The review of the appraisal of general practitioners in United Kingdom, its achievements and problems is given in the article. 

Key words: doctors appraisal and revalidation, National Health System, good clinical practice.

The UK’s National Health Service

The National Health Service (NHS) was founded in the United Kingdom (UK) by the Labour Party health minister Aneurin Bevan in 1948. The socialist government that set it up had the ideal that good healthcare should be available to all, however poor or wealthy the patient is. That principle still stands today, and is one of the reasons that the NHS is so popular with British people. Apart from some parking fees, prescription charges, optician and dentist services, the NHS in England is still ‘free at the point of use’ for all 64.6 million UK residents. The NHS is mainly funded by general taxation but, compared to other Western European countries, the UK spends relatively little on healthcare; this makes it difficult to achieve the improvements in quality of care and outcomes that the public expects.

The NHS sees over 1 million patients every 36 hours[1]. It covers everything from antenatal and maternity care, routine screening, treatments for long-term conditions, mental health care, transplants, emergency treatment, to end-of-life care. The NHS employs more than 1.5 million people, making it the fifth largest employer in the world. Private healthcare, paid for mainly by private insurance, is used by less than 8% of the population, and generally as a top-up to NHS services.

In the UK, family doctors are called General Practitioners (GPs). To become a GP there is a five-year training period after graduation, and then most GPs join a group family practice. Almost half of all fully-trained NHS doctors are GPs, and they earn about the same as their hospital specialist colleagues. The UK has a ‘GP-as-gatekeeper’ system: all medical records are held by the GP who, with the patient, decides whether a specialist referral is necessary. The NHS Electronic Referral Service allows the patient some choice in which hospital they will be seen and have treatment. Except in an emergency, and occasionally in the private sector, patients can only see specialists when they have been referred by a GP. So, very few specialists work in the community: most work in hospitals.

There is a move to encourage development of multi-specialty community providers to focus on joined-up care that is preventative, high quality, efficient, and outcome-focused. This is seen as a key part of the future NHS, with the aim of creating sustainable and integrated care systems, and helping to reduce the high and unsustainable GP workload. This is particularly important as there is a worsening shortage of GPs.

Almost all GPs work in group practices, typically with 3-5 doctors and a similar number of practice nurses, counsellors and health advisors. Every person in the UK is registered with a GP. GPs have on average 1,700 patients registered with them, although this is very variable. They give ‘cradle to grave’ care, but their work has expanded over the last few years: in an effort to reduce healthcare costs, more and more care of chronic diseases such as diabetes, asthma, heart disease and chronic kidney disease has been transferred from specialist to primary care.

When the NHS was launched in 1948, it had a budget of £117 billion (£130 billion, £3,930 billion). Last year, the overall NHS budget was £117 billion (£3,930 billion) [1]. GP practice income is made up of a mixture of capitation fees, payments for meeting targets, and payments for meeting quality standards.

Revalidation for doctors

The General Medical Council (GMC) is a statutory independent organisation whose role is to help protect patients, and improve medical education and practice across the UK [2]. To be able to practice, all doctors in the UK must be registered with the GMC and have a licence. After extensive consultation, revalidation of all doctors every five years was introduced in 2012; in this process, all doctors have to show on a regular basis that they are up-to-date, fit to practise in their chosen field, and able to provide a good level of care. This ‘licence to practise’ is an indicator that the doctor continues to meet the professional standards set by the GMC, and it aims to give confidence to patients that their doctor is being regularly checked by their employer and the GMC. It is based on the doctor having an annual, local evaluation of their practice, called the ‘NHS appraisal’, which is based on the GMC’s guidance for doctors: ‘Good medical practice’ [3]. The appraisal and revalidation system is compulsory for all NHS doctors, whether specialist or GP, newly qualified or senior professor. It also includes doctors who are in difficult-to-reach groups, for example locums and those not in regular employment.

Each NHS clinical organisation is linked with a senior doctor, the ‘Responsible Officer’, whose role is to make a recommendation to the GMC about the doctor’s fitness to practise. This recommendation is based on the outcomes of the doctor’s annual appraisals over the five years, combined with information from the organisation’s clinical governance (quality improvement and safeguarding) systems.

The NHS appraisal system

The NHS appraisal is now a universal process for the UK’s medical profession. It looks at the doctor’s professional development, patient care and patient safety. The annual NHS appraisal meetings between the doctor and their appraiser, a trained and skilled local senior colleague, typically lasts two hours. The appraisal covers four areas of the doctor’s practice [4]:

1. Knowledge, skills and performance:
   • Maintaining professional performance
   • Applying knowledge and experience to practice
   • Ensuring that all clinical records are clear, accurate and legible
2. Safety and quality:
   • Contributing to and complying with systems to protect patients
   • Responding to risks to safety
   • Protecting patients and colleagues from any risk posed by the doctor’s own health
3. Communication, partnership and teamwork:
   • Communicating effectively
   • Working constructively with colleagues and delegating effectively
   • Establishing and maintaining partnerships with patients
4. Maintaining trust:
   • Showing respect for patients
   • Treating patients and colleagues fairly and without discrimination
   • Acting with honesty and integrity
The NHS appraisal process consists of the preparation of supporting information, the appraisal discussion itself, and the production of an individualised Personal Development Plan. These are summarised in Figure 1.

**Preparing for the appraisal**

Before the appraisal, the doctor needs to gather information about their continuing professional development (CPD) and the quality of their work over the past year. This includes six types of ‘supporting information’ (evidence) [5], and the doctor is expected to provide and discuss these at the annual appraisal:

- **Continuing professional development:** doctors need to achieve at least 50 hours of CPD a year. CPD can be reading (e.g. journals), discussions in GPs’ practices (e.g. case discussions), on-line learning and postgraduate medical education courses. GPs are encouraged to provide evidence that they have thought about, and learnt from, these.
- **Quality improvement activity:** this may be a review of a clinical case, an analysis of prescribing or of referrals to specialists, or a ‘clinical audit’ (for instance the proportion of patients with hypothyroidism who have had thyroid function tests in the last year). ‘Significant event analysis’ is encouraged: this is an analysis of something that went wrong, or could have gone wrong. Examples include: a prescribing error, a delayed cancer diagnosis, a complaint, a breach in confidentiality, or how the doctor coped with a staffing crisis.
- **Feedback from colleagues:** every five years, the doctor has to get ‘360-degree feedback’ from colleagues, using a standardised questionnaire which asks other GPs, nurses and staff for written, anonymous feedback.
- **Feedback from patients:** in this, a random sample of fifty patients the doctor has seen are given a questionnaire. This is analysed independently, and lets the doctor compare their own results with the national averages. It also encourages the doctor to reflect on their own attitudes and behaviour.
- **A review of complaints and compliments:** for example, a delayed diagnosis or a ‘thank you’ letter from a patient; this gives the doctor the opportunity to discuss these with their appraiser, learn from them, and improve their practice where needed.
- **The doctor’s written commentary:** doctors are expected to gather all this supporting evidence in an online ‘appraisal portfolio’. This portfolio usually also includes [6]:
  - A **description of the doctor’s work and working environment,** in particular any important changes since the last appraisal.
  - The **doctor’s personal development plans** from previous years’ appraisal discussions.
  - The **doctor’s written commentary** on their achievements, challenges and aspirations.
  - A **discussion of important issues affecting the doctor’s own health and/or that may put patients at risk,** for example an alcohol problem, or anything relating to the doctor’s honesty, or moral principles that relate to medical practice.
  - **Certificates from recent resuscitation and child protection update courses.**

Most GPs take about eight hours to gather the supporting information for their appraisal portfolios. While the quality of the portfolio is key to the quality of their appraisal, it is the doctor’s reflection on the information that will help the doctor and appraiser to identify of areas for development and improvement.

**The appraisal discussion**

The appraisers are experienced, respected and motivated GPs who have been on a special training course. They have regular meetings to discuss best appraisal practice and to compare their decision-making (‘bench-marking’). The appraisal discussion usually lasts two to three hours, and is confidential except in the rare cases that the appraiser identifies a serious ongoing risk to patients, or thinks that the GP is not well enough to practice. Establishing trust between the appraiser and appraised doctor is key to the success of this process. Having reviewed the doctor’s supporting information and commentary, the appraiser is able to support, guide and constructively challenge the doctor – another very important part of the appraisal process.

**The Personal Development Plan**

An important outcome from the appraisal is the doctor’s Personal Development Plan (PDP). In this, the doctor and appraiser decide on the GP’s main learning goals [7]. This is made up of at least three agreed objectives which should be about specific activities, be measurable and attainable, and include what the doctor both wants and needs to learn. The PDP document records what the objectives are, how they will be achieved (Personal study? Lecture? Discussion with colleagues?), when they will be achieved by, and any potential barriers to achieving them. Doctors know that the PDP, and evidence of completion, will be reviewed a year later: What was achieved? What wasn’t achieved, and why?

**The NHS appraisal – formative or summative?**

One controversial aspect of NHS appraisal is whether it should be ‘formative’ or ‘summative’ [8]. Should it be a way to help all doctors to improve? Or should its main aim be to identify ‘bad’ doctors?

In formative assessment, there is no ‘pass/fail’. The aim is to monitor the doctor’s learning and professional development, so that the appraiser can give feedback that helps the doctor to improve their learning and practice. It is designed to help the doctor to identify their strengths and weaknesses, discover areas that need further development, and check whether the doctor is struggling and needs extra support. In contrast, a summative approach aims to evaluate the doctor’s learning and performance, compare it with a standard or benchmark, and then give a pass/fail decision. Views about where appraisal and revalidation fit in this vary, from the management-orientated approach of those who want to use the system to ensure that all NHS doctors meet a minimum standard, to the more professionally orientated approach of those who view appraisal as a way to support all doctors in their professional development.
Оцінювання та атестація лікарів у Великобританії
Ульріке Науман, Майкл Харріс

У статті наведено огляд здобутків та проблем системи оцінювання і атестація лікарів загальної практики у Великобританії.

Ключові слова: оцінювання, атестація, лікарі, національна система охорони здоров'я, належна лікарська практика.

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