WALES APPRAISAL EXCEPTIONS MANAGEMENT PROTOCOL

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Part 1: Background

1.1 Overview

This document provides a recap of some of the key principles of medical appraisal in Wales, its links with revalidation and its management in that context. It focuses on how the minority of situations which diverge from the normal appraisal route will be managed by the relevant organisation, ie the Wales Deanery and / or the Designated Body.

The document describes protocols which apply to a range of different exceptional situations. The aim of agreeing these protocols at an all Wales level is to ensure that exceptional situations are managed in a consistent, fair and supportive way.

As such this document is of primary interest to the Revalidation Support Unit (RSU) at the Wales Deanery and the Appraisal Management Teams within the Designated Bodies. It will also be of interest to appraisers to ensure they are clear on how different situations will be managed and the support that is available to them from their organisation.

Doctors who are experiencing exceptional circumstances may wish to refer to this protocol so that they are clear on the processes to follow, the support that is available and the implications for their appraisal and revalidation.

1.2 Introduction

The All Wales Medical Appraisal Policy states at (3) that:

- Appraisal is a professional, formative and developmental process. It is about identifying development needs, not performance management. It is a positive process to give doctors feedback on their past performance, to chart continuing progress and identify development needs
- During their annual appraisals, doctors will use supporting information to demonstrate that they are continuing to meet the principles and values set out in *Good Medical Practice*[1]

The policy describes the objectives of medical appraisal in Wales as being to:

- Provide individuals with an opportunity to:
    - Reflect on their practice and their approach to medicine
    - Reflect on the supporting information they have gathered and what that information demonstrates about their practice
    - Identify areas of practice where they could make improvements or undertake further development
    - Demonstrate that they are up to date[2]

- Provide assurances to their organisation/s and to the public that doctors are remaining up to date across their whole practice
- Provide a route to revalidation which builds on and strengthens existing systems with minimum bureaucracy

[1] GMC *Supporting information for appraisal and revalidation 2011*
[2] GMC *Framework for Appraisal and Assessment 2011*

The policy emphasises that Appraisal is NOT:

- The mechanism by which serious concerns regarding health, capability, behaviour or attitude are identified or addressed. Such concerns should be managed in an appropriate and timely manner outside appraisal
- A mechanism by which employers review or judge performance against a contract of employment, job plan or service objectives[3]

1.3 Management of appraisal in Wales

For all doctors, annual appraisal is a professional responsibility. It is a requirement of revalidation. For most doctors it is a contractual requirement, or a requirement of continued employment or inclusion on the Medical Performers List (MPL).

The Designated Bodies (DBs) are responsible for providing and managing the appraisal process to all doctors with whom they have a prescribed connection.

From 1 April 2014 the only route to appraisal for all NHS doctors in Wales is via the online Medical Appraisal and Revalidation System (MARS). MARS is provided, managed and supported by the Revalidation Support Unit (RSU) at the Wales Deanery.

The RSU also provides support for the development of medical appraisal across Wales, and provides and manages appraisal for all GPs on behalf of the DBs.

The All Wales Appraisal Quality Management Framework (QMF) makes recommendations for the resources and structures which are needed in each DB in order to discharge their responsibility to provide and manage appraisal. In particular it is recommended that there is a professional management and support structure for appraisal, including an Appraisal Co-ordinator in General Practice or an equivalent Professional Appraisal Lead role and an Appraisal Manager, which is separate to the existing clinical governance / management structures. This separation of functions is perceived to be important to maintain the integrity and quality of the appraisal process and to ensure that robust revalidation recommendations can be made. Throughout this document reference will be made to the Appraisal Co-ordinator / Lead when referring to these roles in the context of their local leadership of the appraisal process.

Appraisal is an individual, personal process and the outputs of appraisal are the property of the doctor. Access to appraisal documentation is restricted in accordance with a scheme of confidentiality which can be accessed through the Library section of MARS under the title of MARS terms and conditions of access: www.marswales.org

Managing the appraisal process effectively and fairly requires the Designated Bodies and the RSU to monitor and manage engagement with the process, to recognise and support cases where doctors have genuine reasons for not engaging with the process and to manage the exceptional cases where doctors do not engage with appraisal in accordance with agreed policy and guidance. The All Wales Medical Appraisal Policy states that 'there will be agreed processes in place for supporting and managing doctors who fail to complete their appraisal within the required timeframes' (7.1). These processes are described in Part 3.

[3] RST *Medical Appraisal Guide for Piloting 2011 v2*

To manage the process effectively, all doctors are allocated a quarter in which to undertake their appraisal. These Allocated Quarters (AQs) are Jan – March; April – June; July – Sept; Oct – Dec. To comply with the requirement for annual appraisal it is expected that the appraisal will usually take place within the same AQ each year. To enable a meaningful appraisal process it is recommended that there is a minimum of 9 months and a maximum of 15 months between appraisals.

Part 2: Appraisal and revalidation

Revalidation is the responsibility of the GMC. It is the process by which licensed doctors demonstrate to the GMC that they remain up to date and fit to practise. Local appraisal systems are an integral part of the revalidation process and engagement with annual appraisal is one of the requirements of revalidation. For this reason it is recommended that appraisal takes place a minimum of one month prior to the revalidation date. Revalidation recommendations are made to the GMC by the DB's Responsible Officer.

2.1 Supporting information

Appraisal provides doctors with an opportunity to present the supporting information required for revalidation[4]. This information is verified by the Appraiser as part of the appraisal process. Responsible Officers make their revalidation recommendations to the GMC based in part on the extent to which information has been verified as part of that process.

In line with the Medical Profession (Responsible Officer) Regulations 2010[5], ROs have a duty to ensure that appropriate, quality assured systems of appraisal are in place within their organisations and equally available to all doctors working for those organizations[6]. In relation to revalidation ROs also have a role in ensuring systems are available to enable doctors to collect the supporting information required for revalidation.

2.2 Whole practice appraisal: the doctor's responsibility

It is the doctor's responsibility to provide supporting information covering all aspects of their professional roles via their annual appraisal. This may include cross specialty, management, education, sporting event roles etc. The Responsible Officer will make a recommendation to the GMC about a doctor's fitness to practise across the whole of their professional practice, normally every five years. In order to do this the Responsible Officer will need to be satisfied that appraisal has covered all of the doctor's professional roles. The appraisal system needs to be able to demonstrate that a doctor is qualified to undertake the additional roles, carries out appropriate development within these roles and is practising safely. This will usually be captured by bringing evidence relevant to all roles to a single annual appraisal, or by a doctor bringing evidence of appraisal or performance review from the additional roles to their main appraisal.

An All Wales policy relating to whole practice appraisal has been agreed and is available at http://revalidation.walesdeanery.org/

[4] http://www.gmc-uk.org/static/documents/content/Supporting_information__for_appraisalappraisal_and_revalidation.pdf
[5] http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents
[6] This includes all doctors regardless of location or branch of practice

2.3 Whole practice appraisal: the Appraiser's responsibility

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

The 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, if these have been covered by others. The liability for errors in that external process would lie with the author of the summary, or the doctor.

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

2.4 Revalidation and clinical governance

In addition to the information provided through engagement with appraisal, in making their revalidation recommendations the Responsible Officer is also required to consider information arising through local systems of clinical governance. To make a positive revalidation recommendation the Responsible Officer has to confirm that any known concerns about the doctor in question are being managed through an appropriate process outside of appraisal.

Clinical governance provides a framework for the Designated Body to monitor, review and improve the quality and safety of care provided by organisation. It is the Designated Body's responsibility to provide appropriate clinical governance (quality and safety) systems and to enable all doctors to engage with these systems.

If the Designated Body's clinical governance processes identify areas for development for individual doctors, it may be appropriate for the Responsible Officer or other relevant clinical line manager to advise the individual that they should address the area in question through appraisal. This will largely depend on timescales as clinical governance is an ongoing process whereas appraisal is annual, and also on an assessment of whether the area for development can be addressed by the doctor through unsupervised CPD. The Responsible Officer or other relevant clinical line manager will need to make a decision as to whether or not the issue needs to be addressed immediately in advance of the appraisal process. The doctor could document this in their 'living PDP' section and still bring this area to their appraisal as evidence of learning and development and / or to include in the PDP to be agreed at the subsequent appraisal.

Similarly, information from the working environment or feedback from colleagues or patients may help doctors identify areas for development. Areas for development identified in this way are analogous to those which are routinely identified and dealt with by doctors, Appraisers and others as part of the appraisal process.

The Designated Body will inform doctors of any such areas for development identified through clinical governance processes so that they can be addressed appropriately. In so doing, the Designated Body will provide specific feedback and guidance based on established clinical governance processes. Doctors should review such information about areas for development as part of their overall PDP and should tick the relevant statement in MARS to indicate that they have been advised to discuss a specific developmental issue. It is up to the Designated Body to seek confirmation from the doctor that the issue has been discussed at their appraisal.

The appraisal summary provides confirmation of what development has been undertaken and what development is planned. It does not constitute an assessment or accreditation of the doctor, nor does it comment on the doctor's competence in these areas. These are clinical governance issues which should be dealt with by the Designated Body outside the appraisal process.

Designated Bodies will have their own processes in place to further investigate and manage any situations where clinical governance identifies potential concerns about a doctor's performance, conduct or health which may not be remediable through unsupervised CPD. Any such processes should be in line with All Wales agreed policies and procedures such as the GP Operational Performance Procedures and the Remediation Policy (currently in draft). Because both clinical governance and appraisal inform the revalidation recommendation it is important that the respective processes are transparent and robust, and that there are clearly defined responsibilities and effective lines of communication between the RSU, Responsible Officers and the GMC. The GMC's Employer Liaison Adviser (ELA) is also available to advise and support the RO in these cases. The GMC encourages early contact with the ELA so that the appropriate course of action can be agreed. Suggested communication links are described in section 3.4.

Appraisal cannot and should not take the place of clinical governance. It is not the purpose of appraisal to identify poor performance, provide assurances about the delivery of health care or provide accreditation of special interests. These aspects of clinical governance have different purposes to developmental appraisal and will be dealt with by the Designated Body through separate processes.

2.5 Engagement with revalidation: non engagement

GMC guidance on revalidation states that a doctor engages in the revalidation process when they are:

- Participating in the local systems and processes that support revalidation, including annual appraisal
- Participating in the formal revalidation process described in the General Medical Council (License to Practise and Revalidation) Regulations 2012

A doctor is not engaging in the revalidation process where:

- There are no reasonable circumstances that account for a doctor's incomplete information or failure to participate in revalidation
- The Designated Body has provided sufficient and fair opportunities to support the doctor's participation in revalidation
- The doctor has not acted on the opportunities available to them to collect information or participate in appraisals (see 3.3)
- The Responsible Officer has exhausted all relevant local processes to address the doctor's failure to engage (see 3.3)

It is the Responsible Officer's responsibility to judge whether there are reasonable circumstances that justify why a doctor has not engaged in the local systems supporting revalidation. If the circumstances are deemed reasonable, the doctor's revalidation recommendation will be 'deferred'. Please see further information on deferment in regards to revalidation below at 2.6. However, if they are not reasonable then the Responsible Officer will need to communicate the non-engagement to the GMC. The ELA is available to advise in such cases and should be informed as early as possible of any cases which may lead to a non-engagement recommendation. In cases of a formal non-engagement recommendation the GMC Revalidation Decision team will ask the ELA for their analysis of the case so it is helpful for them to be fully informed as decisions are made.

A notification of non-engagement is a formal recommendation to the GMC with respect to a doctor's revalidation. This can only be made once the doctor has been officially issued with their notice of their revalidation date. Doctors will be formally notified by the GMC of their revalidation date four months before the revalidation recommendation is due from their Responsible Officer. This is a legal requirement that commences the formal revalidation process.

Despite this, a Responsible Officer can notify the GMC, after consultation with their ELA, if a doctor has failed to participate in appraisal at any time but it will not be classified as a formal notification. By doing so, the Responsible Officer is able to highlight a doctor who is not engaging in appraisal and that as a result, that they do not anticipate being able to make a positive recommendation about a doctor's revalidation. As with formal recommendations the ELA is available to advise in such cases.

When the GMC receive notification of a doctor who is non-engaging, the GMC will issue them with a reminder that they are obligated to participate in the process as it directly supports revalidation. If the doctor continues to not engage with the process, the GMC can bring the doctor's revalidation notice forward. This will in turn bring the 'submission date' for the Responsible Officer's revalidation recommendation forward.

If the doctor continues to non-engage during their notice period prior to the revalidation date then the Responsible Officer can submit a formal notification of non-engagement and/or submit this notification as the official revalidation recommendation[7].

Notifications of non-engagement can result in the GMC withdrawing a doctor's license to practise, through the existing mechanisms in place. Therefore, when a notification of non-engagement is received by the GMC, the following steps will be taken:

1. The GMC will begin the process of administering the removal of the doctor's licence to practise.
2. The doctor is informed that the GMC is intending on withdrawing their licence to practise, and has 28 days to contact them if they wish to appeal this decision.

2.6 Revalidation deferral

[7] More information on this process can be found within the GMC's guidance for Responsible Officers at http://www.gmc-uk.org/doctors/revalidation/13631.asp

If a doctor is to be deferred the GMC requires Responsible Officers to submit a deferral request to the GMC in order to allow the Responsible Officers more time in which to submit a recommendation, thus changing the doctor's revalidation submission date.

The GMC have stated that deferral requests can be made under the following circumstances:

- The doctor has engaged in the systems and processes that support revalidation, but has not been able to gather all of the necessary supporting information in adequate time prior to their revalidation date. This may be due to reasonable circumstances such as maternity leave, sabbatical or break from practice, periods of practice outside the UK, sick leave or the doctor has only recently gained a prescribed connection to the Designated Body and is waiting for their information to be transferred.

- The doctor is participating in an on-going local HR or disciplinary process, the outcome of which the Responsible Officer will need to consider prior to making their recommendation. Any concerns about the doctor's fitness to practise do not meet the threshold for referral to the GMC's fitness to practise procedures. More information on these can be found here: http://www.gmc-uk.org/concerns/index.asp

It is important to clarify that deferment is **not** the method a Responsible Officer would take when raising concerns regarding a doctor's fitness to practise with the GMC. These concerns will continue to be addressed using the existing processes in place, as soon as the concerns arise. The same applies to doctors who are undergoing GMC investigation; the GMC will postpone a doctor's revalidation pending the outcome of the investigation.

The Responsible Officer will propose a new date to submit the revalidation recommendation, which falls within the subsequent 12 months[8].

Part 3: Managing Appraisal Exceptions

The Designated Body has a responsibility to ensure that they offer annual appraisal to every doctor with whom they have a prescribed connection. The vast majority of doctors will take advantage of this opportunity and comply with the local appraisal process. However it is important that the Designated Bodies have clear and consistent processes in place for managing exceptions to this.

3.1 Rescheduling appraisals

There will be occasions when doctors or appraisers need to reschedule an appraisal for a short period of time, for example due to short term illness or unexpected personal reasons. Usually the appraiser and doctor will aim to reschedule the appraisal at a mutually convenient time. Where doctors are able to reschedule their appraisal within 3 months of their original appraisal date the original AQ will remain the same.

[8] Further guidance on this process can be found in the GMC's guidance for Responsible Officers: http://www.gmc-uk.org/doctors/revalidation/13631.asp

Should either or both party be unable to reschedule the appraisal at a mutually convenient time the issue should be referred to the local Appraisal Co-ordinator / Lead for advice. It should be noted that repeated rescheduling may indicate exceptional circumstances as described at 3.2, or could constitute non-engagement and would fall under the processes described at 3.3.

3.2 Exceptional circumstances, appraisal deferrals and MARS account postponements

From time to time many doctors will experience exceptional circumstances which mean they wish to defer their annual appraisal to a later AQ. Exceptional circumstances include for example maternity leave, sickness absence or a period of sabbatical. In all cases the doctor should ensure their RO is notified both at the point at which an appraisal deferral is requested and also the point at which the doctor wishes to be reinstated into the appraisal process. For GPs this is via the RSU, and for other doctors via their local Appraisal Manager / Lead. In these cases the appraisal will be deferred for a minimum of 3 months and the AQ will be changed if necessary.

In a small number of cases the RO may decide that a doctor's MARS appraisal account should be postponed, for example in some cases where the doctor has been suspended from clinical activity.
Postponement means that the doctor will be able to continue entering information into MARS should they so wish but will be unable to book an appraisal. This means that the doctor will not receive reminders via MARS until an appropriate date. If the doctor has had their appraisal discussion but has not completed the process prior to MARS appraisal account postponement, the appraisal summary will be committed on MARS before the doctor's account is postponed unless there are exceptional circumstances. See section 3.4 for further details.

3.3 Non-compliance with the Allocated Quarter (AQ) and non-engagement

Doctors receive a number of reminders via MARS relating to their AQ. These include reminders to select an appraiser and to book an appraisal date within the relevant AQ. The Designated Body has a responsibility to ensure that all doctors have the opportunity to undertake an annual appraisal and does this through monitoring compliance with the AQ. Any doctor who does not comply with their AQ, and has not informed their Responsible Officer of any extenuating circumstances, may be considered to be not engaging with the appraisal process. Non-engagement may be identified at various stages of the appraisal process, and relevant action will be taken accordingly. An outline of the different stages, and likely action to be taken, is described below.

3.3.1 Non-engagement prior to the appraisal meeting

Every doctor is responsible for undertaking their own appraisal. In Wales doctors are expected to register with MARS, enter their personal and professional details and appropriate supporting information, select an appraiser and agree an appraisal date. Extensive support is available to assist doctors in these processes, for example the user guides available via the MARS library pages. Any doctor experiencing difficulty is encouraged to contact the RSU (for GPs) or their local Appraisal Manager / Lead.

A doctor might be considered to be not engaging if they:

- Have not selected an appraiser prior to their AQ

- Have not agreed an appraisal date with their appraiser within 1 month of being contacted for this purpose
- Have not made sufficient appraisal evidence available to their appraiser prior to system lock out

In these cases the RSU / local Appraisal Manager may decide to contact the doctor directly in line with local processes. Any Appraiser who identifies a doctor who may be non-engaging should refer this issue to their local Appraisal Co-ordinator / Appraisal Lead.

3.3.2 Non-engagement during the appraisal meeting

Appraisers are trained to enable them to facilitate the appraisal discussion professionally and help each doctor get the most out of the discussion.

This cannot be achieved unless the doctor is prepared to engage with the Appraiser in the appraisal discussion as a positive, developmental process and as a key part of the revalidation cycle. This includes a willingness to discuss entries with their Appraiser, respond appropriately to questions and feedback, and contribute to the construction of their own Personal Development Plan.

If the doctor is unwilling to participate in the appraisal discussion in this way, the Appraiser may feel that a meaningful discussion cannot be undertaken. In such cases the Appraiser will either advise the doctor of their reservations during the discussion, giving the doctor an opportunity to respond, or refer the issue to their local Appraisal Co-ordinator / Lead after the meeting. After further investigation, in some cases the Appraisal Co-ordinator / Lead may decide the issue should be reported to the Responsible Officer as potential non-engagement.

3.3.3 Non-engagement after the appraisal meeting

After a meaningful appraisal discussion has taken place, the Appraiser will complete the appraisal summary via MARS. This document will be made available to the doctor within two weeks of the appraisal discussion.

The doctor is expected to agree the summary within a further 2 weeks from the date the appraisal summary is committed by the Appraiser. If the doctor is unhappy with the appraisal summary they must contact the Appraiser through MARS with details of any amendment requests in the first instance within 2 weeks of the appraisal summary being committed. The time limit has been put in place to ensure that each appraisal will produce a meaningful PDP that will feed into the doctor's CPD for the year.

Cases where either the Appraiser or the doctor fail to comply with these timescales will be noted by the Appraisal Co-ordinator / Lead who may decide to contact the Appraiser / doctor and manage in line with local processes.

3.4: Concerns and Appraisal Exceptions

Section 2.4 describes the role of clinical governance in revalidation. It is quite clear that investigation of concerns that a doctor's performance, conduct or health may be compromising patient safety is the responsibility of the Designated Body and should be separate to the appraisal process. The ELA is available to advise the RO on potential Fitness to Practise issues.

3.4.1 Investigations and appraisal

In the majority of cases the doctor will remain engaged in the appraisal process while an investigation relating to them is being completed. They may wish to use this opportunity to reflect on learning points for them arising from this situation and any constraints they are experiencing as a consequence. While the Appraiser is not in a position to comment on the investigation, they may be able to help the doctor identify how they can best manage these issues.

3.4.2 Investigations and postponements

In a very small number of cases, for example in some cases where the doctor has been suspended from clinical practice, the Responsible Officer may decide that the appraisal should be postponed while further investigation is being undertaken. In the case of referral to local procedures, the Appraisal may be postponed while the RO, the local Appraisal Co-ordinator / Lead and the RSU liaise over the appropriate course of action.

In such cases the RO will need to inform the RSU so that the doctor's MARS account can be postponed, although the doctor will still be able to enter information into MARS during this period (see 3.2). In cases of postponement the RO will advise the RSU when the doctor's MARS account can be reinstated, and will liaise with the RSU and the local Appraisal Co-ordinator / Lead over the appropriate AQ to assign and whether a specific appraiser should be allocated to the doctor to facilitate this process.

In all cases recommendations arising from the investigation, once complete, should be considered as part of the development planning process.

3.4.3 Concerns identified at appraisal

While appraisal may contribute to performance improvement, it **cannot** and should not take the place of clinical governance or performance management and is not designed to **identify** performance issues. Rarely however, issues may arise in the appraisal which the Appraiser feels may warrant further investigation because they raise potential concerns about patient safety or fitness to practice. It is not the role of the Appraiser to make an assessment of these potential concerns, but as a doctor they have a responsibility to escalate these issues for further consideration. The Appraiser should refer any such case to their local Appraisal Co-ordinator / Lead who will make a decision as whether or not to refer into the local performance management procedure. This will ensure that these decisions are made in a consistent way across the Designated Body and that appropriate processes are utilised.

3.4.4 Concerns and constraints

All doctors are asked to identify as part of the appraisal process any factors which are constraining their performance or development. This is so that the Appraiser can help the doctor to consider any learning points arising from these constraints, and anything they might do to manage or mitigate them.
Documented constraints are collated centrally by the RSU and fed into the Health Board, WG and BMA structure on a local and national level, enabling them to analyse the issues reported in their area and to benchmark these with those reported across Wales as a whole. It is the responsibility of the Health Board to take action relating to these reports where they feel that is appropriate. Very rarely, doctors might include in the constraints section a specific issue which has significant implications for patient safety.

Appraisal is not the mechanism for reporting such significant concerns and the doctor has not discharged their duty as a doctor if this is the only route by which they have raised this issue.

The responsibility of the Appraiser in such cases is to clarify and document whether the doctor has already raised the issue elsewhere, usually with the HB in which case it is the HB's responsibility to take appropriate action. If the doctor has not done so, the Appraiser should seek a commitment from the doctor that they will do so, and document this in the PDP. If the Appraiser and the doctor cannot agree an appropriate course of action, or the Appraiser retains doubts for any reason, it is their duty to seek advice from their local Appraisal Co-ordinator / Lead.