Wessex Local Medical Committees Ltd

Representing the GPs of:
Dorset, Hampshire, Isle of Wight and Wiltshire

A Practical Guide to GP revalidation

by

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Briefing Paper BP03/2009

Revalidation for GPs will be a process by which GPs will renew their GMC licence to practise and be placed on the GMC's General Practice Register.

Revalidation will be a continuing process but will occur in 5 yearly cycles.

The debate has moved on from whether revalidation should happen to how it will be implemented and more importantly how GPs can embrace the process with maximum benefit and minimum effort.

This document is not intended to be a comprehensive guide, but is a personal interpretation of the latest information that is available and some personal views about how the process can be simplified.

The first revalidations will take place in 2010/11 and it is therefore important that all GPs start the process in April 2009. For the year 2009/10 the only requirement will be for each GP to complete their annual appraisal. There will be no requirement for evidence to be submitted prior to April 2009.

Please remember that the process of revalidation has started, so it is important that all GPs understand the process and start working towards this immediately. The process of revalidation will evolve over the next few months and years. The LMC will issue regular updates.

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The Appraisal Process

The annual Personal Development Plan (PDP) will be derived from an annual appraisal. This will need to be agreed and signed off by the Appraiser. The PDP will contain a number of goals.

Practical Advice

Although there will be no required number, most will probably pick between 3 – 5 achievable goals. GPs need to make sure that the work involved is thought through i.e. if they choose a goal which will require a significant amount of work then ensure they do not have too many goals.

Also remember to make the goals SMART

Specific
Measurable
Achievable
Relevant
Time scale

The key bit of this is the reflection – that is how people learn, not just going through the process.

The goals and the outcomes will need to be record.

Learning Credits

There is still a lot of discussion about these: Will they work? How are they measured? This system is being used by all of the medical Royal Colleges

The purpose of the credit system of measuring your continual professional developments is to:

- Ensure that every general practitioner updates and applies their knowledge and skills
- Promotes patient confidence
- Improves patient care

The current position is as follows:

- Doctors need to achieve 250 credits over a 5 year period
- A minimum of 50 credits need to be achieved each year
- A broad range of educational activity will need to be demonstrate – not just focused in one area
- The individual will self assess the number of credits and this will be confirmed by the appraiser.

The following examples are taken from The RCGP documentations:

The general practitioner presents a significant event to a significant event audit meeting; reflects on the discussion and writes up the outcome – 2 Credits

After one half day Protected Learning Time on chronic kidney disease the general practitioner undertakes an audit, introduces a new protocol into the practice and re-audits to show improvement – 15 credits

After a half day Protected Learning Time the general practitioner reviews the practice policy on safeguarding children and checks the notes of three recent case – 6 credits

Practical advice

This is not a measure of time, more a measure of impact. So to gain credits GPs will need ensure the educational activities have variety, that reflection takes place done and if this leads to change and improved patient care the more the better as this will have more value.

There will be local and national help if there is a disagreement about the number of credits claimed.

Multi Source Feedback (MSF)

This will need to be performed at least once every 5 years. There is current debate about whether this will be once or twice in every 5 year cycle. The tool that will be used is about to be trialled. GPs will be required to identify a number of people to complete this, mainly GPs but this could also involve Practice Managers, Practices Nurses, Receptionists etc.

The purpose of this is to reflect on the results and implementation of change if that is considered appropriate.

There will be a MSF particularly designed for locums.

Patient Surveys

Patient surveys have now been taken out of QoF and will be carried out on a quarterly basis by the DoH.

GPs will need to complete two patient surveys during the revalidation cycle.

Practical advice

The RCGP will be approving validated tools to conduct patient surveys.

It would be useful to compare these with previous results, (hence the need to have a consistent approach) reflect on these and ensure then record any action points.

Areas of Concern and Complaints

During the revalidation period some GPs will have undergone investigation by the local Performance Procedures, or may have been referred to the GMC.

If the cause for concern has not been resolved at the time of revalidation the portfolio cannot be considered for revalidation. A recommendation cannot be made locally or by the RCGP to the GMC. In these circumstances the portfolio will be referred to the GMC for them to consider how to proceed.

Far more common will be formal complaints and these should be detailed in the portfolio. The purpose of doing this is not to make GPs suffer and punish them again but to look to ensure there are not patterns that can be identified and to look at the response to the complaint.

GPs will therefore be required to provide the following information:

- A description of events that resulted in a cause for concern being expressed
- The cause for concern
- The assessment of that cause for concern
- Any actions resulting from that assessment
- The outcome of the cause for concern
- Reflection by the general practitioner on the experience, including lessons learned, changes made and the implications for the future

There will be a standard form in the portfolio to report on complaints which will include:

- A description of the events that resulted in a formal complaint
- The concerns expressed by the complainant
- The assessment of that complaint
- Any actions resulting from that assessment
- The outcome of the complaint
- Reflection by the general practitioner on the experience, including lessons learned, changes made, and the implications for the future

Practical Advice

Many GPs and Practices handle complaints very well and resolve them to the satisfaction of the patient, but unfortunately some do not. The LMC frequently see inappropriate responses to complaints. These responses vary but do not take the complaint seriously, are over defensive and occasionally, very aggressive and fail to resolve the issue or learn lessons from it.

Most patients making a complaint want the following:

i. To be taken seriously
Ii The complaint to be investigated impartially
Iii An apology if appropriate – (in response to complaints always say sorry this has happened NB this is not the same as admitting responsibility)

Iv For lessons to be learnt and these implemented within the organisation.

For a complaint, follow the heading set in the portfolio, this will save work in having to write it up twice.

For more information please look at www.wessexlmcs.com

Significant Event Audit

All GPs are involved in these at both an individual and practice level.

These reviews are carried out in most practices. Many practices have well established processes which work well but this is not universal. Revalidation should ensure that all doctors are involved in reviewing their performance and reflecting on this in a constructive way.

An account of a significant event audit should comprise:

- Title of the event
- Date of the event
- Date the event was discussed and the roles of those present
- Description of the event involving the general practitioner
- What went well?
- What could have been done better?
- Reflections on the event in terms of:
    - Knowledge, Skills and Performance
    - Safety and quality
    - Communication, partnership and teamwork
    - Maintaining trust
- What changes have been agreed:
    - For me personally
    - For the team
- Changes carried out and their effect

Once again the e-Portfolio will have forms that will include these fields.

Practical Advice

This is not just about what went badly but is equally useful to look at what went well. Reflecting on personal experience is important and if the GP was not involved, it can be helpful to participate in discussing a significant event. The key issues are the refection, learning and potentially implementation of actions that result from the discussion.

Locums often find difficulty in this area. Locums can look at individual events and reflect on them and discuss them at their locum group for example. Locums could also discuss the significant event with two or three members of the practice team.

Also other practices should be approached to see if a locum could attend one of their significant event meetings.

Clinical Audit

All GPs will be expected to carry out two complete clinical audits during the revalidation cycle. One should be completed by year 3 and the second in year 4 or 5. This must include an initial audit, change implemented, and a re-audit to demonstrate improvement.

A description of a clinical audit should include:

- Title of the audit
- The reason for the choice of topic
- Dates of the first data collection and the re-audit
- The standards set and their justification (reference to guidelines etc)
- The results of the first data collection in comparison to the standards set
- A summary of the discussion and changes agreed, including any changes to the agreed standards
- Changes implemented by the general practitioner
- The results of the second data collection in comparison to the standards set
- Reflections on the clinical audit in terms of:
    - Knowledge, Skills and Performance
    - Safety and quality
    - Communication, partnership and teamwork
    - Maintaining trust

Once again these fields will be present in the e-Portfolio.

Clinical audit may be difficult for locums so some suggested areas for audit are:

- Antibiotic prescribing
- Investigation and imaging
- Prescribing for pain
- Referrals
- Cancer diagnosis e.g. breast/lung/prostate
- Depression case handling
- Medication reviewing
- Hypertension management

Practical Advice

GPs may be required to carry out clinical audit, but that does not mean that you need to manually extract the data - make your IT work for you.

The LMC will develop some examples of clinical audits and publish them on the Revalidation section of the LMC's website, www.wessexlmcs.org.uk .

Remember the PCT does require a number of clinical audits in support of GMS or PMS contracts and some examples of these include:

- Minor surgery
- Osteoporosis
- Use of beta blocker in heart failure
- Inadequate smears
- Referrals and admissions for PbC

Use these audits in your e-portfolio, remember GPs will need to be able to identify the part they have played in the clinical care being audited and that any action implemented should have an impact on their provision of care.

There is a major concern about locums ability to carry out clinical audit because of their contractual status. Some ideas for locums and practices:

1. Prescribing antibiotics and Clostridium Difficile

The increased incidence of C Diff has partially been blamed on the over prescribing of broad spectrum antibiotics by GPs. General advice has been to reduce the prescribing of ciprofloxacin, cephlosporins, co-amoxiclav and clindamycin as these 4 antibiotics can increase the risk of patients developing C Diff.

GPs could audit your use of these antibiotics as a % of total antibiotics prescribed.

The LMC will develop a standard audit with the PCT and publish this on our website shortly.

2. Use of statins.

Most PCTs have prescribing incentive schemes with targets of 80% of statins prescribed as the most cost effective i.e. simvastatin. GPs could audit the prescribing of statin as an individual vs practice vs PCT target.

3. Audit antidepressents

Management of depression has been the subject of NICE guidance, looking at the use of CBT and SSRIs. An audit patients of with moderate or severe depression and the appropriate management could be undertaken.

An audit the use of SSRIs vs other antidepressents could be benchmarked against NICE criteria.

4. Oral contraception and Long Acting Reversible Contraception (LARC)

The latest QoF indicators includes sexual health. It is now recommended that when a patient is prescribed an oral contraceptive the patient should given information about LARC. This could be audited.

5. Conversion rates for cataract ops or knee replacements

There are validated scoring systems for referrals of both cataracts and knee replacements. An audit of referrals against these scores could be carried out. These patients could then be follow up and of those referred it could be seen how many were operated on. Locums can follow these up, but it accepted that this might be more difficult.

6. Referral letters

C&B recommends that referrals should be completed within 3 working days of the patient being referred.

It would be easy to audit performance against this standard and the practice average.

7. Dermatology referrals

GPs are now encouraged to refer all Basal Cell Carcinomas (BCCs) to hospital. GPs could look at those patients referred with a suspected BCC and see what % turn out to have a BCC.

Statement on Probity and Health

The current proposals suggest this statement includes:

1. There are no issues of probity in relation to your work as a GP.
2. There are no health issues that would pose a risk to patients
3. GPs should not be registered with your own practice
4. GPs should have the appropriate insurance or indemnity cover

The slightly controversial one is point 3, where some GPs have chosen to register with their own practice. This can cause problems for the practice and the individual and this must be recognised but there is also something about the professions choice in that it should not be perceived that it is because it is easier to self prescribe but should be about trust; GPs need to trust their GP as well as any other patient. It is often the case that GPs trust their partners more than other colleagues they know less well.

This has been challenged and being considered nationally.

Evidence for Extended Practice

Many GPs perform other roles in addition to core general practice. This might include:

- Teaching students
- Training GP Registrars
- Working as an Appraiser
- Research
- Out of Hours work
- GPs with a special interest (GPwSI)

GPs need to provide evidence as to how you are qualified to carry out these roles, how they keep up to date, and how they remain fit to practice.

As of the 1st April 2009, GPwSIs are required to be accredited and on a PCT register and for revalidation you will need to provide a certificate of accreditation.

Practical Advice

To show GPs qualify for the role, they should detail qualifications, training and experience.

Keeping up to date – GPs need to show that they have undergone regular training and that they update their skills where appropriate.

Evidence of fitness to practice could be provided by a colleague or a consultant who a GP works for.

Submission of evidence

It is expected that the majority of this will be carried out via the e-Portfolio. But some will need to be done via a folder.

The enhanced appraisal which will ensure fitness for revalidation will require the Appraiser to assess the general practitioner's evidence being gathered for revalidation. The Appraiser will be asked to check that the

quantity of evidence is appropriate for that point in the revalidation cycle and that the gathered evidence, as far as the Appraiser can assess, is of appropriate quality for revalidation.

If the evidence falls short of the required standard there will be a system by which this can be corrected.

The outcome of and enhanced appraisal will be sent to the local "Responsible Officer". Each PCT will have a Responsible Officer who will be a senior doctor and who will evaluate the conduct and performance of doctors and make recommendations on "fitness to practice".

The Responsible Officer at a local level will:

- Ensure that appraisal is carried out to a good standard
- Support doctors in addressing any shortfalls
- Ensure any concerns/complaints are addressed
- Collate information to support a recommendation on the revalidation to individual doctors to the GMC

Each PCT will be required to have a local committee consisting of:

- The Responsible Officer
- An RCGP external assessor
- A lay assessor

If the Responsible Officer is not a GP then they will also need to appoint a GP advisor to the panel.

If the local committee cannot resolve an issue it will be referred to a National Adjudication Panel. Some of these cases may then be referred to the GMC for further consideration.

Evidence that will be required

Revalidation starts on the 1st of April 2009 and GPs will receive their first licence to practice in October 2009. The first GPs to go through revalidation will do so in 2010/11.

Practical advice

What should you do in 2009/10 to prepare for revalidation?

The e-Portfolio will become available during 2009/10 but many GPs currently use the NHS Appraisal toolkit - if you do, keep using it.

GPs should provide the following:

- A description of all the professional roles undertaken

- GPs need to have an appraisal during 2009/10. Most GPs participate in the required amount of education BUT they need to become disciplined at recording this, reflecting on it and recording any change that has been implemented. They need to maximise the use of current education before looking to undertake more.

- Sharing notes of a meeting can be helpful but GPs must ensure that they add the learning points and the reflection.

- Agreeing a personal development plan (PDP) for 2010/11 with the Appraiser is essential.

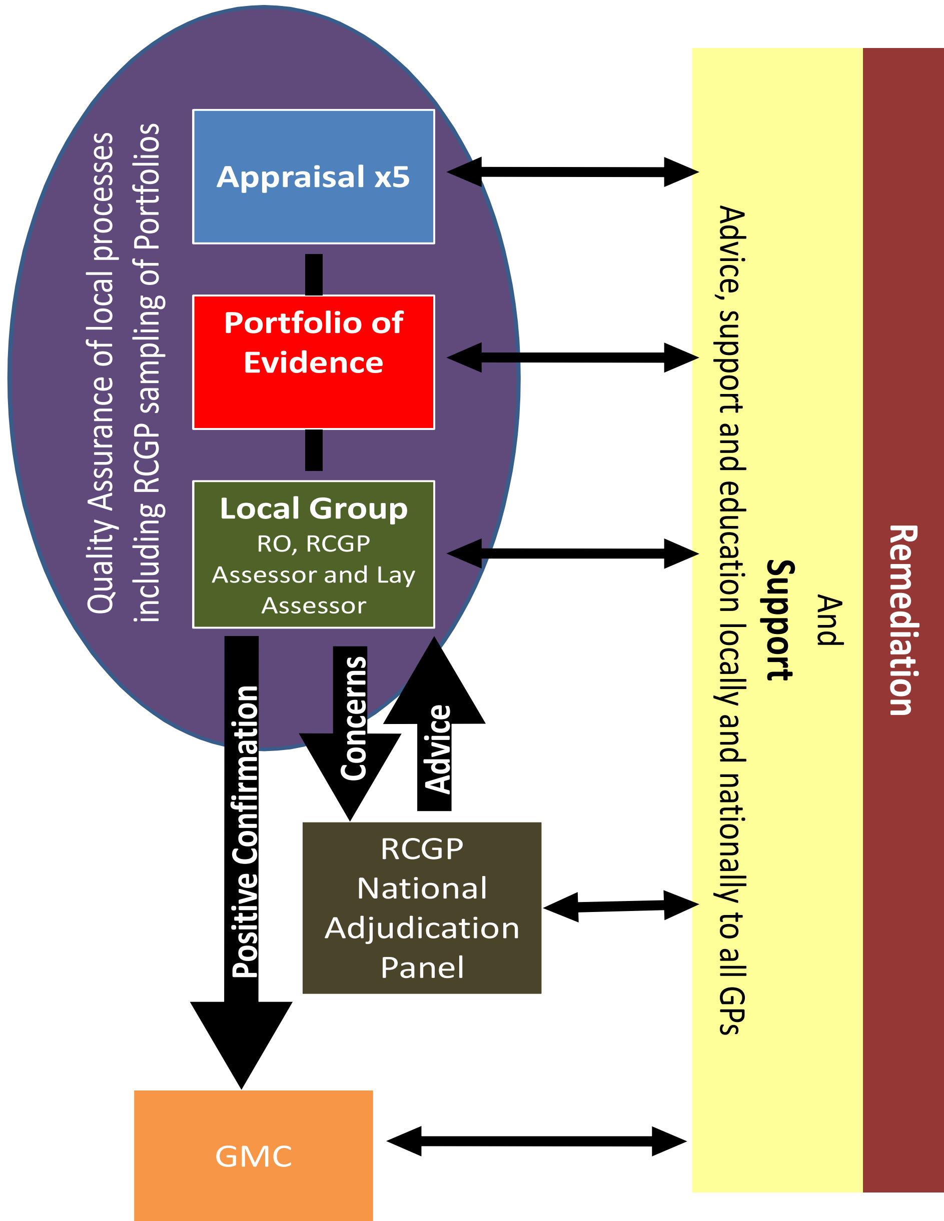
- The system of credits should become clearer but until it does it is important GPs record the time spent on learning and the details of what was done. The credits can always be worked out later.

- GPs should use the first year to record at least one personal significant event and discuss this with colleagues. Remember to record the reflection and action.

- Provide a statement of probity, health and use of health care, evidence of appropriate insurance or indemnity cover

- If GPs perform an extended role then they should start collecting additional evidence for those.

- Clinical audit need not be complicated, it may be useful to look at examples that others have done and GPs should set themselves the task of completing one during the next year.


Quality Assurance of local processes including RCGP sampling of Portfolios
Appraisal x5
Portfolio of Evidence
Local Group
RO, RCGP Assessor and Lay Assessor
Positive Confirmation
Concerns
Advice
RCGP National Adjudication Panel
GMC
Advice, support and education locally and nationally to all GPs
Support
And
Remediation

The Four Domains for enhanced appraisal

1. Knowledge Skills and performance

GP must maintain their knowledge and skill and keep up to date. They must keep legible and accurate clinical records, be able to communicate effectively with their patients and work with colleagues.

They need to be able to asses a patient, examine them appropriately, carry out appropriate investigations and refer, admit or prescribe safely.

Sounds all pretty straight forward so how do GPs provide evidence for revalidation?

Well this involves:

- Annual appraisals, with an agreed PDP and appropriate number of credits
- MSF
- Patient satisfaction survey
- Clinical audit
- Significant event audit

2. Safety and Quality

GPs must recognise their own limitations and ensure patient safety is paramount. Sick doctors can pose a significant risk to patients and so doctors should be able to demonstrate how patients are protected in such circumstances:

The evidence will include:

- Participation in enhanced appraisal
- An annual PDP
- Reflection on previous PDP and ensure plan has been completed
- Participation in significant event monitoring
- Review of complaints to include reflection and action
- Clinical audit
- Health declaration
- MSF

3. Communication, Partnership and teamwork

One of the most import skills a GP must possess, is the ability not only to communicate with their patients but also with their colleagues. General Practice is not just about one single GP - it is only really effective if we work as part of a team.

The evidence will include:

- MSF
- Patient surveys
- Review of formal complaints

4. Maintaining Trust

Doctors need to be considerate, polite, respect patients and above all be honest and if not, doctors cannot expect their trust. Patients' dignity and their right to privacy must be respected. Patient confidentiality has always been and remains a cornerstone of the trust at the centre of the doctor-patient relationship. Discriminate against patients must not occur

Doctors must act with honesty and integrity.

The evidence will include:

- Patient surveys
- MSF
- Review of formal complaints
- Statement of probity

This document is based on the RCGP Guidance as of 1st April 2009. The statements that are contained in this document are correct as of this date. This process is still under development and therefore changes are possible and in fact very likely.

It was decided to produce some advice to help GPs in their preparation for Revalidation which I hope you will find useful.

Dr Nigel Watson
Chief Executive
Wessex LMCs

1st April 2009 (and no this is not an April fools joke!)