Who are non-standard GPs for the purpose of this guidance?

This guidance should be read in conjunction with the Northern Deanery guidance (appraisal pack) which details the current requirements for appraisal and revalidation.

There are a number of groups of GPs who may have concerns about the feasibility of submitting a ‘standard portfolio’. Their difficulties have been closely studied as part of a Pilot funded by the RCGP and run by the Northern deanery in 2009-2010 and may include those:

1. who do not have a fixed regular practice base because they work as a locum
Target readership

This guidance should be made available to appraisees in the categories above. Responsible officers, tutors and appraisers should also be aware of this guidance.

Supporting evidence required for appraisal and revalidation

The GMC has set out guidance relating to information required for appraisal and revalidation. It also refers also to specialty specific guidance to be issued by each Royal College – the RCGP has published several versions of its Revalidation Guidance. The GMC guidance should be seen as mandatory, the College guidance as advisory.

The items of supporting information which mainly pose challenges for non-standard GPs) are:

- **a. Quality improvement activity** (e.g. audits, case review or discussion, review of clinical outcomes)
- **b. Significant events**
- **c. Feedback from colleagues**
- **d. Feedback from patients (where applicable)**

Guidance on the latter 2 are covered in the NEPCSA FAQs on Patient and colleague feedback available on NEPCSA website.

**Review of your practice- Quality improvement activity**

Appraisers need to be aware that the GMC guidance provides for greater flexibility in this category than current RCGP guidance (V7 of RCGP revalidation guide).

The GMC guidance states:

For the purposes of revalidation, you will have to demonstrate that you regularly participate in activities that review and evaluate the quality of your work. Quality improvement activities should be robust, systematic and relevant to your work. They should include an element of evaluation and action, and where possible, demonstrate an outcome or change. Quality improvement activities could take many forms depending on the role you undertake and the work that you do.[...].

Examples of quality improvement activities include:

- **clinical audit:**
case review or discussion: documented account of interesting or challenging cases that a doctor has discussed with a peer, another specialist or within a multi-disciplinary team

What does the College (Version 7 guidance) say about audit?

The appraiser and responsible officer will need to be satisfied that at least one acceptable clinical audit has been submitted.

The key attributes of a clinical audit are: the relevance of the topic chosen; the appropriateness of the standards of patient care set; the reflection on current care and the appropriateness of changes planned; the implementation of change for the GP’s patients; and the demonstration of change by the GP. There is no expectation that the GP will actually undertake the data extraction and/or analysis.

Alternatives to audit as quality improvement activities for non-standard GPs.

A standard audit, as defined by the RCGP, is where performance is measured against an agreed standard [eg NICE guidance], any deficiencies or shortfall defined, and improvement in performance checked by a second data collection.

Many locum and salaried GPs have no involvement in the management of quality in practices in which they work. So showing quality improvement in a practice’s clinical care via a standard audit may not be feasible, or relevant to their role or responsibilities.

1) A more feasible and relevant for such GPs to show quality improvement is in relation to their own practice, for example reviewing an aspect of their personal clinical practice such as:
   a) record-keeping
   b) referrals or investigations
   c) prospective case based condition reviews
   d) random case analysis or review of telephone triage outcomes

2) The relatively small numbers of events involved, when reviewing one aspect of a single doctor’s diverse practice, means that it will usually be possible to provide qualitative, but not quantitative, evidence of change. This is because for example the breadth of focus (range of clinical decisions being reviewed in one disease area) means there is no single standard or criterion or no evidence on which to base criteria.

3) Learning points arising from such review exercises will be key outputs. Case reviews may be particularly useful, both formatively and to demonstrate that learning points are subsequently incorporated into practice.

Condition based review

The appraisee selects a clinical area which they feel needs improvement (based on feedback, or significant events or simply confidence ratings) and for which there are good (preferably) evidence based guidelines. It needs to be a common condition. e.g. UTIs, depression, copd, asthma, anxiety.
The GP carries out a prospective collection of consultations relating to this condition seen by him or herself (printing off the consultation record, summary and medications). After 12-15 are collected the doctor reviews these against guidelines looking for patterns or themes and producing learning points as to aspects of diagnosis or care which might be improved. This is where there is a key difference from audit. The focus of the review is much broader than a single criteria so there can be no standard setting for a single criteria. Learning points can be applied by use of a case review and the whole exercise can be captured using one of the NEPCSA Quality improvement templates.

**Random Case Analysis**

RCGP Revalidation Guidance indicates that an alternative to clinical audit for locum or out-of-hours doctors is random case analysis (RCA). The guidance suggests that clinical decision making, record keeping and standards of care in 20 consecutive consultations are reviewed using a standardised format with an appropriately skilled and experienced colleague or colleagues. Reflection occurs and improvements are agreed upon and demonstrated.

For some doctors it may be possible to keep a list of patients seen and then undertake RCA with access to the medical records. However in many cases this will not be practical so keep a simple record of 20 consultations e.g.

<table>
<thead>
<tr>
<th>Case Reference</th>
<th>Age</th>
<th>Gender</th>
<th>Problem</th>
<th>Management</th>
<th>Issues for discussion</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Learning points, actions and review of changes should be recorded. Document 5 within the NEPCSA Annual Appraisal Pack – Quality Improvement Activity Review Template is an example of how this might be done.
## Comparison table of quality improvement initiatives

<table>
<thead>
<tr>
<th>Type</th>
<th>Data</th>
<th>Focus</th>
<th>Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Condition based review</td>
<td>Series of cases (consultations) with a given condition. Due to small numbers and problems with searches often have to be collected prospectively.</td>
<td>Cases attributable to the individual. Care is reviewed against guidelines for the whole condition. Broader focus (not a single criteria), because of smaller number of cases seen when narrowed to the individual.</td>
<td>Change in behavior evidenced by different clinical behaviours demonstrated in a case review or in further series of cases but takes times to accumulate the cases due to having to be attributable to the individual.</td>
</tr>
<tr>
<td>Review of referrals</td>
<td>Series of referral letters. Sometimes may be focusing on one specialty but again numbers may be too small to do this so may be heterogeneous collection.</td>
<td>Structure and quality of letter content and appropriateness of referrals, sometimes by discussion with peers. - used local form/proforma? - PMH and drug history included? - Alternative pathways not available? - Driver for referral: diagnostic uncertainty; to access treatment/surgery; patient concerns; to access investigations; other - Any lesson learned? - In retrospect was referral the most appropriate?</td>
<td>Learning points and can also demonstrate applied change in case reviews.</td>
</tr>
<tr>
<td>Review of quality of records</td>
<td>Successive consultation records in a randomly chosen day or week are reviewed (retrospective) repeated after an interval (but again retrospective).</td>
<td>Safety netting, consent, chaperone offered. red flags READ coded problem presence of carer or guardian etc.</td>
<td>If the focus is sufficiently narrow it may be feasible to demonstrate a numerical improvement between data cycles.</td>
</tr>
<tr>
<td>Telephone triage</td>
<td>Series of consultation reviewed by a 3rd party in Out of Hours setting.</td>
<td>Sets of standards of the OOH provider. Appraisee needs to provide reflections, learning points captured for example in the NEPCSA quality improvement template.</td>
<td>Can illustrate change via a case review.</td>
</tr>
<tr>
<td>Random case analysis</td>
<td>20 consecutive consultations are reviewed using a standardised format with an appropriately skilled and experienced colleague or colleagues. Suitable for OOH</td>
<td>Clinical decision making, record keeping and standards of care. e.g. appropriate history, ideas, concerns and expectations Excluding serious situations Appropriate assessment – Management plan including prescribing, referral or admission compliance with guidelines Record keeping, Communication with colleagues, Safety netting Time management</td>
<td>Reflection occurs and improvements are agreed upon and demonstrated for example via case review.</td>
</tr>
</tbody>
</table>
**Significant event analysis**

The RCGP revalidation guide (V6) says “It is a technique to reflect on, and learn from, individual cases to improve quality of care overall. A GP must only submit an analysis of a significant event in which he or she has been directly involved, where the event was discussed in a team meeting (usually a Significant Event Audit meeting) with an appropriate selection of other primary care team members present, and **where the changes involve him or herself, perhaps as the person responsible for implementing the change.** Although a significant event should be ideally discussed with the clinical team involved, it will be acceptable to discuss and reflect with a **peer group** (for example chambers or educational group), demonstrating the improvements in care. The doctor can use a case notes review of complex cases with an appropriately skilled and **experienced colleague** or colleagues in which challenging cases are reviewed, reflection occurs and improvements are identified.”

Sessional GPS may have difficulty with this because of

- Lack of feedback after leaving practice: not informed about significant events and not invited to meetings.
- Not aware of how to report them.
- Perceived disincentive of whistle-blowing and losing subsequent employment.
- Will generally hear about own significant events, but hours may mean missing practice meetings, which may be arranged when off, or when covering sessions.
- In addition as a locum you may not be invited to attend practice clinical meetings unless you are working somewhere more long term.

**Solutions**

Sessional GPs should:
1. ask the practice manager or a practice based GP keep them informed of any significant events which relate to their care
2. discuss event or cases personal to them with
   a. a colleague within the practice
   b. their learning group or locum group
3. reflect on the events as a **case review band discuss** with the appraiser if there have not been any opportunities to discuss with colleagues.

For more information about **self directed learning groups** you may find useful:

1. Self directed learning groups: A Guide to making them successful, by Paula Wright, available on the Northern deanery  
Multisource Feedback and locums

There is extensive guidance on MSF available on the NEPCSAs appraisal website. This section covers issues specific to locums.

Getting enough responses

GPs should remember to include colleagues from all their roles (e.g., undergraduate teaching, CCG work, GPwSI role or any other role including private or voluntary medical roles).

Some MSF providers will still produce a report with lower numbers—its worth discussing this in advance. The responses from smaller numbers have to be interpreted with more caution if the required minimum number has not been achieved. This is something to explore during the appraisal. Edgecumbe require fewer responses than CFEP and so Edgecumbe may be a better option if you feel you will struggle to find 15+ colleagues.

Some providers will allow responses to be collected over a longer time which may suit some locums who move around and need to get response over a year from several practices (e.g., portfolio RCGP for example).

Benchmarking and locums

CFEP, who have more ‘trial’ data than Edgecumbe, having run the GMC pilot, have therefore also got more benchmarking data. They have two sets of questionnaires—their own, and the GMC version, both of which are acceptable for the purposes of Revalidation. We have suggested that GPs opt for the GMC version as it is the newest version, but CFEP have data which is specific to different groups of doctors, e.g., locums from their own questionnaire, but not yet for the GMC version. Locums who wish to compare their feedback with other locums should ask to use the CFEP questionnaires not the GMC versions at this point in time—Once enough of the GMC ones have been completed by doctors, locum norms will be available for the GMC version as well, hopefully during the next year.

Administering patient questionnaires

GMC guidance states that surveys should be distributed by reception staff not the doctor in order to ensure an unbiased sample. However, there may be circumstances where locums are unable to obtain this help where they work. In these circumstances, it is acceptable for the doctor to hand out surveys to consecutive patients ensuring no selection is taking place, providing they state this explicitly in their appraisal.

Feedback about this document:

Please send feedback about this document to Dr Paula Wright pfwright@doctors.org.uk.
Appendix 1

Examples from SOAR (Scottish Online appraisal resource):
This website contains toolkits for Sessional GPs and OOH doctors.


Antibiotic prescribing

For ten surgeries, note your use of antibiotic prescribing against your chosen set of criteria and standards. You need to consider setting criteria such as:

1. Patients receiving antibiotics should have a recognised condition for which antibiotics are recommended
2. Antibiotics should be used which are in line with local formulary or microbiology laboratory recommendations for first line use, unless clinically contraindicated
3. When appropriate, microbiology sampling should be undertaken to check on organisms and sensitivities
4. All antibiotic prescribing should use the most effective dose and duration of treatment for the identified condition, in line with local formulary guidelines or the BNF.
5. All antibiotic prescribing should be accompanied by a check for known past history of hypersensitivity.
6. All antibiotic prescribing should be accompanied by a check for potential drug interactions.
7. Broad spectrum antibiotics should only be used where clinically indicated.
8. If a second line antibiotic is used, the reason for its use should be documented.
9. All potentially infective lesions or conditions should be subject to local infection control policies.
10. Patients with MRSA should be handled in line with agreed local guidelines.

These are only examples of criteria which you might choose from. You are recommended to use criteria which you can justify, and you will then need to justify the standards that you set for your performance. You might want to consider repeating the exercise for another 10 surgeries at a later date, to complete the “audit cycle”.

Analgesic prescribing

For ten surgeries, note your use of analgesic prescribing against your chosen set of criteria and standards. You need to consider setting criteria such as:
1. Patients prescribed analgesics should have a condition or reason clearly recorded in their records.
2. Analgesics should be used which are in line with local formulary recommendations for first line use, unless clinically contraindicated.
3. If a non steroidal anti-inflammatory is used, gastric protection should be considered where appropriate (for example elderly, debilitated patients).
4. Non steroidal anti-inflammatory drugs should generally be avoided in patients with a past history of GORD, ulcer disease or upper G-I haemorrhage.
5. Strong analgesics should be prescribed in relatively small quantities on first presentation (a week?).
6. Patients with chronic pain should have a clear record of any adjustment to their regime.
7. Patients who are prescribed opiates often experience constipation: for elderly patients a laxative should be prescribed or a warning of the risk given to the patient and recorded.
8. All analgesic prescribing should be accompanied by a check for known past history of hypersensitivity.
9. All analgesic prescribing should be accompanied by a check for potential drug interactions.
10. If a second line analgesic is used, the reason for its use should be documented.

Imaging and investigations

For ten surgeries, note your use of investigations and imaging requests. You should keep a note of each patient, and at a later date you should

- either contact the practice to find out the result
- or contact the laboratory or X-ray department

You can do the audit against your chosen set of criteria and standards. You need to consider setting criteria such as:

1. A request for a laboratory test should have a clear clinical reason. Can you identify one for each of yours? (For example if checking renal function in hypertension, what reason for also ticking LFTs?)
2. Laboratory samples need to be correctly labelled, in the correct container and to arrive within an appropriate time period.
3. A laboratory investigation should be appropriate. On reflection did you ask for a test that was likely to help with managing the patient’s problem? (For example it is difficult to justify checking TFTs for a young patient who complains of “tiredness all the time” whose TFTs were checked three months ago)
4. Investigations should expect to include a reasonable proportion of abnormal results. (What proportion do you think this should be?)
5. Clear directions should be included on a request form if a telephone report is required. Did you do this?
6. X-rays should only be requested in compliance with the guidelines of the Royal College of Radiologists (to avoid unnecessary exposure to ionising radiation). Do you know what these state or how to find out?
7. Guidelines now suggest alternatives to X-ray investigations in some cases: did you follow all relevant guidelines? (for example SIGN or local guidelines on dyspepsia)

8. Radiologists now have the right to refuse all requests which do not conform to guidelines. All requests for which the referring doctor is uncertain should be discussed before referral. Did you encounter a situation like this?

9. All imaging techniques have limitations. Can you show that your requests take this into account? (For example, an ultrasound scan on a “lump” can only be performed on one that you can definitely palpate)

10. Some imaging investigations can be dangerous or uncomfortable. Do you give patients a clear explanation and explore possible adverse events in advance? (Barium enema or colonoscopy are both uncomfortable and sometimes hazardous; allergy to injected contrast medium may be serious; diabetics who are asked to fast before an examination need special arrangements)

---

www.rcgp.org.uk/_revalidation.aspx

2 http://www.gmc-uk.org/Supporting_information.pdf_42293176.pdf


PLEASE NOTE : This guidance is likely to undergo revisions as further guidance is published by the RCGP, GMC and RST. For the latest version please contact me pfwright@doctors.org.uk.