External Quality Assurance of Medical Appraisal

Evaluation Report for

Wessex Appraisal Service

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1. Introduction

Medical revalidation was launched in 2012 to strengthen the way in which Doctors are regulated, with the aim of improving the quality and safety of all aspects of patient care and thereby, increasing public trust and confidence in the medical system. The requirements for revalidation became legal and statute to practice in the United Kingdom from December 2012. The keystone to revalidation is the annual appraisal, which is defined as a professional process of constructive dialogue in which the Doctor being appraised (the Appraisee) has a formal structured opportunity to reflect on their work and to consider how their effectiveness may be improved.

Doctors who are registered and licensed by the General Medical Council (GMC), are required to undergo annual appraisals during a 5-year revalidation cycle. The effectiveness of the annual appraisal process contributes significantly to the Responsible Officer (RO) revalidation recommendations to the GMC for each Medical Practitioner.

A Framework of Quality Assurance (FQA) was issued by NHS England to ensure that Responsible Officers (RO's) meet the statutory regulations (Medical Performance, RO Regulations 2010 (amendment 2013)). It is recommended that an external quality assurance review occurs periodically to provide evidence that systems and processes are in place.

The Wessex Appraisal Service (the Service) provides a comprehensive medical appraisal service. It is commissioned by NHS and independent healthcare organisations to carry out the Medical Appraisal function for doctors. It is an independent Service hosted to date by Health Education England. It is not a designated body (DB) and therefore does not make individual doctor recommendations to the GMC.

The Service has a well-established history of managing appraisal since 2007-8, originally from within Wessex Deanery. The Service Regional Director has been at the heart of the integration of medical appraisal into doctors' revalidation regionally and nationally since the developmental stages prior to 2012. Commissioners originally purchased medical appraisals through Wessex Deanery, which remains the only directly commissioned and educationally led service in England, although the devolved nations also have Deanery led models. When NHS England was conceived, NHS England Wessex became the new commissioner for the appraisal service from Wessex Deanery (which became HEE Wessex). The Service expanded to introduce medical appraisal to all primary care doctors in

Jersey and all Gibraltar Health Authority employed doctors across both primary and secondary care. Services were also developed for Guernsey primary care, other small, designated bodies, and a small number of independent doctors requiring a medical appraisal.

At the time of the review, there were two hundred and four (204) Appraisers engaged by the Service to facilitate approximately two thousand, six hundred (2,600) appraisals and support a range of Responsible Officers to make their revalidation recommendations.

The Service commissioned Miad Healthcare to conduct an external quality assurance review of their appraisal system from November 2021. Miad Healthcare, as an external organisation with knowledge of appraisal and revalidation, and with the skills to assess systems and provide support, has listed recommendations within this report, in line with NHS England core-revalidation standards and the GMC November 2020 guidance.

During the review, the merged NHS England and NHS Improvement (NHSEI) South West (SW) (Dorset) and South East (SE) (Hampshire & Isle of Wight) made the decision to take the appraisal process back in-house and served notice to Health Education England of that intention. The transition started during the review. The NHSEI commissioners interviewed stated that this decision was not related to the quality of the service provision but the view that outsourcing the process results in everything being 'one step removed' and if standards are to be maintained Medical Directors need to keep direct control of appraisal especially during the implementation of the Integrated Care Systems.

Note of review –during the pandemic Professor Stephen Powis, National Medical Director issued two (2) key Medical Appraisal and Revalidation documents to Responsible Officers and Medical Directors. The first on 19th March 2020 advised on the temporary suspension of appraisals and providing guidance on revalidation deferral if required. The second, published on 3rd September 2020, made recommendation that a flexible approach is taken to the resumption of the appraisal process, starting on 1st October 2020 to achieve normal levels of activity by 1st April 2021. The letter also described the 'Appraisal 2020' format, a re-balanced approach that focuses on a doctor's professional development and well-being and simplifies expectations around paperwork.
Miad Healthcare would like to thank all participants for their co-operation and assistance in giving up their time to complete this review during a very busy and challenging period.

Purpose of External Verification

- To provide a benchmark and basis on which to further enhance the quality of appraisal processes within the Service
- To provide signposts to further develop the infrastructure to support appraisal
- To provide steers to strengthen links with organisation governance arrangements
- To provide feedback and recommendations

This external review provides an indication of the quality of the appraisal process as part of revalidation; this includes acknowledgements of good practice, identifies potential areas for development and lists recommendations to provide a quality appraisal service which will support the RO's decision making. Additionally, the policy review identifies required improvements to the NHSEI Appraisal and Revalidation Policy and lists all the documentation that has been produced by the Service to meet the required standards.

Scope of Engagement/Methodology

This comprised of:

- A review of five (5) appraisal portfolios selected by the Service from the appraisal year 2021-22 which were reviewed remotely, and relevant criteria mapped against the FQA standards. The Service sought the permission of the doctors whose portfolios were reviewed prior to sharing.
- Interviews were conducted via video communications or telephone with the Regional Director, Deputy Service Lead, the Programme Manager, five (5) Commissioners and eleven (11) Appraisees.
- A review of the NHSEI Appraisal and Revalidation policy adopted by the Service and associated documentation in the review were mapped against the Core-Revalidation Standards, NHS England 2014.
- Anonymised surveys and feedback from Senior Appraisers, Appraisers and Administrative staff was collected and analysed.

The review followed strict guidelines with regard to data protection.

2. Review of Findings

Appraisal for Revalidation: part of the review was to check compliance of the appraisal process (appraisal input and output) against agreed and scored standards using the Miad input tool and the NHSEI Excellence QA output tool. This part of the review covered a small sample of five (5) doctors' portfolios selected by the Service which, was at the time, 0.2% of the total appraisee group. The reviewer had remote access to the selected portfolios. Full quality assurance of portfolios is completed by the Service.
The highest attainable score for the Appraisee inputs is 34. The score variation for this review ranged between thirty-four (34) and twenty-two (22).

- Two Appraisees scored thirty-four (34) and thirty-two (32) respectively
- Three (3) Appraisees scored twenty-four (24), twenty-three (23) and twenty-two (22) respectively

This variation is not unexpected in the context of the pandemic and suggests that Appraisees in Wessex are as variable and stressed as doctors elsewhere. Appraisees showed a consistent and thorough approach to the appraisal and summary recommendations or suggestions for further improvement in line with current guidance are contained in section 4.

The RO's depend upon the output summary statements from the Appraiser to provide sufficient and detailed evidence on which to confidently base the decision to recommend a doctor to the GMC for revalidation.

The highest attainable Appraiser output score using the Excellence tool is twenty (20). The five (5) Appraisers selected for the review all attained the top score of twenty (20). The outputs were of an exceptionally good standard. Further detail is contained within section 4.

Infrastructure

Policies: The Service provided information on the policies used to manage and monitor the appraisal process. The NHS England and NHS Improvement (NHSEI) Medical Appraisal Policy is used because the vast majority of the appraisals carried out are commissioned by NHSEI and the remainder of their commissioners agree that this is also used for their appraisals. NHSEI will be updating the policy, which is dated 2015 for review in 2016 and which presents a weakness in the system. There is good evidence, however, that the Service updates Appraisers via regular newsletters and support group meetings on key changes to appraisal guidance. The Miad Healthcare consultant in policy review has made a series of recommendations where policy updates need to occur, and the Service should review these to satisfy itself and the Commissioners that it is up to date in practice whilst awaiting the national policy update. These are contained within the Summary of Recommendations (section 4). The Service do not need to manage concerns in the sense of revalidation concerns as they are not involved in the revalidation of doctors. There is, however, local guidance based on NHSEI Policy Annexe F.

Additional guidance used by the Service include the HEE Information Governance policy, Complaint Management - how appraisees can raise concerns and the HEE Equality Impact Assessment.

Appraisal Connectivity: all the doctors who undertake their annual appraisal with the Service use the FourteenFish Appraisal Toolkit. This toolkit has been widely praised as straightforward and easy to use in the feedback from Appraisees and Appraisers. It is used in conjunction with FourteenFish Appraisal and Revalidation Management System (FFARMS), which is a sophisticated and secure on-line appraisal database and management system.

Communications: there is a strong meeting and communication infrastructure in place, designed to support core staff, appraisers, appraisees and commissioners and to monitor the quality of the service provision. There is a weekly business meeting for all core office-based staff, and regular quarterly Whole Team Meetings, as well as team development activity. The Programme Manager and Regional Director attend the monthly Revalidation Advisory Group (RAG) for NHSEI SW Dorset which reviews all aspects of the appraisal process. There are geographically based appraiser support groups under the leadership of a Senior Appraiser (formerly called a Locality Lead) and regular newsletters with updates and key information. The Service also hold a well-attended annual conference.

The Service is not required to make an Annual Board Report. They provide an Annual Report to their commissioners that covers the details of the appraisals provided and the quality assurance undertaken. The Regional Director meets with commissioners to discuss the report before they take it to their Board.

The Service Core Team Review

Regional Director

The Service Regional Director is a GP and senior medical educator, working for the Service for seven sessions a week. She is the GMC Suitable Person for the RCGP Examiners and manages the Service. She has long term experience of medical appraisal, having established appraisal for Cheshire primary care services and then led the national work on the quality assurance of medical appraisal and the revalidation readiness training of medical appraisers as an Associate Director with the Revalidation Support Team (2008-2013). She has remained at the heart of the integration of medical appraisal into doctors' revalidation since the developmental stages prior to 2012 with roles at the Royal College of General Practitioners (RCGP) and the AoMRC. She holds a master's degree researching the benefits of appraisal. In order to maintain her connection to grassroots appraisal in NHSEI, she is a Senior Appraiser for NHSEI SW (Chippenham).

As the strategic lead for the Service, the Regional Director is also responsible for winning business, attending RO and appraisal lead networks and quality assurance. In conjunction with Winchester University, she has developed academic and research programmes in appraisal, including the master's degree programme. The Regional Director maintains communication links with the senior appraisers, the commissioners of the Service, the LMC and a wide range of regional and national bodies. In relation to the Service, she is supported by a Deputy Service Lead, a Programme Manager, and a small team of administrative staff. There is a weekly core team meeting with a disciplined approach to the business of the Service, for which minutes are taken.

The Regional Director keeps up to date by attending appraisal and educator conferences. She has her own case load of appraisals outside of the Service, and on behalf of the Service, and she is the current chair of the AoMRC Professional Development Committee. She continually reviews and reflects on her own practice in her full scope of work appraisal, which is conducted by an appraiser from

outside the Service to avoid any conflict of interest. Her appraiser work is QA'd as all other appraisers are, including being re-evaluated every five (5) years.

As the Service is independent and the appraisers are paid for facilitating appraisals, like all primary care appraisers in NHSEI, the Regional Director is very conscious of the potential for a conflict of interest. She has put a strong system in place to ensure transparency in the recruitment and appointment of appraisers. This includes an experienced lay person who, for the past six years, has been Chair of the appointments panel, and is involved in screening and shortlisting the appraiser candidates. He also provides an external lay viewpoint in the quality assurance review of portfolios that are felt to be borderline in quality.

There are sufficient resources for the Service to be well maintained and the Regional Director ensures that the Commissioners of the Service are provided with transparent evidence of the quality of the service provision. When feedback was provided in an earlier External QA review that the Service would be vulnerable if the Regional Director left, this resulted in the appointment of the Deputy Service Lead.

The Regional Director has set up systems and processes to safeguard the quality of the Service. The Service has a trained and highly skilled clinical calibration team drawn from among the appraisers to review the portfolios of all appraisees and the appraisal outputs and complete the appraisal checklist in the NHSEI Revalidation Management System (RMS). This activity prevents the 'appraisers marking their own homework' and is an example of best practice commissioned to support the monthly NHSEI Revalidation Advisory Group (RAG), for the main commissioners, who, outside the Service, review the portfolios of all the appraisees going forward for revalidation and make recommendations to their RO. There is an agreed process for each level of appraisee compliance including decisions about a doctor in difficulty. The information on decisions about individual doctors are attached to the doctor's file and are available to the individual and key participants.

During the pandemic the Regional Director ensured that there was flexibility in the appraisal process to accommodate individual doctor's needs, including removing the need to provide information as to why there was slippage and a postponement of the appraisal month (which was formerly required from appraisees). There have been efforts within the Service to follow the NHSEI

guidance about continued flexibility while ensuring that appraisees returned to their required month as the pandemic guidance allowed.

The Regional Director has initiated an escalation policy to support appraisers with managing difficult appraisals. If the local review results in the need to escalate an issue to the appraisee's RO, the Regional Director will ultimately carry this through if the appraiser has sought support, but many will escalate it themselves. Identification of learning from such issues are distilled and anonymised to share amongst the appraisers through the support groups, annual conference, and the newsletters. The QA of the appraisal output, monthly review of appraisee feedback, and liaison with the Senior Appraiser also identifies any change in the quality of the work of individual appraisers which can then be subject of root cause analysis to identify the issues.

The Service mandates that appraisers demonstrate their continued skills and competence every five (5) years. This robust approach has enabled individual appraisers that are potentially struggling to be identified early and appropriately supported.

If the concern relates to an issue of clinical safety, the appraiser will discuss with the Senior Appraiser / Regional Director or her Deputy, who will then revert to the RO. In all scenarios, the appraisee is involved in the discussion.
The Regional Director considers the appraiser to be the doctors' critical friend, holding a reflective mirror up to the doctor's performance and their development needs. The appraisal meeting should be conducted in such a way that gives the doctor protected time to think and evaluate with support from the appraiser.

The Regional Director's passion for the ongoing development and value of medical appraisal is without doubt. Her links with the Regional and National agendas will support the changes required by the Service to meet its current challenge and ongoing development. (Notes can be found at Appendix A(i))

Deputy Service Lead

The Deputy Service Lead is a GP, working for the Service for two (2) sessions a week. She deputises for the Regional Director as required, provides support to joint projects around developing the Service, including the development of the annual conference and delivery of appraiser training. She is the Senior Appraiser for the overseas appraiser group and maintains relations with the overseas clients and commissioners of the Service. She has additional roles outside the Service teaching medical students and training dental appraisers.

She also benefits from the Regional Director's extensive involvement at the national and regional levels, sharing the information that flows from those fora. She and the Regional Director speak at least every other day, so the channels of communication are very strong.

Her appraiser work is QA'd as all other appraisers are, including being re-evaluated every five (5) years.

The Deputy Service Lead is well acquainted with the Service policies and procedures, including the avoidance of conflict or appearance of bias when recruiting new appraisers. She recognises that the overseas appraisal work in particular, is very sought after.

The Service is appropriately resourced and whilst not directly involved in the budget process the Deputy Service Lead actively pursues opportunities to support appraisers or education and research projects.

The Regional Director and Deputy Service Lead ensure the Service is responsive and reliable by working with the Senior Appraisers, who can in turn cascade out information or feed information back from their appraiser support groups. They have established support mechanisms for Senior Appraisers through a WhatsApp group which is particularly useful for rapid queries and responses. She attends the regular weekly meetings, covering all aspects of QA, including the risk register, significant events and feedback, the annual conference and education and research elements. This process also helps pick up anomalies which can be quickly addressed and communicated to the wider appraiser groups as needed.

The Deputy Service Lead explained the ways in which the Service shows its commitment to delivering the principle of appraisal. There is constant liaison with the Programme Manager and the Administrative team to ensure the smooth running of the process and

communication via the FourteenFish system. Through the comprehensive annual report which portrays the scale and demographics of the Service and through the QA processes. The Service developed a response for appraisers to the 2020 guidance issued on the re-balanced approach to appraisal and how any gaps in supporting information (for example the inclusion of mandatory training updates) should be handled. The management of the information flow is key to the effective communication, and this is managed via the meeting and network structure to keep all staff and appraisers involved and informed.

The Deputy Service Lead is keen to ensure that the Service provides the same high level of appraisal standards to its' remaining commissioners following the de-commissioning of the NHSEI Wessex appraisals and also seeks other opportunities to continue with the excellent research that has been ongoing. (Notes can be found at Appendix A(ii))

Programme Manager

The Programme Manager has been with the Wessex Appraisal Service for over eleven years, she works full time (band 6), and has a wide experience of NHS and public sector administration work, gained prior to taking her current post. She holds line management and appraisal responsibility for 4.5 wte, administrative staff, all of whom have job descriptions which were in the process of being reviewed and updated, including her own, when the pandemic started.

The Programme Manager is clear on the responsibilities of her role, including the management and development of the administration team, supporting, and managing difficult situations, support management of the large contracts, management of smaller contracts and assisting with policy development.

Knowledge and skills are maintained by having weekly on-line meetings with the Regional Director, and the NHSEI Appraisal and Revalidation teams, where current issues with Appraisers/Appraisees are discussed and updates provided, attending the RO network meetings, and reading the latest guidance. She did not undergo training for Appraisal and Revalidation as such, as, having joined the process at the beginning she had "on the job" learning, although she ensures that all staff, including herself, sit in on New Appraiser Training. The Service has a range of policies in place which are developed using national guidance from the GMC, NHSEI, HEE and with input from the Service team and Appraisers.

The Programme Manager trains the administrative team to support appraisees and appraisers in the use of the FourteenFish appraisal system, with which she is very familiar.

The Programme Manager described the recruitment process for appraisers and a comprehensive and supportive process from initial notification that an appraisal is required through to Appraiser payment. This includes careful matching of the appraiser to appraisee, reminders that an appraisal is due, setting up the appraisal, and supporting the administrative process to achieve completion within 28 days.

The Programme Manager believes the appraiser team are cohesive and well supported, they have access to their senior Appraiser, the Service and NHSEI for any required guidance. The Service has developed a website which was expanded during the pandemic to give guidance to Appraisers and Appraisees in relation to emotional support or practical advice needed for Covid-19 related concerns. The implementation of the rebalanced appraisal process has not highlighted any needs that cannot be supported.

The Programme Manger considers that the Service has come a long way and provides a good experience for both Appraisers and Appraisees. They work hard to maintain good personal relationships with their contractors, NHSEI and HEE. She considers that going forward the Service could develop and market its training provision. (Notes can be found at Appendix A(iii))

Administration Team

At the time of the review, the Service had a team of 4.5 administrators, all of whom had job descriptions, which were in the process of being revised and updated when the pandemic started. The Programme Manager has line management responsibility for the team. Due to the transition, the team has reduced to 3 remaining administrators who are covering the additional work with overtime. As part of the process, the administrators were asked to participate in a survey, the results of which are summarised below.

Administrator's feedback summary

This survey was completed by four (4) administrators for the Service, who were asked to answer 10 specific questions and one (1) open commentary. All four (4) administrators are involved in all aspects of appraisal coordination. There are clear boundaries between their responsibilities and other members of the Team. Three (3) administrators have a responsibility for handling secure data for which they have received training. All four (4) have undergone Equal Opportunities and Diversity training and three (3) have received GDPR training. Three (3) administrators responded that they were familiar with the Medical Appraisal and Complaints policies and one (1) administrator is involved in a network for support and learning. Three (3) administrators confirmed that they had experienced challenges on their role, one (1) had not. Those that had experienced challenge documented that there was uncertainty about the future having received no information after the loss of their job. New software/technologies had been a concern, but they confirmed that they had received support from their manager and team learning a new job from home.

Challenges or Improvement opportunities identified by Administrators – the following commentary was included in the survey:
"WAS is the gold standard and nationally the best at what it does, so needs little development. The Service is successful and fit for purpose and its good reputation is well-deserved."

Administrative staff should be made to feel valued not just the Appraisers

New Appraiser Training should include emphasis that reading any information from WAS is an expectation of their role.

The Service Commissioners

Five (5) Commissioners of the Service contributed their views and recommendations to the review. A Higher-Level RO for NHSEI, and co-signatory for the contract, a Medical Director and RO for NHSEI, an Appraisal Lead for (Guernsey), an Executive Medical Director and RO an organisation and a Medical Director and RO for another organisation.

All of the Commissioners interviewed confirmed that they had high levels of confidence in and satisfaction with the service provision, which they commissioned for a range of doctors between two thousand through to single figures. All had either contract or service level agreements, points of contact within the Service appropriate to their needs and were aware of the policies and escalation

process. There were very good satisfaction levels generally with the appraisers recruited and trained by the Service and the matching of appraisers to appraisees. One (1) Commissioner commented on the care the Service took to match his appraisees to appraisers with experience in his speciality. Communication was of a good standard, but two (2) Commissioners had not received the Annual Report this year which they usually did, using the activity and output content as part of their annual return. The intention of the Service is to provide a final report at the end of the 21-22 appraisal year to cover all activity to the point of transition.

The Commissioners from NHSEI, were keen to acknowledge that the Service is well-established and respected. Whilst NHSEI has de-commissioned the Wessex Appraisal Service provision this is not a reflection on the Service but the recognition that to ensure a good governance process for both medical appraisal and revalidation that is performance based for a large number of doctors in a changing environment, the process needs to be managed in-house, rather than one-step removed.
They commented on the good escalation process from the Appraisers to the first tier RO's and periodically the higher RO is involved in conversations about the suspension of a doctor especially if it is likely to attract media attention. This has worked well.
The Commissioners raised some thoughts for consideration by the Service going forward, which are as follows:

- The outcome metrics are based around the data process, rather than appraisal quality. Inclusion of a quality metric would be useful.
- The process can never be completely watertight, and recognition is given to the robust systems that the Service has put in place to negate issues. Focussing on the essence of appraisal aims to ensure that the Appraiser output narrative always fully reflects the appraisal discussion without breaching confidentiality.

The Commissioners interviewed that remain part of the Service look forward to continuing the positive working relationships and valued support that have been established. (Notes can be found in Appendix B (i-v))

The Service Appraisers

Appraiser Support and Development: at the time of the review, two hundred and four (204) appraisers worked with the Service, which included seven (7) senior appraisers. There are guidelines in place relating to the recruitment, training, and monitoring of appraisers with constant observation for potential conflict of interest or bias.

Appraisers are initially recruited to the Service via an application form. An external Lay Advisor then shortlists applicants for interview. The Lay Advisor has been with the Service for many years and is very experienced. If an arbitrator is needed the Regional Director is involved.

Applicants are invited for a 45-minute interview with the Lay Advisor and Regional Director, Deputy, or a Senior Appraiser. Each score against an interview sheet and suitable candidates are invited to attend the training. The training which is currently carried out remotely is a summative two-day course consisting of five elements:

- pre-work reading
- half day theory and practice
- observed trio work – groups of three – training observer, appraisee and appraiser roles
- further half day theory and practice
- verbal and written feedback on group work and training, particularly the observation of appraiser skills in the trio work

There is also an induction meeting with their senior appraiser and administrator, to explain the systems and process used within the Service.

The Service provides all appraisers with a Performance Development Review (PDR) annually. This provides information on their individual training and updates and reflections on any appraisal related CPD, their appraisee and administrator and Senior Appraiser feedback and their annual QA of appraisal outputs benchmarked against the Service as a whole and against their peer group in their local appraiser support group.

The Senior Appraiser group support the appraisers individually as required and there are support groups in which the Service expects them to participate.

The senior appraisers and appraisers were asked to contribute to the review content by completing surveys via SurveyMonkey. The following section covers the output of the surveys.

Survey feedback

Senior Appraisers Survey feedback summary

The survey was completed by all seven (7) Senior Appraisers attached to the Service who were asked to answer thirteen (13) specific questions and one (1) open commentary. The questions posed can be found in Appendix C(i)

All of the senior appraisers had job descriptions and had undergone training for the role. All seven (7) had received both Performance Management of Appraisers and Equality and Diversity/ Unconscious Bias training, six (6) Understanding the Role of Senior Appraiser, four (4) Coaching and Mentoring and three (3) Recruitment of Appraisers. Four of the senior appraisers were involved in the recruitment of appraisers.

They maintain their knowledge via attendance at local meetings (7), regional meetings and communication networks (6), attendance at events and through areas of their own practice.

The senior appraisers support the roles of the Regional Director and the Deputy Service Lead through a range of inputs. This includes team meetings where they contribute their experience to the discussions on service development and individual support as required, provide both support and challenge and contribution to policy change. They also act as a conduit for information flow on updates for appraisal and contribute to the development and quality assurance of the appraisers. All of the senior appraisers have contact with their group of appraisers more than twice a year. They all considered that the appraisers were provided with adequate guidance and updates.

The senior appraiser group quality assures the performance of the appraisers using a range of methods. They all apply the SUPPORTS QA Tool to the outputs and have informal conversations with appraisers. All of them are currently reviewing the effectiveness of the rebalanced appraisal.

They all felt supported by the Regional Director and Deputy Service Lead and consider that they have an effective working relationship with the Programme Manager and her Team. A view which was supported by the Programme Manager at interview.

They all agree that the guidance for the escalation of difficult or unusual appraisals is clear.

Challenges or Improvement opportunities identified by Senior Appraisers

The following comments were made in the open text dialogue box of the survey:

Suggest further coaching skills for appraisers.

Quotes included:

I feel sad that it will no longer be that Dorset appraisals will be provided by the Wessex appraisal service - it feels like we are trying to fix something that is not broken

An excellent team with links to NHSEI and RCGP through our senior management team

Keep it in Wessex - the move to NHSEI will be unsettling for all

Appraisers Survey feedback summary (full graphic report under separate cover)

This survey was launched in September 2021 and closed in December 2021. 63% (121) of the appraisers connected to the Service responded to the survey, answering thirty (30) questions relating to their experience of working as an appraiser with the Service and included freestyle commentary.

General information - the Appraiser community connected to the Service is very experienced and stable with 33% (40) of appraisers having been in place since before the introduction of Revalidation in 2012. 26% (32) have been connected between 5-9 years, 21% (26) for 5 years and more recently 19% (23) one (1) year or less. This shows an excellent balance of experienced and newer appraisers having input into the medical appraisal process.

97% (117) of the appraisers surveyed considered the recruitment and selection process used by the Service to be thorough and robust, with only 3% (4) disagreeing.

89% (107) of appraisers agreed to being issued with a job description and person specification. It is recommended that the Service check to ensure that every appraiser working with them has an up-to-date job description and person specification especially on the light of recent changes.

95% (115) appraisers had undergone new appraiser training prior to commencing work as an appraiser with the Service. 85% (100) of appraisers agreed to having participated in annual refresher training. Current Appraiser Skills Assessment (CASA) training has been

completed by 73% (87) of the appraiser group, but some respondents will not yet have been invited if they have not been with the Service for three years. 95% of appraisers included the appraiser role in the scope of practice of their own appraisal.
The Service should review the current appraiser cohort to ensure that refresher training is up to date and encourage them to include the appraisal role in their scope of practice.

Support Groups - one hundred and twenty (120) appraisers responded when asked if they attend regular appraiser support groups. 96% (115) confirmed that they did. 96% (111) found the groups to be very or quite beneficial, whilst only 4% (5) declared them not to be of benefit and five (5) skipped the answer. This is a strong positive response for the content of the support group agenda.

Policy and Internal Structure – the appraisers were asked how familiar they were with the national and local policies and guidance relating to Appraisal and Revalidation. The top two (2) document sources with which they were familiar were the GMC (94%) and the Wessex Appraisal Service (93%).
Appraisers were asked if the Service checked annually whether they had received GDPR training or offered the opportunity to take the training. Out of the one hundred and twenty one (121) responders, eighteen (18) skipped answering the question. 73% (75) confirmed this had happened and 27% (28) responded negatively. The Service populates PDRs for each appraiser but acknowledges that it does not capture training and updates completed outside of the Service, unless informed by the appraiser. A review of the process to capture data for this key area and ensure that the appraiser PDR is up to date would help further reduce the IG risk to the Service.
The survey then asked for responses on appraiser's knowledge of key post holders within the Service. These referred to the job title and not an individual. The response rate to these questions was low. Out of the one hundred and twenty one (121) appraisers involved the following numbers responded.

Who is the Regional Director for the Service? Only fourteen (14) responded and they did not know.
Who is the Programme Manager for the Service? Seventeen (17) responded and they did not know
Who is your Senior Appraiser (Locality Lead)? Eight (8) answered and they did not know.
Who is your Appraisal Administrator? Six (6) answered and they did not know.

Alternatively, the question of how often the appraisers were contacted by their Senior Appraiser was answered by one hundred and five (105) appraisers as follows:

- More than quarterly – 29% (30)
- Quarterly – 52% (55)
- Greater than once a year but less than quarterly – 16% (17)
- Once a year – 3% (8)

Clearly a high level of regular contact is being maintained as 81% (85) of the appraisers agreed they have contact with their Senior Appraisers on a quarterly basis or more. In addition, the Service website has very clear information, including photographs, of each of the roles described above.

Appraiser engagement – 56% (59) of the appraisers completed between 8-12 appraisals annually, with 41% (43) completing between 12-20 appraisals annually. 3% (3) carry out in excess of 20 per annum. Sixteen (16) skipped this response but it is clear from the data available that no appraiser does less than eight (8) appraisals a year which is more than the minimum recommended to keep appraisers skilled and up to date.

68% (73) of appraisers surveyed only facilitate appraisals for NHSEI, whilst 32% (34) facilitate the process for other Commissioners.

One hundred and six (106) appraisers responded to the question of how effective they considered the process for allocation of appraisers to appraisees and the scheduling of the appraisal. 76% deemed it to be very good and 24% considered it good,

Most appraisal discussions are scheduled to last between 2.5-3 hours (80%) with 37% of appraisers stating that they have facilitated an appraisal discussion which has lasted in excess of three (3) hours.

In relation to appraisee feedback on completion of the appraisal, 65 % (67) appraisers had received feedback more than once a year, the remainder received it annually. The Service might want to check if this output tallies with their data. Considering the high numbers of appraisals that are carried out per appraiser it might be expected that more frequent feedback can be provided anonymously.

Guidance and information – 83% (84) of appraisers agreed that they had been provided with guidance to assist with the identification of risk and escalation thresholds identified during appraisal. 17% (17) gave a negative response and twenty (20) did not respond. The Service should check through the communication network that appraisers are aware of the guidance and receive a copy as required.

The Service provides access to the website and a contact resource pack which can assist with sign posting appraisees to additional well-being support highlighted during appraisal. 74% (75) of appraisers agreed that they had this resource, whilst 26% (26) did not. Twenty (20) did not respond. This is an invaluable resource and needs to be available to all appraisers.

Finally, the survey asked appraisers what type of on-going support was available to them. Six (6) elements were identified, of which Peer Support (95%), Appraiser Refresher Training (93%) and Annual Review (72%) were considered to be the top three (3) options. This indicates that there is a strong and cohesive communication and training infrastructure within the Service available to the appraiser cohort.

Commentary – there are many free style comments added to the survey which can be found within the accompanying graphic presentation pack. The Service may wish to consider some of the individual recommendations raised. There follows a small selection of the comments:

I have loved all the appraising I have done on behalf of the Service, and I hope it survives all the current changes to continue to innovate and seed quality improvements in appraisal across the UK

Appraisal is a generic skill (sic) and I appraise across sectors - Wessex Appraisal Service does not give me any specialty specific support. I do have access to the various Medical…

I have always valued the support I have received from the Lead and the admin staff.

Feel that the Quality assurance has become hoop jumping and doesn't recognise that we are professionals conducting the appraisal and perhaps we should be trusted.

I have had excellent support from the Wessex Appraisal service, which has challenged me, but completely appropriately.

Appraisee Engagement - certain designated bodies commission medical appraisal on behalf of the doctors with a prescribed connection to them. Eleven (11) of those doctors, kindly agreed to be interviewed for the purpose of this review. The majority worked in primary care (8), with two (2) from secondary care overseas and one (1) working in research. There was a range of experience, knowledge and support requirements within the group and a variance in the time they had been attached to the Service.

All the appraisees considered that their appraisal experience was excellent or very good in every area, being appraisee centred. The administration of appraisal is excellent and well managed. Those that had transferred from another DB found the transfer to be seamless and appreciated the induction and guidance they received from their contact point. The allocation of the appraiser was well matched to their needs and there is an automatic re-allocation after three (3) years. They are provided with the appraiser contact details to arrange their appraisal meetings. They were all aware that, if needed, they could request a change of appraiser and there were a couple of examples of this request being actioned quickly and with sensitivity.
The appraises all received clear direction of what was expected of them in terms of sending through their portfolios and what the process would be. They considered that they had sufficient time for the appraisal meeting and were not rushed. They deemed their appraisers to be skilled and supportive and there were good examples of how, during the last year in particular, appraisers had helped in sign posting doctors to well- being support or coaching them in considering new ways of working. All appraises felt comfortable providing feedback on completion of the appraisal.

The appraisees generally considered that whilst face to face appraisal meetings is mostly preferable the need to hold meetings remotely had not diminished their experience in anyway, had saved time and reduced the need to travel. It is suggested that a mix of both would be useful with a face-to-face contact initially with a new appraiser to establish a rapport and the consecutive meetings to be managed remotely.

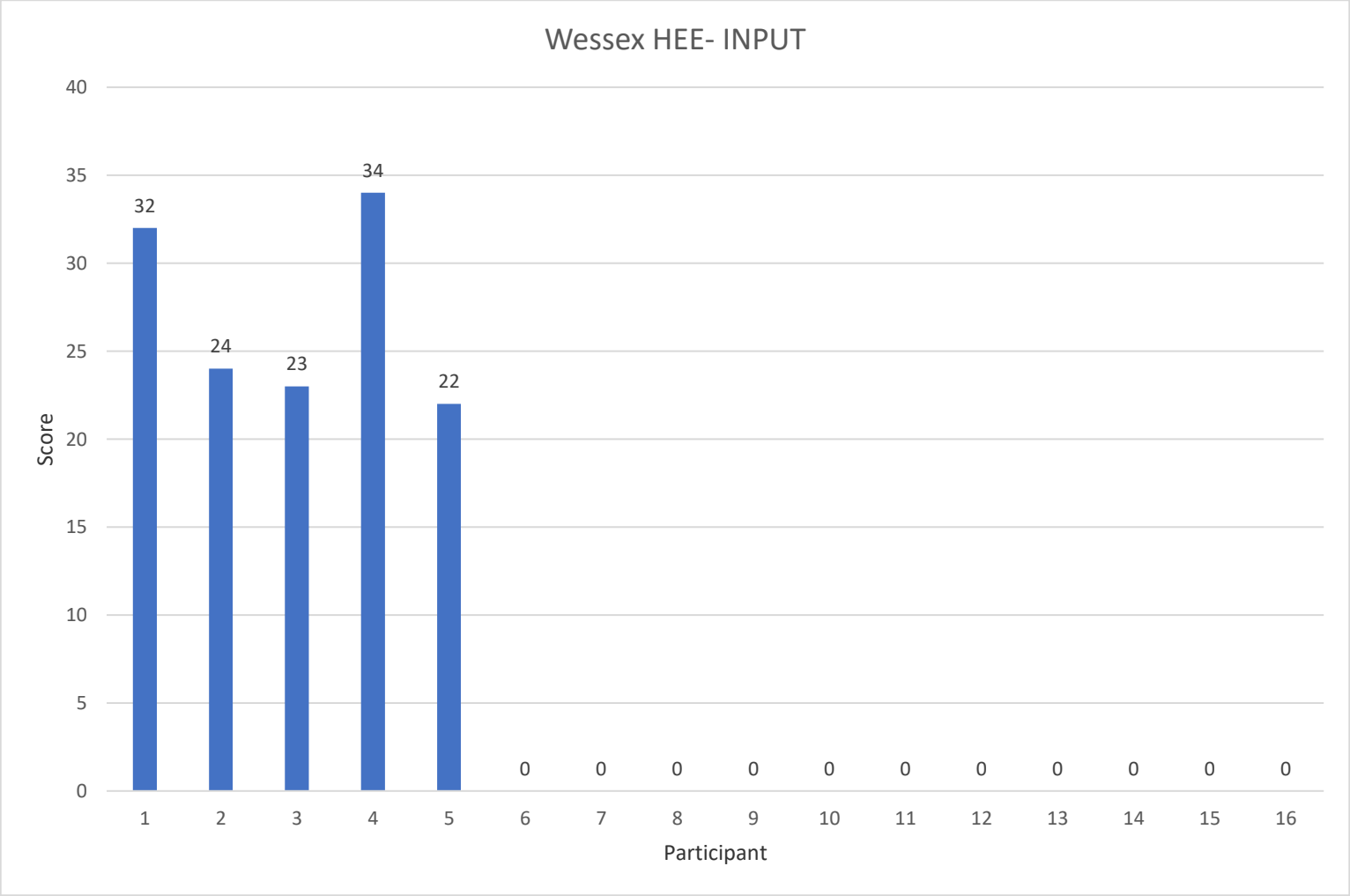
Most of the GP appraisees preferred to be appraised by a GP as they understood the challenges and constraints of working in primary care.
The consensus round the re-balanced appraisal approach was that it was more straightforward, and less time consuming without loss of benefit around reflection or the appraisal discussion. It allows greater focus on the things that really matter.

The Service provided the anonymised October 2021 feedback report from appraisees which were largely positive with good commentary and helped identify an appraiser issue which had been developing over a period. (Notes can be found in Appendix C (i- xi))

3. Portfolio Review Findings

Each of the five (5) doctors' portfolios were reviewed to assess the quality of the input by the appraisee and the quality of the output documented by the appraiser. To ensure a consistent approach, the Miad input tool was used to assess the appraisee input score and the NHSEI Excellence QA output tool to assess the appraiser documentation. The following section contains the details of each section scored.

FINDINGS - INPUTS



The highest potential score attainable is thirty four (34), each element is scored 0-2:

0 - no supporting information provided

1 - further supporting information/ detail required

2 - good

The highest attainable score for the Appraisee inputs depicted in the above graph is 34. The score variation for this review ranged between thirty-four (34) and twenty-two (22), with one (1) Appraisee scoring thirty-four (34). The graph clearly depicts the range for the other four (4) Appraisees. The five (5) portfolios reviewed showed that the Appraisees exhibited a consistent and thorough approach to the appraisal process, particularly in the core criteria of Scope of Practice, CPD and QIA.

Where the review has identified areas that could be improved upon, these have been detailed below.
The individual element inputs of the review are graphically described in the accompanying document (Wessex Appraisal Service input graphs)

Scope of Practice Annex 1 (question 1)
The Scope of Practice element was covered to a high standard, with 100% of Appraisees being awarded a score of two (2). These findings are seen to be supported by the Appraisers in the documented output.

Supporting Information Annex 1 (question 2)
Supporting information was reviewed, first by checking all six of the GMC recommended pieces of information were present or referred to:
1: Continuing professional development
2: Quality improvement activity
3: Significant events and serious incidents
4: Feedback from patients or those to whom the doctor provides medical services
5: Colleague feedback
6: Compliments and complaints

It is accepted that not every piece of supporting information is provided every year in full, but good practice dictates that all six types of supporting information should be discussed and addressed annually through the PDP if absent. Detailing the scope provides a reference point for this section and ensures that the supporting information covers all aspects of the Appraisees work, for example, teaching, managerial, committee and regulatory responsibilities in the UK, EU and Globally.

All of the Appraisees portfolios reviewed, provided sufficient supporting information covering all aspects of their scope of practice. This was supported by the Appraisers in the output section.

Continuing Professional Development (CPD) Annex 1 (question 3)

The GMC requires all Doctors to keep their knowledge and skills up to date and tailored to the specific needs and interests of their whole scope of work. The CPD listed and described in the Appraisee portfolios, has achieved a score of 100% and is compliant with the GMC requirements with alignment to the domains of Good Medical Practice. This represents a clear individual intention to maintain their knowledge and skills.

Reflection of Continuing Professional Development (CPD) Annex 1 (question 4)

As part of the appraisal meeting the CPD should be discussed, reflected upon and shortfalls addressed annually through the PDP. The Appraiser can facilitate further refection, as needed, but it the Appraisees responsibility to demonstrate examples of reflective practice. The reflective notes do not need to capture full details of an experience but should focus on the learning identified and any planned actions arising from the reflective activity.

Four (4) of the portfolios reviewed demonstrated a high standard of reflective practice by the Appraisees which was supported by the individual Appraiser. One (1) Appraisee achieved a partial compliance score of one (1) but there is clear evidence of reflective discussion and support during the appraisal meeting and documented reason for the one-off slippage due to pressure of time following extended leave.

Quality Improvement Activity (QIA) Annex 1 (question 5)

The standard of evidence in the Quality Improvement Activity (QIA) element was consistent, compliant with the GMC requirements and aligned to the domains of Good Medical Practice. Again 100% of Appraisees provided evidence of engagement in Quality Improvement Activity supported by the Appraisers documented output.

Reflection of Quality Improvement Activity. Annex 1 (question 6)

100% of Appraisees provided evidence of reflectivity on their QIA, again this should be seen as a high standard.

Significant Events Annex 1 (questions 7 & 8)

This element asks the Appraisee to review whether they have been involved in any significant events in the appraisal period, by undertaking that review a score of two (2) is awarded. The Appraisee is then asked to reflect on the significant event and provide evidence of learning that has occurred.

100% of Appraisees completed the section asking whether they had been involved in a significant event/incident. Four (4) of the Appraisee portfolios reviewed had described an incident in which they had been involved and had reflected upon the incident and the outcome providing information on the learning and changes that had occurred. One (1) Appraisee had not been invoked in any serious events/incidents and therefore did not provide reflective activity.

The 2020 GMC Guidance on supporting information for appraisal and revalidation recommends that doctors who have not been involved in a significant event/incident should either reflect on their local significant event or serious incident process or what has been happening to mitigate the risk of an event or incident occurring. Consideration should be given to Appraisees adopting a pro-active approach, as described in the Patient Safety Strategy (July 2019), by discussing what a significant event in their area of practice might look like and whether there are sufficient barriers in place to prevent an occurrence. Alternatively, anonymised sharing of other significant events that have occurred relevant to their clinical scope of practice could be used and reflection on that learning regarding individual practice could occur.

Patient Feedback Annex 1 (questions 9 & 10)

Patient and colleague feedback are the fourth and fifth types of supporting information doctors use to demonstrate that they are continuing to meet the principles and values set out in Good Medical Practice. 40% (2) of the Appraisees included patient feedback in this section and both had reflected on the feedback.

Colleague Feedback Annex 1 (question 11 &12)

The standard of the use of colleague feedback seen within the five (5) portfolios reviewed was slightly higher than that of the patient feedback. 60% (3) of the Appraisees had included colleague feedback and reflection.

The GMC considers it to be good practice to include some informal patient and colleague feedback in the appraisal years that do not include MSF, whilst this is clearly the practice for some all Appraisees should be encouraged to include some informal feedback from these key areas.

Complaints Annex 1 (questions 13 & 14)

As with significant events, the Appraisee is asked to review any complaints in which they have been involved. This action is awarded (1) a score of two (2). 100% of Appraisees completed this section fully, with one (1) having been involved in a complaint upon which reflection and learning had occurred. The remainder had not been involved in a complaint and therefore not documented reflective activity. As with significant events/incidents the opportunity of reflective activity could occur using the outcomes of other complaints received by the speciality via the clinical governance framework.

Compliments Appendix 1 (questions 15 & 16)

Compliments are the sixth type of supporting information doctors will use to demonstrate that they are continuing to meet the principles and values set out in Good Medical Practice. 80% (4) of Appraisees documented that they had received compliments, mostly from patients and had reflected on those. The one (1) Appraisee who did not document compliment review had been on extended leave and this is covered by the Appraiser.

Compliments should be viewed as affirmation that the Appraisee is 'getting it right' and it is a positive outcome that these have been included.

Doctor's Achievement of GMC Attributes Annex 1 (17)

The Appraisee is required to consider their achievement of the GMC attributes in the pre-appraisal section of the input form. Referencing their supporting information and how it demonstrates they are meeting the requirements of GMP is a fundamental element of the appraisal and appraisal discussion. 100 % of Appraisees completed this element with good evidence and this is a high standard.

Quality of the Appraiser Outputs

Summary of Appraisal

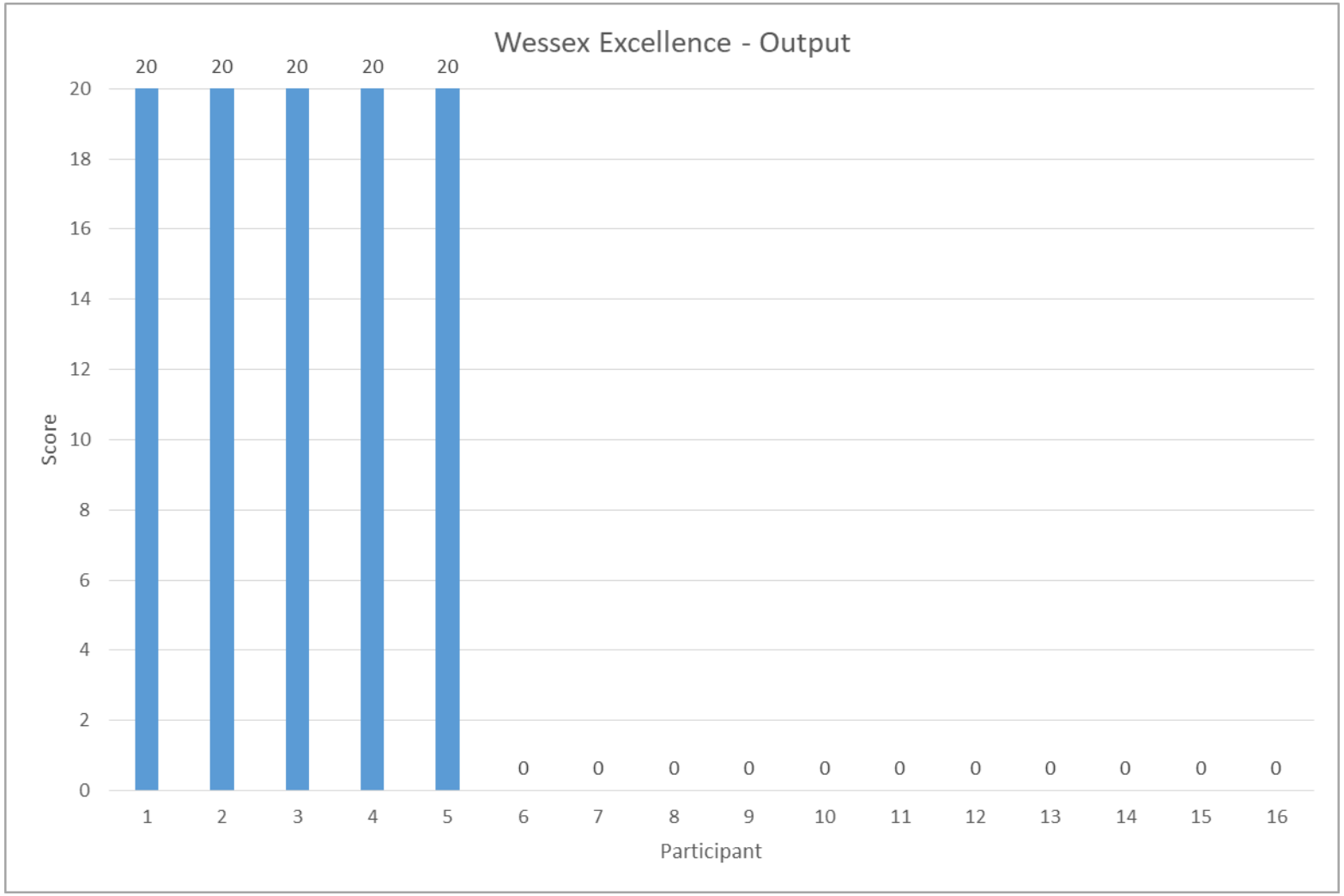
The appraisal summary is a key document used by the Responsible Officer to inform their revalidation recommendation to the GMC. Through correlation with the supporting information submitted in the pre appraisal form, it should demonstrate that the Appraisee has satisfied the four domains of Good Medical Practice[4];

Domain 1 - Knowledge, skills, performance
Domain 2 - Safety and quality
Domain 3 - Communication, partnership, and teamwork
Domain 4 - Maintaining trust

This section describes the findings of the Appraiser outputs from the five (5) portfolios reviewed; namely the overall appraisal, review of the domain summary output report and the Personal Development Plan (PDP). The Excellence QA Tool was used, comprising of ten (10) key questions. The scoring criteria used to evaluate the content: 0 = No content (absent from summary; 1=partially met (room for improvement); 2= Yes content complete (well done). The questions are organised in three (3) specific categories of competence for the purpose of measurement.

- **Overall** appraisal review including stage in revalidation cycle, scope of work, reflective activity, and probity
- **Reviewing** supporting information, PDP achievement, accomplishments, and aspirations
- **Planning ahead** using gap analysis and PDP development

The appraisals provided a benchmark of practice, which is reflected in the following narrative and attached charts (Annex 2, sections 1-4).


Wessex Excellence - Output
20
20
20
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0
0
0
20
18
16
14
12
10
8
6
4
2
0
Score
1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
Participant

Output Narrative

The Appraiser outputs of the five (5) portfolios selected by the Service were reviewed fully. Each output had been completed by a different Appraiser and were all the same high standard. Each Appraiser was awarded a score of two (2) in each of the ten (10) elements defined in the Excellence QA Tool, resulting in a maximum achievable score of twenty (20) points for each Appraiser.

The approach taken to rebalanced appraisal is clear, focussed and well documented. There are well described examples of the sympathetic handling, support and guidance provided to Appraisees facing challenging and difficult situations, both professionally and personally. All Appraisers remained focussed in their documentation and managed to achieve a good balance of being succinct whilst providing sufficient detail to ensure all areas are covered and that the Responsible Officers have solid evidence on which to base their revalidation decisions. The PDP achievements, stage of the revalidation cycle and any outstanding requirements were commented on and seen in forthcoming PDP's as necessary.

The high standard of the appraisal discussion is clearly reflected in the interviews carried out with other randomly selected Appraisees whose portfolios were not reviewed. Each of them expresses a high satisfaction with their appraisal discussions and greatly value the skilled and knowledgeable support and guidance they have received in recent times and prior to the pandemic. It is also apparent that for a few Appraisees their positive appraisal discussion has meant that they have remained in their roles and been able to focus on a revised way forward rather than leaving the profession.

It is evident that the Appraiser training provided by the Service, encourages, and achieves a consistent approach without stifling the individual skills and knowledge of the Appraisers.

The individual element outputs of the Appraisers are graphically described in the accompanying document (Wessex Appraisal Service Output Graphs)

4. Summary of Recommendations

1. Appraisees	**Supporting Information** • Consideration should be given to Appraisees adopting a pro-active approach, as described in the Patient Safety Strategy (July 2019), by discussing what a significant event in their area of practice might look like and whether there are sufficient barriers in place to prevent an occurrence. Alternatively, anonymised sharing of other significant events that have occurred relevant to their clinical scope of practice could be used and reflection on that learning with regard to individual practice could occur. • The GMC considers it to be good practice to include some informal patient and colleague feedback in the appraisal years that do not include MSF. • As with significant events/incidents, the opportunity of reviewing the outcomes of other complaints and reflecting on whether any change of practice needs to occur may be of benefit.
2. Appraiser	• The provision of coaching skills for appraisers would be beneficial •
3. Organisation	• The Service populates PDR's for each appraiser but acknowledges that it does not capture training and updates completed outside of the Service. A review of the process to capture data for this key area and ensure that the appraiser PDR is up to date would help further reduce the IG risk to the Service. **Appraiser Infrastructure** It is recommended that: • a review of the current appraiser cohort occurs to ensure that all refresher training is up to date. • appraisers should be reminded to include the appraisal role in their scope of practice

	• every appraiser working with the Service must have an up-to-date job description and person specification, especially on the light of recent changes. • guidance to assist with the identification of risk and escalation thresholds identified during appraisal be provided to all appraisers • all appraisers have access to the contact resource pack for sign posting appraisees who require additional support identified during appraisal
	Policy Infrastructure Medical Appraisal Policy recommended review points • Improving the Inputs to Medical Appraisal, NHS England, April 2016: Improving-the-inputs-to-medical-appraisal.pdf (england.nhs.uk) • Appraisal Networks Blueprint, NHS England, June 2016: apprsl-netwrk-blueprint-1.pdf (england.nhs.uk) • Medical Appraisal Guide (MAG) model appraisal form, NHS England, 2016: NHS England » Medical appraisal guide (MAG) model appraisal form • Medical Appraisal Guide Model Appraisal Form: User Guide, NHS England, April 2017: mag-form-user-guide-april-2017.pdf (england.nhs.uk) • Prescribed Connections to NHS England, NHS England, April 2016: prescribed-connections.pdf (england.nhs.uk) • Guidance on Supporting Information for appraisal & revalidation, GMC, November 2020: Guidance on supporting information for appraisal and revalidation (gmc-uk.org) • Information flows to support medical governance and responsible officer statutory function, NHS England, August 2016: cg-information-flows-oct16.pdf (england.nhs.uk) There are also Covid-19 updates and the Medical Appraisal Guide produced by the Academy of Medical Royal Colleges (AoMRC) which may need to be referred to: Appraisal & Revalidation during COVID-19 - Academy of Medical Royal Colleges (aomrc.org.uk)

Appendix A (i)

Notes of the interview meeting held on Monday, 4th October 2021 with Regional Director of the Wessex Appraisal Service conducted by Julie Thomson and scribed by Viv Purkiss, both from Miad Healthcare.

LEADERSHIP AND MANAGEMENT

Q1. Can you confirm:

1. The number of doctors: directly commissioned service – no doctors attached to us but about 2,600 doctors for whom Wessex facilitate appraisals
2. The number of appraisers: 204
3. The name of your commissioners: HEE Wessex, Gibraltar, Jersey, Guernsey

Q2. What are your main responsibilities as Regional Director?

The Regional Director is a GP and former GP Tutor and manages the Wessex appraisal service. Involved since the new GMC appraisal regulation was introduced, she began with the Edgecumbe training. Employed as primary care trust educational and appraisal lead. Set up appraisal in Cheshire. Involved in Primary care educators. AD at revalidation support team when developing how appraisal would fit into revalidation and has been the lead for HEE directly hosted appraisal (originally Wessex Deanery). Commissioners purchased appraisal through Wessex deanery – became the only directly commissioned service in England – Deanery lead services. For a long time, NHS England and Wessex had same boundary - what became NHS England Wessex were already commissioning from Wessex Deanery which became HEE Wessex. Gathered up Wessex and Gibraltar both primary and secondary, all primary care in Jersey, have trained some island-based appraisers. Always a mixed model in Guernsey – provide some externality with inhouse appraisals. Some small, designated bodies e.g., Wessex Fertility buy in an appraisal service – they have own RO. Do some appraisals for doctors who revalidate directly with GMC. Also run a charitable endeavour for the GMC doing a free of charge appraisal for someone who e.g., may have been ill or struggle to find fee.

Currently conduct approximately 2,600 appraisals, but this is changing because HEE SW and SE have given notice and are taking back their appraisals, so the volume of appraisals will reduce by 90%. The service has therefore been dramatically changed in the last month. The Regional Director believes this is a final decision and has been reassured by the commissioners that taking appraisals back in house does not in any way relate to questions about the quality of the Wessex Service.

Q3. How would you demonstrate your 'fitness to practise' as the Regional Director or Deputy Service Lead? What evidence do you have (CPD and reflection) that would demonstrate that you are fit for this role?

The Regional Director provides strategic leadership, responsible for winning business, going to appraisal lead networks, responsible for leading on research side, have developed with Uni of Winchester series of postgraduate qualifications in appraisal, 3 candidates have completed a master's degree although there is also certificate and diploma. Also undertake academic qualification research and also fund research bursaries to fund areas of interest e.g., "do overworked doctors need appraisal the most?" "Why do doctors leave the profession? Re-commissioned research in Wessex as implication was that appraisal and revalidation is so burdensome it drives doctors out of profession though this was not replicated – it's the other pressures on primary care. The Professor had been given about 5 negatives in the whole of Wessex about revalidation, balanced by 5 comments that appraisal had helped them to stay. New business, commissioner liaison, strategy, overview of training programme (others are commissioned to develop new training materials). Usually have a panel and do formal evaluations for skills updates and training. Latest evaluation in Thames Valley (not within Wessex) – responsible for QA with a calibration panel who do checklists trained to evaluate training and appraisals. Senior appraisers do QA for ordinary appraisers. The Deputy Service Lead does QA for Channel Islands as she is senior appraiser. Also, line manage the Programme Manager and support rest of admin team – responsible for generating content – take lead on newsletters. Appraisals suspended in first 4 months of Covid – support package and newsletters developed during pandemic.

The Regional Director explained that rather than being both RO and CEO of the organisation, as it is not a designated body and there is no RO function, it was more a focus on the quality assurance of the appraisal service and perhaps half of an RO job. The Deputy Service Lead deputises as CEO, Revalidation Advisory Group (RAG) meetings. Others contribute – The Programme Manager pulls together the appraisal side and the Commissioners deal with responding to concerns. The Regional Director provides clinical input for concerns. So altogether work as a team which includes working with an RO on the clinical performance side and 2 senior managers with in-depth knowledge of the issue. The Wessex appraisal service is clearly operating a partnership model.

In terms of CPD – the Regional Director tries to attend appraisal conferences – Scottish medical educator and appraiser conference – Wessex appraiser service annual conferences – senior appraiser for Chippenham doing appraisals as part of maintaining creditability for her role (approx. 32 appraisals a year) – might do 1 or 2 independent appraisals if approached directly. Aiming to be an appraiser for the Faculty of Medical Leaders and Managers. Associate Lecturer at University of Winchester on qualifications in appraisal. The Regional Director continually reviews her practice, incorporating her reflection into the continued improvement and relevance of her

work and full scope of responsibilities. She is passionate about CQI and committed to thinking creatively about bringing fresh eyes and tools to develop practice within her own team and within own practice as an appraiser.

The Regional Director is the current Chair of Academy of Royal Colleges' professional development committee and leading the team looking at successor to the Appraisal 2020 tool (the BMA comments have just come in).

The Regional Director instigates external QA of the Wessex Appraisal service every 3 years. A Deanery-led QA has been conducted by East Midlands Deanery a couple of times, plus a review by QuartEd 4 years ago. Lots of internal QA about appraisal output, feedback about service, in addition to the current QA being conducted by MIAD.

The Regional Director completed a master's degree about the benefits of appraisal – what makes peak appraisal experiences? How can it be implemented in practice? Top result was confidentiality and being facilitated outside own workplace. Appraisal needs to be open and frank – the Regional Director's research demonstrated that people were grateful for opportunity to speak to external people and would like opportunity to have a fourth appraisal with the same people in some circumstances (like finishing story with same person), Ok if appraiser and doctor happy to do it. Also, things about how to improve the service. Most about appraisers have coaching, mentoring, motivational interviewing skills and not a tick box exercise. The Regional Director has ethos of enthusiasm and passion for appraisal which she brings to others. RCGP survey (2019) demonstrating Wessex, Scotland and Wales came out highest for appraisal was very useful. Consistently a formative ethos leading to improvement and best patient care. Attitudes to appraisal changing but there are some who are still negative towards appraisal.

Q4. Has a situation occurred where there has been a potential conflict of interest or appearance of bias that has been identified? If so, do you have a strategy in place that would resolve any conflict or appearance of bias?

If the Regional Director was appraised within service, that would be a potential conflict of interest, so the Regional Director's appraisal done by South West (reciprocal arrangement). Has to be done by someone external with no line management relationship or historical connection as a colleague. There is potential conflict every time the service engages people to do extra appraisals because appraisals are funded. For example, if the service is commissioned to do an appraisal in Gibraltar there needs to be a system to manage that. To achieve this, the service has included a lay person in the recruitment and selection of Appraisers. A member from Royal College of Psychiatrists for approx. 6 years has been chair of appointments panels and involved in shortlisting for the outside

independent appraisals to cover taking on a new contract and the need to select appraisers, will do screening for candidates. It is clearly recognised that the Regional Director is required to fulfil other contracts but cannot give herself work. There is a robust system and process in place to manage decision making around the selection of appraisers for contracts other than NHS contracts. The Regional Director is vigilant in terms of not exceeding the number of appraisals allowed in NHS contracts, though can fill in under exceptional circumstances e.g., in the case of accident. The service aims to allocate the recommended average number of appraisees to each appraiser.

Q5. In your opinion, are there sufficient funds, capacity and other resources provided by your organisation to enable you to carry out the responsibilities of the role?

Obvious example of feedback was that the service was really vulnerable if the Regional Director left – needed a deputy which was actioned by appointing the current Deputy Service Lead as the Regional Director's deputy. Commissioners tend not to be critical – don't need to ask for anything else as they fully understand and have agreed the quality of the service provided. It is important is the QA is exemplary and really transparent, so they are assured how appraisal summaries are being Quality assured by senior appraisers to ensure appraisers complete correctly.

Q6. How can you demonstrate that your service is responsive and reliable and that the systems and processes run smoothly?

Monthly Revalidation Advisory Group (RAG) – review and recommendation for revalidation. Signing off appraisees who have met all requirements (Greens), where there are no issues, are straightforward. Ambers – e.g., no patient or colleague feedback – are discussed – there will be a reason for delay but it's not contentious. The Red ones e.g., someone not engaging, odd behaviour, needs discussion. Not normally just commissioning RO and the Regional Director – a decision about a doctor in difficulty is taken at that Revalidation Advisory Group so it's a corporate decision. Minutes of the RAG are the equivalent of the Board. Provide a record over time – gives a record of discussion and resolution. Phone calls need back-up e-mails confirming what's happening. The e-mails are attached to the doctor's file. Should be information available to all including the doctor. Not an infallible system but linked to doctor rather than appraiser. A doctor's issue would not be attached to an appraiser's file.

Q7. Can you provide any examples of where you listened and actioned improvements to the service based on your commissioners' requirements?

In terms of documentation – pre-Covid was robustly enforced e.g., asking for a different appraisal date, required completion of the appropriate form to understand why, might be in sick leave, parental leave etc. Not a problem but clearly need to know why the

appraisal date has slipped if it's not in the correct appraisal month. Use revalidation management system (RMS). If don't bring forward appropriate amount of supporting information, would push back for robust documentation.

In Covid if it slips a month can arrange between appraiser and appraisee. Will return to original month, just starting to tighten up scheduling of appraisals again at the request of the commissioner. In SE were flexible but needed to ensure appraisal takes place. Less Covid in the SW area so were continuing with appraisal programme, but flexibility included.

Q8. To what extent is there clear and visible commitment from the organisation (the Board) towards the principles of Appraisal? How is this demonstrated?

The service is hosted in HEE appropriate internal tools and processes have been developed to review the summaries. Took some work about assessment of professional competence based on what is actually done – can learn for a test and forget it all, or assessment drives learning. For Wessex Service, assessment checks that mastery is in place. Randomly review outputs of appraisals and share scores with appraisers. Anything over 16/20 is satisfactory and the average is 18/20.

Q9. Tell me how you ensure that accurate records are kept of all relevant information, actions and decisions related to your role.

There is a structure in place to have a weekly 1-hour core team meeting. Don't include 7 senior appraisers and 4 GP fellows, but there is a clear agenda with a disciplined approach to minutes being taken and distributed. Follow up action points with lead appraisers, in particular where there is a deadline or updates required on some items. In addition, communicate important new updates, e.g., withdrawal of appraisal by SE to team meeting.

Q10. To what extent can you demonstrate application and integration of your policies?

Patient safety first – demoralised, burnt-out GPs are not safe. If get compassion fatigue and lose energy and will, can become slightly dangerous. Biggest difference appraisal makes is to support doctors in regaining power to make changes in their sphere of influence that makes patient care and practice better.

Q11. How do you manage information flow between appraisees, the appraisees organisations, appraisers, your organisation, other stakeholders?

Organised as a core office of 4.5 f/time band 4 administrators, and 1 band 6 programme Manager. A Deputy 2 sessions (1 day) a week and the Regional Director does 7 sessions (3.5 days a week). Other 7 employed members of the team employed 1 session a week to look after geographic patches. 2 years ago, aligned to NHS England nomenclature of senior appraiser. In terms of communication, used a template design from first pandemic related appraisal suspension to create newsletters for appraisers and

doctors to let them know it had been suspended and subsequently to provide weekly support in the first lockdown. NHS England sent out appraisal-related e-mail using database from the RO. The e-mail was wordy not visual. Fewer doctors read wordy stuff – newsletters catch imagination and get message out quicker. Local LMC back up message – website front page has news in middle. The second suspension in January 2021 was only for SE however, important to ensure that SW doctors didn't get confused.

APPRAISAL

Q12. How do you support the Senior Appraisers and ultimately the Appraisees?

Support for appraisal – relationship with senior appraiser should be supportive and the senior appraiser should recognise it is out of character. Starting point to assume that people intend to do well. Hear the story. It's been taken off the performance development review as it is such an outlier. Obviously if someone doesn't want any or all appraisals randomly QA'd that is a different issue. The service has a significant event pro-forma which is used to document learning events which are subsequently also included in the annual report. To avoid the possibility of identification to an individual – cases are screened and in certain circumstances, would not be included on the service website. Annual Reports are public documents, but any significant or learning event distilled to about 2 sentences. Traceability is in confidential office documents and actions and conclusions are noted. Example: A good appraiser suddenly scored a 7 – did a root cause analysis and the summary reflects a difficult appraisal with difficult technology (having to re-write 3 times). Borderline summaries are quality assured by lay person, but this one came to the Regional Director for QA, so she wanted to better understand the detail. The outcome of this significant event was shared at weekly and quarterly meetings in order to emphasise that if appraisers experience difficult appraisals, the protocol is to inform senior management and if there are problems with the technology, it isn't appropriate to select those instances for QA. Escalation process is clearly detailed in the complaints policy, which would bring in lay person and the Regional Director, and if it's about the Regional Director, then an external investigator would be appointed.

Q13. In your experience, how does appraisal form a fundamental component of a broader safety and quality improvement strategy?

Appraisal can affirm doctors who are getting wobbly about their own performance. Appraisal holds up a mirror about the sort of job that is done – often a very good job, pull back from compassion fatigue, etc. An appraiser is a doctor's critical friend with additional knowledge on appraisal and revalidation, coaching, mentoring. There to listen to what the doctor says. A performance concern should be dealt with when it happens e.g., whistle blowing, or bullying must be dealt with as a duty of care at the point it happens.

Reflection should come to appraisal. Doctors can be too defensive to do any learning at the time it happens. Hopefully in appraisal far enough away from the event for reflection.

Q14. What do you need to know as Regional Director that would help you feel assured about the quality of the Wessex Appraisal?
Appreciative enquiry about learning needs, use coaching skills to find solutions to problems. Cumulative benefit of quality improvement in patient care. The Regional Director's research interest is on how compulsory appraisal intervention improves patient care? Hard to say which bit makes a difference, but the Regional Director believes the opportunity to have protected time to think is something that doctors do not get much opportunity for. If appraiser is trained to set up time for rapport, safety, and confidentiality to allow appraisees to stop and think, then working things out for different, better and change falls within that.

Q15. Describe the reporting system in your organisation for keeping up to date with what's happening at 'ground level' with appraisal and revalidation?
Despite the imminent changes to the Wessex Appraisal service, the Regional Director is clearly passionate about the ongoing development and quality assurance of appraisal. The added value items which the Regional Director believes need to keep happening to keep her service up to date at ground level include:

- Ask doctors and appraisers for feedback about the admin team, Director, and the Service
- Ensure the service provides support for appraisers
- Continue to budget for support research to improve the assurance and quality of appraisal. This makes a big difference to address health inequalities through appraisal support for doctors

This service mandates that appraisers demonstrate skills and competence every 5 years. This robust approach has enabled 2 or 3 appraisers to be identified (one with a developing illness), and appropriately supported. A valuable tool to support individuals and flag up potential problems.

Q16. How do you keep informed/up to date about Appraisal and Revalidation at a national level? How often are you accessing local and regional support?
Attend RO/Appraisal lead support groups etc, but regionally attend pretty much every meeting because important to have organisational presence. The Regional Director's involvement and leadership of many national initiatives ensure that she not only accesses local and regional support, but also provides it for RO colleagues and forums

Q17. How do you measure the performance of appraisers?

- Apply quality assurance tool i.e., SUPPORTS QA and previously PROGRESS
- Informal conversations
- Formal reviews
- Feedback from appraisees

Q18. How are you reviewing the effectiveness of rebalanced appraisals?

The Wessex service doctors mainly use the 14 Fish portfolio tool for appraisal, which reflects the NHSEI Appraisal 2020 guidance. Up to 80% doctors use it, Bristol Hospitals use it, and it has now been adopted for GP trainee portfolios - likely to roll into post-training. The Regional Director has met with toolkit providers so that appraisal tools can incorporate Appraisal 2020 although it is difficult for some toolkit providers to change things. Those that originated as job planning or HR systems, have found it harder to change than those who started as appraisal and performance management systems.

Q19. Is the Appraisal 2020 guidance clear regarding escalation of difficult or unusual appraisals?

Yes – we have 15 different commissioners; each RO manages these instances in collaboration with the Regional Director. In practice the systems are not very different – more difference between NHS England South West and South East – SW historically more consistent while SE have experienced more change in terms of Leadership and appraisal processes. KSS also slightly different as Senior appraisers in KSS have additional responsibilities. Used to meet to try and align better pre-Covid, and this has been more difficult for SE and London – especially with Kent variant – everyone has needed to focus on the front line.

MANAGING CONCERNS

Q20. Explain the process by which appraisers ensure that key items of information (such as complaint, significant events and outlying clinical outcomes) are included in the doctors' appraisal portfolios and discussed at their appraisal meetings?

There are typically two types of concern within appraisal – have an internal complaints process, clearly written down, case investigator appointed. In last 2 cases, senior appraiser recommended that parties not to meet again as the relationship had broken down – no bad intent on either side. Escalation in complaints policy which would bring in lay person and the Regional Director, and if it's about the Regional Director, someone external.

Q21. How do the appraisers manage a fitness to practise issue if it is brought to their attention to discuss at an appraisal? Can you give me an example of this and comment on the process?

Second type of concern is if an issue arises for the first-time during appraisal, not a health concern where issue requires help at the time, but something revealed that is a patient safety issue. The initial response is non-judgemental within appraisal and to find out more. Training for appraisers is not to shut the appraisal down, as the appraisee needs to feel trusted and can carry on. Leave enough silence for the person to carry on talking. It will be viewed as a cry for help if revealed for the first time in appraisal. Find out as much as possible. Once done, if there is a potential risk for patients, feed this back to appraisee and say will seek advice. If handled well, can get the person to accompany for advice. Would say if it criminal, it's the police (unlikely). If a significant performance concern, go to RO and the Regional Director. If unclear go to the Regional Director or can go to senior appraiser. Appraiser training is do not rely on e-mail or message – if worried make a telephone call and confirm by e-mail. Be honest on appraisal documentation.

A few times need to reconsider on decisions about agreeing form of words and whether responses are satisfactory – need to go back to doctor and ask for further discussion. All needs to be agreed. Need to keep the appraisee on board and ensure that all parties are engaged.

Q22. Do you have any other thoughts/suggestions for the further development of appraisal within the Wessex Appraisal Service?

Reviewing effectiveness of appraisal by additional research, responses to BMA surveys, questions that changed in post-appraisal feedback. Using many different feedback provides specific ways of understanding what the doctors think. Local research considers doctors, appraisers and ROs. Also, primary/secondary care/tertiary care ROs. Appraisal 2020 is not always implemented by organisations – the national appraisal model will not revert to previous methodology and is endorsed by Medical Director of NHS England, so it's important that it is accepted at a national level. The Regional Director is also mindful of the potential for unintended consequences of change to ICS.

Appendix A(ii)

Notes of the interview meeting held on Friday 8th October 2021 via the phone with the Deputy Service Lead for the Wessex Appraisal Service conducted by Julie Thomson for Miad Healthcare.

LEADERSHIP AND MANAGEMENT

Q1. Can you confirm:

1. The number of doctors: directly commissioned service – no doctors attached but about 2,600 doctors for whom Wessex facilitate appraisals
2. The number of appraisers: 204
3. The name of your commissioners: HEE Wessex, Gibraltar, Jersey, Guernsey

Q2. What are your main responsibilities as Deputy Service Lead?

Deputy Service Lead is spending 2 Sessions/week with 1 session as the Regional Directors deputy. In this regard, if the Regional Director isn't there or unavailable to respond, the Deputy Service Lead takes the leadership role and provides support to the Regional Director in joint projects. Additional current responsibilities – developing/delivering the Wessex appraisal service annual conference and training for appraisers (development of materials and delivery of that training).

The Deputy Service Lead is also a Senior appraiser (NHS not England), for smaller organisations but not including Gibraltar/Jersey/Guernsey. She is the Lead/Senior appraiser for overseas appraisers. Belongs to and contributes to relevant support groups and delivers support groups for Guernsey/Jersey and island owned appraisers' annual meetings. Maintains relationships with clients. Develops annual reports

Q3. How would you demonstrate your 'fitness to practise' as the Regional Director or Deputy Service Lead? What evidence do you have (CPD and reflection) that would demonstrate that you are fit for this role?

RO Deputy training and benefitting from the extensive involvement of national involvement that the regional Director has regarding appraisal. The Deputy Service Lead and Regional Director ongoing dialogue (they speak every other day plus as required) which results in significant learning and leadership input as a Result from the Regional Director's exposure to the many forums she leads or is involved with.

Topics discussed include:

- any news
- reflections – The Deputy Service Lead continues to appraise herself in and out of the putting together the annual conference which helps her focus.
- Belong to support group self and having a lead appraisal
- Other things as arise e.g., email appraisal from Jersey who had heard of the transfer of Wessex NHS changes and need to understand how it will affect them
- The Regional Director's work as an appraiser is evaluated every 5 years

Q4. Has a situation occurred where there has been a potential conflict of interest or appearance of bias that has been identified? If so, do you have a strategy in place that would resolve any conflict or appearance of bias?

Yes – Recruitment. The Deputy Service Lead is always alert that there is always a potential for a conflict of interest or appearance of bias when recruiting new appraisers. These are very sought-after roles out of the UK, particularly Gibraltar/Guernsey and Jersey – lots of applicants.

In order to be fair and transparent, use clear criteria so that the process is a lot more consistent. Small world – overlaps with education etc. so the Deputy Service Lead is always cautious to avoid any potential for conflict of interest. Committed to having good processes in place to avoid this.

Q5. In your opinion, are there sufficient funds, capacity and other resources provided by your organisation to enable you to carry out the responsibilities of the role?

There is a budget, managed by the Regional Director and Programme Manager and to date, not aware that there has been a shortage of funding to appropriately support the role. COVID impacted on NHS costs for appraisal but all delivery during this period was online – feedback regarding quality and perceived quality of training was not diminished.

The Deputy Service Lead always looks for sensible ways of spending the budget on support for appraisers and masters/research.

Q6. How can you demonstrate that your service is responsive and reliable and that the systems and processes run smoothly? I go to my professional line management appraiser. We have established a WhatsApp group - daily use for Q+A networking and morale. This keeps us in constant contact. We have regular IT meetings and good weekly meetings with a rolling agenda based on the current program and priorities. This includes:

- Significant events/Risk registers
- Feedback from doctors
- Monitoring program
- Standing agenda– how are we doing snowed under/capacity to help etc.
- Weekly opportunities for support collaboration of appraisers
- Ensuring there is a mutually supportive safety net
- Conference – weekly litem on development of content and logistics
- Seek feedback from all doctors
- Commissioned 4 research fellows – discuss how to get research rates up

Q7. Can you provide any examples of where you listened and actioned improvements to the service based on your commissioners' requirements?

An example of this is an appraisal in Gibraltar which took place in a not appropriately professional venue. The Deputy Service Lead was alerted and spoke to the appraiser to find out what had happened. There was a good explanation – it had been a request from the appraisee based on logistics. A quick decision was required, and the appraiser wanted to appear flexible, so agreed but forgot to let the Deputy Service Lead know they had deviated from the norm. Appropriate training and support was given and guidance reenforced through communication to all Appraisers.

Q8. To what extent is there clear and visible commitment from the organisation (the Board) towards the principles of Appraisal? How is this demonstrated?

Liaison with the Programme Manager and team. Production of a comprehensive annual report regarding scale and demographics of the service. Quality Assurance is of an extremely high standard. Examples include transparency of SI's, learning etc, e.g., of poor feedback, a culture of being open and honest throughout the services dealings with appraisees, appraisers and commissioners.

Q9. Tell me how you ensure that accurate records are kept of all relevant information, actions and decisions related to your role.

The Programme Manager captures and retains minutes of meetings. Rigour around documenting action points and summarising the decisions taken relevant to appraiser service, recommendations, and agenda items. Use software template so that the next agenda is automatically pre-populated with metrics accessible to all.

Q10. To what extent can you demonstrate application and integration of your policies?

2020 Guidance

- Felt so different from what appraisers had previously delivered and meant in some cases that appraisers had gaps in supporting information to manage
- The Deputy Service Lead wanted to make sure there was confidence in delivery of same high-quality appraisal regardless of changes
- In conf 2020 (autumn) announced mandatory training of 2020 to be able to continue to practice

Q11. How do you manage information flow between appraisees, the appraisees organisations, appraisers, your organisation, other stakeholders?

Continuous programme of training and feedback through ongoing communications driven by outcomes of weekly/monthly meetings. Appraiser networking forums useful and the Regional Director and Deputy Service Lead always readily accessible to appraisers. In the first instance, appraisers go to their own appraiser lead. The service reinforces QA of appraisers by skills assessment every 5 years. Established a principle of "If in doubt, ask"

APPRAISAL

Q12. How do you support the Senior Appraisers and ultimately the Appraisees?

As previous

Q13. In your experience, how does appraisal form a fundamental component of a broader safety and quality improvement strategy?

Context of population safety in the sense that happy Doctors are safer Doctors and less likely to burn out and leave. Their appraisal is an opportunity to stop and think, Stop, and think – an opportunity to consider their practice and the relevance/reflection of their experience.

In terms of Global patient safety - believe that appraisal contributes and supports safe practice. Recognition that it is extremely rare for appraisal alone to uncover safety concerns – it is the triangulation with the commissioner and other aspects of governance and performance management

Q14. What do you need to know as Regional Director that would help you feel assured about the quality of the Wessex Appraisal?

As before

Q15. Describe the reporting system in your organisation for keeping up to date with what's happening at 'ground level' with appraisal and revalidation?

Dedicated ownership within the support team for gathering feedback regularly – clear roles and responsibilities to establish with the Doctor – 'how am I really feeling'

Q16. How do you keep informed/up to date about Appraisal and Revalidation at a national level? How often are you accessing local and regional support?

Good use of National websites and cascade of information from local and national RO forums. Huge input from the Regional Director who is involved is leading aspects of review and development of appraisal guidance. The Deputy Service Lead is proud of the way the Wessex service is able to offer such a comprehensive and high-quality appraisal service. Communication includes newsletters which during the pandemic were very frequent for appraisers but are now back to quarterly. Content is often driven by the outcomes of the team meetings (quarterly, admin and senior appraisers), combined with news from the Regional Director and other forums. In

between one -off emails are used to update as required. Ad hoc communications with the Deputy Service Lead and Regional Director are daily and a result of the accessibility of the leadership team.

Q17. How do you measure the performance of appraisers?

Review of current appraiser skills – a formal transparent scoring system for quality of outputs. GP's know what their score is (max number 20). Generally high scores, Gibraltar and Guernsey 20/20. The Deputy Service Lead has reflected on how a number can reflect a human discussion, reassurance as work is marked by a trained assessor, appraisers complete a 5-year evaluation and feedback is regularly provided to appraisers. If an appraiser did not meet the required standard, they will be monitored closely on all appraisals and appropriate training and support provided.

Q18. How are you reviewing the effectiveness of rebalanced appraisals?

Same rigour applied as pre appraisal 2020. Senior Appraisers calibration and scoring of outputs to ensure that robust QA is maintained.

Q19. Is the Appraisal 2020 guidance clear regarding escalation of difficult or unusual appraisals?

Yes. As far as we are concerned, there is no change, if in doubt ask, low threshold for sharing information if there are concerns or a need to calibrate and support appraisers.

MANAGING CONCERNS

Q20. Explain the process by which appraisers ensure that key items of information (such as complaint, significant events and outlying clinical outcomes) are included in the doctors' appraisal portfolios and discussed at their appraisal meetings?

Doctors are given 2 weeks' notice e.g., if revalidation is imminent and there is little or no feedback, is it appropriate to recommend a deferral. Using appraisal 2020 process meant that in some instances, there was lighter content from the doctors:

- Appraisers became more comfortable
- More focus to Appraise in a way that surfaced verbal reflections

Q21. How do the appraisers manage a fitness to practise issue if it is brought to their attention to discuss at an appraisal? Can you give me an example of this and comment on the process?

There hasn't been a specific example of fitness to practice, but if the appraisal was stopped, that would be classified as an SI, which has not happened for years.

The only one a long while back, relates to a scenario the Deputy Service Lead had anticipated would be different as the Dr hadn't submitted a portfolio of supporting information, had not had an appraisal for a few years and was already on the RO's radar – on the cusp of concerns.

The Doctor was aware of the importance to engage with appraisal and had been told would be straw that broke the back. The Deputy Service Lead was conscious that this could be identified as a cry for help and wanted to support him/give him the benefit of doubt. When the Doctor arrived for the appraisal, the Deputy Service Lead explained she had been unable to prepare but went ahead anyway. He still didn't engage (and later went on to have performance issues). Based on stringent evaluation of the facts, The Deputy Service Lead decided to terminate the appraisal and take appropriate advice regarding next steps. When this was communicated to the Doctor, he was surprised and asked if could carry on, stating he was sorry etc, but the Deputy Service Lead had appropriately judged the situation and took the difficult decision to escalate.

Q22. Do you have any other thoughts/suggestions for the further development of appraisal within the Wessex Appraisal Service?

Obviously extremely sad and disappointed that HEE have given notice. We will continue to provide the same high level of Appraisal to our commissioners, but not sure to what extent we will be able to continue with excellent research opportunities and the many other additional aspects of our service, when the scale of appraisal is so drastically reduced.

In closing, the Deputy Service Lead reflected on how useful she had found this discussion.

Appendix A(iii)

Interview with the Programme Manager for the Wessex Appraisal Service. Interview took place on Wednesday 27th October 2021 @ 09:00 hrs.

The Programme Manager has been with the Wessex Appraisal Service for over eleven years, she works full time (band 6), she has a wide experience of NHS and public sector administration work prior to taking her current post. The Programme Manager currently has line management responsibility for 4.5 wte, all staff have job descriptions which were in the process of being reviewed and updated, including her own, when the pandemic started. The Programme Manager is clear in the responsibilities of her role, including the management and development of the team, supporting and managing difficult situations, support management of the large contracts, management of smaller contracts and assisting with policy development. She has annual appraisal with her line-manager the Regional Director, Wessex Appraisal Service, and the Programme Manager appraises her team.

The Programme Manager maintains her knowledge and skills by having weekly on-line meetings with the NHSEI Appraisal and Revalidation team, where current issues with Appraisers/Appraisees are discussed and updates provided, attending the RO network meetings and reading the latest guidance. She did not undergo training for Appraisal and Revalidation as such, having joined the process at the beginning she had "on the job" learning.

The Service has a range of policies in place which are developed using national guidance from the GMC, NHSEI, HEE and with input from the Service team and Appraisers.

The Programme Manager is up to date with her Information Governance and other mandatory training, and she also manages the process that ensures all staff undergo statutory and mandatory training appropriate to their role.

Appraisers are initially recruited to the Service via an application form, an external Lay Advisor then shortlists applicants for interview. The Lay Advisor has been with the Service for many years and is very experienced. If an arbitrator is needed the Regional Director is involved.

Applicants are invited for a 45-minute interview with the Regional Director, Lay Advisor and a senior Appraiser, each score against an interview sheet and suitable candidates are invited to attend the training. The training which is currently carried out remotely is a two-day course consisting of five elements:

- pre-work reading
- half day theory
- trio – groups of three – training observer, appraisee and appraiser roles

- feedback on group work and training
- meeting with senior Appraiser, and Administrator, view slide set to clarify different systems MAG etc and administration processes.

The Wessex Appraisal Service uses FourteenFish Appraisal and Revalidation Management System (FFARMS) which is a bespoke system that was designed in conjunction with the Wessex Appraisal Service. FourteenFish was originally developed with the aim of offering GPs a better way of recording CPD and performing appraisals.

The Wessex Appraisal Service is commissioned by NHS and non-NHS organisations to carry out the Medical Appraisal function for doctors. It is an independent service hosted to date by Health Education England. The service provides a comprehensive and supportive process from initial notification that an appraisal is required through to Appraiser payment, including matching Appraiser to Appraisee, reminders that an appraisal is due, setting up the appraisal, supporting the administrative process to achieve completion within 28 days, which is not entirely compliant currently due to pressure of Appraiser clinical work, and payment of the Appraiser.

The Appraiser team are cohesive and well supported, they have access to their senior Appraiser, the Service and NHSEI for any required guidance. The Service has developed a website to give guidance to Appraisers and Appraisees in relation to emotional support or practical advice needed for Covid-19 related concerns. The implementation of the rebalanced appraisal process has not highlighted any needs that cannot be supported.

The Programme Manager considers that the Service has come a long way and provides a good experience for both Appraisers and Appraisees. They work hard to maintain good personal relationships with their contractors, NHSEI and HEE. This past year has been very challenging for everyone, and the Programme Manager found that when two of the experienced members of her team left for other jobs it knocked the team stability. Although they have been replaced it has been difficult to integrate the new team members as they are mainly working remotely. This situation is improving, but the NHSEI decision to de-commission the Service is disappointing and has unsettled everyone.

The Programme Manager considers that the Service could market the training provision to be a business in its own right as a further development.

Appendix B(i)

Interview with a Responsible Officer for NHSEI on Tuesday 2nd November 2021 14:15 hrs via Teams, conducted by Pam Strange, Miad Healthcare.

The Higher-Level RO for NHSEI is the co-signatory for the contract that currently commissions the Medical Appraisal Service from Wessex HEE. The Service has provided Medical Appraisal for around 2,000 GPs on behalf of Higher Level RO and his first tier Responsible Officers for the past 2 years. As a higher-level RO, he would make direct contact with the Regional Director, Wessex Appraisal Service, but is aware that the first tier RO's have named contacts within the Service. The Higher Level RO is aware that Wessex HEE Appraisal Service Conduct Appraiser training and have the requisite policies covering Medical Appraisal and Managing Complaints against Doctors. These would have been scrutinised as part of the commissioning contract process.

There is a good escalation process from the Appraisers to the first tier RO's and periodically the Higher Level RO will be involved in conversations about the suspension of a doctor especially if it is likely to attract media attention. This works well and the Higher Level RO is kept briefed accordingly. The outcome metrics the Higher Level RO sees are very much around the data process, rather than appraisal quality. He wants to ensure that appraisal is not a tick box exercise, and the metrics don't currently supply that information. He has seen two appraisals from an Appraiser working with the Service where sufficient documentation in the Appraisal output was not provided to sufficiently assure him that a thorough appraisal had occurred. It did not reflect what had probably occurred in the discussion and he was none the wiser as to what the Appraisee had achieved or had found a challenge. The narrative did not provide the picture needed. This can result in some anxiety that the process is being followed fully, especially when the Appraisee is known to the Higher-Level RO and not recognisable. The process is not watertight, but he appreciates that the Service has worked hard to ensure that it is as watertight as possible.

The Higher Level RO has been satisfied with the Service provision, and whilst NHSEI has de-commissioned the Wessex HEE Medical Appraisal Service provision there is no suggestion that they are unhappy with the Service. The view is that outsourcing the process results in everything being 'one step removed' and if standards are to be maintained Medical Directors need to keep direct control of appraisal especially during the implementation of the Integrated Care Systems.

Going forward The Higher Level RO considers that the Service should focus on the essence of appraisal and ensure that the Appraiser output narrative always fully reflects the appraisal discussion without breaching confidentiality.

Appendix B(ii)

Interview with the Medical Director and Responsible Officer NHSEI on Monday 15th November 2021 at 09:00 hrs via Teams, conducted by Pam Strange, Miad Healthcare.

The Medical Director and Responsible Officer NHSEI commenced in post in April 2021 and has not commissioned the Wessex Medical Appraisal Service as a Commissioner. The Service had been commissioned to meet the appraisal needs of circa 500 doctors through a service level agreement (SLA). The Medical Director and Responsible Officer NHSEI contact points are the Regional Director for the Service or the Project Manager for administrative support. She appreciates that it is a well-established and respected service and has general knowledge of the service provision and how it recruits and trains appraisers.

It is the case however, that when the Medical Director and Responsible Officer NHSEI joined NHSEI the decision was made to bring medical appraisal back in-house. This was not a reflection on the Service provision but the recognition that to ensure a good governance process for both medical appraisal and revalidation that is performance based for a large number of doctors in a changing environment, the process needs to be managed in-house. Her focus, therefore, has been to oversee the transfer of medical appraisal back to an in-house basis.

The Medical Director and Responsible Officer NHSEI has not seen formal feedback from appraisees but does hear informally if there are any difficulties and will follow up if needed. Outcome metrics were in place as part of the contract agreement for the whole region. She fully supports the process of rebalanced appraisal and believes it is exactly what is needed.

The Medical Director and Responsible Officer NHSEI had no concerns over the provision of medical appraisal by the Service. There is now an opportunity to strengthen and align the process with the rest of the patch and developing a bespoke approach to meet the needs of all the doctors will be part of the transition.

Appendix B(iii)

Interview with Appraisal Lead on Wednesday 3rd November 2021 via Teams, conducted by Pam Strange, Miad Healthcare.

The Appraisal Lead has been using the Wessex Appraisal Service for many years and currently commissions the Service for around seventy-four doctors. There is a contract in place between the Appraisal Lead's Organisation and the Service which is reviewed annually. Senior staff from the Service visit the organisation to review the contract and discuss any points of need. The Project Manager is the first point of contact for any issues as they arise throughout the year. Many of the appraisals are on-line currently and that has been working well. There is local appraisal in place as well.

The Appraisal Lead is aware of the recruitment process for Appraisers attached to the Service and considers them to be experienced and supportive. He is an Appraiser for the Service for doctors within his Organisation. He is also aware of the policies in place. There is also an RO who follows the local policy. Any issues of concern will be escalated to the RO by the Appraiser, he is not directly involved. He does not see the formal feedback from Appraisees (but is aware that there is a feedback process) as this will go to the Service and the RO but he does see feedback from his own Appraisees. The Organisation is part of a small community and therefore feedback on their experience is often received by him via word of mouth.

With regard to the re-balanced appraisal approach, it is working well, there are not as many problems as there are on the mainland, but the doctors do produce a range of information, often more than needed.

The Appraisal Lead is very satisfied with the service provision they received over the years, it is of a good standard with excellent support and communication. The appraisals themselves are very thorough. The Service has evolved, setting up a bespoke service to meet the local need and variation of island working. The Service also provide 1.5-day education sessions and a CASA and conference session.

In summary the Service provides an excellent appraisal system which meets the needs of the local doctors very well. It is hoped that the changes the Service is undergoing will not affect the service provision provided to the Organisation.

Appendix B(iv)

Interview with the Executive Medical Director and Responsible Officer on Monday 8th November 2021, conducted by Pam Strange, Miad Healthcare.

The Executive Medical Director and Responsible Officer has been commissioning medical appraisal from the Service since 2018. He used to commission the Service for six doctors, but it is currently reduced to two. There is a contract in place and the Project Manager is the main point of contact. Executive Medical Director and Responsible Officer is aware of the recruitment process for Appraisers and considers the ones that he has had contact with to be of a high calibre. The Executive Medical Director and Responsible Officer knows that there is a clear process in place to escalate any issues of concern from the appraiser to him as RO, but this has not been needed so far.

He has received feedback reports on the Appraisees experience of their appraisal in the past but has yet to receive the annual report on this years' activity. He has always used the information provided by this report as part of the mandatory return to NHS London.

The introduction of the re-balanced appraisal process has not been fully embraced by those doctors attached to him as RO, he has not seen a reduction in the information provided but anticipates that this will occur over time.

The Executive Medical Director and Responsible Officer knows that the Service is undergoing change but considers that there is a robust system in place, and he has no concerns at all.

Appendix B(v)

Interview with Medical Director and RO on Monday 15th November 2021 10:00 hrs via telephone, conducted by Pam Strange, Miad Healthcare.

The Medical Director and RO has been commissioning medical appraisal via a service level agreement (SLA) for up to nine doctors from the Service for the past 4 years. His main point of contact is the Project Manager but there was a change to another administrator, about which he was not informed. He is reasonably happy with the service provision, but it does not always run smoothly. As an RO, he has his own policies in place and doctors provide written permission the Service to carry out their appraisal. There are no concerns about the appraisal discussions themselves, but on occasion they can be slower than agreed.

The Medical Director and RO is aware of the Service policies for Medical Appraisal and Managing Complaints Against Doctors but not aware of the specific recruitment and training of the Appraiser's. He understands that it is line with national guidance. There is an escalation process for the Appraiser to raise concerns to the RO, but this has not been needed to date. He does not receive feedback from appraisees, he usually receives an annual report on activity and outputs, part of which he includes in his annual return, but he did not receive one this year.

Turning to rebalanced appraisal, the Medical Director and RO considers this to be a positive change, but it is taking time for the appraisees to adopt the new approach.

Overall, he is satisfied with the provision of medical appraisal by the Service. It has been a challenging time and the virtual appraisals appear to have worked well. He does not have a problem with GP's appraising the psychologists who are attached to the Organisation, the Service have been helpful in allocating Appraisers who have some experience in the area.

Appendix C(i)

Interview with Dr A, on Tuesday 21st December 2021 conducted by Pam Strange, Miad Healthcare.

Dr A is an Anaesthetist in the civilian general hospital in the British overseas territory of Gibraltar. He is in his seventh year of Medical Appraisal with the Wessex Appraisal Service. When he transferred to the Service, he was well supported in adapting to the changes necessary and the transition was seamless. The three Appraisers Dr A has worked with over the years have been excellent, he recalls that the first one he was allocated was the most constructive and supportive, but all have been of a high standard and well matched to his needs.

All his appraisals until recently have been face to face with the Appraiser coming to Gibraltar. The appraisal has always taken place in a quiet office with plenty of time allocated to the appraisal discussion. He has found these meetings to be very rewarding and thought provoking. Once a mutually convenient time has been arranged for the appraisal meeting, the Appraiser has always been clear on when they need to receive the portfolio which always left sufficient time for review. Having experienced both face to face and remote appraisal, Dr A, prefers the face-to-face process which he finds more responsive, but both have been effective. The Appraisers have been GP's, but this is not a problem as there is a sharing of experience. Their discussions have always been well balanced and the advice and support in developing and adapting his PDP to meet the needs of his role and his specialist interest of pain management have been valuable and clarified his thinking. Dr A has always provided feedback on his appraisal experience; he is comfortable providing constructive feedback if needed.

Whilst Dr A does not have in-sight into the policies or procedures of the Service he does have an administrative contact if he needs any help and is aware that he could change his Appraiser if there was a conflict of interest, but this has not been necessary.

Dr A has found the rebalanced appraisal approach to be more focused and the preparation less time consuming and will be pleased to continue with this approach. There are benefits on being able to focus on his current roles and development needs.

Dr A considers that all his appraisals with the Service have been a very positive experience. All of the Appraisers have been well trained and skilled and have come to the appraisal meeting well prepared with an in-depth knowledge of his portfolio which he finds

very re-assuring. This has helped him to maintain and develop higher standards of care in his practice. The whole process runs smoothly.

Appendix C(ii)

Interview with Dr X, via the telephone on Wednesday 24th November 2021, conducted by Pam Strange, Miad Healthcare.

Dr X is a GP, who has kindly agreed to carry out this interview outlining her experience of Medical Appraisal with the Wessex Appraisal Service. Dr X has completed five appraisals with the Service, having previously transferred from the London region where she had used the Clarity system. She found the transfer to be seamless both in the transfer of her data and the introduction to the Service and its systems. She was initially supported by the Project Manager who was very helpful and was again supportive when Dr X required to re-arrange her appraisal due to maternity leave. There was also an administrator allocated to her for each appraisal if she needed support.

Setting up the annual appraisal is straight forward, with a reminder e-mail kick starting the process. Mutually convenient arrangements for the appraisal meeting are agreed between Appraiser and Appraisee, with clear expectation from the Appraiser of the deadline for receipt of her completed portfolio, usually two weeks prior to the meeting. The Appraisers have always been clear on the steps and time frame of completion of the appraisal process following the meeting. Whilst it has not been necessary, Dr X is aware that she could ask to be allocated to another Appraiser if required.

Dr X was allocated to a senior GP for her first three appraisals, she found the process to be very helpful, it was a joint process with a good degree of challenge and discussion, particularly around the development of the PDP. Her current Appraiser, with whom she has had two appraisals, is the best she has experienced. The first appraisal was face to face and the second was completed remotely because of the pandemic. Dr X found it helpful that she had already met the Appraiser, which made the remote meeting easier, and she felt it went well, no difficulties. The Appraiser is supporting a focus on her future career and how that should be developing in the light of her clinical interests. The process allowed for discussion of a range of career options and reflection on her strengths to develop into specific areas.

Dr X's experience of the re-balanced appraisal process is that it is more straightforward and less time consuming, without any loss of benefit to the reflective activity and discussion. It is more focussed and just as valuable. This was especially apparent during her pregnancy and maternity leave with her well- being at the fore front of the discussions.

Providing feedback on her appraisal experience is not a problem for Dr X, especially as it has always been a very positive experience. If that was not the case however, she would not find it difficult to provide constructive feedback.
The Appraisers have always been from the same speciality and Dr X considers this to be of great value, understanding the unique difficulties and challenges of Primary Care. This has been of particular benefit to her when considering the next steps in her career and being able to discuss options that she had not considered. She feels more confident going forward especially in the ability to balance her new family responsibilities with that of further developing her career to be a better GP.
Overall, the whole appraisal experience with the Service has been a very positive one, it is smooth running and supportive. Dr X values her annual appraisal especially being able to discuss and seek support and guidance over her career development, making it a very helpful and supportive experience.

Appendix C(iii)

Interview with Dr P, via the telephone on Thursday 6th January 2022, conducted by Pam Strange, Miad Healthcare.

Dr P is a Clinical Director and Chief of Clinical Pharmacology for his Organisation. Dr P transferred to the Wessex Appraisal Service in 2018 and since then has had four appraisals. His transition to the Service was smooth and well supported. He had support to familiarise him with the FourteenFish system and the appraisal process after which, it was straightforward. Email contact is made when it is time for his appraisal, and he makes the arrangements with his appraiser to hold the meeting. The Appraisers are clear on their timings. For two of the appraisal meetings Dr P travelled foe his appraisals (his choice) and two were conducted remotely. Whilst he prefers face to face, the remote meetings worked well and are less time consuming.
Both of the Appraisers are GP's and due to the nature of his work, Dr P spent time initially clarifying and explaining his role as he is not patient facing but does hold responsibility for patients undergoing trials. He is also involved in research and teaching. Once the range of work had been established the appraisal meetings worked very well, to a high standard and each was a very positive experience.
The pharmaceutical industry is highly regulated; therefore, Dr P needs to ensure that through his PDP the required training to meet the legislation and requirements to carry out his specialist work are included. It therefore almost creates itself. He found it helpful with his first Appraiser to consider his personal well-being which had not been part of the appraisal meetings previously and through this discussion was able to review his work/life balance. The Appraiser was very helpful in facilitating a way forward with him.
The second Appraiser had the opportunity to review Dr P's previous appraisal summaries and was able to quickly understand his work which was valuable to their first meeting where a keen interest was shown about his work. It is Dr P's view that appraisers do not need

to have the same background as their appraisee as long as they have the skills and training to engage in the process in a supportive and questioning way. Both of his appraisers are very skilled, and he was comfortable providing feedback following the appraisal meeting.
Dr P welcomes the rebalanced appraisal approach; it is more focussed and certainly moving in the right direction. Previously it was very time consuming. He felt this was not needed to such an extent as doctors matured in their careers.
Overall Dr P considers his experience with the Service to be very good and he is very satisfied. It runs smoothly and their communication is timely and effective. There is nothing he would want to change.
Dr P considers that the GMC should customise the process much more to make it less onerous and the GMC should provide training included in the fee as his equivalent regulatory body does in Italy where he is still registered.

Appendix C(iv)

Interview with Dr G on Thursday 16th December 2021 conducted by Pam Strange, Miad Healthcare.

Dr G became a GP in 2007 and has had his annual medical appraisal with the Wessex Appraisal Service since its' inception. He has experienced face to face appraisal until recently and although the virtual appraisal worked very well, his preference is for face to face. The Service supplies good administrative support, he is reminded by e-mail when his appraisal is due, and he sets up the meeting with the Appraiser. The Appraisers have all been excellent and a good rapport has been achieved during the appraisal discussions. He has always valued the participation in the development of the PDP, having checks and balances to ensure he is achieving his continuous clinical development

A new Appraiser is allocated after three years, which is about right, although it could extend for another year. The Appraisers have all been GP's, which Dr G views as essential as GP's understand the challenges and difficulties faced in primary care by colleagues. This would not be the same with cross professional Appraisers nor would the shared discussion be as valuable. Dr G is aware that should a conflict of interest arise he can arrange to change his Appraiser, but this has not arisen.

Dr G considers the re-balanced approach to appraisal to be easier and more focussed which he values at this stage in his career.

Dr G has been very satisfied with his appraisal experience with the Service, the recommendations he would make would be with the wider process, perhaps reducing medical appraisal from an annual event to three- or five-year process if all was well with the appraisee. NHSEI could monitor complaints/incidents relating to doctors and increase appraisal as needed. Not dissimilar to the CQC regulatory model.

Appendix C(v)

Interview with Dr T, via email on Tuesday 11th January 2022, conducted by Pam Strange, Miad Healthcare.

Dr T is a GP who has undergone ten appraisals with the Service. When she connected with the process, the transfer was straightforward, and she was well supported. Dr T has access to the Medical Appraisal policy. The process is clear, when her appraisal is due, she makes contact with her Appraiser via email or phone. She has a clear outline of the Appraisers timings for the appraisal process. Her Appraiser's details are supplied to her by the Service at the beginning of each three-year cycle. She receives subsequent reminders when her appraisal is due. The Appraiser is changed every three years. Dr T has always known that if there is a conflict of interest or she is not happy with the allocated Appraiser, another Appraiser can be allocated. She did request this on one occasion for personal reasons and a re-allocation was made without any problem at all. Dr T has a contact point with whom she speaks if there are any problems.

Pre-pandemic appraisals were face to face, the last few have been held remotely and Dr T stated, "I loved it. It meant I did not have to travel and saved time this way. I would not mind having remote appraisals going forwards". The Appraiser for the remote meeting was very approachable and supportive and the appraisal discussion was good. The rebalanced approach was very positive and included signposting to support her wellbeing during the challenging times being experienced. The Appraiser also challenged and guided Dr T into not making hasty decisions but used the PDP process to help her develop ideas on what can be improved upon or changed over the coming year to improve her situation. A very positive experience.

Dr T is comfortable providing feedback following her appraisal and this has never been a problem. Her Appraisers have all been GP's which she is happy with as Dr T considers that anyone outside of the speciality would not understand how a GP works or the challenges they face.

Dr T is very happy with her Appraisers, her appraisals, and the support she receives form the Service.

Appendix C(vi)

Interview with Dr R, via the telephone on Thursday 20th January 2022, conducted by Pam Strange, Miad Healthcare.

Dr R is a GP who has undergone two (2) appraisals with the Service, he started his appraisal for revalidation with them and was well supported in his introduction to the systems and processes in place. As a trainee, he was used to having a portfolio, and therefore adapted to the process easily. He has a single point of contact if any support is needed.

Dr R has had two (2) Appraisers, the first he was allocated he found very helpful and supportive especially in guiding him through the requirements of appraisal and reflection as a GP. Unfortunately, when it came to his second appraisal it rapidly became clear that it was going to be impossible to agree a mutually convenient date due to work and personal commitments and he was therefore allocated another Appraiser who was equally helpful.

Dr R is given the contact details of the Appraisers and he then makes contact with them to agree a meeting date and the timings of forwarding the portfolio. One appraisal was face to face, one carried out remotely. Both were very good; he has no problem with remote working but may prefer to have a face to face if there were issues, he wanted to discuss in depth.

Both Appraisers were experienced GP's, skilled and tactfully challenging. The appraisals were focussed, and it was very useful to be able to have discussion around the development of his PDP. At the conclusion of the appraisal meeting the next steps were agreed and he was aware of what the timeframe would be to complete the process. The latter appraisal was using the rebalanced approach and Dr R appreciated the 'lighter touch' and the inclusion of the well-being challenges was supportive, helping to reflect on his personal as well as work circumstances. He has provided feedback following both appraisals and is comfortable so doing.

In summary, Dr R is generally happy with his experience of the Service and considers the less bureaucratic approach to be positive. It is less of a tick box exercise and focusses on well-being overall and in his career development. He also finds the newsletter helpful.

Appendix C(vii)

Interview with Dr Y, via email on Wednesday 29th December 2021, conducted by Pam Strange, Miad Healthcare.

Dr Y is the Clinical Director for Medicine and a Consultant Nephrologist and Physician. Dr Y kindly agreed to an interview around his experience as an Appraisee undergoing medical appraisal with the Wessex Appraisal Service, but due to work pressures covering colleague sickness in the hospital it was agreed that Dr Y would provide comments based on the questionnaire via email.
Dr Y has no real concerns, he has been assigned two Appraisers whilst with the Service, both of whom he found to be personable, accommodating, and helpful. He was initially reticent that being appraised as a secondary care specialist by a primary care doctor would not work as the working practices are very different although this hasn't been a major issue in his experience.
The appraisal system, 14Fish toolkit works well and the abridged form is excellent.

Appendix C(viii)

Interview with Prof N, on Wednesday 15th December 2021 conducted by Pam Strange, Miad Healthcare.

Prof N is a GP, a Professor of GP Education, GP Trainer and an International Development Advisor to Kosovo and Kuwait. For the purpose of this interview Prof N shared his experience of medical appraisal with the Wessex Appraisal Service, with whom he has had an attachment since the Service began. His overall view of the Service is that it is superb. The administration is excellent and well managed, he is clear on the process. Every three years there is an automatic change of Appraiser. As a senior doctor in the area some Appraisers are known to him some are not. His last Appraiser was not known to him, he was a very experienced GP and was talented at digging into the information supplied. He found the experience to be very good and Appraisee centred. All the Appraisers have been of a high standard and feedback is provided accordingly.
Prof N sees appraisal as a key part of his working life, the process covers all his areas of practice and interest. He has not experienced a conflict of interest with any of the Appraisers allocated to him but is aware that if that was the case there is a process to follow to change the Appraiser.
The rebalanced approach to medical appraisal is less onerous, reflection as you progress is key to useful practice development.
Prof N considers the Service to be well run and well established with a group of highly skilled Appraisers.

Appendix C(ix)

Interview with Dr W, GP, GP Associate Dean (ARCP), on 24th November 2021 conducted by Pam Strange, Miad Healthcare.

Dr W has completed nine appraisals with the Wessex Appraisal Service, firstly using the MAG system and then transferring to FourteenFish, he found the transfer from one system to the other to be seamless and well supported by the Service. The contact point for anything outside of his Appraisal is the Project Manager but when his appraisal is due, he receives and email with a named administrator to contact for that appraisal. He then connects with his Appraiser to arrange the discussion meeting and forward his portfolio at least two weeks prior to the meeting. Dr W has found the process of the rebalanced appraisal approach more straightforward and less time consuming, but it has not changed the quality or content of the appraisal discussion.

Dr W has had face to face appraisals throughout, with an Appraiser who is a GP, which he finds extremely valuable particularly around the guidance and mentorship that he has experienced through his appraisals. In addition, his Appraiser is usually geographically close to him which is very helpful. He considers that the Service is very careful to match an Appraisee with an appropriate Appraiser to ensure the best possible experience. Dr W has found all of his Appraisers to have been excellent and have provided him with the right amount of challenge and support at the different stages of his career. This is particularly reflected in the development of the PDP which has been a joint, constructive discussion about his future development needs in both his clinical and academic career.

On completion of the appraisal discussion the Appraiser writes up the discussion and shares the document with Dr W, who checks and asks for any amendments on accuracy that may be required, before signing it. Once the appraisal has been submitted, a feedback form is issued which he completes accordingly.

Dr W has not found it necessary to need to change to another Appraiser due to conflict but is well aware that this could be easily arranged if required. He did experience one appraisal where the Appraiser had to be changed at short notice due to circumstances outside the Appraiser's control, and whilst he was slightly nervous as to how this would work, again he was well matched, and the appraisal went very well.

Whilst Dr W has not experienced a remote appraisal himself, he has carried out remote appraisals with trainees, which he considers to be less effective and supportive as it is hard to pick up on the nuances of the discussion. He also feels that doctors may avoid talking about some areas of their work if they are going to find it upsetting as they don't want to "breakdown" on a remote interview.

Dr W's reflection of the Wessex Appraisal Service is that he has always experienced an excellent and supportive appraisal which goes beyond just being an appraisal discussion. The Appraisers have provided skilled and expert input into his thinking which makes it more than an appraisal, something that may not always be appreciated by the more junior doctors.

Appendix C(x)

Interview with Dr Q, via the telephone on Thursday 20th January 2022, conducted by Pam Strange, Miad Healthcare.

Dr Q is a full time GP who has been with the Service previously when working in the area and then returned to them for the past five years on return to the area. She found the transfer process to be very straightforward and has always had a contact point should she require any administrative support. A couple of times Dr Q Dr Sharma was not notified as to who her appraiser was, but she made contact with her administrator, and it was sorted out very quickly. On one occasion, Dr Q made a request to change a newly allocated appraiser as a result of negative feedback she had received from other appraises and this was done immediately without problem. There was another occasion when her allocated Appraiser did not respond to her as anticipated and when she was able to make contact, she found that she had stopped being an Appraiser due to ill health. This had not been communicated to her or another Appraiser arranged. She thought this was as a result of administrative staff change. She is aware that there is a medical appraisal policy but has not had cause to use it.

Dr Q makes contact with her Appraiser via email and an appointment is made for the meeting. The Appraiser is always clear on the timeline pre and post appraisal. She has experienced face to face and remote appraisals and has found no difference in the way they are conducted and believed this is now as a result of all the remote working that has been done during the pandemic, people are more skilled and sensitive to working remotely. She feels there are benefits to both, no travel and parking with the remote process but it is also good to meet with someone face to face. Hopefully there will be a mix of both going forward. Perhaps meeting with a new Appraiser for the first meeting so that a rapport can be established and then remotely for the following two appraisals.

All of the Appraisers have been GP's and Dr Q prefers this to be the case as they know about the way primary care works and the challenges faced by GP's. She does not have the confidence that an appraiser from secondary care would always appreciate the

difficulties faced. All of her Appraisers have been skilled and supportive, they have been interested in her work and ensured that her PDP met her needs.

Dr Q works on a way that ensures she uploads her supporting information very regularly. She found the rebalanced appraisal approach useful but doubts whether it will change her approach to appraisal. She likes to ensure that she has evidence that she continues to provide the highest quality care to her patients that is available. If appraisal was not in place she would still work in this way.

Dr Q provides feedback following her appraisal and does not have a problem with this.

Overall, Dr Q considers it to be a good service and all aspects are covered. Including individual well-being is a positive experience and considers it as the NHS acknowledging the efforts that staff have made during the pandemic.

Wider comment.

Dr Q would like to add the following commentary to be fed into the wider NHSEI network. She considers that it is nice to have appraisal, but even before appraisal there were good doctors. If you become a doctor you don't have to be told to be good, you keep up to date, her view is that the amount of money and time spent on appraisal nationally runs into millions of pounds. Perhaps this could be re-allocated to patient care if a different less expensive way of working could be developed.

Appendix C(xi)

Interview with Dr D, via the telephone on Tuesday 2nd November 2021, conducted by Pam Strange, Miad Healthcare.

Dr D is a GP, who has kindly agreed to carry out this interview outlining her experience of Medical Appraisal with the Wessex Appraisal Service. Dr D has been with the Service for 7 years and did not transfer from another Designated Body. She originally started her appraisals using the MAG 3 form which was fairly straightforward prior to the Service transferring to the FourteenFish Appraisal and Revalidation Management System which she considers to be very good and easy to use.

If Dr D needs any support, she has a contact administrator but has not used her as the whole process is very easy to use and efficient. She has always been allocated an Appraiser by the Service but does appreciate that if there is a conflict of interest or any difficulty it is easy to change to another Appraiser. Contact to set up the Appraisal discussion is triggered by the Service and set up via phone and e-mail contact initially. The Appraiser has always been clear on when they expect to access her portfolio prior to the meeting. Appraisal discussions were always face to face and invariably flowed well. Since the pandemic they have been carried out remotely and whilst it worked far better than anticipated and Dr D got a lot out of the experience, she would prefer face to face.

Dr D's experience of Appraisers during the 7 years has been variable, she now realises that her first Appraiser for a 3-year cycle was not as effective and supportive as her subsequent Appraisers and felt that it was rather a tick box exercise. This Appraiser was not a GP and worked in the acute sector and Dr D did not get as much out of the process as she should have. Dr D considers that the Appraiser should have the same background as the person they are appraising for it to be truly meaningful. She was then allocated to an interim Appraiser who was very helpful before meeting her current Appraiser with whom she enjoys a very supportive and creative relationship, which has resulted in her looking forward to her appraisal.

Dr D's experience of the rebalanced approach to appraisal is positive. She describes herself as studious but did not find the process as onerous as it had been and managed to complete the process in about 12 hours which was less that she had previously achieved.

Dr D gave an example of how her appraisal discussion had helped her take care of her own wellbeing. She recognises that everyone is struggling. She discussed with her Appraiser how she was coping and the challenges she was facing currently. It was a holistic discussion and as a result she has reduced her sessions from 6 to 5 in the short term which has allowed her to take greater control and remain working as a GP. She also found the PDP discussion valuable, which helped her develop an individual and meaningful plan towards helping her to fine joy in being a GP again.

Dr D does provide feedback following her appraisal, with her current Appraiser this is very easy, she cannot recall whether she gave constructive feedback around her first Appraiser, probably not. She is not convinced that feedback really works in the current format if someone wanted to give constructive feedback, it is a tick box exercise.

Dr D's current Appraiser is a coach as well as an Appraiser and whilst she is not coached during the appraisal discussion, she has found that this background has bought a very helpful perspective to the process and has helped her think differently. She is now at the stage in her career where she needs to forward plan and she has been struggling with this and needed support which she has received. She has greater understanding of her need to look after herself as an individual and described the process as a "metaphoric hug".

APPENDIX D Criteria for appraisal portfolio INPUT review (Miad Healthcare)	
1.	Scope of work: Has full practice been described
2.	Sufficient supporting evidence from all roles/ places of work
3.	CPD - Is it compliant with GMC requirements
4.	Is there evidence of reflection by Appraisee
5.	Is QA activity compliant with GMC requirements
6.	Evidence of reflection on QA by Appraisee
7.	Review of SI has been included
8.	Evidence of reflection/learning on Supporting information
9.	Patient feedback exercise has been completed
10	Evidence of reflection on patient feedback is included
11	Colleague feedback exercise has been completed
12	Evidence of reflection on colleague feedback is included
13	Review of complaints is included
14	Evidence of reflection on complaints
15	Review of compliments is included
16	Evidence of reflection on compliments
17	The Dr's achievement of the GMC attributes is discussed in the pre-appraisal section by the Appraisee

Appendix E Excellence QA Tool

EXCELLENCE QA Tool: Improving and quality assuring appraisal output documentation Appraiser: Quality Assured by: Date:							**Score** 0=No (absent from summary) 1=Partially (room for improvement) 2=Yes (well done)
Do the summary of appraisal, sign off statements and the Personal Development Plan (PDP):		**Score**	**Comments**	**Score**	**Comments**	**Score**	**Comments**
		Appraisal 1 RO name:		**Appraisal 2** RO name:		**Appraisal 3** RO name:	
Overall	***E**ncompass all?* DOES THE SUMMARY COMMENT ON CONTEXT, INCLUDING STAGE OF REVALIDATION CYCLE, AND REFLECTION ON THE WHOLE OF THE SCOPE OF WORK?						
	E**X**clude bias and prejudice? ARE ALL STATEMENTS OBJECTIVE, FREE FROM BIAS AND PREJUDICE AND BASED ON EVIDENCE? IS IT A TYPED, PROFESSIONAL DOCUMENT?						
	***C**hallenge, support and encourage?* DOES THE SUMMARY DEMONSTRATE THAT THE APPRAISAL WAS CHALLENGING, SUPPORTIVE AND FOCUSSED ON THE NEEDS OF THE DOCTOR?						

	***E**xplain why any statements (including health and probity) have not been agreed?* DOES APPROPRIATE COMMENTARY EXPLAIN ANY 'NO' OR 'DISAGREE' ANSWERS?	**(Score 2 if N/A)**					
Reviewing	***L**ook at supporting information, lessons learned, and changes made?* DOES THE SUMMARY DRIVE QUALITY IMPROVEMENTS BY REFLECTING WHAT HAS BEEN LEARNED AND WHAT NEEDS TO BE CHANGED AS A RESULT?						
	***L**ook at last year's PDP and reflect on each objective?* IF ANY OBJECTIVES HAVE NOT BEEN ACHIEVED, HAVE THE REASONS BEEN DISCUSSED AND DOCUMENTED?						
	***E**ncourage excellence, celebrate accomplishments, and record aspirations?* DOES THE SUMMARY CAPTURE EXAMPLES OF GOOD PRACTICE AND RECORD ASPIRATIONS (SOME OF WHICH MAY HAVE A TIMESCALE OVER ONE YEAR)?						

Planning ahead	***Note any gaps/no gaps in the requirements for revalidation and how they will be addressed?*** WHAT SUPPORTING INFORMATION IS OUTSTANDING FOR EACH ROLE?						
	Contain SMART PDP Objectives? *Are they* **SPECIFIC, MEASURABLE, ACHIEVABLE, RELEVANT AND TIMELY?** DO THEY CHALLENGE THE DOCTOR TO MAKE QUALITY IMPROVEMENTS?						
	Explain the new PDP items? DOES THE SUMMARY SHOW HOW THE PDP OBJECTIVES ARE RELEVANT AND DERIVE FROM THE SUPPORTING INFORMATION AND APPRAISAL DISCUSSION?						
Overall Comments Total							

Appendix F – Statement of responsibility

We (Miad Healthcare) cannot accept responsibility for the accuracy of the above information, which remains the responsibility of management. We have not independently verified the sources or accuracy of the information or sought to establish this by reference to other evidence.

Consequently, this Review is based on the information we have received from management and therefore can only be as accurate as the information provided to us prior to its production.

On Behalf of (Miad Healthcare)

Signed: ……..

Date: ……..

On Behalf of (client name)

Signed: ……..

Date: ……..