GIG CYMRU NHS WALES

Addysg a Gwella Iechyd Cymru (AaGIC)
Health Education and Improvement Wales (HEIW)

WALES APPRAISAL EXCEPTIONS MANAGEMENT PATHWAYS

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Part 1: Background to Appraisal

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 may be managed by the relevant organisation, i.e., the Revalidation Support Unit (RSU), HEIW and / or the Designated Body (DB). For further information on appraisal in Wales, please refer to the All-Wales Medical Appraisal Policy.

The document describes pathways which apply to a range of different exceptional situations. The aim of agreeing these pathways 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 RSU and the Appraisal Management Teams within the DBs. It will also be of interest to appraisers to ensure they are clear on how different situations may be managed and the support that is available to them from their organisation.

Doctors who are experiencing extenuating circumstances may wish to refer to this pathways document so that they are clear on the suggested processes that may be followed, the support that is available and the implications for their appraisal and revalidation.

1.2 Management of appraisal in Wales

For all doctors, annual appraisal is a professional responsibility and 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 DBs are responsible for providing and managing the appraisal process for 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 RSU.

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.

It is recommended that there is a professional management and support structure for appraisal, including an Appraisal Co-ordinator (AC) and Appraisal Manager in General Practice (GP) and an Appraisal Lead (AL) and Revalidation Manager (RM) in Secondary Care (SC), which are separate to the existing clinical governance and 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 AC/AL when referring to these roles in the context of their local leadership of the appraisal process.

Appraisal is an individual and 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.

Managing the appraisal process effectively and fairly requires the DBs 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 time frames' (7.1). These processes are described in Part 3.

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, 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 General Medical Council (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 (RO).

2.1 Supporting information

Appraisal provides doctors with an opportunity to present the supporting information required for revalidation[1]. This information is verified by the appraiser as part of the appraisal process. ROs 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[2], 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 organisations[3]. 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 Revalidation and clinical governance

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

[1] https://www.gmc-uk.org/registration-and-licensing/managing-your-registration/revalidation/guidance-on-supporting-information-for-revalidation

[2] http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

[3] This includes all doctors regardless of location or branch of practice

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

If the DB's clinical governance processes identify areas for development for individual doctors, it may be appropriate for the RO 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 Continuing Professional Development (CPD). The RO or other relevant clinical line manager will need to decide whether the issue needs to be addressed immediately in advance of the appraisal process. The doctor could document this in their Personal Development Plan (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 DB 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 DB 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 probity statement in MARS to indicate that they have been advised to discuss a specific developmental issue. It is up to the DB 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 DB outside the appraisal process.

DBs 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. 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, ROs 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 where necessary 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 DB through separate processes.

2.3 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 GMC (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 DB 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)

The GMC's procedure for managing non-engagement with revalidation can be found at: Recommendations of non-engagement - GMC (gmc-uk.org)

2.6 Revalidation deferral

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

The GMC's procedure for managing a recommendation to defer can be found at Recommendations to defer - GMC (gmc-uk.org)

Part 3: Managing Appraisal Exceptions

The DB 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 DBs 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 three months of their original appraisal date, the original AQ will remain the same.

Should either or both parties be unable to reschedule the appraisal at a mutually convenient time the issue should be referred to their local AC / AL 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 Extenuating circumstances, appraisal postponements and MARS account restrictions

Occasionally doctors will experience extenuating circumstances which mean they wish to postpone their annual appraisal. Extenuating circumstances may include parental 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 postponement 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 RM or AL. In these cases, the appraisal may need to be deferred and the AQ changed.

In a small number of cases the RO may decide that a doctor's MARS appraisal account should be restricted, for example, in some cases where the doctor has been suspended from clinical activity. In these cases, the RO will need to inform the RSU so the MARS appraisal account restrictions can be applied.

MARS appraisal account restrictions mean 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 restrictions, the appraisal summary will be committed on MARS before the doctor's account is restricted unless there are extenuating circumstances. See section 3.4 for further details.

3.3 Non-compliance with the AQ and non-engagement with appraisal

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 DB 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 RO 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 should be taken accordingly. An outline of the different stages, and possible action that may be taken, are described below.

3.3.1 Non-engagement prior to the appraisal meeting

Every doctor is responsible for undertaking their own appraisal. In Wales, NHS 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, including the MARS Help and Support page - Doctor | MARS help and support (heiw.wales) Any doctor experiencing difficulty is encouraged to contact the RSU (for GPs) or their RM / AL (for SC doctors).

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 one month of being contacted for this purpose
- Have not made sufficient appraisal evidence available to their appraiser prior to system lock out – a doctor's MARS account will be locked 14 days before the appraisal meeting date for GPs, and 7 days before the appraisal meeting date for all other specialties.

Please note, the above is not a definitive list.

In these cases, the RSU or RMs/ALs 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 AC / AL, in the first instance.

3.3.2 Non-engagement during the appraisal meeting

Appraisers are trained to enable them to facilitate the appraisal discussion professionally and to 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 PDP.

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 AC / AL after the meeting. After further investigation, in some cases the AC / AL may decide the issue should be reported to the RO 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 ideally within two weeks of the appraisal discussion.

The doctor is expected to agree the summary within a further two 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 within two 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 AC / AL who may decide to contact the appraiser/doctor and manage in line with local processes.

An appraisal is not considered complete until the appraisal summary is agreed by the doctor. The doctor will not be able to progress towards their next annual appraisal until the summary agreement has been confirmed on MARS.

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 DB 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 RO 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 AC / AL 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 restricted, although the doctor will still be able to enter information into MARS during this period (see 3.2). In cases of restriction, the RO will advise the RSU when the doctor's MARS account can be reinstated and will liaise with the RSU and the local AC / AL over the appropriate AQ to assign and whether a specific appraiser should be allocated to the doctor to facilitate this process within appraisal.

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. Rarelyhowever, 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 assess 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 AC / AL who will decide 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 DB 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 DB, WG and BMA structure on a national level. DBs are able to collate and review local reports via MARS and benchmark these with those reported across Wales as a whole. It is the responsibility of the DB to take action relating to these reports where they feel itis 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 DB, in which case it is the DB'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 AC / AL.

<u>Appendix 1</u>

Definitions List:

AC – Appraisal Coordinator

AL - Appraisal Lead

AQ – Allocated Quarter

CPD – Continuing Professional Development

DB – Designated Body/ies

ELA – Employer Liaison Advisor

GMC – General Medical Council

GP – General Practice/Practitioner

MARS – Medical Appraisal Revalidation System

MPL – Medical Performer's List

PDP – Personal Development Plan

RM – Revalidation Manager

RO – Responsible Officer

RSU – Revalidation Support Unit

SC – Secondary Care