

Whole Practice Appraisal

1. Introduction

With the advent of revalidation the GMC requires a doctor to present supporting information covering all aspects of their professional duties. This will require information being presented at an annual appraisal. Doctors often undertake multiple roles – either cross specialty or in management, education etc. There are doctors who cover sporting events, either for payment or gratis. All of these roles will be covered by revalidation requirements and will need to be represented at an appraisal discussion.

Whilst appraisal skills are generic, the knowledge of acceptable standards and work practices are not. A GP appraiser may not have the knowledge to validate information presented in a fellow GPs folder dealing with a clinical assistant post in dermatology. A hospital appraiser may not be aware of operating data or procedures in a particular private institution.

The responsible officer (RO) will be best served if information is held in one set of appraisal documents. This set of documents would normally cover the appraisal provided by the responsible organisation. In order to satisfy requirements this appraisal should cover whole practice. In areas of practice that the appraiser does not feel able to properly appraise, the doctor's information should be presented in a format that has been subject to review by a peer in that area of practice. This document suggests the methods by which the RO can be satisfied that whole practice review has occurred over a revalidation cycle.

2. Whole Practice Appraisal

At its simplest, whole practice appraisal will be performed by a peer appraising a doctor who works wholly in the same role in one institution (or a peripatetic locum GP in multiple practices / locum in hospital practice working within the same specialty). A single appraisal summary will be produced covering the doctor's whole practice.

In other situations (notably joint academic and clinical) two appraisers will conduct the discussion simultaneously. This may be practical in certain circumstances but would not apply in others.

There are many examples of doctors working in multiple roles where appraisal at one interview by one appraiser may not be possible. In this situation the appraisal summary that will be presented to the RO should become the "lead appraisal" and information from appraisal or performance review should feed into the lead appraisal. The "lead appraiser" should be satisfied that adequate appraisal or performance review has been undertaken in the additional role(s) but would not normally be expected to include the information from the additional role(s) in the appraisal discussion.

Whole Practice Appraisal

The summary should include a reference to the other appraisal and the (other) summary attached. It would be appropriate however to include items within the PDP – or reference the PDP contained in the appraisal summary.

An example could be a doctor working in a clinical setting, an educational role and undertaking research. The institutions that employ this doctor may be independent of one another and indeed may be physically distant making a joint appraisal impossible. The doctor will have identified an RO and the suggestion would be that the appraisal that is administered and provided by the Responsible Organisation to which the RO is attached would be the lead appraisal.

Exceptions would include a situation where a doctor's most substantive role lies outside this responsible organisation, and/or through negotiation with, and consent of, the RO.

In the case of a General Practitioner, in the vast majority of cases, the RO will be the Medical Director of the Health Board that holds that GP on their Medical Performers list and as such the GP appraisal conducted by the deanery appraisal system will be the lead appraisal.

3. Whole Practice Appraisal in action

Whole practice appraisal is a new practical concept – there are examples where it has taken place for many years (notably clinical academics). The systems to ensure whole practice appraisal could become complex and unsustainable without a lead appraisal. There are a number of possibilities to consider: -

- The doctor with clearly identified roles in which the employing institution has established appraisal or performance review systems
- The doctor with clearly identified roles in which there are one or more roles that do not have established appraisal or performance review systems (or systems are known to be poor)
- The doctor has poorly identified or changing roles
- The doctor is professionally engaged in work that has no peer input or supervision
- The doctor is a peripatetic locum and seeks work from multiple organisations in different roles (and possibly across borders)
- The doctor who performs a role in sporting or charity organisations unpaid (that does not match their roles in mainstream practice)
- The doctor that performs a role that is within the remit of their specialty either to a higher level than normal or is not considered mainstream practice

In order for the RO to be confident in a revalidation recommendation, supporting information and clinical governance processes must cover whole practice. That supporting information must meet or exceed GMC requirements in each role performed by that doctor. Appraisal will remain the vehicle to collect that information and appraisal must have robust quality management in place, in order for the RO to be confident of its outputs.

Whole Practice Appraisal

4. Responsibilities of the Appraiser or those involved in Performance Review

With appraisal comes responsibility. The doctor is responsible to provide sufficient information, mapped to the GMC's requirements, in order for meaningful appraisal to occur. The appraiser (or performance reviewer) has the responsibility to ensure that the information meets or exceeds GMC requirements in each separate role. This is covered by GMC regulations relating to truthfulness and protecting patients.

The appraiser conducting the "lead appraisal" simply reports the observations of others, or when this is absent or doubtful would seek clarification from the doctor. The lead appraiser in this situation should have an overt line management structure to seek advice on the extent to which a doctor's role (outside the appraisers experience) has been represented in their supporting information.

The lead appraiser does not hold responsibility for the veracity of the information discussed at other appraisals/performance reviews. This responsibility lies with the *duties of the doctor* who performed that task. If there is doubt over the provenance of the appraisal/performance review there should be a clear protocol for escalation of concern, firstly within the appraisal system (lead appraiser/ appraisal co-ordinator – professional) and ultimately to the RO. This escalation process should ask – can I trust this information?

The lead appraiser does not need to examine the documentation from other systems but may utilise its outputs in construction of the PDP.

The lead appraiser has responsibility to uphold *good medical practice* regarding probity, however the lead appraiser does not take on vicarious liability for the information fed in by other appraisal or performance management systems (in a very similar way that the appraiser takes on no liability for the doctor who has dishonestly represented information for an appraisal discussion).

The lead appraiser should therefore simply ask themselves – is this an appraisal/performance review that has been produced by an institution? If the answer is "no", then a discussion should ensue either at appraisal and/or with a line manager (professional).

4.1 Liability of Appraisers

An appraiser acting within the boundaries of *good medical practice* and representing the appraisal discussion honestly and truthfully should hold no liability for information that is wrong or untruthful.

The appraiser, accepting the output of another appraisal or performance management procedure, where a fellow professional (usually a doctor) has appraised the performance of another, cannot be held liable for errors within

Whole Practice Appraisal

that documentation. Performance concerns that may be raised within that documentation MUST be dealt with by the organisation providing that appraisal/performance review.

The lead appraiser therefore, has the responsibility to report that the appraisal/performance review has occurred but should not (normally) be expected to read or comment on areas of practice outside their remit as an appraiser in the role that they are undertaking. The liability for errors in that external process would lie with the author of the summary, or the doctor themselves.

Appraisers would normally be covered for liability by their employing organisation.

4.2 Template for Review in Other Roles

Some of the roles doctors perform outside of their main appointment will be subject to formal appraisal and performance review and in those circumstances a copy of the appraisal or performance review can be added to the lead appraisal documentation.

In situations where doctors are not subject to formal review, the following template has been agreed by the Wales Revalidation Appraisal Implementation Group in order for doctors in Wales to represent whole practice within their lead appraisal.

Template for Review in Other Roles

To Whom It May Concern

I am aware of the role that Dr. (insert name) performs as (insert role) at (insert place of work or organisation). This role is not subject to annual appraisal, simply review of performance. In my capacity as (supervisor/peer/specialist in this area), I confirm that Dr. (insert name) is suitably trained and maintains his/her skills and knowledge commensurate to the role. He/she performs to a satisfactory level and there are no unaddressed concerns about their practice.

Name

Signature

Date