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FIPO
federation of independent practitioner organisations

FIPO CONSULTANT APPRAISAL SERVICES

A PILOT STUDY ON

CONSULTANT MEDICAL APPRAISAL

IN THE INDEPENDENT HOSPITAL SECTOR

The General Report and Conclusions

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FIPO-CAppS Pilot Study of Consultant Appraisal in Independent Sector Hospitals

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FIPO Consultant Appraisal Services (FIPO-CAppS)

Part 1- Pilot Study of Consultant Appraisal in Independent Sector Hospitals

Pilot Summary

Establishing an appraisal service for consultants working exclusively in hospitals in the independent sector is essential for revalidation and annual renewal of practising privileges.

The FIPO-CAppS pilot study of 30 consultant appraisals assessed all aspects of the administration, conduct and outcome of the appraisals, the suitability and reliability of the appraisal procedure and the suitability of the appraisal documentation for revalidation purposes as assessed separately by eight Responsible Officers (ROs).

All participants agreed to review the process through a detailed SurveyMonkey electronic survey at the end of the appraisal.

MSF was not included in this pilot but this may improve the analysis of results and the confidence of the ROs in making their recommendations to the GMC.

In this Part 1 Report the main findings of the study are summarised. A separate Part 2 and more detailed but redacted review of the findings is being sent to all participants (Appraisees, Appraisers and Responsible Officers) as a feedback mechanism. This may be obtained by others on a restricted basis from the FIPO office.

Key Findings

Whilst the majority of consultants work in one or two hospitals there is a substantial minority that work in more. It is apparent that reports from all hospitals were not received during this pilot. There is a need to reinforce the concept of whole practice appraisal and that hospital reports from all areas of work are essential when presented for appraisal in either the NHS or private sector.

Consultants in the independent sector have a considerable range of practice and are generally older on average than NHS consultants, which may present specific problems.

There was considerable variation in the ease with which consultants could obtain workload and other details of performance from individual independent hospital groups. This should include all details of clinical activity, complaints, audits, complications, governance reports etc. Private hospital data is also required to complete whole practice appraisal within the NHS.

The appraisers were generally positive about the appraisees' documentation but this view was not always shared by the Responsible Officers.

There was variation amongst ROs in their view on the standard of appraisal documentation and their ability to make recommendations to the GMC on revalidation, based on the pilot study documentation.

Despite the variation between ROs, individuals were generally consistent in their evaluation of appraisal documentation.

Key Conclusions

There are a number of impediments to establishing an appraisal service. Costs must be realistic and appraisees must understand the complexity of the service they are buying.

Administration of this pilot scheme was time consuming and cumbersome.

More support is required to ensure that information brought to the appraisal is adequate and organised. Appraisees did not bring all the information from all the hospitals in which they worked to the appraisal.

The information on work practices and governance issues provided by private hospitals needs amplification.

Appraisers found the process manageable and the information provided to them generally reliable but there are exceptions that need to be addressed,

The review and detail of the information and its interpretation as entered by the appraisers on the appraisal documents was varied and often illegible. The ROs were generally more critical than the appraisers.

Appraisers and appraises were generally positive about the appraisal process and its value, however, the documentation needs refinement.

Development of appropriate IT platforms is seen as essential.

The post appraisal electronic surveys can, with some modification, be used in future appraisals as a quality control measure on the actual process and as a method to measure variation in RO performance.

Systematic benchmarking of RO appraisal assessment will provide the basis for demonstrable system confirming fairness across the board.

Feedback to appraisers would be helpful. This may be done at local level as a routine by individual ROs, but application of the system developed here would allow cross checking by other ROs to provide external audit and review.

Feedback to appraisees may well help to improve the process and aid the collection of the doctor's personal portfolio.

Introduction

Consultants with practising privileges in independent sector hospitals fall in to two groups; those with an NHS appointment and those fully independent and with no NHS affiliation representing around 4% of the total (OFT Report 2011).

Consultants already undergo annual appraisal, but to satisfy the requirements of revalidation and the final Medical Appraisal Guidelines (MAG) both the administration and content of the appraisal require significant revision.

FIPO, The Federation of Independent Practitioner Organisations (**Appendix 1**) has set up a sub-committee, FIPO-CAppS (FIPO Consultant Appraisal Services) to consider the requirements of an appraisal scheme for consultants working solely in the independent hospital sector, who may number anything from 600 to 1,200.

The FIPO-CAppS pilot study used updated documentation to conduct appraisals on 30 consultants to assess appraiser and appraisee input and their satisfaction with all aspects of the administration, conduct and outcome of the appraisal. In addition the study tested the suitability and reliability of the appraisal procedure and documentation for Responsible Officers (ROs) to make recommendations to the GMC for revalidation purposes. Eight ROs took part in the assessment process and their responses were evaluated.

Methodology

30 fully independent consultant appraisees without any NHS appointments were recruited through the London Consultants' Association (LCA) membership and through hospital networks. Paper based appraisals were conducted by consultant appraisers recruited and trained for the study. Four appraisers carried out two appraisals and the remainder conducted just one appraisal. Multi-Source Feedback (MSF) was not included in this pilot. The pilot study began in July 2011 and ran for five months.

Appraisals were administered through the FIPO office where appraisers were selected for the consultants: all participants agreed to review the process though a detailed SurveyMonkey electronic questionnaire at the end of the appraisal which also allowed freehand comments.

Appraisees, appraisers and ROs were each given a unique computer generated number for the purposes of this pilot. These long numbers have been converted into a simplified numbering structure for ease of presentation as shown in the Code Structure (**Appendix 2**). All participants may thus track their own performance but strict confidentiality has been preserved and participants will be able to identify only their own status within the pilot study.

All participants were given clear instructions before the appraisal. Appraisees were asked to consult with their appraiser before the appraisal and to submit information to include a hospital report on workload and governance issues. The appraisees' supporting portfolio of information should have been agreed before the appraisal. The appraisal documents were based on previously utilised but modified paperwork with checklists and standard sections for listing of supporting paperwork, a section

for agreed comments between appraiser and appraisee, a PDF (Personal Development Plan) and a summary of the appraisal.

Each redacted set of completed appraisal documentation (without the supporting portfolio of information from the doctor) was submitted to seven independent hospital sector ROs and one NHS RO (Chairman of the NHS London RO Network Board), who were then asked to complete a separate SurveyMonkey questionnaire on each appraisal.

ROs reviewed the initial 25 appraisals to assess whether they could make a recommendation to the GMC based first on just the summary of the appraisal and second on the full set of appraisal papers. ROs were allowed to enter freehand comments at different points in the questionnaire. A system of scoring of the RO responses allowed comparisons to be made between ROs so that their ability to recommend to the GMC could be assessed. In addition to a comparison of the ROs' GMC recommendations on appraisal a further assessment was made of their views on the component parts of the appraisal. This allowed a separate method of RO assessment which could be compared with their recommendations and also gave a composite score on each appraisee and various aspects of their appraisal paperwork.

In calculating results percentages as well as actual numbers were used. All the percentages have been rounded up or down to the nearest number but it should be noted that the figures quoted are based on small numbers (30 for appraisers and appraisees and 25 for ROs). Where averages are quoted these are based on the middle range of the results on the SurveyMonkey reports and aggregated for each specific question.

In this Part 1 report the main findings of the study are summarised. Part 2, a separate and more detailed but anonymous review of the findings, is being sent to all participants (appraisees, appraisers and Responsible Officers) as a feedback mechanism. Others may obtain this on a restricted basis from the FIPO office.

FIPO-CAppS Pilot - Results

The results of the Pilot study are considered under four headings;

- **The Appraisees**
- **The Appraisers**
- **The Responsible Officers**
- **The Appraisals**

The Appraisees

APPRAISEES' DEMOGRAPHY AND PRACTICE PROFILE

Age: The average age of appraisees was 61 years and 36.6% of consultants were over the age of 65 years.

Comment: This may reflect the fact that many consultants continue in independent practice after leaving the NHS and this may throw up special age related issues.

Specialty: The appraisees came from a wide range of specialties with 4 anaesthetists, 4 orthopaedic surgeons, 3 obstetricians/gynaecologists, 3 plastic surgeons and 3 general surgeons, 2 psychiatrists and single consultants in cardiology, dermatology, diabetes, gastroenterology, general medicine, gynaecology (alone), oral and maxillo-facial surgery, radiology, respiratory medicine, urology and vascular surgery/ medico-legal.

Time in independent practice: The average period in independent practice was 25 years. 56.5% of appraisees had been in private practice for up to 25 years and 43.5% for longer.

NHS Experience: The average period as an NHS consultant was just over 15 years. 30% had spent less than 5 years as an NHS consultant. The remainder were spread in terms of NHS experience up to 30 years with 20% having been an NHS consultant for more than 30 years.

Post NHS Practice: The majority of appraisees (83%) had left the NHS within the last 15 years.

Independent Sector Practice: 43% of appraisees worked in just one independent hospital whilst 57% worked in more than one hospital (Table 1).

Table 1 - ***The number of hospitals worked in by appraisees (Whole practice)***

Number of Hospitals Worked In	*Number of Appraisees*
One Hospital	**13**
Two Hospitals	**11**
Three Hospitals	**3**
Four Hospitals	**2**
Five Hospitals	**0**
Six Hospitals	**1**

Comment: This is an issue as whilst the majority of consultants work in one or two hospitals there is a substantial minority that work in more. It is apparent that reports from all hospitals were not received during this pilot. The vast majority of consultants working in private hospitals have an NHS appointment and their independent practice may be similarly diffuse. There is a need to reinforce the concept of whole practice appraisal; hospital reports from all areas of work are essential when consultants present for appraisal in either the NHS or private sector.

APPRAISAL TIME FACTORS

Appraisal Interview: The appraisal interview took between 1-2 hours in almost two thirds of appraisals (63%) with just 13 (4 out of 30) taking between 2 and 3 hours and almost one quarter (23%) taking less than an hour.

Total Appraisee Time Spent in Collecting and Collating a Personal Portfolio and for the Appraisal: There was a wide range of time taken in total to complete the whole appraisal process, including the collection and collation of the consultants' portfolios, the completion of documentation and the actual appraisal itself. 5 appraisees (17%) took more than 24 hours in total. On average for the whole group the average time taken was over 10 hours. If those who took more than 24 hours are excluded then the average of the remainder was 7.5 hours.

Views on Time spent in the Appraisal Process: 77% of appraisees reported that preparation time was as expected with the remainder (13%) saying that it took longer than expected. No one thought it was less than expected. 80% thought that the time spent in preparation was appropriate.

Comment: The variation in time may be due to different specialty requirements of the appraisee or to variation in efficiency of data collection.

Appraisers' and Appraisees' Specialty: Just 13 out of the 30 of appraisers (43%) were from the same specialty but the majority were from the same general specialty i.e. surgeon on surgeon (**Appendix 3**).

Comment: This pilot did not determine the need for precise specialty driven appraisals. However, there were no specific complaints from any participants about this.

The Appraisal Venue: Most appraisals were carried out on hospital premises with 3% in a private hospital, 33% in a private consulting room and 13% in a NHS hospital. Of the remaining 3 appraisals 2 were held at the Royal College of Surgeons and one in a Medical Society. No appraisals were conducted remotely e.g. by Skype.

THE APPRAISEES INFORMATION

Appraisee Information Gathering from Hospitals: The majority of appraisees were positive in terms of the ease with which they could obtain their clinical information with 83% overall finding this easy or reasonable.

However, there was considerable variation in the ease with which consultants could obtain work load and other details of performance from individual independent hospitals or hospital groups, with some saying this was easy or very easy, and the remainder saying that this was impossible in the same hospital.

Comment: As noted previously there did not appear to be reports from all hospitals where the appraisees were working.

The FIPO-CAppS Template of Hospital Information: Three-quarters of appraisees (76%) felt that the hospital information about their clinical activity compared reasonably with the FIPO-CAppS suggested template of information required (**Appendix 4**).

Comment: No clear conclusions can be drawn about information from hospitals because of small numbers. The information will be hospital based rather than group based and so will vary in quality and is also specialty dependent with surgical workload more easily quantified than some of the medical specialties. At this stage it is not possible to assess the ease with which suitable hospital reports can be generated from the independent sector and which should include all details of clinical activity, complaints, complications, audits, governance reports etc. It is also evident that the vast majority of consultants will require theses independent hospital reports to complete whole practice appraisal within the NHS.

Pre-Appraisal Discussion with the Appraiser: Only 47% said that there was a pre-appraisal discussion.

Comment: It was disappointing that although instructions were given for a pre-appraisal contact over half the appraisees and appraisers were not in contact before the appraisal.

Information Requests by the Appraiser: Across all heads of information just over a quarter (27%) of respondents required further information as requested by their appraiser before the appraisal. A similar number (30%) needed further information during the course of the appraisal.

APPRAISEES AND THE APPRAISAL PROCESS

Activities Discussed at the Appraisal and the Appraisees' Comments: The degree to which the various components of the appraisal were discussed varied from 67% (clinical governance information provided by the organisation) to 98% (CPD). Although all components of the appraisal should have been discussed in each and every case the appraisees were generally very satisfied that the amount of discussion devoted to the various components of their appraisal was appropriate (average satisfaction rate 94%).

Comment: This could be construed as worrying as each component of the appraisal should have been discussed with 100% compliance in all aspects.

Appraisees' General Views on the Outcome of the Appraisal:

- 83% of appraisees (25 in all) thought their appraisal was well structured; 3% (1 appraisee) disagreed and the remainder (4 appraisees) were neutral.
- 73% agreed (30% strongly) that the PDP was constructive; 1 appraisee strongly disagreed and 20% (6 appraisees) were neutral on this point.
- 90% agreed that the Summary of the appraisal was fair and acceptable.
- 93% of appraisees stated that the appraiser performed well with 1 person strongly disagreeing and 1 neutral.
- A slightly higher score was recorded for the appraisers' objectivity with 97% of appraisees agreeing and 1 neutral on this question.

Comment: The appraisees' general opinion of their appraisers was very high which is encouraging but also raises the possibility that this response is one of politeness or very subjective.

The Impact of the Appraisal Discussion:

- 63% of the appraisees (19) broadly supported the concept that the appraisal gave them a fresh opportunity to review their practice, which they would not otherwise have had, but 27% (8) were neutral on this point whilst 10% (3 appraisees) disagreed.
- 53.3% (16) thought that the appraisal helped them better understand their practice whilst nearly 26.7% (8) were neutral and the remainder 20% (6) disagreed.
- 58.6% (17) agreed that the appraisal would have detected potential harm from the appraisee towards patients with almost a quarter (24.1%) disagreeing (but only 29 appraisees answered this question).

Comment: There is no universal agreement about the value of the appraisal in improving the appraisees' practice or professional approach.

The Appraisal Discussion and the GMC Requirements: Two thirds (20 appraisees) said that the appraisal struck a balance between GMC requirements and developing the doctor's practice. The remainder stated that the appraisal mainly reviewed GMC requirements.

Domains of Good Medical Practice: Appraisees were asked to state how easy it was to provide information to the four GMC Domains and their subheadings and the results are shown in Tables 2, 3, 4, and 5.

TABLE 2 - GMC Domain 1: Knowledge, skills and performance

GMC DOMAIN 1	Very Easy	Reasonable	Difficult	Impossible
Maintain your professional performance	66.7% (20)	23.7% (7)	6.7% (2)	3.3% (1)
Apply knowledge and experience to practice	55.3% (16)	36.7% (11)	6.7% (2)	3.3% (1)
Keep clear, accurate and legible records	56.7% (17)	33.3% (10)	3.3% (1)	6.7% (2)

TABLE 3 - GMC Domain 2: Safety and Quality

GMC DOMAIN 2	Very Easy	Reasonable	Difficult	Impossible
Put into effect systems to protect patients and improve care	53.3% (16)	30.0% (9)	10.0% (3)	6.7% (2)
Respond to risks to safety	53.3% (16)	30.0% (9)	10.0% (3)	6.7% (2)
Protect patients from any risk posed by your health	60.0% (18)	26.7% (8)	6.7% (2)	6.7% (2)

TABLE 4 - GMC Domain 3: Communication, Partnership and Teamwork

GMC DOMAIN 3	Very Easy	Reasonable	Difficult	Impossible
Communicate effectively	73.3% (22)	10.0% (3)	13.3% (4)	3.3% (1)
Work constructively with colleagues and delegate efficiently	63.3% (19)	20.0% (6)	10.0% (3)	6.7% (2)
Establish and maintain partnerships with patients	66.7% (20)	16.7% (5)	13.3% (4)	3.3% (1)

TABLE 5 - GMC Domain 4: Maintaining Trust

GMC DOMAIN 4	Very Easy	Reasonable	Difficult	Impossible
Show respect for patients	60.0% (18)	20.0% (6)	16.7% (5)	3.3% (1)
Treat patients and colleagues fairly and without discrimination	56.7% (17)	23.3% (7)	16.7% (5)	3.3% (1)
Act with honesty and integrity	56.7% (17)	20.0% (6)	13.3% (4)	10.0% (3)

These results have been aggregated in Table 6 for all Four Domains.

TABLE 6 - Aggregated scores for Four Domains and all Questions

Aggregated Scores	Very Easy	Reasonable	Difficult	Impossible
All Four Domains	60%	24%	11%	5%

Overall 60% of appraisees found it very easy to satisfy the four GMC Domains and almost a quarter (24%) found it reasonably easy to do so (84% in total). A small number of appraisees found some of the Domain demands impossible to fulfil.

Comment: The GMC Domains are central to the appraisal. Some are more easily achieved than others. Overall there is general agreement that these measures were easily met in the opinion of 60% of appraisees and reasonably met in a quarter. However, a substantial minority found these difficult to demonstrate or achieve and this suggests more emphasis on these Domains is required as is now happening as part of the "Top-Up Training" for appraisers.

The Appraisees' Overview of the Whole Appraisal Process: 53% thought the benefits of the appraisal were high with another 27% seeing this of average benefit. However, 20% of consultants felt the exercise had medium to low benefits (6 out of 30 consultants).

Comment: This suggests that there remains some scepticism about the benefits of appraisal; it is unclear if this small sample is generally representative.

The FIPO-CAppS Organisation: Two thirds of appraisees thought that the FIPO-CAppS organisation was excellent and one third said it was acceptable.

Comments: Whilst this is encouraging it is explained by the high level of effort required to handle the administrative workloads of this pilot study. Many participants needed constant prompting and advice on the process.

The Appraisers

APPRAISERS' DEMOGRAPHY AND PRACTICE PROFILE

Appraiser Numbers: 30 appraisals were conducted by 25 senior clinical consultants and one in medical management. 4 appraisers did 2 appraisals each. The appraiser numerical results are presented as from the total of 30 appraisals.

Appraisers Age: 83% were below the age of 65 years; the average age was 60 years.

Appraisers NHS Commitment: Just half the appraisers 15 (50%) were currently working in the NHS. Only 14 answered the question of the time since leaving the NHS and 8 had left within the last 5 years, 4 within the last 10 years and 1 over 30 years ago. The average time spent as an NHS consultant was 22 years.

Appraiser Specialty Interests: The 26 appraisers were drawn from a wide range of medical and surgical specialties. There were 6 anaesthetists, 4 gynaecologists, 3 general physicians, 2 dermatologists, 2 orthopaedic surgeons, 2 plastic surgeons, and 1 general surgeon, ophthalmologist, medical manager, cardiologist, ENT surgeon, radiologist and urologist.

As noted previously 40% of appraisers were from the same specialty as the appraisee. However, there was general matching i.e. surgeon to surgeon and physician to physician (**Appendix 3**).

Previous Appraisal Experience: 22 of the 26 appraisers had previous experience of appraising colleagues. All appraisers had attended training sessions organised by FIPO-CAppS prior to this pilot study.

APPRAISERS' TIME FRAME FOR THE APPRAISAL

Appraisers' Time Spent on the Appraisal

- Only 4 out of 30 appraisers (13%) did not spend any time reading the appraisees documentation. In the others the average time spent in reading this was just over one hour.
- 40% of appraisers (12) did not discuss anything with the appraisee before their meeting. In the remainder the time spent was on average half an hour.
- In the appraisers' judgement two thirds of appraisals took 1- 2 hours and around 27% took less than 1 hour. Just 2 out of 30 appraisals took between 2 – 3 hours. On average the appraisal time was about 80 minutes.
- Almost two thirds of appraisers completed the appraisal papers at the appraisal interview. However, 23% of papers were completed after the appraisal mostly in less than 1 hour but in a few cases (4 out of 30) in up to 3 hours.

Comment: There is a slight mismatch in the number of discussions prior to the appraisal when the appraisee and appraiser responses are compared. The numbers of appraisers who completed the documentation after the appraisal was surprising and did lead to some delays.

APPRAISERS' VIEWS ON THE APPRAISAL DOCUMENTATION

Appraisers' Confidence in the Appraisees' Portfolio before and after the Appraisal

- One quarter felt the appraisees' supporting paperwork was more than adequate initially and 45% felt it adequate but the remainder of over one third were neutral or felt this was inadequate.
- Following the appraisal almost 90% of appraisers reported the paperwork as satisfactory. However, 2 appraisers felt otherwise and I appraiser was neutral.

Comment: This raises a question of how the appraisers allowed the appraisal to continue if unhappy with the paperwork. The appraisal should have been stopped but no doubt this was difficult within the pilot but will be an issue for the future training of appraisers.

Appraisers' Review of the Amount of Paperwork produced at the Appraisal

- Overall the appraisers thought that the amount of paperwork was about right.
- CPD, Probity and Health Declarations were all very satisfactory.
- Audits and Complaints were less satisfactory with 20% of appraisers finding these inadequately supported by data.
- Significant Events and Case Reviews were considered inadequately documented by 13% of appraisers.
-

Comment: the Responsible Officers did not always share this generally positive view of the appraisees' documentation.

APPRAISERS' VIEWS ON THE APPRAISAL

Appraisers' Views on the Outcome and Character of the Appraisal

- 90% of appraisers felt that appraisees had made a good assessment of their supporting information.
- The appraisal discussion was felt to add value to the whole process by 90% (27 out of 30 appraisers) with 1 disagreeing and 2 of the appraisers neutral.
- Appraisers had less confidence in identifying ways in which the appraisee could deliver better care with 47% only agreeing (14 appraisers), 33% neutral (10 appraisers) and 20% disagreeing (6 appraisers).
- The Summary of the Discussion was thought to be realistic and acceptable by a large majority of 29 appraisers (97%) with one appraiser neutral.
- The Personal Development Plan was thought less realistic and acceptable than the Summary of the Discussion although a large majority still agreed with this (25 appraisers – 83%) with 5 appraisers neutral.

Comment: The generally favourable view of the Summary and PDP was not reflected in some of the comments from the ROs. It should be noted that none of the appraisers had any concerns about their appraisees that could lead to a need for remediation, restriction of practice or a failure to recommend for revalidation.

Appraisers' analysis of the FIPO-CAppS Documentation and the Procedures of the Appraisal
The FIPO-CAppS documentation met with general approval with 90% of appraisers (27 out of 30) agreeing with their adequacy and 10% (3 appraisers) being either neutral or feeling the documentation and explanations behind this was inadequate.

Comment: The positive reaction by the appraisers is similar to the appraisees.

THE RESPONSIBLE OFFICERS

THE RESPONSIBLE OFFICERS' RECOMMENDATIONS

The Responsible Officers (ROs) were asked three questions on SurveyMonkey.

- The first was to consider what recommendation they would make to the GMC on each of 25 appraisals based on the appraisal summary alone.
- The second was what recommendation the RO's would make based on the full documentation of the appraisal.
- The third question involved each RO evaluating the content and reliability of the documentation supporting various parts of each of the 25 appraisals in order to try and give some quantifiable basis to assess the recommendation being made.

ROs were allowed a freehand entry after each question.

The original codes used by the ROs have been modified and colour coded for ease of presentation and can be seen in **Appendix 2**.

The overall results for each RO showing their recommendations based on the summary and the full documentation are summarised in Tables 7 and 8.

TABLE 7 - RO recommendations to the GMC based on *the appraisal summary alone*

	SUMMARY RECOMMEND	SUMMARY DEFER	SUMMARY FAIL
RO1	23	2	
RO2	15	10	
RO3	19	6	
RO4	22	3	
RO5	14	11	
RO6	13	12	
RO7	7	18	
RO8	13	10	2
Summary Appraisal Totals	**126**	**72**	**2**
% Result on Summary Alone	**63%**	**36%**	**1%**

TABLE 8 - RO recommendations to the GMC based on *all the appraisal documentation*

	FULL RECOMMEND	FULL DEFER	FULL FAIL
RO1	22	3	
RO2	15	10	
RO3	19	6	
RO4	23	1	1
RO5	20	2	3
RO6	19	6	
RO7	13	11	1
RO8	18	5	2
Complete Appraisal Totals	**149**	**44**	**7**
% Result on All Papers	**74.5%**	**22%**	**3.5%**

Overall, based on the summary statement and under the conditions of this pilot study two thirds of the ROs (63%) felt able to make a positive recommendation to the GMC and one third (36%) felt they needed to defer that decision.

Once the full documentation of an appraisal was reviewed (without the supporting portfolio of the appraisees' practice) three quarters of the ROs (74.5%) were able to positively recommend with 22% deferring the decision and in 7 appraisals (3.5%) failing to recommend.

Only seven appraisals were approved by all ROs based on the complete appraisal documentation (A3, A11, A13, A14, A16, A18, A19).

- Five appraisals were approved by all but one RO (A4, A7, A10, A20, A25).
- At the other end of the scale there were two appraisals which received only two RO recommendations (A1, A17).

The failure to recommend a doctor for revalidation carries enormous implications but there were no appraisals where there was a majority of appraisers who were recommending a failure to recommend.

- In five appraisals there was one RO who would definitely not recommend revalidation to the GMC (A1, A8, A15, A17, A21, A22) and one other appraisal (A1) in which two ROs failed to recommend).
- In each of these appraisals there were some positive recommendations by other ROs, (A1 – two positive, A8 – seven positive, A15 – seven positive, A17 – two positive, A21 – four positive, A22 – three positive).

The appraisals that had a failure to recommend are depicted in Table 9.

TABLE 9 – Failure to Recommend on Six Appraisals – the views of all the Responsible Officers

Appraisal All Papers	Appraisal Numbers					
	A1	A8	A15	A17	A21	A22
Will Recommend To GMC	RO1	RO1	RO1	RO1	RO1	RO3
	RO3	RO2	RO2	RO4	RO2	RO4
		RO3	RO3		RO3	RO5
		RO4	RO4		RO4	
		RO6	RO5			
		RO7	RO6			
		RO8	RO7			
Defer Decision for more Information	RO2			RO2	RO5	RO1
	RO6			RO3	RO6	RO2
	RO7			RO6	RO7	RO6
	RO8			RO7		RO8
				RO8		
Will not Recommend To the GMC	RO4	RO5	RO8	RO5	RO8	RO7
	RO5					

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MEASURING THE RESPONSIBLE OFFICERS' PERFORMANCE

The Responsible Officer Performance
The RO final recommendations show considerable variation and this extends across many of the appraisals. In order to further gauge this, the ROs responses were assessed on the SurveyMonkey which asked each RO to evaluate the paperwork of the appraisal. Each RO gave his/her opinion on the content and reliability of different parts of the documentation supporting the appraisal. This question covered the following subsections:

1. **CPD**
2. **Audits and other Data**
3. **Complaints Review**
4. **Significant Events**
5. **The Hospital Information**
6. **Probity**
7. **Health**
8. **The Personal Development Plan (PDP)**
9. **The Appraisal Summary**
10. **Any Other Information Presented**

Each subsection was assessed on a five point scale as follows: **Excellent (5), Very Good (4), Acceptable (3), Poor (2), Unacceptable (1).**

Based on this the maximum score would be 50 for any single appraisal (10 questions, top score 5 per section). Taking an aggregated score for 25 appraisals a maximum score would be 1250. Using this method all eight ROs were assessed and this is shown in Table 10 and graphically in Figure 1. The terms "hawk" and "dove" have been used to describe the ROs but this should NOT be seen as in any way derogatory as some variation must be anticipated in RO responses.

TABLE 10 – The Appraisal Evaluation Scores From Eight Responsible Officers

RO	Score
RO1	601
RO2	566
RO3	621
RO4	700
RO5	636
RO6	551
RO7	577
RO8	677

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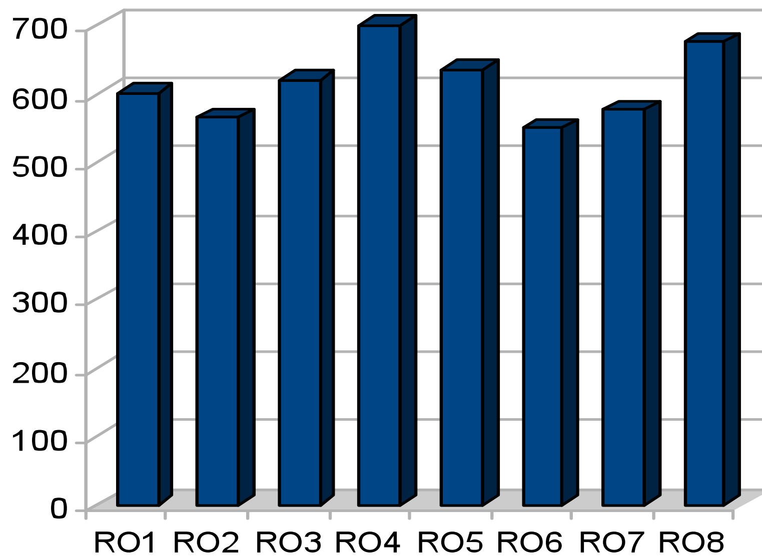
Figure 1 Showing the Responsible Officer Evaluation Scores



The average appraisal evaluation score was 616. Based on this the lowest total score by an RO was 551 (hawk – RO6) with the highest at 700 (dove – RO4).

A comparison between these documentation evaluation scores and the decisions by the ROs to recommend the appraisees based on all the paperwork is shown in Table 11 in which the decision to recommend has been ranked in ascending order. The average of positive recommendations made by the ROs was 18.6.

TABLE 11 – The Appraisal Documentation Evaluation Scores from Eight Responsible Officer compared with their Decision to Recommend

	ALL PAPERS RECOMMEND ASCENDING	ALL PAPERS DEFER DECISION	ALL PAPERS FAIL TO RECOMMEND	EACH RO's PAPER EVALUATION
RO7	13	11	1	557
RO2	15	10		566
RO8	18	5	2	677
RO3	19	6		621
RO6	19	6		551
RO5	20	2	3	636
RO1	22	3		601
RO4	23	1	1	700

- RO4 was the leading dove and made the most positive recommendations on the appraisees in this study. RO4 also had the highest score on the appraisal paper evaluation (i.e. was the most accepting of the documentation).
- RO1 is also a dove with a high number of positive recommendations but had a slightly below average paper evaluation score of 601.
- The most hawkish of the ROs on the appraisal paperwork evaluation was RO6 who nevertheless made about the average number of positive recommendations. However, RO6 made exactly the same decisions to recommend and defer as RO3 (19) who scored much higher on the paper evaluation (621 compared with 551).
- RO7 made the least positive recommendations in this study (13) and also had the second lowest score on the appraisal paperwork evaluation and on the combined assessment would appear to be the most hawkish. RO7 is close behind RO6 on the paperwork evaluation but RO6 made 19 positive recommendations to the GMC as opposed to 13 by RO7 who asked for more information and deferred a decision in 11 appraisals.
- RO2 had a similar record as RO7 in making a positive recommendation on the appraisees and had a similar low paperwork evaluation score. This was consistent with a high deferral rate and the need for more paperwork.
- RO5 failed to recommend the most appraisees (3) but also had an above average paper evaluation score; this apparent inconsistency may be due to the larger number of positive recommendations swamping the poorer paper evaluations of those who were failed in this RO's opinion. RO5 made a clearer decision to pass or fail with few deferred decisions.
- RO8 failed to recommend 2 appraisees, was positive on 18 and still had the second highest paper evaluation score of 677 and this may again mean that the high positive recommendation rate swamped the failed to recommend appraisals on the paperwork evaluation.

Comment: It is the ratio of positive to negative recommendations that the RO makes to the GMC which will determine if he/she is a hawk or a dove but this must be made in the context of comparisons with other ROs using the same case mix of appraisees. A decision to defer the judgement for further information is most reasonable when doubt exists. The evaluation of the appraisal paperwork adds another dimension of assessing the logic and thought processes behind the ROs decision and a combination of these two factors (GMC recommendation and appraisal evaluation) would appear to be a useful method of assessing the fairness and reliability of the ROs decisions'. This will need some refinement, larger numbers and improved electronic techniques to assure this process.

THE APPRAISALS

EVALUATING THE INDIVIDUAL APPRAISALS

The RO evaluation of the appraisal paperwork has a dual function first as a measure of the ROs' hawkishness and but also as a feedback and quality assurance method for the appraisal process and the functions of the appraisers.

In this study the number of appraisals carried out by any individual appraiser was too small to allow any conclusions to be drawn about their actions. In addition, the appraisers were not asked to make exactly the same evaluation of the appraisal documentation.

Using the paper evaluations of all the ROs it has been possible to plot a total score for all the appraisals based on the 10 subsections evaluated. These results have been interpreted as the ROs' comparative review of the overall appraisal documentation in this study. The aggregated scores of each sub-section are shown below in Table 13. In the Part 2 Report of this pilot study the individual results for each appraisal is broken down by the subsections and these can be compared with the general scores from all the appraisals.

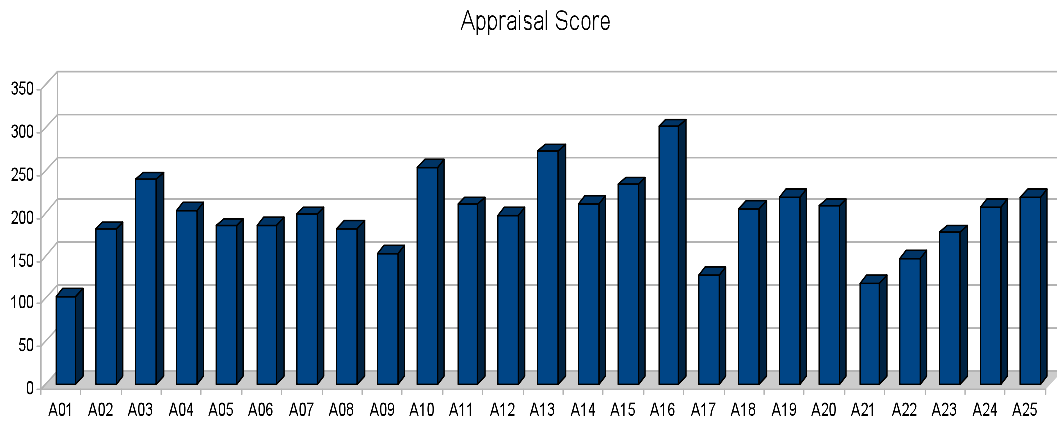
The overall appraisal documentation scores is shown in Tables 12 A and 12 B

Tables 12 A & 12 B – The Appraisal Scores based on the Eight Responsible Officers' Paper Evaluation

Table 12 A – Appraisal Order			Table 12 B – Evaluation Order	
Appraisal Number	RO Paper Evaluation		Appraisal Number	RO Paper Evaluation
A1	102		A1	102
A2	181		A21	118
A3	239		A17	128
A4	203		A15	133
A5	185		A22	147
A6	186		A9	153
A7	198		A23	177
A8	182		A2	181
A9	153		A8	182
A10	254		A5	185
A11	210		A6	186
A12	197		A12	197
A13	272		A7	198
A14	211		A4	203
A15	133		A18	205
A16	301		A24	207
A17	128		A20	208
A18	205		A11	210
A19	219		A14	211
A20	208		A19	219
A21	118		A25	219
A22	147		A3	239
A23	177		A10	254
A24	207		A13	272
A25	219		A16	301

It should be noted that the top score would be 400. The average score here was 193.4 just below 50% of the possible total. These results on the 25 appraisals are shown graphically in Figure 2.

Figure 2 - Showing the Appraisal Scores based on the Eight ROs' Evaluation of the Complete Appraisal Paperwork.



Comment: There are variations in the scores for each appraisal which tie up reasonably closely with the numbers of recommendations or otherwise made by the individual ROs.

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ASSESSING THE APPRAISALS OVERALL

The ROs' evaluation of the appraisal paperwork was aggregated in order to give an overall assessment of the various components of the appraisal. The maximum score is 1,000 (eight ROs, maximum score on any question is 5 and 25 appraisals assessed). The overall average score here is 493.5.

Table 13 shows the questions asked and the overall score given to each response

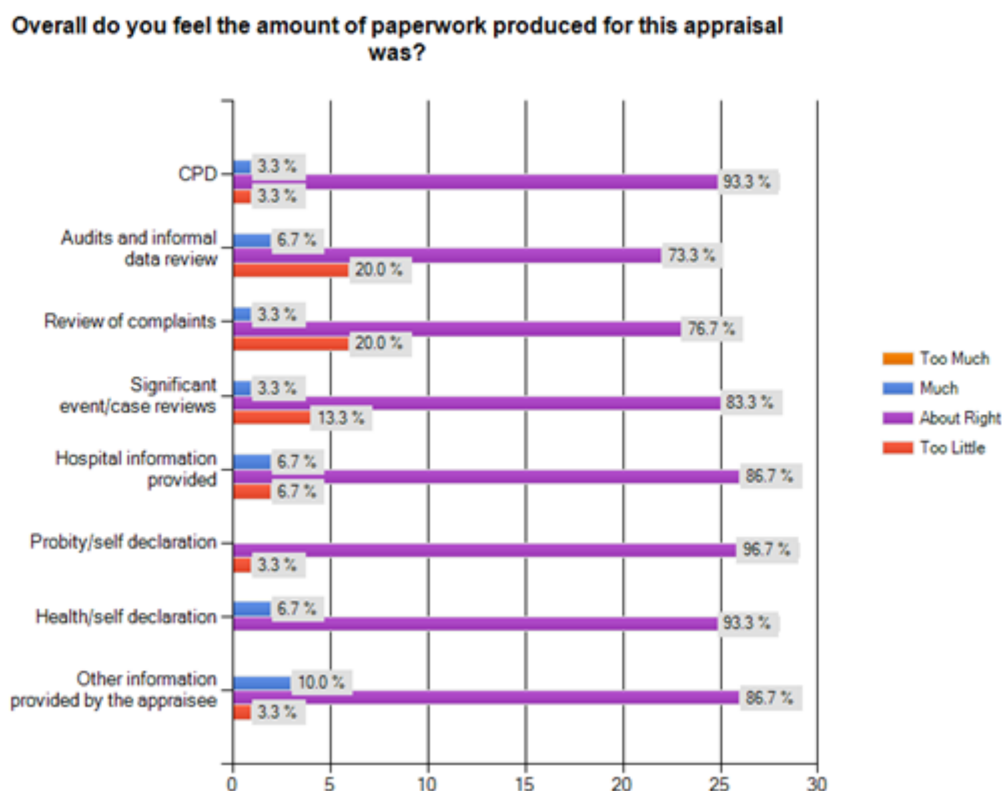
TABLE 13 – The Aggregated 8 RO Evaluation Scores for 25 Appraisals

	Excellent (Score 5)	Very Good (Score 4)	Accept-able (Score 3)	Poor (Score 2)	Unaccept-able (Score 1) Numbers shown	Total Score for the Whole Group	Group Average Score by Section
CPD	45	192	276	62	(10)	585	23.4
Audits and data	25	196	222	76	(7)	526	21
Complaints Review	15	124	225	46	(8)	418	16.7
Significant Events	15	80	159	40	(9)	303	12.1
Hospital Information	20	124	198	58	(7)	407	16.3
Probity	30	132	438	22	(3)	625	25
Health	30	144	429	22	(3)	628	25.1
PDP	50	192	228	84	(12)	566	22.6
Appraisal Summary	35	164	309	78	(8)	594	23.7
Any Other Information	20	104	126	30	(3)	283	11.3
	Group	Overall	Average	Total	Score	197	

Probity and health are clearly easy to establish and there appears to be a reasonable assessment of the Appraisal Summary and the PDP although a very high number of PDP submissions were unacceptable (12 out of 25 appraisals). This means that this low acceptance rate was compensated for by the remaining appraisals with high scores. Significant events were less well-recorded possible because these are less frequent and loosely defined. Audits and complaints are dependent on hospital and consultants input and seem less well documented whereas CPD is perhaps more easily measured and thus recorded a higher score but like the PDP, there was a relatively high rate of unacceptable appraisals (10 out of 25). Hospital information will need upgrading to achieve a higher score.

The overall opinion of the 30 appraisers about the paperwork produced for the appraisal (excluding the PDP and Summary) is shown in Figure 3. It can be seen that the amount of paperwork for most aspects most aspects of the appraisal documentation was deemed just about right with less information on audits and data review and on complaints.

Figure 3 – SurveyMonkey Report on 30 appraisers' Views on the Appraisal Paperwork.



<u>Comment</u>: This overall assessment of the appraisal documentation gives an insight into the relative ease with which the various components of the appraisal were obtained and presented. The numbers here are again small but this methodology would allow different institutions to be externally reviewed and compared. There is clearly a variation in the manner in which some sections of the appraisal documentation was completed with polarisation of acceptability in particular with CPD and the PDP form. This may be reflected by some current confusion about the CPD requirements and also the fact that a clear PDP plan may have been a novel feature to some appraisees. This contrasts with Probity and Health which are relatively easy to confirm. A significant event is a vague topic and would depend on a proportionate system of local clinical governance which would need to define what constitutes "significance". This also raises issues of the consultant awareness of what is recorded on his/her hospital file and whilst it reinforces the FIPO view that appraisers should be aware of local governance procedures and be able to liaise with the governance teams at hospital level, the wider issues of the definitions of a significant event remains unclear and could be open to challenge. Of course it is understood that repeated issues would be brought to the ROs attention before any appraisal or before the 5 yearly GMC recommendation is required.

One other factor here is that the ROs did not see the supporting information from the consultants' portfolio and so any deviation may be due to the appraisers interpretation rather than a defect in the paperwork presented at the appraisal. These figures by the ROs are broadly similar to the appraisers view but the questions for the appraisers have not been recalculated in the same way and their review was of 30 appraisals as opposed 25 for the ROs.

Discussion

This pilot study was conducted in the knowledge that the NHS RST would be publishing a revised MAG and that the Royal College of Physicians and other Royal Colleges have commissioned Equiniti to develop a 360º appraisal as part of an IT based system which will also allow consultants to download and maintain their personal appraisal portfolio. Nevertheless, we felt it was important to test aspects of the appraisal process which are likely to undergo relatively minor changes.

Consultants working exclusively in the independent sector and with practising privileges will report to the RO where they do most work. They will require appraisal services that are robust and which provide ROs with the necessary information to make a suitable recommendation to the GMC. We do not refer here to doctors working in an unmanaged environment and who will report elsewhere. We believe that there are differences between these groups and those doctors working in a managed independent hospital environment where the governance systems are well established and generally very good.

Knowing how many consultants require this service is essential for planning an appropriate level of resource. This number is currently being assessed and is likely to be between 600 and 1,200 and it is vital to know this so as to ensure that sufficient appraisers are in place across the specialties and the UK. These appraisers must be properly trained and supported and that will be an expensive exercise. Ensuring appraisers are indemnified is essential to recruitment.

Independent hospitals generally have good internal governance systems and these must be differentiated from other groups with ROs who work in unmanaged, largely out-patient environments or who deal with specific specialist faculties. We believe that appraisers should be drawn from the same environment and be aware of the hospital governance procedures as they would be when appraising within an NHS Trust. This will ensure an understanding and fairness in the interpretation of data. As an example this study showed that "Significant Events" were the least well presented section of the appraisal in the opinion of the ROs. Whilst this may be due to poor hospital documentation there is also the question of what constitutes a 'significant event'. Experience shows that this will vary between institutions and governance teams and local knowledge and contacts between appraisers and these governance teams or the hospital Medical Advisory Committee would be helpful.

The new appraisal system will require third party administration if the independent sector hospitals do not provide this themselves.

Developing a system that works will require co-operation from independent sector providers (supplying information, developing templates and outcome measures in conjunction with specialist groups), from ROs (defining requirements to allow recommendations to be made on revalidation and developing consistency) appraisers (developing the necessary skills to ensure the appraisal process is robust) and appraisees (ensuring that all necessary information is collected and entered into the system, and managing their personal appraisal).

FIPO-CAppS as a potential supplier would need to recruit, train and support appraisers, provide the necessary administrative support, integrate MSF and develop quality control systems. The cost of the appraisal will be borne by the consultant appraisee and will have to cover the cost of administration, appraiser

training and provision of the necessary infrastructure. This consultant charge is hard to compute at present but this may make little commercial sense to outside bodies unless the cost to the consultant is raised to high levels.

Administratively, the FIPO-CAppS process in the pilot study was onerous and time consuming but worked reasonably well. It would be improved by using the Equiniti or other IT based system, which will be essential for MSF. The paper-based system is awkward and consultants needed constant advice and prompting about the whole process despite detailed written instructions. Legibility of handwriting was also an issue. The IT system should also assist the consultant to collect his/her portfolio and may also assist in the collection and collation of hospital data.

The numbers in this pilot study were relatively small and so statistical conclusions are hard to make and the range of activities of the appraisees was quite wide.

There was a general acceptance and approval of the documentation by both the appraisees and appraisers. This was not necessarily accepted by the ROs. This suggests a need for more education for all participants in the appraisal process.

The ROs reviewed the summary and then the full documentation of the appraisal. They were unaware of the consultant's name or practice which is different to a Medical Director in a NHS Trust who will have direct personal knowledge of the appraisee or what will eventually happen in the independent sector when the process goes live. However, this allowed an impartial view of the appraisal papers.

The fact that ROs were not completely consistent in their approach is unsurprising as this is a new task, and there has, as yet, been little opportunity for bench marking. The challenge is to provide enough information for the RO recommendation to be a meaningful exercise without providing excessive information. The RO may need to ask for additional information and the system needs to accommodate this.

There are inevitably "hawks" and "doves" amongst ROs but this would be anticipated and it is unclear what represents an inappropriate reaction, if any. However, this raises questions about RO consistency and fairness in making recommendations to the GMC. It may be that ROs will need to review all documentation leading to an appraisal but if so this undermines the appraiser's role. MSF was not included in this pilot but this may improve the analysis of results and the confidence of the ROs in making their recommendations to the GMC.

The freehand comments by all parties were illuminating and often contradictory. They do not lend themselves to easy analysis but highlight the major perceptual differences between appraisees, appraisers and ROs.

The FIPO-CAppS pilot has allowed the development of systems of quality assurance that can be refined to future use. These could be applied within and across institutions.

Conclusions

Establishing an appraisal service for consultants working exclusively in the independent sector is essential for revalidation and annual renewal of admitting privileges.

There are a number of impediments to establishing this service, which will require adequate funding from appraisees if it is to be viable. Costs must be realistic and appraisees must understand the complexity of the service they are buying.

There is a considerable range of practice of consultants in the independent sector; they are generally of an older age group than average which may present specific problems.

MSF was not included in this pilot but this may improve the analysis of results and the confidence of the ROs in making their recommendations to the GMC.

Administration of this pilot scheme was time consuming and both appraisees and appraisers often failed to follow careful instructions.

A secure electronic system would improve the administration of appraisal.

The supporting information brought to the appraisal was varied. It would appear that appraisees did not bring all the information from all the hospitals in which they worked to the appraisal. This has wider implications for fully independent and NHS consultants in terms of whole practice appraisal.

The information on work practices and governance issues provided by private hospitals needs amplification. 'Significant events' were the least well documented.

A pre-appraisal discussion needs to be encouraged to ensure that the system works well but only occurred in around half the appraisals in this study.

Mostly the appraisees found this a useful exercise but their contribution to the exercise was varied and in some cases superficial.

Appraisers found the process manageable and the information provided to them generally reliable but there are exceptions that need to be addressed,

The review and detail of the information and its interpretation as entered by the appraisers on the appraisal documents was also varied and often only partly legible. Overall the ROs were more critical than the appraisers.

Appraiser and appraisees were mainly positive about the process and its value but despite this general approval of the appraisal process there is some need for refinement of the documentation. Development of appropriate IT platforms is seen as essential.

The post appraisal electronic surveys can, with some minor modification, be used in future appraisals as a quality control measure on the actual process and a method to measure variation in RO performance.

The RO assessments of the appraisal will encourage the appraisees (and appraisers) who will need to see a demonstrable system of fairness across the board. Feedback to appraisers would be a positive encouragement but whilst this may be done at local level as a routine by individual ROs the system as developed here would require cooperation and cross checking by other ROs to provide external audit and review.

The Part 2 Report on the FIPO-CAppS Pilot Study

A second part of this pilot study is a feedback to all participants and others by request. In Part 2 there is a detailed analysis and comparison of the ROs' recommendations, their evaluations of each appraisal and the freehand comments from both ROs and appraisers on different aspects of the appraisals.

Acknowledgements

This study would not have been possible without the co-operation and support of all who took part. We would like to express our gratitude to all: appraisers, appraisees and ROs plus the administrative support provided by the FIPO office and Linda Hulks and Lenna Cumberbatch in particular.

APPENDICES

APPENDIX 1

FIPO BACKGROUND

The Federation of Independent Practitioner Organisations (FIPO) (www.fipo.org) represents professional independent medical organisations and specialist groups in Britain. It provides guidance, policies and co-ordination to membership organisations, acting on behalf of the profession to advance the cause of independent health care.

More than twenty five professional medical organisations including Royal Colleges, the major specialist associations, the GMC and the Patients Association have endorsed the **FIPO Charter for Patients and their Doctors**, reaffirming their commitment to high-quality patient care. Outlined in the Charter is the ethos that governs each doctor's duties to their patients, the patient's rights and the principles inherent in best medical practice, such as the GP to consultant referral pathway.

FIPO promotes the highest standards of health care provision, which is based on expert consultant advice for best patient care and clinical outcomes monitored through hospital clinical governance and audit. This process will be further enhanced by the advent of revalidation and strengthened medical appraisal. FIPO supports this initiative and through a sub-committee FIPO-CAppS (FIPO Consultant Appraisal Services) will be offering consultants a system of quality assured appraisal. The current Pilot Study is part of the process to test the systems and to improve all aspects of the appraisal process for consultants in the independent sector with practising privileges.

FIPO is supported by the following specialist organisations each of which has one or more representatives on the FIPO Board

Association of Anaesthetists of Great Britain & Ireland
Association of Coloproctology of Great Britain & Ireland
Association of Independent Radiologists
Association of Ophthalmologists
British Association for Surgery of the Knee
British Association of Aesthetic Plastic Surgeons
British Association of Plastic, Reconstructive and Aesthetic Surgeons
British Association of Urological Surgeons
British Elbow and Shoulder Society
British Foot and Ankle Association
British Hip Society
British Orthopaedic Association
British Orthopaedic Foot and Ankle Society
British Orthopaedic Trainees Association
British Society of Gastroenterology
ENT-UK
Group of Anaesthetists in Training
Hospital Consultants and Specialists Association
Independent Doctors' Federation
London Consultants' Association
Society of British Neurological Surgeons
Sussex Association of Consultants

Observers
British Society for Gynaecological Endoscopy
Society of Cardio - Thoracic Surgery
Young Consultants Otolaryngologists Head & Neck Surgeons

APPENDIX 2

THE CODE STRUCTURE FOR ALL PARTICIPANTS

All participants were allocated random numbers in this Pilot in order to preserve anonymity. Appraisees had a numbered appraisal and Responsible Officers had separate codes. For ease of presentation these have been converted in to simpler format. The numerical order has no particular significance. All participants should be able to track their own contribution to this pilot study.

Appraisal Number	Number for SURVEY REPORT
1048	A1
1278	A2
1970	A3
2393	A4
3007	A5
4000	A6
4304	A7
4915	A8
4926	A9
4981	A10
5106	A11
5232	A12
5707	A13
7458	A14
7762	A15
7948	A16
7998	A17
8286	A18
8371	A19
8851	A20
9068	A21
9202	A22
9206	A23
9413	A24
9739	A25

RESPONSIBLE OFFICER ORIGINAL PILOT NUMBER	RESPONSIBLE OFFICER NUMBER FOR SURVEY REPORT
C11	RO1
C17	RO2
C32	RO3
C41	RO4
C45	RO5
C59	RO6
C74	RO7
C88	RO8

APPENDIX 3

THE SPECIALTY INTERESTS OF APPRAISEES AND APPRAISERS

Please note that the order of this list does NOT correspond to the appraisal order as laid out in the results. Those highlighted were not considered by the ROs in this pilot study.

Appraisee Specialty	Appraiser Specialty
Anaesthetics	Anaesthetics
Anaesthetics	Anaesthetics
Anaesthetics	Anaesthetics
Anaesthetics	Anaesthetics
Cardiology	Cardiology
Gastroenterology	General Medicine
General Medicine	Dermatology
General Surgery	Plastic Surgery
Gynaecology	Gynaecology
Gynaecology	Gynaecology
Gynaecology	Ophthalmology
Gynaecology	Gynaecology
Maxillo-facial Surgery	ENT
Orthopaedic Surgery	Orthopaedic Surgery
Orthopaedic Surgery	Orthopaedic Surgery
Medicine/Diabetes	General Medicine
Plastic Surgery	Anaesthetics
Plastic Surgery	Gynaecology
Plastic Surgery	General Surgery
Psychiatry	Medical Management
Psychiatry	Medical Management
Radiology	Radiology
Respiratory Medicine	General Medicine
Urology	Urology
Vascular/Medicolegal	General Surgery
Dermatology	Dermatology
General Surgery	Ophthalmology
General Surgery	Anaesthetics
Orthopaedic Surgery	Plastic Surgery
Orthopaedic Surgery	Plastic Surgery

APPENDIX 4

SUGGESTED HOSPITAL TEMPLATE DOCUMENT
ON CONSULTANT ACTIVITY

Good Clinical Care

	Consultant Data	Peer Group Results where available	Comments e.g. complexity, availability	
Total Admissions				
Total Surgeries				
Unplanned readmissions n (%)				
Unplanned returns to theatre n (%)				
Unplanned transfers out n (%)				
Mortalities n (%)				
Average Length of Stay for index procedure				
Day case conversion rate				
SSI rate – sepsis rate - (tick procedure)				
CABG **Hip replacement** **Knee replacement** **T A Hysterectomy** **Spinal** **Other**				
	% overall compliant	% compliant consent		
Hospital Medical records Audit				
	Total number	Number dismissed	Number upheld	Details attached
Adverse Occurrences Attach reports if indicated				
Medical Advisory Committee Issues Reported				
Limitations on Practice (if applicable)				
GMC issues notified to Provider				

Maintaining Good Medical Practice

Participation in National Audits at this Hospital		Attach evidence of participation
Participation in private provider based CPD (if provided)		

Relationships with Patients

	Total Number	Number Upheld	Details attached
Complaints			
PROMs data (where available)			
Patient Satisfaction Results (where available)			

Working with Colleagues

Details completed upheld complaints relevant to working with colleagues	
Details completed upheld incidents relevant to working with colleagues	

Probity

Copy most recent CRB	
Confirmation by Provider that all required documentation in date	

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