

Employer Appraisal

A Revalidation Project for the General Optical Council

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This report was commissioned by the General Optical Council to inform the development of its revalidation policy. The report examines employer appraisal schemes to assess their potential to generate evidence for registrant revalidation and possible alternatives for practitioners who fall outside established appraisal schemes.

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Executive Summary

Introduction

- The GOC is the statutory body with responsibility for regulating the optical professions. In response to a call from Government it is developing a policy for the periodic revalidation of practitioners on its register. This report concerns a project to explore employer appraisal to help inform the development of the GOC's revalidation policy. (Paragraphs 1–3)

Remit and approach

- The project was commissioned to establish whether registrants are appraised by their employers; to examine whether appraisals could contribute to revalidation and whether employer appraisal schemes could be accredited; and to identify possible alternatives for registrants who are not appraised. (Paragraph 4)
- A largely qualitative study was undertaken with data collected by means of face-to-face and telephone interview, focus group meeting, a limited review of academic and policy literature, and examination of appraisal documentation. A small-scale survey to establish the appraisal practices of universities and colleges providing education leading to registration was also undertaken. (Paragraphs 5-7)
- The informant population encompassed a broad professional and geographical spread and the main work and business categories. For the purposes of the project three main employment categories were identified for data collection and analysis: the commercial sector, the NHS, and universities and colleges. (Paragraphs 8-11)

The concept of appraisal

- To clarify terms the concept and characteristics of employer appraisal are explored and discussed. For the purposes of the study, appraisal is construed in its widest sense as any system designed to help an employer review and improve an employee's job performance. (Paragraphs 14-21)

Registrants working in the commercial sector

- The vast majority of registrants work in the commercial sector as employees or in a self-employed capacity. Many provide services on behalf of the NHS through GOS contracts. In the commercial sector appraisal policies and practices are a matter for employers to determine but appraisal is generally considered to be a matter of good employment practice and can have commercial benefits. It is also considered an essential component of effective clinical governance. (Paragraphs 22-30)
- The variety of approaches to appraisal in the commercial sector reflects the diversity in size and structure of optical businesses. Most appraisal schemes are based on an annual cycle with interim reviews. The highest level of scrutiny revealed was monthly review meetings based on direct observation of practice and an audit of case records. (Paragraphs 31-33)

- Companies with a centralised management function and clear corporate policies tend to operate a standardised approach to appraisal and achieve a high completion rate. There is greater variability in appraisal practices and completion rates in companies with distributed and devolved management structures where managers are able to exercise greater discretion. (Paragraph 34)
- Informants reported that the value of appraisal owes more to the commitment and skill of the appraiser than to the design or operation of the appraisal scheme, yet it appears that more effort is invested in refining appraisal policies and documentation than it is in training appraisers. There is little evidence that appraisal schemes are quality assured or systematically evaluated. Appraisals are often conducted by non-optimally qualified line managers, many of whom have had little or no appraisal training. (Paragraph 35-36)
- Pro-forma documentation focuses on performance in key areas such as ‘customer experience’, and/or requires an assessment against specified performance indicators such as ‘number of rechecks’, and/or statements of best practice such as ‘maintains a professional image whilst at work’. There is a strong orientation overall towards commercial performance which is also evident in criteria such as ‘conversion rate and average order value’. Some informants felt it was neither possible nor desirable to distinguish between behavioural, commercial and clinical criteria in appraisals because all were inextricably linked in a composite professional performance. In the domiciliary field in particular appraisals appear to have a stronger professional focus and in a minority of companies are conducted by registrants. (Paragraphs 37-40)
- Appraisals in the commercial sector usually comprise: a retrospective review; feedback from the appraiser; consideration of education, training and development needs; goal setting and action planning; completion of a written record of the discussion; joint ‘sign-off’; and in some cases reporting of grades and or training needs for collation or action centrally. Most have some form of rating scale and in many cases there is a link to remuneration. (Paragraph 41-42)
- It was reported that poor performance was tackled speedily when it occurred rather than being deferred until the next appraisal. Some informants observed that the limited scope of appraisals meant that a satisfactory outcome did not guarantee competence, but that other mechanisms such as spot checks of records, complaints analysis, and the use of ‘mystery shoppers’ were used to identify poor performance. (Paragraph 43)
- Some of the larger independent practices operate appraisal schemes but appraisal is much more of a rarity in this part of the sector. In smaller practices appraisal is considered unnecessary because employees are given feedback on their job performance as and when it is required, and because there is little prospect of supported development or of career or pay progression. (Paragraphs 44-47)
- Self-employed locum practitioners were considered to be a particular challenge in terms of maintaining quality because they escape appraisal and close scrutiny. Informants conceded that poor practice was rarely tackled because the easiest option was to avoid re-engaging a locum whose performance or conduct was questionable. Concern was expressed that some locums worked too few hours to guarantee continuing competence which some informants felt justified setting a minimum number of hours for revalidation. Some employers had in the past appraised their regular locums but did not do so now because they had been advised that HMRC could construe it as evidence of a contract of employment. (Paragraph 48-51)

- With notable exceptions, most employers were reluctant to consider amending appraisal schemes to accommodate additional elements for revalidation. Concerns were raised about feasibility, costs and time. Some objected to the underlying assumption that revalidation was a matter for employers, asserting that it was for the regulator to assure employers that a registrant was competent and fit to practise. Appraisal was considered to be part of a contract between employer and employee which should not be hijacked for regulatory purposes. (Paragraphs 52-53)
- The appraisal schemes examined vary in scope and content. While fit for the purpose for which they were designed, on the whole they do not deliver the standardised, valid and reliable evidence which it is envisaged will be required for revalidation. Professional practice is also scrutinised through methods such as 'safe and legal' checks, audits of case records and complaints analyses, which tend to be the principal means by which poor practice is identified and tackled. (Paragraphs 54-57)

Registrants working in the NHS

- In contrast to the commercial sector registrants in the NHS are employed on national terms and conditions of service. These include an annual appraisal in the form of a development review based on the national Knowledge and Skills Framework (KSF), culminating in a personal development plan. Pay progression is linked to a satisfactory review at two critical points (gateways) on each pay scale. The KSF provides a comprehensive but demanding framework for appraisal. (Paragraphs 58-67)
- Despite its status as a mandatory element of a national pay agreement, there is evidence that the KSF review has not been universally adopted as intended. Recent external reviews have raised questions about progress implementing the KSF and about its complexity as a tool for annual development reviews. NHS employed optical staff report varying experiences, with some indicating that they have not been appraised for several years. Some informants questioned the relevance of the KSF to optical roles, suggesting that it was too generic, and highlighted how time-consuming it was for both reviewer and reviewee; others reported having found it a helpful tool. KSF based development reviews are often undertaken by non-optical line managers, calling into question their ability to make judgements about the professional dimension of a registrant's practice. (Paragraphs 68-74)

Registrants employed by universities and colleges

- Registrants in academic roles represent a small minority of the registrant population but occupy influential positions as role models and professional experts. Registrant academics are united by a common educational purpose but undertake a variety of roles which, for some, includes an element of clinical practice. (Paragraphs 75-78)
- All universities and colleges surveyed operate appraisal schemes. As autonomous bodies each has its own scheme but they are similar as regards content and process. They are designed to apply to all academic staff irrespective of discipline or profession so are generic in nature, focusing on academic role functions such as teaching, research and educational management. They do not cover registration competencies sufficiently to provide an assessment of continuing competence and fitness to practise. There is no integrated appraisal scheme to take account of clinical work as there is for medical academics. Most registrant academics are appraised by

line managers who do not share the same disciplinary or professional background. (paragraphs 79-84)

General issues

- Informants raised a number of general issues about revalidation, especially in respect of alternatives to appraisal, concluding amongst other things that: continuing education and training should count towards revalidation but current requirements should be strengthened to make CET more challenging and to promote interaction with professional peers; evidence for revalidation should focus only on a registrant's current field and scope of practice; and that it would be unrealistic to require observation of practice as a routine component of revalidation, but that it should be reserved for the final stage in the process if there are doubts about a registrant's continuing competence. (Paragraphs 91-102)

Doctors, dentists and other health professions

- Some health professions regulators have published their revalidation plans which could be helpful in resolving a GOC revalidation policy. For example, appraisal is to be at the heart of revalidation for doctors, but the GMC will rely on 'Responsible Officers' located in NHS Trusts to assess a doctor's fitness to practise and to make recommendations to it about revalidation. Efforts are underway to enhance the appraisal of doctors within the NHS and a comprehensive quality assurance framework has been proposed to help guarantee appraisal standards. (Paragraphs 104-114)
- For dentists, the GDC anticipates using a variety of sources of evidence for revalidation, including appraisal, but it will not be compulsory. The General Osteopathic Council has consulted on detailed proposals for its registrants which rest on self-assessment and self-declaration, citing appraisal as one source that might be used as evidence of employer feedback. Other health professions regulators have yet to publish detailed plans. (Paragraph 115-128)

Conclusions

- The majority of registrants employed in larger optical companies are appraised by their employers but appraisal policies and practices vary, in part as a consequence of different organisational and management structures. Appraisal schemes are much more of a rarity in smaller independent practices. Registrants employed in the NHS are subject to annual KSF development reviews but there is evidence that the practice is not universal. The majority of registrants employed in universities and colleges are appraised but the focus is on academic responsibilities. An unknown number of self-employed and locum registrants are not subject to appraisal. (Paragraphs 129-134)
- Most employers that operate appraisal schemes have detailed appraisal policies and pro-forma documentation; most follow a similar review process; and most document appraisal action plans. However employer appraisal schemes have a number of limitations that might be considered to undermine their value as a source of evidence for revalidation, including poor validity, low inter-appraiser reliability, completion by non-optimally qualified appraisers, inadequate appraiser training, the inconsistent application of policies, underdeveloped quality assurance, complexity, and a tendency to norm-referencing. (Paragraph 136)

- These limitations are important if appraisal is to become a mandatory source of evidence for revalidation and if appraisal schemes are to be accredited, but they are less significant if appraisal is construed as an individualistic event signifying independent scrutiny of job performance, personal reflection on professional practice and development planning. If appraisal is to be a discretionary source of evidence, registrants could choose to cite evidence from appraisals in support of an application for revalidation; they might also cite the fact that regular appraisal has occurred as evidence of regular scrutiny. Evidence might therefore be *from appraisal and/or of appraisal* (Paragraphs 137-139)
- With notable exceptions the majority of employers were reluctant to commit to making any amendments to their appraisal schemes to accommodate additional requirements for revalidation. Objections concerned practicalities such as the additional costs and time associated with a more rigorous professionally-focused review, and philosophical concerns about the intrusion of professional regulation into the employer-employee relationship. Negotiating amendments to well-established appraisal schemes in any of the employment sectors reviewed would be a substantial undertaking. (Paragraphs 140-142)
- Accrediting employer appraisal schemes would require clarification of a statutory or other mandate, an estimate of costs (relative to benefits), policies concerning the accreditation process, and a set of standards against which to judge appraisal schemes. Standards developed for medical appraisal could provide a useful blueprint. However it is not clear how accreditation could be made mandatory, but nor is it certain that employers would have sufficient incentive to submit to a voluntary scheme. (Paragraphs 143-147)
- A number of alternative mechanisms might be used to enable registrants who are not appraised to gather and furnish evidence equivalent to that available to registrants who are appraised, but all the methods elaborated have cost implications. Furthermore, in the interests of equity, if adopted the methods would need to be open to all registrants irrespective of their employment status. (Paragraphs 148-150)
- Based on an analysis of the findings, and drawing on the observations informants made about wider aspects of revalidation, recommendations have been submitted to the Revalidation Workstream Group for its consideration. (Paragraph 151)

Introduction

1. The General Optical Council (GOC) is the statutory body with responsibility for regulating the optical professions. Its aim is to protect the public by setting and promoting high standards of education and conduct. Together with the bodies that regulate the other health professions, the GOC has been asked by Government to develop proposals for the periodic revalidation of the practitioners on its register.¹
2. The GOC has indicated that it is committed to developing a revalidation scheme for its registrants that is risk-based, targeted and proportionate. The scheme is to be designed to sustain, improve and assure the professional standards of optometrists and dispensing opticians, as well as to identify and address poor practice.
3. The GOC has recently concluded a consultation which sought views about its initial proposals for a scheme of revalidation.² It has also commissioned additional work to further inform development of its policy. This report addresses one strand of that additional work by examining the potential contribution of employer appraisal schemes and possible alternatives for practitioners who are not appraised.

Remit and approach

4. The project was commissioned to:
 - establish whether registrants are appraised by their employers;
 - examine the frequency, nature and content of appraisals to assess whether they could provide evidence for revalidation;
 - determine whether employers would be willing to adapt appraisal schemes to do so, and to make recommendations about how such schemes might be accredited;
 - make recommendations about alternative mechanisms for registrants who fall outside established appraisal schemes.
5. It was judged that the aims of the project were best served by an exploratory study of a largely qualitative nature. Data were collected principally by means of face-to-face and telephone interview, focus group meeting, web search, a limited review of relevant academic and policy literature, and examination of appraisal documentation. In addition a small-scale email survey was undertaken of universities and colleges that provide education approved by the General Optical Council.
6. Interviews were conducted using a schedule detailing areas for exploration, rather than a highly structured survey questionnaire. In practice the schedule was used

¹ See the 2007 White Paper: *Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century* (Cm 7013), and the 2008 publication from the Department of Health: *Principles of Revalidation: Report of the Working Group for Non-medical Revalidation*.

² The General Optical Council consultation document – *Revalidation: initial consultation* – set out initial proposals based on a preliminary report from the Revalidation Workstream Group. The consultation closed on 25 September 2009.

flexibly to respond to the diversity of informant experience encountered. In addition to being invited to provide factual information and to talk about their experience of appraisal, informants were also asked for their views and opinions about whether and how appraisal – or an alternative form of review – could contribute to revalidation.

7. Professional associations and representative bodies were consulted to elicit their views and opinions, and also to invite recommendations about potential informants (to whom they also helped negotiate access). The range of informants required for the study was achieved by seeking further suggestions from initial contacts, then by searching for potential informants for categories that were poorly represented, to whom direct approaches were then made (a survey method known as snowballing).
8. The sample population is not representative in a statistical sense but the informants consulted encompass a broad professional and geographical spread and the main work and business categories. A number of informants were also able to refer to the experience of the wider profession through their involvement with larger groups and fora. The nature of careers in the optical profession is such that many informants had experience of working in a number of different employment situations and were keen to talk about those experiences as well as the primary reason they had been approached.
9. Informants were given an undertaking that nothing reported would be attributed to, or easily identifiable as coming from, a particular individual or company. This transpired to be very important for a minority of informants, particularly those operating in an especially competitive commercial environment, but for many the issue of anonymity was of no particular significance. However some organisations were reluctant to disclose primary documentation and others did so on the understanding that it would not be reproduced in this report. A list of informants who contributed to the project – and to whom the author is indebted for their time and candour – is provided in the appendices.
10. Appraisal usually occurs in managed work environments and is associated with an employer-employee relationship, but there is no authoritative source of data that provides a comprehensive and accessible account of the numbers of registrants in each type of employment or work setting. For the purposes of this project three main work settings were identified as providing the most coherent categories for an examination of appraisal practices, each sufficiently distinctive to be studied and reported separately. The categories are:
 - registrants employed by or working in the commercial sector, a category which comprises several further sub-divisions, including owner-practitioners and the self-employed;
 - registrants employed by and working in the National Health Service;
 - registrants employed by universities and colleges.
11. It is important to stress that these categories provide a working research and reporting framework to help distinguish different approaches to appraisal. The categorisation should not be taken to imply that all registrants fall neatly into one or other category; some practitioners occupy roles in more than one category simultaneously, and many move between categories during their careers.

Structure of the report

12. The report starts with a brief overview of the concept of appraisal to clarify terms and to provide context. This is followed by sections that report findings about appraisal policies and practices in different work settings. The report of findings for each category is prefaced with a short account of the nature of the workforce and employment in that sector. This is followed by an explanation of the extent and type of appraisal undertaken and a brief commentary on points of relevance to its potential role in revalidation. A section dealing with general issues independent of employment category completes the report of fieldwork findings.
13. To place the findings into the wider regulatory context, an examination of the revalidation policies being proposed by other health professions regulators follows. This and the preceding sections then inform a response to the questions posed in the project remit by way of conclusion.

The concept of appraisal

14. The term appraisal refers to the process of identifying, observing, measuring and developing human performance in organisations.³ Appraisal is recognised as a powerful management tool in which employees get regular feedback about their performance and how to improve it, in which managers and their staff work together to set goals, identify training needs and discuss career opportunities, and through which managers gain insight into different jobs, fostering better working relationships.⁴ In the NHS implementation of staff appraisal has been cited as a 'high impact' human resource change,⁵ and in the business world appraisal has been identified as having a positive impact on the performance of large businesses accredited as *Investors in People*.⁶ In short, appraisal is used to enhance the value of human capital; often an organisation's most costly and important asset.
15. A frequently stated purpose of appraisal is to help employees to identify and improve their strengths and to minimise their weaknesses. It is the developmental purpose of appraisal that is most often cited by human resource experts, a focus reflected in policies which emphasise opportunities and support for personal growth. Yet increasingly appraisal is linked to pay and reward. In this respect the terms 'performance appraisal', 'performance review' and 'performance evaluation' are used to describe a process that is fundamentally the same but which emphasises assessment of an employee's contribution to the organisation as the core purpose. Policies based on this construction often refer to the alignment of an employee's objectives with those of the organisation and to their contribution to the delivery of key performance outcomes. In practice the two conceptions are

³ Cardy R L and Dobbins G H, *Performance Appraisal*, in Cooper, C L (Ed). The Blackwell Encyclopaedia of Management, Blackwell Reference Online, accessed 17 October 2009:

http://www.blackwellreference.com/public/book?id=g9780631233176_9780631233176

⁴ Montague N, The Performance Appraisal: A Powerful Management Tool, *Management Quarterly*, Summer 2007, pp 40-53.

⁵ One of ten high impact changes associated with good human resource management practice and the positive impact this has been shown to have on indices of patient mortality (see: *National Framework to Support Local Workforce Strategy Development*, Department of Health, 2005).

⁶ Bourne M, et. al., 2008, *The Impact of Investors in People on People Management Practices and Firm Performance*, Centre for Business Performance, Cranfield School of Management, Cranfield University.

often conflated in appraisal guidelines, leaving line managers with the task of reconciling potentially competing aims in the same scheme.

16. The content of appraisal schemes and the processes followed vary in their detail but most conform to a number of common characteristics. Based on a set of key elements advanced by the Chartered Institute of Personnel and Development,⁷ these characteristics include the following:
- measurement – which involves assessing performance against agreed targets or objectives and may involve the use of numerical and other ratings scales (and in some cases forced ranking systems);⁸
 - feedback – providing information to the individual on their job performance and progress, which increasingly draws on multiple sources of information (including the techniques of peer appraisal and 360 degree feedback,⁹ which are now frequently cited as methods for generating a more rounded evidence base);
 - positive reinforcement – emphasising what has been done well and making only constructive criticism about what might be improved, (implying the need for a high level of interpersonal skill on the part of the appraiser and a fundamentally positive relationship between appraisee and appraiser);
 - an exchange of views – a frank discussion about what has happened, how the appraisee can improve their performance, the support and coaching they need from managers to achieve this, and their aspirations for their future career;
 - agreement – jointly reaching an understanding about what needs to be done to improve performance generally, and to overcome any issues raised in the course of the discussion, often formalised in specific (measurable) objectives and a personal development plan.
17. The plethora of books about how to conduct appraisals that populate the management shelves of most bookshops suggests the ubiquity of appraisal as a management tool in contemporary business, but also highlights how difficult it is for appraisers to do well.¹⁰ The CIPD makes the point that there is no single correct way to conduct appraisals, describing a constructive appraisal meeting as one where:
- the appraisee does most of the talking and the appraiser listens actively to what is said;
 - there is scope for reflection and analysis of performance, but not personality;
 - the whole period is reviewed, not just recent or isolated events;
 - achievements are recognised and reinforced;

⁷ CIPD, Performance Appraisal, (Revised February 2009) accessed October 2009: <http://www.cipd.co.uk/subjects/perfmangmt/appfdbck>.

⁸ It has been suggested that forced ranking systems using a bell curve to eliminate marginal performers can lead to widespread discrimination. See for example: Murphy T H and Margulies J, *Performance Appraisals*, ABA Labor and Employment Law Section Equal Opportunity Committee, March, 2004.

⁹ Peiperl M, Getting 360 degree feedback right, *Harvard Business Review*, January 2001, pp142-147.

¹⁰ For a typical example of tools and tips see: Langdon K and Osborne C, 2001, *Appraising Staff*, London, Dorling Kindersley.

- the meeting ends positively with an agreed action plan.
18. The CIPD contrasts this characterisation with a sketch of the bad appraisal meeting: one that focuses on a catalogue of failures and omissions, is controlled by the appraiser, and ends with disagreement. In reality because many employees are not trained to undertake rigorous self-assessment, and because many managers have not been trained to appraise, the practice of appraisal falls somewhere between these two characterisations. It has been observed that appraisals rarely seem to achieve the improvements intended and that this tends to provoke human resource experts to revise appraisal policies – usually resulting in more structure, more process and more paperwork – which although intended to help, baffles and alienates both managers and employees.¹¹ It is said that organisations should empower managers to deliver the standards required and resist the temptation to dictate structure and process.¹²
 19. The process is nevertheless important, not least because of the legal considerations that have to be addressed when designing and operating an appraisal scheme – including issues such as confidentiality, data protection, race relations, sex discrimination, disability discrimination, and the need to ensure that appraisal is not used as a disciplinary mechanism to deal with unsatisfactory performance. For the employer keen to get it right, the challenges of both designing and operating an appraisal scheme are addressed comprehensively in a publication produced by the Advisory, Conciliation and Arbitration Service.¹³
 20. The concept of appraisal appears to be regarded as unproblematic in health professions regulatory policy since neither the White Paper¹⁴ nor the position statement on non-medical revalidation¹⁵ defines appraisal. Both documents refer to appraisal liberally throughout but say no more than that, as far as revalidation is concerned, appraisal should comprise both a summative assessment (looking back to assess whether performance has met specific standards) and a formative assessment (looking forward to any changes that might need to be made).
 21. For the purposes of this study appraisal is construed in its widest sense – as any system designed to help an employer review and improve an employee's job performance.

Registrants working in the commercial sector

22. The vast majority of practitioners registered with the General Optical Council work in the commercial sector.¹⁶ They may be employed or self-employed, work in independent practices, in branches of retail multiples, or in companies providing domiciliary services. Some registrants own or part own optical businesses, others occupy management or professional roles in the regional offices and headquarters of the larger optical companies. A small number are employed by professional and representative bodies.

¹¹ Goodge P and Coomber J, How to improve appraisals, *People Management*, 29 January 2009, p 57.

¹² Ibid.

¹³ Advisory, Conciliation and Arbitration Service, 2008, *Employee Appraisal*, London, ACAS.

¹⁴ Op cit (footnote 1).

¹⁵ Op cit (footnote 1).

¹⁶ Subtracting estimates of the number of registrants employed in the NHS and academia from the total number of registrants, suggests that the percentage employed in the commercial sector is in excess of 85%.

23. An unknown number of self-employed registrants work partly or wholly in a locum capacity, not least because a relatively flat career structure coupled with significant opportunities for flexible and part-time working enable practitioners to vary their working patterns during their professional lives, and to move in and out of practice with comparative ease. In short, the employment status of registrants and the settings in which they work are many and varied.
24. Terms and conditions of employment in this sector tend to reflect labour market demand and supply. For example, in addition to a competitive salary many employed registrants benefit from financial support to cover expenses such as registration, membership of professional associations, and continuing education and training, which are provided by companies that wish to remain attractive to potential employees. Appraisal is rarely mentioned in recruitment and publicity material but some form of development review can be inferred from the many references to support for continuing education and training and professional and career development – inducements cited by employers keen to attract the best applicants.
25. Optical companies have considerable scope to adopt human resource policies and practices that are commercially most advantageous to them (employment and other legislation notwithstanding), and are largely responsible for the quality of the services they provide (subject to regulatory requirements concerning matters such as health and safety or the employment of staff exercising protected functions). Employee appraisal is generally considered to be a matter of good employment practice – and is a key indicator in quality standards such as *Investors in People* – so it is not surprising that some form of individual performance review appears to be commonplace in larger companies, not least because the personal contribution of employees and their development and job satisfaction are inextricably linked to commercial success. However it appears that in smaller independent practices formal appraisal schemes are much less common, not least because they are more difficult to operate or are considered unnecessary where small teams work closely together on a day-to-day basis.
26. Around 10,000 commercial sector optometrists provide NHS services¹⁷ under General Ophthalmic Service contracts.¹⁸ Of nearly 20 million sight tests conducted each year nearly 14 million are for the NHS, of which around 3% are undertaken during domiciliary visits.¹⁹ The General Ophthalmic Services contract imposes a number of obligations on contractors to meet certain standards, but it is only recently that recommendations have been made about appraisal in a review of local processes to identify and deal with concerns over the performance and conduct of healthcare professionals.²⁰ The review recommends that before admitting a practitioner to its Performers List (an arrangement only recently extended to general ophthalmic services), a Primary Care Trust “should normally ensure that there is a satisfactory and complete record of appraisals” (p15). The

¹⁷ This figure is taken from the NHS Information Centre for Health and Social Care publication *General Ophthalmic Services: Workforce Statistics for England and Wales 31 December 2008*, and is a summation of figures for England and Wales, less the number of ophthalmic medical practitioners. There is no recent comparable data in the public domain for Scotland (although figures for the year 2000 report 1252 ophthalmic opticians), or for Northern Ireland.

¹⁸ The purpose of General Ophthalmic Services is to provide – through community opticians’ practices – preventative and corrective eye care for children, people aged 60 and over, people on low incomes, and those suffering from or pre-disposed to eye disease.

¹⁹ Figures cited by the Federation of Ophthalmic and Dispensing Opticians in *Optics at a glance 2008*.

²⁰ *Tackling Concerns Locally – Report of the Working Group*, Department of Health, March 2009.

corollary is that once a practitioner is admitted to a Performers List, the PCT “should promote access to training, appraisal and where necessary remediation and reskilling” (p3).²¹

27. In contrast to the more general construction of employee appraisal as a technique associated with human resource management, the *Tackling Concerns Locally* report construes appraisal as a tool to promote quality, locating it under the umbrella of clinical governance. The report acknowledges that not all components will apply to healthcare professionals who work outside the clinical governance structures typical of managed environments. Recognition of the difference between hospital and community based services will no doubt be welcomed by the contractor professions, but guidance developed and promulgated jointly by the professional and representative bodies suggests an established commitment to meeting clinical governance standards.²²
28. A checklist in *Quality in Optometry*²³ developed to help ophthalmic practices assess themselves against the national core and developmental standards for health²⁴ includes the following criteria:
 - the operation of an appraisal system for all staff;
 - a designated member of staff responsible for appraisal and training; the recording of continuing education and training and continuing professional development; and
 - personal development plans for all clinical staff.
29. Judging by informant responses in this study, use of the framework is variable. While none of the informants spontaneously referred to it, when prompted many were aware of it or had used it, and a minority reported having found it extremely helpful. It is likely to be of even greater use as contract compliance arrangements are introduced, suggesting that in future greater attention might be given to the criteria concerning appraisal.
30. In summary, it can be said that employee appraisal is generally regarded to be a matter of good employment practice and can also have commercial benefits. It is also cited as an essential component of clinical governance and is regarded as an important feature of ophthalmic practices contracted to deliver services on behalf of the NHS.

Appraisal policies and practices

31. Evidence about past and current appraisal practice was collected from a wide range of informants through individual and group interviews. Employed optometrists, dispensing opticians, and contact lens opticians reported their experiences of being appraised in a variety of employment settings. Independent practice owners (the majority were also registrants) provided information about

²¹ *Tackling Concerns Locally: Performers List System – A review of current arrangements and recommendations for the future*, Department of Health, March 2009.

²² *Quality in Optometry: A Toolkit for Clinical Governance in Optometric Practice*, February 2007, Version 1.0, developed and published by the Association of Optometrists, the Association of British Dispensing Opticians, the College of Optometrists, and the Federation of Ophthalmic and Dispensing Opticians.

²³ *Ibid.*

²⁴ *Standards for Better Health*, 2004 (updated 2006), Department of Health.

whether and how they appraise their staff. They also offered their views and opinions about what they considered feasible for the future. Professional advisors, directors and other senior officers and representatives of a number of the larger multiples provided information about their policies and practices, and they too offered views and opinions about revalidation and what mechanisms would be both practicable and acceptable to larger employers.

32. Appraisal documentation was requested where appropriate, particularly from the larger companies that operate corporate appraisal schemes. Some were willing to share sample documents in confidence for the purposes of this review but it is noteworthy – yet understandable – that many commercial organisations do not routinely publish or share corporate documentation. This raises questions about whether a predisposition towards commercial confidentiality could impede attempts to accredit appraisal schemes (if the GOC were to adopt this approach to revalidation).
33. The variety of approaches to appraisal revealed during this study reflects the diversity in size and structure of optical businesses in the commercial sector. Nevertheless some generalisations are possible to illustrate the more important similarities and differences. For example, almost without exception informants who reported having an established appraisal scheme said that it was based on an annual cycle, often with interim reviews. One company that operates an unusually rigorous clinical governance regime undertakes monthly face-to-face reviews based on observation of practice and an audit of case records. Other informants, particularly those in smaller independent practices, report a much less uniform picture with appraisals occurring on a more informal basis, if at all; and even in the larger companies appraisal policies and practices vary, in part as a result of different organisational and management structures.
34. Companies with a centralised management function tend to have well established appraisal policies and practices that apply to all staff. The corporate ethos, performance management culture, and standardised approach to appraisal provides a strong incentive for local managers to ensure that appraisals are completed to time, enabling companies in this category to have confidence that all their employees undergo regular appraisal. In contrast, informants from companies with a distributed management structure, such as venture partnerships and franchises, espoused a standardised approach to appraisal – and in some cases referred to the availability of central advice and support and to the provision of templates for local use – but indicated that they were inclined towards a light touch as regards frontline operations, devolving greater responsibility to local directors, partners or store managers. Judging by the experiences reported by both senior and frontline staff, it appears that in this type of business appraisal practices can be much more variable within the same organisation. It would therefore be more difficult for companies of this type to say with any confidence that all the staff employed in their branches were appraised regularly or to a common standard.
35. Where appraisal practices are standardised and ubiquitous, the reported experience of appraisees is nevertheless mixed, and tends to confirm what many informants in this study said: that the value of appraisal owes more to the commitment and skill of the appraiser than it does to the design or operation of the appraisal scheme. Yet, paradoxically, greater management effort appears to be spent refining appraisal policies, pro-forma and rating scales than it does to training appraisers. Whether the frequent reinvention of appraisal policies and documentation improves the process for appraisees is difficult to judge, not least

because during this study little evidence was found of individual appraisals being quality assured for consistency or of appraisal schemes being evaluated systematically.

36. Appraisals are often conducted by a general (non-optical) or store manager, but in most cases there are also headquarters or regional professional staff to whom general managers can turn for advice and guidance if it is needed, particularly if performance or professional education and training issues arise. Only a small minority of informants reported having had appraisal training and some implied that it was a skill that was just assumed of anyone who took on a management role. However appraisals conducted by non-optical managers in large companies were thought by some informants to have been undertaken by appraisers who had received general management training. Some independent practice owners/managers highlighted how challenging it was for them to conduct appraisals in the absence of any management training whatsoever, or in many cases any personal experience of ever having been appraised.
37. Where it has been developed centrally, pro-forma documentation tends to be generic. It usually revolves around a review of performance in key areas (for example 'customer experience' or 'communication'), and/or requires an assessment against specified performance indicators (for example 'number of rechecks') and/or statements of best practice (for example 'maintains a professional image whilst at work'). In many cases there is a strong orientation towards commercial performance in terms of the nature of review criteria (for example 'conversion rate and average order value') and in the relative emphasis given to commercial dimensions in the appraisal overall. An overview of areas commonly appearing in the appraisal documentation reviewed, with composite illustrative criteria, appear in Box A.
38. In some instances standard operating procedures, guidelines, or evidence from 'safe and legal' audits enable appraisers – especially non-optically qualified managers – to question aspects of professional practice, even if they do not fully understand all the implications of doing so. For example a performance indicator such as 'number of complaints' provides an explicit measure of professional performance easily understood by a non-optical appraiser, but it may require intervention by a professional adviser to assess whether or not the action taken by the appraisee to remedy the underlying problem was consistent with established clinical and professional standards.
39. In some cases pro-forma documentation encompasses a professional practice dimension but this is often limited in scope, serving only as a very general proxy assessment of clinical competence. However some informants were keen to assert their view that it was neither possible nor desirable to distinguish between behavioural, commercial and clinical criteria in appraisals because all were inextricably linked in a composite professional performance. Some informants conceded that under their schemes it would be possible for a practitioner to be appraised as having performed well on commercial grounds yet at the same time for poor clinical practice to go unnoticed, but most were confident that clinical deficiencies would be revealed in other ways, for example through audits of patient records.

Box A: Examples of areas typically reviewed in appraisals

Customer experience	<ul style="list-style-type: none"> - minimizes waiting times - places customer at ease - ensures clinics do not overrun - deals with questions and concerns promptly and accurately
Complaints	<ul style="list-style-type: none"> - deals with complaints promptly and efficiently - resolves complaints at source - works to avoid escalation - identifies and deals with issues underlying regular complaints
Promoting services	<ul style="list-style-type: none"> - actively promotes services offered from within consulting room - delivers strong conversion rate - achieves high average order value
Communication	<ul style="list-style-type: none"> - interacts well with patient - listens to customers and colleagues - gives competent handovers
Teamworking	<ul style="list-style-type: none"> - actively involves self in team - supports colleagues needing assistance - works in shop floor to help team when not with customer
Professional skills	<ul style="list-style-type: none"> - consulting room maintained as effective clinical environment - appropriate professional image and appearance maintained - meets appropriate hygiene standards - completes examinations within time allocated - record cards are clear, accurate and complete - satisfies (and has signed) standard operating procedures
Finance	<ul style="list-style-type: none"> - meets sales targets - number of rechecks - controls costs - minimises wastage - accounts for expenditure
Keeping up-to-date	<ul style="list-style-type: none"> - ensures professional and commercial knowledge is up-to-date - undertakes required continuing education and training

40. In other cases, particularly in the domiciliary field²⁵ or where there is a developed regional professional structure, appraisals have a stronger professional focus and

²⁵ Appraisal by fellow registrant (rather than general manager) appears to be more prevalent in the domiciliary field where assuring quality standards is considered to be especially important, not least because it involves lone working, entering patient's homes, and dealing with potentially more challenging patients, all of which require experienced registrants with well-developed clinical, professional, communication and interpersonal skills.

in a minority of companies are conducted by senior optometric staff (sometimes in parallel to a review of a more commercial nature by a general manager). In many cases appraisals also include – or are supplemented by – an audit of case records. Some schemes use comprehensive audit pro-forma with scoring systems requiring a judgement about the level and quality of information recorded against each criterion assessed. On a more general point, the concept of retrospective records audit – rather than direct observation of practice in real time – was reported by many informants as the principal means by which they assure quality and the mechanism through which they would identify poor practice.

41. In contrast to appraisal criteria, which are usually explicit, the process of appraisal is not always spelt out (at least in the guidance documentation that was reviewed for this study). The stages described below have been inferred from the pro-forma documentation that has been examined and from the descriptions of process recounted by informants. In essence, appraisals in the commercial sector usually comprise:
- a retrospective review of actions arising from the previous appraisal, and consideration of evidence or examples generated by both appraisee (in some cases as a comprehensive self-assessment) and appraiser, related to the criteria, key results areas or indicators in pro-forma documentation;
 - feedback from the appraiser on appraisee performance over the year (both strengths and weaknesses), especially in respect of company or departmental performance indicators or key results areas;
 - consideration of any education, training or development needs arising, the opportunities for satisfying them, and the nature and extent of support or coaching required;
 - goal setting and identification of any actions to be taken in the coming year, with target dates;
 - completion of a written record of appraiser comments and agreed actions in free text, and completion of grading boxes (some schemes also permit free text comments by the appraisee);
 - joint sign-off;
 - and in some cases, reporting of grades and/or training needs to a central management, finance, human resource or training function.
42. Most appraisals in larger companies include some form of rating or traffic light system to denote overall performance. In some cases this is pay-related, usually in the form of a share of any bonus attributed to the appraisal grade or rating achieved. Where there is a link to remuneration managers are usually obliged to arrive at a spread of overall appraisal grades (to satisfy financial quotas for each band),²⁶ but not necessarily as a normal distribution because it is generally understood that registrants rarely fail to satisfy minimum performance standards and are not expected to appear in the lowest band.

²⁶ There is therefore a degree of norm-referencing (and the potential for discrimination – see footnote 8) which raises questions about the utility of appraisal for revalidation.

43. A number of informants were at pains to point out that poor performance was tackled speedily when it occurred, if necessary through disciplinary policies and procedures, and that problems were never left to emerge only during an annual appraisal. Some informants observed that the limited scope of appraisals meant that a satisfactory outcome did not guarantee competence, but that other mechanisms were in place – such as spot checks of records, analysis of complaints, and the use of ‘mystery shoppers’ – to identify poor performance.

Independent practices

44. Some of the larger independent practices report operating an appraisal scheme, and in some cases to having a designated member of staff to take the lead on appraisal and related practice-wide responsibilities such as training and the assessment of trainee dispensing opticians. One informant cited the appointment of a business manager with general management experience as the catalyst for adoption of an appraisal scheme, and another referred to human resources advice and support that had been provided by ABDO to help it develop staff appraisal. Another informant indicated that a human resource specialist was used on a sessional basis, partly to help develop an appraisal scheme and then to support the practice owner in carrying out appraisals. The involvement of an independent expert was considered especially helpful in guaranteeing fairness and in demonstrating to employees, with whom the owner worked closely on a day to day basis, that appraisal would be impartial. Nevertheless the overall impression gained from most informants who had experience of running or working in independent practices was that initiatives of this sort are atypical.
45. Formal appraisal systems are far less common in smaller practices, not least because appraisal is regarded as rather artificial where very small teams work closely together on a daily basis. Some informants said that smaller practices – particularly those outside metropolitan areas – often enjoy stable staffing and tend to employ only a handful of staff for whom appraisals have little relevance (because there is no prospect of bonuses, development plans or career progression) and because performance issues are dealt with if, as and when they occur.
46. In a case where an optometrist and dispensing optician were in partnership (apparently a common business model) informants said they implicitly trusted the other to perform to an appropriate standard but conceded that neither observed nor reviewed the other. This reflects the high level of intra-professional trust some informants said was commonplace in small practices.
47. Overall the impression gained from both employer and employee informants was that far fewer employees are appraised in independent practices than are in the larger companies, and that independent practices rely much more on being able to give employees informal feedback on a continuous basis as and when it is required. A striking but perhaps not surprising finding was the number of registrant informants who reported that they had never been appraised, observed, scrutinised or reviewed during many years of professional practice.

Locum practice

48. Self-employed locum practitioners were cited by many informants as presenting a particular challenge in terms of maintaining quality standards. In some cases companies appear to rely heavily on locum staff to maintain service levels, but in others they are used infrequently or not at all. Some informants reported long-

standing and entirely satisfactory associations with locum staff who had become indistinguishable from employees (save for the nature of their contract). However the general tenor of informant experiences and opinion was that locum staff represented the greatest risk to standards because they escaped appraisal or close scrutiny and tended to move – or be moved on – quickly if any doubts arose about their conduct or performance. A numbers of informants admitted that they had used locums who they would not re-engage, admitting that poor performers tended to be passed on to become someone else’s problem in another practice.

49. Some employers had in the past – and would again – appraise their regular locums and offer them training and support, but said they could no longer do so because Her Majesty’s Revenue and Customs construed this as evidence of a contract of employment, calling into question the locum’s self-employed status and rendering the ‘employer’ liable for employment costs. One of the reasons the issue was raised was because of a general perception that the proportion of locums who had been out of practice, or who had worked only infrequently, appeared to be growing (it was said particularly because the flexible working patterns enjoyed by the optical professions were attractive to practitioners with young families). It was asserted that practitioners who worked infrequently would benefit from the training and support some practices and companies were willing – but unable – to provide. A number of informants made the point that there should be a threshold set specifying the minimum number of examinations to be undertaken or hours to be worked in the period preceding an application for revalidation.
50. A minority of the informants who raised concerns about the quality of locum staff, and who suggested that poor performance was over-represented among self-employed locums, conceded that they too had worked or were working as a locum in addition to their main employment, citing their regular employment as the factor that distinguished them from the negative stereotype of locums they otherwise advanced.
51. Some informants highlighted the problems they had encountered as locums in being expected to work in poorly equipped and badly managed practices. They said this could impact on the quality of their work and were keen to ensure that situations of this sort should not be allowed to influence decisions about revalidation.

Willingness to amend appraisal schemes

52. In the absence of a definitive statement of the evidence that would be required for revalidation, some informants were reticent about committing to anything, and with a couple of notable exceptions, the majority of informants expressed a reluctance to consider amending their appraisal schemes to accommodate the additional elements that might be required for revalidation, citing both practical and philosophical objections. As to the former, a number of informants said that assessing competencies and making a judgement about continuing fitness to practise would require that appraisals be conducted by another registrant, which for many businesses was simply not feasible. Documentation would need to be amended, for example by the insertion of an additional schedule of appraisal criteria focusing on core competencies, and as a consequence would extend the time taken to conduct an appraisal, something most informants said their company would not be willing to countenance.

53. A number of informants expressed a strong objection to the underlying assumption that revalidation was a matter for employers, asserting that it was in fact for the regulator to assure the employer that a registrant was competent and fit to practise. A number argued that appraisal was part of a contract between employer and employee, and that it should not be hijacked for regulatory purposes. Several made the point that the registration and criminal records checks they carry out currently, should be sufficient to provide the assurances they need that a practitioner is competent and fit to practise.

Commentary

54. The vast majority of General Optical Council registrants are employed by and work within the commercial sector, although many also undertake work on behalf of the NHS. If appraisal is to be used to provide an assurance of continuing competence and fitness to practice, it must be capable of doing so across the diversity of employment arrangements and work settings in this sector. Arrangements of equivalent rigour will be required for the self-employed and locum practitioners, and for the many practitioners who work in smaller independent practices where appraisal schemes are a rarity. There is no comprehensive workforce census data for the sector so it is not possible to say with any confidence how many registrants are employed by larger companies (that do not publish staffing data), many of which do operate appraisal schemes, and how many are employed in companies where appraisal practices are more variable, or in smaller independent practices, or who work as locums.
55. Appraisal is regarded as good employment practice, can be of commercial benefit, and is cited as a key element of clinical governance. While many of the larger optical business operate appraisal schemes these vary in scope and content. Most are geared towards an appraisal of commercial performance rather than clinical competence, although some informants argue that it is possible to infer problems associated with the latter from an assessment of the former, conceding nevertheless that a satisfactory commercial performance does not guarantee continuing competence or fitness to practise. Regular audits of case records, 'safe and legal' checks, and complaints analyses – rather than appraisal – are the mechanisms used to identify poor practice. Only in couple of cases were senior optometrists willing to admit to having sufficient confidence in their scheme to 'sign-off' employed registrants as competent and fit to practise for the purposes of revalidation.
56. None of the appraisal schemes examined have explicit cross-references to the GOC registration competencies, although this can be inferred from some of the appraisal criteria (and more especially from the small minority of schemes using observation schedules). The absence of a direct read-across raises questions about the validity of appraisals as assessments of competence for revalidation. Reliability is also an issue because many appraisers have not been trained, a substantial number are not professionally qualified to make judgements about competence and fitness to practise, and informants report variable application of appraisal schemes within the same organisation. Many cite the attitude and commitment of the appraiser as the most critical determinants of a productive appraisal. Furthermore, appraisal policy and guidance appears to be amended frequently, suggesting that it may be a 'moving target' as far as accreditation is concerned.
57. Finally, despite a commitment to maintain quality standards and to provide quality patient care, even if appraisals were valid, reliable and standardised within

organisations and across the sector, there is nevertheless a marked reluctance in many businesses to subvert the employer-employee relationship to satisfy an external regulatory requirement that many believe should already be guaranteeing a minimum standard.

Registrants working in the NHS

58. In contrast to the commercial sector where there is scope to individualise terms and conditions of employment, and to determine appraisal policies and procedures, the NHS directly employs optometrists and a small number of dispensing opticians on centrally prescribed terms and conditions of service established through national negotiations. Following several years of development a new pay system – *Agenda for Change* – was agreed in order to harmonise pay and conditions and to ensure equal pay for work of equal value for all NHS employees.²⁷
59. Following introduction of the new scheme in a small number of early implementer sites in England, the formal agreement came into effect in 2004. The new arrangements then began to be rolled out across the NHS in all four countries of the United Kingdom. Implementation has taken longer than originally anticipated and in England both progress and impact have been questioned in recent reviews.²⁸ Furthermore, the introduction of Foundation Trusts – which are permitted greater freedom to manage their own affairs – has introduced the prospect of deviation from national agreements on matters such as terms and conditions of employment.²⁹
60. All NHS optometrists are now employed on the national terms and conditions of service agreed under the *Agenda for Change* reforms and will have been allocated to new pay bands based on an evaluation of the jobs they do. The new terms and conditions replaced automatic annual increments with a different approach to pay progression, associated with gateways and a development review process (appraisal) underpinned by the *NHS Knowledge and Skills Framework*.³⁰ Each NHS post has an outline of the knowledge and skills required, against which job holders are reviewed annually.³¹
61. Based on a summation of the latest available data from NHS workforce censuses, there are in the region of 1900 optometrists directly employed by NHS organisations across the United Kingdom (although the occupational coding for this group includes orthoptists and perhaps also a small number of dispensing opticians).³² The reported whole time equivalent is in the region of 1330 posts

²⁷ With the exception of doctors, dentists and the most senior managers.

²⁸ See for example: National Audit Office, *Department of Health NHS Pay Modernisation in England: Agenda for Change*, January 2009; and House of Commons Public Accounts Committee, *NHS Pay Modernisation in England: Agenda for Change, Twenty-ninth Report of Session 2008-09*, HC310.

²⁹ To date only one Trust has opted out of the Agenda for Change national agreement (see: Job Cut Warning to staff, *Health Service Journal*, 24 September 2009 pp 4-5).

³⁰ *The NHS Knowledge and Skills Framework and the Development Review Process*, Department of Health, October 2004.

³¹ See for example national profiles for roles in optometry and orthoptics for use as job evaluation templates produced by the Association of Optometrists.

³² Sources: *NHS Hospital and Community Health Services, Non-Medical Workforce Census England: 30 September 2008*; *NHS Scotland Workforce Statistics for 30 September 2008*; Welsh Assembly Government, *Stats Wales, 2008*, and the latest published workforce data from Northern Ireland, the *Health & Personal Social Services Workforce Census, March 2005*.

since a significant number of hospital optometrists work on a part-time basis.³³ Some part-time NHS optometrists also engage in locum or independent practice in addition to fulfilling their NHS employment contracts, but all NHS employees are subject to the same terms and conditions of service irrespective of any external commitments.

62. Hospital optometrists work in a variety of clinical situations and fulfil a number of roles, some of which are highly specialised and require advanced learning and skills. The contrast in working situations is noteworthy: some work in large departments and enjoy daily contact with professional peers and multi-disciplinary teams, whereas others are more isolated, often working alone and sometimes across several NHS organisations. For them, peer support and scrutiny is not the daily occurrence it is for those in large ophthalmic departments.

Appraisal policies and procedures

63. As an integral part of the *Agenda for Change* national agreement, annual development reviews and personal development plans are mandatory for all NHS staff.³⁴ The developmental purpose of the review is a significant feature of the national agreement.³⁵ However it is also used to inform a decision about pay progression at two key points (gateways) in each pay band.
64. The foundation for the review process is a generic Knowledge and Skills Framework (KSF) designed to encompass all NHS posts covered by *Agenda for Change*. Each review is undertaken with reference to a KSF post outline – which should be available for all NHS posts – which specifies the knowledge and skills required for the job. Post outlines are derived from an analysis of the content of key job types in the NHS with reference to one of four levels (which reflect the challenge and complexity of the knowledge and skills to be applied) on six core dimensions, and one of the four levels on relevant dimensions identified from twenty-four specific dimensions (see Box B). Specification against all six of the core dimensions is obligatory for all posts. In the guidance document each dimension and level is further elaborated by indicators and examples of application.
65. The review process is described as comprising four stages recurring in an ongoing cycle of learning. In summary these are:
- a joint review of the work of the post holder against the demands of their post, undertaken by the individual and the reviewer, who is usually the line manager;
 - joint agreement of a Personal Development Plan identifying the individual's learning and development needs and interests and how they will be met;
 - subsequent learning and development undertaken by the individual, supported by the reviewer;

³³ The AOP Hospital Optometrists Group suspect this is an over-estimate resulting from coding errors (personal communication).

³⁴ *NHS Terms and Conditions of Service Handbook*, Amendment 13, Pay Circular (AfC) 1/2009.

³⁵ The term 'development review' is used in preference to 'appraisal' and there is a presumption that staff will progress through pay gateways.

- evaluation of the learning and development that has taken place and how the individual has applied it in their work.

Box B: NHS Knowledge and Skills Framework Dimensions

Core dimensions:	Communication Personal and people development Health, safety and security Service improvement Quality Equality and diversity
Specific dimensions:	Health and well-being (of which there are 10) Estates and facilities (3) Information and knowledge (3) General dimensions (8)

66. The development review process itself is unremarkable but the way in which it revolves around a review against a detailed specification of the knowledge and skills required for a post points to a comprehensive yet potentially complex and challenging scheme. Users require a good grasp of the 120 competency-like statements and – to be able to apply these to specific settings and jobs – the myriad indicators and examples of application. Moreover, in addition to basing feedback on personal observation and experience of the individual's work – and the observation and experience of colleagues, and in some cases patients or clients – the reviewer also examines evidence selected and submitted by the reviewee to demonstrate how they have applied the requisite knowledge and skills; a potentially time-consuming and demanding process for both parties.
67. It is neither possible nor appropriate to recount all the features of the scheme here – not least because the document describing the anatomy of the KSF and providing operational guidance about the development review process runs to 267 pages – but also because those elements of relevance to a review of its potential role in revalidation are highlighted in the commentary below. The commentary is based on an analysis of policy documents, national guidance, published reviews, the personal experiences and views of hospital optometrists and the knowledge some of them have gleaned through key roles in regional and national networks.

Commentary

68. *Agenda for Change* prescribes the terms and conditions of employment for the majority of NHS staff. It includes a requirement that all staff have an annual development review and personal development plan. Pay progression is dependent on a satisfactory review at two gateways on each pay scale. The review is based on the application of the knowledge and skills required to do the job, assessed against the dimensions and levels embedded in the *NHS Knowledge and Skills Framework* (KSF). The review process itself comprises elements and stages typical of most appraisal methodologies, but the detail of the

KSF and the requirement to substantiate the application of knowledge and skills with examples demands the collection (by the reviewee) and analysis (by the reviewer) of a significant portfolio of evidence, judged against indicators and examples of application.

69. National terms and conditions of service, a standardised development review process, and specification of the knowledge and skills required for the job drawn from a national competency-like framework, collectively point to a system that could deliver assurances about a registrant's continuing competence and fitness to practise. However the observations and comments of a number of informants, together with the findings of recent national evaluations, highlight implementation issues that call into question the potential for its accreditation (if the GOC were to adopt this approach for revalidation).
70. In a minority of cases informants reported that development reviews were occurring regularly and that the KSF had been helpful. In these instances some senior optometrists had sufficient confidence in the system to indicate a preparedness to 'sign-off' or attest to a registrant's continuing competence and fitness to practice for the purposes of revalidation. It was observed by one that if senior optometrists in the NHS were not prepared to do this they ought not to be employing the practitioners whose competence or fitness to practise they doubted. However these informants gave the impression that their positive approach to staff appraisal was independent of the scheme per se; in other words it had less to do with the merits of *Agenda for Change* or the KSF and rather more to do with their management ethos they espoused.
71. These positive views were contrasted by those expressed by other informants who variously reported that the KSF had not been implemented in their Trust or department, that they had not been formally appraised for several years, or that where KSF development reviews had been introduced they were considered cumbersome and excessively bureaucratic. This reflects findings in national evaluations which report patchy implementation and concern about the scheme's complexity and tendency to generate large volumes of paperwork.³⁶
72. Among the concerns expressed about KSF development reviews that are relevant to consideration of its potential contribution to revalidation are that:
 - KSF post outlines are too generic and fail to capture the essential clinical aspects of an optometrist's role;
 - reviewers do not always share the same professional background as the reviewee (in many cases reviewers are general managers), calling into question the reviewer's ability to make judgements about professional practice;
 - the time attributed to the development review, and the rigour with which it is conducted, owe more to the reviewer's commitment than to the scheme itself;

³⁶ The House of Commons Public Accounts Committee (p5) (op cit: footnote 28) reports that "despite [the KSF] being re-launched twice, by autumn 2008 only 54% of staff had received an annual knowledge and skills review"; and the National Audit Office recommended "simplifying the guidance for using the Knowledge and Skills Framework...and the amount of supporting documentation staff need to bring to their review" (p9).

- the selection, collection and collation of supporting evidence is time consuming for the reviewee, and its analysis is time-consuming and challenging for reviewers (although a minority view was that the time taken to try to understand examples of application and to tailor the KSF indicators to optometry was rewarded by especially productive reviews);
 - while personal development plans are the intended corollary of development reviews, hospital optometrists do not receive funding for the continuing education and training that ensues, as their community optometry colleagues do.
73. A number of general issues were raised, including the observation that problems should be identified and dealt with when they occurred and not held over for discussion in an annual review.³⁷ However poor performance was said to be very rare in hospital optometry and the only recollections informants had of instances where an optometrist's performance was called into question concerned administrative matters or personality clashes. The low incidence of problems was attributed in part to working alongside ophthalmologists in multi-disciplinary teams with a commitment to effective clinical governance. It was observed that optometrists working in larger departments enjoyed a culture of learning and development in which audit, quality assurance (for example of sampled images associated with diabetic retinal screening) and regular case reviews are commonplace.
74. Without exception NHS employed informants supported the principle of revalidation but were divided on the question of whether or not the KSF development review could play a part. Furthermore, they emphasised the distinctiveness of their role, highlighting how the default position – for example in the sequencing of competence development and assessment for pre-registration optometrists – tended towards community optometry, and thus how any revalidation scheme should focus on the roles they undertake and the knowledge and skills they use, not just on a generalised conception of the majority registrant.

Registrants employed by universities and colleges

75. Registrants occupying academic roles represent a small but important group, not least because of their influential position as role models and professional experts. When revalidation is introduced it is conceivable that some may decide that they do not wish to apply for a licence to practise, perhaps choosing instead to concentrate on visual sciences research. However it is likely that most registrant academics will decide that their credibility as teachers continues to hinge on their ability to practise as optometrists or dispensing opticians. As such they will have to submit to the same requirements to demonstrate continuing competence and fitness to practise as all other licensed registrants.³⁸ It is therefore appropriate to try to establish whether or not academics undergo regular appraisals, and if so how these appraisals might contribute to their revalidation.

³⁷ A view strongly supported by the group reviewing local mechanisms for handling poor performance (op cit: footnote 20).

³⁸ Current regulations require that at least half the total (full time equivalent) staff allocated to an optometry degree programme should be registered with the General Optical Council. A decision about the proportion of registrants who must also be licensed to practise will be required for the future.

76. Heads of Departments in each of the institutions approved to conduct education and training leading to qualifications recognised by the GOC for registration were surveyed by email.³⁹ An 82% response rate was achieved after one follow-up request.⁴⁰ In addition to the content of emailed responses, documentation detailing appraisal policies and procedures from some of the institutions approved to run courses leading to registration was sampled and reviewed.
77. Based on the responses received it is estimated that there are in the region of 200 registrant academics employed by universities and colleges to deliver courses in optometry and ophthalmic dispensing, but it would be misleading to imply that this is a homogenous group. Registrant academics are united by a common educational purpose but undertake a variety of roles. For example some registrants are employed on a full-time basis and are engaged primarily in teaching; others are also research-active; some are employed on a part-time basis, combining their academic role with NHS commitments or with independent practice; and some are engaged mainly in educational management or academic leadership.
78. The nature of some academic posts is such that members of this group can be more distant from practice than other registrants. Current regulations concerning mandatory continuing education and training are liberal enough to enable them to remain on the register. However the introduction of a licence to practise and periodic revalidation may present a more challenging prospect for those academics who practise infrequently or in a very limited field.

Appraisal policies and procedures

79. All the universities and colleges responding to the survey reported that they had policies and procedures for staff appraisal or performance review. In the vast majority of cases appraisals are conducted annually, with just one respondent indicating that in reality they occurred less frequently. One other respondent noted that an interim review was also undertaken six months into the annual cycle (but documentary sources indicate that other institutions also undertake interim reviews).
80. The vast majority of appraisal schemes are generic in nature, designed to apply to all the academic staff employed by the organisation, and take no particular account of subject, discipline or professional background. Some schemes distinguish between academic and academic-related staff but the principles, procedures and templates used appear very similar for both. A small minority of cases include (or it was said could include) a clinical dimension, but most focus on performance in academic and associated role functions such as teaching, research and educational management so do not include an explicit review of registration competencies. However the distinction between academic and clinical activity is considered to be rather artificial; and because the appraisee populates the appraisal with job-specific content, clinical work and professional behaviour is implicit in many reviews.
81. Universities that provide medical or dental education have separate appraisal arrangements for senior clinical academics who hold honorary contracts with the

³⁹ Eleven institutions are approved, some offering courses in both optometry and dispensing.

⁴⁰ Two optometry degree providers failed to respond to the email survey.

NHS. The arrangements are based on the 'Follett Principles'⁴¹ and seek to integrate reviews of teaching, research and clinical performance in a joint approach that involves both the university and NHS employer. This approach does not appear to have been adopted by universities for other health professions that also combine academic and clinical work, whether through honorary NHS contracts or full contracts covering a part-time service contribution.

82. On the face of it each educational establishment has a distinctive appraisal policy and procedure, but closer examination reveals a high degree of commonality regarding fundamental principles and essential procedures. In so far as it is possible to generalise, analysis of the documentation sampled points to:
- a common conception of purpose (connecting individual performance and personal development to the mission and operational goals of the organisation);
 - a common values base (emphasising that the process should be constructive, positive and of mutual benefit to the individual and the organisation);
 - a common assumption about primary responsibility (which rests with the individual appraisee – both to self-assess and to act on the agreed outcomes of the review – supported by the organisation);
 - a common process (involving a rounded reflection on activity, workload, performance and achievements during the preceding year, followed by consideration of the priorities for the coming year in the context of the organisation's plans, and an assessment of the individual's training and development needs);
 - the provision of guidelines, checklists and templates (to assist both parties in the review, to standardise the process, and to promote fairness and equity);
 - the importance of reaching agreement (about goals, targets or objectives for the coming year, and about development needs and opportunities);
 - a general acknowledgement that the core content of the review is confidential (but that training and development needs are fed upwards to inform group, department and organisation-wide staff development and training plans);
 - a common requirement that key outcomes from the review are summarised and documented;
 - agreement that the process should never be confused or conflated with disciplinary procedures;
 - regular evaluations of the effectiveness of the scheme (in some cases involving Trade Unions).

⁴¹ The Follett Review (DfES, 2001) made a number of recommendations regarding the appraisal, disciplinary and reporting arrangements for senior clinical academic staff, not least the principle of joint working to integrate separate responsibilities.

83. Appraisals or performance reviews are conducted by academic line managers. In smaller departments this may be the Head of Department. In some larger departments and faculties it appears that appraisals can be conducted by academic line managers who have substantially different professional, disciplinary or subject expertise from the appraisee. However in some departments registrants do appraise registrants. Only in a minority of cases is direct observation of teaching a formalised part of the appraisal process, and there is only limited evidence that clinical practice is routinely observed, audited or reviewed for appraisals.
84. Only one respondent reported a direct link between appraisal and remuneration (in the form of performance-related pay linked to achievement of objectives); another respondent indicated that a link did exist but only at professorial level. In most cases policies about senior salary reviews and promotions are separate. However some respondents observed that there is inevitably an indirect – but not necessarily explicit – relationship between annual appraisal and pay, in so far as general performance can influence decisions about readiness for promotion or progression.

Commentary

85. Appraisal or performance review is an established and well documented aspect of staff management and development in universities and colleges. As autonomous bodies universities do not have to conform to any national scheme so each institution has its own policy and procedures,⁴² but the underpinning principles and methods of the schemes that were sampled appear to be remarkably similar.
86. There are a number of factors that militate against the use of appraisals in academia as a means of revalidating registrants. Appraisals are conducted by line managers who may not share the same professional or disciplinary background as the registrant, calling into question the validity of any judgements about continuing competence or fitness to practise that arise from these reviews.
87. Schemes tend to be generic in nature and broad in scope. Content varies because the appraisee (and to a lesser extent the appraiser) populate the process with personalised job-specific content. This tends to focus on academic – rather than clinical – role functions; and although the distinction between academic and clinical activity is considered to be somewhat artificial, direct observation of clinical practice or comprehensive assessment of continuing competence is neither explicit nor commonplace.
88. The integrated approach adopted for medical and dental academics – in which clinical performance is a key dimension – has not been adopted for academics in other health professions. Had it been, its scope and apparent rigour suggests that it might have delivered the assurances required for revalidation.
89. The content of appraisals in universities and colleges is not standardised, nor is it sufficiently focused on the GOC competencies to justify blanket accreditation as a mechanism for establishing continuing competence and fitness to practise for revalidation. In any event there is little incentive for universities and colleges to submit their appraisal schemes for GOC accreditation, not least because it would

⁴² However appraisal and staff development policies and practices are subject to review as part of institutional audit (see for example, Quality Assurance Agency, 2009, *Handbook for Institutional Audit*, England and Northern Ireland).

apply to so few of their staff. It was observed by respondents that appraisal is an employment issue, not a professional regulatory matter. Universities are self-governing institutions and the GOC has no locus of authority beyond its statutory responsibilities concerning the quality of programmes leading to the qualifications it recognises for registration. Furthermore, it seems unlikely that universities would welcome an invitation to submit to further external scrutiny.

90. In summary, appraisal schemes in academia do not appear to provide a system sufficiently focused on registration competencies to provide a standardised assessment of continuing competence or fitness to practise, or to provide the assurances it is anticipated will be required for revalidation. However, regular performance reviews promote reflective practice and personal professional development, so evidence of regular appraisal (irrespective of content) could be cited by a registrant in support of a claim for revalidation as an indication of their commitment to professional growth and development.

General issues

91. A number of issues arose in discussion with informants which are not specific to any one of the work categories examined in the preceding sections but which are relevant to wider considerations about revalidation. In addition informants were invited to offer their views about the alternatives that might be put in place for those registrants unable to call on evidence of appraisal in support of a claim for revalidation. These are reported below together with some of the more general observations that were made about revalidation.

Continuing education and training

92. The majority of informants indicated that mandatory continuing education and training should count towards revalidation. A substantial number of the larger optical businesses commission or provide in-house continuing education and training but few draw on outputs from appraisal to inform their decisions about the selection of content. In this respect some informants drew a distinction between continuing professional development, which they saw as relating more closely to personal development plans arising from appraisal, and continuing education and training which was construed as a form of professional updating and refreshment.⁴³
93. Most informants were of the view that a failure to achieve the number of continuing education and training points required should automatically disqualify a registrant from being revalidated, but the majority said that current requirements were not sufficiently challenging to serve as an indicator of competence or continuing fitness to practise. The most significant criticisms of the current arrangements were that:
 - it is too easy to select topics of personal interest which do not challenge or extend professional thinking, with registrants repeating the same (non)learning event or activity time and time again;

⁴³ The College of Optometrists has recently piloted a voluntary CPD scheme designed to promote professional and personal development amongst its members. The trial should provide insights about the extent to which registrants are willing and able to collect and record life-long learning activity that could be cited in support of a claim for revalidation.

- journal articles, distance and online learning – and didactic non-interactive events – have limitations because there is no real exposure to professional colleagues or to critical challenge, and because it is too easy to cheat;
 - it encourages uneven provision of opportunities over the cycle and thus discourages the ongoing critical and reflective stance towards professional practice that is the hallmark of a profession.
94. Some informants said they recognised that the threshold for continuing education and training had been set at a level commensurate with expectations at the time at which it had been made mandatory, but that it was now time to 'raise the bar'. The most frequently suggested potential improvement was that continuing education and training should include some form of interaction with professional peers, for example in workshops, participatory conferences, journal clubs, learning sets, or peer review groups.
95. A minority of informants reported having had experience of participating in, or of convening and running, peer review sessions in which real cases are presented by participants and reviewed by colleagues.⁴⁴ Subject to creating a supportive climate and having a skilled and facilitative convenor, this was judged by informants to be far superior to many other forms of learning because of registrants' exposure to critical and constructive peer appraisal.
96. Some informants said that evidence of having participated in peer review should rank more highly than other forms of continuing education and training in any bid for revalidation. However some also recounted how difficult it had been to get support for peer review activities from professional associations, or to achieve recognition for continuing education and training points. It was said that a particular problem concerned the requirement to specify detailed learning outcomes in advance of the event for which points are being claimed – something that was possible only in very general terms prior to a case presentation and critical discussion.
97. The principal messages to emerge were that appraisal tends to inform objectives and plans for continuing professional development rather than continuing education and training; that both should count as evidence towards revalidation but that the latter should be made more rigorous, especially as regards a requirement for interaction with professional peers. In this respect it was suggested that more could be done to support local and innovative approaches to professional learning beyond registration, particularly in the form of case review in peer groups.

Scope of practice

98. Views were mixed about the scope of practice that should be subject to revalidation. Some informants felt that if the revalidation standard is to be registration competencies, then evidence of continuing competence should be sought for the full scope of practice that these encompass. Other informants argued that revalidation should focus on a registrant's current scope of practice and should not seek evidence about competencies which had not been exercised for some time, in some cases for many years. For example, some optometrist informants said they had been deemed competent to fit contact lenses at the point

⁴⁴ One informant referred to the use of prepared hypothetical cases developed by a training company and supplied as a PowerPoint presentation to serve as the basis for discussion.

of entry to the register but had not done so since, and would not attempt to do so without refreshing their skills. They argued that if a registrant was not currently practising a particular competence, it should not need to be revalidated; yet most said they did not want to lose the right to exercise the full range of responsibilities for which they had originally been trained. Some contact lens optician informants expressed concern about optometrists who they thought 'dabbled' in contact lens fitting extremely infrequently, questioning how they would be identified and how they would revalidate these competencies.

99. These considerations tended to give rise to unresolved ruminations about which – if not all – competencies could be regarded as core or essential for all registrants. The important point of principle to emerge was that registrants should be required to revalidate not to re-qualify. Most informants concluded that any demand for evidence should focus on a registrant's current field and scope of practice, and that any more extensive demands should be made only in exceptional cases where some doubt had been expressed or had arisen about the accuracy or veracity of a bid for revalidation.

Observation of practice

100. Some informants felt that revalidation might be regarded as providing a hollow assurance of competence and continuing fitness to practise if it did not involve some form of direct observation of a registrant's clinical practice, particularly for isolated practitioners who are not exposed even to indirect observation by colleagues. For a minority direct observation already occurred as a matter of routine, but the majority of informants said they had not been exposed to this level of scrutiny since pre-registration training. Many said they would be uncomfortable being observed, and some questioned who could be judged as having sufficient expertise to undertake such assessments. Others said there was an established tradition of assessing pre-registration trainees and a body of skilled assessors that could easily be expanded. However some informants were quick to cite unsatisfactory pre-registration experiences associated with highly subjective assessors and those with too 'academic' a perspective to inspire confidence in this method for revalidation.
101. The idea of peer observation for all registrants was rejected as too costly and unworkable, with some informants citing overly intrusive and unrealistic inspections by Primary Care Trust optometric advisers as grounds for resisting further external scrutiny of this sort. Others regarded the commercial nature of optical business as sufficient reason for resisting observation and scrutiny by professional peers who might also be local competitors. A minority of informants who worked in small towns in more rural areas were less worried about being observed by local peers, reporting a more collaborative culture in which local commercial 'competitors' sought to tackle and resolve professional matters through fora such as the Local Optometric Committee.
102. Some informants referred to the accreditation schemes in Scotland and Wales to assess the competence of practitioners offering extended general ophthalmic services, weighing the merits of lab-based assessment of clinical practice against observation in situ. One informant went as far as to suggest that test centres should be established by universities so that registrants could be revalidated following successful completion of a series of objective structured clinical evaluations (OSCEs). However the vast majority of informants felt the retrospective audit of records provided a window on practice sufficient to establish competency failure, and that direct observation would be necessary only for –

what they anticipated would be – the small minority of registrants whose evidence for revalidation raised some doubts about continuing competence; and the general consensus was that in these exceptional cases the registrant should be observed (on more than one occasion) in the situation in which they worked, not in the unfamiliar surroundings of a clinical skills laboratory in a university.⁴⁵

General messages about revalidation

103. The majority of informants expressed unreserved support for the principle of revalidation. When invited to describe what a revalidation scheme might look like, most resorted to statements of principle, referring in particular to fairness, proportionality, cost and risk. Far fewer were able to convert these aspirations into concrete suggestions about operational policy, or to indicate precisely what would be reasonable to expect of registrants. However a number of cautionary observations and suggestions were advanced by informants that they felt should be taken into account in constructing a revalidation scheme. These included:
- the importance of guarding against constructing too sophisticated a system that would in the end do no more than provide conformation that the perfectly competent are competent, yet still fail to identify the poor performer;
 - ensuring that any demand for information is consistent with employers' legal obligations, particularly about data protection;
 - the need to avoid targeting registrants who exercise advanced skills or prescribing rights on the grounds of risk, because this is to ignore their demonstrable commitment to professional development and skills assessment, which indicates an openness to scrutiny and a high degree of professional self-awareness that may be absent from registrants who do not 'raise their head above the parapet';
 - recognising the importance of raising general awareness about revalidation amongst frontline practitioners – from whom there will be resistance – before introducing mandatory requirements, because many registrants do not understand the background to revalidation and see it as no more than a whim of the regulator;
 - a flat career structure and diversity of employers means there is no tradition of deferring to 'senior registrants', so revalidation should rely on self-certification not, for example, on the concept of 'Responsible Officers' attesting to the competence of other registrants;
 - the principles of equity and fairness notwithstanding, consideration should be given to differential schemes for optometrists and dispensing opticians to recognise that the latter represent a very low risk, that they are not remunerated for continuing education and training, and also to guard against elective deregistration to focus on unregulated functions, which would defeat the object of securing greater public protection.

⁴⁵ Performance assessment by direct observation of practice is an established method. Extant guidance states that assessment "takes place at a registrant's usual place of work" (para 7, *Guidance to Registrants who are to undergo a Performance Assessment*, GOC, undated).

Doctors, dentists and other health professions

104. The work being undertaken by the regulators of the other health professions is a source of potentially useful information about approaches to revalidation. To date only some of the regulatory bodies have published their plans or consulted on proposals. The most salient features of the proposals that are in the public domain – particularly references to appraisal – are considered below.

Doctors

105. Proposals for revalidation from the General Medical Council (GMC)⁴⁶ are of particular relevance for three main reasons: the GMC is introducing a licence to practise (as the GOC has proposed for its registrants); appraisal is to be at the heart of the process; and its plans are at an advanced stage of development so they are accessible to scrutiny. Yet while there is much of interest in the revalidation proposals for doctors, a number of the elements do not readily translate to the optical sector.
106. For example the GMC has been able to build its policy on an established culture of appraisal, not only among doctors directly employed by the NHS but also among contractors such as General Practitioners, and it is able to rely on the NHS, Department of Health and Royal Colleges to establish and manage processes essential to revalidation. Furthermore, the GMC intends to devolve responsibility for evaluating revalidation applications to designated senior doctors. To do this a new role of 'Responsible Officer' has been created (under provisions in the Social Care Act 2008) which has enabled the GMC to develop a revalidation policy that revolves around 'sign-off' by a senior professional.
107. The Responsible Officer (RO) will have a duty to assess the fitness to practise of doctors connected to the organisation in which the RO is employed, and then to recommend to the GMC whether or not the doctor should be revalidated. More detailed guidance about the role of the RO is expected from Government later in the year, but it is likely to be undertaken by the medical director of an NHS Trust, or a senior doctor in a primary care organisation for General Practitioners on the performers list held by that organisation. Doctors who are self-employed or working in the independent sector will be expected to submit to these arrangements,⁴⁷ or to use similar arrangements that might be offered by the Royal Colleges, but all schemes will have to be approved as having conformed to the GMC's *Framework for Appraisal and Assessment*.⁴⁸
108. Revalidation is to occur every five years and will have two elements: relicensing, which will confirm that a doctor continues to practise in accordance with generic standards drawn from the guidance document *Good Medical Practice*,⁴⁹ and recertification, for specialists and General Practitioners, which will show that doctors meet the standards for their speciality.

⁴⁶ See for example: *Revalidation: Information for Doctors and Frequently Asked Questions*, Issue 1, June 2009, General Medical Council; and also the recent paper from NHS Employers: *Better, safer doctors: implementing medical revalidation*, Briefing 62, June 2009.

⁴⁷ The GMC assumes that larger independent sector organisations will have their own Responsible Officers; otherwise doctors will have to make arrangements with the Responsible Officer in a local NHS organisation.

⁴⁸ *A Framework for Appraisal and Assessment Derived from Good Medical Practice - Explanatory Notes*, Draft 13, June 2008, v1.3, The General Medical Council.

⁴⁹ *Good Medical Practice*, General Medical Council, 2006.

109. The GMC claims the process will not impose additional bureaucracy because revalidation will be the by-product of local systems for clinical governance. Employer appraisal is to be the principal mechanism through which doctors will demonstrate that they meet the relevant standards. Appraisal, which was introduced for NHS medical consultants in 2001 and for General Practitioners in 2002, is said to be valued by doctors because of its confidential nature and the opportunity it provides to reflect on professional practice and to consider development needs.⁵⁰ However it has been criticised for being implemented patchily and inconsistently.⁵¹ The GMC concedes that not all appraisal systems are sufficiently robust but points to work that is underway to improve them.⁵²
110. The GMC's *Framework for Appraisal and Assessment* has been developed to help doctors to reflect on their practice and to identify areas of practice where they could make improvements. It comprises four domains (see Box C), each of which is elaborated by attributes which define its scope and purpose and by generic standards cross-referenced to *Good Medical Practice*.

Box C: The GMC Framework for Appraisal and Assessment	
Knowledge, skills and performance	<ul style="list-style-type: none"> - maintain your professional performance - apply knowledge and experience to practice - keep clear, accurate and legible records
Safety and quality	<ul style="list-style-type: none"> - put into effect systems to protect patients and improve care - respond to risks and safety - protect patients and colleagues from any risk posed by your health
Communication, partnership and teamwork	<ul style="list-style-type: none"> - communicate effectively - work constructively with colleagues and delegate effectively - establish and maintain partnerships with patients
Maintaining trust	<ul style="list-style-type: none"> - show respect for patients - treat patients and colleagues fairly and without discrimination - act with honesty and integrity

111. Doctors will be expected to collect information during the five-year period preceding revalidation and to retain it in a portfolio. The Royal College of General Practitioners (RCGP) portfolio guidance serves as a useful example of the areas where it considers evidence will be required to satisfy both GMC and RCGP criteria and standards (see Box D). The RCGP has expressed its preference for General Practitioners to maintain an e-portfolio rather than a paper based record, an approach the GOC might wish to consider in light of its established system for electronic recording of continuing education and training (if it opts for a portfolio approach to revalidation).

⁵⁰ Op cit (see footnote 48).

⁵¹ Department of Health, 2006, *Good Medical Practice*. London. DH.

⁵² See for example: Shelly M and Judkins K, May 2009, *Assessing the Quality of Medical Appraisal for Revalidation*, NHS Revalidation Support Team.

Box D: Evidence required for the revalidation of General Practitioners⁵³

- 1: statement of professional roles and other basic details
- 2: statement of exceptional circumstances
- 3: evidence of active and effective participation in annual appraisals
- 4: a Personal Development Plan from each annual appraisal
- 5: a review of the Personal Development Plan from each annual appraisal
- 6: learning credits in each year of the revalidation period and in the revalidation period overall
- 7: multi-source feedback from colleagues
- 8: feedback from patients
- 9: description of any cause for concern and/or formal complaint
- 10: significant event audits
- 11: clinical audits
- 12: statement on probity and health
- 13: additional evidence for areas of extended practice

112. The GMC guidance acknowledges that no doctor will be able to provide evidence of compliance with every generic standard on every occasion. A further point of relevance is the advice it gives that the appraiser should not only be familiar with the role and working environment of the appraisee, but in the case of General Practitioners and specialists, should also be from the same speciality (although not necessarily the same sub-specialty).
113. A framework to assure the quality of medical appraisal has been proposed comprising internal mechanisms in each employing organisation, audit by regional medical regulation support teams (in England only), and independent external review (on a sampling basis every three years) by the system and professional regulators (although the quality assurance role of the Royal Colleges has yet to be agreed). The guidance to help employing organisations assure the quality of medical appraisal and revalidation includes a checklist for self-assessment built around four high level indicators (see Box G), each elaborated by detailed standards for self-assessment.
114. The scope and detail of the framework serves to highlight the investment of resources, time, training and management commitment required to secure

⁵³ *Guide to the Revalidation of General Practitioners*, RCGP, April 2009.

effective appraisal of a consistently high standard. Whether the planned initiatives will deliver standardised appraisal of a consistent quality remains to be seen, but it seems unlikely that any of the other health professions will be able to marshal the stakeholders and resources required to replicate this approach in its entirety, if indeed any considered it appropriate to opt for the medical model of revalidation.

Dentists

115. Proposals for revalidation from the General Dental Council (GDC) are based on a set of standards against which it will request evidence.⁵⁴ The standards are grouped under four headings (see Box E). In its draft revalidation standards and evidence framework, the GDC further elaborates each area with a number of outcome statements, against which are set indicative sources of evidence.

Box E: GDC Standards and evidence framework	
Professionalism	<ul style="list-style-type: none"> – puts patient interests first and acts to protect them – clinical team and peers – self
Clinical	<ul style="list-style-type: none"> – medical emergencies – drugs and prescribing – radiology – disinfection and decontamination – referrals – clinical care
Communication	<ul style="list-style-type: none"> – patient and family – clinical team and other professionals
Management and leadership	<ul style="list-style-type: none"> – personal and practice organization – legislation and guidance – leadership and training

116. Dentists will be required to produce a portfolio of evidence of performance developed during the five years preceding revalidation (e-Portfolios are in development). Some elements will be compulsory. Evidence is to come from a variety of sources including clinical governance and practice inspection schemes, personal development plans and CPD, multi-source feedback (including from patients), and third party reviews of patient records.
117. It is significant that the proposals indicate that although some dentists might use evidence from appraisal schemes, this will not be compulsory, perhaps in recognition of the large number of dental practitioners who – like many GOC registrants – do not work in managed environments nor participate in appraisal, but own or work in small independent practices. Similarly, the proposal to quality assure existing systems or practice accreditation schemes as satisfying certain

⁵⁴ Proposals were set out in the consultation document *Developing Revalidation – your chance to get involved*, published earlier this year. The consultation closed in September and a further consultation based on responses and additional work is planned early in 2010.

components of revalidation so that registrants do not have to duplicate evidence, is also of relevance to this review.

118. Registrants will be required to submit a declaration which will be used to determine whether or not they have met the requirements. A 10% sample will be drawn from those who have met the requirements and their portfolios will be examined to validate the decision. Two further stages in the process are proposed to remedy deficiencies in evidence and to handle those who fail to comply with the revalidation requirements.
119. The GDC proposes that practitioners revalidate in the field in which they practice. The implication is that it will enable, for example non-practising academics, to substitute appraisal evidence for the practice inspection component. The corollary of this principle is that practitioners on the specialist register will be expected to revalidate in their speciality.

Other health professions

120. The General Osteopathic Council (GOsC) consulted on its proposals earlier in the year.⁵⁵ It has opted for an approach based on self-assessment and self-declaration using a pro-forma encompassing the key performance indicators of safe osteopathic practice set out in its *Code of Practice* and *Osteopathic Practice Standards*. The Council proposes that revalidation should occur once every five years. If the self-assessment application is judged to fall short of what is required, three stages follow which escalate the level of scrutiny: first to a request for further information or evidence by way of clarification; then to peer review, which may be of written evidence or an interview with a trained GOsC assessor; and finally a formal assessment of clinical practice using a procedure similar to the final year student assessment.
121. The (draft) self-assessment pro-forma guides the registrant through questions grouped under five headings: how you practise osteopathy; patient partnership; clinical practice; professionalism; and continuing professional development. Respondents will be required to cite the evidence they have used to support their declarations (see Box F). Employer appraisal is suggested as one source that might be used as evidence of employer feedback.
122. As a quality assurance measure it is proposed that stage one submissions will be sampled on a random basis to ensure the evidence cited exists. This is similar to the process the GOsC operates to quality assure continuing professional development.
123. The Health Professions Council – which regulates 14 professions, including orthoptists – is at an early stage in the development of its policy. In a paper to a recent Council meeting it outlined plans for research, feasibility studies, and a fact finding visit to the USA and Canada.⁵⁶ However its stated position is that revalidation is just one part of a process to assure continuing fitness to practise, and that following these investigations it might still conclude that only minor changes – or no changes at all – will be necessary to its existing processes.

⁵⁵ *Revalidation for Osteopaths: Consultation Document*, March 2009, General Osteopathic Council.

⁵⁶ Health Professions Council, 10 September 2009, Revalidation Project Update, (accessed from the HPC website, 27 September 2009).

Box F: Suggested sources of evidence to support an application to the GOC for revalidation

- References to clinical practice documentation, including anonymised patient records
- Clinical audit outcomes
- Policy and information documents relating to your osteopathic practice, such as patient information leaflets and written practice procedures
- External feedback – from patients and colleagues, assessments, mentorship, supervision, employer appraisal, colleague/peer corroboration, and external practice audits
- CPD activity record or other record of training, including documents showing structured self-reflection on own practice of osteopathy.

124. The Nursing and Midwifery Council has recently commissioned a research partner to explore appraisal processes, remediation and outcome based continuing professional development to help it develop options for a risk based approach to revalidation. The work will report to the Council in April 2010 when options will be considered, standards developed and the profession and public consulted.

Commentary

125. From this brief review it is evident that revalidation policy is developing at different rates for each profession. The emerging proposals and plans appear to reflect the particular character and regulatory traditions of the professions concerned, and also the resources available to them. Two elements are of particular relevance: the issue of self-declaration versus independent assessment; and the role of appraisal.
126. The General Medical Council has devolved the primary responsibility for assessing a doctor's continuing fitness to practise to senior medical officers by creating a new statutory role – the Responsible Officer. In contrast other regulators have opted for self-assessment and self-declaration, reserving expert assessment for those cases where there is doubt about a registrant's application for revalidation. This is relevant to this study because the accreditation of employer appraisal schemes could be a means of devolving primary responsibility to others to assess and attest to a registrant's continuing fitness to practise; but this presupposes that the appraiser is competent to make such a judgement (at the very least that they share the same professional background) and that appraisals are equally consistent, valid and reliable.
127. Employer appraisal is an essential and central component of the revalidation of doctors (which is possible only because the majority work in managed environments), but the GMC recognises that further work is needed to standardise and improve appraisal. Whether this will be achieved remains to be seen but it is clear that considerable resources are being invested in measures to do so, and that these plans appear to have the support of the major stakeholders (including the Department of Health, Royal Colleges and NHS Employers). Other regulators recognise the potential role of appraisal but – perhaps acknowledging

its patchy adoption and inconsistent application – cite it as just one potential source of evidence.

128. The common thread running through proposals from other regulators is the emphasis on the collection and collation of information from multiple sources – including appraisal – in a portfolio of evidence. The incentive for the registrant to maintain a portfolio rests on both its value as a source to inform completion of a self-assessment, and also the knowledge that it might be sampled for confirmation or clarification of an application for revalidation.

Conclusions

129. This section summarises the findings reported in the preceding pages, draws conclusions and makes recommendations. It commences with a brief response to each of the study objectives which have been recast as four key questions:
- Are registrants appraised by their employers and could appraisals provide evidence for revalidation?
 - Are employers willing to adapt appraisal schemes to deliver evidence for revalidation?
 - How might employer appraisal schemes be accredited?
 - What alternative mechanisms might be used for registrants who fall outside established appraisal schemes?

Are registrants appraised by their employers and could appraisals provide evidence for revalidation?

130. In the commercial sector the majority of registrants employed in larger companies are appraised, but appraisal policies and practices vary. Companies with a centralised management function and clear corporate policies tend to operate a standardised approach to appraisal and achieve a high completion rate. There is greater variability in appraisal practices and completion rates in companies with distributed and devolved management structures because local managers are able to exercise more discretion.
131. Appraisal is much more of a rarity in privately owned independent practices, although some of the larger group practices do have, or have had, appraisal schemes. In these work settings, where feedback about job performance does occur, it tends to be provided on a more informal and continuous basis rather than being codified in an appraisal scheme.
132. Registrants employed in the NHS are subject to annual appraisal in the form of a KSF development review but there is evidence that this is by no means universal, despite its status as a core element of a national agreement covering terms and conditions of service.
133. The majority of registrants employed in universities and college are appraised but appraisals are designed to address academic role responsibilities.

134. An unknown number of self-employed and locum registrants are not routinely appraised (although some may have been in the past before this was deemed to call into question their self-employed status).
135. In the absence of detailed data about the numbers and types of employment of much of the optical workforce it is not possible to say with any degree of confidence how many registrants undergo appraisal, or of those who do how often it occurs. Universities, the NHS and most of the larger optical businesses operate an annual appraisal cycle, but evidence collected during this study suggests that in practice the regularity and rigour of appraisals varies.
136. Most employers that operate appraisal schemes have detailed appraisal policies and pro-forma documentation; most follow a similar review process; and most document appraisal action plans. Commonly occurring appraisal criteria are shown in Box A. None of the schemes examined assess the full range of registration competencies but a minority – those that involve direct observation of practice – could provide the quasi-independent judgement about continuing competence and fitness to practice that might be regarded as the gold standard for revalidation. However most employer appraisal schemes have some limitations that might be considered to undermine their value as a source of evidence for revalidation. These include:
- poor validity (appraisal criteria that do not correspond to revalidation criteria – that is the registration competencies);
 - low inter-appraiser reliability (lack of consistency in the application of standards from one appraiser to another within the same scheme);
 - completion by non-optically qualified appraisers (who are not equipped to make the informed professional judgements required for revalidation);
 - absent or inadequate appraiser training (calling into question the rigour, objectivity and consistency of appraisals);
 - inconsistent application of policies and procedures (intra-organisationally and, more importantly, between organisations and sectors);
 - absent or underdeveloped quality assurance (raising doubts about the integrity, rigour and consistency of appraisal schemes);
 - complexity (which can alienate users as is said to have occurred with the KSF);
 - norm-referencing within local appraisal populations (and distortion of results as a consequence of reward quotas in pay-related schemes).
137. These issues are significant if appraisal is to become a mandatory component of revalidation and if appraisal schemes are to be accredited. This is because appraisal schemes would need to be broadly comparable in terms of content, process and outputs to satisfy the minimum standards of a model scheme. The issues are much less significant if, for the purposes of revalidation, appraisal is construed as an individualistic event. This also relates to the distinction between revalidation and re-qualification. If registrants are expected to demonstrate continuing competence across the full range of contemporary registration

competencies through appraisal, then considerations such as objectivity, validity, reliability and consistency matter; but if registrants are permitted to cite appraisal as evidence of recent scrutiny and constructive feedback on professional performance, and to determine which aspects to use to demonstrate continuing competence within their current scope of practice, it is much less important that appraisal schemes are comparable one with another or that they satisfy objective standards.

138. Informants said that what mattered most were an appraiser's interpersonal and appraisal skills, not the scheme within which the appraiser had to operate or the documentation they were obliged to use. Some informants drew attention to the value of appraisal as a constructive dialogue and referred to the manner in which appraisal serves as a guide to clinical competence and professional conduct, even if specific competencies do not feature as appraisal criteria and are not directly observed. Appraisers said they could infer the overall standard of a registrant's professional performance and conduct from a generic appraisal, and that competency failure would in any event be highlighted by other checks. It might therefore be argued that it is not just the evidence that can be generated from appraisals that is important, but the fact that an appraisal discussion has occurred. In this sense it is the event as much as the content that should count towards revalidation.
139. Irrespective of the merits of a particular appraisal scheme, the very fact of exposure to independent scrutiny through regular reviews of job performance might be considered sufficient as far as appraisal is concerned to justify a positive revalidation decision. In this sense it would be evidence *of* appraisal that counted. On the other hand appraisal might occur only very infrequently yet be of very high quality, perhaps resulting in exceptionally comprehensive feedback or a very detailed and longer term personal professional development plan. This could provide a registrant with comprehensive evidence to cite in a bid for revalidation; a case in which it would be evidence *from* appraisal that counted. This points to the value of resolving a policy which retains maximum flexibility by leaving it open to registrants to decide whether and what appraisal evidence to cite in an application for revalidation, and by accepting evidence of and evidence from appraisal.

Are employers willing to adapt appraisal schemes to deliver evidence for revalidation?

140. In the absence of a definitive statement about the nature and scope of evidence that will be required for revalidation, it was difficult for commercial sector employers to decide whether they would be able or willing to amend appraisal schemes, but with a couple of notable exceptions most were reluctant to give an undertaking to do so. Some expressed concern about the practicalities and cost, others advanced more fundamental objections about the intrusion of professional regulation into the employer-employee relationship.
141. Any amendment to the NHS appraisal scheme (the KSF development review) would require national negotiation through the NHS Staff Council. The Council was not approached to test whether it would be receptive to a proposal for amendment. However recent parliamentary scrutiny and debates about progress in implementing the KSF suggest that now is not the most opportune time to seek any amendments considered necessary.
142. Universities and colleges operate their own appraisal schemes which are usually agreed with the academic staff-side unions. They are generic and designed to

apply to all academic staff, irrespective of discipline. There is no national scheme so negotiations would have to be conducted with each institution to secure any amendments considered necessary. With the exception of medical academics, there is no evidence that universities have a tradition of adopting different arrangements for small professional groups, or indeed that they have any incentive to do so.

How might employer appraisal schemes be accredited?

143. In this context accreditation refers to a mechanism by which the GOC could officially recognise an appraisal scheme as having satisfied certain minimum standards in respect of its use as one element in the process of determining a registrant's continuing competence and fitness to practise. It is beyond the scope of this project to set out detailed proposals for an accreditation scheme but it is appropriate to highlight some of the issues that would need to be resolved to do so. These include:
- clarification of the statutory or other mandate for accreditation, or confirmation of its voluntarism;
 - a transparent account of costs and an indication upon whom the burden of funding would fall;
 - a set of standards or criteria against which appraisal schemes would be assessed for accreditation;
 - a policy about the accreditation process – for example how applications for accreditation would be made; who would assess them, what qualifications assessors would need and how they would be appointed; whether assessment would rely on documentation alone or require field visits; what rights of appeal an applicant might have if an application was rejected; how often an accredited scheme would need to be reviewed.
144. On the first point there is at least the potential to seek additional statutory powers to introduce a scheme of accreditation alongside Rule changes to accommodate other aspects of revalidation (such as licensure), but how a statutory right or responsibility of this sort would be framed is difficult to envisage. On the other hand, a voluntary scheme – in which organisations operating appraisal schemes for registrant employees would be at liberty to determine whether or not to seek accreditation – is entirely conceivable but assumes that employers would have sufficient incentive for wanting to do so. Furthermore, a voluntary scheme could undermine fairness and equity because it places one dimension of revalidation outside the registrant's control, potentially advantaging or disadvantaging a practitioner according to whether or not their employer decided to seek accreditation (on the assumption that registrants would not be permitted to cite appraisal evidence from non-accredited schemes).
145. As to the second point, concern has been expressed by registrants, employers and representative bodies about the potential costs of revalidation, suggesting that an especially persuasive case would be required to secure the necessary funding – from whatever source – to resource an accreditation scheme.
146. The fourth point refers to the detailed work that would be required to resolve an overarching policy and to determine an operating framework; and since the GOC already has systems to approve training establishments and programmes and to

approve continuing education, this is arguably the most straightforward aspect of developing an accreditation scheme.

147. This leaves the third point: what might appraisal scheme accreditation standards look like? Given the centrality of appraisal in medical revalidation and the work that is underway to bolster current appraisal practice, the standards for assuring the quality of medical appraisal represent a potentially useful starting point (see Box G).⁵⁷ Since most GOC registrants do not work in managed environments in the NHS where systems of clinical governance are more highly developed, some of the expectations are unrealistic and would need to be stripped back.

Box G: Assuring the Quality of Medical Appraisal for Revalidation

High Level Indicators

Elements underlined are elaborated elsewhere in the document to indicate the sources and types of evidence that might be used to assess the extent to which an organisation satisfies the standards.

High Level Indicator 1: Organisational Ethos There is unequivocal commitment from the highest levels of the responsible organisation to deliver a quality assured system of appraisal, in support of revalidation, that is fully integrated with local clinical governance systems.

High Level Indicator 2: Appraiser Selection, Skills and Training The responsible organisation has a process for selection of appraisers. Appraisers undertake initial training and their skills are reviewed and developed.

High Level Indicator 3: Appraisal Discussion The appraisal is informed by a portfolio of verifiable supporting information that reflects the whole breadth of the doctor's practice and informs objective evaluation of its quality. The discussion includes challenge, encourages reflection and generates a Personal Development Plan (PDP) for the year ahead.

High Level Indicator 4: Systems and Infrastructure The management of the appraisal system is effective and ensures that all doctors linked to the responsible organisation are appraised annually.

Source: see footnote 57

What alternative mechanisms might be used for registrants who fall outside established appraisal schemes?

148. For the purposes of revalidation the principle of equity demands that any mechanism for registrants who are not appraised should be equivalent in all relevant respects to the appraisal schemes that apply to those who are; but

⁵⁷ Shelly M and Judkins K, May 2009, *Assessing the Quality of Medical Appraisal for Revalidation*, NHS Revalidation Support Team, p11.

employer appraisal schemes are not homogeneous – standards and processes vary. As a consequence it cannot be said that all employed registrants enjoy the same level of scrutiny and constructive feedback, so there is no uniform standard to be replicated in an alternative scheme for registrants who are not appraised. However there are mechanisms that could be used to provide registrants who are not appraised with opportunities to submit themselves to scrutiny and to receive the constructive feedback enjoyed by those who are. These include:

- soliciting appraisal from employers – or for locums from their temporary employers – using model documentation designed for the purpose, developed by the GOC or by professional associations (if the latter this could be accredited by the GOC, if accreditation is adopted for employer appraisal schemes);
- seeking peer review of practice by a colleague recognised as having met (GOC) specified standards as a reviewer, again using documentation, guidance, and perhaps also reviewer training, developed and provided by professional associations;
- participation in peer group review of case presentations, a facility which could be organised by professional associations and networks or as an adjunct to continuing education events;
- submission of anonymised case records for review by independent auditors (approved by the GOC) who would provide a report to the registrant which could be submitted as evidence for revalidation;
- commissioning a full performance assessment (from a GOC approved assessor) to provide a comprehensive and independent review of practice.

149. The main disadvantage of all these measures is that they would incur a cost, which would presumably fall mainly to registrants.⁵⁸ Consequently there would be little incentive for registrants to pursue any of these mechanisms – beyond a sense of professional responsibility – unless they were obliged to do so as the corollary of a decision to make the use of employer appraisal (where it exists) a mandatory source of evidence for revalidation. The apparent inequity in treatment in respect of registrants who are able to cite evidence from employer appraisal schemes at no direct cost to themselves, is comparable to other employer funded benefits which vary from one employer to another and which reflect market forces.

150. The mechanisms cited above assume the support of professional associations to help facilitate opportunities for registrants who are not subject to employer appraisal. Other options were dismissed by informants as unworkable. For example the potential for Local Optometric Committees in England to provide a locus of support was rejected on the grounds that this would confuse contractual issues with professional regulation. Similarly, informants were resistant to the idea that Optometric Advisers could expand practice inspections to generate evidence for revalidation, again citing a confusion of responsibilities as the main objection. Furthermore, Optometric Advisers felt they already had demanding responsibilities in what was, in some areas, considered to be an under-resourced function. Other

⁵⁸ If the GOC was to hold a list of approved assessors or reviewers, it might also wish to consider a system of reimbursement to reduce the direct cost to registrants.

local professional fora are voluntary groups which meet infrequently and which have no particular mandate beyond the mutual benefits of association.

Recommendations

151. Based on an analysis of the findings, and drawing on the observations informants made about wider aspects of revalidation, a number of recommendations have been submitted to the Revalidation Workstream Group for its consideration.

ENDS

APPENDICES

Appendix A: Principal Informants

Fiona Anderson	Dispensing Optician, trainer and assessor in 20 branch independent practice	North East Scotland
Jane Bell	Self-employed locum Optometrist (trainee independent prescriber)	South of England
Ed Bickerstaffe	Employed Optometrist – nationwide domiciliary	West of England
Susan Blakeney	Optometrist, Optometric Adviser and Chair, Optometric Advisers Group	London/South East
David Cartwright	Professional Services Director and Optometrist	Boots/Donald and Atchison
Lisa Collins	Optometrist and Countywide Head of Optometry, NHS Trust	West of England
Duncan Cruickshanks	NHS Hospital Optometrist	Forth Valley Scotland
Maria Dengler-Harles	Optometrist NHS Trust	North West England
Kim Devlin	Contact Lens Optician/ Dispensing Optician and Independent Practice Owner	South East England
Christine Dickinson	Programme Director and Optometrist	Manchester University
Pat Donovan	Head of Department	Bradford College
Abdul Mohammed Essa	Employed Optometrist	Multiple, South East England
Anne Fedrick	Communications and Member Services Manger	FODO
John Fried	Dispensing Optician and 5 branch Practice Owner	London
Rachel Frost	Human Resources Director	Galaxy Optical
Sir Anthony Garrett	Chief Executive	ABDO
Georgina Gordon	Chief Executive	Local Optometric Committee Support Unit
Jim Gordon	Dispensing Optician and Independent Practice Owner	South West
Rob Hampson	Employed Optometrist	Multiple, North East England

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Lynn Hansford	Optometrist, Practice Owner, Secretary: Optometry Wales	Wales
David Hewlett	Chief Executive	FODO
Chris Hull	Head of Department of Optometry and Visual Science	City University
Trevor Hunter	Curriculum Manager Applied Optics and Medical Sciences	City and Islington College
Bob Hughes	Chief Executive	AOP
Phil Hyde	Head of Professional Services and Dispensing Optician	Vision Express
Laura Hytti	Registration Supervisor	GOC
Linda Kennaugh	Director of Education	GOC
Julie-Anne Little	University academic, and Optometrist	Northern Ireland
Karen MacQueen	Operation's Manager & Contact Lens Optician	ASDA
Michael Mere	Contact Lens Optician	Multiple, South West of England
Paul Milligan	Employed Dispensing Optician	Multiple, North of England
Jocelyn Morgan	Finance Director	Galaxy Optical
Jo Mullin	Director of Education	College of Optometrists
Stuart Parr	Employed Dispensing Optician	Multiple, Scotland
Aiman Poptani	Employed Optometrist in Independent Practice	London
Kiran Rait	Employed Optometrist	Multiple, Central England
Kim Read	Secretary, North Yorkshire Local Optical Committee and Optometrist	Yorkshire
Dawn Roberts	Clinical Director, Optometrist and Optometric Adviser	Healthcall
Gill Robinson	Director of Professional Training and Development	Specsavers
David Sculfour	Hospital Optometrist, NHS Trust	Central England
Dimple Shah	Optometrist, Professional Adviser	Contact Lens Manufacturer
John Siderov	Head of Department and Optometrist	Anglia University
Claire Slade	Professional Services Manager and	ASDA

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	Optometrist	
June Stewart	Communications Director and Dispensing Optician	Optical Express
Niall Strang	Programme Organiser, Optometry	Glasgow Caledonian University
Glen Tomison	Director of Business and Dispensing Optician	Healthcall
Andrew Tompkins	Hospital Optometrist, NHS Trust	North West England
Matt Trusty	Partner and Dispensing Optician	Franchised Multiple
Jo Underwood	Principal	ABDO College
Timothy Wess	Head of School	Cardiff University
Nick Wingate	Head of Professional Services	Outside Clinic
James Wolffsohn	Optometric Subject Leader	Aston University