

From The Chief Medical Officer:
Dr Henrietta Campbell CB

Castle Buildings
Upper Newtownards Road
Belfast BT4 3SJ

Telephone: 028 90 520563
Fax: 028 90 520574

E-Mail: henrietta.campbell@dhsspsni.gov.uk

HSS(MD)30/2002

All General Practitioners
Directors of Primary Care in each HSS Board
Chairs of LHSCGs
GP Advisers in each HSS Board
Chief Executive of NICPGMDE
Chief Executive of The Beeches

18 October 2002

Dear Colleague

GP APPRAISAL

1. INTRODUCTION

This paper sets out the model for the introduction of GP appraisal in 2002/2003. It builds on the principles of appraisal as outlined in the CMO letter of 22/1/02 (available on www.dhsspsni.gov.uk) and takes account of the feedback received from consultation, and local and national developments. Training of appraisers and appraisees will be completed in Spring 2003, thus enabling all GPs to participate in an appraisal scheme thereafter. It is strongly advised that once general practitioners have knowledge of the scheme, they should commence the gathering of relevant information to enable annual appraisal to be undertaken. In addition, they should reflect on issues that they wish to raise during appraisal, and consider their development needs.

General practitioners here have strongly indicated that GP appraisal should be led and owned by general practitioners, and should be delivered as close as possible to local service provision. It should also complement the continued development of the quality agenda through clinical and social care governance and professional self-regulation.

The model identified in this paper is an interim one, which will be evaluated within two years. It will take account of national and local developments including the new GP contract and the increasing opportunities and roles anticipated for Local Health and Social Care Groups. The evaluation will take account of other developments associated with the implementation of Best Practice, Best Care.

2. **DEFINITION AND AIMS OF APPRAISAL**

The primary objective of GP appraisal is a formative one; appraisal will give GPs the opportunity to review their performance, to chart continuing progress and identify needs.

The aims of the annual scheme are: -

- To help the individual doctor to develop and improve;
- To contribute to the requirements of the General Medical Council's process of revalidation where a doctor will be required to demonstrate fitness to practise;
- To contribute to the promotion of quality throughout HPSS organisations;
- To help assure the public that general practitioners are engaged in professional development; and
- To contribute to clinical and social care governance as a necessary requirement for all doctors.

3. **THE OBJECTIVES OF THE SCHEME**

The objectives of the scheme are to: -

- Utilise the annual process and associated documentation to meet the requirements for GMC revalidation;

- Review regularly an individual's work and performance, utilising relevant and appropriate comparative data from local, regional and national sources;
- Recognise, acknowledge and value achievements;
- Discuss individual expectations and their role in the delivery of high quality services and priorities;
- Set out and agree individual objectives, aligned to practice and organisational objectives and service priorities;
- Set out personal and professional development needs and agree plans for these to be met;
- Identify the need for adequate resources to enable any service objectives in the agreed action plan to be met;
- Provide an opportunity for GPs to discuss and seek support for their participation in activities for the wider HPSS.

4. **TIMESCALE**

The aim is to commence implementation in the last quarter of 2002, with increasing numbers of GPs having the opportunity to participate in the appraisal process early in 2003. The first decisions on revalidation are likely to be in 2004/5. The timetable for introduction of appraisal needs to meet revalidation requirements.

The medical advisers of HSS Boards will undertake certain responsibilities for the GP appraisal scheme until such times as these can be delegated to Local Health and Social Care Groups.

5. **REVALIDATION**

Appraisal will provide a regular, structured system for recording progress towards revalidation and identifying development needs (as part of personal development plans), which will support individual GPs in achieving revalidation.

While appraisal and revalidation will be based largely or wholly on the same sources of information, and appraisal summaries will inform

revalidation, the objectives of the two processes are distinct and complementary. Revalidation involves an assessment against a standard of fitness to practise in line with the seven headings of the GMC's guidance *Good Medical Practice*. It will allow a doctor's licence to practise to be renewed. Appraisals are concerned with the doctor's professional development within his or her working environment and the needs of the organisation for which the doctor works.

Despite these differences, appraisal and revalidation should be linked for the sake of economy of effort, with the GMC's Good Medical Practice as common ground. Despite the fact that appraisal and revalidation are distinct processes, the benefit of appropriate information sharing is considerable. The arrangements for the introduction of appraisal for GPs working within the HPSS must integrate appropriately with those for revalidation.

6. **APPRAISAL PROCESS AND CONTENT**

The content of appraisal will be built around the core headings in Good Medical Practice in addition to the GPs contribution to the organisation and delivery of local services and priorities. The GMCs core headings are: -

- Good clinical care;
- Maintaining good medical practice;
- Relationships with patients;
- Working with colleagues;
- Teaching and training;
- Probity; and
- Health.

The appraisal process should: -

- Emphasise a positive and developmental approach;
- Be fair and effective;
- Be well informed;
- Where possible, show how patient care and working within HPSS organisations can be improved;

- Provide adequate preparation time, and be adequately prepared for, by both appraiser and appraisee;
- Specific time should be set aside to prepare for and undertake appraisal and any follow up review meeting (if found necessary);
- Be undertaken at regular intervals with skill, professionalism and confidentiality;
- Be supported by LHSCGs and HSS Boards.

Standard documentation will be used to provide a consistent approach to the structure, process and outcome of appraisal.

7. GP APPRAISERS

An appraiser will be another GP with the capacity, the capability and local knowledge to undertake an appraisal. The appraiser should be of good professional standing. Key skills and knowledge include:

- An understanding of the appraisal process and linkages to the wider HPSS system;
- Knowledge of the working environment of the appraisee;
- The respect and trust of the appraisee and local GP community;
- Good interpersonal skills appropriate to an appraisal interview; and
- The ability to advise and facilitate completion of the appraisal cycle. Where appropriate, this may include influencing strongly those who can commit any necessary resources.

In order to ensure consistency of approach, each appraiser will be asked to undertake a 2-day residential training programme, led by the Northern Ireland Council for Postgraduate Medical and Dental Education and The Beeches.

Each general practitioner should now consider whether they have the attributes to become an appraiser. In addition, each practitioner should consider which individual in their area they would respect and trust to be their appraiser. They should actively encourage those they

consider suitable to put their names forward for training as an appraiser.

Ideally, an appraiser should work within the broad configuration of a LHSCG(s). To this end, following satisfactory completion of training and with the consent of the individual appraiser, a Directory of Appraisers will be held within the LHSCG of those who have completed training and who are willing to act as appraisers within the Board area. It will be the responsibility of the clinical and social care governance lead(s) within the LHSCG(s) to maintain this Directory. Until LHSCGs have established their infrastructure, the GP medical adviser in each HSS Board will also hold this.

An appraiser who has satisfactorily completed training will hold a Letter of Agreement with the LHSCG(s) for delivery of appraisals. As an interim measure, until LHSCGs can assume this responsibility, this Agreement will be with the relevant HSS Board. This Agreement will include:-

- the level of remuneration for each completed appraisal taking account of regional recommendations;
- a commitment to the delivery of a minimum number (6) of appraisals per annum;
- a commitment to further training, as required;
- indemnity arrangements for appraisers, which will be described in detail; and
- arrangements for appraisal and development of appraisers.

From a number of locally appointed appraisers, a lead appraiser will be nominated by the appraisers, subject to ratification by the Local Appraisal Group. The lead appraiser's Agreement will define the role and responsibilities of the lead appraiser. Additional sessions will be made available for this role, subject to endorsement by the Local Appraisal Group.

8. APPRAISEES

In recognition of the need to raise awareness of the content of GP appraisal and local appraisal processes, workshops will be led by NICPGMDE/The Beeches within LHSCGs. These workshops will be voluntary. General

practitioners will be able to claim postgraduate education allowance for their attendance. They will commence in October 2002 and will continue until early in the New Year. Further details will be sent to each GP.

Appraisees will be able to choose their own appraiser from the Directory of Appraisers within their LHSCG. It is recommended that in choosing an appraiser, a GP should consider three names from the Directory of Appraisers. This is to ensure availability, and will take account of local appraiser workload. It would generally not be acceptable for an appraisee to choose someone from the Directory who is related to them or who is a partner in their practice. Should a GP not be able to find a local appraiser, they should inform the clinical and social care governance lead, in the first instance. The clinical and social care governance lead may seek the advice of the local lead appraiser.

9. **APPRAISAL DOCUMENTATION**

Appraisal documentation is an important facet of appraisal. Completion of documents prior to appraisal provides the basis for constructive dialogue between appraiser and appraisee. It then allows a record to be made of both the reflections on past performance and identified professional development needs.

The use of standardised documentation should ensure that information from a variety of HPSS sources will be recorded and expressed consistently. The documentation will provide a formal, supportive, consistent structure to the appraisal process. It covers the process in sequence and suggests the information and evidence that the parties to appraisal will wish to bring to the process.

Every GP being appraised should prepare an appraisal folder. This is a systematically recorded set of all the documents, information, evidence and data that will help inform the appraisal process. Once the folder has been set up it can be updated as necessary. The documentation will allow access to the original documents in the folder in a structured way, record what the appraisal process concluded from them and, finally, what action was agreed as the outcome following discussion.

The appraisal process will not in 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 be available from existing sources. As Local Health and Social Care Groups develop, some evidence may be supplied via the Group and through enhancements

of Data Retrieval in General Practice, which may provide base line data to aid clinical audit. The development of appraisal and revalidation procedures may identify types of information that should be made available to enhance the evidence base.

There are six forms. These forms cover:

- 1 Basic details;
- 2 Current medical activities;
- 3 Material for appraisal;
- 4 Summary of appraisal discussion with agreed action and personal development plan;
- 5 Detailed confidential account of appraisal interview (optional framework);
- 6 Notification of completion of appraisal and summary of non-confidential issues to be included in a combined anonymised report.

Forms 1, 2 and 3 must be completed by the GP before the appraisal discussion. The first two forms are brief and factual. Form 3 requires care. Appraisees are invited to submit documents in support of form three and these will need to be assembled.

Some of the material appraisees provide now will carry forward without further work to future appraisals.

The appraiser will bring three further forms to the meeting. Form 4 is the formal summary of the appraisal and should be completed during and immediately after the discussion. This is the responsibility of the Appraiser. Form 5 may be used to make a more detailed and confidential record of the appraisal discussion, but it is optional. Form 6 confirms that appraisal has taken place and will highlight significant non-confidential issues, which emerged during the appraisal.

Form 1 Basic details – This form is straightforward and self-explanatory. Appraisees are required to give standard personal details and information relating to practice address, qualifications, GMC registration, current and previous posts held.

Form 2 Current Medical Activities – This form requires a brief and factual description of the work the appraisee does in the practice and in other posts. Appraisees will be able to give more detail later.

Form 3 Material for appraisal – This form, and the papers the appraisee supplies with it, will be the main basis of the appraisal. It is organised around the headings used by the General Medical Council in Good Medical Practice and the Royal College of General Practitioners in Good Medical Practice for General Practitioners, and it is strongly recommended that appraisees look at these documents as prompts. The same headings will be used to summarise the appraisal discussion.

The wording under each heading differs, but typically appraisees are asked to provide:

- A commentary on their work;
- an account of how their work has improved since their last appraisal;
- their view of their continuing development needs;
- a summary of factors which constrain them in achieving what they aim for.

It is not expected that the appraisee will provide exhaustive detail about their work. But the material should convey the important facts, features, themes or issues, and reflect the full span of their work as a doctor within and outside the HPSS. The form is a starting point and framework to enable them and their appraiser to have a focused and efficient discussion about what they do and what they need. It is a tool, not an examination paper or application form, and it can be completed with some flexibility. **Common sense should be exercised if appraisees feel they are repeating themselves, or if they want to include something for which there is no apparent opportunity. And if a section or a page really needs only a word or two there is no need to do more.**

The work appraisees put into completing this form is their main preparation for appraisal, and the value of their appraisal will largely depend on it. It will also be an important part of the appraiser's preparation.

The form is fairly open-ended, although some prompts and suggestions are supplied to help appraisees. Please expand the spaces available as necessary, or attach extra sheets.

Appraisees are invited to submit documents in support of what they say in the form. They are not expected to “prove” their assertions about their work, but the appraiser will probably want to explore some of them with them through discussion and the documents will help both appraiser and appraisee.

The papers appraisees assemble in support of the form should be listed in the appropriate spaces and supplied for the appraiser in a folder, organised in the same order. If the same material is listed in the form more than once, to illustrate different points, do not include it twice in the folder but explain on the form where it is to be found.

The first papers in the appraisee’s folder should be the summary of their last appraisal and their Personal Development Plan (ie last year’s Form 4).

All the papers may well be appropriate for inclusion in the Revalidation Folder.

Form 4 Summary of appraisal discussion with agreed action and personal development plan – This form sets out an agreed summary of the appraisal discussion and a description of the action agreed, including those forming the appraisee’s personal development plan. The form will be completed by the appraiser and then agreed by the appraisee.

Form 5 Detailed confidential account of appraisal interview – This form provides an optional framework for keeping a fuller account of the appraisal discussion than is recorded on Form 4. It might inform or help the next appraisal round.

Although, as the guidance makes clear, an appraiser has a duty to pass on any serious concerns arising during appraisal that could affect patient care, this form is confidential and is not intended to form part of the documentation going to the LHSCG or HSS Board (see Outcomes of Appraisal).

The appraisee should nevertheless exercise great caution in commenting on third parties. Any comments made about third parties should be supported by firm evidence. Appraisees should not use this form to record concerns about the performance of colleagues on which action should be taken under a separate procedures, for example GMC fitness to practise procedures.

Completion of this form is not obligatory.

Form 6 has two functions. Firstly, it confirms that appraisal has taken place. It will be sent to the clinical and social care governance lead in the LHSCG. Until these Groups are fully operational, the notification of completion of appraisal will also be sent to the GP medical adviser of the HSS Board.

The second function of Form 6 is to provide an opportunity for feedback on issues arising during the interview, or from the Personal Development Plan, **excluding areas of confidentiality**, which require action at a local or regional level. Each appraiser will produce an amalgamated, anonymised report on the appraisals undertaken by him/her over the year. This will be sent to the clinical and social care governance lead in the LHSCG in which the appraisals have been undertaken. In the interim, a copy will also be sent to the HSS Board GP adviser for action and/or discussion at the Local Appraisal Group meetings. Examples of issues that a report might highlight are emerging training and development needs, and organisational or service themes requiring action or investment. It should also review the overall process and operation of the appraisal scheme.

10. **PREPARATION**

Preparation for the appraisal should be completed during protected time that has been specifically set aside. The appraiser should ensure that the GP being appraised has adequate advance notice of the date of their appraisal. Ideally this should be at least 2 months. The GP being appraised should prepare for the appraisal by identifying those issues, which he or she wishes to raise with the appraiser and prepare an outline personal development plan (PDP).

The GP and the appraiser should gather information about and reflect before hand upon the following:

- Achievements and challenges in the last twelve months (clinical and non-clinical), seen where relevant in the context of earlier appraisals.
- Service, practice and (where relevant) wider objectives for the next year and beyond.
- Personal (and, if appropriate to a discussion about the individual in context, practice) development needs, and how these development needs can be met.

The information and paperwork to be used in the appraisal discussion should be shared between the appraiser and the appraisee at least two weeks in advance to allow for adequate preparation for the discussion of supporting information. The discussion should be based on accurate, relevant, up-to-date and available data.

The appraisal discussion should be held in a comfortable work setting, free from interruptions and distractions such as phone calls and demands from other staff.

Once the appraiser has received the paperwork from the appraisee and supporting evidence, they will contact them to:

- Confirm the date and time of the interview;
- Discuss the agenda for the meeting;
- Identify any gaps in the supporting evidence and discuss how these may be filled before the interview date.

11. **TIME ESTIMATES**

The time required for GPs to undertake appraisal is obviously likely to differ according to each individual taking part. However, research commissioned by the Department of Health in England suggests that the average time commitment for appraisal is an average of 4½ to 6½ hours. This includes between 2 and 4 hours for preparation.

In recognition of the protected time that is needed to prepare for and complete appraisal, each appraisee will receive £300 per annum, upon notification to the LHSCG that appraisal has been completed (Form 6). Initially, payment will be via HSS Board.

In addition, an appraiser will receive a payment of £300 for each appraisal, upon submission of Form 6 to the LHSCG (or HSS Board). Appraisers should ensure that availability does not conflict with hours of availability under GMS Terms of Service.

12. **OUTCOMES OF APPRAISAL**

The appraisal should conclude by setting down, as an action plan, the agreements that have been reached about what each party is committed to doing. This should include the essentials of the personal development plan

(PDP). The appraisee may wish to liaise with a local GP tutor if they wish to consider further support in the development of a PDP, although at present this resource is limited.

The appraisal should identify individual needs that will be addressed through the PDP. The plan will also provide the basis for assessment of resource needs and clinical and social care governance issues within a practice or LHSCG.

The detail of the appraisal discussion will be confidential to the participants.

The appraiser and appraisee should agree a written overview of the appraisal that should as a minimum include:

- A synopsis of achievement in the previous year (e.g. **Forms 3 & 4**);
- Objectives (an action plan) to be pursued by the appraisee over the next year (**e.g. Form 4**);
- The key elements of a PDP for the appraisee (**eg Form 4**);
- Actions expected of the LHSCG/HSS Board to address needs in the local context or that of the wider system (**eg Form 4 and summarised on Form 6**);
- A standard summary of the appraisal as recommended by the GMC for the individual's revalidation folder (**eg Form 4**);
- A joint declaration that the appraisal has been carried out properly (**eg Form 4, Form 5(optional) and Form 6**).

The key points of the discussion and outcome must be fully documented and both parties must complete and sign the relevant documentation. It is anticipated that both the appraiser and appraisee will hold copies. Should the appraisee have concerns about this, the appraisee may hold a signed copy, provided that the appraiser or future appraisers has access to it, upon request. All records will be held on a secure basis and access/use must comply fully with the requirements of the Data Protection Act. All appraisers will be provided with full guidance on their responsibilities in respect of Data Protection.

It would be exceptional for serious concerns about performance to first come to light during the appraisal process. The appraisal itself should be formative. However, both the appraiser and appraisee need to recognise that as registered medical practitioners they must protect patients when they believe that a colleague's health, conduct or performance poses a threat to patients (GMC Good Medical Practice paragraphs 26-28)

The Chief Medical Officer's letter of 22/1/01 acknowledges that the appraisal process is not the vehicle for dealing with underperformance. However, if it comes to light during the appraisal process that there is potentially a serious performance issue, which requires further discussion or examination, then the appraisal process should be stopped and action taken. The appraiser must refer the matter to the Board GP medical adviser for action. A separate document on procedures for the management of underperformance at local level has been produced.

The appraiser and GP should make arrangements to make contact at least once more during the course of the year for about 30 minutes in order to review progress in relation to the actions and PDP. This could be arranged and resolved via a telephone call rather than an actual meeting.

13. **PERSONAL DEVELOPMENT PLAN**

Key development objectives for the following year and subsequent years should be set in the PDP. These objectives may cover any aspect of the appraisal such as personal development needs, training goals and organisational issues, CME and CPD.

A PDP is a useful tool to help individuals plan and meet their development needs. It can then be used as a basis for enabling a comprehensive action plan to be developed.

To be of value, individuals will need to update their plans on a regular basis as part of the appraisal process.

A PDP will help to describe personal development objectives and the development activities designed to help achieve them. A PDP should take account of:

- professional development needs;
- the requirements of the practice;
- personal ambitions.

Key states in preparing a plan are:

- identifying current level of competence;
- specifying competencies to develop;
- deciding how to develop these competencies and by when;
- setting performance criteria to be achieved as a result of the development;
- taking development action; and
- deciding how and when to review progress.

CPD in primary care should be purposeful, patient-centred and educationally effective. It should integrate patient interests with those of the HPSS both regionally and locally and be constructed in such a way as to encourage team working within primary care and facilitate the appropriate adaptability of professional roles.

The process of CPD should:

- be purposeful and personally motivating;
- raise individual awareness;
- consider the development needs of the practice;
- be evidence based where possible;
- develop knowledge of and opportunities for research and development;
- place the individual at the centre of the educational process.

14. **APPEALS PROCEDURE**

In the unlikely event of a lack of consensus between appraiser and appraisee, the following process should be followed. This process should be able to address any worries or complaints from the individual GP about the fairness and consistency of the scheme, the appraiser, the outcomes of the appraisal or the use of the information.

1. An individual GP's concerns about his or her appraisal should be raised in the first instance with the appraiser.
2. If concerns remain, they should discuss them with the local lead appraiser who will try to find informal resolution to the problem through discussion and mediation.

3. In exceptional circumstances, where concerns cannot be resolved, the lead appraiser should consult with the GP adviser who may consider referral to the Local Appraisal Group.
4. Where concerns or views relate to the appraisal system as a whole, or where local resolution has failed, the concerns should be brought to the Regional Appraisal Group.

15. **LOCAL AND REGIONAL APPRAISAL GROUPS**

There should be a Local Appraisal Group (LAG) in each HSS Board area with representation from key groups including LMC, RCGP, local NICPGMDE representation, lay representation and the HSS Board GP medical adviser. In addition, the clinical and social care governance lead (or medical nominee) of LHSCGs should be a member of the Local Appraisal group. The local arrangements for the training and the convening of the Local Appraisal Groups will be the responsibility of the Board GP adviser. It will be the responsibility of the GP Adviser (or designated person) to produce an annual report for the Local Appraisal Group, based on the aggregated information relating to Form 6 and supplied by the appraisers.

To ensure congruence of initiatives, it is proposed that a Regional Appraisal Group will be convened to set standards for appraisal training and to oversee implementation and quality assurance of the appraisal process. In exceptional circumstances, the Regional Group may also be involved in appeals procedures, when local resolution has not been possible.

The Group will include representation from RCGP, GPC, NICPGMDE, Local Appraisal Group representation, HSS Board representation, lay representation and DHSSPS. It is envisaged that this Group will come under the auspices of the Standards and Guidelines Unit, as outlined following consultation on Best Practice, Best Care.

16. **ROLES AND RESPONSIBILITIES**

Each GP will be responsible for participation in an appraisal process and for providing the appropriate documentation and evidence to support this formative process. Locums should participate in the appraisal process within the LHSCG or HSS Board where most of their general practice work is located.

Each GP will be responsible for ensuring personal knowledge of the appraisal scheme and documentation.

The GP appraiser will have satisfactorily completed a training programme led by NICPGMDE and The Beeches.

The GP appraiser will be responsible for submitting to the clinical and social care governance lead, and in the interim, the HSS Board GP adviser any major actions identified through the appraisal process. This will take the form of an anonymised aggregated report.

An annual summary report, on emerging themes, will be submitted by the GP Adviser to the Local Appraisal Group and where appropriate, the Regional Appraisal Group. It will also be sent to the Chief Executive of the HSS Board (or nominee).

Regulations will determine that general practitioners, working within the configuration of a LHSCG, will participate in an appraisal scheme. Until it can be delegated to the LHSCGs the HSS Board's GP adviser will hold this responsibility.

The maintenance of the Directory of Appraisers will be the responsibility of the LHSCG. In the interim, this will also be held by the HSS Board.

Responsibility for delivery of an appraisal scheme at local level will rest with the Local Appraisal Group.

The Local Appraisal Group will be responsible for quality assuring local processes taking account of participant experiences and changing circumstances.

The Local Appraisal Group, should ensure that robust processes are in place to deal with worries and concerns from individual GPs about the process or outcomes of appraisal.

The annual appraisal of GP registrars, and retainees will be the responsibility of NICPGMDE.

NICPGMDE/The Beeches will be responsible for the training of appraisers. In addition, they will be responsible for the delivery of awareness raising sessions to general practitioners.

HSS Boards together with LHSCGs are responsible for ensuring that action is taken, in as far as possible, to address development needs, including service development, identified during appraisal.

The Regional Appraisal Group will be responsible for the standards of appraisal training, overseeing implementation and quality assurance of the process.

Should concern about an individual's performance arise through the appraisal process, all doctors must understand that the safety of patients comes first at all times. Doctors should be aware of their professional responsibilities as outlined in Good Medical Practice paragraphs 26-28. If an appraiser is not sure what to do, they should discuss with the HSS Board GP adviser who will have knowledge of local underperformance procedures.

17. **CONCLUSION**

The introduction of GP appraisal is an opportunity to promote quality in the development and delivery of primary care. It will help provide general practitioners with the time to reflect on their needs for continuing professional development. It will complement the introduction of clinical and social care governance. Importantly it will provide GPs with the necessary infrastructure to enable revalidation to be achieved.

Yours sincerely

HENRIETTA CAMPBELL (DR)
Chief Medical Officer