



## Appraisal and revalidation of consultant psychiatrists in the NHS

### A report from the Special Committee on Clinical Governance

'Every consultant being appraised should prepare an appraisal folder. This is a systematically recorded set of all documents: information, evidence and data which will help inform the appraisal process' (NHS appraisal, Department of Health, 2001a). This document goes on to state:

"the appraisal process will not of itself result in the generation of significant amounts of new evidence or information, rather it will capture the information that already exists. What goes into the folder will, for the most part, be available from clinical governance activity, the job planning process and other existing sources. It may also include peer observation and direct comparison with other units. One result of the appraisal process will be to identify gaps to be filled or where perhaps data needs to be better collated or presented. This is likely to be more apparent in the early years after appraisal is launched."

The General Medical Council (2004) has issued guidance on revalidation that will license doctors to practise. The route to revalidation will normally be through the presentation of satisfactory appraisal documentation, whether the doctor works within a managed health care process or not (General Medical Council, 2004). There is general agreement that the revalidation process must link closely to well-conducted and effective appraisal, and this must be good news for consultants in managed organisations in which the process is now well established. The Special Committee on Clinical Governance of the Royal College of Psychiatrists is of the view that a good appraisal should both be developmental and include frank discussion about issues of performance, and that these processes are not mutually exclusive. However, there is also a view that consultant appraisers find it difficult to genuinely challenge practice for improvement when dealing with a consultant colleague. Failure on the profession's part to ensure that both development and performance review are firmly embedded in the appraisal process may jeopardise the future place of appraisal as the main route for successful revalidation.

The new consultant's contract (British Medical Association & Department of Health, 2003) includes a requirement for consultants within National Health Service

(NHS) managed organisations to have participated in and achieved a satisfactory appraisal, and to have participated actively in a formal job planning process; in fact, the contract explicitly links this process to pay progression and consideration for *Clinical Excellence Awards*. The precise relationship between a job planning process and appraisal is as yet unclear, although there is a strong lead from the Department of Health and the British Medical Association that the two processes are separate. Inevitably a formal process of job planning, carried out by a medical manager (British Medical Association Guide, 2004) focusing on service objectives, and the 'job itself' (exactly what the consultant does and some comment on how well he or she does it) will throw into relief the role of 'professional appraisal', a process that will increasingly attempt to identify whether the doctor achieves satisfactory professional standards and keeps up to date. Time will tell whether the two roles diverge or converge. For many medical managers it is difficult to see how one individual will have the time or personal resources to do both a formal appraisal and convene a separate job planning meeting for every consultant within their managerial span, particularly in large Directorates, and delegation of roles seems inevitable. If this proves to be the case then professional appraisal is likely to be increasingly 'devolved' within a health care organisation to suitably trained consultants, while medical managers focus on job planning and service objective setting. Given that annual appraisal is cyclical, and comes around with frightening frequency, it is perhaps an academic discussion as to whether appraisal precedes or follows job planning, although within a given year appraisal possibly more easily follows the job planning process – despite the Department of Health and the British Medical Association suggestion that appraisal should 'inform' job planning (Modernisation Agency, 2003).

This report attempts to identify the data that might be available in mental health services supporting both appraisal and the job planning process, and to give psychiatrists and the services in which they work a steer as to the gaps that might be evident in the early stages of the process. It may also help mental health services to identify information needs to help psychiatrists fulfil the appraisal, revalidation and job planning processes. It is important to recognise that the collation of this data is a developing process, and over time trusts and psychiatrists working in non-NHS settings will need to modify and adapt current data collection, or develop new systems to enable psychiatrists to fulfil these obligations.

The key to a successful appraisal is careful preparation both by the appraiser and appraisee. The only way appraisers can prepare for the appraisal meeting is by having in their possession the relevant data required within the folder in advance of the meeting. Failure to prepare or collate data inevitably leads to an unsatisfactory process. The General Medical Council expects doctors to use the standards set by the medical Royal College representing their specialty as benchmarks in the collection of information for their folders (General Medical Council, 2004). The College report *Good Psychiatric Practice 2000*, is the appropriate reference for psychiatrists (Royal College of Psychiatrists, 2000).

Psychiatrists are also familiar with the preparation of personal development plans through the peer review process, and these plans play an important part in the appraisal process. The plan is both cyclical and developmental, and over time should be seen as an integral and important part of the appraisal process. It is not, and should not be, a 'shopping list' of courses, but a set of achievable personal objectives which fit in with one's individual professional role, the strategy and forward plan of the team or trust, and also take the development and skills of psychiatrist colleagues into account. It is therefore advisable that during an in-year appraisal the appraiser has access to a summary agreement of the previous personal development plan and key issues arising from the process. The Special Committee on Clinical Governance believes that the College's continuing professional development policy advising psychiatrists on how to plan their personal development (as a doctor, as a psychiatrist, as a specialist and specific to the current role) and the Form E accounting for in-year achievement, signed off by the peer group has much to commend it.

The appraisal documentation agreed by the Department of Health in conjunction with the British Medical Association is 'one size fits all', but in practice has proved a good enough template for the appraisal process.

## Good medical practice

### Good medical care

This section covers the questions: how good a consultant am I?, and how well do I perform? It includes professional and personal data, but once this has been successfully completed it probably does not need anything other than occasional updating. Consultants will find it useful to use the electronic version of the form. The format consists of boxes into which personal data are entered, and a number of supplementary questions in the form of a list. Consultants should be encouraged

This report is intended to apply to all areas of the UK, although it is acknowledged that there will be differences in practice in the various jurisdictions.



to enter as much data as possible directly on the form, and to answer questions in narrative also on the form. This makes the task of the appraiser easier and reduces the need to refer constantly to the appended form. Finally, there is a section providing space to list the paper documentation attached. This documentation should be clearly marked according to the section referred to in the appraisal form, for ease of identification.

More recently, a web-based electronic toolkit for appraisal has been developed with the facility to store data, upload documents and keep a running version of appraisal over a number of years. The appraiser can then access this over the web, laying the groundwork for a better appraisal meeting ([www.appraisal.nhs.uk](http://www.appraisal.nhs.uk)).

All consultants will be expected to enclose their agreed job plan, which should outline their weekly timetable of programmed activities (and, for consultants on the old contract, fixed sessions), and helps to answer the question, 'what do I do?'. There are clearly laid out mediation processes for consultants unable to agree a satisfactory job plan with their employers, and although this could be commented on in appraisal, failure to agree the detail should not make it impossible for a consultant to fulfil all the professional requirements for completing an appraisal and thereby being revalidated. The committee is concerned that there will be occasions when consultants will be engaged in a contractual dispute with an employer, and that this should not, in itself, cause difficulties with obtaining a licence to practise. The issues will need to be laid out in the appraisal documentation, bearing in mind that this is a 5-year cycle, and it is unlikely that such a dispute would continue for 5 years. However, it will be for the revalidation panel to decide whether prolonged difficulties of this sort call a standard revalidation process into question. The General Medical Council will undoubtedly have something to say on this matter in the future as the scheme unfolds.

Consultants in all disciplines should be able to give information as to the number of patients under their care, and this can usefully be presented using care programme approach data for many mental health services, and team-based assessment and treatment data for child and adolescent mental health services and addictions services where this approach is not applicable. It is important to note that consultant psychiatrists in the NHS work mostly as members of clinical teams, and the case-load of the team is often not the same as the consultant's personal case-load. Consultants should be able to present detailed data concerning their personal case-load, but perhaps more importantly, describe how this relates to

the rest of the team and to colleagues with similar responsibilities. Consultants can avail themselves of the information that trusts routinely send to the Department of Health, although at present much of these records are aggregated and not useful at an individual team level. However, as services improve their performance management locally, consultants should be involved in the presentation of this information, particularly as it will help the individual consultant to answer the key questions, 'what do I do?' and 'how well do I do it?'

There are a number of explicit questions about audit that the consultant can answer directly on the form. Clearly, audit projects can be attached as separate documentation, but care should be taken not to make the paperwork so cumbersome that the appraiser is defeated by the sheer volume of added material, overlooking the opportunity to discuss key issues.

## Serious untoward incidents

Consultants will need to present data on the number of serious untoward incidents relating to patients under their care. In the case of suicide or homicide the consultant should include the recommendations of any inquiry, and whether any action was consequently required. Data on such incidents should be available for the whole service. Mental health services should be expected to provide each consultant with accurate annual serious and other untoward incident data relating to their area, for inclusion. The committee is of the view that the key issue relating to serious incidents is showing evidence of action taken and lessons learned, and that simply providing raw data of total numbers without context and how those numbers relate to other similar services and the practice of the individual is rather unhelpful.

## Complaints

Consultants could present a local report on the management and record of complaints for the service and team, but as a minimum should include any specific complaints made against them that have resulted in an investigation undertaken by a medical manager or other senior clinician/manager. The outcome of this complaint should be included (the letter from the Chief Executive to the complainant should suffice). Consultants are advised to include clarification within the documentation as to the nature of the complaint in relation to their personal performance, although this could be done by the appraiser as one outcome of the

appraisal process. If no complaint has been received, this fact should be recorded.

## Measures of outcome

All consultants should be able to outline the ways in which their clinical teams are approaching the measurement of clinical outcomes for patients. These developments should include outcome measures that are planned but await the introduction of a patient-based clinical information system, and outcome measures that the team currently employs. Examples of how these measures are collected, collated (if this is possible in local circumstances), and what use is made of the data by the service or clinical team should be included here. The College believes that the reporting of outcomes is an area in need of development and that all consultants should have a key role in the use of outcome data within their teams wherever possible, and that blocks to this process should be outlined within the appraisal process.

## Performance indicators

There is a wide range of new performance indicators which are being reported on locally, and relate directly, or indirectly, to the National Service Framework (Department of Health, 1999) for Mental Health and Modernising the NHS. Consultants should routinely have access to the data being reported to the Department of Health. Trusts should be asked to consider making any centrally provided data available to individual consultants, as well as providing a breakdown of the data by consultant where possible.

Much of the routine clinical data that are required for both appraisal and revalidation should be available for consultants from a robust clinical information system. It is generally difficult for consultants across organisations in all disciplines to access their own individual contact data for presentation at appraisal, and for the appraiser to be able to make sense of this information by having access to comparative data. The College strongly advises trusts and local health commissioning and monitoring bodies (primary care trusts, strategic health authorities and health boards in Scotland) that sufficient resources should be made available to ensure the development of local, fully integrated, patient-based clinical information systems that support the clinical work of the teams at individual practitioner level and are linked with social services and primary care systems, and that access to these systems through a robust and well-resourced information



technology infrastructure is considered by the College a high local priority. The College is concerned that mental health is not considered a high enough priority for local development when in direct competition with the acute trusts and is generally already lagging well behind in the provision of local networks and mental health specific systems. This will significantly handicap psychiatrists in the revalidation process, although the College is aware that many other Colleges feel that their members are equally disadvantaged.

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## Maintaining good medical practice

This section records continuing professional development (CPD) activity. The College policy is detailed in *Good Psychiatric Practice: CPD* (Royal College of Psychiatrists, 2001). The College believes that 20 hours of external CPD and 30 hours of internal CPD, supplemented by 100 hours of reading and other self-directed activity, should be a reasonable annual minimum. The College has decided that the achieving of CPD and the personal development plan should be developed within a peer review process, and be transparent and open to external scrutiny. Consultants should include a personal development plan, copies of their annually submitted Form E and the annual CPD certificate issued by the College for appraisal and revalidation.

All consultants are required to keep paper evidence of external meetings attended (for example, the meeting programme), as each year the College will randomly audit 5% of returns. These papers can usefully be included in the annual appraisal folder. All section 12 approved doctors (section 20 in Scotland) should include information about the current status of their section 12 (20) training, the approximate number of sections completed in the year, and any difficulties or complaints received through the Mental Health Act Tribunal office or the Mental Health Act managers, and action taken as a result. There is no explicit indication within the generic paperwork to include this important information.

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## Working relationships with colleagues

Consultants will include here evidence of satisfactory working relationships with colleagues from all disciplines. Examples of this will include documentary evidence of any team-based peer review process with another team with direct

participation, evidence by questionnaire of good relationships with referrers, particularly in primary care, and members of the immediate (and extended) clinical team. The College is currently supporting the development of a questionnaire to enable individual clinicians to participate in a full 360-degree appraisal process. The questionnaire is currently undergoing field testing and if adopted could provide a useful means by which consultants could demonstrate the perception of their practice by colleagues, subordinates and managers. In the interim, the appraisal folder can provide examples of good working relationships with colleagues, chairing committees that require consensus and colleague support required in this section. Alternatively, if consultants already have access to a 360-degree appraisal tool the College would recommend its use.

In the rare case of professional conflict developing and management action being required, the outcome of the management action should be included in the appraisal and revalidation portfolio.

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## Relations with patients and carers

There are various ways in which consultants can demonstrate their relationships with patients and carers, including a description of the ways in which the team engages patients in the service, patient satisfaction questionnaires that enquire about relationships and satisfaction with the medical staff, results of peer reviews that include assessment of patient outcomes (user-commissioned surveys can be especially helpful here), and changes to services and practice to improve the patient experience. Consultants should also refer to the complaints section for any actions undertaken to improve the patient experience as a result of a complaint. Carer surveys and assessment of carers' experience are usually somewhat underdeveloped but could provide useful data, as could organisations demonstrating active patient or service user involvement.

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## Teaching and training

This section provides an opportunity to summarise all teaching and training activities, but the consultant should also include examples of feedback from teaching. Supervision of trainees can be mentioned, with any written feedback from the tutor of the training scheme providing corroborative evidence of effectiveness as a trainer. Research and

other supervisory activities should be included in this section.

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## Health and probity

The section on health and probity should include concerns raised about health problems that directly relate to performance (a useful question is 'has there been any health problem that has resulted in the consultant having had to change his or her clinical practice in any way?') and issues of probity when action has been taken. With the need for increased transparency and declaration of conflicts of interest, this section could provide a useful opportunity to list significant pharmaceutical company sponsorships (for example, attendance at international conferences).

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## Management activity

This section provides an opportunity to outline all formal management commitments change and service development projects. Independent corroboration of services can usefully be included, including Commission for Health Audit and Inspection reports where directly involved in management. The consultant can also include leadership roles and committee chairs.

For clinical academics, the Follett report (Follett, 2001) outlines a joint appraisal process whereby all clinical academics are required to have a single appraisal meeting that will be conducted jointly between the consultant academic, the NHS and the academic institution. Apart from a brief introduction in the research section, there is no substantial difference between the NHS and the clinical academic forms. A helpful guide accompanies the clinical/academic paperwork that consultants are advised to read. It highlights the importance of preparation and giving time to the appraisers to read and digest the information before the appraisal meeting takes place. All Follett-type appraisals must be conducted by two appraisers together with the academic. This imposes logistical problems from the outset, but it is important that the two appraisers have an opportunity for discussion before the meeting commences, to establish any areas of mutual concern, and to identify what the representatives of each organisation will bring to, and expect from, the appraisal process.

Many consultants are in their second or third cycle of appraisal. Early feedback suggests that although many consultants find the process excessively bureaucratic and cumbersome, equally as many appreciate the opportunity to take stock



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of what they do and how well they do it, and compare it over a number of years. It is now essential for NHS trusts to improve the provision of easily accessible data for consultants to assist in the appraisal process, and to support consultants in receiving training to take on professional appraisal roles. It is also up to us, as consultants, to make the appraisal process worth all the effort.

The Special Committee on Clinical Governance is keen to hear from non-consultant career grade psychiatrists and their experience of appraisal, and will be working with other College committees on the route to revalidation and the appraisal process for psychiatrists in training and psychiatrists wholly in the independent sector.

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