

# Guidance for appraisees with difficulties submitting the “standard evidence” portfolio.

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## **Who is this guidance for ?**

This guidance should be read in conjunction with Northern deanery guidance (appraisal pack) in current requirements for appraisal and revalidation as it is not intended to comprehensively describe these requirements.

The appraisees who may fall into this category are appraisees:

1. who do not have a practice base through working as a locum
2. who work a limited number of clinical sessions, as locums, salaried doctors or having a predominantly non GP based role
3. who have had a significant break from work, or new to nhs
4. who work in non standard environments e.g. out of hours, secure environments, etc
5. who are under investigation by the PCT for performance or failing to meet PCT appraisal requirements
6. who have defaulted on their appraisal for 2 or more consecutive years

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. This can be found on the GMC website. It refers also to guidance which is expected to be issued by each Royal College. [Note : The latter is considered “guidance” and not mandatory in the way that the GMC guidance is].

The supporting information which is required is as follows:

1. General information – providing context about what you do in all aspects of your work.
2. Keeping up to date – maintaining and enhancing the quality of your professional work: e.g. Your CPD.
3. Review of your practice – evaluating the quality of your professional work.
  - a. Quality improvement activity (e.g. audits, case review or discussion, review of clinical outcomes)
  - b. Significant events
4. Feedback on your practice – how others perceive the quality of your professional work
  - a. Feedback from colleagues
  - b. Feedback from patients (where applicable)
  - c. Review of complaints and compliments

## Exceptional Circumstances and Equivalent Portfolios

What does Version 6 say about “equivalent portfolios” and “exceptional circumstances” ?

*If the working life of a GP justifies an equivalent portfolio of supporting information and the rationale is accepted by that doctor’s appraiser, the portfolio should indicate this fact in exceptional circumstances. The portfolio should be processed through revalidation just like any other portfolio.*

*This section of the document describes possible ways in which supporting information might be submitted by those who would find a standard portfolio of supporting information for revalidation impractical. Such GPs may submit a portfolio containing equivalent supporting information – an equivalent portfolio. This group includes:*

1. *Those in clinical general practice who may find elements of a standard portfolio difficult to accumulate; this includes doctors whose main or only work is as:
  - a. *peripatetic locums*
  - b. *out-of-hours doctors (and those working in similar clinical contexts such as in walk-in centres)*
  - c. *GPs in remote or very small practices*
  - d. *GPs in the Defence Medical Services or the Foreign and Commonwealth Office*
  - e. *GPs working in secure environments.**
2. *Those who were not in work for all years in the 5-year revalidation cycle or who are on extended*
3. *career breaks, including those working overseas*
4. *GP registrars whose licence becomes due for renewal*
5. *Those whose only or predominant work as a doctor is not as a clinical GP, but is in NHS management; educational management, political roles, health informatics, academia or staff, appointments within the Defence Medical Services.*

*GPs who work part time, as retainers, flexible career scheme doctors, salaried GPs or long-term locums, with a fixed practice base, would not normally be considered to be in a special group.*

*If the working life of a GP justifies an equivalent portfolio of supporting information and the rationale is accepted by that doctor’s appraiser, the portfolio should indicate this fact in exceptional circumstances. The portfolio should be processed through revalidation just like any other portfolio.*

*The alternative methodology for accumulating supporting information in an equivalent portfolio must still meet the underlying attributes that each area of supporting information is intended to demonstrate. For example, clinical audits are included in the standard portfolio to demonstrate that GPs set themselves appropriate criteria and standards; reflect on the care they deliver; and improve their care when necessary. These attributes must also be demonstrated satisfactorily in the supporting information in an equivalent portfolio using an approved alternative to clinical audit if appropriate to do so.”*

It is interesting to note that there are some contradictions in this section: for example working as a salaried part time GP does not constitute exceptional circumstances but being part time through carrying out a predominantly non-clinical role (e.g. NHS management; educational management, political roles, health informatics, academia or staff, appointments within the Defence Medical Services) **does** constitute exceptional circumstances.

## ***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*

## **What does the College (Version 6 guidance) say about audit ?**

*The appraiser and responsible officer will need to be satisfied that at least one acceptable clinical audit has been submitted, and that it meets the key attributes of a satisfactory clinical audit. These attributes are:*

- *the topic(s) chosen for the clinical audit(s). Given the GP's clinical roles, are the topics appropriate?*
- *the audit reflects the care undertaken by the individual practitioner*
- *the standards of care set for the GP's patients. Are these based on a recognised evidence base*
- *and are they appropriate, or are they reflecting local or national priorities?*
- *reflection on current care. Has the GP reflected on the findings of the first data collection and*
- *reached appropriate conclusions?*
- *the changes planned after the first data collection. Has the GP decided on appropriate changes?*
- *the implementation of change. Has the GP acted to improve care for his or her patients?*

In addition it says:

*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.*

The headings which should be used for audit are:

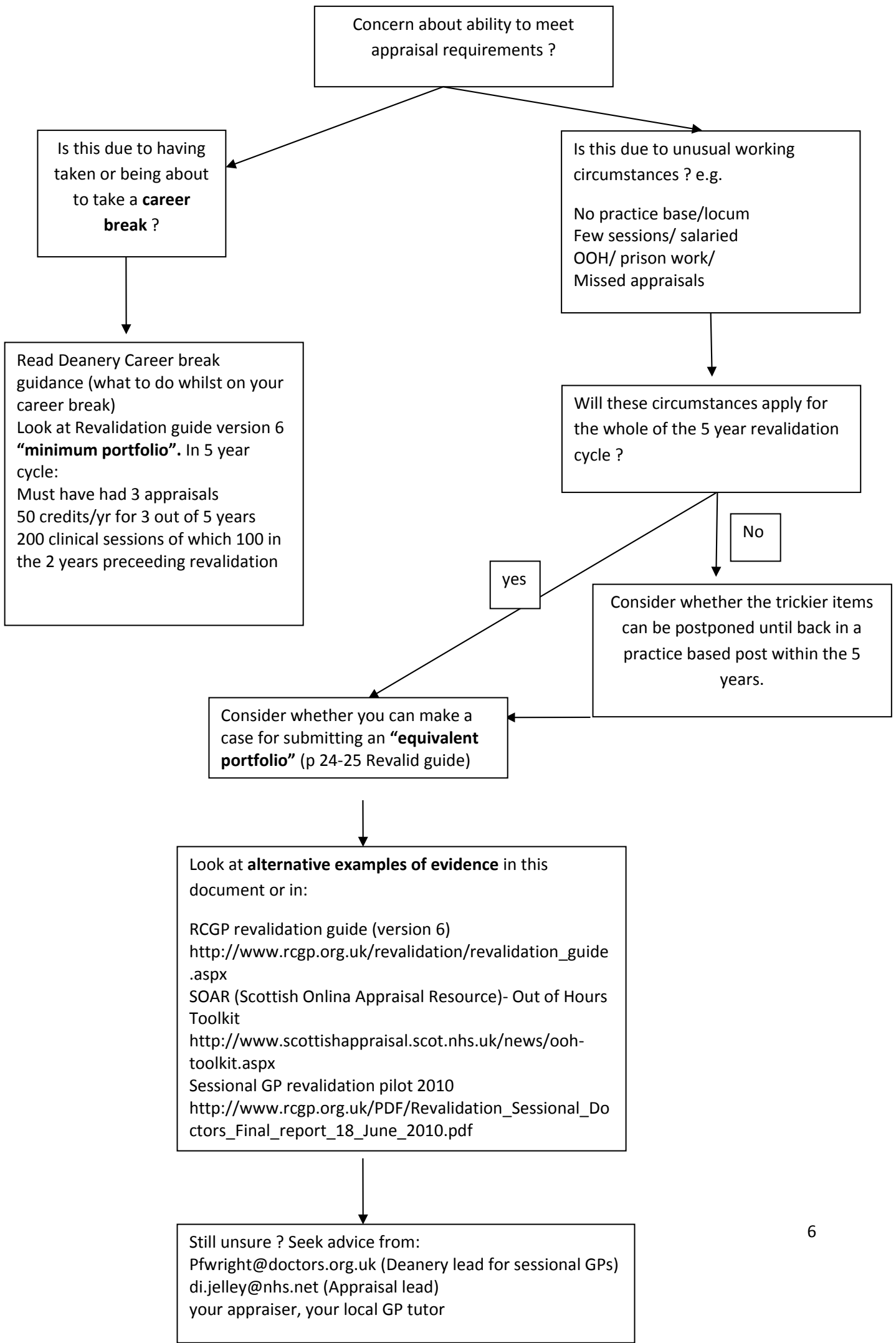
- 1) the title of the audit
- 2) the reason for the choice of topic
- 3) dates of the first data collection and the re-audit
- 4) the criteria to be audited and the standards set, with their justification (reference to guidelines etc.)
- 5) the results of the first data collection in comparison with the standards set
- 6) a summary of the discussion and changes agreed, including any changes to the agreed standards
- 7) the changes implemented by the GP
- 8) the results of the second data collection in comparison with the standards set
- 9) quality improvement achieved
- 10) reflections on the clinical audit in terms of:
  - i) knowledge, skills and performance
  - ii) safety and quality
  - iii) communication, partnership and teamwork
  - iv) maintaining trust.

**Audit: Reasons why a standard audit may not be feasible or appropriate for a sessional GP.**

- moving between practices and therefore not able to follow changes through
- your role does not include the ability to influence or therefore improve systems outside of your own personal practice (e.g. locums, many salaried Gps)
- unable to access medical records outside of consulting time (locums, Out of hour doctors)

The consultation on revalidation proposals also reported that “Respondents commented that the model for revalidation must be proportionate and realistic and must minimise the amount of time doctors have to spend away from patients.”

The examples which follow are intended to recognise the constraints above and the reality of the defined role of many sessional GPs (with limited influence or impact on services other than their own personal actions).



## Examples of “Quality improvement activities” appropriate for Sessional Doctors

### Examples from RCGP revalidation guide Version 6

- 1) A locum or out-of-hours doctor may undertake an ‘action audit’ in which the care of presenting cases of a defined nature are continually reviewed against pre-set criteria and standards with continuous reflection and improvement recorded.
- 2) One example might be keeping a log of all referrals and patients causing concern, and then on return to the practice or clinic following the patient up, learning lessons from the outcomes
- 3) A doctor may undertake a random case analysis, in which 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 agreed and demonstrated

### Other Examples

#### ***Records audit***

Audit your record keeping on a series of consultations highlighting key elements of information which you feel you might need to improve. These might be: whether you have entered:

- patients account (history)
- examination
- plan
- safety netting
- documentation of consent
- chaperone offered
- patient advice and use of PILS
- red flags
- REAd coded problem
- presence of carer or guardian

#### ***Condition based review***

Pick a clinical area which you feel may merit improvement for which there are good (preferably) evidence based guidelines and which you see a reasonable number of cases of e.g. UTIs, depression, copd, asthma, anxiety,

- carry out a prospective collection of encounters printing off (anonimised) the consultation and patient summary and meds
- once you have collected at least 10, look carefully at how you have managed these in the context of the guidelines you have found and see whether there are any patterns or themes or learning points as to aspects of diagnosis or care which you have omitted or need to improve.
- identify key changes which you need to make in your personal practice

-repeat the exercise

**Review of Referrals (adapted from SOAR)**

|  | 1 | 2 | 3 | 4 |
|--|---|---|---|---|
| referral sent within recommended time period?  |   |   |   |   |
| used local form/proforma?  |   |   |   |   |
| PMH and drug history included?   |   |   |   |   |
| Alternative pathways not available ?   |   |   |   |   |
| Driver for referral:<br>diagnostic uncertainty; to access treatment/surgery; patient concerns; to access investigations; other |   |   |   |   |
| Routine/Urgent/<br>fast track?   |   |   |   |   |
| Outcome as expected?   |   |   |   |   |
| Any lesson learned?  |   |   |   |   |
| In retrospect was referral the most appropriate?   |   |   |   |   |
| Was the most appropriate method or pathway used?   |   |   |   |   |
| Appropriate investigation? (if applicable)   |   |   |   |   |

## **Examples from SOAR:**

### ***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***

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 timeously. (Were all of yours?)
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)

## 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 (again from V6)

- *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:**

Discuss cases relevant to you with:

-a colleague within the practice

-your learning group

-if neither possible then reflect on it as a case review- identifying any improvements which you can personally make in future.

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

*Self directed learning groups: a guide to making them successful. by P Wright. Available on the [www.nelg.org.uk](http://www.nelg.org.uk) website (education page).*

*or*

*Support for Sessional GPs, By Morrow G, Wright P, Kergon C. RMBF*

## ***Doctors taking a break- do they have to submit the same portfolio ?***

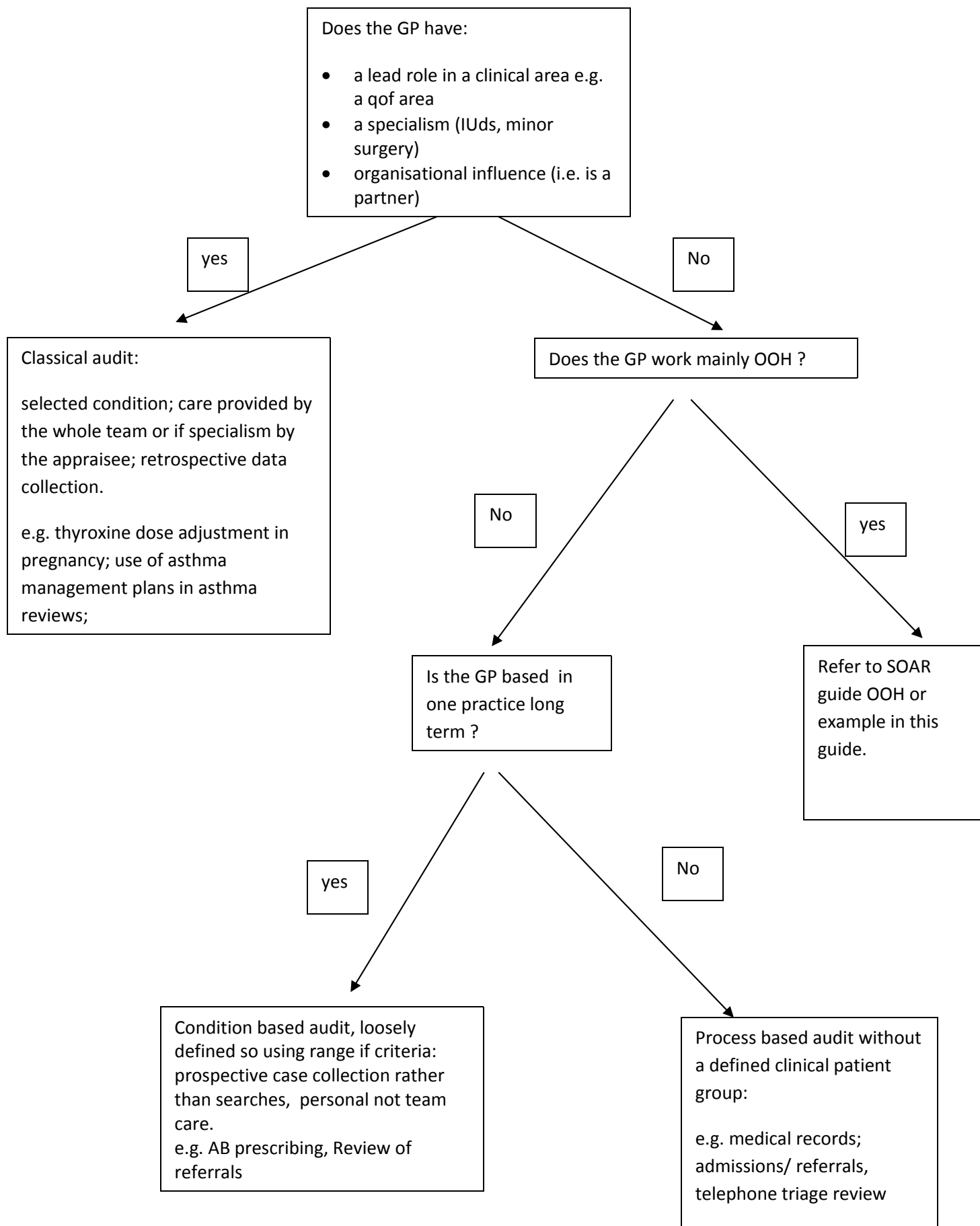
The RCGP guide states that:

*“However, there are many doctors who will be absent from British clinical general practice for periods of 2 years or less due to pregnancy, illness, career breaks, sabbaticals, working abroad or taking on non-clinical roles. For such doctors, the RCGP recommends that there has to be a minimum content to a portfolio if it is to be considered in the routine manner by a responsible officer.*

*When revalidation is fully established over a 5-year cycle the RCGP proposes that the minimum supporting information that a responsible officer will normally need before a GP’s portfolio can be considered for revalidation will be:*

- 1. active participation in approved appraisal with a PDP agreed and a review of a previous PDP in at least 3 of the 5 years in the revalidation cycle*
- 2. demonstration of 50 learning credits in each of at least 3 of the 5 years in the revalidation cycle*
- 3. documentation of at least 200 clinical half-day sessions (equivalent to 1 day a week over a period of at least 2 years) in the 5 years in the revalidation cycle (of which 100 should be undertaken in the 2 years prior to revalidation). A half-day would normally last 4 hours and include at least 2 and a 1/2 hours of face-to-face clinical contact and be conducted in an approved environment within the United Kingdom. The sessions will be undertaken as a generalist and require the doctor to be on the GMC’s GP Register but can be within a range of settings.”*

Advising appraisees on the kind of audit which is feasible



## References

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Oxford guide to appraisal and revalidation for sessional GPs

<http://www.oxfordprimarycarelearning.org.uk/>