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**Appraisal for GPs**

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## Chapter 1

### Introduction and background

#### ***Chapter 1 - main points.....***

- This report provides a framework of guidance for those involved in introducing appraisal for GPs.
- Effective GP appraisal should benefit patients and the public in general, the NHS, the medical profession and individual GPs.
- The report is based on the findings of research carried out by ScHARR.
- It describes a model for GP appraisal and makes suggestions about its implementation, drawing throughout on what has been learned from successful appraisal systems in other settings.

- 1 This report is about the appraisal of general medical practitioners. It provides a framework for developing workable arrangements that will benefit patients, the National Health Service and individual GPs.
- 2 The Department of Health commissioned the School of Health and Related Research at Sheffield University (ScHARR) to prepare the framework on the basis of a brief research project which distilled the experience and views of Health Authorities (HAs), Primary Care Groups (PCGs), Primary Care Trusts (PCTs), the profession itself and a wide range of other interested bodies and individuals. ScHARR was also asked to 'import' the accumulated lessons learned from appraisal systems in other settings. Appendix A is a brief note about ScHARR and the authors. (Appendix B is a glossary of abbreviations.)

### **The policy context**

- 3 In *Supporting Doctors, Protecting Patients* (1999), the Chief Medical Officer proposed that all doctors employed in or under contract to the NHS should undergo regular appraisal. *The NHS Plan*, published in July 2000, confirmed that participation in annual appraisal would be a condition of contract from 2001. It located appraisal within the general framework of clinical governance, alongside other proposed mandatory requirements to participate in clinical audit and contribute to a reporting scheme for adverse healthcare events. It linked annual appraisal to the General Medical Council's (GMC) proposed mandatory five-yearly revalidation process, 'underpinning and providing much of the data to support' it.
- 4 Although the overall appraisal requirement is the same for consultants and general practitioners, different issues arise in developing an effective approach and this report is not directly about the appraisal of consultants. Some of the material may nevertheless be helpful to those involved with it.

### **Importance to stakeholders**

- 5 There are four key stakeholders in relation to GP appraisal: *the public* as patients and payers; *the State* as healthcare provider, represented by the NHS as the contract holder (or 'employer') for GPs; *the profession*, represented for this purpose by the GMC and professional organisations (eg the British Medical Association and the Royal College of General Practitioners); and *individual GPs*. Effective GP appraisal will benefit all of them.

#### *The general public*

- 6 Those using and ultimately paying for the services provided by GPs have the keenest interest in the quality and reliability of the work they do. Public perceptions are changing rapidly. Expectations of doctors (and the NHS as a whole) are rising as one particular manifestation of a growing, society-wide demand for good service and satisfaction. Confidence in doctors is however dropping as a manifestation of declining trust in professionals generally, and also in the wake of recent prominent clinical failures within and outside general practice. The widening expectation gap, and the passions associated with it, are major forces for change.
- 7 The general public will welcome quality improvement processes in healthcare generally, and the effective appraisal of GPs and other doctors in particular.

### **The NHS as GP contract holder**

- 8 As the major provider of general medical services, and the nearest thing most GPs have to an 'employer', the NHS has four key responsibilities:

- to ensure that the GPs it contracts with are qualified and competent to practice
  - to ensure that whilst they are in contract with the NHS, GPs are clear about and accept what is expected of them in delivering primary care services
  - to ensure that GPs are appropriately resourced, supported and developed to enable them to meet these expectations
  - where individual GPs are struggling to do so, for whatever reason, to take action to support the GP and protect patients.
- 9 Appraisal should play an important part in enabling the NHS, through its HAs and PCTs (the Chief Executives of which have statutory responsibilities for service quality), to meet each of these responsibilities.

### **The profession**

10 The GMC has four key responsibilities:

- to set professional standards of medical work which are applicable to all doctors and which they should observe wherever they practice
- to license and register doctors, ensuring and signalling that the individual is appropriately trained and competent to practice in a particular field
- to ensure that doctors throughout their working lives remain fit to practice, and to take action (by attaching conditions to or withdrawing registration) in cases of incompetence, misconduct or ill-health affecting fitness to practice
- to regulate the profession in such a way that 'employers' of GPs, their patients and members of the general public have confidence in them, and so that doctors themselves can have confidence and take pride in their profession and their membership of it.

11 A successful approach to appraisal can help the GMC to discharge its responsibilities by generating information about individual practice.

12 The British Medical Association (BMA) has a distinguished history of promoting scientific activities for its members and a commitment to quality in medical practice. As a registered trade union it has a strong interest in the reputation of doctors and its related ability to negotiate successfully on their behalf. Appraisal, done well, can support both aims.

13 It should also support the aims of the Royal College of General Practitioners (RCGP), which has pioneered quality development through vocational training and audit, and by benchmarking individuals and practices against high professional standards.

#### *Individual GPs*

14 As this report will emphasise, GPs themselves have much to gain from appraisal:

- opportunities to negotiate relative priorities amongst competing demands
- a vehicle for influencing resources and policy
- access to objective advice on practice issues
- a source of personal and professional support
- a means to improve professional practice and satisfaction.

14 Doctors set out to be *good* doctors, and appraisal can help them.

15 Many GPs accept the general principle of appraisal, but they may have misgivings about it in practice. It is unfamiliar; appraisal is an awkward concept to apply in the particular context of GPs' independent contractor status (because accountability is not straightforward); it may in itself increase pressures on time and other resources; and it feels threatening, particularly in the present climate of public anxiety about medical performance. The design of an appraisal scheme and the approach to its introduction should acknowledge these issues.

#### **The project's purpose and approach**

16 This project set out to provide:

- a descriptive framework for appraisal
- information about current appraisal work in general practice
- models of good practice in appraisal drawn from the Human Resources (HR) literature and experience within and outside the NHS
- a model for GP appraisal which reflects good practice
- proposals for implementation which similarly reflect the lessons of history and the general practice context.

17 The project has been carried out over a three month period, through a combination of:

- documentary analysis (the research and professional literature about appraisal, within and outside the healthcare context, and relevant official documents – Appendix C is a bibliography)
- written and telephone surveys of health authorities, PCGs, PCTs, Directors of Postgraduate General Practice Education, academic departments of general practice and research institutes, and key individuals in the Department of Health and other selected national bodies with a strong interest in general practice
- face to face interviews with individuals or groups identified through the wider surveys.

18 The main instrument for gathering material from the field was an initial letter (in January 2001) to a wide range of NHS organisations, and a similar letter to other bodies. The letters described the main areas of interest. Appendix D is a note about the project's methodology.

19 The research team included an NHS human resources expert and a GP as well as staff of SchARR's Health Policy and Management division.

20 Although the project has been funded through the Department of Health's main Policy Research Programme, this is not a conventional research report. The aim has been to offer timely, accessible and practical guidance to help those concerned in the NHS to tackle something which is important but also difficult. It may however be useful to say here, because it is not emphasised elsewhere, that the conclusions and suggestions made have a foundation as far as possible in systematic enquiry.

### **Organisation of the report**

21 The Chapters of the report roughly follow the aims summarised above:

- Chapter 2 asks what appraisal is, how it has been applied in the NHS, what the present work has shown about its use in general practice, and how appraisal in general practice fits into the wider picture of related approaches including GMC revalidation
- Chapter 3 conveys what has been learned from experience within and outside the NHS about good practice in appraisal including key success factors

- Chapter 4 offers a model for appraising GPs
- Chapter 5 suggests an approach to its implementation.

22 Each chapter begins with a text box summarising its main points. An Executive Summary based on these text boxes is available separately from ScHARR (Tel: 0114 222 0718 or e-mail [l.a.hall@sheffield.ac.uk](mailto:l.a.hall@sheffield.ac.uk)).

## Chapter 2

### Definitions, NHS experience and appraisal's connections

#### **Chapter 2 - main points.....**

- Appraisal is a long established concept and remains one of the most basic of organisational processes.
- The history of appraisal indicates a continuing shift of emphasis from performance assessment to performance development, and the NHS is following this trend.
- Appraisal is underdeveloped in general practice and there is some confusion about its purpose and linkages to other processes.
- SchARR offers a definition of appraisal as a positive, developmental, employer-led, two-way, action-oriented process, primarily directed at quality improvement.
- Appraisal and revalidation (which is primarily a quality *assurance* process) are very different but should be linked for the sake of economy of effort, with the GMC's *Good Medical Practice* as common ground.
- Appraisal is not primarily about poor performance but about improving performance right across the spectrum from the best to the worst.

- 1 The Oxford English Dictionary defines appraisal as 'a formal evaluation of the performance of an employee over a particular period'. This is true but insufficient for present purposes, and the first two parts of Chapter 2 expand and refine the idea, putting it into the context of changing thinking about management. The third part looks at appraisal in the NHS, including general practice. The fourth section locates appraisal within the wider frameworks of

GMC arrangements for professional accreditation and NHS clinical governance.

### What is appraisal?

- 2 The concept of appraisal has been with us for a long time. There is a record of a comment about performance evaluation from China over 1,700 years ago (interestingly, but not surprisingly, it was a complaint about the appraiser). Appraisal is firmly established now as one of the most basic of organisational systems. The Industrial Relations Services (IRS) survey of 1999 identified it as the most popular means of linking individual work objectives more closely to a business's aims and objectives.
- 3 Discussion about appraisal often reflects an underlying continuum between two extremes of focus or orientation. On the one hand, there may be a focus on assessing, rating or scoring an individual's current performance against predetermined standards; this is appraisal as *performance assessment*, and it may have various purposes (linking for example to reward or promotion). On the other hand, the emphasis may be on developing capability, promoting education and personal development, and facilitating future achievement beyond current levels; this is appraisal as *performance development*.
- 4 There is a clear trend in thinking and practice along this continuum. Developments in appraisal during the 1980s and 1990s indicated a marked shift from assessment on management's terms towards the development and better application of skills on the employee's terms (Long, 1986; IRS, 1999)

Some definitions.....

McGregor (1957) says that employee appraisal aims to provide systematic judgements for salary increases, promotions and sometimes termination; to tell a subordinate how he/she is doing and suggest changes in behaviour and/or skill; and to provide a basis for counselling and coaching.

Armstrong (1984): "Performance appraisal is the process of reviewing an individual's performance and progress in a job and assessing his potential for future promotion. It is a systematic method of obtaining, analysing and recording information about a person that is needed for the better running of the business: by the manager to help him improve the job holder's performance and plan his career; and by the job holder to assist him to evaluate his own performance and develop himself."

ACAS (1987) says that "appraisals regularly record the assessment of an employee's performance, potential and development needs".

Armstrong and Baron (1998): "Appraisal is a stock taking exercise, a formal review of what the individuals do now and what they might have to do in the future, and what they need to know to improve their skills and competencies".

Pat Lane of the North Trent Department of Postgraduate GP Education (1998): "The development and appraisal scheme is designed to provide you annually with an informal process of reviewing and assessing your development needs, job performance, capability, training and education requirements."

The British Association of Medical Managers (BAMM) says in *Appraisal in Action* (1999): "Appraisal should look back over a period of time at what went well and what could have been improved. It should then look forward towards equipping the individual to face tasks in the future".

The Department of Health, in *Supporting Doctors, Protecting Patients* (1999), says appraisal is "a positive employer led process to give (a doctor) feedback on their performance, to chart their continuing progress and to identify development needs. It is a forward looking process essential for the developmental and educational planning needs of an individual. It is not the primary aim of appraisal to scrutinise doctors to see if they are performing poorly but rather to help them to consolidate and improve on good performance, aiming towards excellence."

The General Medical Council, in *Revalidating Doctors* (2000): "The purpose of appraisal is formative – to support doctors in maintaining and improving their professional performance".

### **A SchARR definition**

5 The SchARR team offers a definition which extrapolates the trends in thinking about appraisal. It is broadly consistent with recent descriptions of appraisal in Department of Health and other official papers (see text box). Appraisal is an opportunity, an annual process for:

- exploring role expectations, negotiating relative priorities, and setting and aligning individual and organisational objectives at local level
- reviewing progress towards achieving previously agreed objectives and agreeing future objectives
- recognising, acknowledging and valuing achievements
- exploring what is needed from the organisation to help and support the individual in making the best contribution they can

- identifying personal development needs and the means of addressing them, and forming a personal development plan
- helping the individual to produce information for any external accreditation purposes
- exceptionally (because there should be other mechanisms), early identification of an individual struggling or performing poorly
- securing continued overall improvement in performance.

## **Appraisal in the NHS**

### *In general*

- 6 The NHS experience of appraisal reflects its wider evolution. The early 1970s saw the introduction of a trait-based 'tick-box' approach to appraisal in the nursing profession; it spread to other professions during the decade but was discredited because of its reliance on subjective and often unilateral assessor ratings.
- 7 In the late 1980s the introduction of general management was accompanied by a national approach to appraisal for all NHS managers called Individual Performance Review (IPR). This linked performance directly to pay, with salary bonuses dependent on assessment by more senior managers of performance against objectives.
- 8 The Institute of Personnel and Development, and many individual HR practitioners, have advised strongly since the early 1990s against a direct link between pay and appraisal. Most studies have suggested that it is unlikely that appraisal will be an open and honest process, capable of enabling development and improvement, if pay is at stake.
- 9 During the 1990s, with the emergence of NHS Trusts and their local pay freedoms, the link between appraisal and pay for senior managers has generally been severed in line with the wider trend.
- 10 In December 2000 the NHS Executive gave an indication of its proposals for implementing the appraisal requirement with Consultants. The 'Advance Letter' ((MD) 6/00) built on the *Supporting Doctors, Protecting Patients* definition of appraisal and promised further guidance and standardised documentation. It emphasised the importance of the GMC's *Good Medical Practice* framework, and of consistency and links with the revalidation process; and it highlighted the importance of training for appraisal.

### *In general practice*

11 General practice has not experienced formal, systematic *employer-led* appraisal. There are various reasons for this, and it is important in planning the introduction of appraisal to recognise that several of them still apply:

- there is no employer in the conventional sense, although Personal Medical Services (PMS) schemes are beginning to change the landscape
- in the main, GPs have a form of contract, rather than employed status
- the national contract for General Medical Services (GMS) has traditionally conveyed objectives for GPs and linked their performance to pay and to access to other resources, and has been accepted as the main framework for 'managing' performance
- local audit arrangements, training practice accreditation, postgraduate educational work, and quality development and assurance programmes (eg those run by the RCGP) have flourished; but they have generally been managed by GPs, with management support, and this has reinforced the independent *position* of general practice whilst appropriately improving its *performance*
- features of the traditional culture of general practice are a spirit of individual enterprise and a preference for locally determined work patterns, and discomfort with externally imposed systems.

12 Local non-medical management has generally sought to *influence* rather than *manage*, sometimes very successfully, but conventional appraisal has not been an option.

13 The survey carried out by SchARR for the purposes of this report did not discover much progress in implementing employer-led GP appraisal. Of the 33 HAs (34%) that responded, 20 said that some planning was in hand but none had implemented a formal system. Few of the 466 PCGs or PCTs responded to the letter. The SchARR team acknowledges that this might reflect the level of other demands on them but nevertheless feels sure that significant local investments of time and resource in appraisal work would have been reported. In fact only ten PCGs and three PCTs referred to any planning work in hand.

**Quote.....**

“GP appraisal is not on our agenda.”  
HEALTH AUTHORITY MEDICAL ADVISER

14 There is evidence from the survey and literature (Jelley, 2000; Jelley and van Zwanenberg, 2000; Haman, Irvine and Jelley, 2001) that voluntary *peer* appraisal is used to good effect in some individual practices, amongst partners, but the extent of this is hard to judge from a survey directed at management organisations. Educational appraisal is used in many areas (Trent for example), led by GP Education Directors and GP Tutors. It is also clear that work has begun in general practice, and is well developed in many areas, around personal and practice development plans. The introduction of personal development plans and the encouragement of reflective practice has received investment and support from Health Authorities and PCG/Ts over the last couple of years. Many suggest progress made in this area could form a good basis upon which to build appraisal.

**Quote.....**

“Our main actions in the past year have been to roll out a Personal Development Plan workbook to enable GPs to complete a PDP by April 2001. The approach taken is to try to help GPs to see the benefits of this type of reflective self-assessment on a regular basis.”

CHIEF EXECUTIVE PRIMARY CARE GROUP

“It is our intention that these Professional Practice Development Plans (PPDPs) shall form the basis of the annual appraisals of GPs.”

DIRECTOR OF PRIMARY CARE

“The health authority is working with leaders in GP education locally to provide funding for the facilitation of PPDPs in each practice and also for PDPs. It is hoped that one use of these will be to act as an appraisal tool in the future.”

CLINICAL GOVERNANCE LEAD

15 The survey exposed concerns and uncertainties about the purposes and nature of appraisal.

**Quote.....**

“...from my very limited understanding of the government’s plans, I believe that ‘appraisal’ is to be used more as an assessment tool, which is a completely separate process.”

CONTINUING MEDICAL EDUCATION TUTOR

“...too strong an emphasis on performance monitoring might turn people’s enthusiasm off.”

CONSULTANT IN PRIMARY CARE DEVELOPMENT

“The idea of an appraisal system is to identify poor performance on an individual or practice level and to support and remedy problems if they are discovered.”

CLINICAL GOVERNANCE LEAD

“There seem to be conflicting ideas about the meaning and purpose of appraisal.”

CME TUTOR

### ***Where does appraisal sit in the scheme of things?***

16 The survey also brought out very clearly that the relationship between appraisal, revalidation and the management of poor performance, and their position as elements of clinical governance, are not well understood. Indeed the SchARR team have also encountered some confusion in their interviews and external meetings.

#### ***Quote.....***

“...there is concern about how a process of appraisal links with GMC revalidation and these concerns will need to be explored further if appraisal is going to succeed for the profession at large.”

MEDICAL ADVISOR

“(there is no) clear consensus about the purpose of appraisal, particularly its relationship to performance review.”

DIRECTOR OF POST-GRADUATE GENERAL PRACTICE EDUCATION

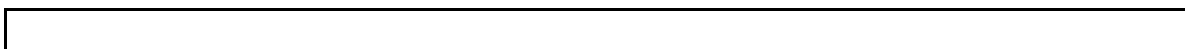
“...it is intended that this (appraisal) will be discussed and the process agreed with the clinical governance leads in the near future.”

DIRECTOR OF PUBLIC HEALTH

17 It may be helpful to offer some clarifications.

### **Revalidation**

18 Taking revalidation first, the SchARR team feel it is essential to appreciate that it is a completely different animal from appraisal. The differences can be illustrated by putting defining statements about employer-led appraisal alongside corresponding statements about revalidation.



***Appraisal is.....***

- led by the organisation/employer and focused on the performance of the individual employee
- a way of aligning organisational and individual objectives
- part of a wider systematic approach to performance management and development within the organisation
- an annual process
- a process internal to the management organisation
- a local process, customised to suit local and individual circumstances
- a two way process, because it can encompass consideration of contextual, environmental or systemic factors inhibiting individual performance
- primarily performance-developmental (or 'formative', to use the medical education parlance)
- action orientated, with agreed action commitments on both sides
- as far as possible, a process with accepted, agreed outcomes
- confidential, with many outcomes shared narrowly.

***Revalidation is.....***

- led by the professional regulatory body (in this case the GMC)
- a way of checking that an individual doctor is fit to practice
- part of the individual lifelong requirement of being able to practice as a doctor
- a quinquennial process
- a process external to the management organisation
- a national process which is standard for all doctors, whoever employs them
- a one way process
- an assessment process ('summative')
- status oriented (ie confirming fitness to practice), with required actions (if any) on one side only
- a process with imposed outcomes
- a matter of public record.

- 19 The point of distinguishing so firmly between the two different processes is to emphasise that appraisal has a life, purpose and value of its own. In many ways it should be a more routinely influential process than revalidation: it should play a key part in performance development for everyone who submits to it, whereas revalidation will lead directly to change (possibly, it is true, devastating change) only for the few doctors whose conduct, competence or health raise serious questions about their fitness to practice. (A recommendation for revalidation will only be withheld when *existing* grounds for GMC action are suspected to be present, and normal GMC procedures for investigation and decision will then be followed.)
- 20 In other words appraisal should be made to deliver its own, distinctive potential benefits, whatever it can also do in support of revalidation.
- 21 Having separated them conceptually, it is then sensible to make the appropriate practical reconnections. Appraisal and revalidation are likely to have overlapping (although not coterminous) agendas. The common ground is likely to include the specifications of the General Medical Council's *Good Medical Practice (1998)*, a third edition of which is subject to consultation at the time of writing, and the RCGP's *Good Medical Practice for General Practitioners*. Both processes will no doubt wish to consider whether a doctor is practicing medicine well, keeping up to date, relating appropriately with patients, working effectively with colleagues, enjoying sufficiently good health and generally conducting himself or herself appropriately.
- 22 Straightforward 'economy of effort' considerations suggest that the work done in serving one objective should contribute to achievement of the other. There should be some common documentation around the common areas of focus, which should not necessarily be the sum total of appraisal's focus. The GMC is likely to invite GPs seeking revalidation to submit summaries of their annual appraisals.
- 23 The later chapter which suggests a model for appraisal in general practice, and the resources required for it, returns to the point.

#### *Identifying and working with poorly performing doctors*

- 24 As some of the quoted responses to the survey suggest, appraisal is linked in people's minds to issues around poor performance. In fact the ScHARR team was dismayed to hear the link made almost automatically in the first few moments of interviews or meetings.
- 25 Appraisal *is* about performance right across the spectrum from the very best to the very worst; and it *is* about 'underperformance' in the sense that everyone, in any sphere of activity, can almost always be helped to perform

better. But, emphatically, neither appraisal nor this report is primarily about poor performance.

- 26 The NHS cannot (and should not) rely on a formalised annual appraisal process to detect very deficient performance. As ScHARR urged in *Measures to assist GPs whose performance gives cause for concern* (1997), a wide range of information has to be scanned continuously to ensure that serious problems are detected and positively addressed as soon as possible. Of course, major performance difficulties will sometimes emerge or be discussed during the appraisal process, but the key points are that this is not its primary purpose, and an NHS interested in addressing poor performance would be unwise to put all its eggs in that particular basket.

### **Clinical governance**

- 27 The diagram in the text box shows the links between clinical governance, revalidation and appraisal (and other things too). It is not necessary to complicate the position further here by agonising about the meaning of 'performance management' and 'performance review', and their relationship with appraisal, revalidation and the rest. Suffice it to say that clinical governance, an excellent and inclusive concept, *is* performance management in relation to clinical work, and it includes the process that is the main concern of this report.







## Chapter 3

### The lessons of history

#### ***Chapter 3 – main points.....***

- Successful appraisal depends upon commitment from the whole organisation.
- It is essential to be clear about the purpose of appraisal and not to expect it to carry too many different agendas.
- Staff and line managers should be involved in designing and implementing the overall appraisal approach, which should be based upon general principles of good practice but tailored to local circumstances.
- Training for those involved, both as appraisers and appraisees, and committing protected time to the process, are key success factors.
- The appraisal discussion itself is crucial, and it is essential to plan for it and handle it systematically and skilfully as a two way process with agreed outcomes to be pursued by the appraisee and appraiser.
- It is difficult to achieve openness and honesty in appraisal, and thus to realise its potential benefits, in an organisation that has a 'blame culture'.

#### **Overview**

- 1 Chapter 2 said what appraisal is and how it fits. This chapter is about what makes it work. It begins with an overview and then focuses on six key success factors. The material is 'generic' and not specifically NHS focused.
- 2 Both Long's 1986 study and the 1999 IRS survey confirm that appraisal remains a key management process and a cornerstone of many organisational improvement processes such as Investors in People. Both suggest that the keys to successful appraisal include the following:

- having commitment from the top
  - being clear about the purpose of the process
  - involving staff and line managers in designing and implementing the overall appraisal scheme, and taking trouble to get it right
  - training those involved and committing time to the process
  - handling the appraisal discussion itself effectively
  - ensuring the process 'fits' the wider organisational strategy and culture.
- 3 The corresponding pitfalls have been well summarised elsewhere. The Institute of Personnel and Development argue that schemes are in jeopardy when they try to meet many and conflicting objectives and Long (1986) says they may also run into trouble because of inadequate preparation. This can include "insufficient consultation with top management to clarify objectives, insufficient consultation with line management to clarify their needs, insufficient attention to the needs of employees, insufficient time for induction and appraisal skills training, and most importantly insufficient resources to meet individual training and development plans arising from the discussion."
- 4 The next sections look in more detail at some of the critical issues.

#### *Commitment*

- 5 Obtaining commitment from the top and throughout the organisation is crucial. Securing it depends on a number of factors:
- ensuring that the appraisal scheme is relevant to the needs of the organisation, and that its purpose is clear and well communicated and acknowledged by appraisers and appraisees alike
  - ensuring that the appraisal scheme has local ownership by involving people in its design and implementation
  - investing in terms of time and training to undertake appraisal.

#### **Quote.....**

"The success of a system will be dependent on the willing participation and engagement of the majority of GPs."  
 DIRECTOR, CENTRE FOR PRIMARY CARE

6 *Maintaining* commitment is also crucial and failure to live up to promises made during the design and implementation phase, as well as during actual individual appraisals, can lead to disillusionment.

7 Maintaining commitment depends on a number of factors:

- leading by example: Roberts (1998) suggests that senior manager attendance at appraisal training, and senior manager participation in appraisal as appraisees as well as appraisers, is crucial
- using the outcomes: action must be taken and seen to be taken (by the organisation and the individual) to address issues identified through the appraisal process
- investing up front: ensuring adequate resources are available in training, education and service development budgets
- system care: monitoring, regularly reviewing and rejuvenating the appraisal system ensures that it continues to add value. Pratt (1985) says even the best run schemes require (and get) constant review.

#### *Clarity of purpose*

8 Research and experience suggest that a major barrier to introducing, implementing and maintaining a successful appraisal system is a lack of clarity from the outset about its purposes; and many researchers have doubted whether appraisal can serve many purposes at once. Devries et al. (1980) detected purposes in some schemes as many and varied as decisions on salary, promotion, retention or discharge; career counselling, training and development; human resource planning; and the validation of selection techniques.

#### **Quote.....**

“Clarity of purpose both explicit and implicit is at the heart of successful appraisal systems. What those involved understand, believe or perceive to be the purpose of the system directly influences the way in which they engage with the process and clarity is essential.”

NHS TRUST HR DIRECTOR

“There seem to be conflicting ideas about the meaning and purpose of appraisal.”

CME TUTOR

“At the heart of this is a lack of clarity about the purpose of appraisal.”  
COMMITTEE OF GP EDUCATION DIRECTORS JANUARY 2001

9 The trend is towards sharper focus and greater clarity. Long (1986) identified a trend towards focusing on the first four of seven common objectives for appraisal systems:

- reviewing past performance
- helping to improve current performance
- setting performance objectives
- assessing training and development needs
- assessing salary increases
- assessing future potential and promotability
- assisting with career planning.

10 The key message is that introducing successful appraisal requires crystal clear definition of its purpose and connections with other processes.

#### *Designing a good scheme*

11 Getting the appraisal scheme itself right emerges in the literature as a close second in priority order to ensuring that its objectives are clear and understood. The way in which the scheme is designed and implemented can either support or contradict the stated purpose and enable or disable participants.

12 These are some of the design principles that influence the most successful schemes:

- Staff should be involved in the design of the scheme, for three reasons: it will probably lead to a sensible and workable scheme; people tend to support what they have created and involvement from the start will help to build commitment to the appraisal scheme itself; the process of engagement might also carry a useful general message about management approach, building commitment to the organisation as a whole.
- Clear guidance should be issued to both appraisees and appraisers setting out the purpose and objectives of the scheme, and outlining the process including documentation, timescales and outcomes.
- The formal annual appraisal discussion should not stand alone. In the majority of systems it is recognised that appraisal needs to be part of an

ongoing process of dialogue between the appraiser and appraisee. The periodic 'snap shot' must be informed by this and cannot substitute for a continuous process of looking at how things are going. Long says: "Ideally the appraisal discussion should be seen as merely one formal event in a continuum of informal work-related communications between the manager and job holder".

- The appraisal discussion should not be seen as the vehicle for dealing with performance problems. Stewart and Stewart (1983) indicate that it is rare for an organisation to have a well thought out policy on poor performers and even rarer to find one which trains managers to deal with them. In that context, the temptation to use appraisal for identifying and dealing with poor performance, in the absence of other acknowledged processes, is understandable. But the 'best practice' message is that performance problems should be coped with as they arise within the framework of a separate, explicit approach. Storing up serious problems for appraisal is obviously very risky for the organisation. It also diminishes the value of appraisal by casting it as a fault finding, troubleshooting process and surrounding it with an aura of threat.
- The documentation supporting appraisal should be helpful and fairly simple and not burdensome or bureaucratic. If there is too much paperwork, appraisal can come to be dreaded as a chore by all concerned. And experience suggests that scoring, rating and box-ticking tend to reduce the scope for dialogue.
- It is at the heart of successful appraisal that it should be a two way process. The most effective systems recognise that individuals seldom work totally alone but are part of teams, and that they work in an environment of physical things and systems. Success and failure often reflect the features of teams, workplaces and systems rather than simply working individuals. These factors have to be addressed as part of the appraisal process. In the most effective appraisal systems both appraiser and appraisee come away with actions to take.
- If appraisal is to be a two-way process with a potential impact on investment and other management decisions it will work best if it fits in with the natural cycles of organisational life, and this is not straightforward. It involves decisions about which business or other cycles are the most important and it implies that appraisals should be bunched, at least to some extent, so they all take place during the optimal period. This in turn may have implications for the number of individual appraisers required because their overall workload may not be spreadable over the full year.
- The two-wayness of appraisal may need to be demonstrated quickly for credibility's sake. But early environmental or systems changes may be

difficult to achieve because of natural lead times for investment and implementation. One possibility is to pre-identify and announce resources which will eventually be committed in the light of an appraisal cycle.

- The majority of systems (two thirds of respondents in the IRS survey) encourage individuals to undertake self appraisal alongside the formal process, reflecting systematically on their performance (particularly their achievements), and perhaps seeking feedback from colleagues or users of their service. This provides a useful starting point for discussion in the appraisal and helps to ensure that attention is paid to what is important to the appraisee.
- Research suggests that participants in successful appraisal systems feel the system operates with integrity and that the information it generates is used with discretion. In the most effective appraisal systems the *detail* of the appraisal discussion is treated as confidential, although there must be some externally visible and useable outputs for it to serve its purpose. Usually the appraiser and appraisee agree explicitly what should be shared more widely. The 'open' output generally consists of a summary action plan, often with three dimensions: work related objectives or actions which will be pursued by the employee, actions to be taken by the appraiser or some other person in the organisation or system, and a personal development plan for the employee. In some organisations there is also a brief joint statement from the appraiser and appraisee indicating that the appraisal had taken place according to protocol and outlining any issues they wish to share with more senior management. Fowler (1991) suggests that the action plan should also incorporate target dates for review and completion.
- It would be usual for this document to be shared with a more senior manager who would have a shared responsibility with the appraiser for ensuring the commitments given in the plan were followed through. He or she might also be responsible for 'reading across' appraisals to identify general themes requiring investment or action, ensuring that the appraisal process is being carried out consistently and fairly across the piece, and responding to and seeking to resolve any difficulties that might arise between an appraiser and an appraisee.
- Research suggests that where this stage exists it is more likely that appraisal will contribute directly to decision making and result in action, and that there is greater confidence in a system that is seen to be monitored by more senior managers. (This obvious potential benefit of appraisal is at jeopardy in a 'blame culture' which discourages openness.)
- Finally it is clear from research that schemes may suffer from what one survey respondent called mid-term inertia, and that to remain successful

they need to be regularly reviewed, rejuvenated and relaunched. It is therefore important to build into the scheme's design a review process which includes seeking the views of those involved in it.

### *Capability and capacity*

- 13 Some of the most damaging concerns about appraisal, as reported by the individuals involved, revolve around the skills of the appraiser or (from the other perspective) the appraisee's understanding and readiness to participate. The need for both to have time to prepare and engage fully – capacity as opposed to capability – is obviously crucial too.
- 14 The success of appraisal is directly related to appraiser skill. All the evidence suggests that if appraisers have not been adequately trained the appraisee's experience of the process is likely to be poor.

**Quote.....**

“Unless training is universal and comprehensive the appraisal program will not be effective”.

GROTE (1998)

- 15 But appraiser capability is not just a matter of specific training in conducting appraisals. The most effective appraisers meet a broader set of criteria, some to do with their wider skills and personal style and some to do with their position in the organisation and relationship with the appraisee. The specification is demanding and (as later chapters discuss) not easy to meet in the context of general practice, with its distinctive organisational position and links.

- 16 The appraiser should:

- have good or even exceptional interpersonal skills
- be committed to the concept of appraisal
- be trained to undertake appraisal and have had the opportunity to practice 'off line'
- be fully familiar with the particular documentation and process of the scheme
- have a good knowledge of the appraisee's job and the context and circumstances within which it is performed

- have knowledge of the individual's work throughout the year so that the appraisal discussion is part of an ongoing dialogue rather than an isolated episode
- have a reasonable working relationship with the appraisee
- be in a position to reach conclusions and agree objectives and actions on behalf of the organisation during the appraisal process
- have the direct authority, or be empowered, to make or strongly influence wider organisational decisions (ie influence or effect change) and ensure outcomes are actioned (eg investing in additional staffing, upgrading technology or other facilities, arranging additional support, training or development).

17 Research and practice also point up the importance of ensuring that appraisees are adequately briefed and trained to get the best out of their appraisal. Kaye and Krantz (1982) observed that preparing employees for their role in appraisal is sometimes the missing link in the process.

18 However well the appraisers are selected, and however thoroughly both appraisers and appraisees are prepared, they will struggle without a top level commitment to resourcing the time they need to get ready for, carry out and follow up appraisal discussions properly.

19 Research suggests that the task of appraisal has sometimes been imposed on managers and staff without recognition of the time required for it, to pick up alongside and without detriment to other work. This has on occasions turned appraisal, which should be a positive experience, into a burden. Appraisal undertaken between two unprepared individuals in a busy environment, subject to interruption and rushed in the midst of other 'priorities', may be worse than no appraisal at all.

**Quote.....**

"There currently appears to be little additional free time and resource to support GP appraisals and this is going to be a major hurdle in the foreseeable future."

HEALTH AUTHORITY MEDICAL ADVISER

"Appraisal is a useful tool if used wisely in the right hands, but something which if done wrongly can, like any tool or drug, do harm."

GP TUTOR

20 Resource issues are addressed in Chapter 4.

### *Conducting the appraisal discussion*

21 A great deal has been written about the conduct of the appraisal discussion itself. It is this segment of the process that most often leads to complaints. Research and experience suggest that some simple, practical steps can improve the chances of success:

- Both the appraiser and appraisee should prepare for the discussion by looking back at previous appraisal outcomes and commitments, reflecting on achievements and challenges during the period since the last appraisal (including whether agreed actions have been taken), and looking forward at what might be achieved in the coming period and what might be required in support. They should collect together any other information which might inform the discussion.
- Where possible the appraiser and appraisee should agree beforehand on the main agenda of issues for discussion, ensuring that there are no surprises.
- The appraisal discussion should be held in a comfortable work setting free from interruptions and distractions such as phone calls and demands from other staff (including more senior staff).
- The environment should facilitate two way discussion, with relaxed seating and appropriate lighting.
- Sufficient time should be protected for the discussion, usually at least ninety minutes. If it looks as if the agenda will not have been covered by the end of the allotted time it is better to meet again to finish off rather than rush the crucial ending.
- The discussion should follow a logical sequence, leading at the end to a constructive action plan. Writers and practitioners have suggested that the discussion might be structured in the following way:
  - the appraiser and appraisee remind themselves of the purpose of the discussion
  - they confirm or agree the agenda
  - they work through the agenda point by point agreeing actions each party needs to take
  - they check out their understanding of the agreements made and produce the action plan
  - they identify any other key business.

- Experience suggests that a good way of starting is for appraisers to ask the appraisee about their *achievements* in the previous period. The annual appraisal discussion is an ideal opportunity to acknowledge, celebrate and reflect upon success.
- The literature also suggests that appraisals are most successful when the appraisee does most of the talking and is given the opportunity to comment on and make suggestions about what the organisation could change to help improve performance; and where the appraiser adopts a problem solving style. Fletcher (1973) advocated an early focus on job challenges rather than the individual job holder.
- Appraisal works best when the appraiser, on behalf of the employer, also sees it as an opportunity to learn and develop and is open to feedback about what they might be done differently to help improve performance.
- The appraisal should conclude by setting down in writing, as an action plan, the agreements which have been reached about what each party is committed to doing. This should include the essentials of the appraisee's personal development plan.
- Experience suggests that appraisals which finish on a positive note are more likely to secure the commitment of both parties to address the agreements they have reached in the discussion.
- Long identified an increasing trend towards openness in the performance review process. The IRS survey indicated that 90% of employees now see their full appraisal report.

### *Appraisal in its context*

- 22 Much has been written about the impact of the context within which appraisal takes place: the nature of the organisation's work, the skills and educational backgrounds of its staff, and its culture.
- 23 The literature suggests that successful appraisal systems need to be designed locally (with staff involvement) to fit the local context. Long (1986) concludes that "ready made systems imported from other organisations rarely function satisfactorily". This is not to say that lessons cannot be learned from others, but it is probably better to develop appraisal locally in the light of general principles, based on wider experience, than to copy.
- 24 The research on organisational culture and appraisal suggests that schemes should be consistent not only with their stated purpose but also with the way in which the organisation functions generally: its values, style and customs. Pratt (1985) argues that an approach to appraisal which expects openness

and disclosure is unlikely to succeed in an organisation which punishes mistakes or exploits vulnerability.

## Chapter 4

### Developing an appraisal model for GPs

#### ***Chapter 4 – main points.....***

- No example of locally comprehensive employer-led GP appraisal is available for emulation, and this chapter offers a model.
- In most cases Health Authorities carry the formal responsibility for appraisal, but they should delegate its management to PCTs as soon as possible and then continue to satisfy themselves that a satisfactory process is in place.
- ScHARR suggests a senior individual should be identified to design and manage the appraisal process on behalf of the Chief Executive and Board.
- The scheme should be designed in consultation with the profession locally.
- Clear guidance should be produced which describes the local scheme and sets out the responsibilities of the HA or PCT Chief Executive, the lead manager for appraisal, appraisers, GPs themselves and others.
- The scheme should provide for the appraisal of all GPs on at least an annual basis.
- Appraisers should be GPs, recruited from different roles and settings, who meet key criteria of capability, capacity and professional and organisational credibility.
- Around 3.5 hours, or one session, of appraiser casework time should be set aside each year for each appraisee.
- The appraisal discussion should be structured around an agreed agenda which addresses issues of importance to the GP, the appraiser and the HA/PCT, with the GMC's *Good Medical Practice* as backdrop.

- The detail of the appraisal discussion should be confidential but a summary with specified elements should be shared with the senior individual managing the scheme.
- The GP should retain a standard summary of the appraisal as recommended by the GMC for inclusion in her or his revalidation folder
- There should be clear local procedures for resolving individual concerns and for addressing general suggestions about improvements to the appraisal system.
- Anonymised overview reports on appraisals should be prepared periodically to support action and investment in relation to training, development, organisational or service themes.

## **Introduction**

- 1 The task is to transfer good appraisal practice described in Chapter 3 into the distinctive context of general practice outlined in Chapter 2. No one appears to have done it yet on a comprehensive, system-wide basis.
- 2 Interest in GP appraisal is growing, often led by GP educationists or clinical governance leads, but the position is patchy. Work has focussed mostly on informal peer appraisal and the formation of personal development plans, and on encouraging reflective practice amongst GPs.
- 3 There has been a comparatively large amount of work on the difficult issues around poor performance, often using an earlier SchARR report as the basis for action. The links between this and appraisal, and the risks involved in exaggerating them, have been discussed already.
- 4 This chapter offers a framework for developing a comprehensive GP appraisal scheme. It begins with a 'system specification' – the 'what' question about GP appraisal – and many of its elements should be recognisable from the discussion of good practice in the last Chapter. It goes on to outline the roles and responsibilities of key bodies and individuals in an attempt to provide clarity about leadership and direction – the 'who' and 'how' questions. There is a brief discussion of PMS and other 'special cases'. (Chapter 5 deals with implementation issues, also bearing in mind the lessons of experience elsewhere.)
- 5 It is expected that some elements of appraisal, including some standard documentation, may be specified centrally for universal application; but it is also strongly recommended that there should be plenty of room for

appropriate variation in other aspects of local schemes and in approaches to their implementation. This latitude should be exploited in full consultation with the profession.

### **A specification for GP appraisal**

- 6 All GPs working in general practice must undergo formal appraisal on at least an annual basis.
- 7 The focus of the appraisal should clearly be the individual GP, but viewed and appreciated in the context of his or her whole working environment, including particularly their practice.
- 8 The GP and the appraiser should be clear about the purpose and process of the appraisal, and procedural and quality standards should therefore be provided.
- 9 Both the GP and the appraiser should receive training in order to take part successfully in the appraisal process.
- 10 The appraiser should have the following credentials:
  - good knowledge of the job and the context and circumstances in which it is carried out
  - good interpersonal skills
  - at least some knowledge of the GP's work throughout the year
  - a reasonable working relationship with the appraisee
  - the confidence of the GP community
  - the confidence of the HA or PCT (which it should be is discussed later)
  - the authority to agree actions and commit resources on behalf of the HA/PCT or the credibility to influence strongly those who can.
- 11 In order to meet the first of these requirements, the appraiser should be a GP, and in order to meet the fifth and sixth requirements he or she should be an *effective* GP who might have performed relevant roles outside the consulting room (in management or education, for example). The identification of appraisers is discussed again later.
- 12 The appraiser should be appointed by and act on behalf of the HA/PCT.

- 13 The GP and appraiser should both prepare before the appraisal meeting and sufficient time should be set aside for this.
- 14 In general terms, they should gather information about and reflect beforehand upon the following:
- achievements and challenges in the last twelve months (clinical and non-clinical), seen where relevant in the context of earlier appraisals
  - service, practice and (where relevant) wider objectives for the next year and beyond
  - in the light of objectives, personal (and, if appropriate to a discussion about the individual in context, practice) development needs
  - progress in collecting evidence for revalidation purposes.
- 15 The appraiser and appraisee should try as far as possible to share information before the meeting and agree a joint agenda.
- 16 The *backdrop* to detailed decisions about the appraisal agenda should be the areas set out in the GMC's *Good Medical Practice* (1998) and the RCGP's elaboration of it (RCGP, 2000), the fields covered by the GMC's revalidation folder, National Service Frameworks (NSFs) and other key policy statements, and whatever forms of national (GMS) or local (PMS) contracts or other agreements prevail. Haman, Irvine and Jelley (2001) provide good practical material on the content (and conduct) of appraisal interviews.
- 17 The aim should not be to work rigidly work through every aspect (quite impracticable) but to focus on carefully selected areas of particular importance to the GP, the appraiser and the HA/PCT. The HA/PCT, for example, may wish to see discussion of referral or prescribing data with a particular GP, or to nominate a theme for discussion with all GPs during a particular cycle (perhaps work in relation to one of the NSFs).
- 18 There should be no major surprises in the appraisal. If there are known significant issues of poor performance they should have received attention in accordance with other accepted processes. If, exceptionally, serious concerns first arise during the appraisal discussion the appraisal should be paused and the issues referred in line with the appropriate procedures. Appraisal should be resumed in due course, as appropriate.
- 19 The discussion should follow the agreed agenda and take place in protected time in a suitable environment free from interruptions. A minimum of 1.5 hours should be allowed.

- 20 The appraisal discussion should be a two way dialogue focussing upon joint problem solving and development.
- 21 The *detail* of the appraisal discussion should be confidential to the participants. The appraiser and appraisee should agree a written overview of the appraisal which should minimally include:
- a synopsis of achievement in the previous year
  - objectives (an action plan) to be pursued by the appraisee over the next year including milestones and review dates
  - actions expected of the HA/PCT to address needs in the local context or wider system
  - the key elements of a personal development plan for the appraisee
  - a standard summary of the appraisal as recommended by the GMC for the individual's revalidation folder
  - a joint declaration that the appraisal has been carried out properly.
- 22 Copies should be retained by both the appraiser and appraisee for future reference and review, and shared with the senior person in the HA/PCT with responsibility for overseeing the appraisal process (this is discussed later).
- 23 The revalidation document should be submitted to the GMC at the appropriate time.
- 24 There should be an expectation that the appraiser and GP should meet at least once more during the course of the year for a maximum of 30 minutes to review progress in relation to the actions and personal development plan.
- 25 An aggregated and anonymised report on appraisal outcomes should be collated and submitted annually to the HA/PCT, covering emerging training and development, organisational or service themes requiring action or investment. It should also review the overall operation of the appraisal process. The timing of the report should be linked to planning and decision making cycles.
- 26 There should be a clear process in place which can address any worries or complaints from individual GPs about the fairness and consistency of the scheme, the appraiser, the outcomes of the appraisal or the use of information (this is discussed later).

27 The HA/PCT should seek to ensure that sufficient monies are made available in year for training and development needs identified through appraisal. Appraisal should be a significant driver for investment choices and management action.

## **The responsible organisation**

### *In general*

28 There are two different issues in play in locating management responsibility for GP appraisal. There is first of all a question of 'sensibleness': what is the most reasonable way of managing GP appraisal in the local health community? There is also however a formal question about statutory responsibility: who holds the GP's contract?

29 In terms of sensibleness, the SchARR team believe that the responsibility for implementing and managing GP appraisal schemes, and for addressing many of the issues they identify, should rest in the future with Primary Care Trusts.

30 Over quite a short time, health authorities will change significantly, covering larger geographical areas and performing high level strategic functions with relatively fewer staff. Some of their present work will pass to PCTs and their attention will probably turn to six core functions:

- interpreting government policy for local implementation and coordinating the local Health Improvement Programme (HIMP) as its vehicle
- providing a point of contact for financial allocations and service planning
- performance management
- partnership coordination, including working with local government
- building local culture, capacity and capability
- informing and influencing the Centre.

31 If this is the direction of travel, it will be inappropriate to expect them to manage GP appraisal (or any other detailed, local human resources systems). PCTs on the other hand are perfectly placed and scaled to do it.

32 There is also however the formality of the contract position to be considered. General Medical Services (GMS) are provided under the terms of a contract which is negotiated centrally and administered locally by health authorities. Formally speaking, health authorities and not PCTs hold the contracts of local GMS GPs. (They are also to have new duties to hold local registers of doctors

working in general practice.) The general convention with appraisal is that it is essentially an employer-led transaction between employer and employee. In the GMS context the nearest thing to an employer is the health authority as contract holder, and it should arguably therefore have responsibility for appraisal.

- 33 The SchARR team expects however that formal responsibility for contracting with GPs will pass over time to PCTs through changes in the GMS framework portended in the NHS Plan (a new GP contract converging with Personal Medical Services arrangements) as well as through growth in PMS itself. (PMS is discussed again below.)
- 34 Meanwhile, even though they currently 'manage' GMS doctors in the formal sense, the proposal here is that health authorities should delegate the responsibility for appraisal to PCTs as soon as possible, because it is more *sensible* to do so than to hold on to an ill-fitting role. The practical role of the HA would then be *to ensure that satisfactory GP appraisal systems are in place and working, and to hold PCTs to account for them*. The role of the PCT would be *to implement, manage and account for local systems*.
- 35 Health authorities may very reasonably interpret 'as soon as possible' to mean 'when PCTs are ready for it', having an eye to the newness of PCTs, the scale of their agenda and the capacity available to them. The SchARR team supports this but hopes that PCTs will make ready as soon as possible, perhaps by working closely with Deaneries and benefiting from their expertise and support. Health authorities might consider formulating local criteria of readiness to assist PCTs in their organisational development work. Until they are satisfied that PCTs are in a position to assume delegated responsibility for appraisal, and obviously where PCTs are not yet in place, responsibility should remain with the HAs (working, where relevant, with their Primary Care Groups).

#### *In relation to PMS and other particular cases*

- 36 The accountability of GPs in Personal Medical Services schemes varies. In schemes established from April 2000 where there is a local PCT, the PMS contract (which incidentally includes a requirement to undergo appraisal, as the GMS contract will do in due course) is with the PCT. PMS schemes established before April 2000 have the option of remaining in contract with the health authority. Formally, responsibility for appraisal work with PMS doctors should rest with the contract holder. By local agreement, however, for the reasons discussed above, it may be sensible for a health authority which carries responsibility to delegate it, if possible, to the PCT (if there is one). The managerial responsibility issue should not need to vary between PMS doctors who are salaried and those who remain independent.

37 Appraisal with non-principals working in general practice should be carried out as far as possible in line with the specification set out above. The responsible organisation should receive the same material as they do for principals. There might be logic in the appraisal being carried out by the principal on whose behalf the non-principal is working. However this raises questions about their training and proficiency in appraisal work. The SchARR team would prefer to see non-principals appraised by 'accredited' appraisers (more on this later), with hopefully a tripartite agreement at practice level on the role that the principal should play and their entitlement to information.

### **Responsibilities and processes within the HA/PCT**

38 The responsibilities of the HA or PCT should be as follows:

- to ensure that an appraisal scheme is in place which covers all doctors working in general practice within the organisation's span and commands the confidence of the profession locally
- to ensure that all relevant doctors undergo annual appraisal in line with the scheme
- to establish workable arrangements for identifying, appointing and training appraisers
- to ensure that appropriate mechanisms are in place to quality assure appraiser and appraisee training, and to regularly review the appraisal process in the light of participant experiences and changing circumstances
- to ensure that robust processes are in place to deal with worries or complaints from individual GPs about the process or outcomes of appraisal
- to ensure that action is taken as far as possible to address the education and development needs of GPs and service development requirements identified and agreed in the course of appraisal.

39 It should be for the HA/PCT to determine, in close consultation with the profession locally, how to discharge these responsibilities, incorporating any standard national requirements. Typically, however, the SchARR team anticipates that a senior individual (a 'lead manager', who may or may not be a clinician) will be identified to design, manage and account for the appraisal process as part of the organisation's clinical governance effort. He or she should be able to call on appropriate administrative services, and on the informed advice and full support of relevant managers and clinicians. Whatever arrangements are made to achieve this locally should in the SchARR team's view be as streamlined and non-bureaucratic as possible.

40 It may be helpful to outline, for local refinement, the possible responsibilities and accountabilities of individuals within this framework:

- *The Chief Executive:* is the officer ultimately accountable for the discharge of the six key responsibilities set out above.
- *The lead manager for appraisal:* coordinates the design, implementation and conduct of GP appraisal, facilitating the engagement of GPs, GP educationists and others; leads the process of identifying, training and allocating GP appraisers (with some latitude in allocation for GPs and appraisers to express preferences); in consultation, ensures that appraisal agendas include issues of particular interest to the HA/PCT; receives the individual outcomes of appraisal; identifies cross-cutting education and development themes and service development issues which are barriers to improving patient care; provides a report setting out these issues and making recommendations for action; follows up on agreed actions and reports on progress; acts as the first port of call in the case of concerns or disputes (see below); arranges for evaluation of the appraisal process as a whole.
- *The GP Appraiser:* undertakes appraisal with a number of designated GPs; prepares for appraisals and agrees the agenda with GPs in consultation with the lead manager; ensures that appraisal is conducted in line with good practice; supports GPs in considering their practice over the last year; agrees objectives and the key elements of a personal development plan, and actions which the organisation should attempt to take; discusses progress towards revalidation (and assists with any overview required after five years for the GMC revalidation folder); records appraisal outcomes and conveys them to the lead manager; maintains confidentiality over the detail of appraisal discussions; builds positive working relationships with the appraisee and follows up appraisal discussions to review progress at least once during the following year; identifies any early warning signs that a GP may be struggling and agrees with the individual how this will be dealt with; in exceptional circumstances, if seriously deficient or dangerous practice is encountered, refers in line with local procedures (remaining mindful of overriding individual professional duties in relation to the performance of colleagues).
- *The GP:* undergoes training for and participates fully in the appraisal scheme; prepares for the appraisal discussion; agrees objectives, actions and the essentials of a personal development plan for the coming year with the appraiser; agrees on matters outside his or her individual control which inhibit performance and should be referred; takes the opportunity to prepare evidence for inclusion in the GMC revalidation folder; seeks to achieve objectives and fulfill the personal development plan; discusses

progress with the appraiser at least once during the year before the next full appraisal.

- *The GP Tutor/Educationalist*: supports the development of appraisal training and where appropriate accredits and/or runs it; perhaps acts as a supervisor or mentor for GP appraisers; advises on Continuing Professional Development (CPD) issues arising from appraisal and supports the development of education and training strategies to address these.

41 It will be important locally to be explicit about the detail of responsibilities. For example, the appraiser should agree some key elements of personal development plans arising from the appraisal process, but this does not imply responsibility for 'signing off' the finished full plans. This may well be a task for others. The worst case would be if good existing systems, of whatever kind, were somehow stalled because of uncertainties or misconceptions about appraiser responsibilities.

### **Identifying appraisers**

42 It is clear for reasons outlined already that appraisers of GPs must themselves be GPs. A major challenge will be to find them.

43 The individuals who currently possess the appropriate skills are usually located in academic departments of general practice or have educational roles. However the SchARR survey detected mixed views about attempting to locate the appraiser role with them.

44 Concerns about members of academic departments centre around their perceived lack of understanding of day to day general practice and the contexts within which their colleagues work (although in reality many of the individuals concerned *are* in practice, often in very demanding settings).

45 Concerns about the appraiser role being assumed by GP Tutors (and frequently voiced by them) revolve around potential conflicts between their core 'formative' role in developing performance through education, and what was taken to be a different role in managing performance 'summatively' through appraisal. For reasons that have been rehearsed in this report, this may reflect a misunderstanding of appraisal. GP Tutors have relevant experience and training and may often be well suited to the appraiser role.

46 The suggestion from some has been that appraisers should specifically be 'ordinary' practicing GPs who have been trained to undertake appraisal.

47 The SchARR team feel that a debate which tries to lay the appraiser role at the door of one or more specific groups of people is unnecessary and

probably unrealistic. The aim should be to find people who *want* to be appraisers and have the capacity and capability to do the work. They might be found in several different parts of the system. Earlier in the chapter it was suggested that appraisers should have very good knowledge of the job and of the context and circumstances in which it is carried out, and the confidence of both the profession locally and the HA/PCT. It was argued that the appraiser should be an effective GP and *might* have performed relevant roles outside the consulting room (in management or education, for example). Within that framework, it should be for organisations locally to find the people.

- 48 It is difficult to be precise about the number of appraisers who will be needed. However it is suggested as a starting point that for each appraisee, each year, the minimum appraiser commitment for casework will be 0.5 hours for preparation, 1.5 hours for the discussion itself, 0.5 hours for writing-up, 0.5 hours for a mid-year review and 0.5 hours for arrangements and travel – 3.5 hours in all, or around one session. This can be translated into an FTE (full time equivalent) appraiser casework requirement for a particular HA or PCT by dividing the total number of doctors working in general practice, including those working part time (who will still need ‘full time’ appraisal) and non-principals, by 440 (the approximate number of sessions contributed annually by a full time GP). Thus a PCT with 100 GPs will require the equivalent of 0.23 FTE appraisers for casework. Each individual appraiser will need to set aside between 2.0 and 3.0 days each year, in addition to casework time, for their training in appraisal and for general administration (eg preparing and presenting overview reports).
- 49 It is clear that the required overall resource could be supplied by more than one GP in a particular area. A view will have to be taken on the workload that individual appraisers should undertake, with an obvious impact on how many need to be trained. A balance will be needed between making the most of scarce skills and reinforcing them through practice, and on the other hand placing unsustainable expectations on people who have their own practices to look after (and possibly other roles too). It has been suggested several times to the ScHARR team that the number of appraisals an individual could reasonably be expected to undertake in a year is between 10 and 25. This could however be affected by any ‘bunching’ of appraisals in a HA/PCT area to connect them (as discussed earlier) to business and planning cycles.
- 50 If neighbouring HAs/PCTs wished there could be pooling of both appraiser training and the casework time provided by individuals (although appraisers may be most effective in the organisations and areas they know).

### **Resolving differences**

- 51 There needs to be a clearly described and agreed procedure for dealing with concerns or complaints about either the appraisal scheme as a whole or

individual appraisals. This should form part of the overall appraisal procedure and therefore widely shared. In line with the general direction of proposals in this report, it should be for local organisations to agree the detail of their procedures in consultation with the profession. One or two suggestions may nevertheless be helpful:

- Individual GP concerns about their own appraisal should be raised in the first instance with the appraiser.
- If personal concerns remain the GP should discuss them with the HA/PCT lead manager for appraisal.
- The manager will in the first instance try to find an informal resolution to the problem through discussion and mediation, involving others as appropriate.
- If the concern is about the outcome of an appraisal, one option might be to offer an alternative appraiser for a 'second opinion'.
- In the exceptional circumstances that concerns cannot be resolved in these ways, the lead manager (or Chief Executive) might convene an appropriately constituted panel to consider the matter further.
- The final recourse within the organisation would be the Board itself. Beyond that it would be for the GP to take the matter up outside the organisation as they would any other serious dispute or grievance.
- ***Where concerns or views relate to the appraisal system as a whole the proper route is through the lead manager to the Chief Executive.***

## Chapter 5

### Implementing GP appraisal

#### ***Chapter 5 – main points.....***

- In the present context of general practice appraisal will not be welcomed by some, but it will be difficult or impossible to implement effectively without the cooperation of GPs.
- Recognising the contextual challenges, it is suggested that appraisal should be introduced carefully, with full GP consultation about design and implementation, and with adequate resources, to ensure that it is properly embedded and valued.
- Local schemes should be reviewed and improved on a continuous basis.
- Processes should be established locally and nationally for sharing learning about effective appraisal.

#### **Introduction**

- 1 It is obvious from the relevant research and literature, and the SchARR team's own work, that the way in which GP appraisal is implemented will be crucial. The first steps will be over significant hurdles, and the appraisal venture and its potential benefits might be jeopardised by an injudicious start.
- 2 Specific lessons about introducing appraisal, and more general lessons about change management, can be learned from others. But the context in which appraisal is introduced is always unique and therefore schemes must be tailored to fit local circumstances.

#### **The general practice context**

- 3 The context within which GPs are working is changing rapidly. The profession recognises this. *Shaping tomorrow: issues facing general practice in the new millennium*, published in 2000 by the British Medical Association, explored the ways in which the traditional cornerstones of general practice are being redefined. The expectations of patients, the general public and Government are changing, and financial and human resource issues impact on the sustainability of conventional approaches. Nothing is sacred, not even the basic idea of personalised continuing medical care.
- 4 GPs themselves have increasingly diverse expectations of their working lives. The composition of the GP workforce is changing, with increasing numbers of women in post and a pattern of earlier retirement. Younger GPs are looking for a different balance between work and home life, and are more reluctant than their predecessors to enter into lifetime commitments. New patterns of employment are likely to emerge, often based on the flexibilities of PMS.
- 5 The development of clinical governance and the emerging requirement for revalidation, often welcomed by doctors as ways of improving quality, nevertheless carry with them more transparent accountability and this is a challenge.
- 6 The emergence of PCGs and PCTs, the changing role of health authorities and the expanding prescriptive framework of HImPs, National Service Frameworks and guidelines from the National Institute for Clinical Excellence all require GPs to examine their practice and review their relationship with the NHS.
- 7 Recent high profile clinical failures, and disasters such as the Shipman case, have created an environment within which protecting patients, rooting out bad practice, and dealing with poorly performing GPs dominate the psyche of the general public, politicians, NHS managers and GPs themselves. This makes it difficult to secure a reasonable balance between performance assessment and performance development.
- 8 These combined pressures have created a sense of threat in many GPs (and other doctors too) and there is an understandable cautiousness about 'initiatives' and change, especially if they smack of managerialism and the erosion of (for many) a valued degree of independence.

### **Working with the context**

- 9 In this context the risk is that appraisal will be seen as yet another imposition, insensitive to the needs of general practice, and driven by a desire to identify poor performers. But appraisal will be difficult or impossible to implement effectively without the cooperation of GPs.

**Quote.....**

“GPs in our area view appraisal with mixed reactions. I have no doubt that many see it as a potential threat, and a stressful and possibly unnecessary process.”  
CLINICAL GOVERNANCE LEAD

“The hope is that undue consideration will not be given to the Shipman scenario and political correctness. Of much more importance is the wish of local professionals to participate in an ever-improving provision of care to the local population.”  
CHIEF EXECUTIVE, HEALTH AUTHORITY

“I have met with resistance to the measures which have to be introduced and I know that appraisal will not be acceptable to most GPs in our PCG.”  
CLINICAL GOVERNANCE LEAD

“I am certain that appraisal could be a very valuable tool for GPs. I am committed to promoting reflection and a culture of life long learning in general practice. I fear that these excellent educational activities will be hijacked by politicians and thereby lose their credibility.”  
GP TUTOR

10 Recognising the contextual challenges, it is suggested that appraisal should be introduced:

- in a measured way which ensures it can be embedded in the day to day workings of general practice
- according to a set of nationally agreed principles, within which there can however be variation to meet local requirements
- with the involvement of GPs at local level, in partnership with management
- as a system that is NHS owned but professionally led
- on the basic assumption that GPs want to do a good job
- with a focus on supporting all GPs to do their jobs even better
- with a clear message that the *primary* purpose of appraisal is to deliver improvements in patient care not revalidation
- with separate procedures for addressing poor performance

- with adequate resources.

### **The first steps.....and beyond**

11 Generally speaking, research and experience suggest that the important early steps in introducing appraisal will include:

- securing and demonstrating commitment at the top in the HA or PCT and amongst leaders of the profession locally
- involving those affected by it in designing the scheme and agreeing how it will be introduced
- setting aside, visibly and from the beginning, adequate resources for training and development.

12 The lead manager for appraisal proposed in Chapter 4 should command widespread respect and trust.

13 He or she should be asked to produce, with advice, a draft scheme and a timed plan for its introduction and both should be the subject of consultation.

14 The initial aim should be to explore how the basics of GP appraisal can work, building early confidence and establishing a platform for development. This would entail setting up the essential mechanics, identifying and training appraisers and linking them with their appraisees.

15 All GPs should experience appraisal during the first year, except that a small number of individuals might be 'passported', if they wished, for the sake of manageability. This 'one year only' option might be offered for example to those who have recently been accredited or reaccredited as trainers or gained RCGP Fellowship by assessment.

16 Initially, appraisals might have relatively modest ambitions:

- to begin to establish the appraiser/GP relationship
- to ensure that GPs have personal development plans or have begun work on them
- to explore one or two other aspects of practice, agreed locally, for which robust information is available
- to produce a basic action plan for the GP for the coming year
- to generate information for the revalidation folder

- to produce limited, sensible recommendations for action to be supported by the HA/PCT or practice which would help the GP to maintain and develop their practice
  - to explore how appraisal should be developed for future years as a vehicle for addressing a more comprehensive and searching agenda.
- 17 Progressively, the strategy would then be to use a greater range of better information (including material from self-appraisal, 360 degree feedback tools and patient surveys, for example), to open up dialogue on a wider spectrum of individual work, to ensure more refined development and action plans, and to consolidate the concept of a two way process engaging both GPs and the organisation in making changes for the better.
- 18 Following the introductory phase, the key challenge will be to ensure that a continuous improvement cycle is in place, so that appraisal is renewed and refreshed on an ongoing basis.

### **Sharing experience**

- 19 Implementing GP appraisal comprehensively will require significant commitment and investment of time and resources at local level. The work outlined above will have to be undertaken within each organisation, but it should be possible to accelerate development and achieve economies of effort by establishing mechanisms and resources locally, regionally and nationally to spread learning:
- the establishment of a small, time limited national team, linked to the Modernisation Agency, could support the development of GP appraisal by providing advisory and consultancy input and acting as a national focal point from which to disseminate good practice
  - local learning and development networks could be established by NHS Executive Regional Offices or health authorities
  - an interactive GP appraisal website could be established for the dissemination of developments and good practice.

# Appendix A

## About ScHARR and the authors

### The School of Health and Related Research

ScHARR is part of the Faculty of Medicine at the University of Sheffield. It undertakes health related research to high standards with an international reputation, and provide education, training and consultancy services to the NHS and more widely.

ScHARR's overarching purpose is to assist health professionals and organisations to realise the benefits of applying research findings to the practical realities of delivering and managing health care. With its unique diversity of skills and experience, and its close contacts with the Department of Health, health authorities, NHS Trusts and primary care organisations, the School is a natural partner of the National Health Service.

ScHARR can be contacted on 0114 222 5454. Its website is at [www.shef.ac.uk/~scharr](http://www.shef.ac.uk/~scharr).

### **David Martin** BA DipAppPsych PhD CPsychol AFBPsS

David worked as a clinical psychologist with young offenders at the Department of Health's Youth Treatment Centre in Brentwood. He was Assistant Director of Social Services in North Yorkshire and Deputy Director in West Glamorgan, then General Manager of Bradford Family Health Services Authority and Assistant Regional General Manager at Yorkshire Health. After a period as a Director at Trent RHA, managing the RHA/Regional Office transition, he joined Sheffield University's School of Health and Related Research in 1996.

### **Paul Harrison** BA MSc

Paul is currently Director of Human Resources at Community Health Sheffield NHS Trust, and regional HR lead for primary care on behalf of NHS Executive

Trent. He has held progressively senior HR posts in Sheffield Health Authority, Northern General Hospital and Community Health Sheffield. He is a member of the Institute of Personnel and Development and a qualified Investors in People Adviser. He has a part-time secondment to ScHARR to work on primary care research with an HR dimension.

**Helen Joesbury MB ChB DCH DObst FRCGP**

Helen is a Principal in General Medical Practice and a part time Clinical Senior Lecturer in the Institute of General Practice and Primary Care at the University of Sheffield. She was a member of the original ScHARR team that carried out research on underperformance in general practice, funded through the national Policy Research Programme, and is now working on follow-up studies funded by the R&D group at NHS Executive Trent. She advises on primary care in developing countries.

**Richard Wilson RGN BA MA(Econ)**

Richard had an acute sector nursing background, and then worked as a Senior Research Fellow at Edge Hill College with a focus on rehabilitation services and the needs of people with learning disabilities. He joined ScHARR as a Research Associate at the beginning of 2001.

# Appendix B

## Glossary of abbreviations

|         |  |
|---------|--|
| ACAS    | Advisory, Conciliation and Arbitration Service |
| BAMM    | British Association of Medical Managers        |
| BMA     | British Medical Association                    |
| CME     | Continuing Medical Education                   |
| CPD     | Continuing Professional Development            |
| FTE     | Full-time Equivalent                           |
| GMC     | General Medical Council                        |
| GMS     | General Medical Services                       |
| GP      | General (Medical) Practitioner                 |
| HA      | Health Authority                               |
| HImp    | Health Improvement Programme                   |
| HR      | Human Resources                                |
| IPR     | Individual Performance Review                  |
| IRS     | Industrial Relations Services                  |
| NHS     | National Health Service                        |
| NSF     | National Service Framework                     |
| PCG     | Primary Care Group                             |
| PCIP    | Primary Care Investment Plan                   |
| PCT     | Primary Care Trust                             |
| PDP     | Personal Development Plan                      |
| PPDP    | Professional Practice Development Plan         |
| PMS     | Personal Medical Services                      |
| RCGP    | Royal College of General Practitioners         |
| SchHARR | School of Health and Related Research          |

# Appendix C

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## Appendix D

### Research methodology

#### Summary of approaches

*The research was conducted using a range of qualitative methodologies:*

- an initial review of available material, including discussions with some key stakeholders
- a literature survey
- a national postal survey of health authorities, Primary Care Trusts, Primary Care Groups, GP Education Directors and academic institutions
- discussions with individuals and organisations with a particular interest in GP appraisal
- attendance at a regional conference on GP appraisal
- testing and reflecting on emerging findings and thinking with the help of a reference group of GPs and others, brought together specially to advise on GP Appraisal.

#### Initial review of issues and literature

Early initial discussions were held with Directors of Postgraduate GP Education, officials at the Department of Health, individual GPs, and GP representatives on PCG or PCT Boards. A rapid literature search was undertaken by ScHARR's Information Resources Section to identify significant material about appraisal within and outside health care. Searching on a number of key words and phrases, they found nearly 400 references in five databases. The main themes emerging from this survey and from early discussions were the basis for designing survey and semi-structured interview materials.

#### National postal survey

The Project Team drew on SchARR's experience of surveying the NHS in an earlier, similar project which led to the 1997 report *Measures to assist GPs whose performance gives cause for concern*. The open-ended approach adopted then, using a straightforward letter format, was received very positively as it enabled health authorities and others to respond in the way most appropriate to their local circumstances.

A letter was therefore drafted to Chief Executives of health authorities, PCGs and PCTs setting out the purposes of the project, outlining the team's main areas of interest and encouraging recipients to respond in the way they thought most appropriate, and to send any relevant local materials. A similar but customised letter was also sent to a range of national organisations asking them for their views on the introduction of appraisal for GPs.

### **Interviews with interested parties**

Interviews were arranged with a number of organisations (and many individuals) with an interest in GP appraisal, including:

- British Association of Medical Managers
- Committee of Directors of Postgraduate GP Education
- Department of Health
- General Medical Council
- General Practitioners Committee of the British Medical Association
- National Primary Care Association
- NHS Alliance
- NHS Confederation
- Overseas Doctors Association
- Royal College of General Practitioners
- Small Practices Association.

### **Regional Conference**

Members of the SchARR Team attended a Regional Conference on *Appraisal in Primary Care* run by NHS Executive Trent and the North Trent Deanery. It was attended by over 80 people working in primary care across the Trent Region. Views were gathered from a number of focus groups about expectations of appraisal including benefits, process and content issues, barriers to successful implementation, and steps that might be taken to overcome them. SchARR produced a summary of this conference for an NHS Executive Trent series of bulletins on Clinical Governance in Primary Care.