Tees, Esk and Wear Valleys
NHS Foundation Trust

Appraisal Policy for Doctors

Ref: HR-0041-v3

Status: Ratified
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1 Introduction

Tees, Esk & Wear Valleys NHS Foundation Trust believes that appraisal for doctors is a professional process of constructive dialogue, in which the doctor being appraised has a formal structured opportunity to reflect on his or her work. The ethos of appraisal is developmental and allows the doctor to consider how his or her effectiveness might be improved.

The implementation of this Policy reflects anti-discriminatory practice. Should any doctor believe that the terms of the Policy are not being complied with, they have the right to raise their concerns by using the Trust Grievance Policy & Procedure.

2 Why we need this policy

2.1 Purpose

This Policy and the accompanying Appraisal Procedures will provide all doctors with a guide to ensure that they are clear about what is expected from them as they prepare for appraisal and revalidation. It will enable medical staff to develop in their post and contribute to Trust, service, locality and team objectives.

3 Scope

3.1 Who this policy applies to

The Policy applies to all Consultants, Associate Specialists and Specialty Grade doctors (SAS) and Trust Grade doctors within Tees Esk and Wear Valley NHS Foundation Trust, along with clinical academics (with an NHS contract) and Trust locums.

3.2 Roles and responsibilities

Role	Responsibility
Chief Executive	On behalf of the Designated Body (Tees, Esk & Wear Valleys NHS Foundation Trust) is responsible for ensuring that the Responsible Officer (RO) is provided with appropriate resources to allow him/her to discharge their duties. The Chief Executive will ensure that indemnity is provided for appraisers both internal to the Trust and appraisers that are external to the Trust;
Board of Directors	• Monitoring and approving a framework to support the appraisal and revalidation of doctors that are compliant with all relevant legislation, guidelines and NHS best practice standards;

	• Ensuring that any key recommendations set out by the GMC are incorporated into our policy and procedure. • Ensuring that corporate departments support revalidation by the collection, access and delivery of information including accurate and timely outcomes data.
Medical Director/Responsible Officer (RO)	Is accountable to the Chief Executive for the appraisal process and accountable to the GMC for his/her decisions. The Medical Director/RO is responsible for ensuring that the Appraisal Policy for Doctors and the processes therein comply with the relevant national guidance and legislation. The responsibilities include ensuring that appraisers are properly trained to carry out this role and are in a position to undertake appraisal of a doctor's whole scope of practice. The RO will make a recommendation to the GMC based on the information provided through the appraisal. The RO will need to have enough information to make one of the three recommendations: • Make a positive recommendation that the doctor is up to date, fit to practise and should be revalidated (it is expected this will be the case for the vast majority of doctors); • Request a deferral because the RO needs more time or more information to make a recommendation about the doctor (eg this might happen if the doctor has taken an extended break from practice); • Notify the GMC that the doctor has failed to engage with appraisal or with the appraisal process.
Associate Responsible Officer	Is accountable to the Responsible Officer and responsible for: • Ensuring that all doctors undertake an annual appraisal in line with this Policy; • Training and support to doctors and appraisers; • Allocating an appraiser if there is any conflict of interest between a doctor and deputy medical director/clinical director; • Ensuring that an Annual Report on consultant appraisal is prepared for the Trust Revalidation Group and the Board of Directors.
Trust Revalidation Group	Overall responsibility for monitoring compliance with this Policy: • Confirming the appointment of appraisers; • Undertaking an annual review of the appraisal cycle; • Monitoring the performance of the appraisers using the Annual Report as a basis for this review (see appendix 3 for Terms of Reference)
Revalidation Team	• Ensuring information is sent to the doctor in timely fashion; • The monitoring of activity on the official appraisal database, SARD (Strengthened Appraisal & Revalidation Database); • Recording information detailed from SARD on when doctors have submitted and completed appraisal;

	• Alerting the Associate Responsible Officer and Medical Staffing Manager of any missed appraisals or any late returns of documents; • Preparing monthly, quarterly and annual reports in a timely manner, such as: Quarterly Trust Revalidation Group, FQA Quarterly Report, Trust Board Report, Annual Organisational Audit Report as well as any other requests for information from appropriate sources.
The Appraiser	• Responsible to the Responsible Officer; • Responsible for facilitating a whole practice appraisal with doctors; • Is expected to carry out between 6-8 appraisals each year; with a minimum of 4 but this may vary on demand; • Will not carry out appraisals for the same doctor for more than 3 consecutive years. Any appraisal that is carried outside of these limits <u>will not</u> be accepted by the Revalidation Team; • Is responsible for completing the PDP, the summary of appraisal, agreeing the revalidation statements and 'signing off' the appraisal. • Is responsible for ensuring that once the appraisal has been 'signed off' it is submitted on SARD within 28 days of the appraisal taking place. • The appraiser is encouraged to use a coaching style. • Must participate in annual appraisal training.

Doctor	• Responsible for their own revalidation, including demonstrating they are sufficiently reflection on information from their practice, learning and making improvements
	• Doctors are required by the GMC to:
	    o Keep their connection details up to date in the GMC online account.
	    o Collect and reflect on supporting information that reflects the whole of practice.
	    o Take part in annual **whole practice appraisals** (including work done privately)
	    o Send the GMC further information if requested.
	    o Make sure their responsible officer or suitable person can make a recommendation about them.
	    o Familiarise themselves with GMC guidance and engage with the processes that support revalidation.
	• Doctors are required by the Trust to:
	    o Submit their portfolio to the appraiser two weeks in advance of the appraisal
	    o Submit a 'signed off' copy of the documentation to the appraiser within 21 days;
	    o Complete the appraisal feedback form and return to the Revalidation Team within 28 days;

	• Raising any concerns about the appraisal process in accordance with this Policy

4 Policy

4.1 Links to Revalidation

The appraisal process is the vehicle through which the GMC's revalidation requirements will be delivered for doctors. Successful completion of the appraisal process as outlined in this Policy will provide sufficient evidence to support the process of revalidation.

4.2 Links to Job Planning

The job planning process is separate from the appraisal process. Job planning is an annual event and will be carried out by the relevant clinical and operational managers at a meeting held separately from the appraisal meeting.

At times when a doctor is not being appraised by their clinical line manager it will be necessary for an exchange of information to take place between the line manager and appraiser prior to the appraisal meeting.

5 Principles of Appraisal

5.1 Appraisal should be a positive process to give doctors feedback on their past performance, to chart their continuing progress and to identify development needs;

5.2 It is a forward-looking process, using coaching skills and is essential in identifying the developmental and educational needs of individuals. The primary aim of appraisal is to help doctors consolidate and improve on good performance, aiming towards excellence;

5.3 Appraisal is underpinned by continuing professional development and if used properly can help to develop a reflective culture within service. It provides doctors with an opportunity to demonstrate the evidence that will be required for revalidation;

5.4 The aims of appraisal are to:

- Regularly review a doctor's work and performance, utilising relevant and appropriate comparative operational data from local, regional and national sources;
- Consider the doctor's contribution to the quality and improvement of services and priorities delivered locally;
- Set out personal and professional development needs and agree plans for these to be met;

- Provide an opportunity for doctors to discuss and seek support for their participation in activities for the wider NHS;
- Utilise the annual appraisal process and associated documentation to meet the requirements for revalidation as determined by the GMC;
- Provide assurance that a doctor is fulfilling their duties, roles and responsibilities to an acceptable standard as stated by the GMC.

5.5 The content of appraisal is based on the following key documents which doctors are expected to make themselves familiar with:

- Good Medical Practice: General Medical Council: 2013;
- Good Medical Practice Framework for Appraisal & Revalidation GMC, March 2011;
- Medical Appraisal Guide, March 2012;
- The Royal College of Psychiatrists ‘Revalidation Guidance for Psychiatrist’ (College Report 194 2014);
- Guidance for doctors: requirements for revalidation and maintaining your licence GMC, April 2018
- Guidance on supporting information for appraisal and revalidation, GMC April 2018
- The GMC protocol for making revalidation recommendations, GMC April 2018

6 Appraisal Process

6.1 Doctors are expected to follow the Appraisal Procedure (see Appendix 4);

6.2 The appraisal year runs from 1st April to 31st March;

6.3 Each doctor will have an annual appraisal and should not be appraised by the same appraiser more than three consecutive years;

6.4 A doctor can return to a previous appraiser but must have a minimum gap of 3 years.

6.5 Preparation for the appraisal is included in protected time that is in the Supporting Programmed Activities (SPAs) element of the job plan;

6.6 For the purposes of revalidation it is a doctor’s responsibility to participate in annual appraisal. Failure to do so may be regarded as non-engagement in the appraisal process and may result in referral to the General Medical Council and failure to be revalidated;

6.7 Appraisers may not necessarily be clinical leaders or from the same speciality however all appraisers will be trained to what had been Revalidation Support Team standards and can be either Consultants or SAS grade doctors;

6.8 Any disputes relating to the allocation of appraisers will be dealt with under the Appraisal Procedure (Appendix 1);

7 Procedure to be followed for doctors who have not completed and annual appraisal

7.1 In such cases the process in the Appraisal Procedure (**Appendix 2)** should be followed;

7.2 An appraisal will be classified as 'missed' if:

- The appraisal meeting is not completed between 9 and 15 months of the previous appraisal;
- The appraisal meeting is not completed between the 1st April and 31st March of that appraisal year;

7.3 If a missed appraisal is part of non-engagement from the appraisal process, the Responsible Officer may make the decision to refer to the General Medical Council.

8 Confidentiality

8.1 The appraisal documentation may be viewed by individuals other than, the appraiser and the doctor. These include:

- The Responsible Officer
- The Revalidation Team
- Clinical leaders - for quality assurance of appraiser work
- Clinical leaders - addressing any concerns highlighted in the appraisal;
- Medical education – confirming standards for recognition of trainers.

8.2 Clarification as to who has access to appraisal documentation is contained in the Appraisal Procedure (**Appendix 3);**

9 When an appraisal meeting should be adjourned

- Where it becomes apparent during the appraisal process that there is a potentially serious performance, conduct or health issue (that has not been previously identified) which requires further discussion or examination, the appraisal meeting should be stopped.
- The matter must be referred by the appraiser immediately to the relevant Clinical Director/Associate Clinical Director to take appropriate action.
- The Clinical Director/Associate Clinical Director will inform the relevant Deputy Medical Director, the Associate Responsible Officer and the Responsible Officer.
- Appropriate Policy and Procedure will then be followed, after discussions with Medical Development.

10 When an appraisal is unsatisfactory

10.1 There is no absolute guide as to what constitutes an unsatisfactory appraisal; however guidance is given in the Appraisal Procedure **(Appendix 4)** on what is considered to be essential documentation that should be detailed in the portfolio. In addition, it is expected that all doctors are familiar with the standards that are set by the General Medical Council and the Royal College of Psychiatrists;

10.2 If any part of the essential documentation is not identified in a portfolio (unless a satisfactory explanation can be offered by the doctor) then this must be brought to the attention of the doctor prior to the appraisal meeting. This should provide an opportunity for the doctor to produce the relevant supporting information.

If the information is not immediately available then the appraiser may then agree an action plan with the doctor so that the issue is addressed in the subsequent appraisal cycle or the two parties can agree that an alternative form of evidence would be sufficient;

10.3 Other areas such as failure to address issues that have been previously raised, such as lack of essential documentation, issues about clinical performance or personal behaviour may result in an unsatisfactory outcome. However these issues would have to be sufficiently serious to justify this course of action.

10.4 Part of the developmental approach to appraisal should be in supporting the doctor in improving the quality of evidence in the appraisal portfolio. It is only when there has been a clear failure to respond to actions outlined in previous appraisal summaries that the appraisal could be considered as being unsatisfactory. If the issues cannot be resolved with the doctor then the matter should be discussed with relevant Senior Clinical Director/Clinical Director or Deputy Medical Director and then referred to the Associate Responsible Officer;

10.5 It should be noted that if a doctor has been allowed to complete their own summary of appraisal this will not be accepted by the Responsible Officer. The doctor will be asked to undertake a further appraisal with another appraiser and for the summary of appraisal to be completed by the appraiser in line with Trust Policy

11 Complaints arising from the appraisal process

The appraisal process relies on a two way dialogue and aims for mutual agreement. If a doctor considers that any aspect of the appraisal process has not been carried out effectively or fairly, an approach should be made to the appraiser in the first instance. If the doctor and appraiser are unable to resolve the difficulty, then the doctor has an automatic right to raise concerns with the Associate Responsible Officer.

The doctor may raise a concern in writing to the Associate Responsible Officer or the Responsible Officer who will investigate the issue (or nominate someone of sufficient experience).

A judgement will be made by the Associate Responsible Officer or the Responsible Officer and communicated in writing to the doctor and appraiser. Should either the doctor or appraiser be unhappy with the outcome, they may instigate the Trust Grievance Procedure. Please refer to the Grievance Procedure on InTouch for further information.

12 Exemption from appraisal

12.1 All doctors who have been in post for more than 6 months (including Trust locums) before the end of an appraisal year will be expected to participate fully in an appraisal, that appraisal year. This will allow doctors time to gather sufficient supporting information;

12.2 A doctor may be exempt from the appraisal process if:

- they have been in a post with TEWV for less than 6 months prior to the end of an appraisal year **OR**;
- The doctor has not held a substantive Consultant, SAS, Trust doctor or General Practitioner post prior to joining TEWV **OR**;
- The doctor is a locum and has not held a locum post prior to joining TEWV

13 New appointments

13.1 Prior to appointment, the doctor's previous Responsible Officer will be contacted to confirm that the candidate has participated in appraisal and that there are no concerns regarding being up to date and fit to practice;

13.2 For new appointments, the procedure in the Appraisal Procedure **(Appendix 6)** should be followed;

13.3 New doctors will have a meeting with their clinical manager to discuss issues such as appraisal date, PDP and job plan within the first two months of their appointment;

13.4 New doctors will have their annual appraisal within the first twelve months of their appointment. Their appraisal date will generally fall in the month of them commencing their post, depending on when they start with the Trust and when their last appraisal was.

14 Postponement of an annual appraisal

14.1 The GMC requires all doctors to undergo an appraisal annually. This is a requirement for successful revalidation. There is however exceptional circumstances when a doctor may request that an appraisal is postponed such that no appraisal takes places during one appraisal year, for example if a doctor is off on long term sick or on maternity leave.

14.2 Each case will be dealt with on its merits and the Trust is mindful that no doctor must be disadvantaged or unfairly penalised as a result of pregnancy, sickness or disability. Doctors who have a break from clinical practice may find it harder to collect evidence to support their appraisal, particularly if being appraised soon after their return to clinical practice. However, often, an appraisal can be useful when timed to coincide with a doctor's re-induction to clinical work. Appraisers will use their discretion when deciding the minimum evidence acceptable for these exceptional appraisals;

14.3 The Trust has the right to consider taking formal action if a doctor does not undergo an annual appraisal without having good reason;

14.3 The procedures relating to when postponement may be appropriate, the procedure to be followed, the application form and the certificate if the applicant is successful is found in the Appraisal Procedure **(Appendix 7)**.

15 Private/Non-NHS/Non-TEWV practice

Revalidation requires a "whole practice" appraisal, hence evidence must be provided for the whole scope of work. Supporting information must be provided as shown in the Appraisal Procedure **(Appendix 8)** and the doctor should arrange with the private or non-NHS sector provider to complete and sign the form;

If the doctor is self-employed and performing private/none NHS work they should discuss with the appraiser what evidence should be included in the appraisal portfolio.

16 Exit reports for Trust and Agency Locum Doctors

The Trust has a duty to provide information for locum doctors that they can utilise in future appraisals. All locum doctors that have been with the Trust for over 3 months should receive an Exit Report. This will be prepared by the Revalidation Team on behalf of the Senior Clinical Directors/Associate Clinical Director or Head of Service as shown in the Appraisal Procedure **(Appendix 9)**;

17 Doctors who do not have a prescribed connection with TEWV

17.1 Doctors employed through a Service Level Agreement or on a sessional basis by TEWV and whose majority of NHS practice is not with TEWV shall receive a report detailing essential supporting information. This shall be completed by the Revalidation Team on behalf of the Senior Clinical Director/ Associate Clinical Director or Head of Service in any areas that this doctor has practiced and should be placed in their portfolio for utilisation in appraisals outside TEWV. This is found in the Appraisal Procedure **(Appendix 10)**;

17.2 Doctors employed through a Service Level Agreement or on a sessional basis by TEWV and whose majority of NHS practice is with TEWV will be appraised in line with this Policy and their Responsible Officer shall be TEWV's Medical Director;

18 Quality assurance programme for appraisal

Quality assurance (QA) of medical appraisal will comprise of:

18.1 **The Process** which will be carried out as part of the Annual Report which is reported to the Board of Directors and monitored by the Trust Revalidation Group;

The Revalidation Team will produce an Annual Report on medical appraisal. The details of this are found in the Appraisal Procedure **(Appendix 11)**;

18.2 **The Work of Appraisers** which will be delivered through the appraisal of the appraiser and the additional three processes:

18.2.1 Recruitment and Selection

The Trust Revalidation Group will have overall responsibility to appoint appraisers, who will have been selected using the job description person specification and application form found in the Appraisal Procedure **(Appendices 12, 13 and 14)**;

The Medical Director as the Responsible Officer will **not** be an appraiser;

18.2.2 Appraiser Training

New appraisers will receive training in keeping with the NHS England recommendations;

Existing appraisers will receive invitations to 4 Appraiser Update Sessions per year of which two must be attended in the appraisal year. The content of the sessions are similar for May/September and then for November/February. These will be arranged by The Revalidation Team and led by the Associate Responsible Officer;

An annual training report will be provided to the Trust Revalidation Group as part of the Annual Report.

18.2.3 Annual Appraiser Performance Review

An appraiser's performance will be assessed against the following:

- Agreed standards for appraisers;
- Review of appraiser documentation;
- Review of doctor feedback;

Details are contained in the Appraisal Procedure **(Appendices 15-19).**

Medical Development will collate information for each appraiser into an annual appraiser feedback report which will be reviewed at the Trust Revalidation Group annually.

The appraiser will receive a copy of this report and will be expected to include within his/her own appraisal portfolio.

If the performance of an appraiser causes concern there will be a face to face meeting that will take place between the appraiser and the Associate Responsible Officer. This will

automatically be triggered if a doctor has been allowed to complete their own summary of appraisal. Further specific training may be advised within a specified time frame.

If agreement cannot be reached on how the performance of the appraiser can be improved or if there has been failure to improve following a previous review then the Associate Responsible Officer may recommend to the Trust Revalidation Group that this individual is deselected as an appraiser. The Trust Revalidation Group will have the final say in this matter. This decision can be appealed and the appeal will be heard by the Responsible Officer.

19 Related documents

This Policy should be read in conjunction with the Medical Remediation & Disciplinary Policy, HR-0008. This Policy includes links to other relevant HR Policies in the Trust such as the Grievance Policy and Procedure HR-0002.

20 How this policy will be implemented

Compliance with this Policy will be monitored by the Trust Revalidation Group using the Annual Report as the basis of the compliance assessment.

- This policy will be published on the Trust’s intranet and external website.

21 Document control

Date of approval:	13 February 2019	
Next review date:	13 February 2022	
This document replaces:	HR-0041-v2	
Lead:	Name	Title
	Elaine Corbyn	Medical Development Manager
Members of working party:	Name	Title
	Revalidation Group	
This document has been agreed and accepted by: (Director)	Name	Title
	Dr Ahmad Khouja	Medical Director
This document was approved by:	Name of committee/group	Date
	Revalidation Group	14 November 2018
This document was ratified by:	Name of committee/group	Date
	Executive Management Team	13 February 2019
An equality analysis was completed on this document on:	19 December 2018	

Change record

Version	Date	Amendment details	Status
V3	13 Feb 2019	The policy has undergone full revision with minor amendments to wording.	Published

Appendix 1 - Equality Analysis Screening Form

Please note; The Equality Analysis Policy and Equality Analysis Guidance can be found on InTouch on the policies page

<table>
<tr><td>Name of Service area, Directorate/Department i.e. substance misuse, corporate, finance etc.</td><td colspan="6">Medical Development Department</td></tr>
<tr><td>Name of responsible person and job title</td><td colspan="6">Elaine Corbyn, Medical Development Manager</td></tr>
<tr><td>Name of working party, to include any other individuals, agencies or groups involved in this analysis</td><td colspan="6">Revalidation Group – Dr Ahmad Khouja Medical Director, Dr Joe Reilly, Dr Lenny Cornwall, Dr Tolu Olusoga, Dr Pratish Thakkar, Dr Suresh Babu, Dr Jim Boylan, Dr Steve Wright, Bryan O'Leary, Elaine Corbyn, Chloe Cooper.</td></tr>
<tr><td>Policy (document/service) name</td><td colspan="6">Appraisal Policy for Doctors</td></tr>
<tr><td rowspan="3">Is the area being assessed a…</td><td>Policy/Strategy</td><td>x</td><td>Service/Business plan</td><td></td><td>Project</td><td></td></tr>
<tr><td colspan="3">Procedure/Guidance</td><td></td><td>Code of practice</td><td></td></tr>
<tr><td colspan="5">Other – Please state</td><td></td></tr>
<tr><td>Geographical area covered</td><td colspan="6">Trust wide</td></tr>
<tr><td>Aims and objectives</td><td colspan="6">To oversee the strategic process of appraisal and revalidation for all doctors</td></tr>
<tr><td>Start date of Equality Analysis Screening
(This is the date you are asked to write or review the document/service etc.)</td><td colspan="6">November 2018</td></tr>
<tr><td>End date of Equality Analysis Screening
(This is when you have completed the equality analysis and it is ready to go to EMT to be approved)</td><td colspan="6">19 December 2018</td></tr>
</table>

You must contact the EDHR team if you identify a negative impact. Please ring Sarah Jay on 0191 3336267/3046

1. Who does the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan benefit?

All Doctors in relation to the appraisal and revalidation process and TEWV by ensuring there are robust processes in place to ensure that our doctors are appraised annually and revalidated every five years.

2. Will the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan impact negatively on any of the protected characteristic groups below?

Race (including Gypsy and Traveller)	No	**Disability** (includes physical, learning, mental health, sensory and medical disabilities)	No	**Sex** (Men, women and gender neutral etc.)	No
Gender reassignment (Transgender and gender identity)	No	**Sexual Orientation** (Lesbian, Gay, Bisexual and Heterosexual etc.)	No	**Age** (includes, young people, older people – people of all ages)	No
Religion or Belief (includes faith groups, atheism and philosophical belief's)	No	**Pregnancy and Maternity** (includes pregnancy, women who are breastfeeding and women on maternity leave)	No	**Marriage and Civil Partnership** (includes opposite and same sex couples who are married or civil partners)	No

Yes – Please describe anticipated negative impact/s

No – Please describe any positive impacts/s

3. Have you considered other sources of information such as; legislation, codes of practice, best practice, nice guidelines, CQC reports or feedback etc.? **If 'No', why not?**	**Yes**		**No**	

Sources of Information may include:	
• Feedback from equality bodies, Care Quality Commission, Equality and Human Rights Commission, etc. • Investigation findings • Trust Strategic Direction • Data collection/analysis • National Guidance/Reports	• Staff grievances • Media • Community Consultation/Consultation Groups • Internal Consultation • Research • Other (Please state below)

4. Have you engaged or consulted with service users, carers, staff and other stakeholders including people from the following protected groups?: Race, Disability, Gender, Gender reassignment (Trans), Sexual Orientation (LGB), Religion or Belief, Age, Pregnancy and Maternity or Marriage and Civil Partnership
Yes – Please describe the engagement and involvement that has taken place
No – Please describe future plans that you may have to engage and involve people from different groups

<table>
<tr><td colspan="6">5. As part of this equality analysis have any training needs/service needs been identified?</td></tr>
<tr><td>No</td><td colspan="5">Please describe the identified training needs/service needs below</td></tr>
<tr><td colspan="6">A training need has been identified for;</td></tr>
<tr><td>Trust staff</td><td>Yes/No</td><td>Service users</td><td>Yes/No</td><td>Contractors or other outside agencies</td><td>Yes/No</td></tr>
<tr><td colspan="6">Make sure that you have checked the information and that you are comfortable that additional evidence can provided if you are required to do so</td></tr>
<tr><td colspan="5">The completed EA has been signed off by:
You the Policy owner/manager:
Type name: Elaine Corbyn</td><td>Date:
December 2018</td></tr>
<tr><td colspan="5">Your reporting (line) manager:
Type name: Bryan O’Leary</td><td>Date:
December 2018</td></tr>
<tr><td colspan="6">If you need further advice or information on equality analysis, the EDHR team host surgeries to support you in this process, to book on and find out more please call: 0191 3336267/3046</td></tr>
</table>

Appendix 2 – Approval checklist

To be completed by lead and attached to any document which guides practice when submitted to the appropriate committee/group for consideration and approval.

	Title of document being reviewed:	Yes/No/ Unsure	Comments
1.	**Title**		
	Is the title clear and unambiguous?	YES	
	Is it clear whether the document is a guideline, policy, protocol or standard?	YES	
2.	**Rationale**		
	Are reasons for development of the document stated?	YES	
3.	**Development Process**		
	Are people involved in the development identified?	YES	
	Has relevant expertise has been sought/used?	YES	
	Is there evidence of consultation with stakeholders and users?	YES	Stakeholders – doctors and managers implementing and updating document as per Health Education England updates.
	Have any related documents or documents that are impacted by this change been identified and updated?	YES	
4.	**Content**		
	Is the objective of the document clear?	YES	
	Is the target population clear and unambiguous?	YES	
	Are the intended outcomes described?	YES	
	Are the statements clear and unambiguous?	YES	
5.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?	YES	
	Are key references cited?	YES	
	Are supporting documents referenced?	YES	
6.	**Training**		
	Have training needs been considered?	YES	Quarterly training is offered to all appraisers, however, they must attend 2 training sessions per year.

	Title of document being reviewed:	Yes/No/ Unsure	Comments
	Are training needs included in the document?	NO	
7.	**Implementation and monitoring**		
	Does the document identify how it will be implemented and monitored?	YES	
8.	**Equality analysis**		
	Has an equality analysis been completed for the document?	YES	
	Have Equality and Diversity reviewed and approved the equality analysis?	YES	
9.	**Approval**		
	Does the document identify which committee/group will approve it?	YES	
Signature: Elaine Corbyn			

Appendix 3 – TEWV Revalidation Group Terms of Reference

MEMBERSHIP

Dr Ahmad Khouja	Responsible Officer / Chair
Dr Lenny Cornwall	Associate Responsible Officer
Dr Suresh Babu	Deputy Medical Director (Durham and Darlington)
Dr Lenny Cornwall	Deputy Medical Director (Teesside)
Dr Tolu Olusoga	Deputy Medical Director (North Yorkshire)
Dr Steve Wright	Deputy Medical Director (York and Selby)
Dr Pratish Thakkar	Deputy Medical Director (Forensic Services)
Dr Jim Boylan	Director of Medical Education
Dr Joe Reilly	Clinical Director of Research & Development
Bryan O'Leary	Associate Director of Medical Development
Elaine Corbyn	Medical Development Manager
Chloe Cooper	Appraisal & Revalidation Advisor

QUORUM

Responsible Officer **OR** Associate Responsible Officer
One Deputy Medical Director
One Medical Development Representative

AIMS

1. This group will oversee the strategic development of medical appraisal systems and processes taking into account Trust Policies and Procedures relevant to this development, including job planning and pay progression, and informed by national standards and guidance;

2. The group will provide a critical review of the medical appraisal systems and processes on an annual basis informed by a report from the Associate Responsible Officer and Medical Development;

3. The group will contribute to the annual end of year Medical Appraisal report to be submitted by the Responsible Officer to both the Trust Board and GMC;

4. The group will monitor and update the medical appraisal policy and procedure on an annual basis;

5. The group will govern the quality assurance of medical appraisal as outlined in the Medical Appraisal Policy;

6. Consider the applications for new appraisers, oversee the training and quality assurance of appraisers and deselecting appraisers where necessary.

Tees, Esk and Wear Valleys NHS Foundation Trust

Appendix 4 – The Standard Appraisal Process