



Wessex Local Medical Committees Ltd

Representing the GPs of:

Dorset, Hampshire, Isle of Wight, Wiltshire and Jersey

Quality

What will this mean for you and your Practice?

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Introduction

The vast majority of individual GPs and practices provide high quality care to their patients. A recent publicationⁱ from The Commonwealth Fundⁱⁱ looked at the quality of primary care in 11 countries, including Australia, France, Germany, Holland, New Zealand, USA, and the UK. In most of the quality indicators, the UK either came out first or second and overall the conclusion was that British General Practice comes out top in providing a high quality service.

The Department of Health has also praised General Practice as being of high quality, providing value for money and being the envy of the Western world. One could therefore think that with these statements, in association with GPs being the most trusted professionals in the opinion of the public, there would be no need to take any further action regarding quality.

Quality is being portrayed by some as a new issue but this is clearly not the case. Education and training have been key features of general practice for many years.

A number of events have challenged the assumption that all doctors and healthcare organisations provide a safe service that is of high quality. Examples include the events surrounding Harold Shipman, the Bristol Royal Infirmary Paediatric Cardiac Surgeryⁱⁱⁱ, and Clifford Ayling^{iv}.

Twenty years ago a doctor could enter general practice and there would be no requirement for further education or any need to show that they had kept up to date or that the practice was a safe and effective environment to work in. For the vast majority of practices and GPs this did happen because doctors want to provide the best service they can for their patients so they do seek knowledge and develop services to ensure they are safe and effective.

Although a number of high profile cases have not diminished the trust in the profession, it is repeatedly asserted that there is a significant variation in quality between the best and the worst and this is both in terms of organisations and professionals.

Over the last 20 years much has changed to develop training and education and assure safety. Doctors have a responsibility under their registration with the GMC to keep up to date, work effectively with their colleagues and treat patients with respect.

A Postgraduate Education Allowance (PGEA) was introduced in 1990 to incentivise GPs to attend a minimum of 30 hours of education meetings per year. Significant Event Audit started to be introduced in the 1990's and by 2004, was something that occurred in every practice on a regular basis. GP appraisals were introduced for GPs in England in 2002. The Quality and Outcome Framework was introduced in 2004. Standards for Better Health became a statutory requirement for all NHS organisations in 2004. These are just a few examples of what has happened in recent times which support development and assure quality.

The purpose of revalidation is to ensure that doctors are up to date and fit to practice and to reassure the public about patient safety.

Over the next three years there will be significant change that will look at the quality and development of the individual GP and the organisation they work for. This includes:

- *Revalidation*
- *Practice Accreditation*
- *Care Quality Commission Registration*
- *Practice Quality Accounts*

Although these initiatives are still being developed, much is known about how they will be structured and potentially how they will integrate with each other. This document is an attempt to keep GPs informed of the current plans and thinking and help them prepare for inevitable change. Many decisions are yet to be finalised so there is no guarantee as to the final proposals.

Strengthened medical appraisal and revalidation are two processes inextricably interlinked and valuable in that they allow doctors to collect one set of supporting documentation to meet two needs. Together they are part of a five year continuous process. There is no big final hoop to jump through and no-one should "fail" to revalidate at the end of five years as a surprise as there should have been lots of warnings that they were not on track long before then (and the offer of support and remediation).

Revalidation^{v, vi}

All doctors will need to be relicenced in order to continue to practice as a doctor and recertified to continue to practice as a specialist and this includes GPs.

Revalidation = Relicensing plus Recertification (for fully qualified specialists/GPs)

Comprehensive information is available on the RCGP website:

http://www.rcgp.org.uk/_revalidation.aspx

The guide is updated approximately every 3 months.

Relicensing:

- For all doctors
- This will show that the GMC^{vii} has received positive assurance that a doctor continues to practice in accordance with the generic standards set by the GMC

Recertification:

- For all doctors on the GMC's specialist and GP registers list
- This will show that the GMC has received positive assurance that a doctor continues to practice in accordance with the speciality standards drawn up by the relevant medical Royal College and agreed with the GMC

For GPs

This means that a qualified GP will need to meet all the requirements of relicencing over a five year period PLUS all the requirements of the RCGP for recertification.

What are the standards?

The GMC has divided Good Medical Practice into 4 domains:

- Knowledge, skills and performance
- Safety and quality
- Communication, partnership and teamwork
- Maintaining trust

Each domain has 3 attributes

(Each of which has standards associated with it, 75 in all – but evidence does not have to be mapped to the standards, only the attributes).

Knowledge, skills and performance

- Maintain your professional development
- Apply knowledge and experience to practice
- Keep clear, accurate and legible records

Safety and quality

- Systems to protect patients and improve care
- Respond to risks regarding patient safety
- Protect patients from risks posed by your health

Communication, partnership and teamwork

- Communication skills
- Work constructively with colleagues and delegate appropriately
- Establish and maintain partnerships with patients

Maintaining Trust

- Show respect for patients
- Treat patients fairly and without discrimination
- Act with honesty and integrity

The word “evidence” has now been replaced in some circles by “supporting information”. It is expected that when a doctor uploads supporting information to the electronic portfolio it will automatically map the information to the appropriate domains, as indicated by the individual. Some information will map into more than one domain. The data below shows how all the various standards can meet the proposed requirements of revalidation.

Where will the supporting information come from?

Knowledge, skills and performance

Maintain your professional development

What	How
<ul style="list-style-type: none">• Maintain knowledge of the Law and relevant regulations• Keep your knowledge and skills up to date• Audit your clinical work and the team you work with	<ul style="list-style-type: none">• Learning credit• MSF from colleagues

Apply knowledge and experience to practice

What	How
<ul style="list-style-type: none">• Assess patients• Investigate, treat• Prescribe safely• Evidence based treatment• Consult colleagues• Refer• Support self care	<ul style="list-style-type: none">• Patient survey• MSF• Review of complaints<ul style="list-style-type: none">• Description• Lessons learned• Action taken

Keep clear, accurate and legible records

What	How
<ul style="list-style-type: none">• Contemporaneous records• Record clinical finding, information given to patients, drug treatments	<ul style="list-style-type: none">• MSF

Safety and quality

Systems to protect patients and improve care

What	How
<ul style="list-style-type: none">• Know limitations• Reflective practice• Patient safety• Quality assurance	<ul style="list-style-type: none">• Annual appraisal• PDP• Significant event audit• Complaints review• Clinical audit

Respond to risks to patient safety

What	How
<ul style="list-style-type: none">• Safeguarding children• Safeguarding adults• Colleagues performance	<ul style="list-style-type: none">• MSF• Professional indemnity

Protect patients from risks posed by your health

What	How
<ul style="list-style-type: none">• Independent medical advice• Immunisations	<ul style="list-style-type: none">• Statement of health• MSF• Registered with another practice

Communication, partnership and teamwork

Communication skills,
Work constructively with colleagues and delegation
Establish and maintain partnerships with patients

What	How
<ul style="list-style-type: none">• Listen to patients• Inform patients• Treat patients with courtesy• Treat colleagues with respect• Support colleagues• Delegate appropriately• Consent before examination	<ul style="list-style-type: none">• Patient survey• MSF• Review complaints

Maintaining Trust

Show respect for patients

What	How
<ul style="list-style-type: none">• Be polite, considerate and treat patients with dignity• Respect confidentiality	<ul style="list-style-type: none">• Patient survey• MSF• Review complaints

Treat patients fairly and without discrimination

What	How
<ul style="list-style-type: none"> • Treat colleagues and patients fairly without discrimination • Provide care on basis of need • Respond to complaints 	<ul style="list-style-type: none"> • Patient survey

Act with honesty and integrity

What	How
<ul style="list-style-type: none"> • Be honest in any report, research etc • Have indemnity cover 	<ul style="list-style-type: none"> • Statement of probity • MSF

The debate about revalidation continues with no overall decision having been made about the content, but most who are involved are fairly certain what will be included. The BMA is leading the profession’s view and is working with the GMC, the Royal Colleges and the Department of Health to try to reach an agreement.

All doctors who wish to continue to practice were issued with a “licence to practice” in November 2009, which essentially was the first stage of revalidation. The Revalidation Support Team will be supporting pathfinder pilots across England in 2010/11. The first doctors to go through a “live” revalidation decision are expected to do so towards the end of 2011.

It is therefore essential that GPs understand what will be expected of them and start to prepare and adapt now to make the process beneficial and have the least impact on workload etc.

The components of revalidation will be:

- Strengthened medical appraisal
- CPD Hours or “Credits”^{viii}
- Clinical audit
- Significant event monitoring
- Patient satisfaction survey
- Multi-source feedback
- Evidence of reflection on practice, e.g. reflective notes, case based discussion etc.

Strengthened medical appraisal

The purpose of appraisal is to support personal and professional development in an ongoing way throughout a doctor’s career, taking into account the context within which they are working. The purpose of strengthened medical appraisal has been redefined to include helping the appraisee to ensure that they are on track to revalidate.

It is true to say that when talking to GPs they have mixed views about the value of appraisal. Some question whether it has any purpose or value. Others find it a potentially career and sanity saving opportunity to reflect.

A document describing the principles of appraisal was published by the RCGP in 2008^{ix}.

What does appraisal do?

- Gives focus and energy to professional development
- Encourages reflection
- Encourages synthesis of lessons from the past
- Encourages and challenges development of skills
- Directs planning for the future
- Ensures individual has time to consider their own needs
- Ensures individual has time to consider service needs

What are the differences in strengthened medical appraisal?

It does all of the above, but also includes supporting the appraisee in providing the supporting documentation to demonstrate that the doctor is on track to revalidate.

Please note that the new elements need to be ratified and piloted before they are confirmed!

- Supporting documentation is collected all year about personal and professional development and reflection on the quality of an individual's practice. *(The same as now but there will be more guidance about what you need to collect)*
- Documentation is "mapped" against the attributes *(new)*
- The appraiser assesses the "evidence" the individual has chosen to present, having been trained to benchmark it and they will let the individual know whether information is absent, insufficient to demonstrate performance against that attribute, or sufficient to demonstrate performance for the purposes of revalidation. *(new)*
- The doctors self assess their performance against each of the attributes *(new)*
- When all is in place the doctor will have a confidential, formative and developmental appraisal discussion *(same)*
- All previous years' PDPs will be signed off (not completing an objective will be acceptable as long as it is justified and not a recurrent issue (as now)). *(Up to 5 PDPs instead of just one to review)*
- Together with the Appraiser, the doctor agrees a summary of the discussion and a PDP is developed that is derived from the priorities that have been discussed *(same, but more rigorous as the Appraiser has to sign that he/she agrees that it reflects the top priorities from the discussion, which is new)*
- The Appraiser confirms that there are no immediate concerns about patient safety from the evidence presented, including the discussion *(same as now but in writing, whereas until now it has been implicit)*

CPD Credits ^{viii}

The RCGP's proposal is that doctors should collect 250 learning credits over a 5 year period or a minimum of 50 credits per year.

Learning styles vary and may be reflected in a number of different activities which include attending meetings, e-learning, reading, teaching, clinical audit and case based discussion to name but a few.

Recently the proposed system of credits has been revised following the pilot studies.

The current proposal is that each credit would equate to 1 hour, but if a significant impact could be demonstrated it would be rewarded with a multiplication factor of 2.

For example:

1. Attending a clinical meeting for 1 hour, listening and recording reflection with no change in practice – worth 1 credit
2. Same clinical meeting but, in addition, the GP applies the learning to the management of patients with the clinical condition discussed and changes the management – worth 1 credit x 2 because of impact – total of 2 credits.
3. Same clinical meeting resulted in an audit of patients with practice discussion – worth 1 credit for meeting, 1 credit for planning audit (1 hours work) and 1 credit for discussion of audit - equates to 3 credits x 2 for impact , so total of 6 credits.

There will need to be demonstration of a variety of learning methods, for example you could not read the BMJ for 1 hour per week and claim 52 credits.

Practical skills are an important part of gaining knowledge, so learning a new skill such as liquid based cytology or aspects of minor surgery would also be considered to have a significant impact and be worth a multiplication of 2.

Management activity is also important and could form a part credit. For example taking on the lead role for practice finance or establishing a patient participation group could be considered to have significant impact and again would attract a multiplication factor of 2.

Significant Events when discussed would normally have an impact and would attract a multiplication factor of 2 if change can be demonstrated.

These proposals are still being consulted on and as yet have not been agreed but seem far more workable than the initial proposals.

The credits would be self assessed and then confirmed annually with the Appraiser. Evidence from the pilots showed that individuals tend to under-assess their own CPD and do far more than the proposed 50 credits per year without any difficulty.

The latest proposals that relate to CPD credits are available at:

http://www.rcgp.org.uk/practising_as_a_gp/professional_development/cpd_credits_scheme.aspx

Personal Development Plan (PDP)

A PDP should be the outcome of an annual appraisal and should be agreed by the appraisee and appraiser. This should represent the work plan for the forthcoming year and will be recorded in the electronic portfolio.

It is expected that a number of goals will be set and this will usually be between 3 and 5. These goals should be SMARTIES:

Specific

Measurable

Achievable

Relevant

Time-bound

Interesting – you won't do it otherwise no matter how SMART

Economic – in terms of time, effort and money

Shared Success – identify what you will do with the result once the goal has been achieved: share it with your team or just your appraiser.

The current advice is that it is not always possible to achieve all the goals that have been agreed but it would be expected that at least two thirds would have been met and an explanation be available where a goal has changed during the course of the year or proved unachievable.

Patient Satisfaction

Practices are used to carrying out regular surveys of patient satisfaction as it was a requirement in the Quality and Outcome Framework (QOF). This was removed in April 2009 and the survey is now carried out by the Department of Health using a very different set of questions. Some practices conducted patient satisfaction surveys which related to the individual GP rather than the practice but this was far from universal.

A requirement for revalidation will be to conduct a patient satisfaction survey that relates to the individual doctor - this might be considered as an integral part of the 360 degree appraisal or Multi Source Feedback (MSF).

The real question is not whether this will be part of revalidation but whether it will be required once or twice during the five year cycle. Once carried out there will need to be supporting information that the results of the survey have been considered and if necessary action taken upon reflection. (This reflection and action could be counted toward a doctor's CPD Credits).

Multi Source Feedback (MSF)

This is sometimes called 360 degree appraisal and aims to seek the views of clinical and non clinical colleagues. When done well, it can be a useful tool which is supportive and can influence behaviour. But when done badly it can be very destructive.

There have been several pilots of MSF which have taken place over the last few months. One of these is being carried out in Dorset and one in Portsmouth PCT (administered by the Peninsular Medical School). This consists of seeking the views of 50 patients, 10 non clinical colleagues and 10 clinical colleagues. The patients completed a questionnaire and this was sent to the administrator of the pilot to analyse and feedback the results and the comments. The colleagues had to complete a short on-line questionnaire which was also analysed and fed back.

The comments are seen by a moderator and any personal or inappropriate comments are removed.

It is interesting that on a scale of 1 -5, 1 being poor and 5 being excellent, patients are far more likely to score a GP as being 5 than colleagues. The result of this is that, often, patient scores will be higher than a GP's colleagues.

It has yet to be agreed whether this will take place once or twice during the 5 year revalidation cycle. If it occurs once and each GP is required to find 10 colleagues to complete an online questionnaire, this will mean each clinician on average will be asked to complete 2 of these per year.

There needs to be evidence that this will be constructive and that it has a positive impact on clinicians. The problem may be that those who are positive about carrying this out are those who generally get good feedback and are prepared to listen and change, but those who are very negative and need to listen to how they are perceived by others will not like what they hear and will ignore the outcome of the process. In order to avoid even good clinicians being devastated by a negative comment, the feedback from the MSF needs to be facilitated and one concern is that some tools do not provide for this and the report can end up sitting in your e-mails in the middle of morning surgery.

The other issue is funding. To carry this out there will be a cost attached and this has been estimated as being between £120 - £300 per GP. This will need to be funded and should not fall as an additional cost to the clinician.

Further details are available on the RCGP website, contained within the Revalidation section.

Clinical Audit

Most GPs will be used to carrying out clinical audit. It has been suggested that GPs should carry out a minimum of two clinical audits during each 5 year revalidation cycle. This would include the initial audit; the agreed changes implemented and then a re-audit to demonstrate improvement.

A description of a Clinical Audit should include:

- the title of the audit
- the reason for the choice of topic
- dates of the first data collection and the re-audit
- the standards set and their justification (reference to guidelines etc.)
- the results of the first data collection in comparison with the standards set
- a summary of the discussion and changes agreed, including any changes to the agreed standards
- the changes implemented by the GP
- the results of the second data collection (the re-audit) in comparison with the standards set
- quality improvement achieved
- reflections on the Clinical Audit in terms of:
 - knowledge, skills and performance
 - safety and quality
 - communication, partnership and teamwork
 - maintenance of trust.

The electronic portfolio will have a standard form in which these fields can be recorded. These audits are expected to be related to the work carried out by an individual GP. This may be more challenging for locums. Guidance will be issued with examples to help particular groups of doctors.

For example Clinical Audits could include:

- antibiotic prescribing or prescribing for pain
- investigation and imaging or referrals and admissions
- cancer diagnosis,
- medication reviewing
- management of a long term condition

Significant Event Monitoring

This is commonly carried out in all practices as it is a requirement in QOF. The proposal is that each GP should record 5 Significant Events over a 5 year period. An account of a Significant Event Audit should not allow patients to be identified and should comprise:

- title of the event
- date of the event
- date the event was discussed and the roles of those present
- description of the event involving the GP
- What went well?
- What could have been done better?
- reflections on the event in terms of:
 - knowledge, skills and performance
 - safety and quality
 - communication, partnership and teamwork
 - maintaining trust
- what changes have been agreed:
 - for the GP personally
 - for the team
- Changes carried out and their effect.

The electronic portfolio will have a standard form to complete all these fields.

It may be difficult for certain groups, such as locums or single handed GPs, to discuss Significant Events. It is interesting to see that some Sessional GP Groups have already started to discuss these where they have regular meetings.

It seems likely that in order to have a balanced portfolio that reflects practice there will be a suggestion that some examples of significantly good practice are included, as well as “near misses” or adverse incidents. Good practice provides opportunities for learning too!

Patient safety is not only the responsibility of every GP but also every practice. Life is not without risk but every precaution should be taken to reduced patient risk.

The seven steps to patients’ safety are available at:

<http://www.nrls.npsa.nhs.uk/resources/collections/seven-steps-to-patient-safety/?entryid45=61598>

There is some excellent guidance on the National Patient Safety Agency’s website:

<http://www.nrls.npsa.nhs.uk/resources/?entryid45=61500>

See Annex C for a [template for Significant Event Monitoring](#).

Complaints

During the course of a year a GP may have been investigated for poor performance by the PCT, the National Clinical Assessment Service (NCAS) or the GMC,

The key elements of their reports, which should not identify patients or other relevant individuals, should be:

- a description of events that resulted in a cause for concern being expressed
- the cause for concern
- the assessment of that cause for concern
- any actions resulting from that assessment
- the outcome of the cause for concern
- reflection by the GP on the experience, including lessons learnt, changes made and implications for the future.

If a cause for concern is unresolved at the time of Revalidation, a Revalidation Portfolio cannot be considered by the GMC and a decision will be made on a case by case basis.

Many GPs will have had a formal complaint made against them. A formal complaint is one that is activated, or should have activated the practice Complaints Procedure, involved the PCT, or involved any other formal health service organisation.

Although many such complaints are satisfactorily resolved at an early stage, a GP’s Revalidation Portfolio should include all such complaints. The intention is not to rake over old events but to look for two points: a pattern of complaints that may suggest systemic issues; and inappropriate responses to complaints (poor reflection, lessons not learnt, etc.). The description of such complaints should be sufficient for the Appraisers, Responsible Officers and Assessors to satisfy themselves regarding these two points and should include:

- a description of the events that resulted in a formal complaint
- the concerns expressed by the complainant
- the assessment of that complaint
- any actions resulting from that assessment
- the outcome of the complaint
- reflection by the GP on the experience, including lessons learnt, changes made and implications for the future.

There will be a standard form within the electronic Portfolio to record such information.

There is some excellent guidance on complaints, which included the changes to the NHS complaints procedure which took place in 2009, on the LMC website:

[Wessex LMCs Complaints Guidance](#)

Remediation

There has been much talk about what will happen to those who fail to be revalidated. This is a process and no one should suddenly come to the end of 5 years and suddenly find that they “fail”. It may be that GPs fail to complete one section of the required elements satisfactorily. It is then expected that this will be referred to the Responsible Officer to assess the situation.

For example, a person could have been due to ill health or maternity leave and not completed their required number of CPD Credits. In this example, it is expected that an account would be taken of this and a judgement made, and this would not be that the doctor had to complete twice as many credits in the following year.

If significant elements of poor performance are identified during this process then it might be that additional training is required. If, for example, the MSF has shown that a GP’s consultation and communication skills are poor, additional training in these areas may be of help. What is unclear is whether this would be a requirement and who would fund this.

The BMA’s position is that if additional measures are brought in by which doctors are assessed who then ‘fail’ to meet these demands which may result in some remediation, this should be funded via the NHS and not by the individual.

Responsible Officer (RO)

Each PCT and Trust will have a Responsible Officer and some may have more than one. For GPs it is expected that there would be a Responsible Officer who is a GP and employed by the PCT, supported by a number of individuals.

Following 5 satisfactory completed appraisal cycles, the RO would look at any other evidence available which might include any outstanding performance issues etc. If everything was satisfactory the RO would forward the recommendation that the revalidation cycle was complete and satisfactory. The final decision about relicencing rests with the GMC, based on the recommendation of the RO. The GP would be issued a further licence to practice for 5 years and would be recertified to work as a GP.

The final proposals for ROs are yet to be agreed.

Practice Quality

Individual and practice quality are separate issues but there is considerable overlap between the two and both should be viewed as part of the same spectrum.

It is very hard for a GP of high quality to perform well in an underperforming or poor practice.

The details about the Care Quality Commission, Practice Accreditation and Quality Accounts are factual as known at the time of publication, January 2010. Potentially, with a change in Government in the next 6 months, there may be a significant change in policy direction. All main political parties, when talking about the NHS, have focused on funding and quality.

Care Quality Commission (CQC)

The CQC is an independent regulator of health and social care in England. It was established in April 2009 and took over the roles of the Commission for Social Care Inspection, the Healthcare Commission and the Mental Health Commission, which were all abolished on 31st March 2009.

All providers of healthcare to NHS patients will be required to register with the CQC and meet the 16 core standards (see below). For general practice registration this is unlikely to be required before 2012.

The 16 Core standards

1. Care and welfare of service users
2. Assessing and monitoring the quality of provision
3. Safeguarding vulnerable users
4. Cleanliness and infection control
5. Management of medicines and medical devices
6. Meeting nutritional needs
7. Safety and suitability of premises
8. Safety, availability and suitability of equipment
9. Respecting and involving service users
10. Consent to care and treatment
11. Complaints
12. Records
13. Competence and suitability of workers
14. Staffing
15. Effective management of workers
16. Co-operating with individual providers

See Annex A for details of each standard.

These requirements will replace Standards for Better Health and National Minimum Standards that currently apply to NHS and independent sector providers respectively. Many GPs have not heard of “Standards for Better Health”, but all Practice Managers will be aware of them.

The majority of these requirements are in place in the majority of practices. Of particular note are the following:

4. Cleanliness and infection control

This requires providers to protect people against the risks of acquiring a healthcare associated infection, using compliance guidance set out in the code of practice for the NHS on the prevention and control of healthcare associated infections

At present there is no nationally agreed strategy for infection control in general practice. The danger is that the requirements of secondary care are simply applied to general practice. It is expected that a new strategy for primary care will be published within the next 2 years.

7. Safety and suitability of premises

This requires providers to use premises that are suitable for the purpose used and maintained to provide a safe environment for users of services.

This could potentially have a significant impact for both PCTs and practices. It is well known that some practice premises are not fit for purpose and do not provide a safe environment. In a time of financial deficit, practices have found it very difficult to secure funding to improve or replace premises that are inadequate. CQC will have the power to simply visit a practice unannounced and if they deem the premises to be unsafe can “close them down” with immediate effect.

The quality standards will focus on achieving outcomes rather than ensuring that processes are in place.

Improving poor practice

In a statement from the CQC, they stated “conditions will be placed on poor practices, which will require them to draw up action plans to improve in a set timescale. Inspectors will check on improvement”.

Two major questions remain unanswered:

1. Funding: How much will CQC registration cost and who will pay?
2. How does CQC registration link with Practice Accreditation?

Funding

This is being discussed and the GPC’s position is that if a fee is applicable for general practice then it must be funded by the PCT or the DoH and not simply fall as an additional cost to practices.

Link to Practice Accreditation

At a recent conference, the CEO of CQC stated that the core requirements for CQC registration would be met if a practice achieved Practice Accreditation. The RCGP, GPC and CQC are working closely together to ensure this is the case.

Practice Accreditation

It is unfortunate that although the proposals for practice accreditation have been around for some time, the details are still unknown to most GPs.

It has been repeatedly stated that Primary Medical Care Provider Accreditation (PMCPA) will be voluntary, patient-focused, developmental and professionally led.

The RCGP is working with other organisations to develop an accreditation model for primary medical care providers. Recently 36 Practices took part in a pilot which has helped to refine the criteria which has now been reduced from 112 to 90.

PMCPA is organised around six developmental domains containing 90 criteria covering organisational standards common to all primary care providers.

The current domains are:

1. Health Inequalities and Health Promotion
2. Provider Management
3. Premises, Records, Equipment, Devices and Medicines Management
4. Provider Teams
5. Learning Organisation
6. Patient and Carer Experience, Involvement and Responsiveness

Why PMCPA?

In a recent publication the RCGP stated, “The accreditation process is designed to create a culture of safety and quality within primary care and encourage organisations to strive to continually improve systems and processes that support the delivery of clinical services.”

The RCGP also described PMCPA as:

- A voluntary scheme
- Reflects the multi-disciplinary approach to primary care
- Supports delivery of patient-centred care
- Enables compliance with the Care Quality Commission
- Complements Revalidation

So in reality what does all this mean?

It is accepted by many that the quality of general practice in this country is high. The vast majority of the 8,300 practices are well organised and focused on delivering the best service they can to their patients.

Not all practices perform to a high standard and the variation between the best and those who are at the poorer end is unacceptable to many. It is over simplistic to assume that this is always the fault of the practice. There are a significant number of practices who have historically received poor funding, work from inadequate premises and may work with the most challenging patients. These practices will struggle to recruit the GPs that they need.

In addition there is concern that the new providers of primary care or the private organisations who have taken over practices do not provide care to the same quality. Practice Accreditation if it works, should ensure this is not the case.

What remains to be answered is:

1. Is Practice Accreditation going to become compulsory?
2. If Practice Accreditation is voluntary, will it be a quality kite mark?

3. Will there be a basic level and an advanced level – for example, entry level meets the requirements of CQC and level 2 achieves a higher standard, such as the RCGP's Quality Practice Award?
4. Will there be additional funding made available to achieve these standards?
5. Who will judge if a practice has met the required standards and who will fund this process?
6. How long will a practice remain accredited for?
7. Training practices are assessed regularly; will Practice Accreditation integrate with training requirements?

Practice Quality Accounts

In 2008, a document was published by the Department of Health called “High Quality Care for All”. This proposed that all providers of NHS care should produce and publish Quality Accounts to provide the public with information on the quality of care they provide. The Department of Health has introduced legislation to require the publication of Quality Accounts from April 2010. General Practice will be exempt for the first year

‘Quality Accounts’ will be reports to the public on the quality of the services they provide looking at the three domains of quality:

- safety;
- effectiveness;
- patient experience.

The proposed aim of the “Quality Account” is to support the NHS in improving the quality of healthcare services.

The current proposals that will apply to all NHS Trusts from June 2010 are:

1. The Trust Board must declare their accountability for the contents of the Quality Account. The Chief Executive would be required to sign a statement summarising the Trust’s view of the overall quality of services that it provides.

2. Priorities for improvement

It is proposed that the “Quality Account” should include a description of areas for improvement including:

- a. Three to five priorities for quality improvement.
- b. Key improvement initiatives for each priority.
- c. Reporting on improvement targets against defined measures.

3. Review of quality performance

4. It is proposed that a “Quality Account” should include a description of at least three indicators for each of the domains of quality under the separate headings of:

- a. Safety
- b. Effectiveness
- c. Patient experience

5. Providers will be required to report on the status of their CQC Registration and any conditions that have been placed on them.

6. Data quality

It is recognised that good quality data underpins the delivery of effective patient care. Improving data quality is therefore a priority.

There are four proposed indicators to highlight data quality:

- a. The patients NHS number is the key identifier for patient records.
- b. Clinical coding – improved use and accuracy – suggests a clinical coding audit would be appropriate.
- c. Accurate recording of the patients GP Practice - essential to enable the transfer of clinical information and improvement is required in some areas.
- d. Information Governance Toolkit used by NHS Trusts record a score for Information Quality and Records Management. These scores will be published and acted on if improvement is required.

General Practice would therefore be required to publish their first “Quality Account” in June 2011, subject to the implementation of the Health Bill 2009 and content is likely to be very similar to that required of NHS Trusts.

The requirements imposed on a Hospital Trust, with a significant management infrastructure, should be greater than that required by a practice. As yet the proportionality discussion has not been completed.

For General Practice there are many issues contained within the proposals which overlap with existing schemes or are potentially new requirements. For example:

1. The Quality and Outcome Framework (QOF) - Existing

The QOF is the largest database of clinical quality measures available in the world. This data is already in the public domain and could be extensively used in a practice’s “Quality Account”.

QOF does not only include clinical indicators but also contains organisational and management indicators.

Patient experience, although unpopular in its present form, is a major part of QOF.

2. IM&T DES (Existing)

Most Practices have signed up to the IM&T DES and the completion of the Information Governance Toolkit was a part of this for many.

3. CQC Registration (New)

This will be part of the overall “Quality Account”, as yet it is not clear if CQC will publish performance ratings for practices as they do NHS Trusts.

4. Practice Accreditation (New)

Not only does this directly link with CQC registration but will also be a fundamental part of the “Quality Account”.

5. Balanced Scorecard (Existing)

This has been implemented in very different ways by PCTs. In supportive PCTs, they have shared practice specific data, compared this with benchmarked data, had and acknowledged a stimulating debate in allowing practices to compare their performance against their peers - BUT it is not a panacea for assessing quality.

In less supportive PCTs this has been used to grade practices often using the Red, Amber and Green rating system, using crude indicators which often reflect the population which is registered with the practice rather than an accurate indicator of the practice’s quality.

The new measures of quality, namely CQC registration, Practice Accreditation and Quality Accounts should all be part of the same process as there is huge overlap between them all. Whether this happens remains to be seen.

Requirements for CQC Registration

The DH has published the final list of requirements for CQC registration; these are:

1. *Care and welfare of service users*

This requires providers to assess each user of service's needs, to identify and deliver safe and suitable treatment and care to meet those needs. This requires providers to have a sound evidential basis for the care and treatment they provide or put in place appropriate risk management for innovative procedures.

It will work alongside equalities legislation and requirement 9 to ensure each individual's diverse needs are taken into account and that people are not unlawfully discriminated against in the provision of health and adult social care services.

2. *Assessing and monitoring the quality of provision*

This requires providers to assign management responsibilities and to operate systems that assess and are accountable for the overall safety and essential quality of care and treatment provided. This requires providers to learn from the views of users of services, including complaints, from incidents and near misses and sources of expert advice.

3. *Safeguarding vulnerable users*

This requires providers to protect users of services against abuse. This requires providers to act proportionately and in the best interests of the user of services when using any form of restraint or other technique to address disturbed behaviour.

4. *Cleanliness and infection control*

This requires providers to protect people against the risks of acquiring a healthcare associated infection, using compliance guidance set out in the code of practice for the NHS on the prevention and control of healthcare associated infections.

5. *Management of medicines and medical devices*

This requires providers to ensure medicines and medical devices are appropriate for the purpose used and are handled and used safely.

6. *Meeting nutritional needs*

This requires providers to guard against malnutrition and dehydration where meeting users of services' nutritional and hydration needs are integral to the service provided (e.g. in residential care or for inpatients). This requires providers to provide sufficient quantities of nutritious food and assist users of services to eat and drink where needed.

7. *Safety and suitability of premises*

This requires providers to use premises that are suitable for the purpose used and maintained to provide a safe environment for users of services.

8. Safety, availability and suitability of equipment

This requires providers to ensure equipment is appropriate for the purpose used, handled, and used safely. It requires providers to have sufficient equipment to ensure the safety and essential quality of care and treatment offered.

9. Respecting and involving service users

This requires providers to treat service users with respect and to protect their dignity, privacy and independence. It requires providers to treat all users of services equally and have regard for their diverse needs. It requires providers to inform users of services about their treatment and care and involve them in decision making. It will work alongside equalities legislation to ensure people are not unlawfully discriminated against

10. Consent to care and treatment

This requires providers to ensure they obtain informed consent for the care and treatment they provide.

11. Complaints

This requires providers to operate an effective complaints process. It requires the complaints process to be accessible for service users. It requires providers to investigate complaints and, where possible, resolve them to the satisfaction of the complainant.

12. Records

This requires providers to keep records relevant to the carrying on of the regulated activity and specifically the care and treatment they provide to service users and to maintain the confidentiality of the information they contain.

13. Competence and suitability of workers

This requires providers to operate effective recruitment procedures that ensure workers are competent and suitable for the roles they perform. It will work alongside equalities legislation to ensure that recruitment is free from unlawful discrimination.

14. Staffing

This requires providers to have sufficient numbers of competent staff in place at all times to ensure the safety and welfare of service users.

15. Effective management of workers

This requires providers to operate effective people management to support workers in fulfilling their roles, ensure they operate within their competency and undergo necessary training and development. It will work alongside legislation to ensure that workers have equal opportunities and are free from unlawful discrimination.

16. Co-operating with individual providers

This requires providers to work together to ensure that service users are safe as they move between services. This requires providers to work together where they share responsibility for a service user's overall care and treatment. This requires providers to work together in developing their response to emergencies. This requires providers to support service users to access other services they need.

Practical advice about how to prepare for Revalidation

Although the first doctors to be revalidated will not occur until late 2011 (and the final contents are as yet not agreed), sufficient is known to allow GPs to prepare for the development of the current system of appraisal etc. enabling a smooth transition to what will be required.

General advice:

1. GPs need to get into the habit of making this a year round activity and not something to be done at a rush in the two weeks prior to appraisal.
2. Be proactive about learning needs i.e. identifying what is required and planning to address it rather than being reactive on the basis of what training/education is available.
3. a PDP is not set in stone but be prepared to discuss what you have done that is different and justify any shortfall in activity
4. Be flexible, there should be a different emphasis each year e.g. prescribing analysis one year and referral audit the next.
5. Be aware of your strengths and weaknesses and be prepared to discuss and address them.
6. Look at the whole picture i.e. not just your individual clinical practices, but the NHS as a whole, what patients want, how general practice fits in, where will general practice be in 5 or 10 years and where will you be in 5 or 10 years. How do all these factors affect your clinical practice now?
7. This is not something that is being done to us but something we need to do for ourselves.

Electronic Portfolio

GP Trainees are used to using [e-Portfolio](#) which is an electronic toolkit to record their educational development over the time they undertake their specialist training. The [NHS Appraisal Toolkit](#) is used by many GPs to assist them undertake their annual appraisal.

There will be a new electronic Portfolio to help with revalidation. It would seem the likely electronic solution will take the best from e-Portfolio and the NHS Toolkit to produce something that is practical and user-friendly.

One important development will be that any information added will automatically be able to be added to the relevant domains as defined by the GMC.

Advice: Use the NHS Toolkit and try to record and store as much information as possible electronically.

Appraisal

All GPs should now be used to undergoing an annual appraisal. Some GPs are well organised and collect supporting information of their education and development during the year; they record their reflections and potential actions which result from their reflections. Others collect little or no information or simply fill their folder with as many documents as possible but fail to demonstrate any reflection or impact.

Remember it is the quality of the supporting information which is important not the quantity. Those who are well organised are going to find the process much easier.

The system of CPD Credits seems complicated and 50 hours of education may seem excessive to some, but look at what you do now and ensure that you think of including management as well as clinical areas, for example:

- Partnership meetings
- PHCT meetings
- Practice based commissioning meetings either at locality level or within the practice
- QOF – many GPs take a clinical lead in an area and do a significant amount of development work without identifying the time spent or impact that resulted from the activity
- E-learning – BMJ and the RCGP provide excellent modules for self directed learning

Advice: CPD is more than just attending lectures; GPs have different learning styles. Be organised and record time spent on education and development. Ensure there is a variety of learning from reading to e learning to clinical meetings. Also include management as well as clinical aspects.

Use clinical discussion within the practice or wider group in a positive way and remember this is an important aspect of clinical development.

Significant Event

To record these, the following headings may be helpful:

- title of the event
- date of the event
- date the event was discussed and the roles of those present
- description of the event involving the GP
- What went well?
- What could have been done better?
- reflections on the event in terms of:
 - knowledge, skills and performance
 - safety and quality
 - communication, partnership and teamwork
 - maintaining trust
- what changes have been agreed:
 - for the GP personally
 - for the team
- Changes carried out and their effect.

Remember this does not only have to be reviewing negative events, as much can be learnt from positive events.

Each GP will have to record a minimum of 1 per year and ensure that it is reviewed with their peers.

Advice: For GPs who work largely in one surgery, arrange a quarterly meeting to discuss Significant Events. Over the year, all GPs should have the opportunity to present a Significant Event and the peer review resulting from the discussion.

Locums may find this more challenging but many locums belong to sessional GP groups and have established this as part of their regular meetings.

If a practice uses a small number of regular locums, consider inviting them to the practice educational meetings.

Clinical audit

Clinical audit does not need to be complicated or time consuming. It should be used to improve care.

Advice: *There are many good examples available. Do not spend lots of time collecting data or searching for it as this is what practices have administrative staff for. Look at areas where the GP contract requires an annual audit, such as minor surgery, cervical cytology etc.*

For locums, look at audits which can be tailored to the work pattern. For example, the auditing of referral rates and prescribing of antibiotics are just two examples.

Multi-Source Feedback

There are various models currently being tried.

Advice: *Until a tool to deliver this has been agreed, it is probably best to only undertake this if the GP is particularly keen to do so.*

Patient Satisfaction Surveys

Patients must be suffering from survey fatigue! The national survey of patient opinion is now taking place on a quarterly basis. When this was carried out by the practice there was an opportunity to look at individual performance but this is no longer the case.

Advice: *Patient satisfaction should be part of the MSF, so wait until that has been agreed before undertaking any further surveys about individual GPs performance, unless the practice has a specific need.*

Complaints

Practices are generally very good about considering complaints and addressing the problems, with most being resolved at practice level. Very few find their way into appraisal folders.

Advice: *Do not be reticent about including a complaint in your appraisal. The important issue is what action was taken and the lessons learnt from this, rather than giving the opportunity to rake over old ground.*

Annex C Significant Event Monitoring

Date of the event
Description of the event
Date the event was discussed
What went well?
What could have been done better?
Reflections on the event in terms of: <ul style="list-style-type: none">▪ knowledge, skills and performance▪ safety and quality▪ communication, partnership and teamwork▪ maintaining trust
Agreed changes – including name of person responsible for implementation
Timescale for changes and review date

ⁱ <http://www.commonwealthfund.org>

ⁱⁱ The Commonwealth Fund is a private foundation that aims to promote a high performing health care system that achieves better access, improved quality, and greater efficiency, particularly for society's most vulnerable, including low-income people, the uninsured, minority Americans, young children, and elderly adults.

ⁱⁱⁱ The Bristol Royal Infirmary, in 1999 an inquiry led to the cessation of paediatric cardiac surgery in Bristol due to poor outcomes.

^{iv} Clifford Ayling was a Kent GP who was imprisoned for 4 years in 2000 for a number of indecent assaults on female patients.

^v <http://www.revalidationsupport.nhs.uk/>

^{vi} http://www.rcgp.org.uk/_revalidation.aspx

^{vii} <http://www.gmc-uk.org/>

^{viii} http://www.rcgp.org.uk/practising_as_a_gp/professional_development/cpd_credits_scheme.aspx

^{ix} http://www.rcgp.org.uk/_revalidation/revalidation_supporting_tools.aspx

Other useful resources:

http://www.nesc.nhs.uk/primary_areas/primary_care/primary_care_taskforce/appraisal_service.aspx

<http://www.wessexlmcs.com>