GUIDANCE ON SUPPORTING INFORMATION FOR SESSIONAL GPS.

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WHO ARE SESSIONAL GPS FOR THE PURPOSE OF THIS GUIDANCE?

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 2009-2010i and may include:

1. locums without a fixed regular practice base
2. Those working a limited number of clinical a sessions sometimes because they have a significant role outside of general practice (e.g. academic, management, etc.)
3. who work as salaried doctors and therefore may have limited organisational /management influence on practice systems
4. who have had a significant break from work,

TARGET READERSHIP

Appraisees in the categories above; Responsible officers, tutors, appraisers.

SUPPORTING EVIDENCE REQUIRED FOR APPRAISAL AND REVALIDATION: GMC AND RCGP GUIDANCE

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. Whilst GMC guidance is mandatory, the College guidance is advisory.

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

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

REVIEW OF YOUR PRACTICE- QUALITY IMPROVEMENT ACTIVITY

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"

THE UPDATED (2016) RCGP REVALIDATION GUIDANCE ON QUALITY IMPROVEMENT

Extract:

1. "The RCGP recommends that you should demonstrate the ability to review and learn from your medical practice by reflecting on representative **quality improvement activities (QIA) relevant to your clinical work every year, with a spread of QIAs across all of your scope of work over a five year cycle.**
2. Going forward, you are advised to choose **representative** quality improvement activities, appropriate to your scope of work and circumstances, that reflect how you review and improve the quality of your practice every year.
3. ***QIA may take many forms, including, but not restricted to: large scale national audit, formal audit, review of personal outcome data, small scale data searches, information collection and analysis (Search and Do activities), plan/do/study/act (PDSA) cycles, significant event analysis (SEA) and reflective case reviews, as well as the outcomes of reflection on your formal patient and colleague feedback survey results, Significant Events and Complaints***.
4. For some parts of your scope of work, particularly relating to **specific clinical skills** such as minor surgery, joint injections, cervical smears and IUCD/IUS insertions (where applicable) it may be possible and appropriate to maintain a log of personal outcome data and reflect on the outcomes.
5. If you are in a role where there is **organisational, regional or national outcome data** provided, it is best practice to demonstrate how you reflect on your personal involvement and response to the information provided about your performance.
6. You **do not need to have undertaken data collection personally** but your reflection should describe your personal involvement in the activity and what you have learned about your own performance in relation to current standards of good practice, including what changes you plan to make as a result, or how you will maintain high standards of performance.
7. **No fixed number of QIA is being recommended,** as some will be very brief interventions, and others will be very significant projects. The RCGP recommend that you keep in mind the principle of providing documentation **that is reasonable and proportionate and does not detract from patient care,** while ensuring that your QIA cover the whole of your scope of work over the five year cycle and demonstrate clearly how you review and improve the quality of your practice every year. If in doubt, **discuss your plans** for the coming year with your appraiser and use your professional judgement about what is appropriate.

Clinical audit, defined by the Healthcare Quality Improvement Partnership (HQIP) and endorsed by- the National Institute for Health and Care Excellence (NICE) is:
A quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change.

The previous version of RCGP guidance explained clearly the limitations of using Clinical Audit as evidence for appraisal for Sessional GPs:
"Clinical audit with retrospective data collection is one of a number of established tools for improvement of quality in systems and teams. <u>For doctors with managerial responsibility within their practice this may be one form of quality improvement</u> activity to submit as it will

demonstrate they are involved in continuously improving the quality of their systems of health care. For some GPs, however – particularly those **without a fixed practice base or employed GPs who usually have no managerial role and therefore no or limited organisational influence to bring about change in the behaviour of colleagues** – audit in its traditional format may be more challenging and less relevant to the individual's appraisal. Additional challenges that audit presents to locum GPs include limited access to records, a lack of continuity in the place of work and the ability of the GP to influence other team members. The essential elements of audit – reviewing, reflecting and improving – can however be incorporated into other review exercises that support quality improvement in the individual; these are discussed further below."

ALTERNATIVES TO AUDIT AS QUALITY IMPROVEMENT ACTIVITIES.

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.

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:

- record-keeping
- referrals or investigations
- prospective case based condition reviews
- random case analysis or review of telephone triage outcomes

Due to the narrowed focus on the individual's practice (as opposed to the teams) there is a need to broaden the clinical focus away from very specific criteria (such as referring to pulmonary rehab for COPD patient) to a broader "condition-based" focus (e.g. diagnoses and management of COPD patients). The relatively small numbers of patient which any given doctor sees with one condition 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.
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.
A portfolio of anonymized examples of Quality Improvement has been compiled by Paula Wright and is available on the HENE appraisal webpage.

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 a Quality improvement templates (see NEPCSA website).

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.

Case Reference	Age Gender	Problem	Management	Issues for discussion

Learning points, actions and review of changes should be recorded.

COMPARISON TABLE OF QUALITY IMPROVEMENT INITIATIVES

Type	Data	Focus
Condition based review	Series of cases (consultations) with a given condition. Due to small numbers and problems with searches often have to be collected prospectively.	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.
REVIEW OF REFERRALS	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.	Structure and quality of letter content and appropriateness of referrals, sometimes by discussion with peers. • used local form/proforma? • PMH and drug history included? • Has past management of this problem been described? • Alternative pathways not available? • Driver for referral/ IS THIS CLEAR? (diagnostic uncertainty; to access treatment/surgery; patient concerns; to access investigations; other • Any lessons learned? • In retrospect was referral the most appropriate?
REVIEW OF QUALITY OF RECORDS	Successive consultation records in a randomly chosen day or week are reviewed (retrospective) repeated after an interval (but again retrospective).	Safety netting, consent, chaperone offered. red flags READ coded problem presence of career or guardian etc. See criteria in
REVIEW OF CONSULTATION RECORDS AGAINST NICE QUALITY INDICATORS	Focused on specific conditions e.g. • Feverish child • COPD • Asthma • stroke	Criteria listed p 44 of Urgent and Emergency Care Clinical Audit Toolkit (see resources). e.g. for feverish child in face to face consultation Alertness • Rash • Neck stiffness • Fontanelle • Records temperature • Records heart rate • Records respiratory rate • Capillary refill • Records diagnosis or suspected diagnosis • Adheres to NICE Guidance SPECIFIC WORSENING INSTRUCTIONS
TELEPHONE TRIAGE/OOH	Series of consultations reviewed by the doctor or a 3rd party in Out of Hours setting.	Sets of standards of the OOH provider. 1 clear/relevant history 2 Recording other relevant information -pmh/dh/sh 3 For those seen face to face - appropriate examination/documenting observations 4 Appropriate management 5 Safety netting 6 Easy to follow thought process IF review is carried out by a 3rd party (e.g. OOH reviewer) then appraisee needs to provide reflections, learning points captured for example in the NEPCSA quality improvement template. Several examples of criteria for review in the RCGP Urgent and Emergency Care Clinical Audit Toolkit (see resources)

OOH RECORDS REVIEW	Review of GP special Notes Review of DNARs and End of Life Care documents put in place by OOH	Whether followed guidelines.
CASE REVIEW IN OOH	From SOAR OOH toolkit (see resources) Clinically challenging situations:	Reflective case reports on: • Deaths in the OOH period: both sudden and anticipated deaths • Patients with a mental health problem whose behaviour causes major concern • Situations involving personal risk • Probity: intimate examinations, concerns about children at risk
RANDOM CASE ANALYSIS	20 consecutive consultations are reviewed using a standardized format with an appropriately skilled and experienced colleague or colleagues. Suitable for OOH	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 Communication with colleagues, Safety netting

A portfolio of actual examples of QIAs (which are not audit) is available collected by Paula Wright. This is available on the website of the North East Sessional GP group **WWW.NESGP.ORG.UK** (appraisal page) or on the Health Education North East GP appraisal page.

CRITERIA FOR REVIEW FROM URGENT AND EMERGENCY CARE CLINICAL AUDIT TOOLKIT, RCGP, RCPCH

For further details about using this toolkit and criteria please refer to the Toolkit document (reference in resources).

1. Elicits REASON for call/visit
   A. Clearly identifies main reason for contact
   B. Identifies patient's concerns [health beliefs]
   C. Accurate information e.g. demographics taken by Call Handlers
   D. Gives a good explanation of the process

2 Identifies EMERGENCY or SERIOUS situations
   A. Asks appropriate questions to identify or exclude [or suggest] such situations
   B. Appropriate use of ILTC protocols
   C. Phrases questions in a way the caller can understand
   D. Quickly establishes the need to respond to a serious or emergency situation and acts accordingly

3 Takes an appropriate HISTORY (or uses algorithm appropriately)
   A. Elicits significant contextual information (e.g. social history)
   B. Identifies relevant PMH/DH [including drug allergy]

4 Carries out appropriate ASSESSMENT
   A. Face–to–face settings–complete examination of all relevant body regions documented
   B. Targeted information gathering or algorithm use to aid decision making
   C. Links findings to history

5 Draws CONCLUSIONS that are supported by the history and physical findings
   A. Constructs appropriate diagnosis or differential based on the history and findings to date/identifies appropriate 'symptom cluster' with algorithm use
   B. Prioritizes appropriately
   C. Streams/Refers patient appropriately

6 Makes appropriate MANAGEMENT decisions following assessment
   A. Decisions conform to relevant clinical guidelines (with any exceptions clearly and correctly justified)
   B. Practices in accordance with relevant code of conduct
   C. Decisions are safe

7 Correctly fills in appropriate DOCUMENTATION
   A. Documents information clearly and legibly, following correct procedures and processes
   B. Correct documentation and information given to the patient

8 Appropriate PRESCRIBING behaviour
   A. Generics used [unless inappropriate]
   B. Formula–based [where available]
   C. Follows evidence base or recognised good practice

9 Displays adequate SAFETY–NETTING
   A. Clearly documents advice given about when to return/call back
   B. Records advice given (worsening instructions)

10 Did the clinician address any potential SAFEGUARDING issues?

A. Do the notes demonstrate an awareness of safeguarding issues (where relevant)?

B. If safeguarding issues were suspected was the patient referred to the appropriate service?

C. If an injured child; did the clinician explore the possibility of intentional injury?

11 Makes appropriate use of IT/Protocols/Algorithms

A. Adequate data recording

B. Face–to–face/Call Handler use of IT tools where available/appropriate

C. Clinician on telephone–appropriate use of support tools or algorithms

D. Identifies discrepancies in information passed between clinicians if needed

E. Appropriate referral to another service if required

12 Displays EMPOWERING behaviour

A. Acts on cues/beliefs

B. Involves patient in decision–making

C. Use of self–help advice [Inc. Patient Information Leaflets]

D. Responds appropriately to caller requests for information

13 Develops RAPPORT

A. Demonstrates good listening skills

B. Communicates effectively [includes use of English]

C. Demonstrates shared decision making

D. Conducts themselves in a professional manner

14 Satisfies ACCESS criteria where appropriate [info available]

SIGNIFICANT EVENT ANALYSIS

Recent guidance from the RCGP on SEAs has changed. Most SEAs routinely discussed in General practice do not meet the GMC definition of SE (critical incidents, significant untoward incidents and/or serious incidents requiring investigation) and are therefore a form of QIA and one possible option for your QIA submission. These can be submitted on an appropriate template but there is no longer a minimum requirement to submit 2 every year.
Extract from 2016 RCGP guidance:

1. "The GMC definition of Significant Events (SEs) includes critical incidents, significant untoward incidents and/or serious incidents requiring investigation. By definition, these are serious events where significant harm could have, or did, come to a patient or patients. The GMC consider the type of significant event analysis (SEA) routinely undertaken in primary care to be a quality improvement activity (QIA). You should include general practice significant event analysis as a form of QIA, except where the event crosses the threshold of significant harm described above.
2. All GMC level SEs in which you have been personally named or involved **must be declared**, and the reflections on them and actions agreed as a result must be provided in this section of supporting information and reflected on during your annual appraisal.
3. All GMC level SEs should be written **up on a standardised pro forma**, formally analysed to ensure that the root causes are understood and changes are made to protect patients, and discussed with colleagues to maximise and share learning according to GMC requirements.
4. If you have not been personally named, or involved, in a GMC level SE during the year, you **should sign a statement to confirm there were none**.
5. It is best practice to demonstrate that **you are aware of how SEs are captured in the organisations within which you work, across the whole of your scope of work**. You should know how to report any SEs that you become aware of and how to ensure, as far as possible, that you find out if you have been named, or involved, in any."

The National Patient Safety Agency (NPSA) defines significant event analysis as:
"A process in which individual episodes (when there has been a significant occurrence either beneficial or deleterious) are analysed in a systematic and detailed way to ascertain what can be learnt about the overall quality of care, and to indicate any changes that might lead to future improvements."

In the context of Sessional GPs the previous RCGP revalidation guide (version 9) helpfully states that:
"For the purposes of revalidation, you must only submit an analysis of a significant event in which you have been directly involved, where the event was discussed with other colleagues. For practice-based GPs the expectation would be that the discussion around a significant event would occur within the practice-based team meeting (usually an SEA meeting) with an appropriate selection of other primary care team members present, so that necessary changes can be made within the practice. Sometimes, however, employed doctors may not have ***sufficient influence over meetings and their employer to see their significant events discussed in this formal way. For doctors without a fixed practice base the discussion of the significant event in a peer group or learning group allows reflection, learning and planning of changes.*** *For the SEA to be appropriate to your appraisal the changes arising from the*

discussion should involve yourself, perhaps as the person responsible for implementing the change or as someone who needs to change his or her own practice."

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.
- no influence over practice systems so unable to bring in improvements

Here are some actions Sessional GPs should consider:

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 colleague within the practice, their learning group or locum group and capture on a SEA template
3. Reflect on the events as a **case review and 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 HENE http://mypimd.ncl.ac.uk/PIMDDev/pimd-home/general-practice/continuing-practice-support/sessional-gps .
2. Self-directed learning groups for GPs: a support framework for revalidation. 2013, BMJ careers, Paula Wright.

http://careers.bmj.com/careers/advice/view-article.html?id=20012222

MULTISOURCE FEEDBACK AND PATIENT SURVEYS

There is extensive guidance on MSF available on the HENE website and GMC website. This section covers issues specific to locums.

Challenges for Locums and other sessional doctors:

1. poor response rates from colleagues and patients
2. colleagues feeling they don't know the appraise well enough to rate them
3. proven biases in ratings when colleagues and patients don't know the appraise well
4. difficulties in administering the questionnaires to patients- reception staff may be too busy
5. difficulties obtaining contact emails for colleagues
6. influence of lack of induction and support on a locum's perceived performance
7. doctors working in prison and out of hours experience exacerbated problems with administration of patient surveys, response rates and professional isolation

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- it's worth discussing this in advance. Also there is often a cut off for minimum number of responses to produce an average for each question. So for example CFEP will not produce an average rating if there are less than 5 responses to a question but will report the individual responses given (anonymised).
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.
Providers differ in the numbers of responses required to produce the report.
Some providers will allow responses to be collected over a longer period time if you approach them directly which may suit some locums who move around and need to get responses over a year from several practices.

BENCH MARKING AND LOCUMS

As there is a known "bias" in patient responses which results in GPs who have an established relationship with a patient being rated more highly than a locum, locums are advised to use a tool/MSF provider which has developed benchmarks specific to locums. CFEP, who have more 'trial 'data than Edgecumbe, having run the GMC pilot, have got more benchmarking data. They have two sets of questionnaires- their own, and the GMC version. It is worth checking with them whether they have benchmarking data for locums for both questionnaires and making your choice accordingly as both of are acceptable for the purposes of Revalidation. Edgcumb is also developing locum benchmarking data.

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.

WHEN YOU HAVE SEVERAL ROLES

If you work in several roles you will need to ensure that your supporting information reflects your portfolio. The RCGP revalidation guide (version 9) states that: "For doctors who undertake very limited clinical work, they need to be able to demonstrate that they are up to date and fit to practice in the clinical component of their work with appropriate CPD, quality improvement activity and reflection." For more information please refer to the RCGP revalidation guide.

ALTERNATIVES TO FORMAL PSQ/MSF

The RCGP now recommend that "In addition to the formal GMC compliant patient survey, done once in the five year cycle, the RCGP now recommends that you reflect on some of the many other sources of feedback from your patients, including compliments, annually at your appraisal."
This could be in the form of a Feedback log where you capture feedback and your reflections as exemplified in the next page:

FEEDBACK LOG

Date	Source and Context e.g. Patient, Colleague and brief description of consultation or context	Themes or quote from feedback	Personal reflections and further action

FEEDBACK ABOUT THIS DOCUMENT:

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

IF YOU FEEL YOU CANNOT SATISFY APPRAISAL REQUIREMENTS DUE TO YOUR ROLE

Remember to seek advice early if you feel you cannot satisfy appraisal requirement in the role you currently work in. If your role or situation is unusual you will usually need to go beyond an appraiser to the responsible officer or appraisal lead to explore feasible and meaningful options. Remember the following principal for revalidation:

"The evidence required and the standards applied to that evidence must take account of the different working lives of general practitioners; the process must be objective, fair and equitable" (Revalidation for GPs: RCGP Consultation draft 2008).

USEFUL RESOURCES:

GMC guidance on supporting information for appraisal and revalidation
http://www.gmc-uk.org/doctors/revalidation/revalidation_information.asp

Revalidation processes for sessional GPs: A feasibility study to pilot current proposals Report to the Royal College of General Practitioners April 2010
http://www.gmc-uk.org/Item_9___Revalidation_Projects_and_Pilots_Annex_C_33221377.pdf

Quality Improvement Activity Portfolio. Examples collected by Paula Wright, GP tutor. Jan 2016.
http://www.northerndeanery.nhs.uk/NorthernDeanery/primary-care/continuing-practice/appraisal../appraisal

RCGP revalidation guide
http://www.rcgp.org.uk/revalidation.aspx

RCGP example locum portfolio
http://www.rcgp.org.uk/revalidation-and-cpd/~/media/21A1EBAE156C4CB1AC6C27F78666EEB4.ashx

RCGP example OOH portfolio
http://www.rcgp.org.uk/revalidation-and-cpd/~/media/93728CE4D603497AABBFEF867C56D7AA.ashx

SOAR: Scottish Online appraisal resource:
This website contains toolkits for Sessional GPs and OOH doctors.
http://www.scottishappraisal.scot.nhs.uk/appraisal-preparation/sessional-gps.aspx
http://www.scottishappraisal.scot.nhs.uk/appraisal-preparation/ooh-gps.aspx

Urgent and Emergency Care Clinical Audit Toolkit, RCGP, RCPCH
http://www.rcgp.org.uk/clinical-and-research/clinical-resources/~/media/Files/CIRC/Urgent-and-emergency-audit/RCGP-Urgent-and-Emergency-Care-Toolkit.ashx

GMC guidance on multisource feedback
http://www.gmc-uk.org/doctors/revalidation/colleague_patient_feedback.asp

Self-directed learning groups for GPs: a support framework for revalidation. 2013, BMJ careers, Paula Wright.
http://careers.bmj.com/careers/advice/view-article.html?id=20012222