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Evaluating and developing GP appraisal processes

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Executive summary

Introduction

This report details findings from a study undertaken by the School of Primary Care, Severn Deanery and the School of Health and Social Care, Faculty of Health and Life Sciences, University of the West of England, Bristol (UWE) between November 2008 and November 2009 to evaluate and develop GP appraisal processes in an area in the South West of England.

A process of licensing for all doctors practising medicine in the UK is currently being implemented by the General Medical Council (GMC). All licensed doctors will need to demonstrate at regular intervals that their practice meets the generic standards set by the GMC, as described in *Good Medical Practice* (GMC 2006). Licensing will involve a process of revalidation for individual practitioners. It is planned to incorporate revalidation into the current appraisal processes for all medical professionals (GMC 2008).

Although a statutory requirement, GP appraisal has until recently had primarily a formative, developmental purpose (DH 2002). Despite being obligatory, the uptake of GP appraisal has been problematic and inconsistent (Martin et al 2003). To date, only a limited amount of research or evaluation about GP appraisal has been published. However, there is recognised tension between the concept of appraisal as both a supportive developmental process and as a measure for judging fitness to practise.

Study aims

This study set out to evaluate existing evidence submitted by GPs for the purposes of appraisal, and to explore how a model for appraisal could be developed that meets the needs of revalidation but also acts as a developmental process for individual GPs.

Methods

Both qualitative and quantitative methods were used for this study, in order to provide both breadth and depth to the evaluation. Quantitative data sources comprised all the appraisal evidence checklists used by appraisers in one Primary Care Trust (PCT) over the financial year April 2008 to May 2009 (n=123). The evidence checklist

provides a basic template for recording the types of evidence a GP appraisee submits for appraisal purposes, and whether the evidence submitted relates to an individual's personal practice, or to organisational practice within the GP practice as a whole. Data were analysed using descriptive statistics. Comparative analysis of types of evidence was conducted for appraiser, appraisee age and appraisee status.

Qualitative data were collected through 5 focus groups held with 23 attendees at a GP appraisal stakeholder event hosted by the Deanery, and through interviews with all the appraisal leads for PCTs within the Deanery's geographical area (n=7). Data were analysed thematically.

The study was approved by a University research ethics sub-committee.

Main findings and points for consideration

Findings from this study raise particular points for consideration in relation to the appraiser role; the nature of evidence required for appraisal; the situation of sessional doctors; appraisee age; sharing expertise and experience; and the role of the Deanery in appraisal.

Appraiser role

Most focus group and interview participants were adamant that appraisal should retain a strong developmental element. Clear definition of the role and appropriate national training were seen as essential factors contributing to the success of the process.

Evidence required for appraisal

A notable feature of the focus group data was the confusion expressed by many participants about the nature and amount of evidence required for appraisal. Given the perception that appraisal for revalidation is extremely time-consuming for individual GPs, it was felt that having a clear brief about the evidence required is essential. The revised RCGP guidelines published after these data were collected (RCGP 2009, 2010) may go some way to ameliorating this problem, particularly with respect to the description of what constitutes audit for appraisal purposes.

Sessional doctors

Many focus group participants and at least one appraisal lead were concerned that sessional doctors would have problems collecting the required evidence for appraisal. However, the data from this study also suggest that these problems can be addressed. The checklist data revealed very few substantive differences between principal and sessional doctors with regard to evidence submitted for appraisal. In particular, there was no statistically significant difference between the proportions of principal and sessional doctors who provided supporting information concerning their personal practice in relation to significant events, data or audit collection, multi-source feedback and complaints; this was notable, as these four areas have been identified as potentially problematic for sessional doctors (RCGP 2009, 2010). A number of the study participants were able to provide anecdotal evidence concerning innovative practice among sessional doctors with respect to the collection of evidence for appraisal, both at personal and collective levels. All these data, taken together, suggest that sessional doctors' problems in this regard may be overstated, as long as appropriate support is provided by employing practices and PCTs.

Appraisee age

The stereotype of the older GP, near retirement and not computer-literate, and not wishing to engage with appraisal, was present in the data. However, this was counterbalanced by examples of exceptions, and concern expressed about some younger, part-time GPs, whose personal circumstances do not support their involvement in appraisal. No differences were found in the checklist data between younger and older GPs with regard to the evidence they provided for appraisal. This applied to all GPs, and also only to locum GPs. It appears that difficulties encountered arise due to individuals' particular circumstances or personalities, rather than because they belong to a defined category of appraisee.

Sharing expertise and experience

A very strong feature of the qualitative data was the extent to which participants enthused about the benefits they experience when presented with opportunities for sharing expertise and experience. A number of suggestions concerning format were made, including both face to face and on-line media.

The role of the Deanery in appraisal

There was no consistency with regard to participants' opinions about the degree to which the Deanery should be involved in the co-ordination of the appraisal process. However, all the participants, both from the focus groups and the appraisal leads, were clear that the Deanery has a valuable role to play in training and preparation for appraisal for both appraisers and appraisees. They welcomed the idea that the Deanery could provide fora for sharing expertise and experience, as well as providing structured, dedicated preparation for appraisees. The Deanery was also thought to be well placed to help address any lack of consistency among appraisers through appropriate training.

Recommendations

1. Change the organisational culture of practices and trusts to encourage access for sessional and locum doctors to Clinical Governance, Significant Event, Audit and Data Collection, through meetings and improved communication. This could be accelerated by including locum access as a quality criterion to be reviewed at practice inspections by PCTs or by the Care Quality Commission.
2. Encourage, establish and facilitate fora and self directed groups for isolated locums and sessional GPs.
3. Provide examples of innovative ways of collecting evidence for this group.
4. Establish new tools designed specifically for this group, such as patient and colleague feedback.

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Introduction

This report details findings from a study undertaken by the School of Primary Care, Severn Deanery and the School of Health and Social Care, Faculty of Health and Life Sciences, University of the West of England, Bristol (UWE) between November 2008 and November 2009 to evaluate and develop GP appraisal processes in an area in the South West of England.

A process of licensing for all doctors practising medicine in the UK is currently being implemented by the General Medical Council (GMC). All licensed doctors will need to demonstrate at regular intervals that their practice meets the generic standards set by the GMC, as described in *Good Medical Practice* (GMC 2006). Licensing will involve a process of revalidation for individual practitioners. Should they specialise in a particular area, confirmation that their practice meets required standards will also be required from the relevant Royal College or Faculty (Shelly & Conlon 2008). It is planned to incorporate revalidation into the current appraisal processes for all medical professionals (GMC 2008).

Appraisal processes for GPs are currently being developed by the Royal College of General Practitioners (RCGP) so that they will be fit for purpose in terms of requirements for revalidation. GP appraisal typically involves an individual GP meeting face-to-face with a trained appraiser who is also a GP. For revalidation, appraisees are expected to produce a range of evidence over a five-year cycle to demonstrate that they are meeting the GMC's criteria for acceptable medical practice (RCGP 2009). GP appraisal is expected to occur on an annual basis, and is organised and managed through the primary care organisation in which an individual GP's practice is based.

Although a statutory requirement, GP appraisal has up to now had primarily a formative, developmental purpose (DH 2002). Moreover, despite being obligatory, the uptake of GP appraisal has been problematic and inconsistent (Martin et al 2003). There are several issues around the introduction and use of the GP appraisal process. These include:

- Expense incurred by primary care organisations
- Difficulties with the logistics of administering appraisals and processes
- Tensions between the need for a formal appraisal process supporting revalidation /

- re-licensure and the need for appraisal also to meet developmental needs
- Uncertainties about the quality, appropriateness and type of evidence used to support GP appraisal
- Limited opportunities for sessional and locum GPs to collect appropriate evidence.

To date, only a limited amount of research or evaluation about GP appraisal has been published. However, there is evidence that some GP appraisers think that appraisal should have a pass/fail element, and that appraisal should help decide about individual appraisees' fitness for revalidation (Kelly 2007). GPs have also reported being unsure about what constitutes appropriate evidence for appraisal (Boylan et al 2005). In the latter study, there was also concern about appraisers receiving appropriate training. The study recommendations included provision of exemplar evidence material to appraisees, and GP tutor help for appraisees with preparation for interview, compiling evidence and completing forms. Recommendations from a study investigating PCT Chief Executives' concerns about appraisal include making appraisal more challenging and developing training for appraisers (Walton 2007). Some appraisers have also been found to need support to develop their communication and interpersonal skills (Loughrey & Boylan 2008). In addition, over the last few years, there has been discussion in the literature about the potential problems for non-principal GPs concerning the appraisal process (Martin et al 2003, Martin 2004, Jelley et al 2007, Ings and Preece 2009). In particular, it is feared that non-principal GPs may struggle to collect the evidence required for revalidation, a possibility that has been acknowledged by the Royal College of General Practitioners (2009).

Study aims

In light of the above, this study set out to evaluate existing evidence submitted by GPs for the purposes of appraisal, and to explore how a model for appraisal can be developed that meets the needs of revalidation but also acts as a developmental process for individual GPs.

Methods

Ethical approval

Ethical approval for the study was gained from a Research Ethics Sub-Committee in the Faculty of Health and Life Sciences at UWE.

Research design

Both qualitative and quantitative methods were used for this study, in order to provide both breadth and depth to the evaluation. Quantitative data sources comprised all the appraisal evidence checklists used by appraisers in one PCT over one financial year. The sample for the qualitative phase of the study comprised all attendees at a GP appraisal stakeholder event hosted by the Deanery, and all the appraisal leads for PCTs within the Deanery's geographical area.

Data instruments and collection

The evidence checklist was designed when appraisal was still essentially a formative process. This instrument provides a basic template for recording the types of evidence an appraisee submits for appraisal purposes, and whether the evidence submitted relates to an individual's personal practice, or to organisational practice within the GP practice as a whole (Figure 1). Whether or not an appraisee has reflected on particular aspects of practice is also recorded on the checklist. PCT administrative staff anonymised 123 checklists and coded them for appraiser, as well as status and age of appraisee.

Qualitative data were collected through focus groups and interviews. At the stakeholder event 23 participants in five focus groups (Table 1), each facilitated by a non-medical academic, explored aspects of appraisal processes for revalidation, triggered by questions concerning both the appraiser and appraisee perspective (Figure 2). Individual semi-structured interviews were conducted with appraisal leads from the seven PCTs covered by the Deanery. The interview was based on key findings from analysis of both the checklist and focus group data.

<p>Good clinical Care (personal/organisational): Case Reviews Significant events Data Collection or Audit QuoF and prescribing data</p> <p>Maintaining Good Medical Practice (personal): Personal learning log CPR/Child Protection Membership of learning organisations</p> <p>Relations with Patients/Colleagues (personal/organisational): Patient Survey Summary of Complaints OR Statement of No Complaints Information for patients eg practice leaflet Multi source feedback (currently optional) Referrals and relations with secondary care</p> <p>Reflection/appraisal in other roles (personal): Research Teaching Management Probity Health Overview of achievements and challenges Updated PDP</p>
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Figure 1. Types of evidence whose submission is recorded on the GP appraisal checklist

Role	Number
GP appraiser	17
GP appraisee	3
GP appraiser trainer	1
GP educator	1
GP appraisal manager	1
Total	23

Table 1. Focus group participants at the GP appraisal stakeholder day

<p>How should the appraiser role be reconceptualised to satisfy the requirements of revalidation? What development/training needs do current appraisers have in this regard? What preparation do appraisees need, in order to use appraisal to their best advantage? Do different groups (principal, sessional or locum GPs) have different preparation needs?</p>

Figure 2. Questions explored during the focus groups at the GP appraisal stakeholder day

Data analysis

Checklist data concerning type of evidence, appraiser, appraisee age and appraisee status were analysed using descriptive statistics. Comparative analysis of types of evidence was conducted for appraiser, appraisee age and appraisee status, using the Chi-square test, with significance $P \leq 0.05$ (Sim and Wright 2000). Qualitative data were analysed thematically (Bryman 2001).

Findings

Evidence checklist results

Findings concerning the evidence checklists incorporate both quantitative findings from the checklists themselves, as well as qualitative findings from the appraisal lead interviews. Interview respondents are represented by a research code: for example, AL1 indicates Appraisal Lead 1.

Checklists were completed by 10 appraisers, each responsible for between 3 (2.4%) and 20 (16.3%). The mean number of checklists completed by one appraiser was 12 and the median was 14. The characteristics of the 123 GP appraisees appear in Table 2.

Status	30 – 39 years	40 – 49 years	50 – 59 years	≥ 60 years	Female	Male	No (% of sample)
Principal	13	38	22	3	32	44	76 (61.7)
Salaried	7	6	2	1	12	4	16 (13.0)
Locum	13	4	5	5	15	12	27 (22.0)
Other	2	2	0	0	4	0	4 (3.3)
Total	35	50	29	9	63	60	123 (100)

Table 2. GP appraisees by status, age and gender

More appraisees aged between 40 and 59 years were principal GPs than those aged over 60 years or under 40 years (75.9% vs 36.4%) ($X^2=18.80$, $df=3$, $p<0.001$). More males than females were principal GPs (73.3% vs 50.8%) ($X^2=7.41$, $df=2$, $p=0.025$).

Differences between groups

Very few differences were found between GP groups, in terms of type of evidence submitted for appraisal. Tables 3 and 4 show what personal and organisational evidence was collected by GPs with different status, which appeared to be the most common cause of difference.

Practice area	Principal (76)	Salaried (16)	Locum (27)	Other (4)
Case review	48 (63%)	10 (63%)	23 (85%)	3 (75%)
Significant event	65 (86%)	14 (88%)	20 (74%)	3 (75%)
Audit/data collection	59 (78%)	11 (69%)	17 (63%)	3 (75%)
Prescribing	35 (46%)	5 (32%)	4 (15%)	0 (0%)
Learning log	67 (88%)	11 (69%)	24 (89%)	4 (100%)
CPR	68 (90%)	15 (94%)	23 (85%)	3 (75%)
Child protection	57 (75%)	14 (88%)	18 (67%)	3 (75%)
Learning org. Member	65 (86%)	11 (69%)	22 (82%)	4 (100%)
Patient survey completed/in progress	65 (86%)	11 (69%)	14 (52%)	3 (75%)
Complaints received	17 (22%)	5 (31%)	10 (37%)	1 (25%)
No complaints	57 (75%)	11 (69%)	17 (63%)	3 (75%)
No data re complaints	2 (3%)	0 (0%)	0 (0%)	0 (0%)
Information for patients	38 (50%)	7 (44%)	2 (7%)	1 (25%)
Multi-source feedback	13 (17%)	5 (31%)	9 (33%)	2 (50%)
Referrals	34 (45%)	7 (44%)	10 (37%)	1 (25%)
Research	10 (13%)	1 (6%)	1 (4%)	0 (0%)
Teaching	47 (62%)	9 (56%)	13 (48%)	0 (0%)
Management	26 (34%)	2 (13%)	5 (19%)	0 (0%)
Probity	60 (79.0%)	12 (75%)	21 (78%)	3 (75%)
Health	56 (74%)	11 (69%)	24 (89%)	3 (75%)
Overview	57 (75%)	14 (88%)	23 (85%)	3 (75%)
Updated PDP	63 (83%)	13 (81%)	24 (89%)	3 (75%)

Table 3. Personal evidence provided – numbers of GPs and percent of the sample

Practice area	Principal (76)	Salaried (16)	Locum (27)	Other (4)
Case review	7 (9%)	3 (19%)	1 (4%)	1 (25%)
Significant event	44 (58%)	11 (69%)	8 (30%)	3 (75%)
Audit/data collection	44 (58%)	8 (50%)	4 (15%)	2 (50%)
QoF	59 (78%)	14 (88%)	9 (33%)	3 (75%)
Patient survey completed/in progress	21 (28%)	4 (25%)	7 (26%)	1 (25%)
Multi-source feedback	4 (5%)	0 (0%)	0 (0%)	0 (0%)
Referrals	12 (16%)	1 (6%)	1 (4%)	1 (25%)
Research	5 (7%)	0 (0%)	0 (0%)	0 (0%)
Teaching	4 (6%)	0 (0%)	0 (0%)	0 (0%)
Management	8 (11%)	1 (6%)	0 (0%)	0 (0%)

Table 4. Organisational evidence provided – numbers of GPs + percent of the sample

Significant events

68.8% of salaried GPs provided evidence of organisational significant events, compared with 57.9% of principal GPs and only 35.5% of others, including locums ($X^2=6.13$, $df=2$, $p=0.047$). There was no statistical difference in the proportions of GPs from different groups with regard to evidence of personal significant events, and none between principal and non-principal GPs overall. Numbers/ proportions of GP groups

providing both personal and organisational significant events evidence can be seen in Table 5.

Status	Principals	Salaried	Locum	Other	Total
No (% of group/sample)	34 (45%)	9 (56%)	5 (19%)	2 (50%)	50 (40.7%)

Table 5. Numbers/ proportions of GP groups providing evidence of both personal and organisational significant events.

Data collection/audit

57.9% of principal GPs provided evidence of organisational data collection or audit, in contrast with 50% of salaried GPs and only 19.4% of others ($X^2=13.18$, $df=2$, $p=0.001$). There was no statistical difference in the proportions of GPs from different groups with regard to evidence of personal data collection/audit and none between principal and non-principal GPs overall. Numbers/proportions of GP groups providing both personal and organisational data collection/audit evidence can be seen in Table 6.

Status	Principals	Salaried	Locum	Other	Total
No (% of group/sample)	30 (39%)	5 (31%)	1 (4%)	2 (50%)	38(30.9%)

Table 6. Numbers/ proportions of GP groups providing evidence of both personal and organisational data collection/audit.

Patient surveys

78.9% of principal GPs provided evidence of personal patient surveys, in contrast with only 53.2% of non-principal GPs ($X^2=11.15$, $df=2$, $p=0.004$). There was no statistical difference in the proportions of GPs from different groups with regard to organisational evidence of patient surveys and none between principal and non-principal GPs. Numbers/proportions of GP groups providing both personal and organisational patient survey evidence can be seen in Table 7.

Status	Principals	Salaried	Locum	Other	Total
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No (% of group/sample)	18 (24%)	3 (19%)	2 (7%)	0 (0%)	23 (18.7%)
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Table 7. Numbers/ proportions of GP groups providing evidence of both personal and organisational patient surveys.

QoF/Prescribing and information for patients

46.1% of principal GPs provided evidence of personal prescribing, in contrast with 31.3% of salaried GPs and only 12.9% of other GPs (locums, flexible career scheme GPs, GP retainers) ($X^2=10.70, f=2, p=0.00$). 87.5% of salaried GPs provided evidence of organisational QoF, compared with 77.6% of principal GPs and only 38.7% of others ($X^2=18.54, df=2, p<0.001$). 50% of principals provided evidence of personal information for patients, in contrast with 43.8% of salaried GPs and only 9.7% of others ($X^2=15.22, df=2, p<0.001$).

Appraisal leads' opinions

Appraisal leads intimated that they found using evidence checklists helpful in order to monitor the appraisal process:

AL4: It's nice to see that the evidence is there and that there's evidence of reflection. I don't go so far as doing my impact assessment like the college might want me to do; but I've got checklists and examples ...

AL5: I have appraised individuals where if I hadn't had the check list I would not have been able to say fairly, robustly, 'Look we sent you this, you should have produced this, you should have produced this, you should have produced this. This is the level of evidence that we're actually looking for and you haven't produced that, how are you going to move it on? And realistically in your personal development plan, I'm going to have to put down that the evidence that you were asked to produce didn't meet the criteria that you were asked to produce, and that in future that would have failed revalidation had it been today.' The check list was the black and white bit of paper that I had to say that ... it stopped it being quite so waffly ... people in the main will produce lots more evidence than the checklist, but the checklist at least gave us something as a starting block. I don't want it to be that you just produce that evidence, that would be useless as well, because you know people have got loads of stuff they can tell us about, and

actually they want to tell us all the good things they have done and if you're not careful you don't leave room for that. So I like checklists to a point.

AL6: We do use that [the checklist], that's part of it ... was it *GP educator's* debate, that you shouldn't make the summative process formative? Which actually I thought was quite good, so what you do is you tick all the boxes and then you have your appraisal. So actually you come along to me with your list of stuff that you've done to make sure that we've gone through the appraisal process, and then we carry out the sort of, the fluffier side of it.

Focus group and interview findings

These findings are presented as four broad themes: feelings about appraisal; problems identified; suggestions for improving the appraisal process; and the role of the Deanery in appraisal. Focus group respondents are identified by a code: for example, R1 indicates Respondent 1.

Feelings about appraisal

Participants expressed mixed feelings about the enhanced process linked to revalidation for GPs. A few individuals were extremely pessimistic both about its feasibility and its validity. Some individuals also reported that some of their colleagues were no longer happy to be appraisers, due to the changing nature of the process, namely, the introduction of the summative element:

R11 (appraiser): Well it is an over-arching statement that it used to be a supportive role, but now there would be an element of judgement in it, which until now, it wasn't an explicit element, but now it will be an explicit element of judgement on the data that we present. So that changing how – shall we say the dynamics between the appraiser and the appraisee significantly?

R21 (appraiser): You've still got two issues. One is this objective presentation of an individual's performance by the individual, which this is really. And the other one is the objective assessment of whether they're any good..When the next disaster strikes, and it will, and they go back through their revalidation process, they're going to say 'This process isn't worth the paper it's written on in terms of licensing people's fitness to practice'.

AL7: I think the significant disadvantage of it is that I see that for the 95% of GPs who are nowhere near bad enough to fail revalidation, the main purpose of appraisal is to be positive, creative, formative, developmental, with the appraiser as a facilitator, a tool to be used by the appraisee; and so this conflicting role of policeman and educator, mentor, supporter, peer – peer being the most important thing – can be dominant; and I think that's a terrible shame because revalidation is not a problem for nearly everybody, it's only a problem for very poor doctors; and for that to take over all the benefits of appraisal which I think are much more important than the

disadvantages, I think that's why it's a disadvantage; because if you want people to expose their weak points and their fears, then if you're also the policeman that clearly is a disincentive for them to expose them. So it takes a much more skilful appraiser to be helpful, rather than just a box ticker, which I think is a very real problem with revalidation-based appraisal,

R23 (appraiser): Some of the appraiser colleagues in my PCT have a big issue with this, going from formative to judgmental and I don't care what you say, it is judgmental. We have shifted. The goalposts have moved and therefore I think there will be some people who are no longer comfortable to do it, because they are being asked to actually, not just be there as a sounding post and help people reflect on their own practice and make their own changes, but actually to say to them, 'Sorry mate you're not doing this right and therefore we've either got to do this, this and this to make sure that you do tick the boxes'.

AL3: Appraisal's been a generally positive process for most GPs. It's taken quite some years for them to get used to it and understand what's expected and things, but many of them have embraced it and do find it as a good educational and developmental process to be going through. Obviously that aspect will continue and so those are the positive things that stay with it; but there's the little bit of concern from us appraisers that now we'll be having to do a lot more policing, maybe taking a lot more responsibility for being certain that things are put in place in terms of evidence. ... A lot of the appraisers come from an educational background, a lot of them are GP trainers, a lot of them are interested in teaching, so they've gone into the appraisal process with their teaching hats on. The idea of being a policeman is quite daunting to many of them although I think they will step up to the line – but it is a bit daunting for them.

The majority of the participants appeared to have accepted the changes, and were positive about making the process fit for purpose. Some positive views were based on a perception that appraisal could actually become fairer because of the summative element:

R2 (appraiser): One of the things strangely that I think revalidation will allow me to do as an appraiser is to be more fair. In that I am so aware that there

are some people that produce wonderful appraisal material. ... And there are other people ... the effort is so minimal compared with the person who's done such a good job, and I do feel that revalidation is going to allow us a little bit as appraisers to say, 'You know really, you're an intelligent person here, you're a good GP, but actually you're really not doing what you should be doing. You need to show me a little bit more'.

R22 (appraiser): You must have done your SEA [significant event audit]; must have done this, this and this, and provided that has happened then we can go on to talk about your CPD [continuing professional development] and how we develop you over the next year and how we do the formative stuff. So I think dividing it up into the summative and formative is actually very helpful.

AL7: I think there are some benefits to being linked to revalidation, in that because it's a formal statutory, in inverted commas, process, there hopefully eventually will be some clear guidelines as to what has to be done as a minimum standard. So for GPs who are failing or who are likely to fail ... it will make it very clear that they have to meet those requirements, so that's not optional.

Some participants felt that, for appraisers with an educational background, managing a system that was both formative and summative would be unproblematic:

R6 (appraiser): They were talking this morning about the conflict between being formative and summative and actually I'm very familiar with that being a GP trainer, because that is exactly my role as a trainer. I'm a trainer, an appraiser, I'm an assessor, I'm a supporter, I'm a mentor - you have so many different hats as a trainer, that that doesn't feel too uncomfortable as an appraiser.

There was also general agreement that appraisal would improve the public profile of GPs, in that it would be seen to be helping to maintain practice standards:

R4 (appraisee): I think if it [appraisal] goes well and works well, I think our standing, not just in the outside world, but I think actually in the medical world, [will increase] ... amongst other specialties, I think general practice

has often taken the lead, whether it's with the type of exams we produce, or the type of training we produce; the type of interviewing and selection and all that sort of thing; and I think this is an opportunity that I think we shouldn't be afraid of....

Nonetheless, there was some scepticism and confusion as to whether the process, as currently designed, would actually be able to improve and/or maintain standards. This perception appeared also to be influenced by the ongoing delays in implementing appraisal for revalidation. In four of the five focus groups, the opinion was expressed that, even in its enhanced state, appraisal would probably not be able to detect the problems associated with a doctor like Harold Shipman, a perception that was discussed with the appraisal leads:

R19 (appraisal): The trouble is I think that is where the public perception of GPs' performance, the political perception of what has happened, has got muddled and I think this is what revalidation is, probably getting that performance management element into the appraisal process.

AL2: I think the thing that is unhelpful at the moment is the shifting sands ... long periods of confusion, and this has been going on for two years now and looks to go on for another two years yet, and I do think that's a little bit destructive.

AL1: I don't think appraisals were ever set out to catch a Shipman, nor that it should be, because the information made available to us during the appraisal doesn't encompass the information necessary to pass judgment on problems like that ... I think it depends on what we are trying to measure with this revalidation. If what we are trying to measure is that people are not sitting on their laurels and saying right I've got my degree I can now practise for thirty years without reading a single book or a single article ... then the process can help identify those who are not engaging enough. Now if it's looking at dangerous doctors for other reasons, much like in the Shipman mould, which are rare, I don't think it can catch those, I don't think the evidence is geared for that. In my eyes it's a bit of a tragedy that the two have been linked.

Problems identified

Problems with appraisal were identified for both appraisers and appraisees, with some overlap between them. Participants were concerned with three main areas seen to affect appraisers: accountability and consistency of standards; confusion about process and requirements; and workload and impact on practice. There were four problematic areas identified for appraisees: evidence required; morale, engagement and continuity; the varying nature of GPs and GP practice; and resources and workload.

Appraisers

Accountability and consistency of standards

Concern was expressed that an individual appraiser could be held accountable should he/she conduct an appraisal with a GP who subsequently was revealed as being unfit to practise. This concern was based on the lack of standardisation within the current process, particularly around the evidence required:

R22 (appraiser): I think the appraiser role is becoming more – well the responsibility of it is greater, because I think as someone said earlier, that if there's any doubt about a doctor's performance and the GMC are involved, the appraisals will be looked at, the appraisers will be looked at by inference, you know. So I think the responsibility role is much bigger.

AL3: At the moment you know we allow some laxity. If people's portfolio is there or thereabouts, you usually say, 'Well you could do this a bit better next year but you know, it's quite close'; and we never think of not signing off the appraisal and being satisfied unless there's something huge and glaring. Whereas I am sure that once we're taking more responsibility for the revalidation, relicensing process or pathway, although it's not our final say so, I think we'll be under a lot more pressure to be certain that things are done to a standard that maybe makes it more like a pass or fail than we've ever previously had to do.

There was also acknowledgement that currently most appraisers do not receive standardised training or monitoring, and that there is no consistency in the way that

appraisal is conducted in different geographical areas, although exceptions were noted in both cases:

R9 (appraiser): One of the things I'd like to say is that I started off as an appraiser, did a course, have had a couple of meetings, maybe half a dozen or less meetings in the course of eight years and no-one has come along and said '*Name* you're the worst appraiser in God's earth, or you're the best or whatever', I've had no feedback.

R20 (appraiser): And we have to be doing broadly the same as elsewhere; I don't think it's acceptable that in one part of the Deanery the appraiser insists on every bit of that list being done, whatever it is, twelve items. And if it's not there we don't do the appraisal. That happens in some places. In our place, I'll do an appraisal without any of that being there and try and work with the person to try and get them doing it for next year, or get them doing some of it. Now, that's very different, and I think we have to agree across the region, across the Deanery, what's acceptable and what isn't.

AL3: Whenever I've gone to meetings I've been quite pleasantly surprised at how similar the attitude and behaviour of appraisers within different PCTs appears to be.

Suitable channels for dealing with 'problem' GPs were also sometimes unclear:

R8 (appraisee): There needs to be a system ... a transparent system, so that if a problem is flagged up, that the appraisee is aware of that and they are aware of what could happen to that information because of the implications for future practice. So perhaps the appraiser actually is going to need to notify someone – whose responsibility is it to tell the person has a concern? Presumably you identify it at the time, discuss it at the time, but what happens to that information and the implication to the individual? You need to be transparent in the processes that occur subsequently, you need to be transparent.

R23 (appraiser): ... [if] I have identified this doctor may have a problem.. I think it's reasonable to go back in three months later if they simply haven't got their act together, that is reasonable to do. But after that I think you

should be withdrawing and they should be going down the PCT performance path.

AL1: There hasn't been a forum for these things to go to, other than practice, individual and PCT at the moment. So many people feel, you know, well it's a colleague, I don't want to hurt them, I don't want to go to the PCT straight away ... there isn't really any intermediary service.

Confusion about process and requirements

Many participants appeared to be confused about how the new appraisal process would work, and what would actually be required of appraisers. For example, there was confusion about the limits and scope of the appraiser role, as well as about credits and the use of the electronic toolkit. However, the main point of confusion appeared to hinge on what the 'judgmental' (that is, summative) element of the process would entail, in terms of appraiser responsibility for identifying problems with individual GPs:

R18 (appraiser trainer): With the confusion that's happened over appraisal, over the last ten years, there is this sort of drip, drip, drip bit, that the message needs to keep interest in lots of different sources and consistently, and that I think still is not clear.

R19 (appraiser): That's why I was asking, what's the role of the appraiser in that? What summative role does the appraiser have in that? I understand the formative role, but at what point does that become [summative]?

R21 (appraiser): The system, sorry, is very unclear and unless we know what the fundamental philosophical objective of revalidation is, then we can't judge it. Because we're being told different things by different people.

R14 (appraisal): I mean there was a simple thing. You were talking about the credit system. And I had assumed there would be a system in place where I would know the number of credits I would have achieved. But you seem to be giving the impression that the appraiser would actually attribute credits to a piece of work.

R11 (appraiser): Quite how we are going to standardise approaches across patches if, for example - and a very simple example - if one uses one toolkit

and one uses another toolkit. One uses one way of interpreting information and one uses another way of interpreting information, I can see problems there.

There was also some confusion about the issue of audit as evidence. There were differing opinions as to whether audits submitted as evidence had to be personally conducted by appraisees, or whether appraisees could provide evidence of reflection and application to practice based on audit undertaken by someone else:

R21 (appraiser): It's a complete nightmare, because how can they [sessional doctors] do audits? They can't.

AL2: They're submitting possibly a pharmacy advisor audit or a student audit that they haven't really done very much with and so there is that learning curve. You have to explain to them the audit is fine but you've got to be involved, have personal reflection, change your practice, that sort of thing ... I don't think that auditing your referrals is just data collection. I think all audit starts with data collection, even formal audits, but the crucial bit of it is then the reflection, what you do with the results; and if you can write a reflective account of how your data collection in referrals has changed your practice or your data collection in an across-the-board practice audit, I don't think there's any difference really. So I don't see it that much as a just a data collection exercise.

Workload and impact on practice

Another area of concern was the issue of appraiser workload and possible financial implications. Given the summative element within the new appraisal process, there was a perception that appraisers would need to demand a far more systematic approach from GPs, but that this would entail a need for greater monitoring of individuals, particularly in relation to the timely preparation of appraisal paperwork:

R2 (appraiser): I'm probably going to have to sit down with a more defined idea of what I must have, rather than be more flexible for revalidation. That I will need to have this documentation; I will need to have it earlier. I can't actually accommodate you a few days before the appraisal, which does

happen. It actually does need to be more structured; more organised; more committed, from my side as well as from the appraisee's side.

R9 (appraiser): I'm going now, 'prove it'; and if you put something down on your PDP as a plan for next year, I want you to prove to me that that is a valid entry, so it's no good putting down 'I'm going to do a bit on diabetes'. I'm going to say 'prove it, how are you going to do it?' I don't want these wishy-washy things anymore and that's where I've come to.

R19 (appraiser): If you say appraisal starts when, two weeks before, and the appraisal isn't the day, it's actually two weeks before; and I will only proceed if it's up to scratch, therefore we'll negotiate, we'll put the day off, probably this and that, because I want to help them to make sure that when we actually get to the day they will definitely be okay. That's an awful lot more work potentially and changes the whole nature of the appraisal.

AL6: I think it will be a nightmare for the appraiser because the evidence is going to be so voluminous, how are we going to decide which bit to look at. ... I think if somebody has presented the evidence you should look at it all, but its going to be too, as I say, too voluminous to do.

Some participants also thought that appraisers should be able to direct appraisees to appropriate resources, in order to help them prepare for the appraisal process; but it was recognised that this could also take up a lot of the appraiser's time:

R15 (appraiser): But we also need access to resources to be able to help with the groups so that we can say, 'Well this can be done, because if you use this resource this will show you how to do it for your particular expertise'.

R10 (appraisee): Is this not putting an unfair, you know, more workload on the appraisers, suddenly to come up looking for an individual learning style and everything like that and help them through? Yes a bit of guidance is nice, but I think it would be unfair on the appraisers suddenly to say, 'This is now in addition to the appraisal itself, you're going to look at their learning styles, develop with them how they're going to do that'. I don't think that's fair on the appraiser.

All these issues were seen as potentially problematic, in that they could reduce the amount of time appraisers would have to devote to clinical activities. Timing of appraisals was also noted to be difficult, in that many participants reported often having to do the bulk of appraisals in the last few months of the financial year:

R22 (appraiser): It's [appraisal] taking people away from the patients

R3 (appraiser): It's difficult for appraisers as well ...you have nothing for a couple of months and then you've got twenty people saying, 'Can I have my appraisal tomorrow?'

Appraisees

Morale, engagement and continuity

There was a general perception that morale among GPs is low, with 'anxiety' about appraisal in its new form mentioned during three of the focus group discussions:

R13 (appraiser): I think at the moment people are probably getting more comfortable after a number of years with the appraisal process; and then this appears on the horizon, ever coming closer; and I think we have concerns about it and we're fully bought in, we're appraisers. Most GPs sitting out there doing their day job are going to be very anxious about it really I think. For the first few years they're going to be quite concerned and won't see it necessarily as a particularly positive process. I mean maybe once you've been through five years ... it might be seen again in a more positive light. I just think there's quite a lot of anxiety ... it's sort of trundled along so slowly hasn't it, that that hasn't really helped the anxiety and the profession.

R20 (appraiser): I suspect a lot of people have anxiety about this.

Engagement with the process was seen as difficult among some groups of GPs due to circumstances (see below), but also among others who regarded the process as having little relevance to their practice, for a variety of reasons. The opinion was expressed that the introduction of a summative element would force these GPs to engage more closely with the appraisal process, as their livelihood would be threatened if they did not. Problems were identified with both 'under-performers', that

is, those who offered the bare minimum in terms of evidence; and 'over-performers', that is, those who were producing far more evidence than was actually necessary, with obvious implications for their workload:

R15 (appraiser): We don't struggle with lots but we struggle with some [appraisees], and I think some of them will just be that bit resistant about having everything in place you know. I don't know what other areas were like, but engagement was a big issue when we started appraising.

AL1: People who are very set in their ways about seeing their job as an income generator and any time outside the income generator activities – and of course gathering appraisal related information is not income generating – is anathema to them.

R2 (appraiser): I am so aware that there are some people that produce wonderful appraisal material. They've gone to so much trouble and detail; they're committed; they're engaged and it's a delight to tick them and pass them. And there are other people that, for whatever reasons, you're sort of trying to drag them along in the hope that they will engage, and generally they do over a period of time, but the effort is so minimal compared with the person who's done such a good job.

Continuity was also thought to be a matter which needed attention. There was concern that, if appraisees were able to change appraiser as often as they liked, problematic issues identified in one appraisal might not be picked up the following year. Even in satisfactory circumstances, individual development would be difficult to monitor without continuity of appraiser:

AL6: How many appraisals should you have with one appraiser? ... I know we're doing two in five years, it's two different appraisers in five years, so you could say locally you could have the same appraiser for three years. I don't think there's a problem with that, especially if there are external markers that are coming along and saying, 'This has to be achieved'.

R17 (appraiser): Of course, when you see somebody a couple of times and then you don't know if they revert back to that cycle [not producing the evidence in time] the next time [with another appraiser].

Evidence required

Participants felt that many appraisees were still unsure about what sort and amount of evidence was required, and how it should be presented. The issue of audit was discussed in this regard (see above).

R8 (appraisee): But I think the other thing for people is actually, how much?.....What is the acceptable amount [of evidence], how much of this have I got to do? If I put down two 'learning needs' is that enough? is one enough? Is two enough, have there got to be five? You know, how many case reports have I got to do? Is one enough? I think a lot of people want to know, how much of this have I got to do? How much time do you think I should spend on it?

R12 (appraiser): I think that's another point that's added to the anxiety for the appraisees in that although we know the sort of things that will definitely provide the evidence for revalidation, we haven't heard the preciseness of what's going to be needed ... how many? how often? to what extent? those sort of things.

There were reports of GPs simply producing practice data as evidence for appraisal, rather than material pertaining to their own personal practice. There was general consensus that material should be relevant to the appraisee's own practice, and should be presented to highlight reflection and application to practice:

AL2: If the practice does an audit on something because either their whole practice has got to do it or it's a QOF thing or whatever, I think that's fine so long as then you look at the data, you look at your set of patients that might be part of it, reflect on it, think how it's going to change your practice, and change practice; and then look at the re-audit when that happens. So I have no worries about it being an across-the-board thing but ... what we don't accept in *city* is the practice does an audit, it's discussed at a meeting and that's your audit, tick - that won't do.

AL4: You can submit practice data if you've reflected on your own input into it, if it's been used to make changes. You can't put raw data of any kind in and hand it to your appraiser and say 'There you are' ... the whole essence of the appraisal process is reflection and so yes, you can use data that is shared data, but you have to explain why you're using it and what your input or your gain from it is.

AL5: I think there are ways of doing it which can use practice data personalised to an element, but sticking up the prescribing figures if you're one of twenty-four docs is useless, that's not going to tell you anything.

R20 (appraiser): I think the other thing is getting appraisees to understand that actually you can't possibly capture all your learning, or this process can't capture all your learning and thinking about what's going on ...

The varying nature of GPs and GP practice

This issue was a source of major concern for most participants, particularly in relation to sessional GPs (that is, salaried GPs, locums and out-of-hours GPs):

R3 (appraiser): Sessionals often like the freedom to do lots of different things and work in a not-so-structured way. But the flip side of that is it makes it incredibly difficult for them when they have to come into a structured system for revalidation, it doesn't fit with maybe some of their personalities as well you know, the way they work is much more - I'm sure they're all really excellent doctors, but they don't fit in a nice neat little box which is what revalidation would like them to do (laughs).

R4 (appraisee): I do have a concern because unless I get regular sessions in a practice - which is unlikely, because it's not what I'm aiming for, I wasn't aiming to be doing - it's going to be very difficult to get two significant event houses, because I'm not going to have the ability to go back and see what's happened to patients I've seen.

R12 (appraiser): I think the sessional doctors are a difficult group, I don't mean difficult in personality, I think they're difficult in their needs, different in their needs, different in their behaviour. That means it's harder to quantify,

and they're all very varied. You know if you'd got in this room a group of sessional doctors, what they'd be doing, or how they would be doing it, or how they saw it, would be different for every single person probably wouldn't it? And so I think they're going to be one of the big challenges.

R12 (appraiser): Well they're going to struggle with prescribing data because of course they're usually writing on someone else's prescription forms.

R14 (appraiser): For a sessional doctor there are some things that I as a principal can audit, but they wouldn't be able to audit...there are some areas of prescribing, you know, how do we manage chronic conditions? Their management of chronic conditions is usually going to be coming in and seeing what somebody else is doing and just altering it, or jollyng it along, so they can't do that in their audit can they?

A1: On the whole [locum] groups who work predominantly in one place have got less problems because they can engage with the appraisal and revalidation process as part of a larger, supportive team; they are a part of the team so to speak. The ones who are peripatetic or who work in a variety of locations though, face the problem that they don't really belong to one team. They are more or less sole agents and they would struggle to gather evidence from multiple sources like a multi-source feedback or audit, which need to be based on data which is checked and rechecked; and unless they are going back to the same place to work quite how they would do that is difficult. Managing to do an audit as a locum depends on a large degree on how flexible and understanding the practice is too.

AL3: I think the group that are going to struggle the most with all of the data collection, are going to be the locums, the sessionals, the assistants who haven't got a lot of time spent in the same practice and so for them I think it's going to be very hard.

AL4: I've raised it as an issue and said I don't know how we're going to get the sessional doctors able to do audits, for example.

It was also thought that the conditions of practice for non-principal GPs were critical for their ability to meet the requirements of appraisal:

R7 (appraisee): I'm probably the only one here who actually does locums...[I've] never had any difficulties with getting patient satisfaction survey or 360 re appraisal, but I do work for a couple or three practices on a fairly regular basis throughout the year ... I've never really had any great problem, but I think if you're an itinerant locum and you do the odd day here, the odd day there, then it becomes almost impossible to get any proper feedback.

R8 (appraisee): If you're outside training as an entity in any sense - so I would perceive colleagues in non-training practices, who haven't had a GP colleague come into practice within the last six, ten years - they're the people who are going to, I would have thought, really struggle with the mind-set involved in this process.

R22 (appraiser): I think sessional GPs can do it, I mean it's easier for them 'cos they're coming back into the practice, it's the locums who are going all over the place...

However, there was also a perception that different individuals' motivation was a key factor influencing how well-prepared these GPs were for appraisal:

R12 (appraiser): Having said that, you see some excellent papers from sessional doctors you know - so clearly, yes it can well be done. I've done [appraised] sessional doctors who have got probably papers better than some of the principals I do.

R15 (appraiser): I've only done one or two and I have just had all the excuses why they can't do it...I think a lot of the locum GPs have used their work as an excuse not to do things.

There were two examples given in a focus group in which it appeared that these problems might be insurmountable: a doctor who specialised in expedition medicine; and a Polish doctor who came to the UK to do

occasional out-of-hours work. In both these cases, it was questioned whether or not these individuals should remain on the GP performers list, as they appeared to be unable to meet the criteria for appraisal.

Age also seemed to be a factor, with some participants stating that older GPs (with some exceptions) were generally less happy to engage with the appraisal process. By contrast, GPs who had more recently qualified were perceived as having fewer problems with appraisal, as most of them had experienced similar processes during their training:

R3 (appraiser): I think there's a group of particularly older GPs who are still very negative about it, and they go through the motions and they will do the stuff, but they're not engaged in it and it's very difficult to change those attitudes I think.

R11 (appraiser): For some of them it's almost one change too many, because they've had a lengthy career, change upon change, they have felt that 'Right, we can coast for the last few years', and then all of a sudden it's 'No, no you can't, you've got to conform to this new system'. ... I'm not suggesting that everybody's like that but you get a few of them. I certainly got a few of them as an appraiser, which almost resented having to go through another cycle of change. That's the best way I can think of it.

Facilitator: So the main line of distinction is perhaps older, younger?

R12 (appraiser): No not the main line, it is one line.

R12 (appraiser): I think the preparation is very varied because I think people are coming from very different starting points. So if you take the example of somebody who is recently arrived in general practice, both as a junior doctor and a GP registrar, they've developed a sort of PDP that has been along these lines, So appraisal to them is not a big issue, because they've always thought of their practice in this way. If you look at a GP who's near the end of their career, this is like telling them to build a rocket for some of them, isn't it? Just because they've never reflected or reviewed their practice in this way, it doesn't mean that their function is necessarily at a lower level, it's just that they haven't got the building blocks to do the analysis.

AL3: The younger GPs cope very well, the ones that have come from registrarship where you've reflected on your practice and you've reported on everything you've done and you've checked your skills and you've checked your information, so they've really slipped into the appraisal process without a hitch.

AL5: I just have colleagues around me who just feel tired out by the system and complete change in the job that they originally started twenty five years ago, and I've just got a feeling that there are some of them who are pretty well fed up of constant change and bickering and all the rest of it, when all they're trying to do is do a good job for the patient.

In particular, computer use was seen as being difficult for some older GPs, while being unproblematic for GPs who had qualified more recently:

R3 (appraiser): The younger GPs are fine, on the whole they're pretty whizzy with computers, but there's a group of older GPs, among whom I count myself, who are not very whizzy on computers, so it's a bit of a steep learning curve ... they're still finding it difficult to upload documents and get all the stuff together and people just can't be fussed with it, you know, we've got enough to do.

R12 (appraiser): And a lot of the GPs, you know, particularly GPs who are towards the end of their career and perhaps aren't that engaged anyway in feeling they need to jump through hoops, are often not that well computer trained, or computer literate, so they're the ones who really struggle.

However, it was also noted that there were exceptions to be noted in both groups. In addition, it was felt that younger GPs could experience particularly stressful personal circumstances, as they were still trying to establish careers and often had young families, factors which could impact on their capacity to prepare adequately for appraisal.

R16 (GP educator): It's not always true, over lunch we were hearing of an appraisee who had an excellent learning portfolio and was within months of retirement, so it can be done.

R21 (appraiser): Two people I've trained, have appraised and done SRTs. One was a very conscientious older doctor and he'd done fantastically.

AL2: I think if you were to ask a hundred or so appraisers probably it would veer towards the older GP who's maybe nearing retirement, maybe as the senior partner. I don't really think that's set in stone because there are many older GPs who engage fully with appraisal ... I've had two young GPs, one who's only been four or five years out of registrar year and just was clearly not engaging and just wasn't bothering; and I had to postpone the appraisal and – threaten is a difficult word – but threaten him with cancelling it altogether if he didn't produce the right sort of documents; and so I don't think there really is a standard profile, no.

AL7: There are some GPs who work part time, for example, have a young family and think that they only do so many sessions, so they haven't possibly got time to do CPD, which I don't think is acceptable; but they are a group that are harder because they think that, because they're only part time and they've got two children, that they should be exempted from doing CPD. ... actually I'm always refreshed by how few GPs who are nearing retirement - and [I] think, 'Really they can't be bothered' - but I'm actually usually pleasantly surprised.

R6 (appraiser): Some of the appraisees, the ex-registrars last year, aren't that great actually sometimes. They're usually full of worries about getting a partnership, getting jobs, having a salaried post they don't particularly want and they're settling in and finding it more difficult than they thought it was going to be - and they've got young families very often as well. They're worried about their money, they're worried about their mortgage, they're doing a lot of out-of-hours and I find, I was doing an appraisal two or three weeks ago and he wasn't having much time to do any of this to be honest.

Resources and workload

There was general concern among participants about the amount of time it takes for appraisees to prepare properly for appraisal. It was thought that sessional GPs are particularly disadvantaged in this respect, as there are financial implications for their taking time away from clinical duties, both for preparation and for attending appraisal.

There were reports that some sessional GPs can only meet requirements by using their own time for these activities, which was generally considered by the participants to be an unsatisfactory situation:

R10 (appraisee): I did a full day surgery and then extended hours and at 8.30pm the appraiser arrived, so by the time you finished, you know, it was long beyond bed-time. It's unfair to the appraiser, but it also unfair to the appraisee.

R4 (appraisee): No, it takes time and of course, for the sessional bloke and GPs, obviously time is money isn't it?

R5 (appraiser): Yes, that's right, they've got to find the protected time, which means they're losing....you know they're not paid for that.

AL5: There are some very part-time people who it will be a significant part of their workload actually just collecting the evidence, compared with the number of sessions they're actually doing and they'll start wondering if it's worth doing it. If you're only doing forty sessions, the minimum, in the year, how many sessions are you going have to start collecting your evidence for? - well, quite a lot.

However, some participants expressed the opinion that meeting the criteria for appraisal was simply a part of a GP's job, and should be managed accordingly.

R16 (GP educator): The BMA recommend a contract where you spend one session a week learning. We don't all do that, we don't all offer those contracts to our employees, I know we don't in our practice, but aspirationally that is what a locum ought to be aiming at; and if you ask the BMA, they will say then just set your locum rate so that you can earn as much from nine sessions a week as you would from ten sessions a week.

There was some ambivalence about who should be taking responsibility for ensuring that GPs are prepared for appraisal:

R17 (appraiser): I don't think it's the appraiser's responsibility. I think that's the appraisee's responsibility. You know, I think you know what's supposed

to be produced and you can try and do that. I don't think you can suddenly spring it on someone that actually you should have done an audit and think oh great, try and do an audit quickly. You've got to have some notice.

R19 (appraiser): But we could say it's the responsibility of the Deanery to make sure appraisees know what they have to do.

R17 (appraiser): That's what I mean, the information has to be there.

R19 (appraiser): What we could say, we think it's the appraiser's responsibility to make sure they know and have produced it in advance - you could do it either way couldn't you?

R18 (appraiser trainer): The appraisal tool would make it clear and documentation on the tools would make it clear.

R19 (appraiser): So, you're saying it's not the appraiser's [responsibility]?

R18 (appraiser trainer): I'm not saying it's totally the appraiser's responsibility....it's both. Pointing out that ...there's the list of things we need to do.

R20 (appraiser): Essentially it is the appraisee's responsibility. They're the person who's got to jump over this hurdle. It is up to them theoretically and if the appraiser wants to help them on their way...

Suggestions for improving the appraisal process

A range of suggestions for improving the appraisal process arose from the focus groups and interviews. In many cases, they took the form of anecdotal sharing of participants' experiences. These findings are presented in relation to the problems identified above.

Appraisers

Accountability and consistency of standards

The quality (and therefore accountability) of appraisal was considered to be inextricably linked with both the quality of appraisers and wider organisational processes and support:

R2 (appraiser): We've got to have really good appraisers who are comfortable with that role [revalidation]. There's no point in having somebody who's a really kind of 'touchy, feely' supportive educationalist who actually shies away from saying 'right well, here we've got revalidation, have you got all your stuff?'

R1 (appraiser): By the same token, you don't really want people who are a complete pitbull.

R3 (appraiser): The PCT have to be committed, and they have to give a positive message that this is serious, we are investing in it, we're providing resources, we want you to do a good job. It comes down, all the way down to the individual appraisers who are, after all, the people going and doing it, and if they're giving the wrong message we can all go home really.

R13 (appraiser): Someone's supposed to read them [Form 4s] I couldn't sleep at night if I hadn't read all the Form 4s to know how my patch is doing really.

R11 (appraiser): I think that's one of the selling points about toolkit and customization, the Welsh one. That it can actually anonymise data and you can pick and choose. It's got a database on the background so you can say, well I want to see on that box how's the area performing, or on that box I want to see in that box how's the area performing. Rather than going through the laborious process of manually taking out every single one. Particularly for big PCTs, two hundred and fifty odd appraisees. It would be a heck of job.

AL1: There is not enough of a link between the clinical governance and the appraisal process. The clinical governance is viewed as the dirty element of the appraisal process, the spying, shall we say, the story telling part, when we tell on a colleague who might suffer. But we don't view the other aspect of that and if we don't share the concerns, triangulate them, how are we going to spot the people who are in difficulty, to help them not lose their jobs and livelihoods and not to injure someone else in the process? There needs to be closer ties between the two I think, because the PCT at the moment retains overall responsibility for managing these processes.

There was a general feeling that the appraisal process should be standardised nationally:

R8 (appraisee): It can't be that as a trainer you [the appraiser] happen to be more interested, therefore you give more support than somebody who doesn't do that. It has to be the case that what's on offer to the person on

the receiving end is the same across the board. That's why I think perhaps there is perhaps a role for the PCT, or whoever, or the college or for the Deanery putting in some input.

Many participants thought that a more structured approach to appraiser preparation and training is needed:

R15 (appraiser): They say we're going to have more workshops. Currently, since I've been an appraiser, we've only been offered one annual workshop, and I've just been given information about changes each year, and that's happened at the appraisal process rather than actual workshops, and hands-on, and discussion; so I think that will be really good.

R19: We need to be clear whether the evidence has to be there and what quality it is and also whether or not we care that they've done anything about it in advance, or whether we leave that for the day's discussion. So I think there's a lot of training we need to have to be clear.

AL5: I've got a feeling that we will end up with some form of consistency and I've got a feeling we will end up with a course which will be running on an annual basis, and once every three years there will be an element of summative assessment, as it were, of the appraiser where, you know, we will actually say 'Right, will you carry out a mock appraisal please and we'll actually mark you on it and basically revalidate you for a period of time because of it'; and I think that's one of the models that will happen. We do it with GP training, I don't see why appraisals should be any different to GP training. ... surely the same model will evolve with GP appraisal; and it will evolve, it just isn't there yet, it isn't robust yet.

Suggestions were made for the content of such events, and many participants commented that joint meetings afforded them valuable opportunities to exchange information and ideas:

R3 (appraiser): We do quite a lot of appraisal skills training in trios, so we will have a group of three role-playing appraiser, appraisee and observer; and that's worked really well because we've been able to say, 'How do you challenge in a supportive way?' ... you might come away with rather good

phrases to use. And it's helped to increase people's confidence about what's going to be expected and what boxes we're going to have to tick. And I think crucially, you know, the appraisal skill itself. The interviewing, what do you do in the appraisal discussion; and I think that's changed a huge amount and that's where most appraisers feel they need more help.

R6 (appraiser): We have appraiser meetings every three months, we have them quarterly, and we have done some buddying. We've buddied up and we've sat in on each other's appraisals, and we've also looked at each other's Form 4's; and we've had a way of feeding back about the Form 4's and a checklist of what should be on them. Then our feedback is given to us at one of the base meetings by the PCT and it's named, you do get your name there about what the feedback about you has been, so it's very personal.

R12 (appraiser): One of the things we found the most useful of meeting as a team is, because the first half hour or so we discuss issues and problem appraisals so we can share our expertise of what's going on; but the other thing we found very useful is - it's not quite the benchmarking, but it gives us a feel of what standard we are all working at and what expectations we have; and I feel that is really important because the worry with all the appraisers is, are we working to a similar standard? Although we've all read the documentation, we all know, but are we giving a similar quality of appraisal?

AL1: We are trying to introduce role play in the appraiser meetings, like a fishbowl session, where someone is the appraisee, someone is the appraiser and a couple of others are watching so we can do some role play and see how that works as well, so we can see what differences there are and start to tease them out. Also, something that's been very useful this year, has been actually in training new appraisers, when they observe you appraise and then you observe them; I found that very, very valuable to gauge what they do that I could do differently and vice versa, and perhaps they should introduce more of that for the older appraisers as well.

AL7: I think they need good training ... I think they need good training, good support from their colleagues and the regular refresher courses for

appraisers; but I think the quality of appraisal workshops is fundamental, so I think it depends on having small enough appraisal workshop groups that people can feel comfortable in, that they can openly discuss things they're worried about or not very good at, that there is a supportive, non-critical atmosphere within those workshops.

Examples of organisational feedback for appraisers were given:

R13 (appraiser): Well I know they [the PCT] get 80% feedback on all appraisals. They then put it into a spreadsheet and produce information on the quality of the content of the appraisal, but also the organisation of the process, and then we do get appraised every March. I've been appraised by the appraisal lead in the last year about my performances in appraisal, and he has got quite a nice sophisticated tool looking at quality of PDP information and outcomes. Not just reflection, but action as well, so quite sophisticated.

AL7: We have review of Form 4 and PDPs, for each appraiser we review three Form 4s and PDPs and they're reviewed by the appraisal lead or a nominated senior appraiser every year. We have a review, a formal meeting, which includes a summary of the workshops, the training, things that have gone well, things that haven't gone well, what their learning needs are, how are they going to address those and what their PDP with regard to their appraisal work [will be], which is done again by the appraisal lead or a senior appraiser; and we have role play sessions where each appraiser does part of an appraisal with their peers and they feed back and then we feed back; and they feed back on all of us, so they see all the senior appraisers doing role play and they also do role play themselves and they get feedback; and we're going to alternate that, we're not going to do that every year, we're going to do that every other year, that's the current plan; and on the year that we're not doing that we are going to do a feedback form based on an Oxford model which the appraisee and the appraiser fill in about the appraisal ... how the appraisal has gone, or points about it, and then the appraiser actually matches the feedback from the appraisee with the feedback from their own feedback to derive any learning points that they can. The final leg of our appraisal quality assurance is that every appraisee

gets a feedback form that they return anonymously to the PCT. So those are the different ways that we do it.

Confusion about process and requirements

Appraisers need clarification about which aspects or items of evidence to appraise:

R18 (appraiser trainer): One of the things I think we do need to sort out, either by being told or by discussing and reaching agreement, is the whole issue of what assessment means, and what I've said hitherto, is that we would assess and say that a certain piece of evidence exists, so our judgement is yes, the audit exists, or whatever it is; and what I think is abundantly clear that we do need to sort out, is whether we now have to make a judgement of the quality of that audit. So is the quality good, medium or poor. And that's quite a different concept to saying something exists, to saying what is the quality of that. I think that's a pivotal point we need to sort out. That's taking judgement and assessment at two different levels. I don't know that's clear at the moment.

There needs to be more discussion and dissemination of information about appraiser responsibility in terms of the 'judgmental' aspect of the new appraisal, so that appraisers know what is expected of them. They need to be clear about the extent of their accountability with respect to unsatisfactory GP performance.

AL3: With all of these new things that come out as a written word, there's quite a difference from moving from what it actually says you're doing to how you can implement it and what works in practice. It's the same for pathways for conditions or complaints in general practice ... the pathway is clear cut, is immovable, it makes a lot of sense – but then you actually need the artist's paintbrush to change it and mould it to fit the patient that you've got. ... I think exactly the same will apply to those [GMC] attributes and how we can convert them into a meaningful message that you can give to your GPs to say, this is what you need to do and this is how you need to do it.

AL6: I think all you can say is 'I see no reason why this individual shouldn't [carry on practising]' – rather than 'I think this person is fit to practice'. I don't think we can say that. ... I think a statement as bland as that - because stones are unturned in an appraisal and concerns are raised.

Workload and impact on practice

The opinion was expressed that appraisees will need to take more responsibility for the appraisal process; but also that clear systems are needed in place to support appraisal, both for individual appraisers and at organisational level. Participants thought that the primary care organisation should be more involved in administering the appraisal process:

R9 (appraiser): Up to relatively recently, like two years ago, we chased people and said, you said you wanted me as an appraiser, and you haven't booked an appointment, you haven't booked it. We changed totally this year, don't e-mail anyone. They e-mail me.

R2 (appraiser): I think it would be helpful.....within our PCT, the GPs arrange it amongst themselves and there's all this sort of shifting around, and sometimes it is very frustrating if you've taken a day's annual leave to go and do the appraisal [and it's cancelled], you know, that can be quite hard on yourself. So I think there needs to be a general acceptance that there is a harder edge to this. All the way, all the way round.

R3 (appraiser): I think it's the whole organisation and I think it's a real cultural issue, because I think it's about - practices are going to have to change. GPs are going to have change the way that they work – we should be encouraging practices and practice managers and GPs to work together to get all this information easily available. Because you know, we shouldn't all be re-inventing the wheel as individuals, so I think we've got to say to people, 'Look we can do this'. We've got to go in and say there's a 'can do' positive, 'Have you thought about getting your practice manager to put all your appraisal information together on your intranet, or you know, pull all the strands together? You, as a clinician don't have to do all that, there's a big admin element in this, so think about how you as a practice might approach revalidation and appraisal'. So I think it's all the way through down to GP practices, practice managers, everybody has got to think about how you can make this thing work in a positive way to everybody's advantage really.

AL7: I think we're extremely lucky in our PCT, we have a clinical governance team who come to all our workshops to help us, support us, we have good connections with the clinical governance medical lead.

It was also suggested that each appraisee should be allocated appraisal in a particular quarter of the year, in order to minimise overloading appraisers in the last quarter.

There was an opinion expressed that appraisers should have access to centrally available resources for appraisees:

R23 (appraiser): A resource pack I think would be very useful – a One Stop Shop where if you have concerns about the GP, really small concerns that weren't big enough to send off anywhere, but sort of made you think, hang on a minute, they're doing too much, or they're just really run ragged, or something – to sort of indicate maybe, you know, part of my role, 'Here's a resource pack I think you would find really helpful just to have a look at, and there's all sorts of types of resources, counselling - if you wanted to go'..

R22 (appraiser): Well, we've always done that though, I mean, I don't know about you, but I've always had resources that I can say to them, 'Look, you know you might find it helpful to look on this website'.

R23 (appraiser): If it was rolled out for all appraisers to do, so that at the very baseline, problems that could occur are caught very, very early.

Appraisees

Evidence required

Participants felt that appraisees need structured preparation and training in order to make best use of the appraisal process. They should be provided with clear information about the type and amount of evidence required, including clarification about the acceptable nature of audit and the credits process:

R21 (appraiser): The whole process needs to be underpinned by an absolute clarity as to the minimum set of evidence and what constitutes that evidence. ... They need to know [for] example, whether they have to have an audit personally, or whether they have to design it and have it done by somebody else, or whether it can be just something expedient, practice data that they've reflected on. They need to know that. Otherwise one person is going to do a massive great audit all themselves and spend their weekends doing it and another one is just going to do a bit of reflective comment on something that the practice management do and it's not fair.

It should be highlighted that evidence of practical or applied learning from reflection on clinical situations will be required from them:

R6 (appraiser): I think they've got to show that they've absorbed something and taken it home. I often say 'Why don't you, each time you go on a course as a practice, you know each individual if they go on a course, they need to bring back two or three golden nuggets, I call them - call them what you like, and tell your partners about them.'

Support for appraisal for appraisees should include practical advice about on-going preparation and processes. Information could be through various formats and media, but should be available to individuals in a way that allows them to maximise their learning:

R8 (appraisee): I think that's the sort of thing that is really helpful, to actually have a list of supporting evidence that you anticipate they are going to provide. Giving some examples of how you could achieve it. And you could easily put a pack together that you send out.

R9 (appraiser): I think it's very important they know that you are there as a support mechanism as well and the beauty with appraising is thatwe've done something a lot of other people haven't done, we've seen a lot more GPs and we've seen a lot more appraisals. So we get a hint from someone that we did down the road, and we get another hint from someone [else] and 'That's a good idea, I'll take that one up myself'....

R6 (appraiser): I do that, I get ideas from other appraisals and I say 'I know a GP who's done so and so and that's worked for him, you know, so that's an idea for you'.

R10 (appraisee): I think what is needed is a kind of 'dummy's guide' ... you need a dummy's guide how to prepare for your appraisal.

R12 (appraiser): I think maybe some courses would be useful once revalidation is properly started, you know to have days with your GPs to come and learn how you prepare for revalidation. What would be expected,

what is the expectation, what needs to be included, how will it happen? We thought something like that, not for appraisers, but for appraisees this time.

R14 (appraiser): I think one of the things that will be really important is training on how to map the evidence and the development to all the domains. That can seem a little bit like 'oh my goodness', and it's probably actually fairly simple, but it's like with anything new it feels a little bit daunting, so I think we will need to be able to explain that to our appraisees.

Training should include sessions about the use of the electronic toolkit, particularly for those individuals who are not comfortable with IT processes:

R3 (appraiser): There's a group of older GP's among whom I count myself, who are not very whizzy on computers, so it's a bit of a steep learning curve and you're going to have to invest quite a lot of time and support in getting people happy in using the change I think.

R11 (appraiser): Issues about people not knowing how to upgrade files, issues about people using the structured template, and the old system as soon as you did it and you saved it, it would not save it in the toolkit. You have to save it somewhere then go find it and upload it back in, which for people who are not very technology 'savvy' is a problem.

R14 (appraiser): It's a training issue. It's a big one isn't it?

R20 (appraisers): I do like the idea of testing it [the toolkit] on the electronically less able GPs to make sure that it's good. I think that's a good idea.

Morale, engagement and continuity

It is recognised that appraisers will need to be able to manage appraisees' anxiety, at least in the first few years of the new system. It is therefore important for appraisers to retain the supportive and educational aspects of their role, which will, by all accounts, also contribute to their own satisfaction with the process (see above).

R11 (appraiser): I think it's paramount that we retain that [developmental role], because otherwise the conversation with the appraisee will change so much that they may be wearing a mask when they see us, they would think we are only there to judge them rather than to support them and help them as well. How honest would they be in that exchange, or how guarded they would be in that exchange determines how useful the meeting is.

AL3: The whole attitude is to be getting people through, not to be blocking their progress; and I think the educational and facilitative role of an appraiser is still going to be paramount, you know that we will have the knowledge of what they need to attain and we need to get our GPs up to that standard over a matter of a five year cycle.

The process through which appraisers are matched with appraisees needs to be reviewed and standardised. It was thought that appraisees should keep the same appraiser for a few years:

R4 (appraisee): I have to say the one thing I would like to see, which might enhance the formative aspects still of this [appraisal], is actually keep the same appraiser for two years running. I know this idea of swapping round five different appraisers - and fair enough, after three, definitely not have the same one again in case it becomes a bit of a cosy talk - but I think to actually have at least on two successive ones [the same appraiser], then there is a bit of formative planning and you can't make the same excuses twice, or whatever, and I think that should be encouraged actually; because I think that would enhance the formative aspect, rather than it being a summative [process].

The varying nature of GPs and GP practice

It was recognised that processes need to be put into place for sessional GPs to support them in the appraisal process, particularly in terms of providing them with access to relevant material. However, despite concern for their situation, there was a feeling that, as intelligent and motivated individuals, they should be able to find their own solutions to some of the perceived problems. In particular, it was thought that they should be encouraged to use their own organisations, for example, the National Association of Non-Principal GPs, for this purpose. There was also a suggestion that

they could engage with various group structures in order to increase their collective bargaining power with general practices:

R3 (appraiser): NANP have got lots of good kind of ideas about how you can gather your information and evidence, but it doesn't seem to filter down to a local level. When I have an appraisal session I say 'Have you looked on the NANP website? Because there's some good.....' - 'Oh no I didn't even know about that'. So there's a huge gap I think.

R14 (appraiser): As much as here we are trying to say how should sessional doctors collect information, they need their representative bodies to actually be coming up with the solutions...so you would be expecting them to not come [to appraisal] with just the problems - but you know there's clearly some clever people out there, who could have the solutions as well.

R18 (appraiser trainer): The other forum is groups of like-minded, or similar situation doctors. An example here was sessional doctors who were not attached to a practice, who were very concerned about how they were going to do all the data collection, all that stuff which they worried about and so I facilitated a meeting for them. And basically I didn't give them ideas, we just arranged it for them to discuss and they themselves generated loads of ideas between the groups. The power of the group was so much more useful than any individual so at the end of it, they felt 'Well there's all these things, you're doing that, you're doing that,' and they could do it. So that kind of unlocking the potential of a group is something that can help appraisees to perform.

AL1: Another suggestion, probably more realistic, is this new idea it's called Pallant Medical Chambers. It's an organisation that started somewhere in the South East and lots of locums come together in an organisation; and that organisation is responsible for collating feedback for them, running some significant events [sessions], doing some audits, and perhaps acting like a practice. I think the days of the lone ranger locum will soon be gone. Lone rangers, much like single handed practitioners, won't be able to survive in the NHS of 2020.

AL6: I think to have some sort of trade union to help support them would be a good thing, so some sort of coercive effort ... I think their power is collectively rather than individually, actually coming down with sort of edicts and maybe recommendations to practices who are going to employ them. Just like we would have a Locum Pack to give to our locums, perhaps they have a Practice Pack that they give to the practice on what their requirements are, because it's a two way split isn't?

There was a perception that sessional GPs could gather the required evidence, if they were sufficiently motivated and creative. Examples of possible strategies for collecting evidence were given:

AL5: I think that evidence is ever so easy to collect really if you have a will to collect it...I mean there are ways of doing this...if you want to be robust about your own performance you can be robust about your performance and therefore it seems, you know, as if it is doable...I have appraised a sessional GP who was all over the place and she produced some fantastic work because she'd been bothered to do it.

R11 (appraiser): I know a doctor who does only out-of-hours at the moment, but...if she does a referral for something in the middle of the night and gets someone into hospital, she'll find the phone number for the practice, ring the practice, get their address, send a polite note to the principal saying 'I hope you don't mind me asking, I've sent this patient in and I would like to know what happened, if it's okay to anonymise and send some feedback'. So it is okay, it is time-consuming but it can be done.

AL1: They've used the other part of the equation because at the moment it says audit or data collection, so they will collect data rather than do an audit. They will look at their prescribing habits, they will look at their referral habits, they might refer some patients to a hospital, they'll keep the practice details and the patient ID and the date and then go back to the practice and say 'Would you mind telling me what happened to this patient, you know, just out of information?' So they can do before and after - what did they think it was and what it ended up being. They can look at their timekeeping, you know, if they've been given ten minute slots are they taking ten, eleven, twenty minutes per patient?

AL2: You could look at your last ten referrals and you know, audit those ... choose a referral, see that you have included basic information that is required, past medical history, prescribed drugs, that sort of thing. You can look at features of your referral ... if you work at that practice again, you're even able to look at the referral outcome.

AL3: Say you do an audit of your referral or of the outcomes of your referrals – which I think would just about fulfil the [RCGP] criteria so long as you're careful how you word it ... no matter what practice you're in, you could keep the referrals and then organise for the practice manager to send you an outcome, even if you're not in the same place again. ... Going back to the multi-source feedback, again you'd need to ask that of one practice where you've worked a number of times in the last year or where you are known; but I would think it's going to become a part of life as a GP to seek multi-source feedback, so I would think midwives and practice nurses and other doctors are going to be used to filling in MSF forms so I don't think they'd mind being asked.

AL5: You can do an audit of the last twenty patients that you saw, that you sent into hospital as an example and the outcomes, if you bothered to write them down and then ring up the hospital and find out what happened to them...there are ways of doing this...let's look at the last ten times I gave antibiotics and the reasoning behind that. ... I'm not sure the locums have really got that much of a leg to stand on by saying they can't do this, because actually if they wanted to you know they could. Even if it's just to sit down and reflect with, and bounce things off, the practice manager about how their session has appeared to the practice. It doesn't actually take a lot to do that, it just takes a bit of thought about, 'Please can I have some reflective comments about how my performance has been' ...'Has there been any patient feedback?' or 'Please could you just give me some data in two weeks as to how many of the twenty people I've seen actually came back within the next two weeks'. Because if they all came back, well actually did you not reassure them or were they just obsessed with their own GP? Do you see what I mean? There are things you can do, you've just got to want to do it, haven't you.

A minority of participants thought that appraisal should be tailored to different GP groups:

R15 (appraiser): Well not really standards, but ways of doing things, because their way of doing it is going to be different to our way as a principal, and you know their way of collecting information is going to be quite different and their way of doing a patient survey could be quite different.

Interviewer: Do you think that actually the appraisal process should be tailored to suit different groups of doctors?

AL4: You've got to tailor it to a certain extent...within medicine itself, GPs appraise GPs and physicians appraise physicians...you wouldn't expect a GP to be able to do what a physician can and vice versa, so why you expect a locum doctor who's working - alright it's the same speciality, but it's working in a completely different way. I suppose the nearest comparison would be a nurse and physician working in gastroenterology, you wouldn't expect the nurse to collect the same information as the consultant.

However, most participants were concerned that this could result in inconsistent standards:

R12 (appraiser): We certainly can't put the bar too low. That's not appropriate is it? When I said if you were say looking at an audit, or something that you have to be a bit more flexible maybe, I wasn't necessarily thinking that we need to be lowering the bar, we just need to open our minds a little bit to what their circumstances are and maybe why it's had to be done in a slightly different way than we would think was optimum.

...

R11 (appraiser): It's very difficult to have to set two sets of standards, if you said you have a set of standards for principals and a set of standards for salaried doctors and a set of standards for out-of-hours doctors, then it gets very muddled and very difficult.

AL1: You've got to have a common denominator that everybody must have to be able to pass because, on the whole, you can't say well this person is

good enough for a locum, this person is good enough for a principal, because the locum could next year, or even next month, be a principal. On the other hand they need to be realistic at what they're asking; a good example is the audit, they're asking everyone to do an audit; why? How many of the principals do an audit by themselves these days?

AL2: If you have a process which is a national process and is essentially producing a national qualification which is that you revalidate, then there has to be a standardised process. I don't think you could really change it for different groups ... I think that should happen across the board, so GPs shouldn't be any different from secondary care doctors, shouldn't be much different from public health doctors, we should have a fairly standard approach to appraisal I think. I think blurred round the edges, but I think the basic thing is a standard approach.

AL5: All the [medical] colleges are pushing to ensure that... it is not easier to be appraised as an associate or easier to be appraised as a principal or easier to be appraised as a psychiatrist, say, than a surgeon, because actually that's just not equitable across the profession. So I've got a feeling equity across the profession is going to be where the BMA are going to be pushing us...Patient safety revolves around GPs knowing what they're doing....I'm not sure I want to make it easier to get a revalidated locum sessional GP who's only doing forty sessions [annually] than the guy who's doing nine sessions a week...when you have a lay representative looking at what we are doing, they're just not going to let us revalidate somebody who just simply has had an easier route.

AL6: If we're regarding appraisals as the process to assure the public that the workforce is up to scratch, then I think there has to be a bare minimum. There have to be criteria in there that we all have to meet ... there have to be bits fixed in stone.

However, it was thought that appraisal needs to incorporate a degree of flexibility, and that processes need to be put into place for non-principal GPs to support them in the appraisal process, particularly in terms of providing them with training and access to relevant material:

Facilitator: So are you saying that the different groups of GPs ... would require different training sessions or support sessions, or days provided, because of their particular needs?

R2 (appraiser): Not so much with the IT ...

Facilitator: But what it's populated with, and how?

R3 (appraiser): But what it's populated with definitely. Because I think they do have such different challenges that, you know, I think they do need a separate kind of routine to, how to do it really.

R3 (appraiser): What you want is the very practical tips on how do you get the data, what sort of projects would be manageable for a sessional GP...what we've said is go and talk to a practice manager...it's all about using the practice's information.

R9 (appraiser): With locums and people doing work like that, I suggest to them to write to the practice managers with their headings on the appraisal and ask the practice to fill in a questionnaire that they can draft themselves, based on the headings for the appraisal.

R11 (appraiser): Using the CFEP, or GPAQ questionnaire in out-of-hours would be unrealistic [for sessional doctors], because the setting, that was designed for surgery wasn't it? It would be far better for them to have some sort of paper saying what was useful about the meeting with 'Dr. Day' and what could they have done differently.

....

R12 (appraiser): You know how the sessional doctors have their own website and they meet. There are examples of questionnaires on there that you can use if you want to do your own patient survey.

R16 (GP educator): I think ... if you're a locum and you're moving around, to have an on-line site that you can just log onto on any PC or any terminal where you are practising should make it easier shouldn't it?

AL1: I think there are things that can be done and there are things happening in some places but not in all places; for example one of the suggestions was that locums are twinned with the practice, particularly the peripatetic ones.

AL3: I think it should be tailored at the level of the interpretation by the appraiser and the responsible officer, rather than creating a different process for different grades. So I think you just need to have an understanding as an appraiser of the difficulties that those groups have and therefore be able to make the adjustment of the assessment; you know, because someone is a locum or because somebody is a principal, but they'll still have to go through the same assessment. I think you need uniformity of the process of what's required, maybe the differences that the standard to which it's required will vary depending on the position of the individual GP.

AL6: There have to be bits fixed in stone. The rest of it maybe you could tailor for the individual. Things like patient feedback, they're going to be difficult for a locum who's doing a session here and a session somewhere else. It's going to be very difficult to get patients' feedback, even when that's included. So I think there is a place for that [flexibility].

AL7: A lot of GPs, sessional or not, have no idea about audit, they don't really know how to do audit ... I think the sessional GPs need support.

As far as out-of-hours doctors were concerned, it was thought that their employing organisations should take responsibility for ensuring that they receive appropriate support to enable them to meet the criteria for satisfactory appraisal:

R15 (appraiser): That's up to the training of the out-of-hours [organisation] to make sure all their employees are trained to the system.

R9 (appraiser): And the out-of-hours [organisation] should be doing it [providing patient feedback] for their own staff...they're quite a significant employer.

AL6: They are GPs, but it is a different role, out-of-hours; and I think the world has moved on since I started when it was all part of the same job. I do have a view that the out-of-hours, part of their job should be appraised by the organisation employing them ... I think they should sit down and appraise all their [out-of-hours GPs], because it's in their interest to know what standard their employees are working to. ... I haven't done out-of-hours since

we lost the 24 hour commitment, so I think that would be increasingly difficult, it would be increasingly difficult for me to start saying 'What's your performance like out-of-hours?'. I would want a director of that service to be appraising that and to be assuring himself that the individuals are up to scratch.

The issue of GPs not engaging with appraisal, for various reasons, was recognised as difficult to address. One appraisal lead stressed how important it was that the quality of the appraisal process be of a high standard:

AL5: You're not going to value it [appraisal] until you've done it and got something out of it. If you're really cross and angry and you're nearing the end of your time, you're just going to give up or you're just not going to get anything out of it ... you'll do it well enough to get through and remain cross and angry. I just think if we can stop and actually really start doing it properly, I've got a feeling that this will help doctors for the future for their own personal development.

Resources and workload

It was felt that the provision of appropriate training, preparation and resources would go some way to supporting appraisees with resource and workload issues. Participants thought that primary care organisations should be supporting GPs actively in meeting the requirements for appraisal and revalidation. However, it was thought that individual GPs would probably have to continue to bear the financial costs of appraisal:

R3 (appraiser): I think PCTs could do much more when people arrive on their performers list. As a new GP in 'X', I think there could be more information and more about support networks. Because I get the impression, that group that's come out of training, where they've been really well supported, suddenly they're kind of booted out into the big wide world and it can be really difficult, I think. They [the PCT] could do more in the sense of helping people to get their bearings about how you might get into touch with the Deanery, to get advice about putting your portfolio together...it sort of feels like there's not quite enough signposting

R5 (appraiser): They did two [protected learning days] in our PCT and they got such bad feedback on the second one ... they tried to make it generic, but everyone, almost receptionists upwards go to them, and it was just irrelevant to most people. Something like this [conference day], put on obviously for GPs, I'm sure would be a great way of starting that whole process again.

R18 (appraiser trainer): So the question is, what do appraisees need to do? Not what are the difficulties, what they need to do, is do it regularly in small aliquots across the year and...

R19 (appraiser): I knew that (laugh) I just didn't do it (laugh)

R20 (appraiser): I'm sure, sure. But that's something to do with systems to help you do it. A system needs to prompt you to do it in some ways.

Facilitator: So what might have helped you?

R19 (appraiser): A dedicated time, some time in each week to do it. I never seem to find that dedicated time. There always seem to be too many other things to do.

R17 (appraiser): We used to have a protected time once a month. Now we haven't – the practice is still open, somebody still covers it, somebody's still on call, so it makes it much harder to have actual dedicated time to do things...

R20 (appraiser): We've never had 'protected time', we've never done it. What we do is, by rotation, it will be one person, or we will bring in a locum or employed doctor who will be doing that.

R17 (appraiser): Right. That's a good idea. And does that work well?

....

R20 (appraiser): It gives us time to do those things [focus on appraisal and CPD] so it does protect the time for those people that are doing it.

R18 (appraiser trainer): I think it would be reasonable to say each practice should have say, half a day a month, and part of that half-day a month could be.... you set aside half an hour for tweaking your appraisal documentation ... and then you go into an educational activity.

R19 (appraiser): But simple little things like simple short webcasts or powerpoint presentations that go with the practice that can be used 'within

house'. For things for locums, and things that are e-mailed to them from people from local areas, all that sort of stuff.

R21 (appraiser): But I think it [the list of what is required for appraisal] should be based around the website. So that when you go and do it and you look at it, it's there, and you can refer to it. ... and it should include examples as well so, if for example you want to do a 360 ... there should be an example and you can just click on – 'bang', see example.

AL2: It should be fully supported, fully funded and embraced as a thing that you have to do, that's just part of being a PCT ... I've heard on the grapevine, some PCTs think, 'This is to do with GPs, it's their revalidation, they should just get on with it, it's nothing to do with us, why should we get involved in that?' The fact is, if none of their GPs revalidate, or half of them don't revalidate, the PCTs are going to be in a real mire because they've got half the work force has disappeared, so I think it's very important that PCTs engage with this.

R22 (appraiser): Once a year. So you could say well its only one afternoon once a year. At the moment most people do it in their own time....

R23 (appraiser): But it's the work to prepare for that appraisal, so the preparation takes longer. It's the work on top of it, it's not just the appraisal really.

R22 (appraiser): It needs to be as streamlined as possible though.

R21 (appraiser): That's what the fee was for, the fee was to say, doctors and partners in practices, they need someone to stand in for them when they're doing their preparation work.

...

R22 (appraiser): They need to be paid properly, the appraisees and they're not. that's not going to change though, there's no money.

One participant also felt strongly that the profile of appraisal should be raised, so that GPs' resulting extra workload becomes public knowledge:

R8 (appraisee): And I would like to see some public recognition of the fact that this is being demanded by the NHS Executive, and therefore your doctor will not be available to see you for clinical reasons for you know,

three and half hours a week, because he's concentrated on professional development.

The role of the Deanery in appraisal

There was a general perception among participants that the Deanery could (and should) be involved in providing information, training and 'quality control' for both appraisers and appraisees:

R14 (appraiser): One of the things that strikes me is there's more front-end stuff the Deanery will need to provide as a lead. I mean the definitive evidence and standards against which you're going to map things. And then, you know, there's just sort of leadership issues on training and support and how you sell this process really.

AL1: There is a thought of introducing a discussion forum on the Deanery website to encourage people [appraisers] to use it to air problems and concerns. That might be a good way forward for those who have got another year and a half before they can attend another meeting.

AL2: I feel that where the Deanery can come in is in the CPD, the training, the support of that area; and so the initial training of new appraisers, providing update training days for established appraisers, looking at people who are advanced appraisers ... sort of validating appraisal processes, to say 'Yes, you're not way off beam with your appraisal process'. I think also the other areas that they could look at are things like re-accreditation, so every three years say providing a formal re-accreditation for established appraisers; and maybe looking to produce documents or processes on certain aspects like, for example, conflict in appraisal, you know if an appraisee makes a complaint about an appraiser, have a standard conflict resolution process.

AL3: I think I see the Deanery role very much as it is now in a supportive, educational training body that I feel needs to be separate, because I think they are the backup that are monitoring, to some extent, everything else that's going on and, you know, training new appraisers, updating the appraisers. I think one role that they'll have to take on will be almost a revalidation role of the appraisers, to be sure that we're up-to-date and that

we're all working to the same standard and same behaviour – I think they may want to assure themselves that there is an even playing field throughout their region.

AL6: Joining the Deanery firstly gave us some external quality control which I thought was very important for us with revalidation just around the corner. Secondly, it moved us over to the electronic toolkit which I think will work, I'm still quite confident that it will work; and when it does work, I think we will be ahead of the pack in terms of revalidation because it will just be second nature to us. I think the training and monitoring of performance of appraisers is partly the responsibility of the lead appraiser in conjunction with the Deanery. I think we have to work together.

AL7: I think the Deanery can have a role in offering training and in offering retraining and in chairing ... the training and the retraining has been very useful, and the shared group meetings have been very useful.

It was felt that accredited Deanery training for appraisers could increase the credibility of their role among appraisees:

AL5: I wanted to run the Deanery model with an educational band to it so it feels like, you know if you're an appraiser ... you want that as a mark of respect, just like if you're trainer you want that as your badge as respect. You don't want it to be, 'Oh gosh you know he's a detective constable who comes along and has a look at all the things I'm doing' ... I think it should be much more trainer type orientated and that the Deanery badge associated with that is a much better way forward than a PCT badge which is, I'm afraid is performance management. However nice the PCT, it is performance management.

Some participants also thought that the Deanery could play a greater role in co-ordinating and quality assuring the appraisal process across the region:

AL1: I think the Deanery is positioning itself now as an alternative to the piecemeal approach of the various PCTs. Each PCT has done its own thing in the UK. You can see positives and negatives. The positive and the flexibility is that some PCTs may develop good systems others can learn

from, the negative is that there is no standardisation anywhere. So I think that having some standardisation but also some cross-fertilisation of the ideas needs a vehicle to provide that, and that is where the Deanery is well positioned because it's got staff and it's got funding to do it. None of the other PCTs has got the money to actually fulfil this role. ... The three yearly external reviews, they [the Deanery] are planning to co-ordinate those and I think that will be crucial because having good appraisers will drive the process. If the appraisers are substandard the whole process is going to be doomed.

AL5: One of the reasons why I think we need to separate the appraisal process and the PCT process so that the appraisal process can be run through the Deanery, [is that] if one of my appraisers runs into difficulty they can come to me as the Appraisal Lead and say, 'Look I'm actually a little concerned about this' – and it's a separate place from where the appraisal is actually running. That's what I would like to see.

However, this was not a universal view:

AL2: At the moment I feel that a Deanery-led appraisal process wouldn't fulfil the needs that we have at the moment ... it's not meant to sound smug but the appraisal process in our PCT is running really quite well. Having filled in the recent RAG report ... that does validate that we are running a fairly robust process, and I just don't at the moment think that I want the Deanery to take that over, because I wouldn't be confident that we could maintain that.

AL3: So I think that's their level of input [educational] rather than in the more closely controlling of the actual appraisal process.

AL7: I think the Deanery can have a role ... but not, and I really repeat not, controlling the meetings of Appraisal Leads in the area ... I don't think it's appropriate for them to do the quality assurance because they're too close.

...

I actually object to the Deanery sending letters as though they're in charge of appraisal and we don't deliver them to our appraisees. We deliver the letter that we want sent to our appraisees ... a lot of it is very similar but you know

for example, them pushing the toolkit that's caused so much trouble in other PCTs, and then putting it in newsletters as though the thing that's happening and this is how it's happening in the region, I actually think is not appropriate; because it's not happening in all of the region and you know, there are lots of different views on which toolkit's appropriate ... we have a system where we send out a letter every year and we don't want them [appraisees] being flooded with versions from here, there and everywhere. They have minor differences but people get worried about them so there's nothing in here that's urgent, so when we do our newsletter which we do every year with very clear guidance about what they have to do, and how we want it to run in this PCT, and how they can approach us if they're not happy or if they've got any suggestions, I will make sure to have read that and put anything in from there that I'd forgotten about or whatever. ... There may well be things that I pinch from there but it's not the same as sending that out ... we do it annually and that's the system, and we make clear what we need and what's changed; and I think having another one coming from somewhere else and something else in the magazines is not a good idea. I think you keep it simple, I think you keep it clear, as clear it as it can be when it's constantly changing; and I think having more people adding their tuppence ha'penny worth is not a good idea, not that it's less valuable or more valuable than mine but I don't want two lots.

It was also thought that PCTs should retain responsibility for the satisfactory implementation of appraisal for revalidation:

AL1: There needs to be closer ties between the two [clinical governance and appraisal] I think because the PCT at the moment retains overall responsibility for managing these processes. I can see why it would be for them very tempting to give all that to the Deanery and say 'Here you go, you take the blame as well', but I don't think they can give all that to the Deanery.

Points for consideration

The findings from this study raise particular points for consideration in relation to the appraiser role; the nature of evidence required for appraisal; the situation of sessional doctors; appraisee age; sharing expertise and experience; and the role of the Deanery in appraisal.

Appraiser role

Most participants were adamant that appraisal should retain a strong developmental element. While nearly all recognised and accepted that it was appropriate to link appraisal and revalidation, there was concern expressed about appraiser accountability and lack of consistency among appraisers. Clear definition of the role and appropriate national training were seen as essential factors contributing to the success of the process.

Evidence required for appraisal

A notable feature of the focus group data was the confusion expressed by many participants about the nature and amount of evidence required for appraisal. Both appraisers and appraisees thought that far more clarity and guidance was required, in order to help GPs prepare properly for appraisal, and to ensure consistency among appraisers. Given the perception that appraisal for revalidation is extremely time-consuming for individual GPs, it was felt that having a clear brief about the evidence required is essential. The revised RCGP guidelines published after these data were collected (RCGP 2009) may go some way to ameliorating this problem, particularly with respect to the description of what constitutes audit for appraisal purposes.

Sessional doctors

Many focus group participants and at least one appraisal lead were concerned that sessional doctors would have problems collecting the required evidence for appraisal, in particular, audit, multi-source feedback and patient surveys. The fact that the RCGP has recently commissioned research to investigate this issue indicates that this perception is widely held. However, the data from this study suggest that these problems can be addressed. It is notable that the checklist data revealed very few substantive differences between principal and sessional doctors with regard to evidence submitted for appraisal. These data do only confirm that evidence was

submitted, and do not throw any light on the quality of that evidence. Moreover, given the confusion noted among the focus group participants about the nature of evidence required, it cannot be assumed that there was any great degree of consistency in the conception of appropriate evidence among the appraisers completing the checklists. However, the checklists were completed by experienced appraisers, and the same standards were applied to both principal and sessional GP appraisees. A number of participants were able to provide anecdotal evidence concerning innovative practice among sessional doctors with respect to the collection of evidence for appraisal, both at personal and collective levels. All these data, taken together, suggest that sessional doctors' problems in this regard may be overstated.

Appraisee age

The stereotype of the older GP, near retirement and not computer-literate, and not wishing to engage with appraisal, was present in the data. However, this was counterbalanced by examples of exceptions, and concern expressed about some younger, part-time GPs, whose personal circumstances do not support their involvement in appraisal. It was notable that no differences were found in the checklist data between younger and older GPs with regard to the evidence they provided for appraisal. It appears, therefore, that older GPs do not necessarily need extra support to engage with appraisal, and that difficulties encountered arise due to individuals' particular circumstances or personalities, rather than because they belong to a defined category of appraisee.

Sharing expertise and experience

A very strong feature of the qualitative data was the extent to which participants enthused about the benefits they experience when presented with opportunities for sharing expertise and experience. A number of suggestions concerning format were made, including both face to face and on-line media.

The role of the Deanery in appraisal

There was no consistency with regard to participants' opinions about the degree to which the Deanery should be involved in the co-ordination of the appraisal process. It was notable that two appraisal leads, in particular, felt that the process within their PCTs was running very well and was well-supported; they therefore perceived

involvement by the Deanery as potentially causing disruption to established systems. However, all the participants, both from the focus groups and the appraisal leads, were clear that the Deanery has a valuable role to play in training and preparation for appraisal for both appraisers and appraisees. They welcomed the idea that the Deanery could provide fora for sharing expertise and experience, as well as providing structured, dedicated preparation for appraisees. The Deanery was also thought to be well placed to help address any lack of consistency among appraisers through appropriate training.

Recommendations

1. Change the organisational culture of practices and trusts to encourage access for sessional and locum doctors to Clinical Governance, Significant Event, Audit and Data Collection, through meetings and improved communication. This could be accelerated by including locum access as a quality criterion to be reviewed at practice inspections by PCTs or by the Care Quality Commission.
2. Encourage, establish and facilitate fora and self directed groups for isolated locums and sessional GPs.
3. Provide examples of innovative ways of collecting evidence for this group.
4. Establish new tools designed specifically for this group, such as patient and colleague feedback.

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