School of Health and Related Research (ScHARR)
University of Sheffield

Extending appraisal to all GPs

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The School of Health and Related Research

ScHARR

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Contents

	Page
Introduction	1
Background	1
Who are non-principal GPs?	3
What has been done so far about the appraisal of non-principals?	4
General principles	6
A position on variants	6
The official line	7
Appraisal and performance management	8
Appraisal and revalidation	9
Evidence and related concepts	11
Responsibilities, appraisers and the documentation	13
Who is responsible for what?	13
Who should appraise non-principals?	17
The appraisal documentation	18
Material for appraisal	20
Continuous organisation	20
Material for Form 3	22
Conclusion	27
Funding non-principal appraisal and supporting and developing non-principals	29
Funding for appraisal	29
Continuing Professional Development	30
Practical steps	31
Locum CPD time	34
A final reflection	34
Appendix 1: About the authors	35
Appendix 2: Bibliography	36
Appendix 3: Glossary of abbreviations	38
Appendix 4: A ‘fifty case audit’	39
Appendix 5: A simple referral log	41

For Guy

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Chapter 1: Introduction

Chapter 1 – main points……

- It is expected that the GP appraisal scheme will be extended to GPs who are not principals during 2003/2004.
- ScHARR has been commissioned by the Department of Health in England to suggest how this might be done.
- The emphasis in ScHARR's brief is on the 'evidence' that non-principal GPs can be expected to offer in support of the appraisal process, but other issues are also addressed.
- The range of non-principal roles is outlined.
- A survey of PCTs suggests that there is so far little experience of appraisal with non-principals.

Background

1 ScHARR has been commissioned by the Department of Health (DH) in England to make some observations and recommendations about the extension of GP appraisal to all GPs. ScHARR's earlier report on appraisal for GPs made a contribution to the introduction of appraisal for General Medical Services (GMS) principals and their Personal Medical Services (PMS) equivalents in April 2002 (Martin, Harrison, Joesbury and Wilson, 2001).

2 It is expected that the appraisal scheme will be extended to GPs who are not principals during 2003/2004 and the focus of the present project is on the challenges perceived to arise from that. The particular emphasis in ScHARR's brief is on the 'evidence'[1] that non-principal GPs can be

[1] The ScHARR team prefers 'materials' or 'documentation' to 'evidence', for reasons that will be explained later.

expected to offer in support of the appraisal process, and on any emerging and relevant good practice. The key questions to ScHARR are:

- Evidence for appraisal should be accurate, relevant, and up-to-date. What evidence therefore could or should be used to support GP non-principals' appraisal?

- What is the minimum set of evidence that could reasonably support GP non-principals' appraisal?

- What examples are there of best practice in collecting relevant evidence to support appraisal and Continuing Professional Development (CPD) amongst GP non-principals?

3 The task has been interpreted rather more widely, however, as some of the challenges are not directly associated with questions of 'evidence'.

4 The ScHARR team has used the same straightforward approach as it has in earlier projects: there has been a literature search; a simple open-ended survey of all Primary Care Trusts (PCTs) and follow up discussions with a few of them; meetings with a number of key organisations including the Department itself, the General Medical Council (GMC), the General Practitioners Committee of the British Medical Association (BMA), the National Association of Non-Principals (NANP) and the Royal College of General Practitioners (RCGP); and discussions with individuals, including a substantial number of non-principal GPs. People have been very generous with their time and paperwork.

5 This report is addressed to the organisations that will be involved in shaping and implementing appraisal for non-principal GPs and it will be of interest to the national representative and professional organisations. Non-principal GPs themselves will find it helpful: it does not set out to be a detailed 'workbook' but it provides a framework for appreciating the position and purpose of appraisal and many pointers to good practice.

6 The report has five chapters. The remaining parts of Chapter 1 sketch out the non-principal 'landscape' and what has been done for them so far in terms of appraisal. Chapter 2 proposes some general principles and revisits the relationship between appraisal, performance management and revalidation; and the concept of 'evidence' is explored. Chapter 3 is about organisational practicalities: what are the responsibilities of the main stakeholders, who should appraise non-principals, and should the standard forms be modified for them? Chapter 4 looks at what non-principals can supply by way of 'evidence' or supporting material, and how they might go about organising it. Chapter 5 is about funding non-principal appraisal and supporting and developing non-principals.

7 Each chapter begins with a summary of its main points.

8 Appendix 1 is a note about the authors, Appendix 2 is a bibliography and Appendix 3 is a glossary of abbreviations.

Who are non-principal GPs?

9 The diversification of general practice in terms of contractual models is gradually blurring some of the conventional definitions and terms and a new GMS contract would reinforce the trend. This section conveys the current state of play.

10 In broad terms, GPs fall into three contractual categories: GMS principals, PMS providers and non-principals. The first two categories are referred to in official statistics as 'unrestricted principals and equivalents' (UPEs). GMS principals (and currently their PMS equivalents) must be on a Medical List. A new Services List is shortly to be introduced for PMS 'performers'. Non-principals must be on a Supplementary List before they can work as NHS GPs. Lists[2] are managed by Primary Care Trusts. A non-principal may choose amongst PCT Supplementary Lists but can only be on one at a time, and there is a reasonable expectation that he or she will provide services in (but not necessarily only in) that PCT's area. Being on a Supplementary List is a basic pre-condition for a non-principal's access to the NHS Pensions Scheme.

11 Non-principals include salaried associates or assistants employed by practices or PCTs, locums who deputise for principals, retainers and registrars. Retainers have an educational programme overseen by the Deanery; they are placed in accredited practices and receive assistance with fees. Registrars are technically junior doctors subject to summative assessment and are not required to undergo separate appraisal. In addition the recent Flexible Career and Returning to Practice schemes provide special non-principal arrangements to retain GPs or attract them back. All non-principals other than registrars will be required, subject to regulation, to undergo annual appraisal. This will probably be a condition for inclusion in a Supplementary List.

12 The Department of Health estimates that there are currently around 8000 doctors on Supplementary Lists in England: 3500 assistants, retainers and registrars; and 4500 locums. A recent survey by the National Association of Non-Principals (NANP) suggests a slightly higher figure.

13 Locums are an heterogeneous group: some are recently qualified doctors, fresh from Vocational Training Schemes (VTS), doing sessional work to gain experience before settling into a career post; some have returned after a period away from medical practice; some are retired principals who carry on with a limited commitment; others are 'career locums' who have made a deliberate long-term choice to work in that way.

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[2] The proposed new GMS contract (Paragraph 7.33) proposes that the three lists should be merged into a single new Primary Care Performers List.

14 In a recent survey (Tinker, 2003) it was found that non-principals in general work significantly fewer sessions than principals: only 40% do more than four sessions in a week and 23% more than six. They qualified either more recently or longer ago than principals and they are more likely to be female.

15 Associates, assistants, retainers and some other non-principals work generally with a single practice. Some locums also work in just one or two practices and enjoy a degree of continuity. However many locums are truly peripatetic and work in several or even many different practices. Many also work for out-of-hours providers, some exclusively.

16 This report is about the extension of appraisal to non-principals in general but its focus will in fact often be on peripatetic locums. If doctors are working steadily as non-principals in a single practice there is no compelling reason why their appraisal should not follow the 'normal' pattern (when 'normality' is established). Peripatetic locums on the other hand may need a more or less distinctive approach and this is a key issue for the present project. If appraisal can be made to work for them it can be made to work for everyone.

What has been done so far about the appraisal of non-principals?

17 The ScHARR team wrote to all PCT Chief Executives asking for information, thoughts or advice on the extension of appraisal to non-principals. Fifty-five PCTs (ie around 18%) responded in some way, usually through clinical governance leads or educationists, and although it cannot be assumed to be typical an interesting picture emerged.

18 A very small number of PCTs replied in a negative way, complaining about the impossibility, difficulty or inadvisability of appraising even principals. Concerns included financial resources, management workload, competing priorities, a shortage of appraisers and a lack of evidence for the efficacy of appraisal. One said they would not share any ideas with ScHARR because they might finish up having to implement them!

19 A larger group said, in essence, that they were doing their best to implement appraisal for principals but had not yet started to work with non-principals. Typically they fully accepted the importance of extending the scheme and some had clearly begun to think the issues through. But the priority was to concentrate on the larger group first.

20 A few PCTs communicated great enthusiasm for appraisal, having implemented it wholeheartedly and begun to see the benefits.

21 Five PCTs said they were already extending their main appraisal scheme to non-principals, drawing no distinction between them. Where any detail was given, it was apparent that the non-principals in question were mainly doctors directly employed by the PCT, or salaried assistants with continuity in their practice connections. One reported some limited early

experience with PCT-led locum appraisal and another was about to start. A small number of PCTs were encouraging practices to carry out their own voluntary appraisals with their salaried doctors. In one area, practices employing locums were being encouraged to offer them voluntary annual appraisal, rewarded through a local incentives scheme. Mention was made by one PCT of peer appraisal (Haman et al., 2001) as one model for work with non-principal members of practice teams.

22 It was clear from two responses that at least some Deaneries (including South Western and Trent) have established comprehensive appraisal processes for retainers, although their numbers and circumstances have so far dictated a less detailed approach than the national appraisal scheme requires.

23 Rachel Tinker, a GP principal in North Derbyshire, has recently completed a research project comparing the continuing medical education of principals and non-principals (Tinker, 2003). She found that significantly more non-principals (20%) than principals (9%) had had an appraisal during the last year (before the introduction of the national scheme). This no doubt reflects the experience of salaried doctors and retainers rather than locums.

24 A final point here is that where non-principals (including a small number of locums) have been given the opportunity of appraisal it seems often to have been very well received: *"In thirty years nobody has ever spent time on me before."* One of the benefits of extending appraisal to isolated locums should be their re-connection to the worlds of continuing development and professional community…...although for some others, as one respondent said, it may have the opposite effect: *"We have no experience in appraising non-principal GPs as yet but I would suggest that whatever we set up is extremely soft touch and formative otherwise we will drive this group which comprises a large number of valuable retired GPs that still act as locums out of the profession."*

Chapter 2: General principles

Chapter 2 – main points……

- The purposes and processes of appraisal for non-principals should be as far as possible identical to those of appraisal for principals.
- The Department of Health's position is that appraisal is a formative and developmental process.
- It is not designed to 'root out' poorly performing doctors.
- Appraisal should bring great benefits for locums as a new and perhaps unique point of connection, combating isolation, and a context for discussing concerns and support needs.
- The ScHARR team would like to see appraisal conducted so as to achieve its own developmental objectives, not shaped to serve revalidation.
- It would be a pity if the potential of appraisal to connect locums to support were compromised by its being seen as a 'test'.
- The project team would like to see the appraisal discussion itself, with the process of reflection leading to it and the Personal Development Plan that ensues, reaffirmed as the heart of appraisal rather than the supporting 'evidence' or documentation a non-principal can produce.

A position on variants

1 It is proposed, as an overall framework, that the purposes and processes of appraisal for non-principals should be as far as possible identical to those of appraisal for principals. It should not be assumed that the appraisal of non-principals has to be in some way more exacting or 'better' than it is for principals. Nor, since patient care is just as much in play, should it be any less thorough. The documentation should be changed as little as possible. Variation in approach to different kinds of non-principal

should be minimal. In other words every effort should be made to preserve the integrity and coherence of the national scheme. The challenge is to extend its coverage not change its character; the risk is that a proliferation of variants might compromise the focus and authority of the whole venture.

2 If this is the correct starting point, it is natural to reiterate some of the basic principles of the main scheme. The key document is the Department of Health's guidance (Department of Health, 2002), which owes something to the first ScHARR report (Martin et al., 2001). Non-principal GPs themselves may find it useful to visit the Department's web site at www.doh.gov.uk/gpappraisal if their appraisal process is to be modelled on the existing scheme.

The official line

3 The Department's position is that:

- Appraisal is a formative and developmental process. It is about identifying development needs, not performance management. It is a positive process to give GPs feedback on their past performance, to chart continuing progress and to provide a framework within which development needs can be addressed.

- The focus of appraisal should be the core headings of *Good Medical Practice*, the GMC's statement about the standards that doctors should attain (General Medical Council, 2001).

- Standard documentation should be used to ensure consistency.

- The appraiser should be another GP who has been trained to carry out appraisals.

- Both appraiser and appraisee should consider in advance what needs to be discussed and prepare thoroughly for the appraisal discussion.

- Specialised aspects of a GP's work should be appraised by a peer who understands them.

- The appraisal should lead to an action plan which sets out what each party is committed to doing. For the appraisee this will be encapsulated in a Personal Development Plan (PDP). The appraiser has a responsibility to convey or act upon information about 'external' constraints that affect a GP's ability to achieve as she or he would wish.

- Appraisal will provide a regular, structured system for recording and supporting progress towards revalidation and will use similar information. But the objectives of the two processes, although complementary, are distinct.

4 This framework should apply equally to non-principal appraisal. Some issues arise however. They are relevant to appraisal in general and particularly now to the introduction of appraisal for non-principals.

Appraisal and performance management

5 Several respondents to the ScHARR survey, and almost everyone the team has spoken to, have emphasised the importance of fidelity to the formative aims of appraisal in extending it to non-principals. The message is that, whatever the formal contractual requirement, appraisal will work as a meaningful process only if appraisees can see that it is being implemented without cynicism and in the intended spirit. People have picked up strongly on the Department's line that appraisal 'is about identifying development needs, not performance management'.

6 This is in fact becoming a mantra, and there is a risk of oversimplification. ScHARR's view is that appraisal is inevitably about performance, and indeed about *underperformance* in the sense that everyone can always identify and address areas where things can be done better. If appraisal is about performance in this sense, it is also about the *management* of performance – the appraiser and appraisee together are (amongst other things) exploring what needs to be done better by the GP and the system he or she works in, seeing how this can be achieved and making some commitments to action. What appraisal is emphatically not about is the management of *poor* performance. It is not a process for rooting out incompetent doctors. If it is perverted to that aim it will fail both as a developmental tool and as a means of dealing with poor performance. ScHARR argued in its earlier report that PCTs should ensure they have separate and continuous processes for spotting and handling poor performance. Appraisers for their part should suspend an appraisal if they experience serious concerns and exercise their overriding responsibility as doctors to convey their concerns to appropriate others. These principles apply equally to principals and non-principals.

7 Having said that, it is interesting that one or two GPs have suggested that some peripatetic locums may be particularly at risk of performing below acceptable standards. The risk is said to arise from their potential isolation and disconnection: some locums may go for weeks at a time without any meaningful interaction with another doctor. There may also be a risk of what one GP called 'enforced poor performance' where a locum is 'parachuted' into a practice to deputise for a poorly performing absent principal, inheriting poor clinical records and inappropriate prescribing.

8 The ScHARR team believes that appraisal should bring great benefits for locums as a new and perhaps unique point of *connection* and a context for discussing work in failing practices (and other troubles). Its first report argued that appraisal has to be a two way process. The 'performance' of the context in which GPs work is a legitimate area for discussion and the appraisal documentation regularly asks about factors in the workplace which constrain achievement. Appraisal is a good opportunity for locums

to provide systematic feedback to the PCT on the overall experience of being a locum, and on issues of isolation, exposure and lack of support.

9 There is a further performance related point. One chief executive shared his concern that the balance between education and development for the individual GP on the one hand, and holding to account for performance on national and local priorities on the other, is not quite right. The point is not about the quality of a GP's performance but about its focus: whether appraisal plays any part in conveying NHS objectives and binding him or her into them. This is important in general because one of appraisal's purposes is to help align individual and organisational objectives; but what does it mean for non-principals?

10 The first ScHARR report on appraisal suggested that appraiser and appraisee should agree the agenda of key discussion areas before the appraisal discussion. *"The aim should not be to work rigidly through every aspect…but to focus on carefully selected areas of particular importance to the GP, the appraiser and the PCT. The 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 National Service Frameworks)."*

11 In the context of non-principal work, it should thus be a question for the PCT and appraisers of selecting the relevant issues for different groups or individuals. It might not be very relevant for the PCT, through the appraiser, to discuss the achievement of access targets with a peripatetic locum, but it might be very interested in retention and availability issues which bear on workforce targets. Non-principals should welcome such discussions as potentially beneficial to both parties.

12 These are relatively complicated issues, however, and it is important to remember that GP appraisal is in its infancy. Everyone concerned has to learn how to use the process and sophistication will come with time and experience.

Appraisal and revalidation

13 The first ScHARR report set out the relationship between appraisal and revalidation thus:

Appraisal is……

- led by the NHS 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
- mainly confidential, with a few 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.

14 The Department of Health draws a very similar distinction in its guidance. The point of distinguishing so sharply between the two processes is to emphasise that appraisal has a life, purpose and value of its own. *“Appraisal will provide a regular, structured system for recording progress towards revalidation and identifying development experiences that will support individual GPs in achieving revalidation. While appraisal and revalidation will be based largely or wholly on the same sources of information, and appraisal summaries will inform revalidation, the objectives of the two processes are distinct and complementary.”* (Department of Health, 2002).

15 At the time of the DH guidance, ScHARR’s understanding was that the GMC and the Department shared the view that appraisal would not be a passport to revalidation. It would contribute important material, but revalidation would be a distinct process. The GMC may now be taking a different view. In a recent briefing on licensing and revalidation it says: *“The vast majority of doctors, working in managed systems such as the NHS, will be subject to annual appraisal. These doctors can expect that their appraisals (provided they are linked to the headings of* Good Medical Practice *and properly done) will normally provide suitable and sufficient evidence for revalidation.”* (General Medical Council, 2003)

16 If, as a rule, ‘five OK appraisals equals revalidation’ there is a concern that an unwelcome burden may be placed on appraisal, moving it in the direction of a summative, fitness to practice test. The lessons of history (see Chapter 3 of the first ScHARR report) are that the developmental value of appraisal is reduced if it is made to carry too many agendas, and especially if it is linked to concrete pay or career outcomes.

17 It is clearly reasonable, as the Department’s guidance says, that appraisal should inform or contribute to revalidation decisions but risky to make it equivalent. The ScHARR team would like to see appraisal conducted so as to achieve its own developmental objectives, not shaped to serve revalidation. The (probably considerable) value it had in supporting revalidation would be a by-product. On this basis it would be for the GMC to decide what if any additional information it needed, in general and in individual cases.

18 The GMC approach would clearly be efficient and economical of effort and many GPs would themselves appreciate it for that reason. But it might be shortsighted if it deprived appraisal of its high-trust vitality and honesty and made appraisees defensive. This is not particularly a point about non-principals, but it would be a pity if the potential of appraisal to connect locums to support were compromised by its being seen as a ‘test’.

Evidence and related concepts

19 The wording of the Department’s brief for this project (see Chapter 1) emphasises ‘evidence’ and asks about ‘minimum sets of evidence’. Yet in the preamble to Form 3 in its standard appraisal documentation the DH reassures GPs that: *“It is not expected that you will provide exhaustive detail about your work. But the material should convey the important facts, features, themes or issues, and reflect the full span of your work as a doctor within and outside the NHS. The form is a starting point and framework to enable you and your appraiser to have a focused and efficient discussion about what you do and what you need. It is a tool not an examination paper or application form, and it can be completed with some flexibility…….You are invited to submit documents in support of what you say in the form. You are not expected to ‘prove’ your assertions about your work……”*

20 This does not convey the same message as an emphasis on ‘evidence’. ‘Evidence’ might be an appropriate word if appraisal were indeed the revalidation process, with fitness to practice at stake.

21 The project team would like to see the appraisal discussion itself, with the process of reflection leading to it and the Personal Development Plan that ensues, reaffirmed as the heart of appraisal rather than the supporting ‘evidence’ or documentation a GP can produce. Some GPs who have been appraised have found the process of assembling material useful as a prompt for reflection, but many have found the real value in the undivided

attention, advice and support of the appraiser during the protected appraisal discussion – ‘certainly a privilege’, as one put it.

22 This is all directly relevant to the case of non-principals. The project brief focuses on the ‘evidence’ locums (say) can produce because it may be harder for them to supply material under some of the *Good Medical Practice* headings than for principals who have continuity in their patient and colleague relationships. Chapter 4 shows that there is in fact quite a lot they can do, but the point here is that even if ‘evidence’ were a serious problem for locums, it would matter less if reflection, the appraisal discussion and the PDP were seen as the stuff of appraisal rather than proof of fitness for revalidation.

Chapter 3: Responsibilities, appraisers and the documentation

Chapter 3 – main points……

- This Chapter sets out the main responsibilities of 'stakeholders' in the appraisal of non-principal GPs, including practices in which locums regularly work.
- ScHARR's view is that non-principals should be appraised by GPs who have trained as appraisers and have a confident understanding of non-principal work, but may or may not now be working as non-principals.
- It is suggested that a very slightly revised set of documents should be agreed which accommodate non-principals.

Who is responsible for what?

1 This chapter deals with some comparatively straightforward practicalities.

2 First, it may be useful to propose a responsibilities framework. Some of this is a fairly direct 'read across' from the main appraisal scheme and some is distinctively about non-principals. Several of the issues are picked up again in Chapter 5.

PCTs

3 As holders and managers of the Supplementary List, and as the local NHS organisation responsible for the quality of primary care, PCTs are responsible for ensuring that doctors on the List have and maintain the qualifications, experience, knowledge and skills to work in general practice.

4 When the mandatory appraisal requirement is extended to non-principals, PCTs should be responsible (as they are in relation to the appraisal of principals) for:

- ensuring that an appraisal scheme is in place which covers all relevant non-principals working in general practices within the organisation's span, and which commands the confidence of the profession and their representatives

- ensuring that all relevant non-principals on the Supplementary List undergo annual appraisal in line with the local scheme

- establishing workable arrangements for identifying, appointing and training appraisers

- ensuring that appropriate mechanisms are in place to quality assure appraiser training, to regularly review the appraisal process in the light of participant experiences and changing circumstances, and to take action to redress any concerns with the process

- ensuring that robust processes are in place to deal with worries or complaints from individual non-principals about the process or outcomes of appraisal

- ensuring that action is taken as far as possible to address the education and development needs of non-principals, and the service development requirements identified and agreed in the course of appraisal; in particular, ensuring that non-principals are brought 'into the loop' of routine communications about developmental or educational events and opportunities

- encouraging practices regularly employing locums to engage locum doctors in the professional life of the practice and to provide support where possible

- making adequate financial provision to support the appraisal process.

5 The last three points, and the general Supplementary List management responsibilities of PCTs, are addressed again in Chapter 5.

6 The PCT's proposed role presents some challenges. Many locums work in PCT areas other than the one in which they are listed. A few locums mainly work in other areas. The pattern is not yet known in detail, but if a locum works mainly elsewhere, how meaningful will an appraisal be if it is conducted by an appraiser who, against the expectations of the national scheme, has little or no knowledge of the settings in which the appraisee works? How useful will it be for a host PCT to learn about performance constraints in another PCT, which itself may be deprived of valuable insights? What will be the value of advising locums only about educational events in the 'host' area if they are more active in others?

7 The ScHARR team's feeling is that in these circumstances the responsibility for making appraisal work for all its stakeholders (and for

getting information about relevant local opportunities) must shift a little towards the individual locum. They should talk to the relevant practices and PCTs and help to devise or broker the most sensible appraisal arrangements possible: better a worthwhile appraisal than a flawed one. This probably implies that, as a solution in some cases, one PCT should be able to delegate its appraisal responsibility to another PCT, or share it, with funding implications.

Non-principal GPs

8 *Good Medical Practice* places a responsibility on non-principal GPs to keep their knowledge and skills up to date throughout their working lives; to take part regularly in educational activities which maintain and develop competence and performance; to take part in regular and systematic medical and clinical audit; to respond constructively to reviews, assessments or appraisals; and to take part in adverse event recognition, analysis and reporting.

9 Subject to the necessary regulation there will be a mandatory NHS requirement to participate in annual appraisal. Non-principal GPs will therefore have a personal responsibility to ensure that they do so.

10 The non-principal GP:

- 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
- 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 Appraiser

11 The appraiser:

- prepares for appraisals and agrees the agenda with appraisees in consultation as appropriate with the PCT's lead appraisal manager
- ensures that appraisal is conducted in line with good practice
- supports non-principals in considering their practice over the last year

- agrees objectives and the key elements of a personal development plan, and any actions which the PCT should attempt to take

- records appraisal outcomes and conveys the Form 4 summary as required, and otherwise maintains confidentiality over the detail of appraisal discussions

- builds a positive working relationship 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 non-principal 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 practices in which locums (in particular) work

12 Aside from their duty to satisfy themselves about a locum's credentials, 'host' practices can do a great deal to support locums with their appraisal and this is picked up again in more detail in Chapter 5. For present purposes, practices should:

- invite locums to take part in the professional life of the practice, attending practice meetings and training events or discussions, and contributing to significant event or other audit processes

- facilitate their access to professional materials (journals, training videos etc.) and to patient data, particularly prior and subsequent data about patients they have seen (to assist with their own audit processes)

- support steps they might wish to take to learn the views of their patients and colleagues

- ensure that practice principals are available for handover discussions or briefings, facilitating routine communication about patients; and generally for professional exchange and advice.

The GP Tutor/Educationist

13 Local Deaneries, under whose auspices the educational machinery operates, should work with partners to develop a coherent and explicit 'inclusion' strategy for ensuring that non-principal GPs are informed about developmental and educational opportunities and events and have facilitated access to them; and for adjusting their range and character to meet the needs of non-principals as they emerge in PDPs associated with the appraisal process. (There is more on this in Chapter 5.)

Locum agencies and out-of-hours providers

14 Locum agencies (national or local) and providers of out-of-hours services (large or small) have a triangular relationship with the doctors they supply and the NHS. They have their own varied processes for recruiting, monitoring and in some case developing the doctors on their books. Their selection approaches are part of a management relationship which could and sometimes does include appraisal. But the doctors they supply are invariably on a Medical or Supplementary List, for which PCTs are responsible. Where should responsibility for appraising such Supplementary List doctors lie?

15 One major national out-of-hours provider is developing an appraisal system which bears a resemblance to the NHS scheme. The documentation looks similar at first sight, although it does not follow the headings of Good Medical Practice closely. It has the feel of a well-developed and thoughtful approach, tailored closely to the kinds of work their doctors do and the support and development they need, and to the organisation's own need for management information.

16 In principle, the ScHARR team believes that the NHS should not consider delegating its appraisal responsibilities for Supplementary List doctors (even if it were legal to do so), and that agencies and out-of-hours providers should welcome this as an underpinning safeguard for them and a development process for their doctors. Within that framework, agencies and out-of-hours providers would decide if they needed additional internal appraisal arrangements, tailored to their relationship with their doctors, which could be made acceptable to doctors as an additional requirement. This matter may require further consideration by the Department.

Who should appraise non-principals?

17 This issue has generated quite a lot of interest. Some PCT respondents (who were usually clinical governance or appraisal leads, or educationists) argued that non-principals could only really be appraised by other non-principals. They relied on the principle, articulated in the Department's guidance, that: *"The appraiser will have reasonable knowledge, throughout the reporting period, of the work of the GP who is being appraised. He or she will be aware of the environment in which the doctor works and the full nature of services provided….".*

18 This is in fact a challenging requirement even in the case of principals' appraisal because it is difficult for one GP (the appraiser) to acquire real familiarity with the particular practice of another (the appraisee). The ScHARR team interprets the Department's intention as being to ensure that appraisers are themselves GPs and therefore understand the work of GPs; and wherever possible know and probably work in the appraisee's local healthcare system. By extension, non-principals should be appraised by GPs who understand non-principal work and the local health

community, but it would introduce unnecessary inflexibility to require them always to be non-principals themselves. This appears to be the prevailing view in the field.

19 Some have however argued that non-principals should be appraised 'in-house' by a principal in the practice, or one of the practices, they work in. This would guarantee at least some local knowledge and is superficially plausible in that it builds on the traditional role of employer as appraiser (a concept that does not transfer readily to the appraisal of principals).

20 There are serious drawbacks however. First, on the principle that the appraisal of non-principals should differ as little as possible from that of principals, it is essential that they are appraised by GPs who have been properly trained as appraisers. This will not be an in-house option in many cases. Secondly, appraisal is meant to be an independent and objective process and several 'ordinary' non-principals have expressed frank misgivings about being appraised fairly or usefully by some of the principals they deputise for. Thirdly, the appraisee has to feel able to comment on adverse environmental constraints on their ability to practice medicine as they would like (appraisal is a two way process) and the potential for this could be severely inhibited by an in-house process.

21 ScHARR's view is that non-principals should be appraised by GPs who have trained as appraisers and have a confident understanding of non-principal work, but may or may not now be working as non-principals. This implies that the opportunity should be available to non-principals to train and work as appraisers. In theory they should not be barred from appraising principals, although several have represented that they cannot see this working very comfortably in practice.

22 In all cases non-principals should have the same access as principals to whatever approach has been adopted by the PCT to resolving differences over appraisal processes or outcomes, including discomfort about an appraiser.

The appraisal documentation

23 Somewhat surprisingly perhaps, given the potential in general practice for disaffection with forms, the team have not picked up any serious reservations about the standard appraisal documentation. No good reasons have emerged for subjecting non-principals to something different. The challenges for them are around the *material* that can be offered under some of the Good Medical Practice headings rather than the reporting *medium*.

24 Nevertheless it is suggested that very slightly revised documents should be agreed which accommodate non-principals. The main changes needed are in Form 1 (Basic details), giving more relevant opportunities to describe the type and location of work carried out in general practice; in Form 2 (Current medical activities) where an opportunity to say how much

work is done would be useful; and in Form 3 (Material for appraisal) where some of the prompts under headings might benefit from adjustment in the light of the approaches suggested in the next Chapter. The PDP template and Forms 4 and 5 probably do not need any changes.

25 It is hoped that the electronic NHS Appraisal Toolkit (more of which in the next chapter) may in due course be able to add a third, non-principal, example of completed documentation to the GMS and PMS examples it carries now.

26 The Department may be planning to publish amended guidance on appraisal to reflect its extension to non-principals.

Chapter 4: Material for appraisal

Chapter 4 – main points……

- It is sensible for non-principals to assemble and reflect on the things that will eventually inform their appraisal throughout the year; locums in particular should attempt this.
- Two aids to organising this are described, one available and useful to all GPs and one particularly tailored to non-principals.
- There are many structured approaches to reflection, data collection, analysis, the formulation of learning plans and progress monitoring which they can use for appraisal purposes.
- Examples are given together with pointers to helpful resources and publications.
- Some of the main Form 3 headings, particularly those involving patient and colleague relationships, may be more difficult for locums than for principals, but far from impossible.

Continuous organisation

1 This chapter is about leading an organised professional life and completing the appraisal documentation.

2 The basic proposition is that preparation for annual appraisal should be a continuous process for principals and non-principals alike. The material for appraisal is actually generated throughout the year, whether it is to do with direct clinical care, learning, relationships with patients and colleagues, or any of the other main elements of *Good Medical Practice*. The appraisal documentation might seem to encourage a once-a-year panic, and in reality it has probably been like that for many people during the first year. But it is possible and highly desirable for GPs to continuously assemble and reflect on the things that will eventually inform their appraisal. Locums in particular should attempt this as a way of capturing their experiences

and making them 'portable', overcoming some of the drawbacks of a peripatetic workstyle where data is often left behind.

3 There are two particular aids to this, one available and useful to all GPs and one specifically tailored to non-principals.

4 The generally available option is the NHS Appraisal Toolkit, designed and managed for the Department by the Sowerby Centre for Health Informatics (SCHIN) at the University of Newcastle. It is *"based on the principle that a single portal should be available to appraising and appraisee GPs in the NHS. This on-line resource will bring together advice, guidance, best practice, practical tools and access to a community of peers in the appraisal domain."* The Toolkit's address is www.appraisals.nhs.uk/>www.appraisals.nhs.uk. Robinson and Simpson (2003) describe the Toolkit in the context of a general guide to appraisal.

5 The centrepiece of the Toolkit is an electronic version of the standard appraisal forms. With confidentiality fully protected, appraisees can complete their forms on-line over as long a period as they like. When the appraisal is approaching and they are satisfied with their forms, they 'sign them off' and they become available under password control to the appraising GP (but no more widely). The site includes useful prompts, ideas and links. There is an 'Appraisal Checklist', a confidence rating scale which enables users to identify the areas covered in the documentation about which they are 'not very' or 'not at all' confident. A 'Decision Support Tool' is under development, as an integral part of the Toolkit, which will provide a range of suggested approaches to meeting learning needs and addressing areas of shaky confidence. Very importantly, there are 'My Notes' boxes throughout the Toolkit which enable users to store private material linked to the main headings of the documentation.

6 The Toolkit provides a powerful medium for the continuous collection of, and reflection on, the material generated daily which is relevant to appraisal. It can be accessed at any time from any home or work computer with internet connection, or from an internet café for that matter. It can be much more than a convenient way of filling in the forms tidily.

7 The second aid to continuous recording and reflection, aimed specifically at non-principals, is the Personal Learning Portfolio (called 'Striving for Quality') developed for the Department of Health by the National Association of Non-Principals (NANP at www.nanp.org.uk). They describe it as 'a great way to learn and a great way to prove you've been learning'. It is an example of a 'log diary' approach. The basic version is a portable Filofax-based organiser. It has useful general and educational information for non-principals and expandable sections for recording everyday events, reflections and learning. The present sections cover PUNs and DENs (a system for recording patients' unmet need and doctors' educational needs – more on this later), group learning (ie helpful meetings attended), interesting patients (for notes on significant events for example, or

puzzling presentations), and useful reading. There is a section for keeping a basic log of work done, very important for locums (see below).

8 The Portfolio is downloadable in Portable Document Format and there is an electronic version. There are plans to make a version available for handheld computers, useful given the roving life of many locums.

9 A specific suggestion here is that NANP might be supported in revising the Portfolio's format to make it more directly relevant to appraisal. There could be sections on the appraisal Form 3 headings and facilities for cross-referencing them from existing sections. The opportunity might be taken to adjust or add to these in the light of the next section of the report.

10 These are two approaches to the continuous gathering and organisation of material for appraisal purposes, matters of *process* in a sense. In terms of *content*, and not forgetting the caveats in Chapter 2 about 'evidence', what can non-principals, locums in particular, be expected to supply?

Material for Form 3

11 This section lists sources of information which locums might find useful for their appraisal portfolios. Several are relevant to more than one of the main headings in Form 3 of the appraisal documentation, which are taken from *Good Medical Practice*. A rough and ready suggestion is made in each case about the main potentially relevant headings, using this code: GCC – Good clinical care; MGP – Maintaining good medical practice; RP – Relationships with patients; WC – Working with colleagues.

Work log (MGP)

12 All non-principals should be able to demonstrate their workload, and it is particularly important that locums keep a simple but complete record of the sessions they work, with periodic summaries. It will be needed in support of Form 2 (Current Medical Activities) but is also relevant to Form 3 since regular practice and experience themselves play a key role in maintaining and developing skills.

13 The NANP Personal Learning Portfolio (see above) includes a very straightforward work log. Another approach would be to devise a brief form which practice managers could 'sign off' for a locum, saying what work has been done. (NANP might include such a thing in their Standardised Practice Induction Pack, mentioned again in the next chapter.)

Personal development plans (MGP)

14 Arguably the most important and convincing material that a locum (and indeed others) can provide is an up-to-date Personal Development Plan which is being *implemented*. Appraisal documentation should obviously record educational and other development experiences, all the more powerful if they are systematically chosen. It may be messy in the first

year of appraisal, but thereafter it should be the centrepiece. Many of the other sources of information described here should feed the PDP. There are many formats around but it is logical to promote the one in the appraisal documentation. There are also many sources of advice and guidance on how to prepare PDPs. Excellent recent publications by Chambers et al. (2003), Haman et al. (2001), Pietroni (2001), Rhugani (2001), Robinson and Simpson (2003), and Wakley et al. (2000) all provide a wealth of ideas and needs assessment tools which are directly relevant to appraisal and PDPs for non-principals.

Preferred learning styles (MGP)

15 Different people learn more or less readily in different ways. There are several tools (for example Honey and Mumford, 1986) which can be used to identify personal preferences amongst learning styles or media. Learning and development opportunities for GPs have become more diverse and it is useful to have a reasonably systematic way of choosing. Having taken the trouble to make these explorations is also a kind of 'evidence' in itself.

General clinical audit (GCC)

16 Clinical audit is a process for reflecting on or studying clinical practice, comparing actual work with desirable standards, identifying areas for improvement, thinking about potential reasons for shortcomings, taking action to make things better and finding out if it works. It is classically a cyclical process of continuous improvement.

17 It can be performed anywhere on a spectrum from the numerically and clinically sophisticated, involving large numbers of clinicians and/or patient episodes, to the informal, small-scale and personal. The essential features are that it is systematic and motivated by a serious desire to do things better. One non–principal defined it simply as 'a process of scrutinising your work to make it better'. High quality audit may sometimes depend on a large amount of complete and comparable data, acquired over a period of time in a single, settled working environment. This may be a problem for peripatetic locums as Bowie, Garvie and Oliver (2001) found. Their study of 200 non-principals in Scotland established that experience of audit is poor, with many having little knowledge of audit methods.

18 There are however simple approaches to general clinical audit which most non-principals can use and which, for appraisal purposes, will demonstrate the same desire to improve.

19 One approach, which assumes only that a locum will revisit practices from time to time and a system for recalling which patients they have seen, is to call up the records of, say, the last ten or twenty patients seen in a practice more than six months ago to find out what has happened since. Appendix 4 gives a real anonymised example with around fifty records looked at.

Comparable cases from different practices could be extracted and grouped to give themed samples.

20 Along similar lines, Appendix 5 is a referral log kept by a non-principal who works in a single practice one day a week. A simple log was kept of referrals using numerical patient identifiers, and outcomes were later tracked using either scanned-in or paper records. The GP described this as a powerful reflection exercise with good learning from consultant letters.

21 Of course it may also be possible in some practices to take part in practice-based audits as an occasional member of the practice team. In any event locums should certainly try to include some record of basic audit work in their appraisal documentation, and plan ahead so to do.

Significant event audit (GCC, WC, RP)

22 This is a particular form of audit, described by Pringle et al. (1995) and others, which involves the careful analysis of key events, by those involved, with a view to learning lessons and improving practice. Significant events are not necessarily negative, and they may be administrative rather than clinical; the important thing is a process of analysis, reflection and learning. Significant event audit is often carried out within practice teams, and a locum should be able to participate where some aspect of their work is discussed. But it can also be carried out as a personal process, or with other locums.

23 Haman et al. (2001) give a simple format which could easily be adapted for personal use and incorporated in appraisal documentation; or the 'Interesting Patients' section of the NANP Personal Learning Portfolio could be used. A skilled appraiser will help to extract the learning from this kind of material during the appraisal discussion itself.

Prescribing, investigation and referral data (GCC)

24 Principals and PMS equivalents have access to Prescribing Analysis and Cost (PACT) data which enables them to describe and evaluate their prescribing pattern for appraisal and other purposes. This data exists for locums but it is associated with practices in which they work and the prescriber identifier numbers they 'borrow' from them.

25 The team has established that the Department places no barriers in the way of peripatetic locums or other deputising doctors having their own prescribing numbers and pads and thus access to PACT data. The value of having such data is however hard to gauge. Peripatetic locums working in several different practices may be constrained in the range of drugs they prescribe by the ongoing patient management of the principal they are deputising for, and they do tend to have more than the average number of common acute cases to see. Outlying personal prescribing behaviour might therefore be unusual. It would however be worth *knowing* if it exists, at the level of the system, and it could be useful for individual non-

principals to put their prescribing habits into perspective, for appraisal purposes, amongst those of others. Individuals would need comparator information in order to understand their position. This could refer to locums in general, which would probably require action at national level, but they could certainly look at data less formally in company with other locums, through non-principal groups. Even careful scrutiny of personal data in isolation might raise questions and lead to learning.

26 There are technical difficulties in that locum prescribing information 'belongs' in a sense to the practice in which they are deputising, and the practice would need to continue receiving the information as well as the individual; dual identifiers would therefore be needed. Nevertheless this is something about which the ScHARR team suggests the Department itself might initiate some discussion. There has been some consideration at the instigation of NANP but it has not reached a clear conclusion. It would be interesting in the course of discussion to see how far principals are themselves finding PACT data useful for appraisal purposes.

27 There are comparable issues and discussions to be had about locums' investigation and referral data, also potentially useful in supporting appraisal. (See Paragraph 20 above for an informal approach.)

28 (Incidentally the team has also found, as NANP already know, that all doctors working in general practice are entitled to receive copies of the British National Formulary on request.)

Clinical guidelines and protocols (GCC)

29 Locums should certainly refer in their appraisal documentation to clinical guidelines or protocols, whether national, local or personal, which they are aware of and actively using.

PUNs and DENs (GCC, MGP)

30 Richard Eve has devised a well known diary format for recording information about a consultation in which a GP feels on reflection that a **p**atient had an **u**nmet **n**eed. He suggests that the GP tries to identify the **d**octor's **e**ducational **n**eed which, if addressed, would do something about avoiding future unmet need of that type. Copies of the PUNs and DENs logbook, with worked examples, can be obtained from Dr Richard Eve (eve97@msn.com).

Complaints (GCC, WC, RP)

31 Complaints can be a valuable source of learning and non-principals should press for involvement in the handling of any complaints they become aware of that might relate to their work. The problem is often that they do not receive any notification, or are not engaged properly by practices or the PCT. NANP has produced a leaflet, available as part of their

Standardised Practice Induction Pack, which sets out procedures that locums and practices should follow.

Patient appreciation (GCC, RP)

32 If locums receive letters or cards expressing appreciation (or otherwise, if there is some evidence of analysing and learning) they might be included in appraisal portfolios. Haman et al. (2001) give a simple format for recording direct patient comments, positive and negative, during consultation. It can be used (and is probably best used) on a continuing 'diary' basis or as an aid to reflection over, say, the last three months.

Patient surveys (GCC, RP)

33 There are several patient survey tools around. Chambers et al. (2003) list a number, including one available for downloading from NANP (www.nanp.org.uk) and two that have since been 'accredited' for use as quality measures in connection with the proposed new GMS contract (the IPQ devised by Michael Greco at Exeter University, and the GPAQ produced by the National Primary Care Research and Development Centre at Manchester University). The GMC is developing one in connection with its revalidation preparations and, like its Professional Colleague Survey (see below), it might be adapted for local use. Managers in practices visited by a locum could be asked to pass this or another questionnaire to patients and mediate feedback anonymously. There are however some basic problems with patient surveys for locums: they do not tend to have the continuing relationships with patients that would enrich such surveys, although they could still be useful, and they do not tend to have very stable platforms from which to launch surveys of valid numbers of patients.

References from colleagues (GCC, WC)

34 In the course of seeking entry to a Supplementary List, locums will probably have supplied professional references. These may be suitable for inclusion in appraisal documentation if they are fairly recent. And there is absolutely nothing to stop a locum asking for references specifically for appraisal purpose. NANP are working on a reference-cum-feedback document.

Peer feedback (GCC, WC)

35 It may be possible even for locums to persuade their temporary practice colleagues (including GPs, practice managers, nurses, receptionists and others) to give some simple systematic feedback on their work. Haman et al. (2001) again supply two formats which could be used or adapted. Feedback can be sought directly, or anonymously using a '360° feedback' approach. Here a third party compiles and if necessary moderates responses from a number of people nominated by the 'subject', whom they help to assimilate the aggregated information. The advantage of

anonymity may be honesty; the advantage of direct individual feedback may be the opportunity to discuss material fully with its originator.

36 360° feedback tools can be constructed fairly easily, or there are commercial examples (see for example the *Insight* tool available from Edgecumbe Consulting at www.edgecumbe.com). The General Medical Council is developing a 'Professional Colleague Survey' in connection with its work towards revalidation. This could be adapted as a direct or 360° tool for the use of non-principals themselves (and other doctors) and this might be considered.

Description of approaches to integration (WC)

37 A locum should generally seek to be involved in the professional life of the practices they work in regularly, and they should describe the steps they take in their appraisal portfolios. They should include attendance at practice meetings or in-house CPD events, participation in practice audit, and involvement in practice or Primary Health Care Team decision making.

Material for Form 3……

- Work log
- Personal development plans
- Preferred learning styles
- General clinical audit
- Significant event audit
- Prescribing, investigation and referral data
- Clinical guidelines and protocols
- PUNs and DENs
- Complaints
- Patient appreciation
- Patient surveys
- References from colleagues
- Peer feedback
- Description of approaches to integration

Conclusion

38 Some of the main Form 3 headings, particularly perhaps those involving patient and colleague relationships, are more difficult for locums than principals, but far from impossible. There are many structured approaches to reflection, data collection, analysis, formulating learning plans and monitoring progress which they can use: recent publications (cited above) provide almost an embarrassment of riches. But in any case, as Chapter 2 argues, it is the attitude of reflection and the appraisal discussion itself that should command attention rather than the 'evidence'. If the will to reflect

and improve comes through, in however low-tech a way, no one should have too much of a problem.

Chapter 5: Funding non-principal appraisal and supporting and developing non-principals

Chapter 5 – main points……

- PCTs should make adequate financial provision to support the appraisal process.
- Locums (and other non-principals in some circumstances) should be paid fees (at standard locum fee levels) directly by the PCT for reasonable time spent on appraisal.
- Many non-principals are still disconnected from opportunities for Continuing Professional Development.
- There are opportunities to improve incentives and support mechanisms so that non-principals are able to benefit from appraisal and participate fully in CPD.
- Examples are given of actions that should be taken by Deaneries, PCTs, practices and non-principal GPs themselves.

Funding for appraisal

1 The Department's guidance on GP appraisal (Department of Health, 2002) and associated executive communications require PCTs to make adequate financial provision to support the appraisal process. This includes payments to appraisers and steps to ensure that GPs are not out of pocket as a result of undergoing appraisal.

2 The 2002 guidance refers de facto to GMS principals and their PMS equivalents, for whom it requires a funded policy on the provision of locum cover. Locum time for principals should cover reasonable preparation time, the appraisal discussion itself and some form of brief review with the appraiser during the ensuing year.

3 The principle is that time spent on appraisal by a principal is alternative rather than additional 'work'. Additional payments, as though for a new item of service, are not therefore required but locum cover is needed for

the existing work that a principal is prevented from doing by the appraisal process.

4 This principle could apply to non-principals who work in a single practice on a salaried or other continuing basis: the practice might expect paid locum cover from the PCT if the doctor spent their paid time on appraisal instead of on their normal work. If however the doctor underwent appraisal in their own time it would be they themselves and not the practice who would look for some form of compensation to avoid being 'out of pocket' (in the sense of working without pay).

5 This will often be the position for locums. The practices they work for will not expect to fund the time they spend on NHS appraisal, either by paying directly for additional sessions or by meeting higher fee rates if the locum sought to recover these costs in that way. Nor should the locum doctor have to meet the NHS's appraisal requirement for nothing. Because time spent by locums on appraisal will be additional to their paid time and not an alternative use of it, PCTs should pay fees at locum levels directly to locums (and other non-principals in comparable circumstances) for reasonable time spent on appraisal.

Continuing Professional Development

6 In the wake of the Chief Medical Officer's (1998) report, and concerns expressed by the Royal College of General Practitioners (RCGP, 1999), the emphasis in the ongoing education and development of GPs has shifted. Continuing Medical Education (CME), with its traditional focus on attendance at short accredited events of more or less unknown relevance or value to participants, is giving way to Continuing Professional Development, with its focus on systematic personal development plans driven by actual learning needs (see Wakley et al., 2000). Both are routes to the payment of the Postgraduate Education Allowance (PGEA) under the current Statement of Fees and Allowances for GMS principals, but the advent of annual appraisal, with its requirement to produce and implement a Personal Development Plan, generally strengthens the more modern approach.

7 In terms of non-principals, the Standing Committee on Postgraduate Medical and Dental Education reported five years ago on their particular educational needs (SCOPME, 1998). There was widespread concern that a key part of the primary care workforce was disconnected from opportunities for Continuing Professional Development. The report recommended a register of non-principals as a means of establishing and maintaining contact and as a basis for planning, properly organised induction processes, career advice and mentoring, personal development planning and improved access to varied educational activities.

8 Many of the barriers identified in the SCOPME report are still in place. A recent survey (Tinker, 2003) revealed a familiar picture of disconnection,

with a lack of timely (if any) information about courses and a deterrent effect of course costs and the price of learning materials

9 Non-principals are not eligible to receive PGEA by either of the routes outlined above, or any other. (PGEA is in fact part of the GMS principal's remuneration which is withheld until successfully claimed.) For locums in particular there have been few external incentives for them to maintain and develop their skills other than the basic need to remain competent and employable; and if locums are in short supply, as they often are, even that may not be a major factor. Where locums have been positive about their development it has generally been in response to the internal drivers of professionalism, conscientiousness and curiosity. Ineligibility for PGEA has often gone hand in hand with isolation from the developmental support available to other GPs from Directors of Postgraduate General Practice Education and their local educationist colleagues (GP Tutors and others).

10 Now that locums are to be appraised and required to produce PDPs, there are opportunities to improve incentives and support mechanisms, and to enable them to survive and enjoy appraisal and participate fully in CPD. At the very least, locums should be attracted by the contribution that positive appraisal will make to revalidation. At best, if responsibilities are accepted and appropriate actions taken by all concerned, appraisal should be the means of bringing locums in from the cold, to the great benefit of the NHS and its patients.

Practical steps

11 There are various steps that should be taken to support appraisal and Continuing Professional Development for non-principals.

Roadshows and guides

12 The Department of Health should consider sponsoring roadshows on the extension of appraisal to all GPs. It did so in order to launch appraisal for principals and the events around the country were well attended and appeared to be useful. It should also prepare or commission a "Non-principal's Guide to Appraisal" as a straightforward and practical introduction.

Deanery strategies

13 It has been suggested already that Deaneries should develop 'inclusion strategies' for locums and non-principals generally (or revisit them where something already exists). They should work with PCTs and Workforce Development Confederations to see how funding might be made to flow more sympathetically in support of non-principals' development activities. There may be new opportunities. The overall framework for workforce development in the NHS is evolving following publication of *Working Together – Learning Together* (Department of Health, 2001) and the emergence of the NHSU as a major new player (see *Learning for*

Everyone, Department of Health, 2002). The new Higher Professional Education scheme for GPs wishing to pursue post-Vocational Training Scheme (VTS) studies might be modified to help locums, as it does some other non-principals; the present version of the scheme does not do so directly.

GP Tutors/Facilitators

14 The Committee of Directors of Postgraduate GP Education (COGPED) should seek through the Deaneries to establish GP Tutors or Facilitators to work specifically with non-principals in every Deanery, so that all non-principals (and locums in particular) have a named tutor to whom they can turn for advice and support, including support in preparation for appraisal.

VTS preparation

15 Most doctors do not become principals immediately on graduating from vocational training. Many work for quite some time as non-principals, some permanently. Vocational training schemes should introduce appraisal and personal development planning to their students and, specifically, appraisal and CPD in the context of non-principal roles.

CPD and other information

16 The introduction of the Supplementary List provides an important framework for linking non-principals and PCTs, and should facilitate planning and communication around CPD and other issues. It should be fairly straightforward to devise a process for informing (and consulting) non-principals routinely about educational events and other opportunities provided by PCTs and local postgraduate centres, and including them in mailing lists generally (so they receive newsletters and prescribing guidance, for example). PCTs should ensure that non-principals are encouraged to participate in local protected time ventures.

Access to CPD opportunities

17 Some PCTs and Deaneries make educational and developmental activities available freely, or at marginal cost, to those who do not have access to PGEA as a resource from which to fund them. This does not involve much if any cost to the provider if fixed costs for venues and speakers (etc.) are recovered from those who do pay.

Good practice in practices

18 PCTs should also encourage practices to take a positive approach to supporting their locums generally, and specifically in helping them prepare for their appraisals. The proposed GMS contract (NHS Confederation, 2003) includes a comprehensive Competency Framework for Practice Management. This sets out an expectation that locum GPs will be ‘supported in post’ and that practice management may ‘promote systems

for appropriate locum use/integration'. An example of good practice is NANP's Standardised Practice Induction Pack, which includes a proforma which a practice can use to supply new locums with all the information they need to work effectively as part of the team.

19 In her recent survey report, Tinker (2003) identified the importance of practice meetings as a learning medium. They ranked high for principals with almost 60% saying they learned 'a great deal or a fair amount' from them. Only 40% of non-principals claimed this. A quarter never experienced this kind of learning. Practices who employ their locums regularly should not need external encouragement to involve them in practice meetings, and other practice-based learning opportunities such as audit or significant event discussions, but PCTs should be prepared to promote good practice when necessary .

Getting the most out of the Supplementary List

20 Inclusion on the Supplementary List should be seen as a contract between PCTs and non-principals which carries benefits and responsibilities for both. PCTs can expect non-principals to keep up to date and maintain their skills as a condition of listing, to the benefit of patients and therefore PCTs, and they have some sanctions at their disposal. The requirement to undergo appraisal will help to ensure a positive approach by non-principals. If PCTs support their non-principal GPs, it should help them to address the recruitment and retention challenges they face. Non-principals for their part should be able to expect this support and engagement in return for a positive approach to their professional skills, and appraisal will give them a vehicle for conveying a sense of the constraints they experience.

Challenges for PCTs

21 Clearly there are challenges for PCTs (some were mentioned in Chapter 3). It is for example possible that some PCTs will have a disproportionate number of non-principals on their Supplementary Lists: those near medical schools or VTS centres may be 'looking after' locums who have chosen to be listed where they trained and live, even though they may work mainly elsewhere. The current NANP survey of PCTs may throw some light on this

Networking non-principals

22 It should be possible to connect non-principals more effectively with each other to improve opportunities for peer discussion and shared learning. Good progress has been made in establishing local Non-principals Groups; there are more than eighty at the time of writing. NANP provides guidance on setting up and getting the most from them. It points out too that meetings of non-principals groups can be accredited for PGEA purposes even if PGEA cannot actually be claimed. The accumulating certificates of attendance are themselves useful indicators of commitment

to development. NANP has suggested the formation of ‘Non-principal Support Teams’, groups of non-principals supported by a liaison officer.

Practical steps……

- Roadshows and guides
- Deanery strategies
- GP Tutors/Facilitators
- VTS preparation
- CPD and other information
- Access to CPD opportunities
- Good practice in practices
- Getting the most out of the Supplementary List
- Challenges for PCTs
- Networking non-principals

Locum CPD time

23 It is for locums themselves to deal with the notional costs of spending time on development activity. Whilst they should be recompensed directly for time spent at the behest of the NHS on appraisal, they should cover the cost of maintaining their knowledge and skills, of keeping themselves fit for purpose. The discontinued BMA recommended fee levels were presumably set to recover costs of this kind. Given that there is now more flexibility in the fees locums may charge, it is in this case reasonable for them to adjust these so as ensure the recovery of sufficient resources to fund their CPD properly. This is logically equivalent to the use by principals of PGEA, which is an element of GMS remuneration.

A final reflection

24 This report has not been primarily about the general working experience of non-principals, but the theme of isolation, especially of locums, has come through so strongly that it is hard to ignore it.

25 Appraisal will itself be a powerful driver for better connection. It is the NHS connecting in a supportive and developmental way with the individual non-principal. It requires the preparation of a PDP which most do not now have; the PDP in turn provides a framework for making decisions about needs and taking action to meet them, and much of what doctors do in fulfilment of their PDPs will involve professional interaction. For locums, appraisal could be very good news.

Appendix 1

About the authors

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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 Organisation Development at Community Health Sheffield NHS Trust, and HR Advisor to South Yorkshire Strategic Health Authority. He has held progressively senior HR posts in Sheffield Health Authority, Northern General Hospital and Community Health Sheffield and has advised at Regional level on the HR/OD dimensions of PCT development. He is a member of the Chartered Institute of Personnel and Development. He has a part-time secondment to ScHARR to work on primary care research with a Human Resources or Organisational Development dimension.

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Helen is a principal in General Medical Practice and a part time Senior Clinical Lecturer at the Institute of General Practice and Primary Care at the University of Sheffield. She has worked in ScHARR since 1997 on several research projects in the area of clinical governance, poor performance and appraisal in General Practice. She has been a GP Adviser to the Department of Health since 2001.

Appendix 2

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Appendix 3

Glossary of abbreviations

BMA	British Medical Association
CME	Continuing Medical Education
COGPED	Committee of Directors of Postgraduate Medical Education
CPD	Continuing Professional Development
DEN	Doctor's Educational Need
DH	Department of Health
GMC	General Medical Council
GMS	General Medical Services
GP	General (Medical) Practitioner
NANP	National Association of Non-Principals
NHS	National Health Service
NHSU	NHS University
PACT	Prescribing Analysis and Cost Data
PCT	Primary Care Trust
PDP	Personal Development Plan
PGEA	Postgraduate Education Allowance
PMS	Personal Medical Services
PUN	Patient's Unmet Need
RCGP	Royal College of General Practitioners
SCHIN	Sowerby Centre for Health Informatics at Newcastle University
ScHARR	School of Health and Related Research at Sheffield University
SCOPME	Standing Committee on Postgraduate Medical and Dental Education
UPEs	Unrestricted Principals and Equivalents
VTS	Vocational Training Scheme

Appendix 4

A ‘fifty case audit’

This is an unedited but anonymised audit of fifty-five cases six months after consultation, carried out by a non-principal GP in the north of England.

8 August 2002						
Age	**Sex**	**Problem**	**Review**	**Next**	**Same**	**Comment**
61	m	Knee OA	Y	3w	Y	
29	m	Seb cyst	Y	-	-	
47	m	Med cert	N	6w	N	
9	m	Viral abdo pain	N			Admitted 6m later vomiting with proteinuria
1	m	Nappy rash	N	6w	N	
16	m	Osgood-Schlatters	Y	-	-	
8	f	Verruca	N	-	-	
39	f	Rx review	Y	4w	N	? failed to change to 50mg diclofenac as 1w later letter from pharmacist
70	m	Chest infection	Prn	2d	y	Correct diagnosis
34	m	Final med cert	N	6m	N	
12	f	Stretch marks	N	5m	N	
1	f	Eczema	N	2m	N	
19	m	Depression ETOH	2w	4w	Y	
60	f	Rash under colostomy	2w	2w	Y	Returned again to another GP after further 2w
56	f	Tennis elbow	N	2m	N	
>1	f	Diarrhoea	N	3m	N	
46	f	Asthma	1w	1w	Y	Stress @ home ? not identified
7	f	Cough	N	6m	N	
69	f	Wax	1w	1w	Y	Pain with otex - not Rxed by me
60	**f**	**Hip pain**	**N**	**1w**	**Y**	**Cert for more time off***
51	m	LBP	N	3m	N	
2	f	Diarrhoea	N	1m	N	
22	m	Epilepsy	6w	2w	N	
45	**f**	**Panic attacks**	**N**	**1w**	**Y**	**? should have followed up***
1	f	# gait	2m	2m	Y	Ultimate Dx CDH
36	f	Oedema	N	-	-	
6	f	Impetigo	N	-	-	
16 August 2002						
53	f	Pleuritic chest pain + deaf	N	4m	N	

54	m	Vertigo + testicular pain	N	-	-	
41	m	Intercostal myalgia	N	-	-	
43	f	Dry skin	N	6w	N	
47	**m**	**Conjunctivitis + ETOH**	**N**	**3m**	**Y**	**ETOH***
65	m	Anx + AF	Y	3w	y	? not identified depression
48	**m**	**Insomnia**	**N**	**5w**	**Y**	**same advice - another GP***
78	m	OA knee	Y	3w	+/-	
57	f	HRT ongoing	N	5m	N	
52	f	Depressed	Y	1m	Y	
8	m	Hay fever	N	10w	N	
26	f	Abdo pain	N	-	-	
54	m	SOB + chest pain	Referred stat + admitted + no diagnosis			
78	m	Essential BP	Y	3w	y	Rx changed by another GP ?? put off changing or home monitoring
10	m	Pyogenic granuloma + deaf	N	2m	n	?outcome of referrals
8	f	Ganglion	N	4m	N	
70	m	Angina	Nurse	3w	y	
27	f	Arm pain	N	6w	N	
20	m	Wt loss depression	Y	1w	y	Given 4w cert 11/10/02 not seen since
41	f	Itchy rash	N	-	-	
39	**f**	**Abdo pain**	**N**	**2w**	**y**	**Referred with ? pseudo-cyst anx re word "mass" in copy letter***
29	m	Tinea cruris	N	-	-	
62	**f**	**Headache referred**	**N**	**6w**	**y**	**For DLA application!***
19	f	Skin infection	N	2m	N	
49	m	Seb cyst referred MS	N	4m	N	
34	f	Asthma	N	-	-	
8	f	Abdo pain	N	-	-	
Totals						
55	28f 27m 36 not invited to return for review 6 not invited returned with same problem* 12 not returned at all in subsequent 6 months Significant learning points (identified previously) - late Dx of CDH and pseudo-cyst "mass"					

Appendix 5

A simple referral log

This is an unedited referral log kept by a non-principal who works in a single practice one day a week. A simple log was kept of referrals using numerical patient identifiers, and outcomes were later tracked using either scanned-in or paper records.

Date 2002	Number	Referred to	problem/diagnosis	outcome
7/1	16471	ENT	CSOM	modified radical mastoidectomy
	1900	ENT	discharging ears	suction clearance
	1947	Chest	TATT cough	asthma
	5436	orthopoedic	sacro-iliitis	MRI scan spinal stenosis
	9607	gen surgery	vasectomy	vasectomy
11/1	14903	opthal	arteritis	giant cell arteritis
15/1	6391	drugs & ETOH	ETOH	for 1-2-1 work
	3869	opthal	? re opticians report	suspicion glaucomatous #field testing
25/1	1236	gen surgery	RIH	RIH repair
	12234	gen surgery	paraphimosis	settled, not keen on surgery
29/1	8859	ch & adol psyc	behavioural #	DNA re-referred several sessions
	7656	practice MHT	marital #	no compromise from pt re wife's cigs
8/2	10732	practice MHT	low self-esteem	patient became pregnant
	179	opthal	cataract (Dx by me!)	put on WL for extraction
	2773	POAS	severe memory loss	Probable Alzheimers Rx galantamine
22/2	8851	surgery on call	?appendicitis	appendicectomy
	3919	dermatology	hyperhidrosis	Dx confirmed adv re Rx
	1301	orthopod	ant shin splints	shin splints + pes plano-varus no better with arch supports for doppler
8/3	8360	gen surgery	perianal abscess? pilonidal sinus	EUA fistula-in-ano - laid open
	6532	O & G	for TOP	medical termination
	14402	drugs & ETOH	heroine abuse	methadone pogramme
15/3	6952	gen surgery	reversal vasectomy	vasovasotomy
28/3	(left list)	dermatology	facial moles	not NHS
15/4	5531	geriatric	unsteady wt loss anaemia	endoscopy + active stand test
	7386	echo cardio	LVH	mild LVH no # function
	2829	physio	plantar fasciitis	referred podiatry
25/4	4352	A & E	? # scaphoid	treated as # scaphoid
29/4	8658	drugs & ETOH	ETOH for detox ?	"externalising" problem
	16610	orthopod	sciatica	DNA
6/5	20117	biochem	raised testosterone	not significant
	13230	DRC	? for insulin	short term insulin for illness
13/5	14089	Hand clinic	IGThumbnail	wedge resection
	4411	med on call	? MI	MI (awaiting CABG)
20/5	12336	gen surgery	vasectomy	vasectomy
	??	dermatolo	seb wart ? bcc	knocked off so appt cancelled
23/5	11271	gen surgery	pilonidal sinus	pilonidal sinus operated on 13/8
	16782	chiropody	IGT	(no feedback)
	2079	med on call	chest pain ? MI	admit MAU bloods ECG EECG nad

30/5	2822	derm	acne ?for roaccutane	settled
7/6	???	CMHT	personality #	??
5/7	6874	ENT	R hearing loss	for bloods MRI scan and FU
19/7	15060	neurology	diplopia lat rectus #	MRI LP eventually resolved ? due DM
8/8	4092	ENT	unilateral deaf and tinnitus	10dB loss only referred tinnitus training
	2063	Day hospital	falls	gait re-education by physio
16/8	3990	chest pain clinic	?angina	normal exercise ECG probably muscular
21/8	764	Dermatology	pyogenic granuloma	??
	1820	ENT	deaf	h/aid clinic
	9947	gen surgery	abdo mass @ pseudo-cyst	pseudo-cyst
	6866	neurology	headaches	migraine + tension h/aches “not optimistic of dramatic improvement”
2/9	7450	practice MHT	anx + depression	depression triggered by new job
	4379	orthopod	OA knee	MRI scan degen tear med meniscus
6/9	19846	practice MHT	marital #	cancelled appt - to work on it on own
	4574	melanoma clin	pigmented mole?mel	seb wart
	3181	gen surgery	lipoma axilla	excised under GA 11/12
20/9		gen surgery	bleeding PR Hds	
26/9	17059	neurology	small muscle wasting of hands	spinal muscular dystrophy
11/10		ENT	deafness	
21/10	7723	O & G	for TOP	suction TOP
	610	dermat	unilateral rash scalp	settling Dx ?? scrapings taken
25/10	11575	physio	lumbago sciatica	mobilisation, home exercises
4/11	4546	dermat	unhealing scalp wound	crust removed biopsy - benign
7/11	12349	med on call	GF acutely ill	kept in 5 days
	6495	urgent upper GI	dysphagia	endoscopy - nodular friable mucosa oesophagus - Rx repeat endoscopy
11/11	15898	paeds	nausea + anorexia	probable viral gastritis
15/11	8111	A & E	? FB foot	Xray nad for USS
	14644	maxillo-facial	TMJ #	TMJ dysfunction for splint
	4982	dermat	gen pruritus ? depression	no infection - probable depression
	12086	gen surgery	groin pain	pain settled
30/11	15592	physio	ankle pain	cancelled - attending privately
	14307	urology	undescended testis	USS nad for laparoscopy
	208	neurology	tremor ? cause	for CT scan EEG and 2nd opinion
9/12	1244	immunology	food allergy	+ve IgE peanuts - taught epipens
	15423	surg on call	testicular pain	USS admitted orchitis ciprofloxacin
	14991	haematology	anaemia	further bloods FU probable renal #
	15139	ENT	deaf ? serous OM	
	14426	A & E	? # scaphoid	Xray NBI
	13620	practice MHT	PTSD - recurrence	“sudden re-experiencing” common
	15886	gen surgery	LIH	for repair
13/12	1331	dermat	bleeding nipple	
16/12	16654	O & G	TOP	decided to continue pregnancy
	20587	chiropody	IGT	no feedback - D/N dressing
20/12	11725	paed surg on call	? appendicitis	appendicectomy
27/12	7182	practice MHT	DSH	DNA initial assessment