for ensuring that an annual report on consultant appraisal is prepared for the Revalidation Steering Group and the Board of Directors.

If a Responsible Officer or other person (e.g. a consultant) identifies a potential conflict of interest or appearance of bias between the Responsible Officer and one of the doctors being revalidated by the Responsible Officer then a formal application should be submitted to the Responsible Officer's responsible officer (normally either the regional or national responsible officer) for a recommendation as to whether an alternative responsible officer needs to be nominated or appointed by the Trust. (See also External Responsible Officer definition below) The relevant form is at Appendix 1 and the applicant should complete the section explaining the reasons for the potential conflict of interest or appearance of bias and include relevant information and documentary evidence. Where an alternative is recommended, then the Trust will nominate / appoint the person identified by the higher-level responsible officer and confirm this in writing to the doctor and Trust Responsible Officer.

**Revalidation Steering Group -** has overall responsibility for monitoring compliance with this policy. This responsibility includes confirmation of the appointment of appraisers and undertaking an annual review of the appraisal cycle together with monitoring of the performance of the appraisers using the annual report as a basis for this review.

**Associate Medical Director for Revalidation/Lead Appraiser -** will support the revalidation process and advise the appraisers and lead the appraisal peer group. The AMDR will identify the appropriate appraisers for the relevant appraisees from the approved list and confirm the relevant appraisal year. Where a conflict of interest is identified which prevents the nominated appraiser from carrying out the appraisal, then an alternative appraiser would be appointed by the Responsible Officer with the support of the AMDR.

The AMDR will also identify a suitable appraiser who will undertake the appraisal of the external doctors who are required to be appraised for revalidation purposes by the Trust.

**Medical Manager -** is responsible for:

- Identifying appraisers in their directorates to the AMDR and maintaining the list of appraisers within their directorate and ensuring the appraiser has sufficient time in their job plan to carry out the role.
-

**Appraiser -** is accountable to the Responsible Officer. The appraiser should be sufficiently familiar with the appraisee's work in order that they can carry out a suitable appraisal. Their duties include:

- Declaring any conflict of interest which would affect the appraisal (see Section 6.2).
- Seeking advice from the RO/AMDR on whether an exemption should apply to new appointees (see Section 6.12).
- Agreeing a date with the appraisee.
- Arranging an appropriate venue.
- Reviewing the portfolio of evidence prior to the meeting.
- Requesting any missing evidence/documentation and raising with the RO/AMDR if any essential evidence/documentation is not provided without there being a satisfactory explanation (see Section 6.6).
- Preparing and agreeing an agenda of items to be discussed and reviewed one week before the meeting.
- Completing the relevant parts on the online toolkit.
- Signing off statements about engagement, with appraisal, progress with the previous PDP and the appropriateness of the new PDP and GMC requirements.
- Where the appraisal is not completed (or notified as having being completed) within 28 days of the specified appraisal date then the provision of Section 6.15 will apply.
- Advising the appraisee of their right to raise a grievance where the appraisee disagrees with the content or process (see Section 6.11).
- Reporting to the RO/AMDR where there has been a clear failure to address issues from the previous year's appraisal and these issues cannot be resolved with the appraisee (see Section 6.9).
- Reporting to the Medical Director where there is a potentially serious performance issue (that has not been previously identified) that requires further discussion or examination-this will require the appraisal meeting to be stopped. (see Section 6.9).
- Participating in periodic meetings with other appraisers and the RO/AMDR to ensure consistent standards are maintained.

There currently are no minimum number of appraisals that must be completed but this will be kept under review. The maximum number of appraisals for each appraiser will normally be 8. The appraiser is responsible for the completion of the summary of appraisal. Commencing with the date of introduction of this policy, no appraiser will carry out appraisal for the same doctor for more than 3 consecutive years e.g. they will require a change of appraiser for 1 year after 3 consecutive appraisals with the same appraiser. Any appraisal that is carried outside of these limits will not be accepted as

valid by the RO. Any appraiser that is external to the Trust must still abide by these standards and by carrying out an appraisal in the Trust agrees to participate fully in the quality assurance programme.

Where a doctor has moved to the Trust from a previous organisation, then they will be covered by this appraisal process. An appropriate appraiser will be allocated in accordance with this policy. Arrangements will need to be made for the relevant appraisal records to be transferred. This will be the responsibility of the doctor but he/she will be assisted in any case of difficulty by the Trust.
Where a doctor moves from this Trust to another organisation, then they will become the responsibility of the relevant RO in the new organisation. The Trust will ensure that on request from the doctor, the relevant appraisal records are transferred to the new organisation with the normal safeguards regarding confidentiality.

**Appraisee -** is responsible for:

- Ensuring they are appraised annually on their whole practice or seeking a deferment where they believe this is necessary.
- Making the declaration regarding professional obligation and personal accountability (see Section 6.1).
- Collating and preparing the evidence for the appraisal meeting using the evidence checklist and documentation on the on-line tool kit.
- Agreeing a date for the appraisal meeting with the appraiser.
- Agreeing the agenda of items with the appraiser.
- Providing the relevant appraisal information to the appraiser by the agreed date.
- Writing their own reflection on supporting information and any other relevant issues.
- Signing off statements about significant events, complaints, probity, health, the appraisal portfolio and GMC requirements.
- Where the appraisal is not completed (or notified as having being completed) within 28 days of the specified appraisal date then the provision of Section 6.15 will apply.
- Raising any concerns about the appraisal process in accordance with this policy.
- Completing the annual appraiser feedback form and for returning the completed form to the AMDR.

The Appraisal Team are responsible for overseeing the administration of the appraisal system and ensuring that appraisals meet the specified quality requirements.

## 6. Process

### 6.1 Main principles

Appraisals happen on an annual basis within each appraisal year. Appendix 2 sets out the current guidance from NHS England regarding the scheduling of medical appraisal. (This will be updated as necessary). Appraisal should be a positive process that gives doctors feedback on their past performance, charts their continuing progress and identifies their development needs. It is designed to recognise good performance, provide feedback, and assist in the identification of performance issues so they can be dealt with at an early stage. It is also a forward-looking process, essential in identifying the developmental and educational needs of individuals.

Appraisal is, at its heart, a reflective process allowing the doctor to review his/her development professionally with a trained colleague as appraiser - involving challenge where necessary.

The appraiser will review various sources of information with the doctor to gain a rounded impression of that doctor's practice and inform a mutually agreed Personal Development Plan (PDP). Appraisal will identify doctors who are struggling to provide the supporting information that is needed to demonstrate achievement of generic and specialist standards. It will assist those doctors in identifying support and developmental needs at an early stage, before there is any question of concerns about patient safety.

Every doctor is responsible for ensuring that they are appraised annually on their whole practice, so will need to make arrangements to share information from each of their employers, including private practice or voluntary work, on an annual basis.

Before the appraisal discussion, doctors should make a declaration that is visible to the appraiser that demonstrates:

- Acceptance of the professional obligations placed on doctors in Good Medical Practice in relation to probity, confidentiality and personal health.
- Personal accountability for accuracy of the supporting information and other material in the appraisal portfolio.

### 6.2 Selection of appraisers

The process for the selection of appraisers will ensure that doctors with the appropriate expertise, skills and commitment are selected for this important role. The Responsible Officer should scope the number of appraisals that will be needed and ensure there is a sufficient pool of trained appraisers within the organisation to carry out these appraisals. Enquiries from doctors wishing to become appraisers should be considered in the first instance by their Medical Manager. Medical Managers would then recommend a potential appraiser to the RO/AMDR The RO/AMDR would then meet the doctor concerned to ensure they are suitable. The RSG would also decide on their suitability. (See also Section 6.20) There will be a database of appraisers which will be maintained by the Responsible Officer, AMDR and, as appropriate, relevant Medical Managers. The selection and training of new appraisers will be carried out as and when required. National guidelines (GMC, Revalidation Support Team, etc) will be followed regarding curriculum and approved training. Medical staff with appraiser responsibilities will have this included in their own appraisal to ensure their competence and performance is satisfactory. The team of appraisers will have periodic meetings to ensure consistent standards are maintained. Appropriate training will be made available to ensure that appraisers are properly trained to carry out their role (see also Section 6.20).

Appraisers must declare any conflicts of interest with their appraisee. This could include (but is not limited to) the following examples:

- A personal or family relationship.
- Paired appraisals where two doctors appraise each other.
- An appraiser receiving direct payment from an appraisee for performing the appraisal.

### 6.3 Responsible Officer's appraisal

NHS England is responsible for medical appraisal of the Responsible Officer and making recommendation regarding his/her Revalidation. NHS England will allocate a Trained External Appraiser to conduct the appraisal of the Responsible Officer. The Responsible Officer is required to provide additional evidence in regard to his/her role as a Responsible Officer in addition to the general evidence as a doctor. Further guidance is described in the following document (subject to future updates from NHS England):

**"Undertaking a Responsible Officer Medical Appraisal: Guidance Notes for Responsible Officers".**

The appraisal year runs from 1st April to 31st March, and the Responsible Officer must undertake an appraisal in each appraisal year.

### 6.4 Indemnity

Doctors working as appraisers on behalf of the Trust will be indemnified for their actions in the pursuance of their work as part of their usual indemnity arrangements with the Trust as their employer. The appraisal form will require a doctor to confirm that they have insurance/indemnity appropriate to their scope of work. This will be relevant to any non-NHS work carried out by the doctor.

### 6.5 Appraisal arrangements for appointees / leavers

Where a doctor has moved to the Trust from a previous organisation, then they will be covered by this appraisal process. An appropriate appraiser will be allocated in accordance with this policy. Arrangements will need to be made for the relevant appraisal records to be transferred. This will be the responsibility of the doctor but he/she will be assisted in any case of difficulty by the Trust.

Where a doctor moves from this Trust to another organisation, then they will become the responsibility of the relevant RO in the new organisation. The Trust will ensure that on request from the doctor, the relevant appraisal records are transferred to the new organisation with the normal safeguards regarding confidentiality.

All newly employed non-training grade doctors will be provided with an initial staff induction which will include generic training on appraisal and the operation of the Trust scheme specifically. Arrangements will be made and clarified at AMDR level.

### 6.6 Appraisal process

The content of appraisal is based on the GMC guidance published in 'Good Medical Practice'.
The process for appraisal will be as follows:

- The relevant year will be confirmed by the RO/AMDR to both the appraiser and appraisee. (See Appendix 2)
- The appraisal will review a complete year's activity. Each doctor will have an appraisal month. Appraisal meeting should be 9-12 from the appraisal month. The appraisal month does not change if the appraisal was completed during the 3

months window. Appraisal document should be completed within 28 days of the appraisal meeting date (see Section 6.15).

- The appraiser will be confirmed by the AMDR from the list of trained appraisers.
- The appraisee should agree a date with the appraiser that is usually at least six weeks in advance of the appraisal meeting.
- The appraisal documentation should normally be available to the appraiser two weeks prior to the appraisal meeting (one week being the absolute minimum).
- The appraisee and appraiser will normally use the online toolkit for all appraisal documentation (see Section 6.8). Specific groups of doctors such as Clinical Fellows and WAST doctors (Widening Access to Specialty Training) will use a portfolio document to take account of their training needs. Short term doctors could use MAG forms (Medical Appraisal Guide model appraisal form) if agreed by the RO.
- The doctor being appraised should prepare for the appraisal by identifying issues to raise with their appraiser, collecting relevant evidence and by preparing a draft Personal Development Plan (PDP).
- The doctor being appraised is required to write their own reflection on supporting information (CPD, complaints, significant events, feedback from colleagues and patients, quality improvement activities and any other relevant issues).
- The doctor being appraised will have to sign off statements about significant events, complaints, probity, health, the appraisal portfolio and GMC requirements.
- The appraiser should review the portfolio of evidence in advance of the meeting. If evidence is missing there should be an opportunity for the appraiser to request that the evidence is provided in advance of the meeting. The appraiser should prepare and agree an agenda of items that are to be discussed and reviewed one week before the meeting.
- The appraisal meeting must be held in an appropriate environment. This will involve a quiet room and both the appraiser and appraisee must ensure that they are not disturbed during the appraisal meeting.
- All documentation must be completed including the summary of appraisal and the agreed personal development plan. (The appraisal interview should not take place without the previous year's summary being available).
- Where the appraisal is not completed (or notified as having being completed) within 28 days of the specified appraisal date then the provision of Section 6.15 will apply.
- The appraisee is responsible for completing the annual appraiser feedback form and for returning this to the RO/AMDR.

If any part of the supporting information is not identified in a portfolio (unless a satisfactory explanation can be offered by the appraisee) then this must be brought to the attention of the appraisee prior to the appraisal meeting. This should provide an opportunity for the appraisee to produce the relevant piece of information. If the information is not forthcoming and there is no satisfactory explanation offered then the appraisal meeting should not go ahead and the RO/AMDR should be informed.

Following the submission of the appraisal to the RO, the RO might decide that additional information is required. The RO would refer the appraisal back to the appraisee and appraiser to provide such additional information.

### 6.7 Joint Appraisal / Lead Employers

Joint appraisal involving a representative from the University will be arranged for doctors working for the Trust who are employed by a University.

Where a doctor is employed by more than one Trust, a lead employer will be identified to undertake the appraisal on behalf of the relevant organisations. A representative from the other organisation(s) can be invited to also participate in the appraisal following agreement between all parties.

### 6.8 Documentation / NHS Appraisal Toolkit

The Trust has adopted L2P e-system which will be used to undertake and record the appraisal. All aspects of a medical practitioner's role can be, and should be, detailed within this system including clinical, managerial and academic work, research, private practice, locum work and voluntary roles. Doctors should complete up to and including section 16 and submit the package of information to the appraiser by a mutually agreed date. Sections 17, 18, and 19 will be completed during and immediately after the appraisal meeting by both the doctor and the appraiser.
The appraisee and appraiser will normally use the online toolkit for all appraisal documentation (see Section 6.8). Specific groups of doctors such as Clinical Fellows and WAST doctors will use a portfolio document to take account of their training needs. Short term doctors could use MAG forms if agreed by the RO.

### 6.9 Outcomes of Appraisal

It is anticipated that the appraisal process will generally result in a positive outcome with the development of an agreed personal development plan. The maximum benefit from the appraisal process can only be realised where there is openness between the appraisee and appraiser. The appraisal should identify individual needs, which will be addressed through the personal development plan. All records will be held online and any printed copies to be kept on a secure basis and access/use must comply fully with the requirements of the relevant data protection legislation.

The appraiser should record any comments that will assist the RO to understand the reason for the statements that have been made and any other issues that the RO should be made aware of that may be relevant to the revalidation recommendation. The appraisee may respond to the above comments.

Where there is a significant disagreement, which cannot be resolved advice should be sought from the RO/AMDR Soundings on the issue may be taken from a number of appraisers and an opinion on the merits of the case will be conveyed to the appraisee and the appraiser by the RO/AMDR. Such soundings will be confidential and the identity of the individual doctor involved will not be provided. Where the doctor continues to disagree with the content of the appraisal or the process that has been followed then the doctor will be advised by the appraiser of his/her right to raise their concern formally in accordance with the Trust's Grievance Procedure An unsatisfactory outcome of appraisal may also arise from:

- failure to address issues that have been previously raised about clinical performance or personal behaviour

- the appraiser's judgement that there is inadequate evidence in any section of the appraisal toolkit
- Failure to complete the previous year's PDP without adequate explanation.

Part of the developmental approach to appraisal should be in supporting the appraisee in improving the quality of evidence year on year in the appraisal portfolio. Where there has been a clear failure to respond to actions outlined in previous year's appraisal then the appraisal should be considered as being unsatisfactory. If the issues cannot be resolved with the appraisee then the matter should be referred to the RO.

Where it becomes apparent during the appraisal process that there is a potentially serious performance issue (that has not been previously identified) that requires further discussion or examination then the appraisal meeting must be stopped. The matter must be discussed with the RO and referred by the appraiser immediately to the Medical Director to take appropriate action. Where such potentially serious performance issues are reported to the Medical Director then the doctor should be made aware of the nature of the issues. It is expected to be extremely rare that there will be such serious concerns about patient safety presented to the appraiser by the doctors themselves pre-appraisal that require suspension of the appraisal process and referral to a different process. Generally, it will be more appropriate to go ahead with the appraisal discussion to understand the context and put the appraiser in a position to make a professional judgement.

Medical managers need to deal with performance issues as they arise, and not to wait until the appraisal. It may be appropriate to delay an appraisal under such circumstances, but a doctor's appraisal for revalidation has to take place annually. Arrangements should be made as quickly as possible for the appraisal to be rescheduled. Where this is not possible records must be kept and timescales clearly documented.

### 6.10 Records and confidentiality

The detail of discussions during the appraisal interview would generally be considered to be confidential to the appraisee and appraiser. However, within the context of appraisal for revalidation, the RO/Appraisal team will have access to the appraisal documentation. The appraiser will need to escalate any concerns about performance that arise during the appraisal discussion, in line with the Trust's relevant policies and guidelines. Both the Trust and the appraisee will need to retain copies of the appraisal documentation, whether electronically or otherwise, over a five year period. The appraisee should retain and add to their supporting documentation in an appraisal folder. The Responsible Officer has overall accountability for ensuring appraisal takes place for all doctors for whom they are responsible and to securely hold copies of all documentation. The Responsible Officer is also responsible for the quality of the appraisals undertaken by the organisation.

The requirements of Information Governance will be adhered to in respect of all information relating to appraisal. Individuals involved in appraisal will have had relevant training and will familiarise themselves with the relevant guidance from NHS England (Information flows to support medical governance and responsible officer statutory function). When doctors move from one organisation to another, the new RO asks the previous RO to complete the GMC Medical Practitioners Information Transfer Form (MPIT).

### 6.11 Grievances arising from the appraisal process

Grievances arising from the appraisal process should be addressed in the first instance to the RO or, if they concern the RO, to the Chief Executive. This will be regarded as Stage 3 of the Grievance Procedure.

Grievances may be discussed with the Director of Human Resources if necessary to determine the best course of action or to assure the complainant of the integrity of the process.

### 6.12 Exemption from appraisal

Substantive Doctors, who have not held a career grade post prior to joining SHSC and directly employed locums, who have not held a locum post prior to joining the Trust may be exempt from the appraisal process for that year, where they have been in post for less than 6 months prior to the end of an appraisal year. Guidance should be sought from the AMDR in such instances. However, they will in any case be expected to meet with their Medical Manager to agree:

- A personal development plan for the first year.
- Relevant service related objectives that will be discussed at the first job planning meeting.

### 6.13 Deferment of appraisal

All doctors should undergo an appraisal annually if they undertake any professional work. This is also a requirement for successful revalidation. There are however exceptional circumstances when a doctor may request that an appraisal is deferred such
that no appraisal takes places during one appraisal year. Instances when doctors or the RO/AMDR may request a deferment are:

- Breaks in clinical practice due to sickness or maternity.
- Breaks in clinical practice due to absence abroad or sabbaticals.
- Breaks in practice due to suspension from clinical work as a result of the doctor being investigated as a result of concerns over his/her performance or behaviour.

It is a doctor's responsibility to agree the date of their appraisal with their appraiser prior to their appraisal due date. Postponement should be a planned event, agreed 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. 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. A doctor who is professionally active in any manner is expected to participate in the Trust's appraisal system. Absence from professional duties with the Trust does not therefore automatically imply that postponement of appraisal is appropriate if the doctor is still professionally active. 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 and follow the process described below.

Each case will be dealt with on its merits and the Trust is mindful that no doctor must be disadvantaged or unfairly penalised as a result of pregnancy, sickness or disability. Doctors who have a break from clinical practice may find it harder to collect evidence to support their appraisal, particularly if being appraised soon after their return to clinical practice. However, often an appraisal can be useful when timed to coincide with a doctor's re-induction to clinical work. Appraisers will use their discretion when deciding the minimum evidence acceptable for these exceptional appraisals. This policy aims to ensure that these circumstances are dealt with in an appropriate, timely, and consistent manner, minimising bureaucracy and ensuring that all doctors benefit from appraisal at a time which meets their professional needs.

Doctors who think they may need to defer their appraisal should contact their RO/ADMR setting out why a deferment should be considered. Deferment applications should be submitted in writing at the earliest possible opportunity to the RO with full reasons as to why there should be a deferment
The decision can be appealed under the Grievance Procedure and appeals will be dealt with by the Medical Director. The decision to allow a deferment will depend on a number of factors:

- How many appraisals have or will have been missed in a 5 year period.
- Whether there is anticipated to be further breaks from clinical practice in the near future.
- If there have been problems with evidence in previous appraisals.
- If the doctor is undergoing any investigation about his/her performance.

(This list is not exhaustive).

The length of the deferment will reflect the guidance available from NHS England (see Appendix 2).

### 6.14 Doctors subject to investigation / disciplinary action

The nature, conduct and frequency of annual appraisal for doctors that are currently subject to investigation and /or disciplinary action following health, conduct and / or clinical performance concerns that have been raised (including any doctors on restricted duties, excluded by the Trust or suspended by the GMC) will be decided on an individual basis by the Medical Director. Where a doctor at the time of the annual appraisal is subject to investigation and/or disciplinary action following health, conduct and/or clinical performance concerns that have been raised (including any doctors on restricted duties, excluded by the Trust or suspended by the GMC), it will need to be identified what impact this will have, if any, on the appraisal process. This will be decided upon by the RO in conjunction with the Medical Director. The Medical Director will be responsible for keeping an accurate record of these decisions for future reference by either the employer or doctor concerned. In making this decision regard will be had to the responsibilities of an RO in terms of revalidation recommendations and whether there should be a request for deferral (see 6.17).

### 6.15 Process for Supporting Appraisal and Escalation Process for Appraisal

The appraiser and appraisee will receive from the Appraisal Team a notification confirming the month for appraisal. This will be sent out 3 months before the specified appraisal date and will also contain details regarding the documentation and guidance which will be available to support the appraisal and when these will be available. The

appraiser/appraisee will then have a 3 month window (9-12 months from the appraisal months) to hold the appraisal meeting and further 28 days to complete and submit the appraisal to the RO. In the case of honorary academic consultants this documentation will be copied to the relevant University Joint Appraiser.
If an appraisal is at risk of not being completed by the end of window then the appraiser and appraisee have a joint responsibility to ensure that this delay is brought to the attention of the Responsible Officer. They are required to send to the Associate Medical Director for Revalidation an explanation of the issues which have prevented the appraisal from being completed and an action plan as to what needs to be done to complete the appraisal including the timescale. The Responsible Officer will confirm whether the action plan and timescale is agreed and offer any assistance which may be appropriate. In the case of honorary academic consultants, this documentation will be copied to the relevant University Joint Appraiser.

If the RO/AMDR does not agree with the proposed actions and/or timescales or the appraisee disputes the actions/timescales set out, then the RO/AMDR will seek to resolve the matter with the appraiser/appraisee. If this does not occur within a reasonable timescale then the RO/AMDR will contact the Medical Director to discuss appropriate next steps. The Responsible Officer will have regard to submitting a REV6 form to the GMC, requesting the issuing of an “early concern” letter. The relevant appropriate steps will then be set out in writing to the appraiser/appraisee.

### 6.16 Private or non-NHS practice

Where a doctor carries out private practice, supporting information from that work should be provided to allow for a full appraisal of clinical practice. Written evidence from each private employer is required. If no evidence is provided then appraisal will be considered incomplete.

### 6.17 Link to revalidation

Revalidation of licensed doctors will be required every five years and is based on comprehensive annual appraisals undertaken over that five year period. It is designed to improve the quality of patient care by ensuring that licensed doctors remain up to date and continue to be fit to practise. It is used:

- To confirm that licensed doctors practise in accordance with the GMC’s generic standards.
- For doctors on the specialist register, to confirm that they meet the standards appropriate for their specialty.
- To identify, for further investigation and remediation, poor practice where local systems are not robust enough to do this or do not exist.

The relevant Responsible Officer will make one of the following recommendations based on the triangulation of information from appraisal, clinical governance and any other source, to the General Medical Council:

- positive recommendation that the doctor should be revalidated
- request a deferral because they need more information about the doctor
- notify the GMC of a failure to engage with any of the local systems or processes (such as appraisal) that support revalidation

The GMC will act on the Responsible Officer’s recommendations, issuing a new license to practice to those doctors with a revalidation recommendation and dealing with deferrals and notifications of failure to engage according to the circumstances.

Deferral and non-engagement decision will be discussed beforehand with the GMC Employment Liaison Adviser (ELA), The RO and Medical Director have regular meetings with the GMC ELA where concerns about doctors’ performance or engagement are discussed.

If any concerns about a doctor’s performance, health or conduct arise, these will be dealt with through existing processes as they arise without waiting for the revalidation recommendation.

### 6.18 Quality Assurance

Internal Quality Assurance (QA) of appraisal comprises:
- Assurance of the process.
- Assurance of work of appraisers.

Assurance of the process will be carried out as part of the annual report to the Board of Directors by the RO.

Regular review of the appraisal system, policy and supporting guidance will be undertaken each year by the RO/AMDR using NHS guidance. This will include regular formal feedback from both appraisers and appraisees on the management of the appraisal system as a whole.

Quality Assurance of appraiser work is delivered through:

1. Recruitment and selection – through the Medical Director/AMDR
2. Review of ‘probationary’ appraiser performance after their initial two appraisals – through mandatory appraisee feedback.
3. Review of established appraiser’s performance through regular feedback questionnaires from appraisees.
4. Annual appraiser report
. Annual appraiser updates (formal group training and appraiser support)

As part of the quality assurance of appraisal, appraisees will be asked to provide feedback on their appraisal.
Quality assurance of appraisals
1. The appraisal team review all annual appraisals following their submission to the RO. The RO might decide to refer an appraisal back for inclusion of further information.
2. Appraisal team will score at least 50% of annual appraisals using quality assurance tool approved by NHS England.
3. Appraisers report any concerns to the RSG.
4. An extended RSG is held annually as a refresher for appraisers. A sample of appraisals is reviewed during the session.

### 6.19 Exit reports for locum doctors

All career grade locum doctors should receive an exit report that should be completed by the supervising clinician or senior member of the clinical team e.g. team or ward manager.

### 6.20 Training of and Job Planning for appraisers

Those expressing an interest will be eligible to attend an initial external / internal approved orientation course aimed at assessing an individual's competencies to undertake appraisal. This course will contain the necessary approved national core content defined by NHS England. Any external providers used to carry out initial training for new appraisers will be required as part of their contract to regularly assess their training packages for consistency with the current approved core content.
The Medical Managers are required to ensure that any prospective appraiser have sufficient time identified in their job plans to carry out the role.

On appointment, a probationary period of 12 months will follow during which the new appraiser will undertake a minimum of 4 appraisals. After the first two of these appraisals, a formal review will be undertaken with the RO/AMDR to assess progress, deal with any new learning needs identified and confirm whether the appraiser is competent to continue. Established appraisers will have access to ongoing support through the RO/AMDR and RSG. Regular RSGs will be held through the year to provide refresher skills training, group feedback and updates on any changes to the appraisal policy/documentation etc.

Appraisers will be expected to include relevant learning objectives for developing their appraisal skills in their PDPs as a result of their own annual appraisal. Doctors undertaking formal appraiser roles will be expected to discuss their commitments on appraisals within their annual job plan review with their clinical line manager.

Appraisers are allocated time within their Job Plan for carrying out appraisals. This is currently 0.2 PA for carrying out 8 annual appraisals (pro rata for fewer appraisals).

### 6.21 Appraisal of Clinical Directors (or equivalent)

The Clinical Director's scope of work will always include a medical management role. They will often be involved in appraising medical staff. Both roles will be part of their own appraisals, and they should provide the relevant supporting evidence. As an appraiser they will be subject to annual review of their performance and quality assurance of the appraisals they completed on medical staff.

### 6.22 Charging for Appraisal/Revalidation

Where the appraisee is not a member of the Trust's medical staff (employee or Honorary Consultant) then the Trust may make appropriate arrangements for charging the doctor or another organisation for the cost of administering his/her appraisal and for making recommendations regarding revalidation. As this will be a contracting arrangement, it will be a matter for the Medical Director and RSG to determine.

## 7. Dissemination, storage and archiving

The issue of this policy will be communicated to all staff via the Communications Digest. Local managers are responsible for implementing this policy within their own teams.

This policy will be available to all staff via the Sheffield Health & Social Care NHS Foundation Trust Intranet and on the Trust's website. The previous version will be removed from the Intranet and Trust website and archived. Word and pdf copies of the current and the previous version of this policy are available via the Director of Corporate Governance.

Any printed copies of the previous version should be destroyed and if a hard copy is required, it should be replaced with this version.

In addition, the AMDR and Clinical Directors will be instructed to ensure that all relevant medical staff are informed of the policy and associated documentation.

## 8. Training and other resource implications

Refresher training for appraisers, recruitment and training of new appraisers. Appointment of External Responsible Officer.

## 9. Audit, monitoring and review

This policy will be subject to review as set out under Duties and the Quality Assurance Process referred to above.

| **Monitoring Compliance Template** | | | | | | |
|---|---|---|---|---|---|---|
| Minimum Requirement | Process for Monitoring | Responsible Individual/ group/ committee | Frequency of Monitoring | Review of Results process (e.g. who does this?) | Responsible Individual/group/ committee for action plan development | Responsible Individual/group/ committee for action plan monitoring and implementation |
| Review of process and duties | Review of policy | Medical Workforce Planning Group | At least every 3 years, as per Trust policy | Medical Workforce Planning Group | Medical Workforce Planning Group | Medical Workforce Planning Group |

## 10. Implementation plan*:*

| Action / Task | Responsible Person | Deadline | Progress update |
|---|---|---|---|
| Policy to be replaced on the Intranet and Trust website. | Director of Corporate Governance | Within 5 working days of finalisation | |
| A communication will be issued to all staff via Connect. | Director of Corporate Governance | Within 5 working days of issue | |
| A communication will be sent to Education, Training and Development to review training provision. | Director of Corporate Governance | Within 5 working days of issue | |

## 11. Links to other policies, standards and legislation (associated documents)

- BMA – Revalidation: https://www.bma.org.uk/advice/employment/appraisals
- GMC – Revalidation: https://www.gmc-uk.org/registration-and-licensing/managing-your-registration/revalidation/introduction-to-revalidation
- GMC – Good Medical Practice: https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/good-medical-practice
- NHS England – Medical Revalidation: https://www.england.nhs.uk/medical-revalidation/
- NHS England – Quality Assurance of medical appraisal: https://www.england.nhs.uk/medical-revalidation/appraisers/qa-guidance-notes/
- NHS England – The Appraisal System (including QAMA): https://www.england.nhs.uk/medical-revalidation/ro/app-syst/
- NHS England – Medical Appraisal Guide (MAG) Model Appraisal Form: https://www.england.nhs.uk/medical-revalidation/appraisers/mag-mod/
- NHS Employers – Revalidation: https://www.nhsemployers.org/your-workforce/retain-and-improve/standards-and-assurance/professional-regulation/medical-revalidation#2
- RCPsych – Revalidation: https://www.rcpsych.ac.uk/members/supporting-you/revalidation
- RCPsych – Revalidation Mythbusters: https://www.rcpsych.ac.uk/members/supporting-you/revalidation/revalidation-mythbusters
- Good Practice Guidelines for Appraisal, RCPsych, February 2010: https://nww.xct.nhs.uk/media/Documents/Medical/Medical%20Staffing/Appraisal%20and%20Revalidation/Guidance/RCpsych%20-%20Good%20Practice%20Guidelines%20for%20Appraisal.pdf
- Appraisal for Revalidation: A guide to the process, Academy of Medical Royal Colleges, July 2014: https://nww.xct.nhs.uk/media/Documents/Medical/Medical%20Staffing/Appraisal%20and%20Revalidation/Guidance/AMRC%20-%20Appraisal%20for%20revalidation%20a%20guide%20to%20the%20process.pdf
- Medical Appraisal Guide: A guide to medical appraisal for revalidation in England, RST, V4.0, September 2014:

https://nww.xct.nhs.uk/media/Documents/Medical/Medical%20Staffing/Appraisal%20and%20Revalidation/Guidance/NHS%20England%20Medical%20Appraisal%20Guide.pdf

- The Good Medical Practice Framework for Appraisal and Revalidation, GMC, March 2013: https://nww.xct.nhs.uk/media/Documents/Medical/Medical%20Staffing/Appraisal%20and%20Revalidation/Guidance/The%20Good%20medical%20practice%20framework%20for%20appraisal%20and%20revalidation.pdf

- Good Medical Practice, GMC, April 2014: https://nww.xct.nhs.uk/media/Documents/Medical/Medical%20Staffing/Appraisal%20and%20Revalidation/Guidance/GMC%20-%20Good%20medical%20practice.pdf

- CR194 - Supporting Information for Appraisal and Revalidation: Guidance for Psychiatrists, RCPsych: https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/college-reports/college-report-cr194.pdf?sfvrsn=954f9053_2

- The Reflective Practitioner: Guidance for doctors and medical students, September 2018: https://nww.xct.nhs.uk/media/Documents/Medical/GMC%20-%20The%20Reflective%20PRactitioner%20(Sep18).pdf

- Guidance on Supporting Information for Appraisal and Revalidation, GMC, March 2018: https://nww.xct.nhs.uk/media/Documents/Medical/GMC%20-%20Guidance%20on%20Supporting%20Information%20for%20Appraisal%20and%20Revalidation%20(Mar2018).pdf

- Guidance for Doctors: Requirements for Revalidation and Maintaining your Licence, GMC, March 2018: https://nww.xct.nhs.uk/media/Documents/Medical/GMC%20-%20Guidance%20for%20Doctors%20-%20Requirements%20for%20Revalidation%20and%20Maintaining%20your%20License.pdf

- UK Legislation – The Medical Profession (Responsible Officers) Regulations 2010: http://www.legislation.gov.uk/uksi/2010/2841/introduction/made

- UK Legislation – The Medical Profession (Responsible Officers) (Amendment) Regulations 2013: http://www.legislation.gov.uk/uksi/2013/391/contents/made

- The Trust's Policy on disciplinary, Capability, Ill-health and Appeals Policy and Procedure for Medical Practitioners including the Annex on Remediation

- The Trust's Grievance Procedure

## 12. Contact details

| *Title* | *Name* | *Phone* | *Email* |
|---|---|---|---|
| HR Directorate Partner | Sarah Bawden | 0114 2716292 | Sarah.Bawden@shsc.nhs.uk |
| Medical Director | Mike Hunter | 0114 2764838 | Mike.Hunter@shsc.nhs.uk |

## 13. References

Please refer to www.nhsemployers.org

## Appendix A – Version Control and Amendment Log

| Version No. | Type of Change | Date | Description of change(s) |
|---|---|---|---|
| 3 | Ratified / finalised / issued | Nov 2016 | New policy template |
| 4 | Review, consultation, approval, ratification, issue | 2018 to<br>July 2019 | This policy has been amended to reflect NHSE guidance and changes to the Trust Management structure since the last review. |

## Appendix B – Dissemination Record

| Version | Date on website (intranet and internet) | Date of "all SHSC staff" email | Any other promotion/ dissemination (include dates) |
|---|---|---|---|
| 3 | Nov 2016 | Nov 2016 via Communications Digest | |
| 4 | July 2019 | July 2019 via Connect | |

# Appendix C – Stage One Equality Impact Assessment Form

## Equality Impact Assessment Process for Policies Developed Under the Policy on Policies

**Stage 1** – Complete draft policy

**Stage 2** – **Relevance** - Is the policy potentially relevant to equality i.e. Will this policy potentially impact on staff, patients or the public? If **NO** – No further action required – please sign and date the following statement. If **YES –** proceed to stage 3

This policy does not impact on staff, patients or the public (insert name and date) | See below

**Stage 3** – **Policy Screening** - Public authorities are legally required to have 'due regard' to eliminating discrimination , advancing equal opportunity and fostering good relations , in relation to people who share certain 'protected characteristics' and those that do not. The following table should be used to consider this and inform changes to the policy (indicate yes/no/ don't know and note reasons). Please see the SHSC Guidance on equality impact assessment for examples and detailed advice. This is available by logging-on to the Intranet first and then following this link https://nww.xct.nhs.uk/widget.php?wdg=wdg_general_info&page=464

| | **Does any aspect of this policy actually or potentially discriminate against this group?** | **Can equality of opportunity for this group be improved through this policy or changes to this policy?** | **Can this policy be amended so that it works to enhance relations between people in this group and people not in this group?** |
|---|---|---|---|
| **AGE** | **No** | | |
| **DISABILITY** | **NO** | | |
| **GENDER REASSIGNMENT** | **No** | | |
| **PREGNANCY AND MATERNITY** | **No** | | |
| **RACE** | **No** | | |
| **RELIGION OR BELIEF** | **No** | | |
| **SEX** | **No** | | |
| **SEXUAL ORIENTATION** | **No** | | |

**Stage 4** – **Policy Revision** - Make amendments to the policy or identify any remedial action required (action should be noted in the policy implementation plan section)

Please delete as appropriate: Policy Amended / Action Identified / no changes made.

Impact Assessment Completed by (insert name and date) | Sarah Bawden July 2019

# Appendix D - Human Rights Act Assessment Form and Flowchart

You need to be confident that no aspect of this policy breaches a person's Human Rights. You can assume that if a policy is directly based on a law or national policy it will not therefore breach Human Rights.

If the policy or any procedures in the policy, are based on a local decision which impact on individuals, then you will need to make sure their human rights are not breached. To do this, you will need to refer to the more detailed guidance that is available on the SHSC web site
http://www.justice.gov.uk/downloads/human-rights/act-studyguide.pdf
(Relevant sections numbers are referenced in grey boxes on diagram) and work through the flow chart on the next page.

**1. Is your policy based on and in line with the current law (including case law) or policy?**

**X Yes. No further action needed.**

**☐ No. Work through the flow diagram over the page and then answer questions 2 and 3 below.**

**2. On completion of flow diagram – is further action needed?**

**☐ No, no further action needed.**

**☐ Yes, go to question 3**

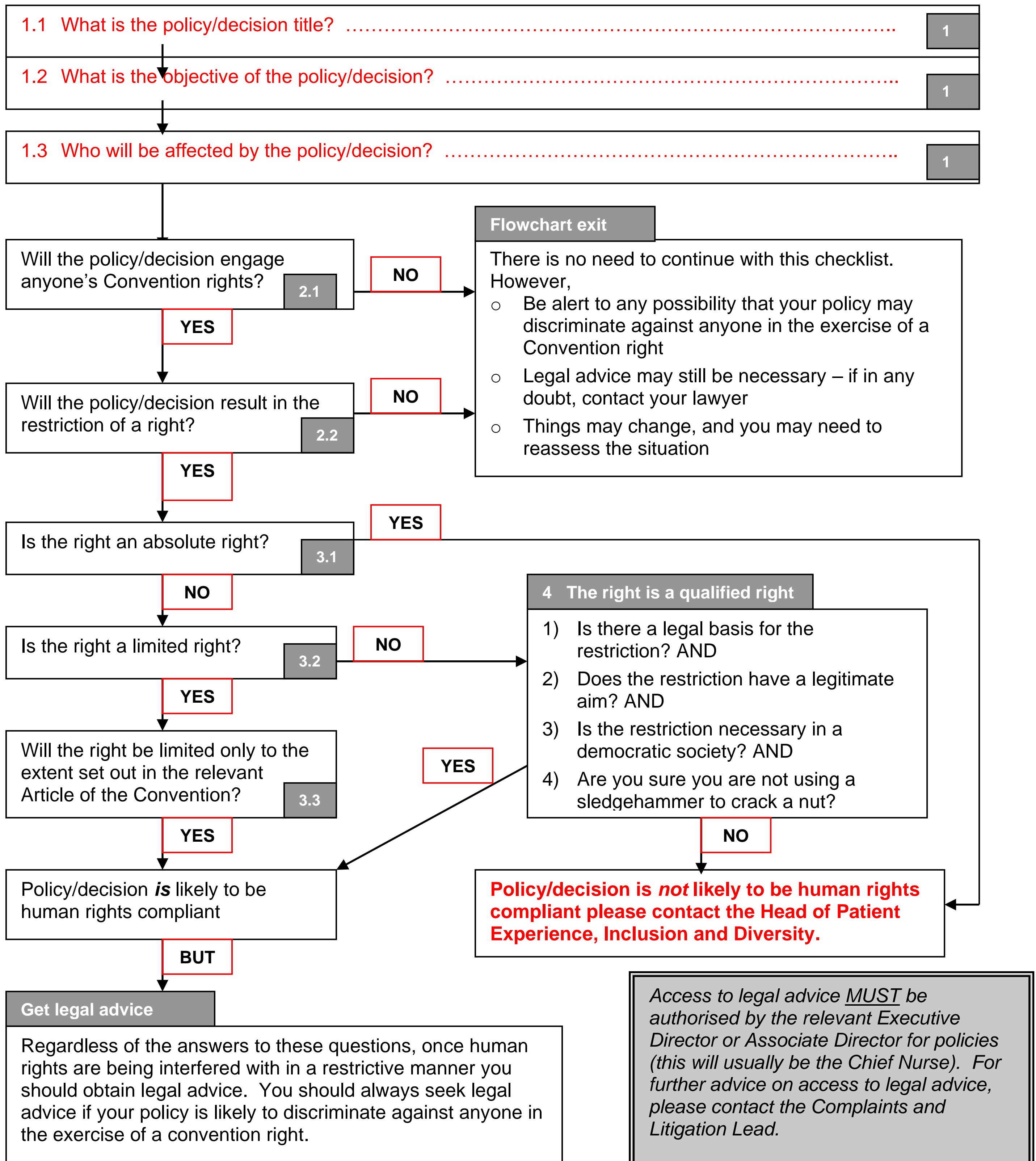
**3. Complete the table below to provide details of the actions required**

| Action required | By what date | Responsible Person |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**Human Rights Assessment Flow Chart**

**Complete text answers in boxes 1.1 – 1.3 and highlight your path through the flowchart by filling the YES/NO boxes red** (do this by clicking on the YES/NO text boxes and then from the Format menu on the toolbar, choose 'Format Text Box' and choose red from the Fill colour option).

**Once the flowchart is completed, return to the previous page to complete the Human Rights Act Assessment Form.**



## Appendix E – Development, Consultation and Verification

This policy was first issued in November 2012. It was revised in October 2014 with minor amendments relating to the Responsible Officer and Information Governance.
In 2016 the policy was transferred to the new template.

Version 4

This version is amended to reflect the NHSE guidance and to accommodate changes in the Trust management structure.

This policy sets out the framework for the appraisal of Consultants and Specialty Doctors. It is based on national guidance. The national guidance was updated and the policy has been updated to reflect these changes.

The changes were drafted in conjunction with the Responsible Officer, reviewed by the Medical Workforce Planning Group and subsequently verified by the Local Negotiating Committee representatives.

## Appendix F –Policies Checklist

***Please use this as a checklist for policy completion. The style and format of policies should follow the Policy Document Template which can be downloaded on the intranet.***

**1. Cover sheet** ✓

All policies must have a cover sheet which includes:

- The Trust name and logo ✓
- The title of the policy (in large font size as detailed in the template) ✓
- Executive or Associate Director lead for the policy ✓
- The policy author and lead ✓
- The implementation lead (to receive feedback on the implementation) ✓
- Date of initial draft policy ✓
- Date of consultation ✓
- Date of verification ✓
- Date of ratification ✓
- Date of issue ✓
- Ratifying body ✓
- Date for review ✓
- Target audience ✓
- Document type ✓
- Document status ✓
- Keywords ✓
- Policy version and advice on availability and storage ✓

**2. Contents page** ✓

**3. Flowchart** ✓

**4. Introduction** ✓

**5. Scope** ✓

**6. Definitions** ✓

**7. Purpose** ✓

**8. Duties** ✓

**9. Process** ✓

**10. Dissemination, storage and archiving (control)** ✓

**11. Training and other resource implications** ✓

**12. Audit, monitoring and review** ✓

This section should describe how the implementation and impact of the policy will be monitored and audited and when it will be reviewed. It should include timescales and frequency of audits. It must include the monitoring template as shown in the policy template (example below).

| Monitoring Compliance Template | | | | | | |
|---|---|---|---|---|---|---|
| Minimum Require-ment | Process for Monitoring | Responsible Individual/ group/ committee | Frequency of Monitoring | Review of Results process (e.g. who does this?) | Responsible Individual/group/ committee for action plan development | Responsible Individual/group/ committee for action plan monitoring and implementation |
| A) Describe which aspect this is monitoring? | e.g. Review, audit | e.g. Education & Training Steering Group | e.g. Annual | e.g. Quality Assurance Committee | e.g. Education & Training Steering Group | e.g. Quality Assurance Committee |

**13. Implementation plan**

**14. Links to other policies (associated documents)**

**15. Contact details**

**16. References**

**17. Version control and amendment log (Appendix A)**

**18. Dissemination Record (Appendix B)**

**19. Equality Impact Assessment Form (Appendix C)**

**20. Human Rights Act Assessment Checklist (Appendix D)**

**21. Policy development and consultation process (Appendix E)**

**22. Policy Checklist (Appendix F)**

**The Application Form, reproduced on the following pages, is for information only. Below is the link to the NHSE guidance.**

https://www.england.nhs.uk/medical-revalidation/ro/con-of-int/

https://www.england.nhs.uk/publication/responsible-officer-conflict-of-interest-or-appearance-of-bias/

**Examples of conflict of interest/appearance of bias**

It is anticipated that an alternative responsible officer will only need to be nominated or appointed rarely, as the majority of situations are minor and can be managed internally through transparent and effective organisational systems.

The responsible officer guidance suggests that a conflict of interest or appearance of bias may occur in the following situations:

- Personal relationships
  - Where there is or has been a personal relationship such as marriage or partnership between a responsible officer and a doctor or where the two are related in any other way.
  - Where there is a close financial or business relationship between a responsible officer and a doctor
  - instances where a third party is involved (e.g. an affair or marriage breakdown)
  - Where there is a known and long-standing breakdown of the professional relationship between a responsible officer and a doctor.
- Managerial or organisational roles (the different roles of managers and clinicians might create a situation where a conflict of interest or appearance of bias might need further consideration):
  - A responsible officer who is appraised by a medical chief executive might then have to make a fitness to practice recommendation in respect of the chief executive.
  - A clinical director might be called on to comment on the clinical practice of their own responsible officer.

## Application Form for the Appointment of an Alternative Responsible Officer on Grounds of Conflict of Interest or Appearance of Bias

| **Section 1. Description of potential conflict of interest or appearance of bias** |
|---|
| **Doctor details:** |
| Name: Click here to enter text.<br>GMC number: Click here to enter text. |
| **Designated body details:** |
| Name: Click here to enter text. |
| **Responsible officer details:** |
| Name: Click here to enter text.<br>GMC number: Click here to enter text.<br>Telephone: Click here to enter text.<br>Email: Click here to enter text. |
| **Higher-level responsible officer details:** |
| Name: Click here to enter text.<br>Organisation: Click here to enter text. |
| **Type of potential conflict of interest or appearance of bias (tick all that apply):** |
| ☐ Close personal or family relationship (past or present)<br>☐ Close financial or business relationship<br>☐ Inverted or conflicting management relationship<br>☐ Known or longstanding breakdown of professional relationship |
| **Details of potential conflict of interest or appearance of bias:** |
| **This should include:** Summary of the situation/Type of personal or family relationship/Nature of financial, business or management relationship/Evidence of longstanding nature of the situation (e.g. history, duration of events)/Evidence of breakdown of professional relationship (e.g. responsible officer named in grievance or legal process)/Formal procedures involved (e.g. investigations, disciplinary processes, grievance procedures, suspensions, legal processes, tribunals, formal appeals)<br>Click here to enter text. |
| Supporting documentation: |
| **Indicate here any documentation submitted in support of this application.**<br>Click here to enter text. |

| **Applicant's statement:** |
|---|
| Based on the guidance contained in *The Role of Responsible Officer: Closing the gap in Medical Regulation – Responsible Officer Guidance 2010* and the above information and accompanying evidence, I believe there is a potential conflict of interest or appearance of bias between the responsible officer and the doctor named above, preventing the proper discharge of the responsible officer's duties as set out in *The Medical Profession (Responsible Officers) (Amendment) Regulations 2013*. I therefore request that an alternative responsible officer is nominated/appointed to act as this doctor's responsible officer.<br>**Name of applicant:** Click here to enter text.<br>**GMC number (if applicable):** Click here to enter text.<br>**Position/role (if not included above):** Click here to enter text.<br>**Address (if not included above):** Click here to enter text.<br>**Contact telephone (if not included above):** Click here to enter text.<br>**Date:** Click here to enter a date. |
| **Section 2. Higher-level responsible officer recommendation** |
| Based on the duties set out in *The Medical Profession (Responsible Officers) (Amendment) Regulations 2013* and the guidance contained in *The Role of Responsible Officer: Closing the gap in Medical Regulation - Responsible Officer Guidance 2010*, and having considered the above information and accompanying evidence, I recommend that (tick one):<br>☐ The potential conflict of interest or appearance of bias **reaches the threshold for an alternative responsible officer to be nominated or appointed by the designated body** to perform the responsible officer role in relation to the named doctor.<br>☐ The potential conflict of interest or appearance of bias **does not reach the threshold for an alternative responsible officer to be nominated or appointed by the designated body** and the responsible officer should continue to perform the role in relation to the named doctor.<br>**Name of higher-level responsible officer:** Click here to enter text.<br>**GMC number:** Click here to enter text.<br>**Organisation:** Click here to enter text.<br>**Email:** Click here to enter text.<br>**Telephone:** Click here to enter text.<br>**Date:** Click here to enter a date.<br>**Higher-level responsible officer comments:**<br>Click here to enter text. |

| Section 3. Confirmation of appointment of an alternative responsible officer by the designated body |
|---|
| The following person has been nominated/appointed to undertake the duties of the responsible officer in respect of the doctor named above:<br>**Name of alternative responsible officer:** Click here to enter text.<br>**GMC number:** Click here to enter text.<br>**Date of appointment:** Click here to enter text.<br>**Comments:** Click here to enter text. |

## Appendix H - Further guidance from NHS England regarding the scheduling of medical appraisal *(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, 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)1 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 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.