

DOCUMENT 9

“Accreditation” of General Practitioners with Special Interests

A Discussion Paper
from the
Royal College of General Practitioners
and the
NHS Revalidation Support Team

Introduction

While protecting and assuring the public and patient, revalidation must be flexible in recognising the non-standard work that many doctors undertake. Revalidation must recognise the circumstances under which doctors in various settings work, including, in general practice, sessional doctors, tribunal doctors, police surgeons, doctors in the Defence Medical Services, doctors in the Prison Service, and those in small or remote practices. In secondary care similar issues will arise for staff grade and associate specialist doctors, and those in non-NHS practice. While promoting and assuring standards, revalidation must not place an unreasonable burden on good doctors just because their work is not mainstream.

One such group is General Practitioners with Special Interests (GPwSIs) and others with a non-standard clinical experience. Although GPwSIs are the easiest to identify and quantify (within the NHS they need to declare themselves as such and be commissioned), there are many other GPs who, consciously or not, develop an extension to their clinical care that is beyond normal contractual requirements. This paper explores issues relating to the accreditation and revalidation of GPwSIs. The advantage of agreeing an approach to this group is that agreement for this group this may have potential read-across to other groups of doctors in non-standard work.

Current advice

The first published version of RCGP Guide to Revalidation for General Practitioners (April 2009) says (Box 1):

Box 1

For clinical activities, including General Practitioners with a Special Interest, the general practitioner should describe in detail the role (in Evidence Area 1) and provide in this section of the portfolio evidence that satisfactorily answers the following three questions:

1. How did you qualify to take on this role?
This should include prior experience, education and qualifications
2. How do you keep up to date in this role?
This should include reference to all education and refreshment undertaken for this role in the revalidation period, including any learning credits recorded in Evidence Area 6
3. How can you demonstrate that you are fit to practise in this role?
This should include appropriate audits of care delivered, including reference to any audits in Evidence Areas 10 and 11, evidence from third party observation of your work, and sign off from an appropriate consultant/expert/colleague who knows your work

A general practitioner who is working as an official General Practitioner with a Special Interest should also provide a certificate of accreditation.

Local accreditation by the employing/contracting organisation and its relation to revalidation

There is significant scope for confusion as there are, or appear to be, multiple systems for accrediting GPwSIs. The confusion will be magnified if there is significant local variation in accreditation, potentially introducing a postcode lottery into revalidation.

Many primary care organisations (PCO) are accrediting their GPwSIs every three years. Each PCO is advised to accredit each GPwSI that they contract. Revalidation will impose a five yearly “accreditation”. Our concern is that in a few years there is a risk that the following undesirable situation may pertain for, say, a GPwSI in dermatology (Box 2):

Box 2

In one year a GPwSI takes part in the accreditation of the service in PCO A. The next year this doctor applies to deliver a similar service in the neighbouring PCO B and the service is accredited and commissioned. PCO B requires the GP to be accredited personally to deliver that service. The next year the GP’s three yearly personal accreditation with PCO A is due for renewal. The next year the GP is due for five-yearly revalidation.

This “accreditation nightmare” should be avoided if possible. The following possible solution is based on the principle of making a distinction between accrediting the *service* and the *doctor*, and between the separate processes of *accreditation* and *revalidation* of the doctor.

1. Commissioning the service

In commissioning the service, the local PCO should have the responsibility for accrediting the service provided by the GPwSI and others working with them. The Service Level Agreement should include the key aspects of the service: place, patients, procedures and person. The “person” referred to is the deliverer of the service and the PCO will need to be satisfied that the person (in this case GPwSI) is trained, certified, mentored, monitored and it working within their competency.

Thus a local community dermatology service, perhaps with an out-reach dermatologist and a GPwSI in dermatology, would work to standards and outcomes specified in the SLA. The SLA will be based on the national models agreed between the Departments of Health and the RCGP, taking into

account the advice of the relevant specialist Colleges, Faculties or societies. A key aspect of the local SLA must be the specified competencies of the GPwSI employed. If the service is to provide a referral service for psoriasis, then a GPwSI in dermatology who is running a pigmented lesion clinic would not be suitable.

The SLA should be monitored by the PCO in contract review meetings at least annually. A full service accreditation should happen at intervals determined by the SLA and should normally accompany contract renewal.

This proposal places the responsibility for ensuring that GPs are commissioned to provide services for which they are properly trained and quality assured on the commissioning PCO. Although the PCO needs to be satisfied that the GP is fit to provide the service and the clinical governance arrangements are appropriate, the PCO is not “accrediting” the GP – it is only satisfied that the GP is fit to provide the service specified.

The PCO will wish to consider whether the GPwSI should or should not undertake a majority of their work in generic general practice. Normally it would be highly desirable for a GP with a special interest in an aspect of normal general practice, for example in diabetes or asthma, to be a credible generic general practitioner. However some GPs offer a service that is not an extension of generic general practice, particularly involving procedures, and a PCO might not insist on a high proportion of their work being in generic general practice.

The evidence that a GPwSI would be asked to provide to a PCO to demonstrate their suitability for delivering a service would be predominantly the evidence that they would be accumulating for their annual appraisals and revalidation (to answer the three key questions in box 1).

2. Revalidation of the doctor

Throughout the five years of the revalidation cycle, the GPwSI will be accountable to one Responsible Officer and will have regular annual appraisals. At appraisal and revalidation the GP will declare what they do (including the nature of their special interest) and will provide evidence that they are fit to undertake their roles.

If a GPwSI changes the nature of their work at any time (they change from running a menopause clinic to undertaking colposcopy for example) they will be under a professional obligation to work within their competency and must demonstrate to the commissioning PCO that they are fit to deliver the new service. At their next appraisal they would also provide evidence that they were suitable training for the new role and that their standards are appropriate.

Revalidation ensures that at the time of revalidation the GP is fit to undertake their roles at that time; appraisal acts as an intermediate check; and commissioning provides the clinical governance framework for the PCO to ensure the quality of care offered. This is the same for generic general practitioners as it is for GPwSI.

Next steps

The proposal in this paper needs to be checked against legislation, regulation and advice to PCOs. It must be discussed with the Department of Health and other stakeholders such as the RCGP, the Academy of Medical Royal Colleges, the GMC and the GPC.

Wider discussion with other groups will help to ensure that there is effective read-across between these issues in relation to GPwSIs, and other groups of doctors working in non-standard settings, some of which are listed in the introduction.

Once an approach has been agreed, the DH guidance on GPwSI and RCGP Guide on Revalidation should be redrafted.

Professor Mike Pringle

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