Revalidation processes for sessional GPs: A feasibility study to pilot current proposals

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Executive Summary

This study set out to explore the potential problems locum, salaried and remote GPs may have with the proposed supporting information required for appraisal as part of the revalidation process.

Fifty-three sessional or remote GPs took part in focus groups or interviews, and attempted to collect some supporting information – clinical audit, significant event analysis, colleague and patient feedback – over a three month period.

It is important to recognise that sessional working is a positive career choice for a sizeable proportion of sessional GPs, who choose to work in this way to achieve an acceptable work/life balance or to fit in with a portfolio career.

The sessional GPs in this study who felt able to collect the supporting information that will be required for revalidation were mainly those who had a fixed practice base for at least one session a week over a period of time. GPs who experienced the most difficulty tended to be peripatetic locums and out of hours GPs with no permanent practice base. Remote rural GPs in small practices highlighted issues relating to the limited practice list size for clinical and significant event audit, and having sufficient colleagues to be able to elicit meaningful colleague feedback.

Findings were that:

- Locums feel that they are perceived to have a lower status than other GPs, and that this translates to a lack of engagement and support from practices in completing appraisal and revalidation activities.

- Out of hours (OOH) and remote GPs also experienced isolation and felt relatively unsupported.

- The availability of a peer group of supportive colleagues would help the completion of supporting information requirements, by providing the opportunity for reflective discussion.

- The main area of concern for remote GPs was having sufficient contacts to meet the requirement of the multi-source feedback tool. They were generally able to complete clinical and significant event audit, although there were concerns about small sample sizes for both SEAs and some audits.

Locum and salaried doctors have identified a range of additional ways of demonstrating that they are reflecting on their clinical practice (apart from SEA and clinical audit), these are summarised in Appendix 8. Findings specific to the suggested forms of evidence were:

Suggestions for culture change
• The requirements of revalidation highlight the need for sessional GPs to be supported in their professional development by both practices and Primary Care Organisations (PCOs).

• This may be enabled if PCOs encourage practices to fully support their sessional GPs in collecting evidence for revalidation, and ensure that all performers are appraised annually and included in all email circulation lists.

• Practices should also be strongly encouraged to recognise the need to support sessional GPs in evidence collection, involve them in practice meetings and provide a forum for exchange of information, clinical expertise etc.

• OOH organisations should provide their regular GPs with specific systems to carry out clinical audit; identify and discuss SEAs and elicit colleague and patient feedback, as well as offering some educational updates. There is a good example of this in appendix 5.

Audit

Locums and Out of Hours GPs reported having the most difficulty in achieving an audit. This mainly focused on access, time and the ability to do something meaningful, and with their temporary and outsider status having access to necessary data (because of unfamiliarity with computer systems, or employers not providing access when a locum was no longer in the practice).

GPs who were based permanently or for a long period in one practice were able to achieve an audit, however time and support were still major issues for them.

Solutions identified were:

  o The RCGP should clarify the definition and aims of audit in the revalidation process, in line with the requirements of the other Royal Colleges.

  o The case must be made for practices to support all GPs to achieve an audit, including providing reasonable access to the patient database to allow sessional GPs to identify relevant information for their audit and/or to offer some administrative support in data collection. The DoH and BMA should clarify data protection concerns in relation to this issue.

  o Practices should be enabled to make routinely collected data available for sessional GPs to use as audit material, and offer opportunities for reflection on the audit data by someone in the practice.

  o Locum agreements should specify not just workload and fee aspects of the placement but also provide clarity about what support the
practice is prepared to give locums towards audit and other aspects of data collection for appraisal. The Chambers model of employment gives an example of this in Appendix 7.

- Alternatives to the audit should be considered for GPs who are peripatetic and have no permanent base at all. As locums and some salaried GPs have relatively little influence on practice systems, their audits may need to focus on their own personal work. The difficulty is identifying a significant number of cases with a given problem seen by one individual. Audits may therefore need to be based on mixed diseases but focusing on generic systems. These could include record standards, communication, review of referral letters against referral guidelines and serial case reviews of random surgeries with colleagues. The RCGP should consider whether comparison of disease management against defined standards in several practices would be an acceptable alternative audit for a locum to carry out.

- PCTs and deaneries to consider funding mentoring schemes. An example can be found at www.support4doctors.org.

- Deaneries, PCOs, LMCs and Chambers Organisations should help facilitate the development of, and provide support to, learning groups (such as self directed learning groups) where meaningful clinical discussion and reflection around cases can occur for locums who have limited opportunities for contact with colleagues.

- Locums need their own prescribing number to enable audits on their prescribing relating to core indicators of good clinical practice, when this electronic system becomes available.

- Some of the weekly CPD provision in the salaried GP model contract could be used for audit which is related to that GP’s development and appraisal and not purely concerned with service development. This requires GMS practices to adhere to the model salaried contract and schedule protected CPD time for audit purposes.

- Locums need to build audit time into their locum fees and be supported to access practice data when needed for audit purposes.

- Appraisal leads can advise practices on the support they can easily offer locums (as above), can disseminate examples of achievable audits, and should ensure appraisers are trained in the difficulties locums face.

Significant event analysis

Conducting an SEA was easier for a salaried GP based in a practice than for a locum without a fixed practice base. Some doctors were unsure how a significant event was defined. Locum GPs often do not hear about significant events they have been
involved in, are rarely invited to meetings where significant events are discussed, and can feel penalised as potential whistleblowers when reporting significant events.

Potential solutions to concerns about SEA:

- There should be a clearer definition of what is meant by the term ‘significant event’, with plenty of examples.

- All practices that employ locums should have a clear mechanism to feed significant events back to locums, who need to make sure accurate contact details are left with every practice in which they work.

- Sessional GPs not only need to be informed if a significant event in which they had a role has been identified, but also be given the opportunity to discuss the event with a clinician in the practice, and where possible should be invited to SEA meetings.

- The locum ‘contract’ should contain references to both of above.

- If attendance at practice SEA meetings is not possible for a sessional GP then it should be acceptable for an SEA discussion to take place in a locum or self directed learning group (SDLG) setting, and for the reflections from this to be considered adequate for the purposes of revalidation.

- Having protected time when colleagues are available to discuss a significant event either as part of salaried contract or factored in to locum pay rates.

**Multi-source feedback**

Locums, OOH, and remote GPs all reported that they would or did struggle to find enough doctors and other staff to nominate for MSF. Some reported that other doctors refused as they felt they did not know them sufficiently well. The high numbers required will continue to be a problem for these GPs. A smaller sample of meaningful contacts may be more valid than a larger sample of people who have very distant knowledge of the GP in question.

Potential solutions to concerns about MSF:

- Recognition that some doctors (locums, OOH and remote GPs) will have fewer contacts for MSF and a reduced number of MSF forms are inevitable. This may require consideration of the way reliability and validity are interpreted and addressed in feedback systems.

- Ensuring that an MSF tool is validated for sessional and remote GPs or adapt the tool for this population.
Clarification of who can be contacted for MSF – how long does a contact need to be known or worked with, and how recently?

Ideally feedback should go via a third party to ensure individuals are protected from being identified, but this will not happen in electronic systems that simply aggregate all comments entered on the online form.

To provide clear guidance on the procedure for MSF – how to set it up, how to complete it, and warnings about the time required and potential consequences if the task is not completed in one attempt.

To provide a list of trained practitioners that would be prepared to support the GP in discussing the feedback and protect individuals from potential harm from negative feedback.

Discuss feedback at SDLG or sessional GP groups, when these are able to offer a sufficiently supportive and robust environment for MSF discussion.

**Patient feedback**

Locum and OOH GPs and those working a small number of sessions or working in remote rural practices could have difficulty accessing sufficient patients. Furthermore patients may see locums and OOH doctors in particular circumstances which do not involve the development of an ongoing relationship. All GPs will require support from practices or employing organisations in collecting patient feedback.

Potential solutions to concerns about PSQ:

- Practices to provide administrative support to help locums get feedback from patients.
- OOH employing organisations to support OOH doctors in gaining feedback from patients.
- OOH doctors to be able to gain feedback by telephone.
- Feedback forms to compare locums with peers (as well as other GPs).

**Alternative approaches**

Alternative approaches to evidence collection may be better identified by stepping back from the currently indicated methods, and addressing what the primary aims of the revalidation evidence are. While audit and SEA may fit into partners’ work, complementing service improvement and professional development, for sessional GPs the focus on service-level improvement may confound their individual development.
Solutions such as the review of more routine cases, or simply enabling the doctors’ reflection through the provision of support, may be more appropriate, and useful.

Conclusions

The RCGP may improve the engagement of these GP groups with appraisal and revalidation by addressing three areas:

- Issues of isolation and lack of support, by encouraging practices and PCOs to engage with all their GPs.

- The logistics of evidence collection. Providing guidelines and flexibility in evidence collection to allow evidence to be more easily and appropriately gathered.

- The purpose of supporting information. By looking at the intention behind the supporting information, alternative methods may be identified which are more suited to non-partner GPs’ ways of working.