

PORTFOLIO OF EVIDENCE OF PROFESSIONAL STANDARDS FOR GENERAL PRACTITIONERS:

**A TOOL FOR CONTINUING
PROFESSIONAL DEVELOPMENT,
APPRAISAL AND REVALIDATION**

A CONSULTATION DOCUMENT

From the

ROYAL COLLEGE OF GENERAL PRACTITIONERS

August 2004

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Foreword

In the last few years British general practice has seen a constant stream of changes. Amongst these have been the arrival of appraisal and preparation for revalidation.

Whilst being keen to demonstrate that they offer high quality patient care, many, if not most, general practitioners have felt a degree of confusion about how to cope with these developments. Change is often viewed as a threat – as Mark Twain once wrote, “I’m all for progress, it’s change I can’t stand”. And yet few would deny that general practitioners have developed their care and are, by and large, delivering very high quality care. However, the modern culture in society means that we need to be able to demonstrate the quality of our care to the British public.

Appraisal was developed as a developmental, educational tool. Most doctors undergoing appraisal have worried about it in advance, and then found it to be an almost unique opportunity to talk about their strengths, weaknesses, aspirations, and fears. Revalidation is scheduled to start in 2005. The RCGP has been adamant that the educational value of appraisal should not be lost by tying it too closely to revalidation. After all, few of us will be honest about our weaknesses if we are concerned about our continuing licence to practise.

This document is a development of an original document on the criteria, standards, and evidence required for revalidation by the RCGP and GPC, with major input from other primary care organisations. It is designed as a solution to general practitioners’ needs. It summarises the RCGP’s proposals on the evidence that general practitioners may wish to gather to demonstrate their professional standards –whether for appraisal, revalidation, or simply for personal growth.

However, it is vital that this concept is owned by the profession. We are sending it at this stage for genuine consultation. We are keen for other general practice organisations to join us in partnership in this work. We have tried to make it user friendly, evidence based, and practical. Please let us have your opinions.

*David Haslam
Chairman of Council, Royal College of General Practitioners.*

Introduction

This document is for consultation with the profession, the public and organisations with an interest in the quality of medical care. It summarises the Royal College of General Practitioner's proposals on the evidence that general practitioners may wish to gather to demonstrate their professional standards. When collected, the evidence should comprise a key part of their folders for demonstrating continuing professional development, appraisal and revalidation.

This text is based on a number of sources:

Good Medical Practice published by the General Medical Council (GMC)¹

Good Medical Practice for General Practitioners published by the Royal College of General Practitioners (RCGP) and the General Practitioners Committee of the British Medical Association (GPC)²

Criteria, Standards and Evidence for Revalidation – a report of the RCGP/GPC/GMC revalidation working party

Revalidation Folder: doctors working in clinical general practice in Scotland published by RCGP Scotland, Scottish GPC and NHS Education for Scotland³

Defining the evidence for revalidation – a report from the NHS Clinical Governance Support Team Expert Group⁴

Revalidation (GMC Reforms fact sheet) produced by the GMC⁵

The policy framework for revalidation: A position paper – a paper of the GMC

*The Good CPD Guide*⁶

In publishing this document for consultation, the Royal College of General Practitioners will be seeking the views, support and endorsement of a number of medical bodies including other Royal Colleges, the British Medical Association and its General Practitioners Committee, the General Medical Council, the NHS Alliance, the National Association for Primary Care, the National Association of Sessional GPs, and the National Clinical Governance Support Team (England). It will also be keen to hear from patient groups and to incorporate their views in the final version.

See the section on Consultation process (pages 21 and 22) for details of how to respond.

Evidence of Professional Standards

The Royal College of General Practitioners will produce a toolkit mapped to the final agreed version of the evidence described here. Some doctors will choose to create their own folder format. Whichever, the evidence of professional standards should be collected in 11 sections with 18 groups of evidence recorded.

- Section 1: Personal and registration details
- Section 2: What you do
- Section 3: Good clinical care
- Section 4: Maintaining good medical practice
- Section 5: Relationships with patients
- Section 6: Relationships with colleagues
- Section 7: Teaching and training
- Section 8: Research
- Section 9: Probity
- Section 10: Health
- Section 11: Clinical governance statement

At first the folder will contain only recent evidence. In time we expect the folder to contain evidence relating to the previous five years. A full folder will therefore take five years to accumulate.

The description of the evidence given in this document relates to clinical general practitioners working in a single practice. However, general practitioners are not a homogeneous group and different types of practice need to be considered:

Clinical NHS general practitioners

The description of the folder in this document is directly appropriate to the clinical NHS general practitioner.

General practitioners with special interests

All doctors will be asked to describe, in their folder, what they do. If a general practitioner undertakes work outside the traditional definition of clinical general practice, whether clinical or non-clinical, they should describe what that work entails and provide evidence to answer three questions:

- How did you establish your competency to undertake this work?
- How do you maintain your competency in this work?
- How can you demonstrate that you are fit to practise this work?

Non-clinical general practitioners

While many general practitioners have significant non-clinical roles, in primary care organisations for example, few do no clinical work. They should provide evidence in

their folder for all the non-clinical activities (such as continuing professional development, working with colleagues, teaching, research, health and probity) and should provide answers to the three key questions (above) for their work.

Sessional general practitioners

Sessional (non-principal) general practitioners' folders will be similar to those of clinical NHS general practitioners with one current exception – they are not all yet part of the NHS annual appraisal scheme. For these doctors, evidence of satisfactory participation in annual appraisal should only be entered when it occurs.

Some sessional general practitioners work predominantly in one practice and their folders will be apart from appraisal, the same as those of their principal colleagues. For general practitioners working in many practices, compiling a folder may be more demanding. Their evidence will be comparable to the evidence for principal general practitioners but will often require more effort to collect. The Royal College of General Practitioners and the National Association of Sessional GPs will issue further advice for sessional general practitioners.

Non-NHS clinical general practitioners

It is expected that non-NHS general practitioners may want to set up an organisation to undertake clinical governance and annual appraisal for their members. However, all general practitioners can generate a folder.

Question 1.

Is the advice appropriate to the categories of GP shown?

Section 1: Personal and registration details

This section of your folder simply records your personal details and details of your GMC registration.

Criterion 1: The doctor records their personal and registration details.

Standard 1: The details are entered in the folder.

Evidence 1: The entry in the folder (for example the Form 1 from the last annual appraisal)

Section 2: What you do

Each doctor should describe the nature and extent of their work as a doctor, and the context in which they undertake that work.

Criterion 2: The doctor defines what he or she does.

Standard 2: A statement of activities covers all important areas of the doctor's work and the contents will form the basis of the evidence elsewhere in the folder.

Evidence 2: An accurate annual statement of the doctor's activities (for example the Forms 2 from the last five annual appraisal forms).

Criterion 3: The context, including any factors which facilitate good patient care and any factors that might hinder the doctor from providing a good standard of care, in which the doctor works should be taken into consideration.

Standard 3: A statement of context is accurate and is taken into account in assessing the folder.

Evidence 3: An accurate annual statement from the doctor describing the context in which they practise (for example the Forms 2 from the last five annual appraisal forms).

Criterion 4: The doctor prepared for, maintains skills in and demonstrates standards in medical activities beyond normal general practice (for example as a general practitioner with special interests).

Standard 4: Annual appropriate preparation, continuing personal development and appropriate standards are achieved in all non-general practice roles.

Evidence 4: Description and evidence of initial skills acquisition; description of continuing skills maintenance and development; and evidence of the quality of service in these additional roles.

Question 2

Do you feel that the evidence requested matches the criteria shown?

Section 3: Good Clinical Care

This section relates to the entries in *Good Medical Practice* and *Good Medical Practice for General Practitioners* on good clinical care.

Criterion 5/6: The doctor regularly reviews clinical practice and demonstrates the achievement of acceptable standards of care.

Standard 5: The doctor participates meaningfully in significant event auditing, with examples including such events as any deaths-in-surgery, new diagnosis of cancer, terminal care at home, sectioning under the Mental Health Act, suicide, patient complaint or prescribing error; and responds appropriately to the findings.

Evidence 5: Reports of at least 10 significant event audits over the past five years of events involving the doctor, each including a learning outcome and evidence of its implementation.

Criterion 5/6: The doctor regularly reviews clinical practice and demonstrates the achievement of acceptable standards of care.

Standard 6: The doctor effectively participates in clinical audit; demonstrates achievement of appropriate standards of care; and responds appropriately to the findings of audits.

Evidence 6: A list of clinical audits, personal or team based, in which the doctor has participated in the past five years; at least one audit report to which the doctor has contributed in each year; and a statement on learning outcomes from those audits with evidence of implementation.

Question 3

Do you think that significant event audits are an appropriate tool to use as evidence of criterion 5/6? Would Sessional GPs have difficulty in providing this information? Are there any other appropriate techniques?

We would also welcome views on whether clinical audit is an appropriate technique to use to demonstrate evidence of criterion 5/6? Should a definitive number be required? Would Sessional GPs have difficulty in collating such evidence? Are there any other appropriate techniques?

Section 4: Maintaining Good Medical Practice

This section relates to the entries in *Good Medical Practice* and *Good Medical Practice for General Practitioners* on maintaining good medical practice.

Criterion 7: The doctor has an annual appraisal.

Standard 7: The doctor participates meaningfully in an annual appraisal undertaken by a trained peer.

Evidence 7: The signed statements from the appraiser (the statements at the end of forms 3 and 4 of the annual appraisal documentation)

Criterion 8: The doctor maintains their personal and professional development.

Standard 8: The doctor has an annual personal development plan based on identified learning needs that are then met. The plan will include educational activity.

Evidence 8: Submission of the annual personal development plan with learning needs and learning outcomes; and a list of continuing medical educational activity.

Criterion 9: The doctor maintains skills in cardio-pulmonary resuscitation.

Standard 9: The doctor can demonstrate continuing proficiency in cardio-pulmonary resuscitation.

Evidence 9: Evidence of proficiency in cardiopulmonary resuscitation training, for example a certification of competence issued at an appropriate course within the last five years.

Question 4

On standard 8, do you feel that a personal development plan will adequately demonstrate a doctor's commitment to continuing professional development? Might there be other ways to demonstrate this?

We would be particularly interested in whether you feel that criterion 9 is appropriate and your suggestions for alternatives.

Section 5: Relationships with Patients

This section relates to the entries in *Good Medical Practice* and *Good Medical Practice for General Practitioners* on relationships with patients.

Criterion 10: The doctor assesses patient views of their practice and their communication skills and reflects on the results.

Standard 10: The doctor has participated in survey of patient satisfaction with the practice's care, services and facilities [perhaps undertaken by the primary care organisation]; has undertaken an independent assessment of their communication skills [for example a validated survey of consecutive consulters analysed outside the practice]; and has reflected on the findings and responded appropriately.

Evidence 10: The results of a patient survey of care, services and facilities within the previous five years; the results of an independent assessment of consultation communication skills; reflections on the findings; and an account of appropriate action taken.

Criterion 11: The doctor maintains their communication skills.

Standard 11: The doctor has reflected on their communication skills, for example through an assessment of videotaped consultations; an observed surgery session with a trained assessor of communication skills; or attendance at a course concerning evaluation of communication skills.

Evidence 11: Certification of taking part in communication skills evaluation in the past five years.

Criterion 12: The doctor maintains an effective complaints procedure.

Standard 12: The doctor has and applies a complaints procedure that complies with professionally agreed guidelines; and learns from complaints.

Evidence 12: Submission of the complaints procedure; copies of all complaints involving the doctor; and evidence that any learning needs identified have been met.

Question 5

Do you feel that the techniques described for criteria 10 and 11 to demonstrate patient satisfaction and communication skills provide adequate evidence? Are there other ways to gather this evidence?

On criterion 12, is this an appropriate way to demonstrate that doctors take complaints seriously?

Section 6: Relationships with Colleagues

This section relates to the entries in *Good Medical Practice* and *Good Medical Practice for General Practitioners* on relationships with colleagues and team working.

Criterion 13: The doctor's entries in patient medical records are sufficient to allow another doctor to take over the care of the patient if required to do so.

Standard 13: Entries in the doctor's clinical records are complete, accessible and understandable.

Evidence 13: A standardised audit conducted by an independent colleague that demonstrates the appropriate quality of the doctor's clinical records.

Question 6

Is this an appropriate way to demonstrate effective working with colleagues?

Section 7: Teaching and Training (if appropriate)

This section relates to the entries in *Good Medical Practice* and *Good Medical Practice for General Practitioners* on teaching.

Criterion 14: The doctor's standard of teaching is sufficient for the regular, formal teaching role(s) undertaken.

Standard 14: The doctor has been accredited where accreditation is appropriate; and evaluates their formal teaching.

Evidence 14: A record of regular formal teaching activities; submission of accreditation (such as trainer accreditation); and, where available, feedback from learners or peers.

Question 7

If this section is appropriate to you, we would welcome your views on whether the evidence is sufficient.

Section 8: Research (if appropriate)

This section relates to the entries in *Good Medical Practice* and *Good Medical Practice for General Practitioners* on research.

Criterion 15: The doctor's standard of activity in undertaking research is appropriate.

Standard 15: The doctor meets the requirements of research governance; maintains research standards; and has no significant conflicts of interest in their involvement in research.

Evidence 15: A record of research activities (as investigator, collaborator or data provider); certification of compliance with research governance; and a declaration of any personal gain from research.

Question 8

If this section is appropriate to you, we would welcome your views on whether the evidence is sufficient.

Section 9: Probity

This section relates to the entries in *Good Medical Practice* and *Good Medical Practice for General Practitioners* on probity.

Criterion 16: The doctor conducts medical activity in an appropriate manner.

Standard 16: The doctor's conduct is appropriate for a medical practitioner.

Evidence 16: Self-declaration of status and processes with the General Medical Council, a clinical assessment agency and any criminal proceedings that might cause doubts concerning conduct or probity; and self-statement that there are no probity issues to be considered.

Question 9

Is this an appropriate way to demonstrate probity?

Section 10: Health

This section relates to the entries in *Good Medical Practice* and *Good Medical Practice for General Practitioners* on health.

Criterion 17: The doctor's health does not compromise that doctor's fitness to practice.

Standard 17: The doctor knows of no health issues that might compromise their fitness to practice.

Evidence 17: Self-declaration of health status.

Question 10

Do you feel that a self-declaration of health status is sufficient?

Section 11: Clinical Governance Statement

The local primary care organisation should be satisfied that there are no local reasons for concern. The folder should therefore include a recent statement from the local primary care organisation.

Criterion 18: The doctor's performance, as known to the local clinical governance team, does not give any cause for concern.

Standard 18: The doctor is not known locally to be giving any cause for concern.

Evidence 18: A statement of "no cause for concern" from the medical director or leader for clinical governance in the local primary care organisation.

Question 11

Are there any concerns about the provision of statements from local primary care organisations?

Using the folder for continuing professional development

All doctors are expected to maintain their standards of care and keep up to date. The primary requirement is reflection – the seeking of insight into how you perform and improvement in quality to meet personal and professional standards.

The evidence described in this document will be sufficient to demonstrate that a doctor is a reflective practitioner.

Question 12

Do you feel that the professional standards set out in the document will be adequate to demonstrate that the doctor is a reflective practitioner?

Using the folder for appraisal

Annual appraisal for general practitioners working in the NHS is organised and funded by primary care organisations. It is a formative experience designed to encourage and maintain reflective practice, personal development and quality assurance. The appraiser is not assessing a doctor's competency or fitness to practise; rarely, however, evidence of unacceptable practice may be revealed during an appraisal process, in which case the appraiser cannot sign up the appraisal as satisfactory and must act appropriately to protect the public. An appraisal is an opportunity to encourage the development of a personal folder that can be used for personal development and, every five years, for revalidation.

The Royal College of General Practitioners has drawn up this document to describe the contents of a folder that is suitable for informing an appraisal.

Question 13

Do you feel that the professional standards set out in the document are suitable for informing an appraisal?

Using the folder for revalidation

The General Medical Council's policy position is still being developed. It is our understanding that all doctors will be required to keep a revalidation folder based largely on the evidence that they accumulate for appraisal; that they will submit their folder to a local group; and that the assessment of that folder will be based on the advice of the relevant College, Faculty or specialist group.

For general practitioners, the Royal College of General Practitioners believes that the evidence of professional standards set out in this document will be appropriate for the assessment of revalidation folders.

Question 14

Despite the current uncertainty about the final design of the system for revalidation, do you feel that the evidence of professional standards set out in the document is sufficient for the assessment of revalidation folders? Are there any areas that have been missed?

Consultation process

We would welcome your views on any aspect of the document. In particular, it would be helpful if you were to comment on the specific questions we have posed.

Question 1 **Evidence of Professional Standards.** Is the advice appropriate to the categories of GP shown?

Question 2 **Section 2: What you do.** Do you feel that the evidence requested matches the criteria shown?

Question 3 **Section 3: Good Clinical Care.** Do you think that significant event audits are an appropriate tool to use as evidence of criterion 5/6? Would Sessional GPs have difficulty in providing this information? Are there any other appropriate techniques?

We would also welcome views on whether clinical audit is an appropriate technique to use to demonstrate evidence of criterion 5/6? Should a definitive number be required? Would Sessional GPs have difficulty in collating such evidence? Are there any other appropriate techniques?

Question 4 **Section 4: Maintaining Good Medical Practice.** On standard 8, do you feel that a personal development plan will adequately demonstrate a doctor's commitment to continuing professional development? Might there be other ways to demonstrate this?

We would be particularly interested in whether you feel that criterion 9 is appropriate and your suggestions for alternatives.

Question 5 **Section 5: Relationships with Patients.** Do you feel that the techniques described for criteria 10 and 11 to demonstrate patient satisfaction and communication skills provide adequate evidence? Are there other ways to gather this evidence?

On criterion 12, is this an appropriate way to demonstrate that doctors take complaints seriously?

Question 6 **Section 6: Relationships with Colleagues.** Is this an appropriate way to demonstrate effective working with colleagues?

Question 7 **Section 7: Teaching and Training.** If this section is appropriate to you, we would welcome your views on whether the evidence is sufficient.

Question 8 **Section 8: Research.** If this section is appropriate to you, we would welcome your views on whether the evidence is sufficient.

- Question 9 **Section 9: Probity** Is this an appropriate way to demonstrate probity?
- Question 10 **Section 10: Health.** Do you feel that a self-declaration of health status is sufficient?
- Question 11 **Section 11: Clinical Governance Statement.** Are there any concerns about the provision of statements from local primary care organisations?
- Question 12 **Using the folder for continuing professional development.** Do you feel that the professional standards set out in the document will be adequate to demonstrate that the doctor is a reflective practitioner?
- Question 13 **Using the folder for appraisal.** Do you feel that the professional standards set out in the document are suitable for informing an appraisal?
- Question 14 **Using the folder for revalidation.** Despite the current uncertainty about the final design of the system for revalidation, do you feel that the evidence of professional standards set out in the document is sufficient for the assessment of revalidation folders? Are there any areas that have been missed?

Comments and views on this document should be submitted by **10 September 2004**. Please indicate whether you are responding on behalf of an organisation or as an individual. If responding as an individual it would be helpful to know which category of GP you are: e.g. Clinical NHS GP, GP with a Special Interest, Non-clinical GP, Sessional GP, Non-NHS clinical GP.

By post to: Corporate Affairs (Portfolio consultation)
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By email to: comments@rcgp.org.uk (email attachments should be in Microsoft Word or Rich Text format only please)

By fax to: 020 7589 3145

Further copies of this document can be obtained from the above address or by telephone 020 7344 3160. Alternatively you are welcome to make photocopies.

A copy of the document can be found on our website and you can also respond directly to us online. <http://www.rcgp.org.uk/corporate/responses/index.asp>

References

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