

**Review of GP Appraisal  
Arrangements  
in Northern Ireland**

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## **1 SETTING THE SCENE**

### **1.1 The Roles and Responsibilities of the Regulation and Quality Improvement Authority**

The Regulation and Quality Improvement Authority (RQIA) is a non-departmental public body, established with powers granted under the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003. It is sponsored by the Department of Health, Social Services and Public Safety (DHSSPS), with overall responsibility for assessing and reporting on the availability and quality of health and social care services in Northern Ireland and encouraging improvements in the quality of those services.

The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland ) Order 2003 places a statutory duty of quality on Health and Social Care (HSC) organisations and requires RQIA to encourage continuous improvement in the quality of care and services throughout all sectors in Northern Ireland.

In order to fulfill its statutory responsibilities, RQIA has developed a planned programme of clinical and social care governance reviews within the HPSS and will also carry out commissioned reviews at the request of the DHSSPS.

### **1.2 Context for the Review**

The primary objective of GP appraisal is to give practitioners the opportunity to review their performance, chart continuing progress and identify development needs.

The aims are :

- To help the individual doctor to develop and improve
- To promote quality and service improvement in the HPSS
- To contribute to clinical and social care governance as a necessary requirement for all doctors
- To help assure the public that general practitioners are engaged in professional development
- To contribute to any further General Medical Council (GMC) processes, should a doctor be required to demonstrate fitness to practice.

Until April 2006, the GP appraisal scheme was managed through Health and Social Care (HSC) Boards, working with local GP appraisal groups and with a Regional Appraisal Group which was led by the DHSSPS.

Since 2006, the GP appraisal scheme has been led by a regional GP Appraisal Co-ordinator, located within the Northern Ireland Medical and

Dental Training Agency (NIMDTA). This arrangement was designed to promote a co-ordinated approach to the identification of educational needs, and to the commissioning and delivery of educational programmes designed to meet those needs, by the formation of an educational consortium managed by NIMDTA.

Most UK general medical practitioners moved to a new contract in April 2004 which was designed as a tool to improve the quality and range of services for patients and to fully utilise the talents of the primary care team.

An element of the new contract is the Quality and Outcomes Framework (QOF), which is designed to remunerate practices for providing good quality care to their patients and measures achievement against a range of evidence based indicators, with points and payments awarded according to the level of achievement.

HSC Boards have an obligation to ensure that services commissioned from GP practices under the terms of the GMS contract are delivered to a high standard of care. As part of this process, each practice has nominated a clinical and social care governance lead and each practice has to produce a governance plan examining relevant aspects of service delivery using the six tools of governance;

- audit
- continuing professional development
- evidence based practice
- significant event analysis
- risk assessment
- public involvement

QOF data, contract data and practice governance plans are reviewed by Board staff at an annual practice visit where areas for improvement are discussed and agreed.

A regional approach to the reporting of adverse incidents from GP practices has been in place since October 2006. Incidents are reported to the relevant Board Medical Advisor and a judgment is then made as to how an incident is dealt with.

Each Board has its own procedures for dealing with poor performance and each practice and Board has its own complaints procedure.

In each Board there is also a team of pharmaceutical advisors, supported by administrative staff, whose key role is to ensure the delivery of safe, effective and efficient prescribing in primary care.

GP appraisal is managed and delivered by NIMDTA through a Service Level Agreement with each HSC Board. Strong links exist between the four Board Medical Advisors and the Regional Appraisal Co-Ordinator to deal with specific issues arising from the appraisal process and information ideally

would be shared on a two way basis between Board governance processes and appraisal.

A key feature of new registration arrangements introduced by the GMC is the concept of Approved Practice Settings which are organisations approved by the GMC as suitable for doctors new to full registration or returning to the medical register after prolonged absence from UK practice. One of the key criteria of an approved practice setting is a system of annual appraisal for individual doctors based on the principles of "Good Medical Practice" which is quality assured by an independent body or organisation.

Appraisal is also an important feature of revalidation which is the process by which doctors will, in future, demonstrate to the GMC on a regular basis that they remain up to date and fit to practice.

The annual appraisal cycle runs from 1 April to 31 March. All GPs who are under contract for the provision of Primary Medical Services with a Health and Social Services Board are contractually obliged to participate in the appraisal system. All GPs who submit an application to join any Health and Social Services Board Primary Medical Services Performers List give an undertaking to "*participate in appropriate and relevant appraisal procedures*".

### **1.3 The Review Ethos**

RQIA operates within a value system that supports the belief that learning is at the heart of improvement. To ensure a clear focus on improvement, organisations need to have effective systems which can identify performance standards and support the learning necessary for improvement.

### **1.4 The Review Team**

RQIA review teams are multidisciplinary, and include both health and social care professionals (peer reviewers) and members of the public (lay reviewers) who have undertaken training provided by RQIA. Review teams are managed and supported by RQIA project managers and project administrators.

Lay reviewers come from a range of backgrounds from across Northern Ireland. Each plays a vital role in review teams, bringing new insights and providing a lay person's perspective on all aspects of the provision of health and social care services.

Peer reviewers work at a senior level in both clinical and non-clinical roles in the HPSS. For the purposes of this review two peer reviewers were selected who combine part-time work in General Practice with part-time roles as Health Board Medical Advisors. As a result they have experienced the

appraisal process from both the commissioning point of view and as an appraisee.

There are identified team leaders for each review team who work closely with the RQIA project manager during the review to guide the team in its work and ensure that team members are in agreement about the assessment reached. The team leaders for this review were the National Appraisal Advisor for Scotland and the Director of the Professional Development Academy in the University of Dundee who is also the immediate past chair of the Royal College of General Practitioners (RCGP) Scotland.

## **1.5 The Review Process**

The review process has three key elements: self assessment (including completion of a self declaration), pre-visit analysis and the validation visit by the review team.

## **1.6 Self Assessment**

Self assessment as a technique is used widely in health and social care regulation, accreditation and licensing across the UK and internationally. A self assessment proforma was developed (and submitted to NIMDTA), based on the document "*Assuring the Quality of Medical Appraisal*" produced by the NHS Clinical Governance Support Team. The completed self analysis proforma and evidence documents were returned to RQIA for analysis. In meeting their legislative responsibility, the Chief Executive of NIMDTA signed a declaration confirming the accuracy of the self assessment return to RQIA.

## **1.7 Pre-visit Analysis of Self Assessment**

Self assessment proformas and supporting evidence documentation were analysed by RQIA project managers prior to the validation visit. The relevant information was collated to provide a framework which was then used by the review teams during the validation visit.

## **1.8 The Review Visit**

Reality testing of the self analysis was carried out by the review team during the visit. Based on the initial analysis, the review team used a semi-structured interview schedule exploring issues identified from the self assessment. In this review, interviews were carried out with several groups which included the Regional Appraisal Co-ordinator and the Director of Postgraduate General

Practice Education, groups of appraisers and groups of appraisees. The Central Board of Management was also interviewed though attendance by this group was very disappointing with representation from only one HSS Board, General Practice Committee (GPC) and the Royal College of General Practitioners (RCGP). GMC also sent a representative to this part of the review.

Initial feedback from the review teams was given to NIMDTA representatives at the end of the review visit outlining the findings of the review under the headings: strengths, challenges and areas of good practice.

## **1.9 The Report**

Following the review visit the RQIA project manager drafted a report that was sent to the review team for comment and then to NIMDTA to check for factual accuracy.

The report will be made available to the general public in print, at [www.rqia.org.uk](http://www.rqia.org.uk) and in other formats on request.

## 2.0 FORMAT OF REPORT

The Clinical Governance Support Team in its report "*Assuring the Quality of Medical Appraisal*"<sup>1</sup> defined four high level indicators that would provide an indication that high quality appraisals were being undertaken.

### 1) **Organisational Ethos**

There is unequivocal commitment from the highest levels of the host organisation to deliver a quality assured system of appraisal that is fully integrated with other systems of quality improvement.

### 2) **Appraiser Selection, Skills and Training**

The host organisation has a process for selection of appraisers and appraiser skills are continually reviewed and developed.

### 3) **Appraisal Discussion**

The appraisal discussion is challenging and effective; it is informed by valid and verifiable supporting evidence that reflects the breadth of the individual doctor's practice and results in a Personal Development Plan (PDP) prioritising the doctor's development needs for the following year.

### 4) **Systems and Infrastructure**

The supporting systems and infrastructure are effective and ensure that all doctors linked to the host organisation are supported and appraised annually.

Under each heading the report will identify strengths, challenges and recommendations for improvement.

<sup>1</sup> Assuring the Quality of Medical Appraisal. NHS Clinical Governance Support Team. July 2005.

## **3.0 ORGANISATIONAL ETHOS**

The Northern Ireland Medical and Dental Training Agency (NIMDTA) is responsible for the delivery of General Practice appraisal in Northern Ireland on behalf of the four HSS Boards. It is a contractual requirement for all GPs who are in partnership in a GP practice, which holds a contract with an HSS Board to participate in an annual appraisal. For all GPs participation in annual appraisal is also a requirement in order to remain on the Primary Medical Performers List (PMPL).

## **3.1 Management Structure**

NIMDTA administers the day-to-day management of the GP appraisal process under the direction of the Central Board of Management of GP Appraisal which is made up of representatives from the four HSS Boards, Northern Ireland General Practice Committee (GPC) , Eastern Health and Social Services Council (EHSSC), DHSSPS, Royal College of General Practitioners (RCGP), Northern Ireland Sessional Doctors Association (NISDA) and NIMDTA.

The Central Board of Management provides a regional forum to oversee the implementation of the GP appraisal scheme, ensuring consistency of approach, dealing with concerns and developing and endorsing any proposed changes to the scheme. The Central Board of Management meets three times throughout the year and there is an e-forum designed to reach agreement on issues between meetings.

The GP appraisal process in Northern Ireland is led by the Regional Appraisal Co-ordinator, under the direction of the Director of Postgraduate GP Education in NIMDTA.

There are 7 lead appraisers and 39 appraisers with each lead appraiser having responsibility for a geographical team of appraisers.

## **3.2 Funding**

The GP appraisal process in Northern Ireland is funded by a budget from DHSSPS. The number of GPs who were appraised rose from 1340 in 2006/07 to 1393 in 2007/08 and it is anticipated that this number will rise to 1529 in 2008/09. Table 1 summarises the appraisal activity for 2007/08.

Table 1

Category	Total Number	Number Appraised	Deficit
GP Partners	1101	1086	15
Salaried GPs	18	18	0
Assistants/Associates	28	26	2
Sessional GPs	224	221	3
Retainers	44	39	5
Returners	5	2	3
OOH Doctors	31	21	10
Prison Doctors	1	1	0
	1452	1414	38

### Appraisal Activity 2007/08

The reasons for non appraisal were:

- extenuating circumstances
- cancellations and failure to rebook
- retirement
- moving outside Northern Ireland

The largest deficit was in the cohort of doctors working solely in out of hours with some clarity required as to who was responsible for their appraisal. This has since been addressed and NIMDTA has taken over responsibility for this group.

### 3.3 Management Time

The workload for those delivering the appraisal scheme breaks down into:

- six sessions a week for the Regional Appraisal Co-ordinator
- two sessions a week for a lead appraiser
- one or two sessions a week for appraisers

Each appraiser is contractually committed to delivery of a minimum of 25 appraisals per year.

### 3.4 Summary of Paperwork Required for Appraisal.

**Section 1:** This section forms the preface to the appraisal folder and comprises form 1 and form 2

**Form 1:** The doctor is required to complete a current curriculum vitae.

**Form 2:** The doctor is required to provide a brief and factual description of his or her current medical activities.

**Section 2:** This section comprises the documentation on which the appraisal discussion will be based and consists of Form 3.

**Form 3:** The areas identified in "*Good Medical Practice*"<sup>2</sup> form the framework of the written record. These are:

- Good Clinical Care
- Maintaining Good Medical Practice
- Relationships With Patients
- Working with Colleagues
- Teaching and Training
- Probity
- Management Activity
- Research
- Health

**Section 3:** The third section of the folder comprises Form 4, Form 6 and Form 6A. These forms are completed by the GP appraiser and subsequently agreed with the appraisee on satisfactory completion of the appraisal discussion. Both parties are required to sign these documents.

**Form 4:** This document provides an accurate summary of both the appraisal submission and issues identified in discussion. An outline of the doctor's learning and developmental strategy over the subsequent twelve months will be included.

**Form 6:** This form is a declaration that the annual appraisal has been satisfactorily completed and that agreement has been sought for the anonymised Form 4 to be quality assured. The appraiser sends a copy of the signed document to NIMDTA and this will prompt payment from NIMDTA to the sessional doctor.

<sup>2</sup> Good Medical Practice, GMC, 2006

**Form 6A:** This form is signed and sent to NIMDTA. It outlines identified training needs and helps to form the basis of any courses or learning activities within Northern Ireland. Towards the end of the discussion the appraiser will agree the basis of the following year's Personal Development Plan which should then be the starting point of the next appraisal discussion.

There also is an evaluation form completed by the appraisee and appraiser which should be a reflection of their whole experience of the appraisal process.

### **3.5 Links to Continuing Professional Development (CPD)**

One of the clear advantages in the GP appraisal process being managed by NIMDTA is that it is also responsible for GP education which should make dealing with training needs identified through the appraisal process easier. Following appraisal the appraiser completes a Form 6A which details anonymously the learning needs of the appraisee. These outcomes are collated and fed back regularly to the Educational Consortium which has representation from all stakeholders in the provision of CPD for GPs. Educational events are then planned accordingly and displayed on the Educational Consortium website which is hosted on the NIMDTA website. The outcomes from Form 6A are also fed back to GP tutors who are employed by NIMDTA.

### **3.6 Links to Other Clinical Governance Processes**

Aspects of the HSC Boards' Clinical and Social Care Governance processes such as audit, complaints, patient feedback forms and serious adverse incident reporting may be brought by the appraisee to appraisal and form part of the appraisal discussion.

A communications protocol has been developed with HSC Boards which outlines principles, processes and procedures relating to:

- regular communication between NIMDTA and HSC Board Medical Advisors.
- serious concerns about a doctor's fitness to practice, identified by the HSC Board Medical Advisor or the appraiser.
- areas for development for a doctor, identified by the HSC Board Medical Advisor
- non engagement with the appraisal process identified by NIMDTA, HSC Board Medical Advisor or appraiser
- performance list issues
- doctors working outwith General Medical Services (GMS)
- Form 6A educational / services needs identified.

### **3.7 Internal Quality Assurance Mechanisms**

Anonymised review of appraisal summary forms and PDPs is undertaken both as a quality assurance mechanism and as a development tool for appraisers. Appraisers are required to submit one in six Form 4s and PDPs for feedback. These are anonymised and forwarded at random to lead appraisers who review them for quality of presentation and content. A similar number of the feedback forms, Form 4s and PDPs are reviewed by the Regional Appraisal Co-ordinator. As already stated there are regular meetings of lead appraisers and appraisers and there is an established system of performance review for all appraisers.

There is a complaints process and an appeals process that can be accessed by any practitioner who is not happy with any aspect of their appraisal. This is used rarely but in cases where it has been used it was described as working effectively.

There is a communications protocol developed in conjunction with HSS Boards which details the protocols to be followed if for any reason an appraiser feels an appraisal should be stopped.

### **3.8 Findings Relating to Organisational Ethos**

#### **3.8.1 Strengths**

- a) The GP Appraisal Unit benefits from strong effective leadership. The team members are strongly committed to the appraisal scheme and share a vision relating to the purpose of appraisal which they feel should remain a formative process.
- b) The commitment and enthusiasm of the management team and the appraisers was noted by the review teams. Each team member seems to be clear about their role, proud of their achievements to date and motivated to deliver. The team of appraisers has remained largely unchanged providing a stable and experienced workforce. The lead appraisers meet three times each year as a group and they also meet three times a year with their appraisal teams. This coupled with being in touch with their teams via e-mail is deemed sufficient by the appraisers. The communication with the Regional Appraisal Co-ordinator was considered to be effective and all appraisers felt the administration backup they received had improved.
- c) There is a robust system of internal quality assurance present with the quality of Form 4s and PDPs being assessed by both the lead appraisers and the Regional Appraisal Co-ordinator. Each lead appraiser undertakes a performance review with the Regional

Appraisal Co-ordinator and each appraiser is reviewed by a lead appraiser. Although the performance review process was initially viewed with suspicion it is now viewed as a useful addition to the training they receive.

- d) During interview of appraisees it was indicated (particularly by the sessional doctors), that appraisal was a method of reducing feelings of isolation and keeping them in touch. Generally it was felt that the strength of the process was the fact that it was formative in nature and if this was changed to a more summative process engagement would be threatened.
- e) The management team felt that engagement with practitioners had improved and the fact that three lead appraisers were also members of General Practice Committee (GPC) greatly helped engagement with the profession.
- f) The team also felt that there is a committed group of stakeholders forming the Central Board of Management of the appraisal process who feel they have adequate structures in place to facilitate strategic decisions.
- g) In setting up the appraisal process for Northern Ireland NIMDTA has looked at good practice in other appraisal systems in the UK and has adopted it as far as possible for Northern Ireland.

### **3.8.2 Challenges**

- a) When asking appraisers and appraisees about the use of Form 6A and the Education Consortium, the review team felt there was a lack of knowledge of the Consortium, its function and its relationship to the appraisal process. Appraisers felt disconnected from the Educational Consortium. Historically the information on the Form 6A was either too broad to organise training, or too specific to meet global needs. From the appraiser's perspective they felt that there was little correlation between the expressed training needs of appraisees and the courses provided. An example would be where certain courses were very oversubscribed and yet were not repeated.
- b) It was felt that links with other governance processes could be improved and formalised. At present appraisers are not informed if they are appraising a GP who is undergoing investigation by a third party. The opportunity to support and assist a colleague and to include relevant areas of development for that GP in the PDP is then lost.
- c) Inclusion of further clinical governance information as part of the evidence supplied for appraisal would also be beneficial along with

evidence from the appraisee as to their contribution within this practice based process.

- d) Although appraisal is clearly seen as a formative and not a summative process designed to identify underperformance, review teams noted that few issues have been raised with HSS Boards through the communications protocol. For appraisal to be effective it requires appraisers to be challenging as well as supportive. This was recognised within the appraiser group where some suggested further training was needed on challenge. Whilst supporting the need for the appraisal process to remain largely formative, consideration should be given to ensuring the process is as effective as possible.
- e) The appraisers reported that the amount of time taken to prepare for and carry out an appraisal had increased. With possible future changes to the appraisal discussion the amount of time was likely to increase further. Reservations were expressed as to whether the level of appraiser remuneration was sufficient to aid recruitment and retention of appraisers.
- f) The appraisal process has now been in place for a number of years though only under the control of NIMDTA for a period of two years. NIMDTA is considering carrying out research into the impact of appraisal on General Practice. The outcomes of this research would be important in relation to value for money and to assess the impact of the appraisal process against the time taken by practitioners to prepare for and undergo an appraisal.
- g) Appraisers expressed the view that the make-up of the appraisal teams did not accurately reflect the demography of the GP community. Specifically they felt that females and younger practitioners were under-represented.
- h) Appraisers felt that there were insufficient opportunities to highlight areas of good practice and cascade these down through the organisational structure. The links with CPD offer an opportunity for work to be carried out on a mechanism for sharing areas of good practice.

### **3.8.3 Recommendations**

- 1) NIMDTA should review links with the Educational Consortium as appraisers and appraisees were unclear about the relationship of the Educational Consortium with the appraisal process.
- 2) NIMDTA should work to establish better links with other governance processes particularly in cases where other organisations have significant concerns regarding a practitioner's performance.

- 3) NIMDTA should work towards inclusion of further clinical governance data as part of the information for appraisal.
- 4) NIMDTA should work to ensure that although formative, appraisal is seen as a challenging process, ensuring that developmental objectives identified in PDPs have been addressed. Further training should emphasise the processes of probing and reflection, thus challenging the appraisee.
- 5) NIMDTA should carry out a review of the level of remuneration for appraisers to determine if it is appropriate in relation to the current and anticipated workload involved with the appraisal process.
- 6) NIMDTA should carry out research into the impact of appraisal on General Practice.
- 7) NIMDTA should work towards recruitment of more appraisers from the cohorts of younger and female practitioners.
- 8) NIMDTA should develop improved methods for dissemination and sharing of good practice.

## 4.0 APPRAISER SKILLS SELECTION AND TRAINING

### 4.1 Appraiser Selection

As recommended in the document "*Assuring the Quality of Training for Medical Appraisers*,"<sup>3</sup> NIMDTA demonstrates a formal and transparent process for the selection of GP appraisers. GP appraiser vacancies are advertised in the Belfast Telegraph and by means of a flyer direct to all GP performers in Northern Ireland. Applicants are able to access an application form and a detailed job description and person specification from NIMDTA's website. Shortlisting takes place within five working days of the closing date and a structured interview process then takes place using both situational and behavioral questions.

Appraisers who are contracted for one session per week are required to carry out a minimum of 25 appraisals per year and those contracted for two sessions per week are expected to carry out a minimum of 50 appraisals per year. Lead appraisers are required to carry out 25 appraisals per year with the other sessions being used to fulfill their management responsibilities.

### 4.2 Appraiser Skills and Training

Training for appraisers delivered by NIMDTA is also based on guidance contained in "*Assuring the Quality of Training for Medical Appraisers*".

NIMDTA provides two days training per year for appraisers and lead appraisers and lead appraisers have an additional two day residential training event annually. This training for lead appraisers is designed to develop their management and leadership roles, reflecting the role they have in managing and leading their particular team of appraisers.

For newly appointed appraisers there is a six-month probationary period and permanent appointment also depends on satisfactory completion of training. It was noted that all candidates had successfully completed the required training. Team meetings may also be used as a vehicle for further training and attendance at training days and team meetings is mandatory.

This year, for the first time, an Appraisal Conference was held which was open to other health care professionals and was designed to provide further training for appraisers and to raise the awareness of the appraisal process.

<sup>3</sup>Assuring the Quality of Training for Medical Appraisers, NHS Clinical Governance Support Team, Jan 2007

Evaluation of training events is carried out and suggestions are requested regarding further training. Evaluation of the ongoing training needs for appraisers was carried out using focus groups and questionnaires. The information collected has been used to inform the development of ongoing training.

Appraiser skills are continually assessed by:

- 1) Monitoring of their performance in the delivery of appraisals
  - number of appraisals pending and booked
  - number of appraisals completed
  - timely submission of documentation
- 2) Feedback on submitted Form 4s and PDPs
- 3) Attendance and contribution at training events
- 4) Attendance and contribution to team meetings
- 5) Timely response to e-mail etc
- 6) Performance review process
- 7) Regular contact with lead appraiser

A Key Skills Framework performance review system has been piloted in 2008. One lead appraiser has been identified to review the process and suggest future developments.

## **4.3 Findings relating to Appraiser Selection, Skills and Training**

### **4.3.1 Strengths**

- a) Appraisers are provisionally appointed after a formal, robust interview process which involves open competition. Full appraiser status is achieved only after completion of a six month probationary period and successful completion of training.
- b) There is comprehensive training supplied to newly appointed appraisers and skills for existing appraisers are continually updated using a variety of approaches.
- c) Feedback and evaluation is carried out on training provided and informs any future training programmes.
- d) All appraisers interviewed felt that the training provided by NIMDTA was appropriate and sufficient and that existing processes kept skills current.

### 4.3.2 Challenges

- a) The stability of the team of appraisers, while a strength, creates problems in that training must continue to be developmental and relevant. Consideration should be given as to how this may be achieved.
- b) There is good communication between appraisers locally but the lead appraisers and appraisers would benefit from more contact with appraisal processes elsewhere in the UK, giving them an opportunity to consider developments and areas of good practice in other appraisal systems and incorporate these into their own system.
- c) Direct observation via video/role play should form part of skills assessment though time constraints have to be recognised in that many appraisers have only one day per week available.
- d) Should further clinical governance information become a part of the evidence for appraisal, further training for appraisers will be required on assessment, interpretation of data and appropriate methods of discussion and exploration around this information.
- e) Appraisers indicated that appraisal of non-UK qualified doctors working in Northern Ireland required additional support from appraisers to complete a satisfactory appraisal. They also noted that an induction process for non-UK graduates would give them greater awareness of the system in which they were working, making appraisal easier to deliver for this cohort of GP's.

### 4.3.3 Recommendations

- 9) NIMDTA should encourage more contact for lead appraisers and appraisers with appraisal processes nationally.
- 10) NIMDTA should ensure that training is made available to appraisers on assessment and use of further clinical governance information in the appraisal discussion.
- 11) NIMDTA should ensure that support and training for appraisers is sufficient to allow a robust appraisal for non-UK graduates.
- 12) NIMDTA should work with HSC Boards on the establishment of an induction process for non-UK graduates.

## 5.0 THE APPRAISAL DISCUSSION

The documentation for the appraisal process is based on "*Good Medical Practice*". When each appraisee submits the previous year's Form 4 and PDP and the current year's Form 3, the text is based on the 7 areas of "*Good Medical Practice*". At the appraisal the guidance from the GMC regarding probity and health is discussed. A self declaration in these areas is discussed and signed by the appraisee in the presence of the appraiser.

At present there is no identified essential evidence set which the appraisee is required to bring to the appraisal.

The portfolio of evidence, the Form 4 and PDP are kept by the appraisee. Appraisers do not routinely keep copies of the Form 4s and PDPs. For the Form 4 feedback process the appraisee indicates on the Form 4 whether they agree to the anonymised Form 4 and PDP being submitted to NIMDTA for feedback. This process quality assures the appraiser's work, not the appraisee's.

Appraisees are advised that their appraisal documentation should be with their appraiser at least two weeks before the meeting. Appraisers can defer an appraisal if they believe the evidence is not available in time or is not of a sufficient standard.

There is an appeals process if an appraisee is not satisfied with the outcome or process of their appraisal. In the first instance the lead appraiser is consulted. If there is no resolution at this level the Regional Appraisal Co-ordinator is consulted. If there is still no resolution the appraisee is asked to put their complaint in writing to the Central Board of Management who will reach a final decision.

A feedback form is available to be completed by the appraisee giving their opinions on the appraisal process and discussion.

## 5.1 Findings Relating to the Appraisal Discussion

### 5.1.1 Strengths

- a) The portfolio of evidence is clearly laid out around the seven areas of "*Good Medical Practice*".
- b) Documentation is available to the appraiser at least two weeks prior to the appraisal.
- c) There is a comprehensive guide to appraisees available on the NIMDTA website detailing the appraisal process and giving advice on

the evidence required and is an effective tool for use by the appraisees.

- d) As part of a robust internal quality assurance process, anonymised Form 4s and PDPs are assessed by lead appraisers and Regional Appraisal Co-ordinator for content and quality.
- e) When asked, the group of appraisees felt that the appraisers were well prepared and that they received "supportive, constructive feedback". They detailed changes in their practice which they had initiated following appraisal. They were very clear that the strength of appraisal was in its formative nature and that if it became more judgmental and summative perhaps this would weaken the process. They were also clear that the confidentiality of the process should be maintained as appraisees were unlikely to be as open if they felt other parties would have access to their appraisal information.

### **5.1.2 Challenges**

- a) At present appraisees may select a different appraiser each year. This arrangement may present problems in maintaining continuity when considering performance concerns such as high workload, partnership concerns or work life balance issues. Concern was also expressed by the review teams that this arrangement may encourage collusion or avoidance. In addition, as the Form 4 remains solely with the appraisee there is no guarantee that it will be available to inform the next year's discussion. As a result existing concerns regarding failure to provide evidence in certain areas of practice or other relevant issues may not be reviewed.
- b) Although appraisal is seen as a formative process it should still be sufficiently challenging. It is noted that further training is to be considered on providing challenge during the appraisal discussion. This initiative was welcomed by the review team.
- c) It can be difficult for sessional doctors to provide enough evidence for the appraisal process. There is no minimum requirement for the number of sessions required to remain on the PMPL and the review team considered that the needs of these groups have to be considered.
- d) It was noted when interviewing sessional doctors some appraisals had taken place in the appraiser's or appraisee's house. It is acknowledged that identifying a venue may be difficult, however this is not a suitable environment for the professional nature of the appraisal discussion.
- e) Appraisees felt that there was a significant amount of duplication in the paperwork year-on-year and that there was much cutting and pasting from previous Form 4s and PDPs suggesting limited change in

objectives in the PDP. Success against the previous year's PDP should form the basis for each new appraisal discussion and where possible objectives should change year-on-year. If objectives have not been met, the reasons for this should be analysed and equally if the objectives have been successfully undertaken the impact of this activity on practice should be evaluated. Care should be taken to ensure the PDP is a dynamic document that realistically reflects the identified developmental and learning needs of the individual doctor in their role. The appraiser's role is to allow the appraisee to reflect on and review their proposed PDP.

- f) There has been poor use made of the feedback forms by appraisees and further consideration should be given to other methods of obtaining feedback on the process.
- g) As there are no definitive criteria on what is suitable evidence for the appraisal discussion it is left to the judgment of the appraiser as to whether the evidence is sufficient. Development of a minimum data set or essential evidence which offers clear guidance on the quality and quantity of evidence should be given further consideration. In addition consideration should be given to sessional doctors who may find it difficult to achieve the minimum data set.
- h) All appraisers and appraisees interviewed felt that the outcomes of the appraisal process should remain confidential. Further discussion is required about whether the Form 4s should be made available, on a confidential basis to the Medical Directors of HSS Boards. It is likely that this debate will be informed by the proposed regulatory changes at a UK level and this may be an opportune time to explore the sensitive issue as to how the outcomes of appraisal are handled.

### **5.1.3 Recommendations**

- 13) NIMDTA should ensure that the Form 4 and PDP are available at all appraisals and are the starting point for each appraisal discussion. This will ensure that the appraisal discussion can be informed by the previous year's documentation ensuring continuity when there is a change in appraiser.
- 14) NIMDTA should ensure that sessional doctors who undertake appraisal are adequately supported. Further exploration of the concept of "affiliated practices" where a sessional doctor could seek agreement from a practice in which they do most of their work, to be affiliated to that practice would afford an opportunity for sessional doctors to use evidence from these practices for their appraisal making it easier for them to collect the necessary evidence.
- 15) NIMDTA should ensure that appraisals for all doctors are carried out in appropriate settings.

- 16) NIMDTA should ensure that appropriate feedback is received from appraisees on their experience of the appraisal process.
- 17) NIMDTA should work towards development of a minimum data set or essential evidence to inform the appraisal discussion.
- 18) NIMDTA should continue to work towards retention of all Form 4s and PDPs. Currently appraisees can submit their Form 4 and PDP to NIMDTA for safe keeping on a voluntary basis. This should be encouraged and should become a mandatory requirement.

## 6.0 SYSTEMS AND INFRASTRUCTURE SUPPORTING APPRAISAL

There is a dedicated administration team in NIMDTA supporting the Appraisal process in Northern Ireland. The team consists of

- Grade 5 administrator x 1
- Grade 4 administrator x 2
- Grade 3 administrator x 1
- Grade 2 administrator x 1 in Human resources.

There is also significant support from the Human Resource Manager and the Finance Manager in NIMDTA.

Appraisees are requested to have their documentation and portfolio of evidence available to their appraiser two weeks prior to the appraisal discussion. On average six hours is allowed for an appraiser to complete an appraisal from initial contact to completion of the documentation.

In the Northern Ireland appraisal system appraisees may choose their own appraiser. All appraiser profiles are available on the NIMDTA website and an appraisee selects five appraisers any of whom they would like to carry out their appraisal.

On receipt of the Appraisal Registration and Declaration Form, NIMDTA forwards the contact details to the first choice appraiser. If for any reason they feel they cannot carry out the appraisal the appraisee is informed and their details are passed on to their second choice appraiser and so on until a suitable appraisal interview is confirmed.

An appraisee can have the same appraiser for three consecutive years. Thereafter they must change appraiser and cannot return to the original appraiser for a period of two years. There is also guidance on appraiser/appraisee matching with reference to conflict of interest.

The appraisal summary forms are retained by the appraisee. Their safekeeping is the responsibility of the appraisee. The anonymised Form 4s used to provide feedback to appraisers and appraisees are securely stored at NIMDTA. These are allocated a reference number on receipt which is matched to the appraiser.

Only members of the appraisal team have access to the Form 4s. The GP appraisal area of the NIMDTA computer system can only be accessed by certain named individuals and is password protected.

It is planned that in future Form 4s and PDPs will be scanned and stored in NIMDTA.

## **6.1 Findings Relating to the Systems and Infrastructure Supporting Appraisal.**

### **6.1.1 Strengths**

- a) The administration team supporting the appraisal process in NIMDTA, in common with the management team and teams of appraisers are committed to delivering the vision for appraisal on Northern Ireland. In preparing for the review visit they were helpful and competent, supplying all the supporting information which helped to inform the review.
- b) The efficient administration systems ensure that the information required to inform the appraisal discussion is with the appraiser in reasonable time.
- c) Appraisees felt that feedback from the appraisal process was both timely and appropriate.
- d) In the first year a backlog of appraisals built up leading to a large number of appraisals being carried out in the final quarter of the year. This led to some concerns regarding the adequacy of these appraisals. This has been addressed and there is now a more even distribution of appraisals throughout the year.

### **6.1.2 Challenges**

- a) Although it was felt that the administration support had improved, the lead appraisers felt that the number of e-mails they received was excessive and in two sessions per week it was impossible to answer these in timely fashion. Some filtering of the amount of information was suggested.
- b) There is a method for matching appraisers and appraisees, however this appears to be carried out on a subjective basis with appraisees permitted to choose their appraiser. Although appraisals carried out by close colleagues is discouraged, this system could be seen as less robust than a system where appraisers are randomly allocated by NIMDTA. Allocation of appraisers would also decrease the administrative burden on NIMDTA staff.
- c) At present, although a large part of the appraisal system is web based, the appraisees still have to collate and present their paper based portfolio of evidence to their appraiser. An e-portfolio, where each appraisee would have a password protected secure folder on the

NIMDTA website, would streamline the process by easing the collation and presentation of information for the appraisal discussion.

- d) In relation to the e-portfolio, in discussion with appraisees this proposal was not viewed positively at this time. It is understood that this is a very small section of the GP community but further discussion with the profession may be needed before taking this proposal forward.

### **6.1.3 Recommendations**

- 19) NIMDTA should review the process for matching appraisers and appraisees.
- 20) NIMDTA should consider development of an e-portfolio allowing each appraisee to have a password protected secure folder on the NIMDTA website to ease the collation of information for the appraisal discussion.

## 7.0 CONCLUSIONS

The GP appraisal process in Northern Ireland, led by NIMDTA, is now well established as a centrally driven, locally delivered appraisal system which has achieved the engagement and support of the majority of the GPs in Northern Ireland. The commitment to the vision of the appraisal process is evident from the management team through to the administration team that supports the process.

There is a well-defined quality assurance process, a recently established scheme for performance management of appraisers and an appeals process which, though rarely used, appears well structured and effective.

The Central Board of Management of the appraisal process oversees the implementation of the GP appraisal scheme and provides an effective forum to facilitate strategic decisions.

There is an open and transparent selection process for appraisers and the training they undergo has been well received. Feedback on training is provided and this gives direction for fulfillment of future training needs.

Proposals for the introduction of revalidation for GPs have involved detailed discussion around introducing a summative element to GP appraisal. The clear feeling from all groups interviewed was that appraisal should remain a developmental process. If it became a more summative process with explicit judgments being made by appraisers it may raise significant issues for appraisers and also the support of the profession for the process would be threatened. Amongst the groups interviewed there was significant concern about how this process could be managed and a belief that if a summative element was introduced as part of revalidation any assessment process should be external to GP appraisal. There was also a recognition that to remain fit for purpose the appraisal system should strive to ensure the consistent provision of a high quality appraisal process that can offer all doctors an opportunity to reflect meaningfully on all aspects of their practice and facilitate their development.

Overall the review teams observed an appraisal system with effective leadership which is currently adequately resourced, very supportive of its appraisers and appraisees and willing to listen to feedback and make changes as a result of this feedback.

The following summary of recommendations is set in the context of an overall highly positive assessment of the GP appraisal process in Northern Ireland.

## 8.0 Summary of Recommendations

### Organisational Ethos

#### **Recommendation 1**

NIMDTA should review links with the Educational Consortium as appraisers and appraisees were unclear about the relationship of the Educational Consortium with the appraisal process.

#### **Recommendation 2**

NIMDTA should work to establish better links with other governance processes particularly in cases where other organisations have significant concerns regarding a practitioner's performance.

#### **Recommendation 3**

NIMDTA should work towards inclusion of further clinical governance data as part of the information for appraisal.

#### **Recommendation 4**

NIMDTA should work to ensure that although formative, appraisal is seen as a challenging process, ensuring that developmental objectives identified in PDPs have been addressed. Further training should emphasise the processes of probing and reflection thus challenging the appraisee.

#### **Recommendation 5**

NIMDTA should carry out a review of the level of remuneration for appraisers to see if it is appropriate in relation to the current and anticipated workload involved with the appraisal process.

#### **Recommendation 6**

NIMDTA should carry out research into the impact of appraisal on General Practice.

#### **Recommendation 7**

NIMDTA should work towards recruitment of more appraisers from the cohorts of younger and female practitioners.

#### **Recommendation 8**

NIMDTA should develop improved methods for dissemination and sharing of good practice.

## Appraiser Skills, Selection and Training

### **Recommendation 9**

NIMDTA should encourage more contact for lead appraisers and appraisers with appraisal processes nationally.

### **Recommendation 10**

NIMDTA should ensure that training is made available to appraisers on assessment and use of further clinical governance information in the appraisal discussion.

### **Recommendation 11**

NIMDTA should ensure that support and training for appraisers is sufficient to allow a robust appraisal for non-UK graduates.

### **Recommendation 12**

NIMDTA should work with HSC Boards on establishing an induction process for non-UK graduates.

## The Appraisal Discussion

### **Recommendation 13**

NIMDTA should ensure that the Form 4 and PDP are available in all cases and are the starting point for each appraisal discussion. This will ensure that the appraisal discussion can be informed by the previous year's documentation enhancing continuity when there is a change in appraiser.

### **Recommendation 14**

NIMDTA should ensure that sessional doctors who undertake appraisal are adequately supported.

### **Recommendation 15**

NIMDTA should ensure that appraisals for all doctors are carried out in appropriate settings.

### **Recommendation 16**

NIMDTA should ensure that appropriate feedback is received from appraisees on their experience of the appraisal process.

### **Recommendation 17**

NIMDTA should work towards development of a minimum data set or essential evidence to inform the appraisal discussion.

**Recommendation 18**

NIMDTA should continue to work towards retention of all Form 4s and PDPs. Currently appraisees can submit their Form 4 and PDP to NIMDTA for safe keeping on a voluntary basis. This should be encouraged and should become a mandatory requirement.

**Systems and Infrastructure Supporting Appraisal****Recommendation 19**

NIMDTA should review the process for matching appraisers and appraisees.

**Recommendation 20**

NIMDTA should consider development of an e-portfolio allowing each appraisee to have a password protected secure folder on the NIMDTA website to ease the collation of information for the appraisal discussion.

**Appendix I : Membership of Review Teams****TEAM ONE**

<b>Name</b>	<b>Title</b>	<b>Organisation</b>
Dr Niall Cameron	GP/National Appraiser Advisor for Scotland	NES Scotland
Dr Katherine MacLurg	GP/Medical Advisor	EHSSB
Niall McSperrin	Lay Reviewer	
Hall Graham	Head of Primary Care Review	RQIA
Tony Hanna	Project Administrator	RQIA

**TEAM TWO**

Dr Mairi Scott	Director of Professional Development Academy	University of Dundee
Dr Stephen Bailie	GP/Medical Advisor	WHSSB
Elizabeth Knipe	Lay Reviewer	
Bridget Dougan	Project Manager	RQIA
Doris Patton	Project Administrator	RQIA

## APPENDIX II

### Glossary of Abbreviations

CPD	Continuing Professional Development
DHSSPS	Department of Health, Social Services and Public Safety
GMC	General Medical Council
GMS	General Medical Services
GP	General Practitioner
GPC	General Practice Committee
HSS Board	Health and Social Services Board
NIMDTA	Northern Ireland Medical and Dental Training Agency
NISDA	Northern Ireland Sessional Doctors Association
PDP	Personal Development Plan
PMPL	Primary Medical Performers List
RCGP	Royal College of General Practitioners
RQIA	Regulation and Quality Improvement Authority