

# APPRAISAL OF DOCTORS IN THE DEFENCE MEDICAL SERVICES AND MINISTRY OF DEFENCE

## Introduction

1. Medical appraisal, as defined within the Medical Appraisal Guide (MAG) produced by the National Health Service (NHS), is a process of facilitated self-review supported by information gathered from the full scope of a doctor's work. Effective medical appraisal and subsequent revalidation<sup>1</sup> will satisfy the requirements of the General Medical Council's (GMC's) Good Medical Practice (GMP) and support the doctor's<sup>2</sup> professional development.
2. It is the responsibility of every Defence Medical Services (DMS) and other Ministry of Defence (MOD) employed doctor to complete their portfolio and to engage in their annual appraisal. The primary activities that drive appraisal are reflection on practice, identification of learning and development needs, and educational activity to meet these needs (continuing professional development), together with information from other sources on all aspects of their practice.

## Aim

3. The aim of this policy leaflet is to detail the requirements for conducting appraisal of doctors, both military and civilian, working in the DMS and all other doctors employed elsewhere in the MOD, to promote excellence in the delivery of healthcare and the provision of medical advice by DMS and other MOD employed doctors, and to meet statutory requirements for revalidation.
4. This policy leaflet follows the GMC and NHS England guidance and should be read in conjunction with:
  - a. [GMC: Good Medical Practice \(GMP\)](#).
  - b. [GMC: GMP Framework for Appraisal and Revalidation](#).
  - c. [NHS England Medical Appraisal Policy](#).

## Scope

5. This MOD policy applies to:
  - a. All full-time uniformed doctors employed within the DMS<sup>3</sup>.
  - b. Civilian Medical Practitioners (CMPs) principally employed by the MOD.
  - c. Civilian doctors employed by the MOD in medical specialties such as public health and occupational medicine, or in managerial appointments.

---

<sup>1</sup> Revalidation started on 3 Dec 12. The GMC began to revalidate licensed doctors from this date onwards and expects to revalidate the majority of doctors in the UK by Mar 16.

<sup>2</sup> In the context of this policy 'doctor' refers to the person being appraised or the appraiser.

<sup>3</sup> The Defence Medical Services comprise the medical services of the Royal Navy, Army and RAF, and the Joint medical structures including HQ Surgeon General, Medical Policy and Operational Capability, and Healthcare Delivery and Training. All DMS and other MOD doctors are required to retain their licence to practise and so must undergo revalidation and, therefore, must also undergo regular (annual) professional appraisals.

## Background

6. All doctors, defined in this policy as registered medical practitioners, are required to have an appraisal in each year (1 Apr to 31 Mar).

7. MOD and DMS doctors are employed across the UK, and overseas; Headquarters Surgeon General (HQ SG) has agreed with the GMC that the process of revalidation and appraisal for the MOD/DMS will follow that within NHS England.

## Purpose of Revalidation

8. The purpose of revalidation is to assure patients and public, employers and other healthcare professionals that licensed doctors are up to date and fit to practise.

9. In order to revalidate the doctor must demonstrate through appraisal that they have collected, maintained and reflected on a portfolio of [Supporting Information for Appraisal and Revalidation](#) to demonstrate the maintenance of their clinical and professional standards and, where applicable, their specialist skills. The key components of this information are listed below:

- a. Continuing Professional Development (CPD).
- b. Quality improvement activity.
- c. Significant events.
- d. Colleague feedback.
- e. Patient feedback (where applicable).
- f. Review of complaints and compliments.

10. The policy on revalidation can be found in [JSP 950 Part 1 Lft 10-2-2 Revalidation of Doctors in the Defence Medical Services and Ministry of Defence](#).

## Purpose of Appraisal

11. Medical appraisal is founded on continuous improvement and is a formal platform for doctors to:

- a. Discuss their practice and performance with their appraiser to demonstrate that they continue to meet the principles and values set out in [GMP](#) and so inform their Responsible Officer's (RO's) recommendation on revalidation to the GMC in each 5 yearly cycle.
- b. Enhance the quality of their professional work by planning their professional development.
- c. Consider their own needs in planning their professional development.

## Professional and Performance Appraisal

12. In the MOD and DMS, whilst the outputs of professional and performance appraisals may be used to inform each other, the two processes must be kept separate. In line with this principle, the appraiser should not be one of the Reporting Officers for the appraised doctor's annual performance report, ie the Officer's Joint Appraisal Report (OJAR) for military doctors or the

Personnel Annual Development Report (PADR) for civilian doctors, although copies of these annual performance reports should be made available to the appraiser by the doctor as part of the evidence presented to support medical appraisal.

### Multi-Source Feedback

13. The aim of Multi-Source Feedback (MSF) is to obtain information from patients (or customers) and colleagues about a doctor's qualities and competencies rather than just their skills and knowledge. Completion of a self-assessment questionnaire prior to the patient or customer questionnaire being carried out is recommended.

14. [Collecting feedback from colleagues and patients](#)<sup>4</sup> (or the customers of those doctors who do not see patients) is a formative activity and the GMC have mandated that all doctors will engage in and reflect on the outcomes of MSF at least once in every 5 year revalidation cycle<sup>5</sup>. The feedback should highlight strengths and identify areas for further improvement. The GMC has also stipulated that:

- a. All information (including responses) is to be held in accordance with the [Data Protection Act 1998](#)<sup>6</sup>.
- b. Subject doctors are not to see individual responses from colleagues or patients/customers.
- c. Feedback to the doctor must be based on the answers from all those taking part.
- d. No respondents should be identifiable.
- e. Questionnaires must be available in an alternative format (such as large print) if requested, to meet the requirements of the [Equality Act 2010](#)<sup>7</sup>.

15. The majority of DMS/MOD doctors work in clinical practice, and hence will use a patient questionnaire. In order to reach a degree of statistical significance the GMC patient questionnaire should usually be issued to no less than 34 consecutive patients<sup>8</sup> to support full and unbiased representation of patients or carers in the feedback sample. It is recognised that in some environments this may not be achievable and that other tools may specify different numbers of patients to achieve meaningful feedback. The appraiser will be expected to judge if a patient survey is sufficiently representative if there are low numbers or a non-GMC questionnaire has been used the RO should be consulted.

16. The patients selected for the feedback should, wherever possible, be consecutive patients. However, there may be times where it is judged inappropriate to seek feedback from a particular patient and doctors and clinical staff may need to use their professional judgement about the appropriateness of requesting such feedback while ensuring no bias is occurring in the sample.

17. Those doctors who do not see patients should instead approach their customers and seek their opinion and feedback via an appropriate management questionnaire.

---

<sup>4</sup> [http://www.gmc-uk.org/doctors/revalidation/colleague\\_patient\\_feedback\\_resources.asp](http://www.gmc-uk.org/doctors/revalidation/colleague_patient_feedback_resources.asp)

<sup>5</sup> Guidance, frequently asked questions and other information including suggested questionnaires are available through the GMC website at: <http://www.gmc-uk.org/publications/13050.asp>

<sup>6</sup> <http://www.legislation.gov.uk/ukpga/1998/29/contents>

<sup>7</sup> <https://www.gov.uk/equality-act-2010-guidance>

<sup>8</sup> Number of patients recommended is derived from pilot studies undertaken by the Peninsula Medical School reported in Feb 12 at [http://www.gmc-uk.org/Information\\_for\\_appraisers.pdf\\_48212170.pdf](http://www.gmc-uk.org/Information_for_appraisers.pdf_48212170.pdf)

18. All doctors should nominate no less than 15 colleagues<sup>9</sup> who are able to provide feedback on their professional performance using an appropriate colleague questionnaire.

a. Data collection for the colleague survey should be managed by a third party independent organisation, but may exceptionally be managed by the appraiser, who should be provided with a list of the e-mail or postal addresses of the colleagues by the doctor. The doctor should not be directly involved in contacting colleagues (although may do so in the context of obtaining email details) and must not see individual returns.

b. Once feedback has been received, self-assessment, if completed, should be compared with the feedback to build and encourage insight into their practice. This reflection should be discussed at the appraisal.

c. Doctors should receive feedback from either their appraiser or another person with experience in providing feedback. A personalised summary should be sent to the doctor and all information must be anonymised. The doctor should not be able to identify respondents.

d. One MSF is required in every 5 year revalidation cycle.

19. Doctors are free to use existing Royal College or other professional body questionnaires. They must discuss their preferred method with their appraiser before commencing the process to ensure that the appraiser is content that this will meet the GMC's requirements for revalidation.

20. Further information on the principles of MSF and the criteria the GMC expects to be met for the purposes of revalidation is available on the [GMC website](#)<sup>10</sup>.

### **Appraisal Process**

21. The appraisal process for the DMS is summarised in the schematic at Annex A.

22. To ensure that appraisers have sufficient time to dedicate to the appraisal process the appraiser is to be afforded at least 6 hours of protected time per appraisal.

23. The appraisal should be conducted within working hours in an appropriate, mutually agreed venue. The venue should allow the discussion to be private and confidential, free from interruptions and provide access to all necessary resources.

24. If, in exceptional circumstances, the doctor and appraiser mutually agree to meet at a time outside normal working hours, the agreement and reasons should be recorded. Both must ensure they are able to give the time needed for an effective and productive appraisal discussion.

25. In extreme circumstances, with the RO's permission, appraisals may be conducted using facilities such as Video Teleconference (VTC) and Skype.

### **Frequency of Appraisal**

26. Every doctor must have an appraisal in each year (1 Apr to 31 Mar); the appraisal should take place during the same month each year and where possible in the month of the doctor's birth. Where deployment or other special circumstances intervene the appraisal may take place within 9 – 15 months from the date of the last appraisal with the RO's prior approval. An application form for deferral of appraisal can be found at Annex B. The form is to be completed by the doctor and

---

<sup>9</sup> Minimum number of colleagues for multi-source feedback similarly derived from the pilot studies undertaken by the Peninsula Medical School reported in Feb 12 at [http://www.gmc-uk.org/Information\\_for\\_appraisers.pdf\\_48212170.pdf](http://www.gmc-uk.org/Information_for_appraisers.pdf_48212170.pdf)

<sup>10</sup> [http://www.gmc-uk.org/static/documents/content/RT - Supporting information for appraisal and revalidation - DC5485.pdf](http://www.gmc-uk.org/static/documents/content/RT_-_Supporting_information_for_appraisal_and_revalidation_-_DC5485.pdf).

submitted to the doctor's RO. Failure to undertake an appraisal in each appraisal year may place a doctor's licence to practise at risk.

27. On return from long term absence eg sickness, maternity or return to professional practice an appraisal must be completed within 6 months of their return. If doctors are unable to fulfil this requirement they must request written permission from the RO for an extension using Annex E.

### **Allocation of Appraisers**

28. Appraisers will be allocated by the HQ SG Revalidation Administration Cell<sup>11</sup> on behalf of the ROs. Doctors will be made aware of their appraiser before the start of the appraisal year. Allocation of appraisers is intended to reduce the risk of collusion and to avoid conflicts of interest or the perception of bias.

29. To provide continuity of appraisal, medical appraisers will normally be allocated to the same doctor for 3 years<sup>12</sup> and must then have a period of at least 3 years before being appraised by that appraiser again. Doctors should not act as an appraiser to a doctor who has acted as their appraiser in the last 5 years. It should not be usual practice for a doctor to request a change of appraiser after having had one appraisal with that appraiser.

30. Should a doctor have concerns in respect to the allocation of their appraiser, they should raise these initially with the HQ SG Revalidation Administration Cell by submitting the Appeal Against the Allocation of a Specific Appraiser Form at Annex C. The HQ SG Revalidation Cell will then liaise with the individual doctor's RO. There must be clear justification for re-allocation of an appraiser before a change can be made. The RO should ascertain whether any other action is appropriate in relation to the matter.

### **Pre-appraisal Preparation**

31. To present their appraisal information DMS doctors are strongly encouraged to use the [Medical Appraisal Guide Model Appraisal Form \(MAG MAF\)](#)<sup>13</sup>. Trust appraisal forms, or an e-portfolio are also acceptable providing the information is presented in a format compatible with the required GMC domains or MAG outputs. In extremis HQ SG produced forms (Annexes D to M) are available for use and should be submitted electronically. For those doctors not using MAGMAF a Form 6 Confirmation of Completion of Appraisal (Annex L) must be submitted.

32. For all RAF doctors a Form 6 (Annex L) must be submitted to the RO in addition to all formats of appraisal documentation including MAGMAF.

33. It is the doctor's responsibility to complete the pre-appraisal documentation and forward it to their appraiser 2 weeks before the appraisal date. All documentation for appraisal must be legible and professionally presented.

34. It is the RO's responsibility to put systems and processes in place to ensure that key items of information (such as specific complaints, significant events or outlying clinical outcomes) are included in the appraisal portfolio and discussed at the appraisal meeting, so that developmental needs are identified. In addition the doctor is also responsible for ensuring that any such information is included.

---

<sup>11</sup> Contact email is SGACDSSStratPol-SO2Reval@mod.uk.

<sup>12</sup> While retaining the principle that appraisal is delivered and supported on a regional basis; where either the appraiser or doctor move to a different region, reallocation of an appraiser to the appraised doctor may be appropriate.

<sup>13</sup> Via Internet (external) <http://www.england.nhs.uk/revalidation/appraisers/mag-mod/> Via Intranet (internal) <http://defenceintranet.diif.r.mil.uk/libraries/8/Doccs5/20150319.1/mag-mod-app frm.pdf>.

35. Appraisal evidence should be submitted at every appraisal to reflect activity in each individual role (including any management and/or deployment role) and should demonstrate maintenance of and development of competence in each area of their work as a doctor.
36. Declaration of probity and declaration of health must be submitted for each appraisal. The declaration of absence of complaints should be submitted for each appraisal when there are no complaints.
37. The appraiser must be granted access to any supporting evidence held on electronic CPD portfolios or storage websites.
38. If the doctor has not provided the required supporting information, the appraisal discussion will need to be postponed until the information is available and the appraiser has had adequate time to prepare.
39. It will be necessary for the appraiser to be aware of healthcare governance or performance issues affecting the doctor, but any concerns will be managed in accordance with extant policy<sup>14</sup>.
40. Where the appraisal is conducted by a non-MOD/DMS appraiser, such as within an NHS Trust, the appraiser is recommended to liaise with the Military Clinical Director assigned to that Trust to assist the appraiser to understand the doctor's full scope of practice.

## **Appraisal**

41. Appraisal should be completed to demonstrate the application of the 6 categories of supporting information, within the 4 domains of the GMC Framework for Appraisal and Revalidation.
42. If in the course of the appraisal process, the appraiser becomes aware of any unaddressed concerns in respect to the doctor they must be reported to the RO.
43. If the doctor has any concerns about the appraiser during their appraisal this must be discussed during the appraisal interview. If the doctor feels unable to raise the matter with the appraiser or if there is no resolution to the doctor's concerns this must be reported immediately in writing to the doctor's RO for consideration of any action required.

## **Post Appraisal Feedback**

44. Following the appraisal discussion, the appraiser and the doctor will agree and sign the outputs of the appraisal statement. The appraiser must forward the MAGMAF or equivalent documentation to the doctor's RO within 28 days of the appraisal meeting. The Form 7 Post Appraisal Feedback Form (Annex M) must be forwarded by the doctor to their RO and the HQ SG Revalidation Administration Cell within 28 days of the appraisal meeting.
45. If an agreement to the outputs of the appraisal cannot be reached the RO should be informed. In this instance the doctor should still submit the outputs of the appraisal, but the RO should take steps to understand the reasons for the disagreement.

---

<sup>14</sup> JSP 950 Policy Lfts [5-1-4 Healthcare governance and assurance](#) and [5-2-4 Management of poorly performing doctors and dentists](#) respectively.



## Appraisal documentation

46. Personal confidential data<sup>15</sup> or other sensitive information is not needed for appraisal and must not be retained by doctors in their portfolio.

47. The content of the supporting information is owned by the appraised doctor, but will necessarily be shared with the appraiser. This information and the appraisal discussions will normally be kept confidential by the appraiser, but subject to the over-riding duty of all doctors to protect patients.

48. The appraiser is not allowed to maintain or keep personal records about a doctor's appraisals for any purpose. All the appraiser's records of the doctor's appraisal portfolio and appraisal forms must therefore be destroyed when the appraisal has been completed and the appraiser has received confirmation of receipt of the output by the doctor and the RO.

## Secondary Health Care Doctors Appraised in the NHS

49. DMS Secondary Health Care (SHC) doctors placed in the NHS will have their appraisals undertaken by the Trust under arrangements made between Commander Defence Medical Group (Comd DMG) and their host NHS Trust.

50. The sS as Designated Bodies (DBs) in legislation retain responsibility for the revalidation of their respective personnel. Each sS RO will therefore make recommendations to the GMC on individual doctors based on appraisal conducted by NHS Trust systems.

51. Following the appraisal discussion, the appraiser and the doctor will sign the outputs of the appraisal form and forward the appraisal documentation to the RO and, if requested by the Trust in which they are employed, a further copy should be forwarded to the Medical Director of the Trust. All doctors should also return an appraiser feedback form to the Trust in accordance with Trust policy.

52. Comd DMG will act as the agent for the sS ROs for SHC doctors in regard to the quality assurance of appraisals undertaken by the NHS, under arrangements agreed between DMG and the host NHS Trust. Comd DMG will request written confirmation that the Trust Appraisal system is quality assured and compliant with GMC policy and that the appraisers have undergone appropriate selection, training and assessment. The NHS Trust will be responsible for forwarding any concerns to Comd DMG who will then communicate with the respective sS RO.

## Doctors in Training

53. All doctors in training with full registration and a licence to practise will be required to undergo revalidation; the RO for all such doctors in the DMS is the Defence Healthcare Education and Training (DHET) Dean, and not the Deanery in which their training takes place.

54. For all doctors in training programmes, which are supported by a Medical College or Faculty, the Annual Review of Competency Progression (ARCP) process will substitute for the annual appraisal. The ARCP Panel will act as the 'appraiser' and will advise the DHET Dean as to the appropriate revalidation recommendation. In order to meet the statutory evidence requirements of the GMC, the Form R, submitted annually by all trainees, has been enhanced to include declarations of probity, health, complaints and compliments.

---

<sup>15</sup> Personal confidential data describes personal information about identified or identifiable individuals, which should be kept private or secret. 'Personal' includes the Data Protection Act 1998 (DPA) definition of personal data, but it is adapted to include dead as well as living people and 'confidential' includes both information 'given in confidence' and 'that which is owed a duty of confidence' and is adapted to include 'sensitive' as defined in the DPA.

## General Duties Medical Officers

55. Army and RAF General Duties Medical Officers (GDMOs) and doctors who have been released from a training programme before completion (ARCP Outcome 4) will be appraised following the same processes as doctors who have completed training. For Royal Navy GDMOs the Navy's Annual Appraisal Review Panel (AARP) will act as the appraiser. It is expected that Army GDMOs will move to the AARP system beginning in Aug 15 with their first panel being held in Aug 16. The RAF will retain face to face appraisal for the time being, with the GDMO e-portfolio being used as a syllabus to guide GDMO supervision by the General Medical Practitioner Associate Trainer (GMPAT)<sup>16</sup> as well as being the GDMO's appraisal tool.

## Selection and Training of Medical Appraisers

56. The term 'medical appraiser' refers to all of those who perform medical appraisals that contribute to revalidation. It is not necessary for the appraiser to be a doctor or to practise in the same specialty as the appraised doctor; indeed 'cross-pollination' is encouraged.

57. All medical appraisers must have undertaken appropriate training, either from DMS resources<sup>17</sup>, or other providers meeting the competences specified by NHS England.

58. Further information regarding appraisers can be found on the NHS England website<sup>18</sup>.

## Appraiser Indemnity

59. Appraisers employed within the MOD are MOD indemnified in their work as appraisers when carried out in the normal course of their military duties.

## Currency of Appraisers

60. All appraisers must continue to develop their skills as appraisers, which is to be achieved through taking part in regional appraiser support and development activities. To remain current an appraiser in the MOD/DMS should undertake a minimum of 3 appraisals in each appraisal year but will usually be expected to undertake at least 6 and no more than 12<sup>19</sup> appraisals per year.

61. If an appraiser undertakes fewer or more than this, the reasoning and arrangements for supervision of this will be recorded by the HQ SG Revalidation Administration Cell as part of the quality monitoring process.

62. Other than in very exceptional circumstances and only with the advance agreement of an RO, an appraiser may undertake more than 2 appraisal discussions on the same day.

63. All appraisers must be in date for mandatory Equality and Diversity training.

64. Appraisers will themselves be appraised in this role as part of their professional appraisal, which will be informed by a collation of the appraisal feedback forms that their RO receives following each appraisal they undertake. They will be expected to maintain currency as an appraiser through CPD agreed in their individual Personal Development Plans (PDP), as well as

---

<sup>16</sup> The e-portfolio should be used as a syllabus guide, from which to tailor a programme for individual GDMOs depending on needs, time constraints and availability.

<sup>17</sup> The Head of Medical Strategy and Policy, is the owner of appraisal training in the DMS. It is expected that the majority of MOD/DMS appraisers will receive their training through the DMS.

<sup>18</sup> NHS Revalidation, [Appraiser training and support](#).

<sup>19</sup> The minimum number may not be reached each year but over a 5 year period it is expected that all appraisers will be able to demonstrate sufficient engagement with appraising to maintain competence.



attending the DMS Appraisers' Conference at least once every 3 years. For an appraiser that is not a doctor the RO must arrange for them to receive feedback.

65. The ROs will note the currency of each appraiser through receipt of the outcome of their own appraisals, together with a record of activity through receipt of the feedback (Annex M) for each appraisal that the appraiser has undertaken.

66. The HQ SG Revalidation Administration Cell will maintain a database of appraisers on behalf of the ROs. In order to maintain an accurate database the RO and the HQ SG Revalidation Administration Cell will liaise when an issue is raised regarding an appraiser's currency and competence.

### **Governance of Appraisal**

67. Under arrangements made through dialogue between the RO and by the Regional Senior Appraiser<sup>20</sup> in which each individual is based, all new MOD/DMS appraisers will be linked to an experienced appraiser as their mentor to assist with their development over the first year.

68. ROs will ensure that they engage enough active, suitable appraisers to complete the necessary appraisals on a timely basis. Where the ratio of doctors to appraisers is higher than 12:1 or lower than 6:1, the justification for this will be recorded as part of the overall governance review of the appraisal process.

69. The RO should liaise with the HQ SG Revalidation Administration Cell and the Regional Senior Appraiser if there are significant concerns raised on the Post Appraisal Feedback Form (Annex M). Similarly, where performance issues arise locally in regard to an appraiser, the Regional Senior Appraiser should discuss these with the appropriate RO.

70. For concerns arising from appraisals in SHC, Comd DMG is to be informed and will engage with the RO of the NHS Trust.

71. The Defence DBs will ensure that there are arrangements in place to support medical appraisers working within their organisations. This includes, but is not limited to:

- a. Guidance and advice on all aspects of appraisal from the Regional Senior Appraiser and HQ SG Revalidation Administration Cell.
- b. Access to sufficient resources (including at least 6 hours protected time per appraisal) to support the role as a medical appraiser. Costs of appraisal lie where they fall; reimbursement for travel and subsistence where this has been incurred will be through the appraiser's administering unit.
- c. Access to training and other resources to support the development and improvement of medical appraiser skills.
- d. Peer support (on a regional basis), and specialty specific support where necessary.

72. The annual review of effectiveness as a medical appraiser is carried out for all appraisers by the sS Appraisal Lead to ensure that appraisers are being appropriately supported; that their development needs are being addressed; and to meet the requirement for ROs to undertake

---

<sup>20</sup> For the purpose of appraisal the DPHC regions will be used.

quality assurance and governance of the appraisal process within the DB for which they are responsible<sup>21</sup>.

### Quality Assurance of Appraisal

73. The appraisal process will be subject to quality assurance to reassure both the RO within each DB and the GMC that subsequent decision making based on appraisal outcomes is appropriate. As appraisal is linked to Healthcare Governance, SG will also require this assurance.

74. The Revalidation and Appraisal Assurance Steering Group (RAASG) will meet biannually to discuss strategic and regulatory matters and ensure that adequate and up to date assurance processes are being followed in the DMS. Revalidation and Appraisal Assurance Working Group (RAAWG) will meet biannually to discuss best practice at the tactical level.

75. Guidance on quality assurance for appraisal has been provided by the Department of Health and NHS England<sup>22</sup>. The tiered support structure with Regional Senior Appraisers, as well as informal networks, and the Annual DMS Appraisers' Conference, provides for the benchmarking of behaviour, processes and outcomes.

76. The quality of the appraisals submitted to each of the DMS ROs and the DMS appraisal process will be assessed through the following processes and recorded on the Assuring the Quality of Medical Appraisal within the MOD/DMS at Annex N.

- a. To assure the process and thus strengthen the confidence of the decisions made by the RO in making recommendations to the GMC, at least 10% of all appraisal forms will be called forward by each RO audit team (selected by the RO but not to be members of their Revalidation Administration Cell) to validate the decisions and statements made by the appraiser.
- b. Post Appraisal Feedback Forms (Annex M) will be collated for each appraiser and an anonymised summary of comments forwarded to the appraiser annually for reflection and discussion in their appraisal.
- c. All appraisers must take part in regional appraiser group meetings; the MOD/DMS Appraisal Support Network will be operated on behalf of the MOD/ROs by the Senior Appraisal Leads in each of the DPHC regions and in British Forces Germany to provide support to appraisers from each of the Services and the MOD and to facilitate:
  - (1) Advice on all aspects of the appraisal process.
  - (2) Peer support with the opportunity to discuss management of difficult areas.
  - (3) Specialty specific support where appropriate.
  - (4) Access to training and professional development resources to improve skills.
- e. All appraisers (less those for doctors in SHC, where these are appointed by NHS Trusts) will be appointed by the appropriate RO, and reappointed every 5 years on the basis of evidence of effective appraisals. This should be determined at each of the appraiser's

---

<sup>21</sup> [The Medical Profession \(Responsible Officer\) Regulations 2010](#).

<sup>22</sup> To ensure the highest level of quality assurance the DMS is to use the [Framework of Quality Assurance for ROs and Revalidation \(Department of Health and NHS England\) 4 Apr 14](#) as the framework for revalidation.

own appraisals by reflection on appraisals, collated feedback, attendance at appraisal support meetings, and evidence of continuous development of appraisal skills.

## **Confidentiality**

77. The appraiser is to maintain confidentiality regarding all information discussed in the appraisal and any outcomes including verbal, electronic and written communication. Where an appraisal is used as a case study for appraiser development all identifying information must be redacted.

78. If the doctor's appraisal is selected as part of the assurance process the appraisal outputs and supporting information will be exposed to the revalidation audit team.

## **Data Protection**

79. The appraiser must not hold or retain (other than for the immediate purpose of undertaking the appraisal) his or her own independent records relating to the doctor or the appraisal (as per para 47).

80. A copy of the appraisal supporting documentation is the information that underpins revalidation and must be retained by the doctor and the revalidation administration cell on behalf of the RO for 7 years following the revalidation recommendation to which it refers.

81. The supporting information may be used for:

- a. Monitoring and managing patient safety and the doctor's fitness to practise (including making fitness to practise recommendations).
- b. To facilitate early recognition of patterns of capability or conduct concerns.
- c. For management and quality assurance of the appraisal systems and processes.
- d. For the protection of the public and the MOD.
- e. For future legal defence by the DB including indemnifying the RO and/or appraiser.

82. The PDP may be shared by the RO with the relevant Specialty Consultant Advisors or Advisors in General Practice and analysed to understand collective learning needs and constraints, with the consent of the doctor. The doctor may also elect to provide their Line Manager with a copy of their PDP to support requests for attendance at professional development activities.

83. Appraisal documentation will not be used for any other purpose without the doctor's consent.

84. Electronic information must always be sent using secure e-mail systems, and the appraiser, Revalidation Administration Cell staff and RO have professional and legal responsibility to handle all information in accordance with legal parameters and safeguards.

## **Annexes:**

- A. Appraisal Process – Schematic for DMS and Other MOD Employed Doctors.
- B. Application for Deferral of Appraisal.
- C. Appeal Against the Allocation of a Specific Appraiser.
- D. Form 1 – Background Details.
- E. Form 2 – Details of Post(s) Currently Held or Held Since Last Appraisal.
- F. Form 3 – Pre-appraisal Preparation.

- G. Annual Probity Declaration.
- H. Annual Health Declaration.
- I. Declaration of Absence of Complaint(s).
- J. Form 4 – Medical Appraisal Folder – Summary of Appraisal Discussion with Agreed Actions.
- K. Form 5 – Personal Development Plan.
- L. Form 6 – Confirmation of Completion of Medical Appraisal.
- M. Form 7 – Post Appraisal Feedback Form.
- N. Assuring the Quality of Medical Appraisal Within the MOD/DMS.

Enclosures:

#### Template Toolbox

- 1. Good Clinical Care (Domains 1 and 2).
- 2. Reflective Templates – SEA (Domain 2).
- 3. Reflective Template – Audit (Domain 2).
- 4. Reflective Template – Case Reviews (Domain 2).
- 5. Reflective Template – Complaints (Domain 3).
- 6. Reflective Template – Health (Domain 2).
- 7. Reflective Template – Probity (Domain 4).
- 8. Maintaining Good Medical Practice (Domain 1).
- 9. Relationships with Patients or Customers (Domain 3).
- 10. Reflective Template – Patient or Customer Survey (Domain 3)
- 11. Working with Colleagues (Domain 3).
- 12. Multi Source Feedback from Colleague – Template.
- 13. Reflective Template – Multi-source Feedback (Domain 3).
- 14. Teaching and Training (Domains 1, 2 and 3).
- 15. Management Activity (Domains 1, 2 and 3).
- 16. Research (Domains 1 and 4).