NHS England



Supporting doctors who undertake a low volume of NHS General Practice clinical work

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Document Title:

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Version number: Pre-Gateway v1.0 June 2018

First published:

Updated: (only if this is applicable)

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We would like to acknowledge the input and thank all stakeholders and expert resources who have contributed to the development of this guidance.

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Overview

This guidance provides a framework for the management of doctors on the NHS England Medical Performers List who are undertaking a low volume (defined as fewer than 40 sessions per annum) of NHS General Practice (GP) clinical work. There are three areas of focus intended to achieve a consistent, transparent and supportive approach across NHS England;

1. Setting out the professional responsibilities of a doctor undertaking a low volume of NHS GP clinical work.
2. Defining a threshold for the definition of a low volume of clinical work and the subsequent management of appraisal.
3. Providing support for doctors undertaking a low volume of NHS GP clinical work and those appraising them.

This guidance has been the product of collaboration with input from key stakeholders including NHS England responsible officers (ROs), the Royal College of General Practitioners (RCGP), the British Medical Association (BMA) and the General Medical Council (GMC). It is intended to provide clarity and reassurance to doctors on the NHS England Medical Performers List with regard to their professional requirements when undertaking a low volume of work, and to aid those appraising such doctors. It is recognised that there would be potential benefits of a similar approach being adopted across the United Kingdom, supporting the management of doctors working across geographical boundaries and reducing duplication of work.

The professional responsibilities of a doctor

All doctors have a professional responsibility to maintain their skill set and knowledge base to ensure that they are safe to practise. The over-arching objective of the GMC is the protection of the public. One of the ways it does this is by promoting and maintaining proper professional standards. NHS England, as a commissioner of services and a designated body for the purposes of revalidation, also has a responsibility to ensure effectiveness via its Responsible Officer (RO) network.

The governance of doctors on the Medical Performers List is directed by the Performers List Regulations and the relevant policies and guidance of NHS England. The '*National Health Service, England – The National Health Service (Performers Lists) (England) Regulations 2013'* provide the following references to volume of work:

- Section 14(5) requires the practitioner to perform services consistent with their inclusion on the Performers List during the preceding 12 months.
- Section 9(10): participate in any appraisal system established by the Board.

From the perspective of inclusion on the Medical Performers List the appraisal system is that described by NHS England's Medical Appraisal Policy 2015 v2.

The role of appraisal for the doctor, their RO and the GMC

NHS England has the following objectives for medical appraisal:

- To support the delivery of safe, high quality, committed, compassionate and caring services to patients;
- To help supervise and support its doctors in achieving continual professional improvement;
- To support the process of medical revalidation;
- To contribute to the achievement of the values of NHS England.

The NHS Medical Appraisal Policy describes the relationship between revalidation and appraisal:

Revalidation is the process by which licensed doctors demonstrate to the GMC that they are up to date and fit to practise. One cornerstone of the revalidation process is that doctors will participate in annual medical appraisal. On the basis of this, and other information available to the RO from local clinical governance systems, the RO will make a recommendation to the GMC, normally every five years, about the doctor's revalidation. The GMC will consider the RO's recommendation and decide whether to continue the doctor's licence to practise.

In summary, in the absence of any significant concerns, doctors on the Performers List who provide supporting information consistent with their scope of work as required by the GMC and NHS England, in their annual appraisal, demonstrate they are up-to-date and fit for purpose and therefore enable their RO to make, as requested, a positive recommendation to the GMC about their revalidation.

As described in the NHS England guidance 'Improving the Inputs of Medical Appraisal' reflecting the requirements of the GMC:

- A doctor must ensure that their appraisal inputs demonstrate fitness to practise across their scope of work.
- The appraiser provides assurance to the system via the appraisal outputs.
- The appraiser may seek guidance, either before or after the appraisal, from a senior or lead appraiser or their RO in situations of uncertainty.
- The RO must be assured that the doctor's appraisal inputs and the appraiser outputs support a recommendation of fitness to practise.

In addition as described within section 5.7 Volume of Work for 'Areas for special consideration':

Depending on the nature of the work, a doctor undertaking a lesser volume of work in an area should take increasing care that their appraisal inputs are sufficient to demonstrate fitness to practise in that area.

Defining a threshold for low volume of clinical work and the subsequent management

There is no NHS England guidance or regulation that currently provides a figure for the minimum amount of sessions below which further reflection should ordinarily be required for ongoing inclusion on the Medical Performers List. This reflects the complexity of general practice and the multiple factors which may need to be considered including the relevance of other aspects of the scope of work. However it is the view of NHS England supported by the relevant stakeholders, that it is necessary and appropriate to support a consistent and supportive approach to define a benchmark of low volume of clinical work.

The purpose of this threshold is to act as a trigger for reflection and discussion about the scope, circumstances and personal development goals consistent with inclusion. It is explicitly not to be viewed as a pass or fail for the doctor but rather as a prompt for the reflective discussion outlined above to take place during annual appraisal. Doctors performing 40 sessions or more per year do not need to reflect further upon their safety purely for reasons of volume of work.

A consistent, transparent and supportive approach

An explicit framework for reflective discussion should be used in the appraisal of doctors who work fewer than 40 clinical sessions a year. This discussion should reassure the appraiser of the ability of the doctor being appraised to provide safe quality care for patients by considering:

1. Patient safety.
2. Support for the doctor to retain and develop their skills across their scope of work.
3. Actions to enable the doctor to flourish within their scope of work.

This approach has the focus of supporting the professionalism and insight of the doctor as appropriate.

Use of Low volume SRT in discussion with the Appraiser

During the annual appraisal, where a doctor declares that they have performed fewer than 40 sessions in the preceding 12 months, then that doctor should include within their Quality Improvement Activity (QIA) a structured reflective template (SRT) to demonstrate and record their reflections on their continued ability to provide safe quality patient care. This SRT should then form the basis of a professional discussion with the appraiser, who will record that such a discussion has taken place. The appraiser should record a summary of the reflective discussion relating to the SRT to evidence signing off the appraisal outputs. The SRT will set out the following criteria to look at relevant factors and the provision of support for the doctors:

1. Volume of work in the scope of practice (over 12 consecutive months);
    a. Clinicians performing volumes closer to the 40 session advisory are likely to be at lower risk of raising safety of quality issues.
2. Spread of clinical work (i.e. breaks);

    a. Clinicians performing low volume work consistently over a 12 month period are likely to present lower risks than those taking significant complete breaks within year.
3. Previous experience;
    a. Clinicians with long pre-existing experience are likely to present lower risk then those with little accumulated prior experience.
4. Overlap in relevant experience from a different role;
    a. Doctors performing significant roles outside general practice but demonstrating parallel skill and knowledge requirements (e.g. A&E work, general clinical assistant roles etc.) are unlikely to present risk.
5. Duration of period of low volume work to date and in the future;
    a. GPs in their first year or two of low volume work are at lower risk of deskilling and therefore likely to be of lower overall risk.
6. Nature of main GP role clinical work;
    a. Whether performing general undifferentiated GP work or more differentiated roles.
7. Integration and benchmarking and access to support;
    a. Doctors that have ready access to educational and mentoring support and to local benchmarking parameters (e.g. referral comparisons, prescribing benchmarks etc.) are likely to be of lower risk.
8. Approach to own clinical risk management;
    a. GPs that demonstrate an awareness of the potential risks of low volume work and mitigate these are likely to be lower risk.
9. Continued Personal Development (CPD)
    a. Doctors constructing a Professional Development Plan (PDP) that specifically addresses some of the above concerns or have a broader ranging PDP consistent with their scope of work are likely to be lower risk.

A doctor should only consider the benefit for their continued inclusion on the Performers List once they have considered these and any other pertinent factors for themselves. The discussion in the appraisal should help support the doctor to put in place mitigating interventions to help them achieve their goal of continued safe clinical practice. These mitigating interventions should be agreed with the appraiser and form part of the doctor's PDP.

Role of the Doctor

Any doctor, consistent with their professionalism, who has performed fewer than 40 sessions in the 12 months prior to their appraisal should reflect on their continued safety using the nine factors as set out above and detailed in appendix A. Those reflections should be entered in a SRT (appendix B) which should be submitted as a QIA. The doctor should engage during their appraisal in a discussion regarding sufficient volumes to maintain their clinical skills.

All stakeholders are keen to promote the appraisal system as a supportive and formative process that should aid all doctors in the planning of their professional development. To this end doctors are encouraged to discuss openly their professional aspirations and to incorporate the resultant reflections in their PDP.

Role of the Appraiser

The appraiser should engage in a discussion with the doctor during their appraisal and help them to reflect on their safety. This discussion should help to define PDP objectives that could mitigate against skill erosion. The completion of a formative reflective discussion relating to work volume should be recorded by the appraiser without necessarily including specific details of the nature of that discussion. If, following the reflective discussion, the appraiser has significant remaining concerns about the safety of the doctor to continue to practice then they should seek the advice of a senior or lead appraiser or their RO.

Role of the Senior or lead Appraiser

If an appraiser seeks advice in relation to the parameters that may be defined as safe in relation to a specific doctor then a senior or lead appraiser may help to standardise appraiser responses through a process of moderated benchmarking to bring consistency to the process. The senior or lead appraiser may:

1. Provide reassurance to the appraiser on the basis of the details presented, thereby allowing the appraiser to complete the appropriate appraisal outputs.
2. If sufficient prima facie evidence exists to suggest a lack of appropriate reflection or insight on behalf of the doctor then the senior or lead appraiser may suggest referral of the doctor to the RO for a supportive interview.

Role of the RO in respect of appraisal

Following the raising of concerns by an appraiser which a senior or lead appraiser has not been able to address through moderated benchmarking, the RO must consider further assessment. ROs are keen to provide a supportive framework for professionals to allow them to consider the impact of low working volumes and how they might ensure appropriate professional development. The RO also has a responsibility to ensure that doctors on the Performers' List are safe to practice, and in assessing this they may wish to take account of:

1. The doctor's insight.
2. Their engagement in the appraisal process.
3. Relationship to a professional body setting standards for the scope of their clinical practice.

To make a full assessment of these issues they may wish to arrange a supportive discussion with the doctor. This process should also include the opportunity for the doctor to have a representative of the Local Medical Committee (LMC) (or other appropriate support) in attendance. The LMC representative should provide professional support to the doctor, including appropriate reminders of their professional obligations.

The supportive interview may result in a number of end dispositions, with professional input from the LMC, to which the doctor would be invited to commit:

1. An agreement that the material and reflection submitted is acceptable and that the agreed appraisal PDP is sufficient to ensure ongoing safety. Under

such circumstances and where low volume work continues then further low volume SRTs would be required in subsequent appraisal years in which low volume work continues;
2. Facilitating access to support (Health Education England (HEE), NHS England, chambers, clinical networks, mentorship etc.);
3. Signposting to RCGP and learning peer support schemes;
4. Consideration of specific schemes, for example retained doctor and career plus initiatives;
5. Withdrawal from the Medical Performers List with the consideration of options for future re-entry including the refresher scheme by the portfolio route.

Any of these options may be linked to ongoing mentoring and review as appropriate. Such agreed review should be clearly set out in the conclusions of the discussion. The doctor may wish to utilise his medical appraisal discussion and the insight of a peer to support his career planning, seeking the advice and support of their RO as appropriate.

Role of the RO in respect of general low volume enquiry outside of appraisal

Doctors reducing their commitment can access advice about the implications to low volume work at any point in the appraisal year by contacting their RO who may then offer advice either in person or via a senior or lead appraiser to allow the doctor to put in place mitigating arrangements from the earliest opportunity should they wish. This process forms part of the supportive RO framework designed to help doctors.



Appendix A: Factors for consideration during the structured discussion about low volume work to inform the judgement of the doctor and their RO

Overlap between GP role and other substantive roles

Maintenance of skills and knowledge is expected to be facilitated if there is significant overlap between the GP role and the other substantive non-GP roles.

Lower risk – unlikely to need any mitigation/safeguards	**Moderate risk – likely to need some appropriate mitigation/safeguards**	**Higher risk**
Significant overlap between GP work and the other substantive role(s), e.g. elderly care, A&E, or GP abroad in developed world.	Moderate overlap (e.g. MSK, sexual health, dermatology) OR **non clinical** but related to the primary role e.g. education, commissioning, public health, GP research, NHS England management, LMC, medicolegal work, benefits tribunals, clinical author.	Minimal or no overlap in the other role, e.g. caring for dependents, specialised research, voluntary work unrelated to health service, work in arts, media, sports or politics.

Scope of practice

Loss of a skill set due to restricted practice has implications for future decisions about scope of practice. A separate factor used to mitigate against this is included ("individual approach to risk management").

Lower risk – unlikely to need any mitigation/safeguards	**Moderate risk – likely to need some appropriate mitigation/safeguards**	**Higher risk**
Undifferentiated /broad, e.g. acute and chronic disease, visiting, palliative care, contraception etc.	Most of different types of activity are included, e.g. for GP: Walk in centre work (no chronic disease).	Restricted such that moving to an unrestricted role would cause concerns (GP: OOH work only).

Duration of work

Skills are likely to be eroded the longer the duration of low volume work. Again this can be mitigated by other factors described here (overlap, CPD, benchmarking etc.).

Lower risk – unlikely to need any mitigation/safeguards	**Moderate risk – likely to need some appropriate mitigation/safeguards**	**Higher risk**
Less than 2 years	Short term (2-5 years) but with probability of extending	Long term Significant commitment to another role in the long term.

Integration, benchmarking and peer support

An important part of maintenance of skills is the formal and informal comparison of the doctor's actions and outcomes against those of his or her peers. Such comparisons are often referred to as benchmarking and can occur both through much formalised reporting routes (e.g. standardised referral and prescribing data) but also importantly through peer discussion. The latter is particularly important for areas which are a) less amenable to measurement and b) where there is lack of evidence based clinical practice and therefore "Bolam's law" may be a more significant contextual guide. Doctors working few sessions are more at risk of missing out on both formal and informal forms of benchmarking and therefore proactive efforts may be required to mitigate this. This is exacerbated where they move around and are not integrated into a clinical team but can be mitigated by integration into other non-work based professional networks such as colleges, learning groups and so on and pro-active involvement in work based meetings even when not a permanent member of the team.

Lower risk – unlikely to need any mitigation/safeguards	**Moderate risk – likely to need some appropriate mitigation/safeguards**	**Higher risk**
Formal benchmarking of routine practice by inclusion in regular (team workplace meetings). Individual benchmarking data to inform QIAs. Readily accessible on site prompt access to peer advice and support.	Workplace contact with peers is more sporadic. Ready informal access to peers for advice and support or stable peer network (may be electronic or virtual) outside work (CPD group). Receives minutes of missed meetings and circulars e.g. from CCG.	Infrequent/rare and/or unpredictable inclusion in workplace based meetings. Contact with the organisation only for complaints/SEAs. Disconnected from usual cascades. Usually working in isolation. No on site peer contact.

Personal Approach to Risk management

Risk must be managed at both organisational and personal level. The doctor can take a number of actions to mitigate the risk arising from their low volume, restricted practice work which include requesting adequate induction, personal logins (for audit trail and medical records), inclusion in information cascades, access to intranet guidance for the organisation, inviting feedback, ensuring they are aware of SEA reporting systems and that they report SEAs and participate in any investigation processes for SEAs linked to their own practice and also ensuring that their contracts for services when working independently allow them to remain within their scope of competence.

Lower risk – unlikely to need any mitigation/safeguards	**Moderate risk – likely to need some appropriate mitigation/safeguards**	**Higher risk**
The doctor is fully inducted with all workplace protocols and systems (e.g. SEAS, accessing emergency equipment and drugs). Doctor places themselves in situations where they never expected to work beyond their usual scope of practice (relevant to narrowed scope-7). Undertakes not to do unrestricted work following a period of narrowed scope of practice without an appropriate refresher scheme.	The doctor moves between different work environments frequently (e.g. locum). The doctor requests adequate induction information or all new work situations. There are not clear mechanisms for feedback between the doctor and the organisation and vice versa. May occasionally be in a position where they have to cover roles which are beyond their normal scope.	Frequent moves with inadequate efforts to ensure familiarisation with protocols and systems. No clear mechanism for ensuring the doctor is not expected to work outside their usual narrowed scope of practice.

Approach to CPD

Low volume clinical work may result in many more conditions being an unfamiliar experience for the doctor than would be the case for a full time doctor. A range of strategies may be employed by the doctor to manage the inevitable shift in decision making from the more intuitive (commonly experienced) to the slower more demanding analytical (type 2) decision making. These strategies may include more forms of externalised memory (accessibility of resources), and alternative ways to maintain exposure to the breadth of clinical practice topics outside of clinical practice itself (which can be theoretical via CPD) or vicarious via peer discussion face to face or through social medical discussion forums.

Lower risk – unlikely to need any mitigation/safeguards	**Moderate risk – likely to need some appropriate mitigation/safeguards**	**Higher risk**
Remains broad. Attempts to mitigate for low volume/	Clinical CPD reduced in amount (replaced with CPD	Reduced Clinical CPD not mitigated by vicarious

Narrowed scope by indirect exposure/vicarious learning, peer contact.	for secondary roles) but sufficient in breadth to support GP role in low volume because reduced clinical exposure is partially mitigated by increased vicarious exposure to cases via learning groups or social media (e.g. Tiko's) and active efforts to pursue PUNS/DENS.	exposure. Relies primarily on immediate peer advice/supervision without clear mechanisms or confidence in ability to source authoritative answers to clinical queries.

Experience

There is a perception that newly qualified GPs are still consolidating their clinical and decision making skills and that their lack of experience places them at higher risk of unsafe practice when working at low volumes. The counterargument is that in the absence of established pattern of working and thinking they do most of their clinical work using the type 2 analytical process which is less prone to cognitive errors than the more experienced GPs who may preferentially use intuitive or type 1 decision making and therefore be more prone to cognitive biases.

Lower risk – unlikely to need any mitigation/safeguards	**Moderate risk – likely to need some appropriate mitigation/safeguards**	**Higher risk**
Significant experience (>5 years since CCT working at least 50% or equivalent)	Post CCT experience of 2-5 years at 50% or equivalent	Less than 2 years working post CCT at 50% or equivalent

Appendix B: Structured reflective template for doctors undertaking a low volume of NHS GP clinical work

The aim of the tool is to allow you to demonstrate with confidence to your appraiser and responsible officer that you are safe, up to date and fit to practise at what you do particularly if you have an unusual or restricted scope of practice, or do a low volume of a particular scope of work. The tool highlights areas of risk and areas of mitigation for those risks. You may wish to refer to NHSE guidance (to be drafted).

	Factors affecting the perception of potential risk to patients for each scope of practice	**Appraisee comments/narrative**
Volume	How many sessions of clinical work have you done over the last 12 consecutive months of clinical practice. Exclude any significant breaks like maternity or sick leave.	
Spread	Is your clinical work evenly spread throughout the year or do you regularly have significant breaks (e.g. > 6 weeks)? Please describe your arrangements.	
Experience	How long have you been working as a qualified GP?	
Overlap with other roles	Please describe any non-GP roles you currently have and to what extent they overlap with your GP role (Offer experience which helps maintain your GP clinical skills)? Please indicate whether they include clinical work and if so what kind.	
Duration of low volume work	How long have you been working at the current volume of work and what are your plans to continue to work at this volume for work.	
Scope of practice	Nature of main GP role clinical work: Do you carry out the full scope of general practice work or is your GP role in any way restricted? (For example only OOH work, only walk in centre work, no visiting etc.). The full scope of general practice would include acute and chronic cases, palliative care, chronic disease	

	management, visiting, contraception, etc.	
Benchmarking, integration and support	Are you able to compare your own practice with that of your peers? For example: Do you receive organisationally generated data on your activity which compares you to your peers? Do you meet regularly with your peers to discuss your work? Do you have easy access to support and advice from your peers (either through work or through networks outside work e.g. learning groups, etc.)?	
Personal approach to risk	How do you limit the impact of your professional working arrangements on clinical risk to your patients? For example: If you work a restricted scope of practice what arrangements do you have in place to stay within the boundaries of your competence? If you move around what actions to you take to ensure you have access to adequate induction and systems information? How do you ensure you are informed promptly of complaints and SEAs and how to you report these to the organisations you work in?	
CPD	CPD – please describe how your approach to CPD helps to ensure you are up to date. Does your CPD give you an ongoing exposure to the breadth of your potential caseload such as to mitigate any reduction in experience? Do you access any vicarious clinical exposure through learning groups or social media discussion forums? Do you rely predominantly on advice from peers on site or are you able to confidently access up to date,	

	authoritative factual information about clinical issues most of the time?	
Actions	Going forward what actions do you feel may be necessary to ensure you retain your competencies across your scope of work and support your development?	

To be complete after the appraisal discussion

Appraisers comments	
Actions agreed by doctor in appraisal	
Comments/Recommendations by Appraisal lead or Responsible Officer	