Medical Appraisal Scotland

NHS Education for Scotland

Guidance on completing Appraisal Form 4

This document is designed to help Medical Appraisers in Scotland complete an Appraisal Form 4 for their Appraisees to a standard that meets the needs of the Responsible Officer and the requirements of the GMC.

The guidance will review the purpose of Form 4 and how to complete a Form 4 effectively and clearly. For detailed technical information on how to complete Form 4 on SOAR, please refer to the SOAR User Guides on the Medical Appraisal Scotland website: http://www.appraisal.nes.scot.nhs.uk/resources/soar.aspx

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Introduction

What is the purpose of Form 4?

The Form 4 has a pivotal role in the appraisal process. It provides proof that the appraisal has taken place and can be used by Appraisal Leads to quality assure and review the performance of Appraisers. Crucially, it enables the Responsible Officer (RO) to review the Appraisees' appraisal history, helping them make an informed Revalidation decision.

Given the significance and importance of Form 4, Appraisers need to put as much effort into drafting the form as preparing for, and undertaking, the appraisal interview itself.

Appraisal is designed to enable the doctor to consider all aspects of their work; to reflect on their achievements, performance and learning for the past year, and to think ahead for next year. These discussions are summarised on Form 4, and they need to be accurate, comprehensive, and clear.

Appraisers need to address (rather than merely "touch upon") all the core elements within the 4 Domains of Revalidation in the appraisal interview and the corresponding Form 4. The Form 4 should record all the key areas discussed at the interview. The Appraiser and the Appraisee will have spent considerable time and effort in preparing for, and undertaking, the appraisal interview. Form 4 needs to reflect this commitment. It can be de-motivating for the Appraisee and make the task of the RO difficult if the Form 4 is completed in a minimalist fashion, omitting description of key areas, issues and outcomes discussed and agreed at the appraisal.

Appraisals are PROFESSIONAL interviews, which must be robust and evidenced by supporting information. Even if the Appraisee is sceptical or lukewarm about the process, Appraisal is **NOT** a tick box exercise, and **IS** a contractual obligation.

Access

Appraisal Forms 1-3 submitted by the Appraisee are confidential and should only be viewed by their Appraiser. No one else will have access to this information, including the RO, unless the Appraisee gives their consent for this information to be shared.

Appraisal Form 4 can be accessed by you, your Appraisee, your local Appraisal Lead and the RO. Future Appraisers can review the previous Form 4 so they can refer to it to inform a forthcoming appraisal. The Appraisee can also download a PDF of the Form 4 to forward it to other organisations that need to be satisfied the Appraisee has had an appraisal.

Consequences

A Form 4 where the Appraiser makes only brief or minimalist comments, or does not refer to the supporting information submitted by the Appraisee, is of very little value.

A poorly drafted Form 4 **CAN** impact your Appraisee's ability to work. As discussed, the RO will utilise it in making recommendations for Revalidation. Additionally if your Appraisee moves to work in another Health Board area or outwith Scotland, their new employer may require proof of their appraisal. If they provide an inadequate Form 4 this could be rejected as not fit for purpose, impacting on the doctor's continuing employment.

Make sure the Form 4 accurately reflects the appraisal discussion.

Form 4 protocols

- Form 4 should be completed on SOAR
- It is the Appraiser's responsibility to draft and complete the Form 4
- Form 4 must be signed off by both Appraiser and Appraisee before the appraisal is considered "complete"
- It should be drafted as soon as possible following the Appraisal

Prompt completion of Form 4s ensures better recall of the appraisal discussion by both Appraisee and Appraiser, and fewer amendments or rejections.

Good Practice

An effective Form 4 should be:

1) Legible
2) Specific
3) Objective
4) Comprehensive
5) Avoids Assumptions
6) Avoids Collusion
7) Charts Achievements
8) Records any significant difficulties experienced

Legible

Make it readable - use punctuation, bullet points, text formatting, etc, and make **meaningful statements**. Avoid abbreviations and jargon.

Specific

Avoid bland comments, such as "Fine", "OK", "More of the same", etc. It needs to be specific to the Appraisee and it needs to accurately reflect the discussion.

Objective

Your summary needs to be relevant, factually correct, evidence based (referencing submitted supporting info), and it needs to highlight any significant omissions and supporting info needed for the next year's appraisal.

Where possible, try and use positive language.

Comprehensive

While there is no need to list every single piece of information, each section should have a concise summary of that part of the appraisal interview. Record observations and conclusions arising from the discussion with reference to supporting information.

It is helpful to summarise the methods and categories of CPD e.g. "50 online modules, 10 clinical meetings," prioritising those which have made the greatest impact on practice, and highlighting key learning points and evidence of implementation of the learning and impact on patient care.

This detail can be used for future reference as an aide memoir or benchmark for measuring progress towards agreed goals. This is vital when there is a change of Appraiser. Remember, you do not need to record a transcript of your discussion!

Avoid Assumptions

✗ *Dr Smith appears to have a healthy life style and obviously has no health issues.*
This is an opinion with no evidence to support it.

✓ *Dr Smith described his life style as healthy and stated that he had no health issues that would impact on his practice.*
No assumptions have been made and this is based on statements made by the Appraisee.

✗ *Dr Jones has a very heavy and difficult workload and I raised my concerns about burn-out.*

✓ *Dr Jones has a challenging workload which she enjoys and finds fulfilling and stimulating.*

Avoid Collusion

✗ *As a single handed practitioner, Dr Cameron's isolation limits his ability to get feedback on his performance*

✓ *We discussed Dr Cameron's view that being single handed affected his ability to get feedback on his practice and how this could be addressed.*

The appraisal process may be flawed by making assumptions or colluding with the Appraisee. These issues can arise in all aspects of the appraisal process, for example, by accepting without question an Appraisee's reassurance that their CPD was appropriate, but without any corresponding reference to resultant impact or development of their practice.

Appraisers may be particularly tempted to rescue and collude with an Appraisee when discussing sensitive areas such as complaints, critical incidents, health or negative feedback.

Achievements

Use **positive language** to describe what the Appraisee enjoys doing, and their feelings about what has been **achieved**. Avoid using words or phrases that are ambiguous.

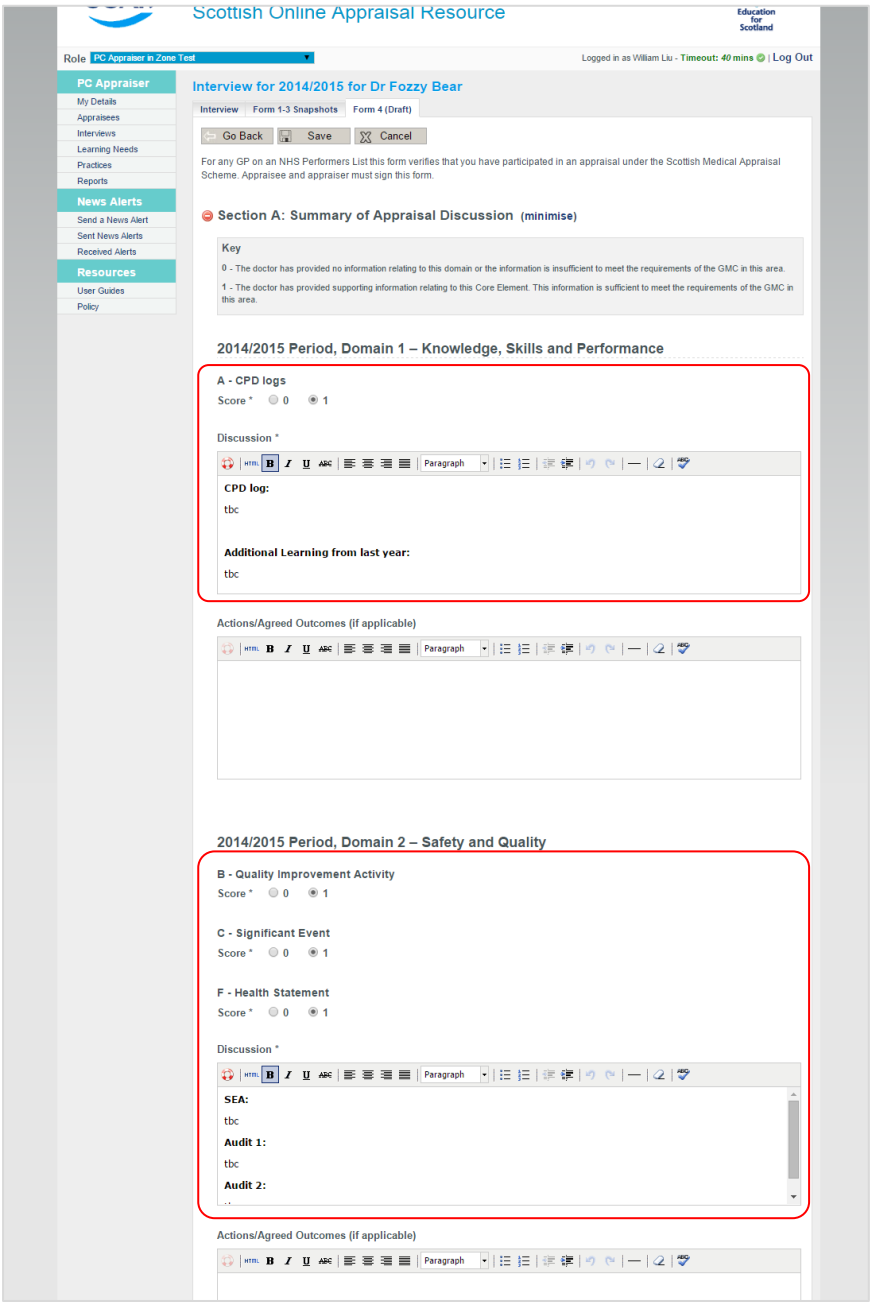
Integrity

You must be satisfied that the Form 4 drafted is an accurate reflection of the key areas addressed and discussed at the interview, and that you have not colluded with the Appraisee.

The integrity as well as the professionalism, empathy, sensitivity, competence and technical skills of Appraisers make the role both challenging and rewarding. Appraisers have a duty to their colleagues to facilitate an appraisal process which is robust, consistent, fair and objective and for the record of the interview to accurately summarise the main areas covered in the appraisal meeting.

Time management

It can pay dividends to prepare a draft Form 4 in advance of the appraisal meeting, leaving space to add **key points** arising from **Discussion** and **Agreed actions** following the interview.



Unacceptable Summary Form

Whilst perhaps easier to describe 'best' practice, it is also possible to highlight pitfalls and examples of things to avoid.

Example of unacceptable GP Form 4:

Summary of Appraisal Discussion		
Domain 1: Knowledge, Skills and Performance		A – CPD logs: 1
Discussion:	Dr Staples' work has changed little over the past year. All's well. PDP largely completed for last year. Apparently attended several lectures in the year.	
Actions / Agreed Outcomes:	Keep it up, if time allows	
Domain 2: Safety and Quality		B – Quality Improvement Activity: 1 C – Review of Significant Event: 1 F – Health Statement: 1
Discussion:	Dr Staples submitted an SEA, it seemed fine. Hasn't needed a doctor in 20 years and previous GP retired but in good health.	
Actions / Agreed Outcomes:	Health not an issue	
Domain 3: Communications, Partnership and Teamwork		D – MSF: 0 D – Patient Surveys: 0 E – Complaints/Critical Incidents Statement: 1
Discussion:	Single-handed practitioner therefore feedback from colleagues not available. Thinks will struggle with MSF. Good rapport with patients reported by the GP. No complaints – popular with patients, clinics always full.	
Actions / Agreed Outcomes:	Keep a record of disciplinary matters relating to the practice staff	
Domain 4: Maintaining Trust		G – Probity: 1
Discussion:	No partnership agreement needed. Practice manager is responsible for the accounts.	
Actions / Agreed Outcomes:	Get feedback from the staff to confirm probity.	

Why is this unacceptable?

The summary lacks detail and is vague and ambiguous.

Appraisal is meant to be free of bias and prejudice and non judgemental. The phrase "apparently attended" (in Domain 1) may imply that there is some doubt about the truth of this assertion. Might this both lack detail and represent prejudice?

There is no record of any achievements. It would be unusual to find no areas of progress or consolidation of good practice.

There is no indication of developmental progress being discussed, or that any changes in the doctor's practice have occurred following the lectures attended.

Neither the tone nor the content of the summary indicate that the doctor is being encouraged to develop. Suggesting that the Appraisee keep up their professional development "if time allows" not only fails to encourage, but seems to indicate that maintaining good medical practice is optional.

The summary suggests that no evidence of attending lectures was supplied. Where supporting information is quoted, its validity may be suspect. For example, the "good rapport" that the GP has with patients is based on self-reporting.

The Appraiser also failed to take the opportunity to document the need to collect **recommended** supporting material.

Some comments fail to show understanding of the issues raised. For example, simply stating that single-handed practitioners 'may struggle' to obtain feedback from colleagues (in Domain 3) overlooks the feedback that could be obtained from the larger team and from colleagues in Secondary Care. Likewise, suggesting "Health is not an issue" (Domain 2) can result in a missed opportunity to encourage the Appraisee to be proactive in maintaining their health.

Where the collection of supporting info is suggested by the Appraiser (e.g. "get feedback from the staff to confirm probity") the recommendation may be unrealistic and inappropriate.

The action points appear feasible, but they either require no action or are set at a very low level of challenge.

The Appraisee has to agree to the content's accuracy by co-signing the summary. This summary contains very little information - if you were the Appraisee, would *you* sign it? If you were the RO, would you be willing to make a revalidation recommendation based on a Form 4 like this?

Example of unacceptable Secondary Care Form 4:

Summary of Appraisal Discussion		
Domain 1: Knowledge, Skills and Performance		A – CPD logs: 1
Discussion:	No issues, satisfactory performance. Seen CPD log and a couple of attendance certs	
Actions / Agreed Outcomes:	None needed	
Domain 2: Safety and Quality		B – Quality Improvement Activity: 1 C – Review of Significant Event: 1 F – Health Statement: 1
Discussion:	Mr Bobson submitted an audit, looks fine	
Actions / Agreed Outcomes:	No issues	

Domain 3: Communications, Partnership and Teamwork		D – MSF: 0 D – Patient Surveys: 0 E – Complaints/Critical Incidents Statement: 1
Discussion:	Good feedback received in MSF, should be ok for revalidation now. One complaint discussed – nuisance complaint (ex-wife of former clinical manager), nothing serious	
Actions / Agreed Outcomes:	None identified.	
Domain 4: Maintaining Trust		G – Probity: 1
Discussion:	Completed Probity statement – no issues	
Actions / Agreed Outcomes:	none	

Why is this unacceptable?

As with the unacceptable GP Form 4 example, the Appraiser has demonstrated a degree of possible prejudice or lack of attention to detail in this appraisal. The comment "looks fine" in Domain 2 in reference to the audit suggests a level of uncertainty. There is also a lack of context and reflection offered. **Appraisal is meant to be a reflective process.** This Form 4 shows no indication of the Appraisee's reflection on his supporting info.

The Appraiser has noted a discussion was had over a complaint (Domain 3), but offered no content or context to the complaint itself, and did not record the Appraisee's reflection on the complaint. "Nothing serious" and "Nuisance complaint" are very dismissive and judgemental comments that the Appraiser should not be making. Critically, patient confidentiality was broken when the Appraiser disclosed who the complainant was – this is unacceptable. Appraisers should describe the complaint and provide some background, but patient identifiable information should never be disclosed.

The comment "should be ok for revalidation" (Domain 3) is an assumption and appears collusive. It suggests that Revalidation is a tick box exercise requiring little effort. Remember, a key objective of Revalidation is to give patients greater confidence in their doctors by demonstrating they are actively keeping up to date and maintaining their skills and knowledge.

In general the summary is too short, and although it referenced some supporting information the Appraisee had provided, it is not comprehensive enough. In Domain 1, the Appraiser mentions the Appraisee had submitted an audit – what was it about? How can the RO be assured that the audit is relevant to the Appraisee's clinical work and what did it show?

Let's look at some better examples of Form 4.

Acceptable Form 4

Below are two examples of an acceptable Form 4.

Example of acceptable GP Form 4

Summary of Appraisal Discussion	
Domain 1: Knowledge, Skills and Performance	A – CPD logs: 1
Discussion:	Dr McArthur submitted his CPD log, detailing learning activities undertaken and last year's and this year's PDP. He also submitted a record of work undertaken in reviewing referrals using a follow-up questionnaire sent to colleagues to whom referrals had been made. Also submitted was a review of feedback from colleagues using the multi-source feedback tool on SOAR; and a record of one complaint and thank you letters from patients. A copy of the Practice's complaints procedure was also submitted. We discussed Dr McArthur's PDP for the last year. He had identified three areas including lipid treatment guidelines and hypertension management. Two of the three topics Dr McArthur had successfully addressed, but time constraints prevented him from addressing the third. Dr McArthur described how his treatment of CHD patients had changed as a result of his PDP including prescribing antihypertensives and cholesterol lowering drugs and the importance of discussing diet with such patients. He was able to demonstrate change as a protocol had been drawn up for the practice nurses who saw most of the CHD patients to address these issues. Dr McArthur enclosed a copy of the protocol with his appraisal submission. This was based on local and national guidelines. We discussed whether it would be useful to audit this in the future. Dr McArthur's preferred learning style is attending courses, using the internet (PRODIGY is a favourite site) and completing online training modules. Dr McArthur also included a calendar of the various meetings – formal and informal / clinical and non clinical – that the practice holds and which he attends whenever possible. He also described the benefits on his own education of participating in training the Practice's Registrar.
Actions / Agreed Outcomes:	We discussed Dr McArthur's PDP for this coming year which looked at 3 areas: • The management of chronic back pain • The management of diabetes • Time management and organisation After discussion these broad areas were narrowed down to: • Dr McArthur will consult with his colleague at the back pain clinic and take advice about what more he could do to

	manage patients with this problem. He will also undertake an online module on the topic. • Update on diabetes management. Dr McArthur takes the lead in his practice on this issue and runs a diabetes clinic. However, he has identified this as an area where he needs to do something to keep up-to-date. He has decided to identify his specific educational needs opportunistically, through using a PUNS & DENS log. The use of on-line learning modules that offer a before and after score was also discussed as a means of clarifying any gaps in his knowledge. • Time Management and Organisation – Dr McArthur will research providers of courses about this topic. He believes colleagues in his practice and nearby practices might also benefit from a course focussed on the needs of GPs in relation to this area. He is hoping that if there is enough interest, his practice may be able to host a session on this topic during Protected Learning Time (PLT).
Domain 2: Safety and Quality	B – Quality Improvement Activity: 1 C – Review of Significant Event: 1 F – Health Statement: 1
Discussion:	(Please also see discussion of SEA in Domain 3) We discussed that last year the practice had achieved an overall high QOF score and that the practice seemed to be on track this year to achieve a similar result. Dr McArthur chose to do MSF this year (ahead of his revalidation next year) – and as his QIA for Domain 2. The review of returned questionnaires from medical colleagues revealed that the vast majority of referrals Dr McArthur made were deemed to be 'appropriate' and 'timely' by colleagues. However, the feedback from a colleague managing a clinic, for those with chronic back pain, suggested that Dr McArthur could do more for patients himself before making a referral. The feedback from colleagues using the MSF questionnaire was also positive. Dr McArthur had already reviewed this feedback with the support of a colleague in a neighbouring practice. Generally the feedback was extremely positive with respondents commenting on his excellent communication skills and warm and supportive manner with patients. However, a number of colleagues described Dr McArthur as being 'poor' at time management and 'organising his work'. Dr McArthur had initially felt annoyed by these comments but on reflection he could see that there is some basis for them.
Actions / Agreed Outcomes:	Dr McArthur intends to consult with his colleague further about this and plans to undertake a course on the topic of back pain in the coming year. Dr McArthur has decided to put "improved time management and work organisation" into his PDP for the year ahead.

Domain 3: Communications, Partnership and Teamwork	D – MSF: 1 D – Patient Surveys: 1 E – Complaints/Critical Incidents Statement: 1
Discussion:	Please see summary in Domain 2 for MSF discussions. i) Dr McArthur had produced a number of thank you cards and notes from patients which were very appreciative. ii) Dr McArthur is very aware of the Practice's complaints system and the role of the Practice Manager in dealing with complaints. There had been one complaint from a patient in relation to a referral letter which for some reason (not known) was not made. The referral was for a physiotherapy appointment. It was not a mistake which could have caused harm, but it had embarrassed Dr McArthur and we focussed on his feelings about this, including ways of dealing with them. Dr McArthur described the different methods he used for producing referral letters – some hand written, some dictated - and the new procedure he had introduced to ensure there was no repetition of this mistake. iii) Dr McArthur's score in the annual patient survey was good and the Practice overall scored the same or higher than the Health Board's average, except in one area, which we discussed. The Practice had met and discussed the issues raised by the survey with a patient representative. iv) The doctors meet in a variety of settings. There is a Partnership meeting once a week, and at lunch times the Partners discuss business matters. There are regular educational meetings (a calendar of these was supplied) and the Partners meet over coffee once a week to discuss clinical issues. There are opportunities for the attached staff to attend these meetings; some take advantage of these invitations.
Actions / Agreed Outcomes:	i) Dr McArthur will write up the missed referral as an SEA. This would objectify the issue and perhaps neutralise it and could be a relevant exercise as the omission had implications for the practice as a whole ii) No other outcome was deemed necessary from the patient survey iii) Dr McArthur would like to have more contact with colleagues working in neighbouring practices and sees hosting joint development events as one way of taking this forward
Domain 4: Maintaining Trust	G – Probity: 1
Discussion:	Dr McArthur acknowledged that he was aware of the GMC guidelines on probity. We discussed the importance of a sound and comprehensive partnership agreement and Dr McArthur showed me

	the protocol the Practice uses to safeguard patients' interests in relation to one of his Partner's research activities.
Actions / Agreed Outcomes:	With the Practice Manager, Dr McArthur will review the current partnership agreement and bring suggestions for change to a Partnership meeting in one month's time, with a view to asking the Practice's solicitor to redraft a new agreement within 3 months.

Why is this acceptable?

Overall this Form 4 is very comprehensive and detailed. All the comments are based on the supporting information submitted, which were all referenced appropriately.

In the summary, the Appraisee had expressed initial scepticism about the negative MSF comments, but was able to reflect on this and change his attitude. As you can imagine, this would have required the Appraiser's skill and patience to turn the discussion around. How much of that discussion should have been detailed? "*Dr McArthur had initially felt annoyed by these comments but on reflection he could see that there is some basis for them*" – we are generally not looking for anything more detailed than this. Remember, the Form 4 is about the Appraisee, not how good the Appraiser was.

The summary described and provided context to the supporting information, and the Appraisee's reflections on them. Equally important is the Agreed Outcomes, which demonstrates a degree of reflection by the Appraisee, and it will also aid him to focus on development in the year ahead.

Example of acceptable Secondary Care Form 4

Summary of Appraisal Discussion	
Domain 1: Knowledge, Skills and Performance	A – CPD logs: 1
Discussion:	Dr McRae has been working as a Consultant ENT surgeon in Fife Health Board since 2006; she is also the Associate Medical Director for Division of Surgery for the past 2 years; as well as Honorary Clinical Senior Lecturer since 2010. Dr McRae is on-call for acute receiving (for around 8 weeks a year) covering the ENT surgery unit in St Wallace hospital. Dr McRae also has various regional and national roles including Regional Advisory Group, Scottish ENT Executive Committee, and National Advisory Panel. Dr McRae is also a GMC trainer (since 2008), and a new NES trained Appraiser (with 8 Appraisees allocated). Dr McRae provided a CPD summary (as well as a detailed log of activities). Dr McRae completed 87 hours of learning, which exceeds the requirements of her College CPD scheme. This was made up of clinical and non-clinical learning, as well as personal learning. Dr McRae attended 5x conferences this past year, where she also spoke and facilitated at three of them. Her CPD also included updates on general medical topics, such as diabetes and respiratory disease, as

	well as non-clinical topics, such as patient safety – relevant to her non-clinical roles. Dr McRae meets the requirements for CPD and has focused her PDP over the last year to cover all her roles – including as a teacher and clinical director.
Actions / Agreed Outcomes:	Dr McRae to remain up-to-date with her college CPD recommendations. Also agreed to incorporate into the PDP her participation in the local and national groups; as well as roles as GMC Trainer, clinical director and NES Appraiser.
Domain 2: Safety and Quality	B – Quality Improvement Activity: 1 C – Review of Significant Event: 1 F – Health Statement: 1
Discussion:	Dr McRae is actively involved in research (in telemedicine) as she is a supervisor of a clinical fellow pursuing a MD by research. Dr McRae has published a number of articles in peer reviewed journals over the last year as co-author including "Head and neck cancer assessment by flexible endoscopy and telemedicine"; "INR devices – an automated future"; and "Remote Diagnosis, an inter island project". Dr McRae also submitted transcripts of talks at two of the conferences she spoke at. Other QIA contributions included reflection on her new responsibility with the regional and national advisory groups. Dr McRae also submitted an audit, along with her reflections, on assessing the effectiveness of medical or surgical treatment in patients with sino-nasal disease who presented to the ENT outpatient clinics. Dr McRae reflected on how the audit has highlighted some simple methods to improve communication (such as including SNOT scores on patient letters); and also how to improve the audit itself if it was repeated in the future. Dr McRae also submitted an SEA, where a patient had died after the patient's guardian refused medical advice and discharged the patient. The incident was reported in the local news. However, following an internal investigation, Dr McRae and her team were found to have acted appropriately and in accordance with local policy. Dr McRae was involved in a motorcycle accident last year which resulted in her being off work for 8 weeks. We discussed the circumstances and the impact on her work and lifestyle. Dr McRae has since sold her motorcycle and bought a car. Dr McRae has a full and varied workload which she enjoys and finds fulfilling and stimulating.
Actions / Agreed Outcomes:	Dr McRae agrees to discuss the possibility of repeating the SNOT audit in her team before the next appraisal. She has also agreed to liaise with the other islands to trial the

	telemedicine approach detailed in her research paper. Dr McRae will also look to develop a common pathway approach to ENT care in the remote islands.
Domain 3: Communications, Partnership and Teamwork	D – MSF: 1 D – Patient Surveys: 1 E – Complaints/Critical Incidents Statement: 1
Discussion:	Dr McRae has received no formal complaints since her last appraisal. We discussed an informal complaint from a patient on waiting time in the ENT clinic. Although it was an off-the-cuff comment by the patient, Dr McRae took it upon herself to investigate. This revealed the patient simply arrived early that day. Dr McRae completed her clinical MSF via SOAR, and is in the process of finalising her Leadership 360 for her non-clinical roles. For the clinical MSF, the report provided favourable feedback for Dr McRae, averaging around 5 and 5.5 (max 6). Dr McRae has rated herself slightly lower in all areas and we discussed her reflections on this exercise. Dr McRae also completed Patient Survey from 52 patients. Feedback was good to excellent on all areas and all comments (31) were very positive and complimentary. During our discussions, it was noted that with the Patient Surveys there was a lack of benchmark scores for comparison. Although Dr McRae did acknowledge the positive comments received.
Actions / Agreed Outcomes:	Agreed to meet with Dr McRae in a few months to discuss her Leadership 360 report. This is to be submitted for next year's appraisal.
Domain 4: Maintaining Trust	G – Probity: 1
Discussion:	Dr McRae completed the mandatory Equality and Diversity training last year. We also discussed the ethical issues around research in the submitted material, as well as her involvement with the regional and national groups – no probity issues were raised.
Actions / Agreed Outcomes:	Continue with annual Health Board training requirements.

Why is this acceptable?

As with the GP example, this Form 4 is thorough and details the key areas of discussion.

In addition to details of the CPD, Appraisers are asked to record a few additional lines in Domain 1 about the Appraisee's background and job, to provide context to the supporting information on "Knowledge, Skills and Performance". This doesn't need to be long, just background, such as how

long the doctor has been in the specialty, how long they've worked in the Health Board, the positions held and clinical involvement.

Undeniably, this Appraisee has experienced a number of challenges in the past year, with increased commitment in the regional and national groups, the difficulties experienced as described in the SEA, as well as the personal health scare. It is quite easy in these situations for the Appraiser to make assumptions or collude with the Appraisee in the Form 4. However, in the summary descriptions the Appraiser made no assumptions in their comments, and the statements were clear and referenced accordingly to the supporting information submitted.

The Appraisee did not score herself as highly as her colleagues in the MSF, and the Appraiser reinforced the positive aspects of the MSF and Patient Surveys reports to recognise achievement and consolidate good practice.

Summary

- Form 4 is a professional document
- Make meaningful and clear statements
- It should cover the scope of the Appraisee's work
- It needs to be specific to the Appraisee, and reflects on the appraisal discussion
- Be objective – the summary needs to be relevant, factually correct, evidence based
- Avoid assumptions – remember evidence-based, referring to supporting information seen
- Avoid collusion
- Use positive language when describing Appraisee's achievements

- Form 4 **WILL** be reviewed by the RO or their delegate when they review an Appraisee's details for a Revalidation recommendation. If the Form 4 is not comprehensive, lacks detail, or does not document all the required supporting information, the RO will ask both you and your Appraisee for further clarification. You may even need to re-draft the Form 4 before the RO is prepared to make a recommendation to the GMC for your Appraisee.

Further support

Newly trained NES-trained Appraisers are asked to submit their sample Form 4 from the training course to their Appraisal Lead for review and discussion, prior to undertaking any appraisals.

For further support or clarification, or if you are unsure about the quality of a Form 4, **consult your Appraisal Lead in the first instance**.

If still in doubt, please submit a helpdesk ticket to: SOAR@nes.scot.nhs.uk

PROGRESS* – Self Assessment Tool	**Score** 0 = absent from summary 1 = room for improvement 2 = done well	**Comments** How can I improve the Form 4 documentation
Appraisal identifier		
Professional – is typewritten, objective, free from bias or prejudice, describes a professional appraisal: venue, time taken, good information governance, no identifiable third party info.		
Reflects a good appraisal discussion – demonstrates support, challenge and focus on the reflection and needs of the doctor.		
Overview – includes a description of the whole scope of work and context for the doctor, the appraisal and the revalidation cycle.		
Gaps – identifies any gaps in requirements for revalidation or scope of work and specifies how they will be addressed (or states if no gaps).		
Reviews supporting information (SI) and lessons learned – reviews SI in relation to *Good Medical Practice*; comments on SI not supplied electronically and any information the doctor was asked to bring. Reviews lessons learned, changes made and actions agreed.		

Encourages excellence – affirms good practice, celebrates achievements and actions accomplished, gives examples of good practice and records aspirations *(some of which may have a timescale over one year).*		
Statements – ensures the input and output statements , including health and probity, have been completed, commented on, and, where appropriate, explanation made to the RO.		
SMART – PDP objectives arising from the supporting information and appraisal discussion are SMART: Specific, Measurable, Achievable, Relevant and have a Timescale.		
Total		
Overall impression:		

*Based on material from Revalidation Support Team training resources and the Wessex Deanery