

Defining the evidence for revalidation

- supporting the Royal College of General Practitioners

Collation of views from the
NHS Clinical Governance Support Team Expert Group

Contents

	Page
1 Introduction	3
2 Expert Group membership	4
3 Background	6
4 Principles of revalidation	8
5 Factors to consider relating to measurement	10
6 The evidence set - summary	12
7 The evidence set - details	14
8 Recommendations for priority development of new items of evidence	31
9 Conclusion	33
10 References	34

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1

Introduction

- 1.1. This document contains the views and recommendations of the NHS Clinical Governance Support Team (CGST) to the Royal College of General Practitioners (RCGP), on the principles, advantages, disadvantages and challenges of performance measurement of GP professional activities.
- 1.2. It also sets out those pieces of evidence that could usefully comprise such an evidence set, suitable for use now. For each piece of evidence we describe the factors that have led to its inclusion, as well as its limitations.
- 1.3. We also indicate those areas, where progress is immediately advisable, in order to substantially improve the validity of the overall evidence set.

2

Expert Group Membership

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3

Background

3.1. Guidance from the General Medical Council (GMC)¹ states that:

3.1.1. From 1 January 2005 every doctor will need a licence to practise.

3.1.2. Licences will be revalidated periodically through doctors demonstrating they remain fit to practise.

3.1.3. Doctors will be required to provide evidence from their medical practice over the specified period, and must routinely collect and retain data from their day-to-day practice to support their case for revalidation.

3.1.4. All evidence must be verified at source or readily verifiable by the GMC.

3.1.5. Doctors who work in a managed environment¹ may provide a certificate to show they are

- participating in a quality-assured appraisal scheme,
- compliant with local clinical governance requirements,
- free from any significant unresolved concerns about their fitness to practise.

3.1.6. Such certification would be by the chief executive or equivalent, or someone with delegated authority such as medical director or clinical governance lead.

3.1.7. In primary care, in order to sign-off a GP, the responsible PCT will need evidence to support this decision.

¹ Managed environment:

In Primary Care, doctors included on General Medical Services lists, Personal Medical Services contracts and supplementary lists held by Primary Care Organisations can consider themselves as working within a managed environment. Other groups of doctors, including, for example, medical managers and prison doctors, may be considered as working within a managed environment, but should verify this with the General Medical Council.

General Medical Council. A Licence to Practise and Revalidation, April 2003

- 3.1.8.** The NHS Clinical Governance Support Team (NHS CGST) has been asked by the Appraisal Steering Group to identify example of evidence that can be used for revalidation purposes.
- 3.1.9.** The Royal College of General practitioners have, in a separate process, been exploring the criteria, standards and criteria to meet revalidation purposes and have produced a draft document, Draft 9².
- 3.1.10.** The NCGST and RCGP have agreed to take this work forward in partnership whilst maintaining the integrity of all professional groups involved. The agreement reached was that RCGP would lead the process, and that CGST would act in a supportive capacity, offering expert input to RCGP deliberations. This document represents this expert input.

4

Principles of Revalidation

- 4.1. There is an increasing requirement for doctors working within the NHS to be accountable, and to be seen to be so.
- 4.2. Increasing accountability should not equate to reduction in autonomy.
- 4.3. There persists a certain level of confusion about the purpose of revalidation³. Our working assumption is that revalidation aims to:
 - secure public trust,
 - by ensuring the continually improving quality of doctors
 - and at the same time, identifying doctors with performance at the “poor performance” extreme of the spectrum.
- 4.4. All doctors have a responsibility to ensure their professional development. Couching the measurements relating to revalidation in terms of on-going professional development enables the process of revalidation to have an educational purpose, greater than simply that of re-certification.
- 4.5. Appraisal is the starting point of professional development⁵. Appraisal is a process of facilitated self-reflection, which takes place in a confidential, supportive setting. The prime characteristic of healthy appraisal is that it is a formative process, without a pass-fail element.
- 4.6. Whilst we fully support the use of measurement of individual performance, both in terms of improving accountability by informing revalidation, and of improving clinical standards by informing appraisal, we believe that introducing excessive measurement into the appraisal framework risks distorting the nature of appraisal, thereby diminishing its educational potential. Therefore, the measurements required for revalidation should be assessed and signed-off outside the appraisal process. The measurements may then be admitted to the appraisal process by the appraisee. In this way the distinct processes of appraisal and measurement become complementary⁵.
- 4.7. Whilst promoting the principle of continuing professional development, the measures recommended in this document are primarily concerned with those *minimum* items that we

regard as *essential* to allow such certification. We have not listed, nor could we do so, the myriad markers of individual excellence that so many doctors could provide. Neither do we seek to stifle or reduce any activities undertaken by doctors in their pursuit of excellence.

- 4.8. “What counts cannot always be measured; what can be measured does not always count”. Our recommendations represent a considered balance of various factors, the totality of which will give the best possible indication that the doctor is free from any significant unresolved concerns about their fitness to practise, at the current time.
- 4.9. We recognise that, for some, the initial evidence set that we propose may seem primitive. This is because, in reality, the number of useful items of evidence that currently exist is small. We have applied the principle that, if there is no clear likelihood that the item has overall value, it should be omitted at this stage.
- 4.10. With this in mind, we believe it is essential that the evidence set that is eventually applied be closely reviewed and refined, year on year, and that processes are set in place to do this. We have also indicated those areas in which early development of accurate new measures might be most fruitful in terms of improving the overall evidence set and hence the reliability of revalidation.
- 4.11. Much work has been done on this theme already. We have been influenced by the work of RCGP (Scotland) and NHS Education for Scotland, in defining evidence suitable for appraisal and revalidation⁶. We recognise and endorse the Royal College of General Practitioners Document: “Draft Criteria, Standards and Evidence (version 9)”². We seek to complement this important work, and assist its completion.
- 4.12. We have also sought to endorse the GMC criteria on Good Medical Practice⁷ and the subsequent RCGP version “Good Medical Practice for GPs”⁸. Our recommendations follow this framework.

5

Factors to consider relating to measurement

- 5.1.** There is no piece of evidence that we have identified, which meets all of the desirable attributes for the purpose. Any piece of evidence that may be useful, therefore, has its advantages and disadvantages. Those attributes, which we have considered to be of greatest importance when weighing a piece of evidence, are:
- 5.1.1. Equivalent to that required of other disciplines.** Whilst each professional discipline will have items of evidence reflecting the specialised nature of the discipline, it is important to ensure that the overall burden of requirement for revalidation is the same for all.
 - 5.1.2. Level of relationship to the individual.** In Primary Care, more evidence currently exists, relating to practice, or PCT activity, than to the individual doctor, e.g. Quality and Outcomes Framework (QOF) data. Ideally, revalidation requires data to be assessed relevant to the individual. The disadvantages of most information that currently relates to the individual are that it may be less standardised, preventing comparisons, and it may be more difficult to verify.
 - 5.1.3. The nature of the doctor's work.** Despite the above limitations, much more information is available for stable GP Principals than for peripatetic GPs, e.g. locums, and non-principals GPs. In addition, the presence of a practice infrastructure makes it easier for Principals to generate personally related data. In our recommendations we have included options that we believe can be produced by peripatetic freelance GPs.
 - 5.1.4. The level of “face-value” credibility.** An item that is perceived by the profession as lacking in value could be damaging to this new process at a critical early stage. The expert group acknowledges that for most of the items of evidence in this paper there is no substantial evidence base in terms of their impact on patient care. Indeed, for certain items of evidence, it is extremely difficult to move beyond face-validity. Nevertheless, where possible, establishing this evidence base is a key requirement for immediate development (see Section 8)

- 5.1.5. Ease of production.** Ideally, evidence should be produced as a by-product of another process. Hence, QOF data may be included, despite its being practice-related. Also, evidence already being produced for appraisal, such as a description of the doctor's practice, or a significant event report, might be included to minimise duplication.
 - 5.1.6. Source of production.** Where possible, data should be collected with minimum disruption to the doctor. Hence, for example, PCTs should provide data where possible. On the other hand, we recognise that to a degree, involvement in the creation of evidence is important for ownership on the part of the doctor. We have therefore sought to achieve a balance in this regard.
 - 5.1.7. Level of objectivity.** Typically, a highly personal piece of evidence, e.g. personal prescribing or referrals audit, is difficult to standardise for the purposes of comparison. Where more objective measures exist, we have sought to include these.
 - 5.1.8. Level of verifiability.** Similarly, personally produced data is less verifiable than, say, is PCT-produced data. Early iterations of the process should seek to establish how such verifiability could be achieved.
 - 5.1.9. Whether the item is compatible with the RCGP “Draft Criteria, Standards and Evidence (version 9)” document.**
 - 5.1.10. Whether “SMART” or not.** Where possible, we have written each item of evidence in “SMART” terms, i.e.: Specific/Measurable/Achievable/Realistic/Timely
- 5.2.** The final set of evidence that we recommend to the RCGP represents our agreed best balance of all of these attributes, such that every attribute is fairly represented in the context of the whole.

6

The evidence set - summary

Summary of evidence set

6.1. The evidence can be usefully categorised into 3 distinct sections:

- Participation in appraisal
- Evidence of meeting minimum standards under “Good Medical Practice”
- General statement of “absence of concern”

Participation in appraisal:

- A description of the professional activities that the doctor undertakes
 - (5x appraisal “Form 2”)
- Evidence of annual personal development plan
- Evidence of annual appraisal
 - (5x appraisal “Form 4” sign-offs)

Minimum standards

- Good Clinical Care
 - Audit: Evidence that the doctor is engaged in reflective practice
 - Evidence of meaningful participation in significant event audit
- Maintaining Good Medical Practice
 - Evidence of re-training in basic cardiopulmonary resuscitation
 - Documentation of clinical learning over the preceding five years

- Relationships with patients
 - A record of at least two patient surveys in the preceding five years, at least one of which is individual to the doctor, with appropriate action taken
 - Communication skills: evidence of at least one half-day of learning in communication skills in the preceding five years, to include resulting learning points
 - Production of practice complaints procedure
 - List of all complaints within the past five years, involving the individual doctor, and subsequent appropriate action taken
- Relationships with colleagues
 - Audit of records for legibility and accuracy
- Teaching (if appropriate)
 - The doctor provides evidence of performance review within teaching role
- Research (if appropriate)
 - Proof of adherence to local research governance procedures
 - Declaration of research involvement
- Other activities (management outside the practice, GPwSIs, GP Appraising, etc)
 - the doctor provides evidence of periodic performance review within these contexts
- Probity
 - Self-declaration of GMC Status, NCAA Status, Criminal Status, to be verified by the PCT.
 - Self confirmation of other potential conflicts of interest
- Health
 - Self-declaration of health status, as in appraisal

Statement of “absence of concern”

- 6.2. Evidence relating to the performance of the doctor not covered elsewhere within this evidence set

7

The evidence set - details

Participation in appraisal:

- 7.1. A description of the professional activities that the doctor undertakes
- (5x appraisal “Form 2”)

Comment:

- Equivalent to other disciplines? **Yes**
- Level of relationship to the individual: **High**
- Achievable by all GPs? **Yes**
- Face-value credibility: **Reasonable. May be seen by some as mechanical, with little relevance to quality. Important though, as indicator of workload/diversity of doctor’s work**
- Ease of production: **From appraisal**
- Source of production: **Individual Doctor via appraisal Form 2**
- Level of objectivity: **To some degree because using standard appraisal forms**
- Level of verifiability: **Depends on PCT relationships with practice**
- Compatible with RCGP Criteria, Standards and Evidence: **Yes**
- “SMART”? : **Reasonably**

7.2. Evidence of annual personal development plan

- To include review of previous year's plan and comment on level to which planned items were fulfilled
- This should not include the full appraisal "Form 4", but rather the Personal Development Plan arising from Form 4 completion. Although the standard appraisal forms do not currently include a specific section detailing the degree to which the PDP is achieved, we regard it as appropriate for revalidation for the doctor to give this detail

Comment:

- Equivalent to other disciplines? **Yes**
- Level of relationship to the individual: **High**
- Achievable by all GPs? **Yes**
- Face-value credibility: **Yes**
- Ease of production: **Automatic in appraisal process**
- Source of production: **Individual doctor via appraisal**
- Level of objectivity: **Depends on quality-assured appraisal scheme**
- Level of verifiability: **Depends on quality-assured appraisal scheme**
- Compatible with RCGP Criteria, Standards and Evidence: **Yes**
- "SMART"? : **Reasonably**

7.3. Evidence of annual appraisal

- Five annual appraisal “sign-off” forms (from appraisal Form 4)

Comment:

- Equivalent to other disciplines? **Yes**
- Level of relationship to the individual: **High**
- Achievable by all GPs? **Depends on appraisal being extended to all GPs**
- Face-value credibility: **Yes**
- Ease of production: **Depends on appraisal being available to all GPs**
- Source of production: **PCT**
- Level of objectivity: **Depends on quality-assured appraisal scheme**
- Level of verifiability: **Depends on quality-assured appraisal scheme**
- Compatible with RCGP Criteria, Standards and Evidence: **Yes**
- “SMART”? : **Reasonably**

Evidence of meeting minimum standards under “Good Medical Practice”

Good clinical care

7.4. Audit: Evidence that the doctor is engaged in reflective practice

- The doctor should provide a resume of his/her engagement with audit, giving examples.
- This does not necessarily require the doctor to generate his/her own audits, but he or she should be able to describe how their practice develops as a result of audit outcomes, be these from PCT, practice or individual measurements.

Comment:

- Equivalent to other disciplines? **Generally, yes.**
- Level of relationship to the individual: **Reasonable. Even if the doctor is not actually running searches or designing sophisticated audits, this item allows him/her to detail their participation in continuous quality improvement by describing the role that he/she plays in generating improvements in quality**
- Achievable by all GPs? **More difficult for peripatetic locums, although suitable audits relating to the peripatetic experience would add value to the continuing professional development of this sub-group of GPs.**
- Face-value credibility: **Generally**
- Ease of production: **Reasonable. The appraisal preparatory form requires the doctor to indicate their involvement with audit; the same information could be replicated to provide this piece of evidence.**
- Source of production: **Personal.**
- Level of objectivity: **Moderate/Low. Could be enhanced by the development of standards over time.**
- Level of verifiability: **Reasonable – depends on the relationship between PCT and practice.**
- Compatible with RCGP Criteria, Standards and Evidence: **Yes**
- “SMART”? : **Acceptably so**

7.5. Evidence of meaningful participation in significant event audit

- To include a minimum 5 reviews in 5 years.
- Each to include a learning outcome.
- Examples of suitable such events include: death in-surgery, new diagnosis of cancer, terminal care at home, a complaint, a suicide, a section under the Mental Health Act

Comment:

- Equivalent to other disciplines? **Yes**
- Level of relationship to the individual: **High**
- Achievable by all GPs?: **More difficult for freelance GPs. Might require, for example, surgeries to contact ex-locums routinely if a complaint arises about their care – if doctor cannot be traced, the only option might be for the surgery to inform the PCT which holds the doctor on their supplementary list**
- Face-value credibility: **Reasonable. The review of significant clinical occurrences is growing in acceptance as a useful trigger for reflection, thereby leading to improvements in clinical care.**
- Ease of production: **Intensive for the doctor, but would link with the appraisal process, in that significant event audit can trigger important reflection within appraisal enhancing personal learning and development. Is a requirement for any GP participating in the QOF, though the QOF requires a greater frequency of reporting. The QOF is not, however, concerned with minimum standards, which is what this item sets out.**
- Source of production: **Individual doctor (could be produced in part by practice)**
- Level of objectivity: **Low. Could be enhanced by developing standardised significant event review format, perhaps by the RCGP. However, this risks reducing the individual input/ownership.**
- Level of verifiability: **Depends on the practice/PCT relationship**
- Compatible with RCGP Criteria, Standards and Evidence: **Yes**
- “SMART”? : **Fairly**

Maintaining good medical practice

- 7.6. Evidence of re-training in basic cardiopulmonary resuscitation (CPR)
- (at least once in each revalidation cycle)

Comment:

- Equivalent to other disciplines? **Likely**
- Level of relationship to the individual: **High**
- Achievable by all GPs? **Yes**
- Face-value credibility: **Might be challenged. We hold that every GP should at least be expected to be proficient at basic CPR**
- Ease of production: **Requires local provision of courses and GP time, but otherwise fairly mechanical. Is a requirement of the QOF, though the QOF requires it more frequently than once every five years. The QOF is not, however, concerned with minimum standards, which is what this item sets out.**
- Source of production: **PCT/individual doctor**
- Level of objectivity: **High**
- Level of verifiability: **High**
- Compatible with RCGP Criteria, Standards and Evidence: **Yes**
- “SMART”? : **Yes**

7.7. Documentation of clinical learning over the preceding five years

- This can be lifted directly from the evidence provided by the doctor for appraisal, and might include, among other things:
 - Course certificates
 - Learning diary
 - e-learning records
 - Reading diary
 - Clinical items included on PDPs

Comment:

- Equivalent to other disciplines? **Yes**
- Level of relationship to the individual: **High**
- Achievable by all GPs? **Yes**
- Face-value credibility: **Yes, though debate exists as to the difficulties of weighing the value of one learning experience against another.**
- Ease of production: **Requires individual organisation. Also, some risk of “points gathering” to meet the minimum hours required, reducing the value of learning. Doctors may choose to attend those courses that offer attendance certificates.**
- Source of production: **Individual doctor**
- Level of objectivity: **Quality of learning resources variable, and previous experience via Postgraduate Educational Allowance (PGEA) indicates that this is not easy to regulate**
- Level of verifiability: **Now that PGEA ending, quality assurance of all courses is more open to question. Issue of accreditation therefore is significant. Reading diary could reflect excellent learning, but very difficult to verify; similarly individually-planned learning events, such as visiting out-patients or another practice.**
- Compatible with RCGP Criteria, Standards and Evidence: **Yes**
- “SMART”? : **Reasonably so**

Relationships with patients

- 7.8. A record of at least two patient surveys over the preceding five years, at least one of which is individual to the doctor, with appropriate action taken

Comment:

- Equivalent to other disciplines? **Unclear**
- Level of relationship to the individual: **Depends on survey. Yes if GPAS or IPQ**
- Achievable by all GPs? **More difficult for freelance GPs**
- Face-value credibility: **Reasonably, to most, though some are sceptical.**
- Ease of production: **More difficult for freelance GPs. QOF annual requirement for Principals.**
- Source of production: **Practice/GP**
- Level of objectivity: **High, if accredited questionnaire used (required under QOF)**
- Level of verifiability: **Reasonable, depends on practice systems and relationship with PCT**
- Compatible with RCGP Criteria, Standards and Evidence: **Yes**
- “SMART”? : **Reasonably**

- 7.9. Communication skills: evidence of at least one half-day of learning in communication skills in the preceding five years, to include resulting learning points.

Examples of such learning could include:

- Attendance at a communications skills course
- Shared surgeries with another doctor
- Peer review of audio- or video-taped surgery
- Self-analysis of audio- or video-taped surgery

Comment:

- Equivalent to other disciplines? **This is an area of critical importance to GPs. Communication skills are central to general practice in a way that they may not be for other disciplines. However, these skills should be developed in any clinician who consults, and are arguably appropriate even for non-clinicians.**
- Level of relationship to the individual: **High**
- Achievable by all GPs? **Yes**
- Face-value credibility: **Yes, though, for a fair proportion of GPs, formal communication skills training will be a new learning experience.**
- Ease of production: **Acceptable**
- Source of production: **Individual GP**
- Level of objectivity: **Value of communication skills courses likely to be variable.**
- Level of verifiability: **Depends on accreditation of courses. Individual communication skills learning, such as shared surgeries, are more difficult to verify, although are likely to be high in learning value. Details of learning outcomes to be taken forward by the doctor can overcome this.**
- Compatible with RCGP Criteria, Standards and Evidence: **Yes**
- “SMART”? : **Reasonably**

- 7.10. Production of practice complaints procedure
- 7.11. List of all complaints within the past five years, involving the individual doctor, and subsequent appropriate action taken
- Doctors are to be encouraged to regard the occurrence of complaints as an opportunity for improvement. As such, a certain frequency of complaint should be accepted as an indicator of a normal professional activity, provided the complaints have been appropriately handled, and the relevant learning undertaken

Comment:

- Equivalent to other disciplines? **Reasonably**
- Level of relationship to the individual: **Easier when practice based. Peripatetic GPs would need to demonstrate that they have a procedure whereby practices at which they work can notify them of complaints that subsequently arise. This would represent a change in behaviour, albeit a desirable one.**
- Achievable by all GPs? **Harder for peripatetic GPs at this time.**
- Face-value credibility: **Yes**
- Ease of production: **Easier for GPs based in a practice**
- Source of production: **PCT/Practice/Individual.**
- Level of objectivity: **PCT can assess whether proffered procedure meets accepted standards**
- Level of verifiability: **New requirement for Practices to notify PCT of complaints as they arise will assist verifiability. This could also assist the process of feeding information back to peripatetic doctors on the PCT supplementary list.**
- Compatible with RCGP Criteria, Standards and Evidence: **Yes**
- “SMART”? : **Fairly**

Relationships with colleagues

- 7.12. Audit of records for legibility and accuracy
- To the standard defined by the RCGP
 - This item also relates directly to the doctor's provision of Good Clinical Care (pages 17-18)

Comment:

- Equivalent to other disciplines? **Reasonably likely**
- Level of relationship to the individual: **High**
- Achievable by all GPs? **Yes**
- Face-value credibility: **Debatable. However, even though this item only indirectly reflects the doctor's relationships with colleagues, it also has validity in terms of reflecting Good Clinical Care (pages 17-18). It also lends itself reasonably well to quantification and hence the setting of a minimum standard. Additionally, there is no immediately apparent alternative item of evidence for this area (see Recommendations for priority development of new items of evidence, pages 31-32).**
- Ease of production: **Logistically more difficult for peripatetic GPs; represents a new process to be assessed, possibly most appropriately by the PCT.**
- Source of production: **Initially, a self-reported audit of notes seems the most likely universally applicable option. Could subsequently be included under the remit of the PCT annual verification visit, for those practices engaged with QOF. Individual production by peripatetic doctors would be more labour-intensive.**
- Level of objectivity: **High if RCGP establishes a standard.**
- Level of verifiability: **Uncertain if self-reported; high, if carried out by PCT**
- Compatible with RCGP Criteria, Standards and Evidence: **Yes**
- SMART?? : **If PCT- administered, yes.**

Teaching (if appropriate, and only for doctors with a formal teaching commitment)

7.13. The doctor provides evidence of performance review within teaching role

- Such as:
 - Trainer re-accreditation
 - Record of teacher training activities
 - Feedback from students

Comment:

- Equivalent to other disciplines? **Likely**
- Level of relationship to the individual: **High**
- Achievable by all GPs? **Only relevant to teaching GPs – achievable by these**
- Face-value credibility: **High**
- Ease of production: **Relatively easy**
- Source of production: **Individual GP**
- Level of objectivity: **Fairly objective**
- Level of verifiability: **Depends on relationship between PCT and teaching bodies**
- Compatible with RCGP Criteria, Standards and Evidence: **Yes**
- “SMART”? : **Fairly**

Research

- 7.14. Proof of compliance with local research governance procedures
- 7.15. Declaration of research involvement

Comment:

- Equivalent to other disciplines? **Likely**
- Level of relationship to the individual: **High**
- Achievable by all GPs? **Only relevant to GPs involved in research – these should be well motivated to supply evidence**
- Face-value credibility: **Reasonable**
- Ease of production: **Relatively simple**
- Source of production: **Individual GP. PCT should be able to provide proof of compliance with research governance.**
- Level of objectivity: **Research governance item objectivity high; self declaration comparatively low in objectivity**
- Level of verifiability: **Research governance item high; self declaration open to question**
- Compatible with RCGP Criteria, Standards and Evidence: **Yes**
- “SMART”? : **Acceptably so**

Other activities (for example, management activities outside the practice, GP appraising, GP with Special Interest.)

7.16. The doctor provides evidence of periodic performance review within these contexts

Comment:

- Equivalent to other disciplines? **Likely**
- Level of relationship to the individual: **High**
- Achievable by all GPs? **Yes, by those to whom relevant (though depends on appropriate performance review being established within the relevant role)**
- Face-value credibility: **Yes**
- Ease of production: **Depends on appropriate performance review being established within the relevant role.**
- Source of production: **Individual GP and the organisation responsible for the respective roles**
- Level of objectivity: **May be variable.**
- Level of verifiability: **Depends on the relationship between the PCT and the relevant organisation**
- Compatible with RCGP Criteria, Standards and Evidence: **Yes**
- “SMART”? : **Acceptably so**

Probity

7.17. Self-declaration of:

- GMC status
- NCAA status
- Criminal status
to be verified by the PCT

7.18. Self-confirmation of potential conflicts of interest.

Comment:

- Equivalent to other disciplines? **Likely**
- Level of relationship to the individual: **High**
- Achievable by all GPs? **Yes**
- Face-value credibility: **High, though may provoke anxieties about the right of individual doctors to privacy when under investigation for unproven allegations.**
- Ease of production: **If PCT unable to produce data, self-declaration, in the first place. It seems likely that the evolution of systems to cross-relate information relating to GMC/NCAA/criminal proceedings between PCTs and the relevant organisations can be expected in the future, at which stage the PCT would be in a position to verify the self-declaration.**
- Source of production: **PCT**
- Level of objectivity: **Reasonable, as simple yes/no statements**
- Level of verifiability: **Questionable if purely self-declared without independent verification. Will increase as PCT verification emerges.**
- Compatible with RCGP Criteria, Standards and Evidence: **Yes**
- “SMART”? : **Yes**

Health

7.19. Self-declaration of health status, as in appraisal

Comment:

- Equivalent to other disciplines? **Yes**
- Level of relationship to the individual: **High**
- Achievable by all GPs? **Yes**
- Face-value credibility: **Uncertain. Depends on level of verifiability.**
- Ease of production: **Easy**
- Source of production: **Individual GP**
- Level of objectivity: **Low at present. Standard self-declaration form produced, for example, by RCGP, would increase this**
- Level of verifiability: **Open to question.**
- Compatible with RCGP Criteria, Standards and Evidence: **Yes**
- “SMART”? : **Reasonably**

Statement of “absence of concern”

- 7.20.** Evidence relating to the performance of the doctor not covered elsewhere within this evidence set
- This item is intended to allow the PCT to make clear that the doctor does not have any aberrant markers of behaviour that are being ignored.

Comment:

- Equivalent to other disciplines? **Likely**
- Level of relationship to the individual: **Depends on the sophistication of PCT data**
- Achievable by all GPs? **Depends on the PCT**
- Face-value credibility: **Reasonable. The statement is an acknowledgement on the part of the PCT that the doctor has not “appeared on the radar screen” of concern.**
- Ease of production: **Easy for doctor, since generated by PCT.**
- Source of production: **PCT.**
- Level of objectivity: **Depends on PCT and the level of sophistication of their quality monitoring and communications processes.**
- Level of verifiability: **Again, depends on the PCT.**
- Compatible with RCGP Criteria, Standards and Evidence: **Yes.**
- “SMART”? : **Yes**

8

Recommendations for priority development of new items of evidence

- 8.1. Evidence base.** We recognise the paucity of evidence with respect to the indicators we have proposed. We believe that we have chosen indicators that at least have “face value” credibility (Section 5.1.4), and agree that in some instances it is not possible to move beyond this. Nevertheless, we acknowledge the importance, where possible, of objectively demonstrating their value at the earliest opportunity, through proper, targeted research.
- 8.2.** Several items were discussed for inclusion, other than those included above. The group were firm in their desire that only items which are fit for use immediately should be included; the addition of others in order to give the impression of a more comprehensive set could be counterproductive. However, the following are items that we recommend could be fit for purpose soon, given sufficient commitment to develop them.
- 8.2.1. Prescribing data.** The vast majority of prescribing data is not traceable to an individual doctor. However, increasingly sophisticated data collection means that individually relevant data will soon begin to become available. As it does, it should be cautiously used to inform the revalidation process. The first such areas to become available are those of antibiotic prescribing and benzodiazepine prescribing, and these should be available at PCT level, for all doctors, including peripatetic. We encourage this development, as it will begin to shed light on this vital area of safety and quality.
- 8.2.2. Referral data.** Another key aspect of doctors’ behaviour is that of referral. However, the variables inherent in the referral process make it inappropriate for referral behaviour to be included in an evidence set designed to demonstrate minimum standards. We recommend that the possibility of including evidence relating to referrals be reviewed as the process develops.
- 8.2.3. Video review.** It is well established that communication skills are central to the quality of performance of GPs. Communication skills teaching is central to the training of new GPs and it is highly desirable that evidence relating to communication skills is included when revalidation is being considered. Some have called for videoed surgeries to be required in the initial evidence set. We believe that the technical requirements of producing a video, combined with the infrastructure required to assess them, and the challenge to the sizable

cohort of doctors unfamiliar with the process of recording their consultations, make the idea of requiring video submission unrealistic at this time. Nevertheless, we recognise the value of video use in the development of consulting skills, and advocate the further exploration of the use of video for demonstrating these skills for the purpose of revalidation.

- 8.2.4. 360-degree review.** Similarly, 360-degree peer review has been proposed by some as the best way of demonstrating good relationships with colleagues. We acknowledge the difficulty in identifying an item of evidence to effectively indicate the status of a doctor's relationship with colleagues, and at the same time recognise the potential benefits of 360-degree review, but are cautious about the compulsory application of 360-degree review for the purpose of revalidation. We believe that its use might add substantially to the evidence, but that more development of the concept is required before it can be universally applied. We also recommend that other means of demonstrating healthy relationships with colleagues be identified and developed.
- 8.2.5. Away days and team meetings.** Similarly, we debated whether documentation of attendance at such events might be a requirement of revalidation. Our conclusion was that not all doctors have the option of attending such events, not all doctors are in positions of being able to insist that such events occur and that it might therefore be counterproductive to insist that participation in team-based events be a requirement of revalidation.
- 8.2.6. Equipment list.** We believe that the variations that exist between individual GP practices make it too difficult to define a meaningful minimum requirement for equipment for a GP. We recommend that this issue be a focus for exploration, to test whether our opinion is true, and whether or not a minimum equipment set can be defined.

9

Conclusion

- 9.1. This document has been written in order to support the distinct but complimentary processes of appraisal and revalidation.
- 9.2. We value the appraisal process as a supportive, confidential developmental tool for doctors and seek to allow it to flourish.
- 9.3. We recognise the potential benefit of revalidation in safeguarding safety for the public, through periodic review of a doctor's performance.
- 9.4. We acknowledge the desirability of objective indicators of performance for doctors, and the need for such indicators to inform revalidation, but recognise the paucity of such indicators, and the rudimentary nature of those indicators that do exist.
- 9.5. We believe that it is proper that such evidence as currently exists be gathered now, in order to begin the iterative process of judging which evidence is useful, which should be discarded, and which should be developed for future use.
- 9.6. We strongly encourage that the assessment of performance indicators be separate from the appraisal process, so as not to contaminate the nature of the latter.
- 9.7. We believe that the most productive route to greater quality and safety lies in lifelong learning, through continuing professional development. Therefore, the more that the revalidation and appraisal processes can be approached in educational terms, the greater their eventual dividend. Doctors are beginning to appreciate the educational benefits of appraisal; the current challenge is to develop a revalidation process that also supports the principles of lifelong learning.

10

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