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

Report to the

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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:

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

- 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.

- 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.

- 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.

- o 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:

- o Practices to provide administrative support to help locums get feedback from patients.

- o OOH employing organisations to support OOH doctors in gaining feedback from patients.

- o OOH doctors to be able to gain feedback by telephone.

- o 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.

Contents

Introduction

Annual appraisal was introduced for all UK general practitioners in 2004. Since then, successive Department of Health publications have clarified the purpose of appraisal, culminating in the White Paper *Trust, Assurance and Safety*[1] which set out the framework for regulation of all health professionals. This was followed by the publication of *Medical Revalidation: Principles and Next Steps* by the Chief Medical Officer in 2008[2], which confirmed the central role of appraisal in the proposed revalidation process.

The GMC is currently consulting on the revalidation process, and the consultation document *Revalidation: the way ahead* clarifies the relationship between appraisal and revalidation[3]. The proposal is that revalidation will be achieved by satisfactory engagement in annual appraisal, which for GPs includes achieving 50 credits for continuing professional development (CPD) activity, plus formal sign-off from the Primary Care Organisation (PCO) confirming that there are no unresolved performance concerns. Satisfactory engagement in annual appraisal will be judged in large part by the production of a portfolio of evidence gathered over a five year period to demonstrate that the GP is up to date and fit to practise. This evidence will need to map to all twelve attributes in the new version of the GMC document *Good Medical Practice*[4]. Appraisers will make judgements on an annual basis as to whether each appraisee is making satisfactory progress towards revalidation based on the supporting information they submit and their engagement in the appraisal process. The Responsible Officer (RO) will use information from annual appraisal and local clinical governance systems in making recommendations for revalidation.

In 2003 a report by the School of Health and Related Research in Sheffield [ScHARR][5] highlighted professional issues faced by locums, including isolation and lack of access to information about education. It stressed the importance of locums being appraised by GPs who understand their role, and encouraged locums to come forward to become appraisers themselves. It also identified responsibilities of both the host Primary Care Trust (PCT) and of employing practices. Host PCTs were directed to offer and make adequate financial provision for annual appraisal for all their GPs. Practices were asked to facilitate the appraisal process for any non-principals they employed by:

- Inviting locums to take part in the professional life of the practice by inviting them to attend practice meetings and training events, and contributing to significant event meetings or other audit processes.

- Facilitating their access to professional materials (journals, training videos etc.) and to patient data, particularly about patients they have seen, to assist with their own audit processes.

- Supporting steps locums may wish to take to learn the views of their patients and colleagues.

- Ensuring that practice principals are available for handover discussions and general information exchange about patients.

The Working Group on Medical Revalidation and Education reviewed the readiness of appraisal and clinical governance systems to support the re-licensure of doctors[6] and found that appraisal systems were 'patchy' in terms of their overall readiness, and

confirmed that locums are the most likely GPs to fall outside the appraisal system. The recent data collection exercise carried out by Strategic Health Authorities using guidance from Assuring the Quality of Medical Appraisals and Revalidation (AQMAR) confirmed that PCOs across England varied in terms of their readiness for revalidation[7]

The RCGP has recently published on its website clear guidance on the evidence it is proposed that every GP will be expected to produce[8]. This document went out to consultation before its initial publication in April 2009, and revised versions have been published in August 2009 and January 2010. The latest version indicates the types of evidence from the core list that are likely to map to the twelve attributes of GMP. The RCGP is clearly aware that some evidence may be difficult for some groups, such as locum GPs working in several practices, GPs working small numbers of sessions, GPs working mainly in Out of Hours settings and GPs in small rural remote practices. A paper published in January 2009 after discussion with various organisations who work on behalf of locum and sessional doctors[9] identifies the evidence areas that may be particularly difficult for these doctors, including clinical audit and significant event analysis (SEA), as well as feedback from colleagues (multi-source feedback or MSF) and from patient (a patient satisfaction questionnaire or PSQ) – all areas that were highlighted in the ScHARR report in 2003.

These concerns are echoed and developed in papers published by the National Association of Sessional GPs (NASGP, http://www.nasgp.org.uk/)[10][11] which review the use of audit and patient and colleague surveys as appropriate tools to judge fitness to practise of any doctor, with particular emphasis on the difficulties faced by sessional GPs in collecting and interpreting this evidence. These argue that full cycle audit is very hard for locums to achieve because of the structural constraints of their working conditions, and the alternative 'personal audits' suggested in the RCGP guide are difficult to measure against any objective standards. It is questioned though whether there is any evidence to suggest that audit as a tool is an appropriate way to judge fitness to practise at all. The robustness of PSQs and MSF for the purposes of revalidation is also questioned, with risks of bias and confounding, especially for sessional and remote GPs.

This study was commissioned by the RCGP (with funding from the Revalidation Support Team [RST]) with the aims of identifying and exploring further the potential problems that locum, sessional and remote GPs may face in collecting evidence for revalidation, and explore the possibilities for alternative forms of evidence.

1.1 Pilot questions

This pilot focused on the question: are the proposals for revalidation evidence collection achievable for sessional GPs with limited clinical time (including peripatetic locums), GPs who mainly work in Out of Hours (OOH) services, and GPs working in rural remote practices?

The detailed objectives were as follows:

- To explore with defined groups of GPs (peripatetic locums, isolated rural GPs in small practices, sessional GPs with limited clinical time, OOH GPs) their views about the current RCGP evidence proposals.

- To identify the specific difficulties they feel they will face in respect of clinical audit, significant event audit, multi-source feedback and patient feedback.

- To discuss any strategies they have used or might use to facilitate evidence collection in these areas.

- To gain agreement from each GP to attempt to collect evidence in one or two of the evidence areas during a three month period and to provide some support to the GPs if needed during the evidence collection process.

- To review the issues that arose during the evidence collection period, to see to what extent they mirrored those already identified, and to feed back comments and suggestions to RCGP.

2. Methodology

2.1 Participants

Participants were drawn from the population of sessional and remote doctors in the North East of England. Recruitment was by e-mails cascaded through GP tutor networks in the Northern Deanery region, and through the North East Locums Group.

GPs contacted through this email were invited to focus groups held in locations across the region in October and November 2009. If a doctor expressed interest but was unable to attend a group, a telephone interview with a member of the research team was offered instead. All participants were invited to take part in follow-up focus groups or interviews in March 2010.

2.2 Focus group structure

The initial focus groups (and corresponding telephone interviews) were structured around the four types of supporting evidence under consideration. Participants were asked to consider individually any problems and solutions around the completion of clinical audit, significant event analysis, and colleague and patient feedback data as they understood them, initially recording thoughts on Post-It notes. These were collected by the facilitator, with group discussion looking at the problems and potential solutions for each evidence type in turn.

At the end of the focus group participants were asked which if any of the supporting information they would attempt to collect, and given a diary in which to record any contemporaneous thoughts on the issues of collecting evidence.

The follow-up focus groups used a structured form (in Appendix 1) on which participants could record individually any helps and hindrances in the process, and used this as the start of discussion. Group discussion again considered each method in turn, then moved to more general questions of novel methods of evidence collection to fulfil the global aims of revalidation.

2.3 Analysis

Focus group and interview transcripts, and focus group outputs (flip charts, post-it notes and structured forms) were reviewed by the research team to identify the main themes. A broad framework was used to expedite analysis, focusing on problems and solutions around each method. Common themes and problems, and alternative methods of collecting supporting information, were also identified separately.

2.4 Quality of evidence

Due to the timescale of the project, it was not possible to evaluate the quality of the evidence collected. This will be done in the proposed extension to this work.

3. Results

Forty-one GPs took part in 10 initial focus groups held at 7 locations, while 12 more were interviewed. At follow-up, 8 focus groups were held (in 7 locations) with 23 GPs,

and 10 telephone interviews conducted. Table 1 gives the numbers of each type of doctor involved.

Table 1. Frequencies of responses to 'type of GP' for initial focus group/interview participants (n=53; some had more than one role)

Type of GP	Number of participants
Locum	29
Out of Hours	14
Salaried	10
Retainer	4
Returner	1
Partner (remote rural)	7

There was a mix of urban and rural practitioners – while not all participants provided this information, 11 described themselves as urban, 18 as rural or remote and four as 'urban and rural'. The majority worked in more than one practice, and reported working between 1 and 10 sessions a week. Several reported working in a single practice while also working in others as locums and/or doing additional OOH work. Practice list sizes reported ranged from less than 1000 to 20000. One GP was not practice-based but worked in a Primary Care Assessment Centre, attached to a hospital.

Participants fell into all age groups recorded: < 35 (n=12), 36-45 (n=18), 46-55 (n=14), 56-65 (n=4). 37 were female, 16 male.

3.1 Analysis of focus group and interview data

The findings in this section are derived from focus group and interview transcripts, written responses from participants on post-its and pro formas, and flipchart notes made by the facilitator during the focus group sessions. This has been supplemented by analysis of participant diaries, completed during the period of evidence collection.

The results are presented under the following themes:

- the context of evidence collection

- the four identified types of evidence (audit, significant event, MSF, PSQ)

- alternative methods

For the existing four types of evidence, problems and solutions raised by the respondents are highlighted.

4. The context of evidence collection: Sessional doctors as a subculture

4.1 Undervaluing of sessional doctors

There was also a feeling that the contribution of locums to a practice was not valued in practices, and that this related to a general perception of locums as 'second class citizens'.

> *"I think locum work – a lot of people put it down but you shouldn't – it's hard work…sometimes other GPs think you're a locum because you can't find another job [rather] than that's what you choose to do…or if you're part-time you're somehow half-partnered and not really bothered…almost treated as if you're just there, that kind of thing." (initial focus group 5)*

> *"Nobody sees you and nobody knows you. I've done locums in practices where nobody's even said anything…they won't even take the time to put in your details – you're just 'Doctor Locum'." (initial focus group 5)*

> *"I don't think I'd be invited [to practice meetings], it's for the partners. I mean there's several times I've been in the coffee room and they'll say – the partners – 'we need to discuss something' and that's my key to leave…" (initial focus group 6)*

It was felt that this would extend to organisations not valuing locums and others in the revalidation process, and that this was the case with regard to appraisal. It was felt there was a lack of support and information, leaving locums 'out on a limb'.

> *"Most of my locums it's been different practices and I've never really stayed in a practice for a long time…the appraisal I have to sort of push for it myself…I said, 'Look, you know, I think somebody should be appraising me' and, you know, I had to do everything myself and when it came to collecting the evidence it was really quite difficult." (initial focus group 5)*

> *"The practices don't seem to actually take responsibility for the fact that they need you and therefore have a duty of care and support for needs" (initial focus group 1)*

4.2 Support from employers

Many participants felt that non-partner sessional GPs are perceived differently, and so not treated the same as other GPs in a practice. This was felt to be demonstrated in practical terms in issues such as access to a practice's records for audit or significant event analysis (SEA).

> *"Moving around, you are disadvantaged because you can't get access to the records, and disadvantaged because you don't follow it up to say, 'actually, such and such happened'. And you are disadvantaged because when they do talk about it, even if they do talk about it in the practice, you are not there." (initial focus group 3)*

A key expression of the different experience of the sessional GPs came in the degree of support received from employers. This appeared to be true in all sectors – whether respondents were employed as locums by partners, by OOH organisations, or in clinics by PCTs. There was a perceived need for organisations to be more engaged and to see revalidation as a priority for the process to work effectively.

In one case a doctor had not been told a patient survey was being carried out and feedback arrangements were poor. Some doctors in practices were not informed about meetings, while some out of hours organisations did not discuss things with their doctors. The lack of organisational engagement was felt to be most critical around the significant event analysis and clinical audit, but was also felt to be a risk to gathering patient feedback, a process which may be seen as onerous.

> *"I have handed them [significant events] into the practice but I've never yet …been invited to a meeting where I've discussed it, and I've never yet been given a letter or feedback as to what's changed from that" (initial focus group 2)*

> *"the big problem I see with doing clinical audit for the purpose of revalidation for GP locums is that they're not my patients and even if I manage to implement change, I don't know whether the people who I implement change on behalf of are either going to be, you know, in terms of clinicians, interested in or bothered or just find it irritating that I would increase their workloads" (initial focus group 6)*

> *"You have to have the practice really on your side to really make it [audit] work. Maybe that's the biggest problem we face…and some practices are and some practices aren't – some practices are very supportive but some just aren't bothered at all" (initial focus group 6)*

4.3 Locum as outsider

There was a feeling that practices and partners may be defensive about any significant events in their practice, and may be reluctant to give a locum access to data. There was perceived to be a consequent risk that any attention brought by a locum to such an event may result in the locum being less likely to be employed by that practice in future.

> *"you come in as a fresh…man in those sorts of problems which might have been going on for a while and you spot something, and you know it could lead to a bit of resentment, I suppose, if you made a big deal of that" (initial focus group 6)*

> *"…as a locum in a practice, if you are involved in a significant event there's a reluctance from a locum point of view almost to voice that there's been a problem, obviously you have to but, you know, you feel it might reflect on your future employment" (initial focus group 9)*

Reporting significant events can be seen as whistle-blowing and result in locums being seen as persona non grata and not being offered more work at that practice. Thus job insecurity may make locums more vulnerable if participating in SEAs.

4.4 Patient profile

The respondent doctors also felt that locums and salaried doctors working few sessions, and out-of-hours (OOH) GPs tend to see a different profile of patients to partners and other full-time GPs. Their patients are more likely to be acute emergency appointments, and sporadic attenders who do not have, or want to avoid, a regular doctor. These patients will not have the relationship with a GP those attending a regular doctor will, and may have a different agenda.

> *"Chronic disease management, palliative care, I don't see practically any of that." (initial focus group 5)*

> *"If you're a locum and you're dashing in and out of places…you're more likely to get a significant proportion of people needing to be seen there and then because they've got tonsillitis or something…the terminal care cases you're not seeing on a regular basis." (initial focus group 10)*

Some participants considered that this raised potential issues regarding patient feedback:

> *"I think you're more likely to get negative feedback as a locum potentially…you've got to kind of like be better than whoever else they were going to see because they've got a bit of a prejudice about I'm seeing the locum – sort of an underclass of GP – so I think…to get the same feedback as a partner you've probably got to be better." (initial focus group 6)*

> *"The patients you get as a locum are often after things that their own GPs won't give them…and when you say 'no' you get negative feedback and all because you are doing your work." (initial focus group 1)*

4.5 Payment

The issue of payment for the activity involved in revalidation was raised. Sessional GPs are not paid outside the sessions they deliver, so time for audit and attending significant event meetings (if they are invited) effectively costs them potential income.

> *"I think as a locum, no [opportunity to discuss SEA] – because that's not what you're paid to do, I think to be honest as a salaried GP again it comes back to the fact that my part-time working hours don't include any of the meetings where this happens, so if I want to be involved I go in my own time and I'm not paid to be there" (initial focus group 6)*

There were fewer specific references to the cultural difference of remote GPs, although they did identify themselves as having distinct issues, such as difficulty in attending educational events, the smaller choice of appraisers and the possibility of knowing them in several other contexts; a difficulty in getting breadth of discussion/input at significant event meetings in small practices; smaller numbers for audit purposes, and, for MSF, smaller numbers of colleagues (with implications for anonymity) and of patients.

4.6   Conclusion

Sessional doctors, and locums in particular, experience isolation in their professional practice, and feel that they suffer from negative stereotyping from other GPs. In particular, they perceive a lack of awareness or concern from the practices which employ them, with regard to their needs in appraisal and revalidation. This ranges from not being included in the business of the practice – such as significant event meetings – to a lack of access to data for completing audit and case reviews. Lack of support from practice staff could also inhibit other activities such as the collection of feedback. While not experiencing these problems, remote GPs could also feel isolated, and the lack of a peer group with whom to share experiences and review practice was noted by all the groups in our sample.

5. Clinical audit

The anticipated difficulties in completing audit ranged from difficulties in identifying a topic which would be both practicable and useful, to practical difficulties in gaining access to the IT system to review data outside surgery time and lack of support from practice staff. These issues were highlighted again in the Follow-up interviews.

5.1 The definition of audit

GPs reported that having clearer guidance on what an audit consists of, details about the process and what is acceptable in terms of sample size would be helpful. Audit was perceived as primarily a means of improving service, which would not necessarily relate to improvement in their practice as individuals. This also related to concerns about the number of cases reviewed – a small sample might be meaningful to the practice but not acceptable as a valid audit to the RCGP. Some GPs also expressed concern about the process not being as objective as it should be.

> *"To be statistically significant obviously 16 patients isn't going to tell you anything in a research sense but if it tells you that in eight of those care wasn't as good as it might have been in terms of standards then fair enough you've learnt something and you will change it even if it's only based on a few patients" (Follow-up focus group 1)*

> *"I'd like the option to be able to pick things that are meaningful to your practice, but maybe have a small sample size." (Follow-up focus group 2)*

> *"But then that's a real difficulty because by auditing it you're influencing your behaviour, so it isn't really a retrospective audit." (Follow-up focus group 1)*

5.2 Gaining access to data

Difficulties were identified around accessing data through computer systems. Difficulties emerged through both familiarity with systems, and access to systems. Knowing the computer system made an audit easier to complete. Some systems allowed access to data from outside the practice, while others required being on-site.

> *"And because I know how to use the system I could do that. So that really helped as well. I didn't have to ask anyone… It's difficult to sort of stay after the surgery if everyone else has gone home and packed up…if the practice is going to be happy for you to come in on a day you're not working and there is a spare computer you can use, obviously you're not employed by them and you might not even have been going back to that practice again. …The only thing is with System One [a GP computer system] you can access it from every computer." (Follow-up tel int. 19b)*

> *"I've been to about six or seven practices that are on System One in the last say six or seven months. If you are allowed to access back to those, you'd actually be able to probably do your own audits from home or…" (Follow-up focus group 6)*

However, obstacles were not just technical – organisational differences also had an effect. Locums in particular reported not being able to go back into the practice after their session has ended. This involved being locked out of the computer system as well as not having access to a computer or a room to work in. This was often pragmatism on the part of the practice – there was no spare space. However it does demonstrate a lack of awareness of the situation and requirements of locums. IT support was also often not available. Travelling back to a practice to do an audit could also involve practical difficulties if the practice was a long distance away.

> *"You mentioned rooms, one of the places I work half the week … I arrive and I can only more or less go into the room when I arrive [and] someone is knocking on the door for me to be out when I've finished and I'm barely getting my dictating done and I'm coming out....there's nowhere else I can sit and read the computer in the place because it's really tight on rooms ….that is a genuine problem with being in that role isn't it." (Follow-up focus group 7)*

> *"So you need to have that kind of… you know, arrangement that… where you're not just a… you are allowed to have access outside your normal working time, really." (Follow-up tel int 62b)*

OOH doctors had different difficulties, although also related to availability of data – often there was no database, with all calls being handled on paper.

5.3   Length of attachment to a practice

GPs reported that an audit was feasible if there was a long term attachment to at least one practice, but impossible if only working in a given practice for a short time.

> *"Do need at least a few surgeries at the same place to do these activities" (Follow-up tel int 29b)*

> *"If you're in there for two or three days, you're not going to be able to influence what's happening with prescribing" (Follow-up focus group 8)*

> *"And it's all very well if you're in a practice where you have weekly meetings or, you know, audit meetings on a regular basis and discuss what you're going to do. You all agree to look at it. Come back with some results, change" (Follow-up tel int 62b)*

Being in a practice long enough to form relationships helped to do an audit, as often staff in the practice helped the doctor gain access to the data needed.

> *"I worked for a few sessions rather than an ad hoc session. So you sort of get a bit of a relationship with the staff and they're happy to do that for you, you know, when you've left that location?" (Follow-up focus group 6)*

> *"Yeah I mean I think the staff have been very good because they…I mean, I can't produce the necessary reports from the computer system. So they have been very helpful to do that and they've also helped me to…or will be helping me to look at the orthopaedic referrals because they did a big audit*

practice…across the whole practice a few weeks ago. So I'm going to get in on that hopefully tomorrow." (Follow-up focus group 6)

Suggestions for those not in supportive practices were to provide locums with a mentor or to set up a locum support group to help them through the audit process.

5.4 Achieving a meaningful audit

Locums frequently stated that doing an audit was one of the least useful activities for revalidation. Locums stated they were not in a position to influence the practice or make recommendations to improve practices. Other related issues were to provide locums with their own prescribing number and enable them to audit their own prescribing. These are already available for salaried GPs but not for locums.

> *"This has resulted in there only being a choice of 'simple' and fairly meaningless audit projects in order to meet requirements, rather than to usefully answer a clinical question" (Feedback form, focus group 5)*

> *"It's difficult to complete an audit cycle and to look and…and I haven't had time to compare my referral rate with the other partner… or the partners in the practice… It's very difficult to think of doing anything else because my exposure to three different practices, or even four actually, in the area means that it's… it's very difficult to get comparative data out of any system really" (Follow-up tel int 62b)*

> *"The problem is of course that we don't have prescribing numbers, so you can't actually then say go back three months later" (Follow-up focus group 8)*

One suggestion to make the audit process less burdensome was for locums to be able to do 'off the peg' audits, which could be less demanding and more achievable. Others suggested being included in practice audits that are carried out for the GP Principals by the support staff.

> *"There might be some way of individuals, I mean I can see if you're only doing two sessions it would be rather difficult. There might be ways that they could come up with say some off the peg audits which you could plug into using their information." (Follow-up focus group 1)*

> *"Time is an issue, templates might help" (focus group 6, rural partner)*

> *"I just wonder about, you know, how easy it would be for us to be included in practice audits because that's what happens with GP principals I think within a, you know, there'll be audits done" (Follow-up focus group 5)*

5.5 Protected paid time for audits

A major issue for all GPs in the study was not having sufficient, or any, protected time to do audits.

"I do know that salaried doctors do do audits and as far as I know they do get protected time. The GPs who are salaried who do all of their work with them. But the sessional GPs wouldn't have those opportunities." (Follow-up focus group 1)

"Protected time, in theory I do have, but regularly eaten into" (Follow-up focus group 7 – written comment)

5.6   Conclusions

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, given their temporary and outsider status.

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.

5.7   Potential solutions to concerns about audit

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

- Practices need 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.

- Practices to consider making some data collected routinely available for sessional GPs to reflect on and use as audit material, and offer opportunities for reflection on the audit data by someone in the practice.

- Locum agreements should specify not just workload and fee aspects of the placement but some agreement about what support the practice is prepared to give locums towards audit (and other aspects of data collection for appraisal).

- 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.

- Deaneries should help facilitate the development of 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.

- The Salaried GP model contract includes a provision for 4 hours of weekly CPD for full timers and pro-rata for part-timers – some of this could legitimately be used for audit which is related to that GP's development and appraisal and not purely concerned with service development. This requires practices to adhere to the model salaried contract and schedule protected CPD time for audit purposes.

- To ensure salaried GPs have the opportunity to take the protected CPD time that should be built into their contract, and could be used for audit activities. Locums need to build audit time into their locum fees and be supported to access practice data when needed for audit purposes.

6. Significant Event Analysis (SEAs)

Concerns about the use of SEA were similar to those about audit – relating to the definition and interpretation of the term, the support of practices, and the availability of data.

6.1 Definition of a significant event

Some participants reported that clearly understanding what a significant event was had made it easier to think of a significant event.

> *"Being aware of what a SEA is and that it doesn't have to be big" (ID 53b, salaried)*

> *"I think learning points is a better phrase. They can be positive or negative things as well" (focus group 1)*

The use of 'significant' appeared to be misleading to some. There seemed to be some confusion among participants as to what significant events were and how 'significant' an event had to be.

> *"I got too hung up on the word significant." (Follow-up focus group 2)*

> *"The case review was more useful…the whole thing has been called a significant event, I suppose other people might have thought my case review was a significant event but it wasn't really, it was just a tricky situation it wasn't – nothing bad happened to me or the patient…" (Follow-up focus group 2)*

6.2 Practice support

The support and engagement of the practice was important here. Few practices have a mechanism to feed back significant events to locums unless something serious has taken place. Even if a significant event has led to a complaint, it may be dealt with by the practice without the locum being informed or involved. Locums may not have access to the practice once they are no longer working there, and so be unable to hear about any events that have taken place. In addition locums or part time salaried GPs are either not invited (locums) or are unable to attend practice meetings (salaried) if they are not working, or have other commitments, on that day.

Locums and salaried doctors are often employed to provide cover allowing partners to attend such meetings. Practice meetings are often scheduled to ensure all partners are available to attend as business decisions need their input. This inevitably means part-time and salaried GPs are more likely to have to have their days off on these days, because of lack of rooms etc.

Several participants thought that having 'locum friendly' practices that would inform them of a significant event, and be willing to discuss it, would be beneficial. It was suggested that practices designated as 'locum friendly' would have systems in place for feeding back to locums, and inviting them to significant event meetings.

6.3 Frequency and availability of events

Several participants (all of whom were either salaried GPs or rural partners) commented that they had found doing an SEA easy because an event that they could write about had arisen during the course of the study.

> *"It's not difficult to come up with ideas…we've got a programme of kind of weekly [meetings]…this includes significant events…" (focus group 5, Salaried)*

However other participants reported that they had found it difficult to do an SEA because they are not involved in or do not hear about significant events from practices.

> *"Not managed – this was the most difficult thing. Nothing I have been personally directly involved in" (Follow-up tel int 63b, Retainer)*

> *"It's almost impossible for me I've not heard of any significant events…unless something really bad happens, you don't hear about stuff basically…you are not involved in meetings or anything to hear about it" (focus group 6, Locum female)*

> *"I've only come up with one, and that was an Out of Hours one and this was only sheer luck that one of the nursing staff mentioned something to me…this is the thing you've got to be dependent on other people because it tends to be in retrospect maybe that something becomes apparent" (focus group 5, OOH)*

> *"Difficult finding an SEA suitable…" (feedback sheet, focus group 7)*

Participants commented that this was in part due to not being included in practice meetings where any significant event would usually be discussed.

> *"The way things are for me. I know that the time they have these meetings I'm not there. I'm working elsewhere and that's the end of it. You can't sort of fit it in" (focus group 6, Locum male)*

6.4 Discussing SEAs with colleagues and peers

Participants who had completed a significant event analysis commented that it was made easier by being able to discuss them in practice meetings and with colleagues.

> *"Significant events…we have them with every practice meeting every month" (Follow-up focus group 6, rural partner)*

Many participants reported that they found it difficult to find someone to discuss a significant event with, in part due to their not being invited to meetings as discussed above, and in part due to a lack contact with a professional peer group.

> *"The significant event meeting at the practice I was working in aren't on the days that I'm there. So I have taken them to my learning group but really you should be discussing them in the practice and with the colleagues who*

are involved. One of the problems is if you do find one [a significant event] you have to feed it back and discuss it" (focus group 2, salaried GP)

Several participants mentioned the importance of learning groups, where significant events could be discussed. However some GPs did think that it would be better to discuss a significant event in the practice so that learning could take place within the practice.

"…. I would actually find it difficult to find someone to talk through with. I don't have a learning set (focus group 2, Locum)

"I guess the other way of doing a significant event is not presenting them in the practice that you work at but presenting them either in a small mentor group or a study group which you can get some feedback from, it might be less useful for a significant event that's involved perhaps processes or systems in a practice, perhaps then you get more learning out of presenting it to colleagues that were involved where a system might be changed" (focus group 5, Salaried)

Time was also seen as an issue for all GPs. Having protected time to go through records and discuss significant events was seen as important.

"…significant event discussions were sort of tagged on the end of a business meeting and they were more or less glossed over which I thought was totally inadequate. A lot depends on the approach of the team" (focus group 1, male)

"There's a lot of it in the preparation and making sure the right people are there and that all the information is available because it's very hard sometimes to have a good discussion if you haven't really established the facts" (focus group 1, female)

6.5   Conclusion

Conducting an SEA seems to be easier for a salaried GP based in a practice than for a locum without a fixed practice base. Locum GPs often do not hear about significant events they have been involved in and are rarely invited to meetings where significant events are discussed, or if they are invited, the meetings are held on a day when the locum is unable to attend. This last point can affect part time salaried GPs as well.

6.6   Potential solutions to concerns about SEA

- 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 need to be informed if a significant event in which they had a role has been identified, and given the opportunity to discuss the event with a clinician in the practice. Where possible they should be invited to SEA meetings.

The above points should be explicit in the contract between locum and employer.

- Having a clearer definition of what is meant by the term 'significant event', with plenty of examples.

- If attendance at practice SEA meetings is not possible for a sessional GP then an alternative SEA discussion could take place in a locum or self directed learning group (SDLG) setting, and 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.

7.   Multi-Source Feedback (MSF)

Comments in initial and follow-up focus groups and interviews highlighted the difficulty of having enough contacts, particularly an issue for locums who rarely saw other GPs in the practice and GPs working in remote areas who had fewer contacts generally. Locums and Out of Hours GPs were concerned about being compared with Principals and Salaried GPs as there would be different norms for these two samples. Those who worked in small practices were concerned about receiving feedback that was identifiable.

7.1   Having contact with other doctors

Locums and Out of Hours GPs both reported having little contact with other GPs despite working in several practices. This clearly reduced the number of doctors they were able to approach for MSF, and some reported that doctors refused to provide feedback on the grounds that they did not know this GP.

> *"A couple of other GPs I asked sort of said well they don't really know me. And I said, well, you know, you could always fill in the feedback forms saying that. And they were quite reluctant." (Follow-up tel int 19b)*

> *"It's actually more rare, I find it more rare for people to come and speak to me…maybe it's just the practices I've been in" (focus group 6).*

> *"So you go in, you see the patients, you have no feedback on your referrals or anything you do, you're prescribing and I don't, it's not good, but that's the way it works" (focus group 6).*

For locums who were only in the practice for one session a week contact with other colleagues was particularly difficult.

> *"I think this is the hardest thing to achieve as a locum. Very difficult to get staff willing to engage in feedback when they don't know you. The practice manager looked at sample CFEP colleague feedback and thought it would be very challenging for staff." (Follow-up focus group 7, feedback form, Locum+OOH)*

> *"Most of my colleagues I worked with in last two years I hardly knew them enough on these details as I worked locum in different practices, then since last August I worked in a Darzi clinic and during my shift there's only me as sole doctor during a shift." (Follow-up focus group 8, feedback form)*

Doctors working in OOH settings had similar concerns.

> *"In my out of hours role MSF and patient satisfaction surveys would be almost impossible to achieve. I do not work with other doctors – contact is informal discussion occasionally, we do not see each other work. The only other staff we have contact with are drivers and clerical staff, and occasionally nurses in the walk-in centres" (feedback form, ID 13)*

A doctor working in a remote practice also challenged the validity and reliability of the feedback tool which has not been validated on this sample.

> *"I tried to find out something about the validity of the questionnaire and there doesn't seem to be much that's published on the validity with respect of small, remote practices" (focus group 4, remote GP)*

Together with doctor contact, numbers caused a major concern for all GPs in the study. Gaining feedback from ten doctors was particularly problematic. Some questioned if they could use contacts who knew them in another role such as teacher or trainer.

> *"Had to contact previous practice where I had done maternity locums to get enough people" (feedback form focus group 6, long term rural locum)*

> *"It went fine and was straightforward to do, but the difficulty was the high number – it was hard to get enough doctors. Nobody in the hospital setting would know me well enough to comment. I had to put down lots of receptionist and nursing staff" (Follow-up tel int 63b, retainer)*

> *"It was difficult to find five GPs who knew me well enough to comment on my work and I relied heavily on one practice where I had worked previously as a salaried GP and now did occasional locums." (feedback sheet 13b))*

7.2   Staff concerns about confidentiality of feedback

GPs in remote and small practices expressed their staff's concerns about confidentiality as it may be obvious who they are due to the numbers.

> *"The admin staff were really worried about the confidentiality because we're their employers and it's really obvious who they are because there aren't many of them and we've asked the same ones pretty much, because they're the best ones that can comment." (focus group 4, remote GP)*

7.3   The logistics of setting up MSF, including the time required

Many GPs reported on the efficiency of the system set up by the MSF supplier. The Deanery was also said to be helpful. Some mentioned receiving help from the practice to chase up questionnaires.

Difficulties involved the site crashing or locking them out during completion of MSF.

> *"I missed the deadline for filling in the colleague thing, that's gone back so it might be my fault. I had to keep emailing him saying, "Please un-password it again". (Follow-up focus group 6)*

> *"You had to have completed it within 20 minutes or else it self destructed or whatever, which is not helpful to people trying to…I mean it means you've got to do it away from the surgery because otherwise a telephone call comes or you're doing something" (Follow-up focus group 6)*

Some GPs reported that setting up the e-mails and liaising with the MSF supplier took up a lot of their time. Some reported they were unable to do this due to the time required. Others mentioned the costs of MSF.

> *"It took me, I don't know, about an hour and a half to do it, to get all the emails" (focus group 1)*

> *"Locum and sessional GPs would have to pay up to £400 per 5 years from their own pockets – most practices pay for partners and salaried doctors to undertake this. Hospital consultants do not have to pay for their MSF. (feedback form, ID 13)*

7.4 Applicability of colleague questionnaire

Some sessional GPs expressed concern about the relevance of the MSF tool for them, and suggested that an adapted version for GPs who have less contact with others would be more useful.

> *"A specific MSF tool for sessional/locum doctors" (Follow-up focus group 7)*

> *"A different/amended version of colleague questionnaire with more generic questions applicable to locums" (Follow-up focus group 7, Locum+OOH)*

7.5 Opportunities to discuss feedback

Deciding who to nominate to provide the feedback was a concern for some. Some reported not having the appropriate contact to name and were left receiving the feedback directly.

> *"I didn't know if they had the skills, but also I thought it might be putting them in a difficult position because they might think, I don't really think I can do this but I can't say no" (focus group 4)*

There was concern about receiving negative feedback and where you would go with it. Locums were more likely to be isolated from available support.

> *"If you got some negative feedback or something that you weren't quite sure about and that you felt that you wanted to maybe sort of change the way you did things and within a practice I suppose you would talk…discuss it and you'd have sort of supervision or…whereas a locum wouldn't really get that?" (Follow-up focus group 6)*

> *"You see if you got it back and you were not happy and it was really quite…knocked your confidence, who would you go to? I mean, I don't know. Who would you go to? GP Choices?" (Follow-up tel Int 19b)*

Others discussed the potential benefits of the feedback and what type of feedback would be most useful. Generally, gaining MSF was seen as positive and helpful comments were welcomed.

"It's actually the text that you learn from. I mean I know in the past when I've done it with registrars I mean, you know, simple feedback like, "He never says good morning when he comes in in the morning" or some of the staff, I mean, it's easily correctable if he appears to be off hand or whatever or is it worth doing that?" (Follow-up focus group 6)

"Yes because I mean it's absolutely of no use…I mean whether someone ticks that you're good or bad, you don't learn anything from it. Even if they've said you're awful, but I wouldn't learn anything from that". (Follow-up focus group 6)

"And if we're all doing it regularly it's not going…it will cease to be quite so threatening and I think we will also all get better at putting sort of helpful comments on because at the end of the day it's meant to be formative…well one hopes it's meant to be formative, not just sort of summative. So helpful comments on there would be as useful feedback." (Follow-up focus group 6)

7.6   Conclusions

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.

7.7   Potential solutions to concerns about MSF

- To recognise that some locums, OOH and remote GPs will have fewer contacts for MSF and a reduced number of MSF forms are inevitable.

- To ensure MSF tools are specifically validated and adapted for sessional and remote GPs.

- To clarify who can be contacted for MSF - how long does a contact need to have known you or worked with you, and how recently.

- Ideally feedback should be offered to go via 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 group.

8. Patient Feedback (PSQ)

The anticipated constraints focused on lack of support from practices in giving out questionnaires; patients not knowing locums well and so being possibly inclined to judge them less favourably; difficulty getting patient feedback in OOH settings, and getting a high enough number of patients in some settings e.g. remote rural practices. There was also a concern about the likely lower response rate for locums than for practice based doctors.

8.1 Practice support

Some participants reported that the practice staff had been very helpful in distributing questionnaires, however difficulties arose in practices that had an automatic check-in system and receptionists did not see all patients, and when the participant was the only doctor involved in the collection of feedback.

> *"I've even got a touch screen sort of log in at our practice…I can't expect the receptionist to sort of stand there loitering waiting for patients to log in to see me, and asking every patient that comes to the door to say 'Are you seeing Dr anon? I have a questionnaire', so it's kind of not really fair on them" (Follow-up focus group 2)*

Peripatetic locums could potentially collect patient feedback from a number of practices but this could present logistical problems.

> *"There was a bit of confusion about that…I think it was just where they were going to send them. Because they normally send them to practices…Just because the receptionist would forget to give them out, patients wouldn't give them back. And it took that long. And it's just… if you're never going to the same practice you have to get them to sort of put them all into envelopes. How do you know how many you're going to get done? And they have to get sent off. Sort of two from one practice, five from another….It could be a bit all over the place" (ID 19b tel int, locum+OOH)*

OOH doctors did not report having the benefit of any administrative support.

8.2 Patient numbers

GPs working as locums, for a small number of sessions, in OOH or in small remote rural practices noted that it would be difficult to get sufficient numbers of patients. For small practices this could result in 'patient overload'. The situation was also different in that patients in such practices tended to be able to see the doctor they wanted to see and might be overly negative if this was not the case.

> *"when you get much smaller practices, I mean less than a thousand, and things like that, it's going to be a major problem because of the plethora of information that's requested from the patients" (focus group 3, rural remote)*

> *"And I think patients tend to choose the doctor that they feel more comfortable with. So I think, you know, the fact that they in general can get an appointment with the doctor that they want…I think if they were coming*

for an appointment and not being given the doctor that they want…they might be overly negative about that doctor" (focus group 3, rural remote)

One OOH doctor raised the possibility of feedback by telephone.

But I think they could actually do it quite easily but even the telephone triaging I think if they would have to pay for them to do it but they could get someone to ring back the next day or later that evening to say did you speak to your doctor? (focus group 1)

8.3 Patients' knowledge of sessional GP

Some participants, particularly locums and GPs working in different settings, questioned how well patients would know them as they did not build up longer term relationships.

"Although I collected the data the process was difficult as patients were mostly walking in patients [Darzi centre] who don't know me, and some had acute conditions" (feedback form focus group 8)

A small number of participants reported that questionnaires were given out and completed before the doctor was seen.

"But a lot of patients, when I was in surgery the receptionists were giving them when they arrived and they were sitting in the waiting room and they were filling it out while they were waiting so they filled it in before they came, so they weren't reporting on that consultation" (focus group 1)

"We've had patients going in to the doctor and saying I've given you a good mark, doctor" (focus group 1)

Some form of patient feedback was considered to be useful however.

"A couple of comments like, 'Listened really well'" or, 'Didn't quite understand why I was here' or, just a comment can sometimes be far more useful as a reflection on someone's opinion on you" (ID 19b tel int, locum+OOH)

8.4 Conclusion

Locum and OOH GPs and those working a small number of sessions, or working in remote rural practices could have difficulty accessing a high enough number of 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.

8.5 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 to provide benchmarks enabling locums to compare with their peers as well as the wider GP populations

NB. Figures on the numbers of patient and colleague questionnaires returned for the sample of GPs, and how results compare to population benchmarks, are presented in Appendix 2.

9. Alternative methods of collecting supporting information

There was a strong degree of scepticism from some participants about the effectiveness of the required evidence collection, with some feeling that direct observation (or video observation) would be a more valid approach to reviewing performance. These concerns notwithstanding, some alternative methods of collecting evidence were discussed in focus groups, and identified as being potentially more useful. These addressed the perceived aims of revalidation, while not being limited to the audit and SEA approaches.

Significant among these alternatives were detailed case reviews, which were introduced by the Northern Deanery and offered to participants during the study. Other approaches were identified by respondents themselves – some had attempted these approaches for appraisal, or heard about colleagues using them. Others however were more speculative.

9.1 Case Reviews

Participants who felt they would not be able to complete an audit were offered the opportunity to complete a case review. Guidance and pro formas were provided by the Northern Deanery. Overall participants reported that case reviews were more useful than audit or significant event analysis.

"I think it's easier than some of the others isn't it as an option…it would probably be quicker than an SEA and audit" (focus group 5, salaried and Locum)

"In fact I think the case review is actually quite good at replacing an audit…" (focus group 4)

"Interestingly, I mean I find it easier to do a case review you know…" (focus group 2, Male locum)

"I thought the case review was more valuable because the significant event audit It kind of hinges a bit on going to a significant event meeting…whereas a case review you could discuss it with a couple of colleagues who it was particularly pertinent to and I think that may prove to be the more valuable" (focus group 7, salaried)

It was generally felt that all GPs would not have any difficulty with thinking of a case which they could present and reflect upon as a case review.

"There's always a case that you can think…as long as you get the space and are able to access the notes and then again you can print things off, if the practice is happy and take them home so I think that's probably one of the easier ones to do" (focus group 2, Male Locum)

'Plenty of interesting cases encountered' (feedback sheet, focus group 6)

However a small number of peripatetic locums still felt that they would find it difficult to find a case to use.

> *'No suitable case came up' (feedback sheet, focus group 5, locum and OOH)*

Several participants commented that doing a case review was a good way of reflecting on your own practice and being able to show a change in practice.

> *"I would think it's far more valuable to do to have a review of your own personal practice than a technically correct audit that actually means little to your day to day practice" (focus group 7, Locum)*

> *"It certainly might feel more immediately relevant to clinical care…not necessarily doing audit because I think we've reflected on the fact that that's not really constructive doing in practice, but as an exercise in actually writing something up and therefore reflecting on a case it might actually be slightly more constructive" (focus group 6)*

> *"I think it covers things like, you know, you sort of discover gaps in your knowledge and you'd take steps to improve it and it helps to make it stick, you know, having written it down and gone through it in detail" (focus group 6, locum)*

Time seemed to be the main issue mentioned by all GPs with collecting this evidence.

> *"I think it's [case review] a good idea…but actually having the time to write them up in the format that needs to be written…we don't seem to get any protected time for it because we're just too busy" (focus group 3, rural full-time partner)*

> *"As I say just again about the time and if you're going back into the practice…those issues are always going to be there unless you go in regularly to somewhere…I find one day a week really does restrict you…if you want to do anything you have to do it there and then…you probably could print off your consultation and take it home…" (focus group 5, Locum)*

> *'No time allotted…' (feedback sheet, long-term locum)*

Being able to reflect upon and discuss a reviewed case was felt to be the most important aspect. Several participants mentioned that they discussed their case with peers either a colleague in a practice (partners, salaried and long-term locums) or within a peer learning group such as a self directed learning group (all sessional GPs).

> *"I wrote up a case and discussed it in my learning group" (focus group 2, female locum)*

> *"For me that is the most useful thing [discussing a case with another colleague in an out of hours organisation]…you know but that's because I feel a bit isolated you know a bit cut off" (focus group 7, OOH)*

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However some sessional GPs did comment that it was difficult to find someone to discuss a case.

> *"I think professional isolation is probably one of the biggest problems"*
> *(focus group 1)*

Respondents reported that case reviews were more feasible to complete than SEAs and audits. They felt that it was a good way of reflecting on and showing a change in their practice, although having protected time to complete a case review still seemed to be an issue. Being able to discuss a case review with colleagues or peers was seen as a beneficial part of the process of doing a case review. However some GPs commented that they would find it difficult to find someone to discuss the case review with as they were not part of a self directed learning group or did not have much interaction with colleagues.

9.2 Random case sampling

Random case sampling referred to the review of a number of cases by a colleague. Rather than a detailed review, this would be the examination of a series of consultations from a randomly chosen surgery with the appraisee potentially inviting feedback directed at specific aspects e.g. prescribing, record keeping, diagnostic reasoning, use of investigations; or a review of referrals by a colleague – with review of action and outcome if known. Participants generally felt that this was more feasible than SEAs and audits.

> *"I did find random case analysis useful, because I think you're doing it with someone that has the skills to do it in a constructive manner" (focus group 3, full-time rural partner)*

There were mixed comments on whether peripatetic locums would find this feasible.

> *"I feel you could do this as a locum – a locum could print off a morning's cases and ask someone to look at them and feed back" (Follow-up tel int, 53b, Salaried)*

> *"I think almost as a locum or even as a part time doctor what would be more useful if for example you had to pick I don't know, five, ten random patients out of a number of surgeries…tell someone else say this is what I did and then they'd say did you think of doing that differently…" (focus group 7, locum)*

> *"But to do random case analysis you would need to be full time in the surgery, you'd need to be able to look at the cases. So you have issues of confidentiality if you are not doing it within the practice team I think. I think those things need to be in house…we have an hour's surgery blocked out for you and a partner as part of your locum contract. That's the sort of thing that needs to happen to make it feasible that the two of you sit down and look at random cases…" (focus group 5, Locum)*

The problem of having a peer group was raised again, with some participants commenting that it may be difficult to find someone to discuss cases with. Reviewing cases could be reciprocal though, if a network could be developed:

"It's finding a colleague who is prepared to [look at your cases]" (focus group 1)

"But it could be a peer thing couldn't it, you could do it for each other and try and be objective" (focus group 1)

9.3   Referral or prescribing reviews

Targeted reviews of referrals or prescribing were identified as elements of one's own practice that could provide evidence of insight and performance. However it was felt by some GPs that the whole practice would need to be involved so it may not be feasible for a peripatetic locum.

"A referral analysis possible to do, but not so easy for locums because they don't get the feedback, easier for a salaried to do but still time consuming" (Follow-up tel int 53b, Salaried)

"I think the referral stuff is always good but it does depend on how you do it and it's difficult for locums" (focus group 1, locum)

One participant mentioned they had done a prescribing review, looking at their prescriptions following one morning's surgery over a month – *"it was useful to reflect on your own practice and check to see if you are following guidelines"* (ID53b, salaried). However this may be difficult for locums as they do not have their own individual prescribing number, and so their prescribing will be conflated with that of a partner, or of other locums.

9.4   Reflection on learning

Several participants commented that it was often difficult to capture the day-to-day reflection and learning points because this was done almost automatically, not having time to write things down or moving around and not having a fixed base.

"I suppose it's that age old thing that we're all doing it, it's just documenting that you are doing it" (focus group 7, Locum)

"It's actually time consuming recording stuff…because it's just another thing to have to actually physically record…you just kind of do it as part of the job really. I mean I never record what I read if I read email with guidelines in I mean I should probably get into the habit of doing it" (focus group 5, salaried and locum)

However some GPs did make some suggestions about how they log their learning.

"I scribble things in a little book, I always have done – it took me years till somebody said you should take that to your appraisal…I never really realised I was doing something that would count as something" (focus group 7, salaried)

"I was introduced to this idea of a reflective diary…I do find it very valuable because you know, you can just write down a heading prompted by a

consultation you've had where you feel you weren't quite up to the mark or you need to look into this further and you go away and read about it. So that's you know a very simple way of showing reflection" (focus group 6, locum)

"I remember saying that they [used] GP Notebook, there was some way of tracking [your learning] but then he was in his own surgery, always in the same surgery and I don't know whether it works… when I dot around." (focus group 5, locum)

"I've never used GP Notebook Tracker…I've been into one but that relies on you being on a fixed computer…I know some of my colleagues use 'Mentor' and that's got some sort of recorder thing where if you look up a subject it records what you've looked up" (focus group 5, salaried and Locum)

9.5   Self directed learning groups

Some participants commented that self directed learning groups or peer review groups would be a good way of reflecting on difficult cases or significant events and writing this up as evidence for peer review and reflection to present as evidence for revalidation.

"Have started going to a self directed learning group and try and write up what was discussed, for example, from presentations or discussions of cases…could discuss SEAs there…problem cases" (ID 63b, Retainer)

"The majority of my CPD is done through that [self directed learning group] it's invaluable" (focus group 7, salaried)

9.6   Conclusion

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.

10. Summary of findings

Evidence to be collected	Salaried GP works part-time in one practice or long term locum	GP works in remote practice	GP is peripatetic – locum moving around many practices	GP works mainly in Out of Hours (OOH)
Audit	With access to records can complete an audit, although mainly in own time (or contracted CPD time if on model contract). Achievable with support in accessing data.	Achievable but audit may involve very small sample of patients (<10) reflecting the size of the practice and patient list size. Achievable with careful selection of disease group or process.	Lack of support from practices can mean lack of access to records after session completed. Difficult to do meaningful audit if there is no longer-term influence on systems. Insufficient cases of any one kind to do disease based audit. Only process based audit possible and re-audit of own 'behaviour' possible, but is not revisiting same patient group.	As for locums access to records is difficult – notes are more likely to be paper-based and so physically harder to access. No opportunity to influence systems. Self-audit achievable with some organisational support.
SEA	Will generally hear about own significant events, but hours may mean missing practice meetings, which may be arranged when off, or when covering sessions. Achievable with increased practice support.	Achievable, although frequency of events may be low due to small list size.	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. Achievable if identified and discussed with peer group outside practice.	Lack of feedback after each session. Achievable with organisational involvement and availability of peer group to discuss case.
MSF	Part-time hours will limit contact with other members of the practice and other colleagues, but over time can complete MSF. Achievable.	Small practice size will limit pool of raters. Referrals to secondary care may be very infrequent, and limited knowledge of individuals.	Often do not see other GPs in practice. Limited contact with other colleagues – insufficient time in practice to develop relationships. Achievability and developmental value questionable – alternatives to current questionnaires may be necessary.	Minimal contact with other doctors and clinical staff. Knowledge of performance only through notes and referrals. Achievability in current form highly questionable.

Evidence to be collected	Salaried GP works part-time in one practice or long term locum	GP works in remote practice	GP is peripatetic – locum moving around many practices	GP works mainly in Out of Hours (OOH)
PSQ	May take longer if part time, but achievable with practice support.	Small list may take longer, but achievable.	Achievable with practice support – practice must facilitate distribution of questionnaires. Feedback may be based on a single consultation with a patient, compared to ongoing relationship of partners while the social/clinical profile of patients may be distinct – the validity of tools for sessional doctors should therefore be established.	PSQ often not appropriate due to emergency context of consultation, home visit or telephone consultations would require retrospective postal survey. Alternative solutions require organisational commitment, and for majority is not achievable at present.
Case Review	Achievable.	Achievable, but needs another GP to discuss case with.	Achievable, but needs another GP to discuss case with, for example in a self directed learning group (SDLG).	Achievable, but needs another GP to discuss a case with, for example in SDLG.

11. Discussion

Revalidation is the process whereby all doctors will be re-licensed to practise in their field of medicine on a five-yearly basis. Revalidation will require each doctor to submit a body of supporting information, the details of which are defined by each Royal College.

The Royal College of General Practitioners has to be sure that the requirements for revalidation are fair, accessible and achievable for all GPs, wherever they work, and in whatever capacity they are employed. GPs work in a wide range of settings, from isolated single-handed rural practices, to large urban group practices serving populations of tens of thousands of patients. Many GPs are partners in the practice; others are employed as salaried GPs to work for a defined number of sessions, whilst others work as unattached locums in a range of practices.

This study has looked at the perceptions of doctors drawn from the more marginal elements of the GP populations – locums, sessional GPs, and those working in remote areas – of the four types of evidence currently specified for revalidation. These are clinical audit, significant event analysis, and colleague and patient feedback. Focus groups and interviews identified problems and solutions around each of these, as well as possible alternative methods which may better satisfy the requirements of revalidation.

Findings fall into three main areas:

- The context of work of these groups of doctors, and their relationship to the wider population of GPs and primary care organisations.

- The appropriateness of the evidence required.

- Alternative means of providing evidence.

11.1 The context of work

An over-arching theme was that locums and sessional doctors often feel marginalised in the workplace, especially if they do not have any fixed practice base. A lack of engagement on the part of employers in their education and development has practical implications for their ability to collect evidence for appraisal and revalidation. This reflects earlier findings, where it has been reported[12] that only a proportion of locum agencies offer regular appraisal, feedback and opportunities for continuing professional development, while others do not accept any responsibility to support the professional development of their staff. In terms of monitoring performance, prescribing concerns are often difficult to track to an individual GP in a practice, especially if they are working there as a locum, because prescribing numbers are shared. Complaints and concerns raised about a locum may be dealt with by a practice without ever feeding back to the individual locum, who thus does not learn about the concerns.

Both the Department of Health and the GMC have acknowledged the lack of support mechanisms and structures for sessional doctors. The GMC has made it clear that the revalidation process should not only be fair and accessible for all, but also that it should not be so onerous and time consuming as to take clinicians away from delivering care for any significant amount of time. This is particularly relevant for sessional GPs, many

of whom do not have any CPD time (such as attendance at practice clinical meetings) built into their working week. The role of practice or PCO support in enabling doctors to carry out audits, follow-up significant events etc are significant in this respect.

Details of how practices and PCOs may improve the experience and engagement with education, appraisal and revalidation are given in the Appendices. Appendix 3 gives some examples of how individual practices and PCOs can improve support offered to sessional GPs, especially in terms of revalidation. Appendix 4 describes how a regional locum group can coordinate educational information from local PCOs and provide crucial support for sessional GPs. Appendix 5 gives an example of how this is being done by an Out of Hours provider, Appendix 6 gives an example from one PCO of steps taken to ensure all locums on the performers list are included and supported in the appraisal process. There is clearly a wider issue of changing the culture of how sessional GPs are viewed and treated and providing more effective at practice and PCO level, but also via OOH organisations, locum agencies etc. There are models already in place, such as the Chambers model championed by Richard Fieldhouse (see Appendix 7), and over time there may be a move towards encouraging all locums to become affiliated in some way to a defined practice or locum organisation, who would provide defined standards of support for their professional development.

11.2 The feasibility of required evidence

Concerns were raised about practical problems in the collection of audit, SEA and feedback data, which would have consequence for the validity of that data in revalidation. Concerns were raised about the extent to which colleague feedback data would be meaningful, given problems with identifying sufficient colleagues who knew the doctors well enough (a problem identified for hospital locums in earlier work[13]). Patient feedback was less of a problem for locums and remote doctors, although out of hours doctors did identify problems. For both types of feedback the support of employers was felt to be important, and often lacking. This was even more true of audit and SEA, where access to data, to premises and to meetings were all felt to be lacking. These findings also echo earlier reports on the issues around evidence collection [6, 10, 11,12].

11.3 Alternative forms of evidence

Focus groups discussed alternative approaches to evidence collection. Audit and SEA emphasise practice systems improvements rather than individual change, and locums are often not in a position to influence changes in practice systems. Similarly conventional feedback survey tools may have to be adapted for use by peripatetic locums, and compared to norms for GPs in similar work situations. These concerns are emphasised in Pike's papers for NASGP [10, 11]. Alternatives were felt by some to be more aligned with the core aims of revalidation, that is, to demonstrate that a doctor is both 'up to date' and 'fit to practise'. This information must demonstrate not only that they are keeping up to date in terms of knowledge and skills, but that they are regularly reflecting on their clinical work and identifying areas for change or improvement to guide their continuing professional development.

The focus group discussions suggested that keeping 'up to date' is an accessible activity for all GPs. Although many sessional GPs cannot regularly attend practice-based educational sessions, they are able to access internet learning modules, do targeted reading with recording of learning points, or attend organised external educational sessions, or take part in self directed learning or peer support groups. The

recent RCGP CPD credits pilot suggested that most GPs in all working situations were able to achieve the 50 CPD credits recommended on an annual basis.

However, the tools suggested in order to demonstrate that doctors are 'fit to practise': clinical audit, SEA review and patient/colleague feedback surveys, are not always easy for GPs without a fixed practice base to use, for reasons identified above. Case reviews, and case sampling, were identified as more useful ways of enabling reflection on performance, although the availability of colleagues to discuss cases with remained a potential hurdle. Appendix 8 gives some examples of how locum GPs have used notes review, random case analysis, modified audits and challenging case reviews, all of which are much more usable tools for locums than clinical and significant event audit, to demonstrate reflection on their clinical work. The ScHARR report [6] similarly identified types of documentation to support the appraisal process that a locum could produce relatively easily, namely educational/learning logs, workload figures, patient complaints or letters of appreciation and personal development plans (PDPs).

The RCGP is leading the process of revalidation for GPs and is already incorporating many of these suggestions as alternatives for sessional GPs in the successive versions of the 'Guidance to Revalidation' document being regularly updated on the RCGP website.

12. Conclusion

Responses from focus groups and interviews with sessional and remote rural doctors identified three main areas in which the RCGP should consider action to improve the experience and participation of these groups in revalidation processes.

(i) Issues of isolation and lack of support. This is particularly relevant to locum GPs who are often excluded, and treated as 'second class citizens' by partners. This may not be through malice, but simple neglect, and a lack of awareness on the part of employers that there are problems faced by GPs with different working patterns. Remote GPs, while they may be partners, may also face isolation from a supportive peer group community, and will also face similar practical difficulties.

(ii) The logistics of evidence collection. All four key elements of supporting evidence presented problems to some of our participants. Numbers of available colleagues and patients to provide feedback, and time, resources and support necessary to complete audit and SEA, were all questioned. While not all participants faced the problems identified, sufficient did to raise the practicalities as a concern.

(iii) The purpose of supporting information. Focus groups identified alternative approaches to collecting information which was felt to satisfy the perceived requirements and aims of revalidation. However, for some, the specified requirements were effectively misleading, with audit particularly being seen as a means of improving the service delivery of a practice, and not relevant to the individual practice of these doctors. On similar lines, the definition of 'significant' in the SEA was felt to confound the purpose of the task. Greater clarity in the aims of revalidation, and how supporting information is intended to deliver those aims may help doctors identify appropriate means of collecting that information.

As revalidation moves towards a full implementation, the priority is to ensure that all GPs are able to produce adequate supporting information. In any five year cycle some GPs may have several years where collection of clinical audit or SEA data may be very difficult. (A recent survey carried out via the NASGP website indicated that of the 216 respondents, 55% had worked in more than five practices in the previous year). It is our hope that the outcome from this pilot is not only to provide useful practical suggestions for evidence collection that are acceptable to the GMC and the RCGP, but also to support a broader aim of making sessional GPs 'equal citizens' in the community of general practitioners.

12.1 Limitations

It was beyond the scope of this study to gain the views of practices on their capacity to support sessional and locum GPs.

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Appendices

Appendix 1 – Pro forma feedback sheet from second focus groups

(Presented to participants on an A3 landscape sheet)

Type of Sessional GP:_____

Evidence you set out to collect	Did you attempt this evidence collection Yes No		What helped you to do this?	If you aimed to collect this evidence but did not manage to what were the difficulties?	What additional support, processes etc. would have helped?	Other possible solutions (not already mentioned)
Audit						
SEA						
MSF (colleague Feedback)						
PSQ (Patient Feedback)						
Case review						

Appendix 2 – Responses to colleague and patient feedback questionnaires

As of 12 April 2010, responses had been received by CFEP UK as presented below. Distribution of questionnaires began in January 2010.

Colleague feedback

Of the 44 participants who had agreed to attempt to collect the feedback, questionnaires had been returned for 32 (73%). A mean of 14 forms were returned, with a range of 4 to 19.

Of these, 28 had received at least 8 responses which is sufficient to receive a full report, based on current reliability figures. A further three had received more than 5 forms, allowing a short report to be generated (although as data collection is ongoing, some of these may accrue more responses and receive a full report).

Colleague feedback responses for the sample are comparable to the benchmarks used by CFEP UK Surveys, with the majority of items falling in the second quartile, close to the median benchmark score. However clinical knowledge, diagnosis and treatment including practical procedures fall in the bottom quartile.

Table A1. Sample colleague feedback scores presented with population benchmark data (provided by CFEP UK Surveys)

	Sample score (%)	Benchmark data (%)				
		Min	Lower quartile	Median	Upper quartile	Max
Clinical knowledge	91	64	93	96	98	100
Diagnosis	89	58	90	94	97	100
Clinical decision making	89	55	59	93	97	100
Treatment including practical procedures	88	58	59	93	96	100
Prescribing	88	63	88	92	96	100
Medical record keeping	90	59	85	90	95	100
Recognising and working within limitations	90	50	86	91	95	100
Keeping knowledge and skills up to date	92	61	90	93	96	100
Reviewing / reflecting on own performance	91	55	86	90	94	100
Teaching (students, trainees, others)	88	50	86	92	96	100
Supervising colleagues	85	50	83	88	93	100
Commitment to care / wellbeing of patients	94	75	93	96	99	100
Communication with patients and relatives	92	59	89	93	97	100
Working effectively with colleagues	90	35	86	92	96	100
Effective time management	84	-	-	-	-	-
Doctor respects patient confidentiality	96	69	94	97	98	100
Doctor is honest and trustworthy	97	75	95	98	100	100
Performance not impaired by ill health	95	50	94	96	98	100

Patient feedback

Of 42 doctors who had agreed to attempt to collect the feedback, questionnaires had been returned for 22 (52%). A mean of 27 forms were returned, with a range of 2 to 45.

16 doctors had received at least 22 responses, which is sufficient to receive a full report, based on current reliability figures. A further five had received more than 5 forms, allowing a short report to be generated (although as data collection is ongoing, some of these may accrue more responses and receive a full report).

Patient feedback responses for the sample are comparable to the benchmarks used by CFEP UK Surveys with all items falling in the second quartile close to the median benchmark score.

Table A2. Sample patient feedback scores presented with population benchmark data (provided by CFEP UK Surveys)

	Sample score (%)	Benchmark data (%)				
		Min	Lower quartile	Median	Upper quartile	Max
Being polite	97	71	96	98	99	100
Making you feel at ease	96	69	94	97	98	100
Listening to you	96	61	94	97	98	100
Assessing your medical condition	95	68	93	96	98	100
Explaining your condition and treatment	94	65	93	95	97	100
Involving you in decisions	94	67	91	94	97	100
Providing or arranging treatment for you	95	68	93	96	98	100
Confidentiality of information	91	69	90	93	95	100
Doctor is honest and trustworthy	92	65	91	94	96	100

Obtaining colleague and patient feedback responses in sufficient numbers was therefore feasible for many of the doctors who attempted it. It is not known however why the remainder of those who signed up to attempt it did not do so – some were not working in the time since January, but others had difficulties as discussed in the Results section of the main report. The caveat from respondents should also be remembered – that even where sufficient responses were obtained (particularly from colleagues), the perceived validity, based on perceptions of the raters' relationships and knowledge of the doctor, may still be low.

Appendix 3 – Examples of how PCOs and practices may improve support to sessional GPs

1. Primary Care Organisations could:

- Offer incentives to practices to brand themselves as 'locum friendly' against specific criteria (e.g. inclusion in practice education meetings, access to IT outside surgery sessions, support with audit and eliciting patient and colleague feedback, personal feedback re. any significant events/complaints relating to the locum etc);

- Contact practices at the beginning of each appraisal year, reminding them of the importance of supporting sessional GPs in their professional development, and in collecting information for appraisal;

- Consider setting a formal 'contract' between PCOs and locums. In such a contract, the locum agrees to provide an agreed minimum number of sessions for the PCO,and to inform them when they move to another location. In return the PCO agrees to provide appraisal, access to CPD and local information systems (from *Tackling Concerns Locally*[1]);

- Make sure that all performers are on all email circulation lists, and advise them to inform the PCO of any change of email address. Train and update appraisers regularly on the specific issues affecting sessional GPs and in alternative forms of evidence that can be submitted.

- See Appendix 6 for a specific example from a North East PCO.

2. Practices could:

- Be aware that locums must revalidate and will need help from the practices in which they work in order to collect the supporting information required for appraisal.

- The National Association of Sessional GPs (NASGP) has produced a standardised practice induction pack to help ensure all appropriate measures have been taken to reduce the risk of under provision and underperformance by GPs unfamiliar with their surroundings [these packs can be purchased from NASGP via the internet (http://www.nasgp.org.uk/spip/practice_pack_flier.pdf).]

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- Provide a locum pack to all locums coming to work at the practice. This should include the core information in the NASGP pack plus the individual practice's approach in terms of revalidation support. Some specific guidance should be included on how the practice might be able to help the locum with clinical audit, providing personal feedback about any significant events/complaints relating to the locum, and support in eliciting patient and colleague feedback.

- Accept that when employing a locum to carry out work for a practice, explicit written terms should be agreed covering not just workload and fees but also other areas such as an induction pack (as above), a personalised computer login (permitting audit and audit trail), access to clinical/educational SEA meetings, and general support with distribution and collection of patient surveys and colleague surveys where requested by the locum.

   o The NASGP has some sample agreements on its website and the BMA/GPC is also currently developing one.

   o In Wales, a free, web-based resource service, called PrakPak is being developed with the aim of pooling organisational information in one place. Practices register with the service and then populate the PrakPak template, allowing nominated users access to practice-specific organisational information. Sessional GPs will particularly benefit from this system once it is established, because it will allow them to access data from a range of practices where they have worked during the year. Details will be available of the Welsh GP appraisal website http://gp.cardiff.ac.uk/appraisal/.

   o Individual doctors may offer their own terms and conditions (e.g. http://doctorianthompson.co.uk/termsandconditions.html).

Appendix 4 – An example of a regional sessional locum group

North-East Employed and Locum Group (NELG)

The NELG (http://www.nelg.org.uk/) is a support group for sessional GPs in the North East which has been running for over 10 years. It provides a one stop shop of support for sessional GPs including information on educational, vacancies, opportunities to network and to meet colleagues to form self-directed learning groups. Its membership includes a wide variety of general practitioners, from recently qualified to recently retired. Members include locums, retainers, Flexible Career Scheme doctors, salaried GPs, academics, OOHs GPs, GPs who teach and others with a fixed practice base. The group is run by volunteers and receives no external funding or support. It has maintained regular communication with the local deanery, LMCs and BMA. Its success lies in its close links with the deanery through the dedicated tutor for sessional GPs, and the web based model which makes many of the support functions (of providing information and communicating with its 250 members) highly cost-effective.

It has a constitution and an online voting/survey facility for election of officers and consulting about key issues.

Aims of the group:

1. To help foster mutual support amongst sessional GPs and reduce isolation.

2. To improve access to information about work opportunities and educational opportunities.

3. To increase understanding in the local GP community of the issues facing sessional GPs.

4. To liaise with local and national organisations regarding issues facing sessional GPs.

5. To promote the role of sessional GPs within general practice.

These aims are achieved through providing: email alerts each time vacancies are posted by practices or educational events are uploaded by providers (free of charge), regular members meetings (both professional and social) which take place as a combined evening with the deanery educational programme; through an email group, group based mentoring, and a web facility for sharing feedback about practices. It also sends out newsletters about sessional GP or educational issues. Local contact details of appraisal leads and education providers are posted on the website. It organises annual events for BMA speakers to come and talk about employment issues.

Its weakness, like that of any sessional GP group is its sustainability in the absence of volunteers to help run it the difficulties of taking on paid help without taking on employment responsibilities.

Appendix 5 – An example of good practice in GP support by an Out of Hours provider

Cumbria Health on Call (CHOC, http://www.chocltd.co.uk/index.cfm) funds one session a week of GP time to coordinate the continuing professional development and annual performance review of all GPs who are salaried by CHOC, or who work for them for more than 50 hours a month on a sessional basis.

The annual review consists of a pro forma based on current DOH documents, reworked for Out of Hours (OOH) purposes to include eleven core competencies most relevant to OOH work.

GPs are supported in collecting feedback from patients and colleagues, and in discussion of any challenging cases or significant events that have occurred in their clinical work. GPs are asked to write up three 'good' consultations and three that did not go well, and use these as part of the review discussion. In addition, any complaints or plaudits received by CHOC are passed on to the GP involved and discussed and followed up as appropriate for each case. GPs are also helped to carry out audits that will fulfil the requirements of revalidation.

The aim of the annual review is to be educational and supportive rather than judgemental, and includes questions about work life/ balance and allows the GP to express their views about the organisation to CHOC. The GPs are also supported to formulate a personal development plan (PDP) which addresses defined educational needs.

In addition CHOC funds an educational programme with some full day and half-day sessions and regular SEA two hour meetings where GPs can bring challenging cases and critical incidents to discuss.

Overall, the feedback from CHOC GPs is very positive about the process, which supports them to engage fully in annual GP appraisal and collate all the evidence required for this process. This is a model that other OOH organisations should seek to emulate.

Appendix 6 – Example of PCO actions to include and support all locums in appraisal process

NHS North of Tyne has a dedicated website that allows all GPs on their performers list to book their appraisal with an appraiser of their choice:
http://www.gpappraisals.not.nhs.uk/

Appraisers are identified by their employment status and a brief profile. This allows locums to choose an appraiser who is also a sessional GP if they feel more comfortable with this option. The appraisal administration team keeps an accurate database of all GPs on the Performers list, updating this as soon as any new information is forwarded from the North East Family Health Services Agency.

This database is used to try and ensure that all GPs on the list book and undertake an annual appraisal in their birthday quarter. The website generates automatic reminders to all GPs if their appraisal is overdue, and all GPs get the same level of input, information and support in relation to appraisal, irrespective of their employment status. GPs who request to defer their appraisal for any reason are reviewed by the appraisal team each month, and supported to engage in the process at an appropriate time if they are going on maternity leave etc. This deferment process may be particularly important for sessional GPs.

The NHS North of Tyne appraisal website ensures that all GPs on the Performers list have equal access to the appraisal process, and sessional GPs not covered by global sum payments to PMS and GMS practices are paid a fee for engaging in the appraisal process. All of these factors aim to ensure that employment status is in no way a barrier to effective engagement in annual appraisal.

Appendix 7 – The Chambers model of employment and educational support for GP locums

The following notes are taken from the Pallant Medical Chambers website (http://www.pallantmedical.co.uk/intro.htm) and from an interview with Dr Richard Fieldhouse, Clinical Director, Pallant Medical Chambers on http://www.support4doctors.org/advice.asp?id=305

Pallant Medical Chambers is a group of GPs who work together to provide freelance medical services to GP practices and some Primary Care Trusts (currently in the South of England and South Wales). The group manages all the non-clinical aspects of being a Freelance GP, as well as providing professional development, support and clinical governance. The aim is to allow GPs belonging to the Chambers to concentrate on their clinical role without having to worry about the administrative work attached to the locum role. The group also provides a single port of call for all locum services for practices and PCTs wishing to employ locums – aiming to offer some guarantee that all GPs belonging to the Chambers will be supported administratively and professionally.

The support managers employed by Chambers arrange monthly meetings, summer parties, run discussion forums and help set up instant messaging services to facilitate close interaction and support between locum GPs. This is in contrast to locums who work outside a managed environment, who are effectively in competition with each other for work and who may go weeks or months without any professional interaction. Chambers managers also deal with all the paperwork that goes with being a locum – booking and confirming sessions, advertising, banking, arranging pension payments and bookkeeping. Managers are also involved in supporting locums to engage in the appraisal process by organizing educational meetings and, where appropriate, correlating feedback from colleagues and patients.

Chambers differ from locum agencies where the managers employ their GPs. In Chambers, the GPs employ their managers and work only and exclusively through the Chambers organisation, rather than for several different agencies.

An important part of the work of Chambers organisations is to provide the evidence each GP needs for revalidation. As an example MSF can be integrated into all aspects of the locum's work, from turning up to their surgery, through patient care, working in teams and audit to handling complaints. Records are kept of when each member's annual appraisal is due and the aim is to ensure that each GP has the appropriate supporting information for appraisal. The basic philosophy is that GPs have the capacity to take control and responsibility for their quality and professionalism just so long as they have a supportive and conducive environment for this. The aim of this model of a locum chambers is to provide the ideal environment to enable GPs to do this.

At present there are 45 GPs, across ten chambers, working with more than 150 practices. It is likely that as revalidation approaches there will be increasing pressure on practices and PCTs to ensure any locums they employ are part of a managed environment with appropriate peer support. The Chambers model is a good example of how locums can be supported in a constructive way that maximizes use of their clinical time and helps them prepare for revalidation.

Appendix 8 – Examples of alternative methods to demonstrate reflection

Demonstration of reflective practice is a core aim of the revalidation process. Where it is not possible to get involved with one specific primary care team (e.g. as a peripatetic locum) – a number of possible methods have been used:

- Case reviews of complex cases can be used instead of formal SEAs. All doctors doing any form of clinical practice can identify challenging cases in the context of their work setting and write these up using the case review template on the appraisal toolkit. If at all possible, these should be discussed with a clinical colleague, and placed in the context of commonly used recently published guidance, whether clinical or ethico-legal, and learning points agreed and recorded on the report.

- Serial case analysis by colleague of a randomly chosen surgery – looking at series of 10 consecutive cases (for example by printing out the consultation screen after each patient) and discussing the process and outcome of each consultation with a colleague. The colleague can consider how they would they would have managed each of the patients, feed back on specific areas perceived to be of value for developmental reasons e.g. QoF coding, safety netting, prescribing, recording of advice etc.

- Records review by appraisee – looking at record keeping from a series of 10-20 consultations from a randomly chosen surgery and considering for example whether notes conform to RCGP standards.

- Reviewing the outcome of 10 referrals if going back into practices over a period of time - appropriateness of referral and reflection on outcome – although no clear standards to measure performance against.

- A record review by an OOH organisation can provide a sample of cases for OOH doctors. Many OOH do this already and the information could be provided to the doctor for appraisal purposes.

- Problem based audit of Case series (e.g. selected based on having same clinical problem) looking at how specific problems are handled against current guidelines (e.g. 10 consultations for contraception, URTIs, osteo-arthritis etc.) This may be best done retrospectively as the action of monitoring may change practice, making improvement harder to identify, but could be done prospectively if necessary as it will still demonstrate reflection.

- Comparing consultations:

  o looking at a series of consultations from two surgeries and reviewing how many included a prescription/investigation or referral and comparing this with two surgeries from another GP in the same practice.

  o looking at 20 consultations and comparing these with 20 of a colleague – for each consultation reviewed asking – was a clear READ coded

problem recorded-was advice given – were Ideas/Concerns and Expectations elicited and recorded – was there appropriate safety netting/ [adapted from Appraisal toolkit for GPs by Dr Paula Wright page 33 available on http://www.nelg.org.uk/content/Appraisal%20and%20Revalidation]

- SEAs may be identified by a locum doctor who cannot always take the case back to the practice to discuss. In this situation the event could be reviewed in other forums, locum groups, SDLGs, young practitioner groups etc, and the learning points identified, even if possible system changes cannot actually be implemented by that doctor.

- Reviews of referrals:

  o Quality of referral letters: and audit of whether key information is included e.g. main problem, previous medical history,medication, reasons for referral (diagnostic uncertainty, to access investigations, to access treatment only available in secondary care, patient anxiety/concerns, need for prescribing which is restricted to secondary care etc)

  o Fast-track referrals: analysis of a series of fast track urgent referrals against available guidance; how many turned out to have cancers; any feedback about appropriateness of referral.

  o Serial Peer review of referrals: (often done in context of PBC): series of referrals discussed with colleague to highlight any possible differences of approach.

- Clinical discussion documented as part of case management: e.g. EMIS practice notes where clinical decisions or management are discussed, can be printed off and will usually include a query and a response which can show consistency or divergence in clinical approach.

- Locum feedback forms completed by practice - devised for peripatetic locums; a simple form which a locum can ask one individual from each practice to complete at the end a placement, however short. When they are accumulated over a series of placements they can serve as an audit trail of perceived efficacy and professionalism.

- Audit: Dr Mark Levy has recently set up a website which aims to help sessional GPs carry out audit when not based in one fixed practice (http://www.guideline-audit.com/index.htm)

A dedicated website for GP appraisal in Scotland has recently been launched, providing resources and guidance, including examples of audits which can be carried out by sessional GPs (http://www.scottishappraisal.scot.nhs.uk/appraisal-preparation/sessional-gps.htm).