



Royal College of  
General Practitioners

ACADEMY OF  
MEDICAL ROYAL  
COLLEGES



UNIVERSITY OF  
BIRMINGHAM



Swansea University  
Prifysgol Abertawe

## RCGP Secure Environments Revalidation Pilot: England

October 2011

### Project team:

Professor Rodger Charlton  
Project Lead  
[r.c.charlton@swansea.ac.uk](mailto:r.c.charlton@swansea.ac.uk)

Professor Jill Thistlethwaite  
Project Senior Researcher  
[j.thistlethwaite@uq.edu.au](mailto:j.thistlethwaite@uq.edu.au)

Dr Elizabeth England  
Project Senior Researcher  
[e.j.england@bham.ac.uk](mailto:e.j.england@bham.ac.uk)

Jane Coomber  
Project Research Assistant  
[j.p.coomber@warwick.ac.uk](mailto:j.p.coomber@warwick.ac.uk)

## Contents

1.	Executive summary .....	4
2.	Background.....	7
3.	Aim and objectives .....	9
4.	Methods .....	10
4.1.	Participants .....	10
4.2.	Data collection .....	10
4.3.	Quality assurance .....	12
4.4.	Data analysis .....	12
4.5.	Ethical considerations .....	12
5.	Results .....	13
5.1.1	GP participants .....	13
5.1.2	Initial GP interviews .....	13
5.1.3	GPs' portfolios of supporting information .....	21
5.1.4	GP follow-up interviews.....	23
5.2.	GP appraisers' interpretation of GPs' supporting information .....	26
5.2.1	GP appraiser participants .....	26
5.2.2	GP appraiser interpretation of GP supporting information .....	26
5.2.3	GP appraiser interpretation of GP supporting information session discussion summary .....	26
5.2.4	GP appraiser follow-up interviews .....	27
5.3.	Acting responsible officers (RO) .....	31
5.3.1	Acting RO participants .....	31
5.3.2	Acting RO interpretation of GP supporting information .....	31
5.3.3	Acting RO interpretation of GP supporting information session discussion summary .....	31
5.3.4	Acting RO follow-up interviews .....	33
5.3.5	Quality assurance .....	35
6.	Discussion .....	36
7.	Recommendations .....	40
8.	Conclusion .....	41
9.	References .....	42
10.	Appendices	
	Appendix 1 Four domains and 12 attributes of the GMC GMP .....	44
	Appendix 2 Pilot snapshot of the commissioning, delivery and GPs' working patterns in English secure environments .....	45

Appendix 4	Follow-up GP focus group topic guide .....	47
Appendix 5	GP supporting information feedback form .....	48
Appendix 6	Follow-up GP appraiser focus group topic guide .....	50
Appendix 7	Follow-up RO focus group topic guide .....	51
Appendix 6	Pilot ethical approval letter .....	52
Appendix 3	GP issues log .....	53

## **1. Executive summary**

### **Background**

Revalidation is the process through which it is proposed UK doctors will demonstrate to the General Medical Council (GMC), government and public that they are up to date and fit to practise from late 2012 onwards. The Royal College of General Practitioners (RCGP), on behalf of the GMC, is charged with proposing the criteria and standards of revalidation for general practitioners (GPs)<sup>1</sup>. The College has commissioned a series of pilots, running concurrently with the NHS Revalidation Support Team Pathfinder Pilots, to investigate if their revalidation proposals are fair, accessible and achievable for all GPs in whatever capacity they are employed in the UK. The RCGP identified GPs working in custodial settings as requiring further investigation to explore the feasibility of their revalidation proposals for this group of practitioners.

### **Aim**

To learn about the issues facing GPs who work predominantly (i.e. at least 50% of their total work role) or in an extended practice role within secure environments, and the feasibility of their re-licensing using the RCGP revalidation proposals.

### **Methods**

- GPs working in English secure environments submitted items of supporting information collected over the past 12 months in a pilot portfolio guided by criteria and standards as detailed in the RCGP Revalidation Guide.<sup>1</sup>
- Initial GP focus groups, follow-up individual interviews and GP reflective issues logs were used to obtain GPs' views on the feasibility of collecting the proposed revalidation supporting information and associated logistics.
- Community and secure environment experienced GP appraisers and acting responsible officers (ROs) interpreted the GPs' specialist supporting information for proposed medical appraisal and revalidation.
- Use of interpretation of individual GP evidence feedback forms and focus group and interviews for GP appraiser and acting RO feedback.

### **Findings**

- Thirty-five out of 50 pilot GP participants who work in secure environments participated in an initial interview.
- These GPs believed that the patient feedback survey and clinical audit would be the most difficult items of supporting information to collect in a custodial environment.
- GPs were concerned that incarcerated patients with low levels of English skills in typically high population turnover custodial institutions will not provide patient feedback that will compare favorably with those of indigenous community patients who have choice and continuity of GP services.
- Sourcing data for clinical audits was perceived to be difficult due to a lack of access to up-to-date read coded patient data for this high turnover patient population group

and the variety of patient data storage arrangements (paper/electronic data housed with a variety of health professionals) within a significant number of these establishments.

- Evidence was considered to be more difficult to gather in immigration removal centres and custody suites that experienced less patient continuity and access to patient medical records.
- Current general organisational support for GPs was reported to vary between the individual secure settings with implications for revalidation.
- Fifteen GPs who practised predominantly in secure environments and five community GPs who worked in an extended practice role in this setting submitted items of information with variable ease for the four generic categories of supporting information.
- Individual patient feedback was only obtained by the prison GPs. However, the successful patient feedback surveys were predominantly doctor administered and carried out in routine clinics.
- GP patient feedback was positive except for a few occasions which appeared to be linked to patients not having their treatment wants (as opposed to treatment needs) met.
- Administrative support and a short and simple questionnaire would facilitate the patient feedback data collection process.
- Alternatives to patient feedback surveys could be peer review of a random selection of patient consultations, patient follow-up questionnaires and evidence of patients' views from internal and external agency reports that identify individual doctor practice.
- Clinical audits were reported to be extremely time consuming to generate, and success was influenced by various factors within the individual custodial institution.
- Small, meaningful practice-based clinical audits (as opposed to population based audits) may be more appropriate for GPs in secure settings.
- The organisational support required for medical appraisal and revalidation includes: guidance for GPs on the supporting information required and appropriate sources of data in custodial environments; accessible sources of data; appropriate data collection and storage tools; staff support to collect information; and protected time to collect this information.
- The community and secure environment experienced pilot appraisers and acting ROs reported they were able to interpret the GPs' supporting information for medical appraisal and make a revalidation recommendation respectively, within the context of the individual secure environment practitioner's setting.
- The appraisers suggested that secure environment GPs would benefit from undertaking medical appraisal with a GP appraiser who had knowledge of the barriers and facilitators of collecting supporting information in a custodial setting.
- Issues that were raised in the pilot that may require further discussion are: the re-licensing of GPs who solely practise in secure settings; the constituents of the extended role statement; and the appropriateness of collecting the majority of supporting information in one practitioner role for portfolio GPs.

## Recommendations

1. To incorporate the following into the commissioner's health care providers' contract to assist secure environment GPs to collect supporting information for medical appraisal and revalidation:
  - a. To promote accessible sources of data (e.g. electronic read coded patient medical data for clinical audits, individual doctor feedback on complaints).
  - b. To promote appropriate data collection tools (e.g. short and simple patient feedback questionnaire translated into several languages).
  - c. To provide staff support to collect information (e.g. administration of patient questionnaires, perhaps assistance to draw off audit data).
  - d. To recommend GP supporting information templates for medical appraisal and revalidation.
  - e. To promote awareness of the time element involved with GPs collecting their supporting information.
  - f. To promote awareness of the benefit to GPs working full-time in secure environments to undertake a weekly community general practice session to maintain the core generalist practitioner skills necessary for GP re-licensing.
2. To ensure GPs have access to a clinician within their specialty to provide support and mini-appraisals.
3. To ensure secure environment GPs can gain support from, and undertake annual appraisals with appraisers who have an appropriate level of insight into the secure environment context, and the challenges associated with collecting supporting information within custodial institutions.
4. To encourage secure environment GP appraisers to share their knowledge of this specialty with other appraisers who may undertake medical appraisal with practitioners working in custodial settings.
5. To encourage GPs working in secure environments to become GP appraisers and ROs themselves to enhance the cadre of supporters available for GPs working in this setting.
6. To clarify the type and amount of supporting information needed for GPs with multiple work roles, including secure environments, within a portfolio career.

## 2. Background

Revalidation is the process through which UK doctors will demonstrate to the GMC, government and public that they are up to date and fit to practise from late 2012 onwards. The RCGP, on behalf of the GMC, is responsible for proposing the standards and methods for the revalidation of general practitioners (GPs) guided by the four domains and 12 attributes of the GMC *Good Medical Practice* (Appendix 1).<sup>2</sup> The RCGP proposals require approval by the GMC.

The RCGP has recommended that the revalidation process for GPs should build on appraisal with GPs presenting supporting information of patient-centred clinical practice and areas of extended practice at annual medical appraisal, which will then be submitted as part of a five-yearly cycle revalidation ePortfolio (table 1). This evidence will be supplemented with evidence from annual appraisals and other local sources including clinical governance data. It will be the responsibility of the GP to collect their supporting information and reflect on this evidence as well as information from other local sources.

It is proposed that the GP appraiser role and annual appraisal will expand from its current formative approach to include a summative revalidation element. These appraisers will be asked to check if the quantity of the GP's supporting information is appropriate for that point in the revalidation cycle and, as far as the appraiser can assess, is of appropriate quality for revalidation alongside other locally sourced information.

The GP's supporting evidence from the five 'medical appraisals' will then be forwarded in a five-yearly cycle to a responsible officer (RO), who will be a 'senior doctor with personal responsibility for evaluating the conduct and performance of doctors and making recommendations on their fitness to practise as part of revalidation'. The RCGP will be available to offer advice and support to the RO throughout the five years on the interpretation of the specialist standards for general practice. In cases where revalidation cannot be recommended by the RO the case will be considered further by the GMC. Only

Table 1 - Overview of the supporting information under four generic headings that the RCGP proposes a GP submits in a five-yearly revalidation portfolio

Generic Heading	Supporting Information
General information	Personal details Scope of practice including extended practice Contextual details Participation in annual appraisal, PDP and review of PDP Statement of probity and health
Keeping up to date	Learning Credits
Review of Practice	Significant event audits including any serious incidents Clinical auditing
Feedback on practice	Colleague survey Patient survey Review of complaints Compliments

after the exercising of the GMC's Fitness to Practise processes will a doctor's ability to practise be placed at risk. The RCGP will have a role in the quality assurance of the assessment process.<sup>13</sup>

The RCGP must ensure that their revalidation proposals meet the medical appraisal and revalidation needs of GPs in whatever capacity they are employed in the UK. One group of doctors considered by the College to require further investigation to ensure there is fair access to medical appraisal/revalidation is GPs working in the non-traditional GP community setting of secure environments.

A secure environment is an institution in which people on remand, sentenced, or awaiting deportation are detained. In England, secure environments currently include 129 prisons,<sup>4</sup> secure hospitals (high and medium facilities),<sup>5</sup> 12 immigration removal centres<sup>6</sup> and custody suites in each of the 39 police forces.<sup>7</sup> The prison population is approximately 85 000 (95% of whom are males)<sup>8</sup> and the secure hospital population around 4 000.<sup>9</sup> Detainee health care is commissioned by the NHS for prisons and secure hospitals and the Home Office for the immigration removal centres and police. GPs are employed as sessional doctors on a mixture of long and short term contracts by a variety of NHS and independent health care service providers (Appendix 2). GPs are employed as forensic physicians (formerly police surgeons) in custody suites. A significant proportion of secure environment GPs work concurrently in NHS and non-NHS organisations.

The group of patients they care for possesses significantly higher levels of physical and psychiatric morbidity than that of the population as a whole and can exhibit challenging behavior.<sup>10</sup> Many doctors in secure environments have specialist areas of interest (e.g. substance abuse). The Department of Health recommends that GPs who work full-time in prisons undertake a weekly session in community practice to reduce the isolation of working in a secure setting and break down the barriers between health care within this specialty and the community.<sup>11</sup>

RCGP revalidation pilots exploring the feasibility of community sessional GPs to gather the RCGP proposed supporting information identified that this process was more difficult for these doctors if they lacked engagement and support from practices and primary care trusts (PCTs).<sup>12 13</sup>

As sessional GPs contracted by a variety of NHS and non-NHS health care providers to deliver health care in custodial host institutions and engaging in a specialised form of general practice, these doctors may experience challenges in trying to meet the RCGP's revalidation criteria and standards.

**The main purposes of this project** were to explore: the feasibility of GPs working in secure environments in England to collect supporting information under the criteria and standards proposed by the RCGP for a revalidation portfolio; and the ability of GP appraisers, ROs and RCGP quality assurers to interpret the GPs' evidence for the proposed revalidation process. In addition, the impact of the RCGP proposals on organisational systems and processes was explored.



### 3. Aim and objectives

Aim - To learn about the issues facing GPs who work predominantly (i.e. at least 50% of their total work role) or in an extended practice role within secure environments, and the feasibility of their re-licensing using the RCGP revalidation proposals.

#### Objectives

1. To test the feasibility of collecting supporting information and identify any training needs for GPs who work in secure environments and who would revalidate against the RCGP specialist standards.
2. To examine the ability of appraisers to interpret portfolios of GPs working in secure environments and to identify any appraiser training needs.
3. To identify any needs that ROs might have in terms of interpreting the contents of a 'secure environments' GP revalidation portfolio and making a fair and consistent decision.
4. To identify any needs that the RCGP might have in terms of interpreting a 'secure environments' portfolio as part of its proposed quality assurance process.
5. To identify any organisational demands which may result from RCGP revalidation proposals.
6. To consider the need for and feasibility of the development of alternative methods of collecting supporting information.
7. To examine possible methods of working with GPs who are experiencing difficulties in the appraisal process and consider suitable processes of remediation to support them.

## 4. Methods

Qualitative research methods with reference to frequency data were utilized to meet the pilot's objectives.

### 4.1 Participants

- GPs who predominantly worked (50% or more of their workload) in prisons, secure hospitals, immigration removal centres and custody suites and who would revalidate against GP specialist standards in England. A sub cohort of GPs with extended practice in secure settings was included.

GPs were recruited from email cascades through the RCGP secure environment group, the Offender Health Research Network and clinical leads of non-NHS organisations (e.g. West Midlands police, GP locum agencies) and attendance of project researchers at regional GP offender meetings between September 2010 and July 2011.

- **GP Appraisers**

Three GP West Midlands appraisers, one of whom had experience of secure settings, were invited and agreed to participate in the pilot.

- **Acting responsible officers**

Two senior GPs, one with secure environment experience and another with community GP experience, agreed to participate in the pilot.

### 4.2 Data collection

#### 4.2.1 GP participants

##### *(i) Initial GP focus groups*

GPs who agreed to participate in the pilot were invited to participate in either an audio recorded focus group or individual face-to-face interviews in their locality or by telephone using a topic guide. Data, collected until saturation was reached, was used to identify:

- GPs' perceptions of revalidation and the current RCGP revalidation proposals.
- Current appraisal arrangements in secure environment settings.
- Potential barriers for these GPs collecting the RCGP proposed evidence for medical appraisal and revalidation.
- If appropriate, suggestions for the development of alternative methods of supporting information collection.

##### *(ii) GPs' portfolios of supporting information*

In addition, these GPs were asked if they were willing to confidentially submit items of supporting information to the research team that they had collated over the past 12 months

(i.e. during the four month project data collection period and over the previous eight months) as guided by the current RCGP revalidation proposals.

As the pilot data collection period was relatively short, the participants were encouraged to prioritise the collection of the following types of evidence: colleague survey (multi-source feedback)<sup>14</sup> and patient feedback using the GMC draft questionnaires,<sup>15</sup> significant event audits and clinical audits.

The participants received oral and written guidance on how to collect their supporting information and had access by email and telephone to members of the research team for the duration of the pilot.

### *(iii) GP issues log*

These doctors were asked to fill in an issues log (Appendix 3) whilst they were submitting their supporting information to explore:

- The ease with which they were able to collate the individual items of supporting information over the past 12 months.
- Processes that could help them to collate the proposed revalidation evidence.
- GP work-related demographic information.

### *(iv) Follow-up GP face to face or telephone interviews*

Doctors who had submitted items of supporting evidence to the research team were invited to take part in either a follow-up face to face semi-structured or telephone interview using a topic guide (Appendix 4) to gain an in-depth view of:

- GPs' experience of collecting the supporting information according to the criteria and standards of RCGP revalidation proposals.
- Barriers and facilitators of this data collection exercise.

## **4.2.2 Pilot GP appraisers**

The GP appraisers participated in a one day session comprising:

- A short GP appraiser pilot role training and opportunity to ask questions, led by the pilot researchers.
- Completing a feedback form for each pilot GP's evidence commenting on the ease with which they rated the individual supporting information (responses 1 = very easy 4 = not at all easy) for the purposes of medical appraisal and revalidation (Appendix 5).
- A member of the research team recorded medical and revalidation related issues raised by the GP appraisers during this session from field notes.
- Follow-up focus group or face to face interview to gain an in-depth view on perceptions of the appraiser's role in RCGP revalidation proposals, their experience of interpreting the GPs' supporting information and views on organisation resources and GP appraiser training needed for medical appraisal/revalidation using a topic guide (Appendix 6).

### **4.2.3 Pilot acting ROs**

The acting ROs participated in a session that followed the GP appraiser interpretation session format with the ROs looking at only a selection of the GPs' supporting information to identify if they were able to interpret this information to assist them to make a fair, consistent and informed revalidation recommendation (follow-up focus group topic guide Appendix 7).

### **4.3 Quality assurance process**

Quality assurance is the systematic monitoring and evaluation of the various aspects of a project, to maximise the probability that minimum standards of quality are being attained by the process. Within the context of a study, a quality assurance process aims to enhance the studies validity. A sample of appraisers' rating of the doctors' portfolios and RO recommendations was assessed by the pilot team for quality assurance purposes and identification of any needs the RCGP might have in terms of interpreting a 'secure environment' portfolio as part of its proposed quality assurance process.

### **4.4 Data analysis**

Quantitative data: Excel software was used to calculate the data frequencies.

Qualitative data: The focus group and individual interviews were transcribed verbatim and then analysed by two researchers using Atlas software (v5.0) to develop themes. Verbatim telephone interview notes were typed up by the interviewer as soon as possible after the interview.

### **4.5 Ethical considerations**

Ethical approval was obtained from the Warwick Medical School Biomedical Ethics Committee (BREC) (Appendix 9). The participants participated voluntarily and informed consent was obtained.

Written consent was obtained from the pilot GPs, GP appraisers and acting ROs.

## 5. Results

### 5.1.1 GP Participants

There were 64 GPs initially interested in participating in this pilot; of these, 50 consented to participate in the project. Two GPs withdrew in the initial stage of the pilot as they left secure environment employment.

#### *GP demographics*

- Two-thirds of the participants were predominantly employed in secure environments (70%, n = 35/50). They were employed in prisons, including two GPs who specialised in substance abuse (64%, n = 32/50), secure hospitals (2%, n = 1) and as forensic physicians (4%, n = 2). This included 2 GP locums.
- The remaining participants comprised community GPs (30%, n = 15) employed in extended practice role in prisons (n = 11), secure hospitals (n = 2) and in immigration removal centres (n = 1) and as a forensic physician (n = 1).
- They were predominantly male (82% n = 41/50) and had received their primary medical qualification in the UK (86%, n = 31/36). The median length of years since first GMC qualification was 19 (range 6 - 37 years).
- The GPs undertook one or more medical roles (ie extended practice), with a minority (17%, n = 8) having equally waited time commitments in two or three roles.

### 5.1.2 Initial GP interviews

Thirty-eight GPs (76%) participated in the following interviews:

- 24 GPs participated in 5 focus groups (n = 2, n = 9, n = 3, n = 8, n = 2).
- 4 semi-structured interviews.\*
- 14 telephone interviews.\*

\*4 GPs participated in a telephone and a focus group interview.

#### *GP demographics of interviewees*

- Seventy-one per cent of the participants were predominantly employed in secure environments (n = 27/38). They were employed in prisons, including two GPs who specialised in substance abuse (63%, n = 24/38), secure hospitals (3%, n = 1) and as forensic physicians (5%, n = 2). This included 2 GP locums.
- The remaining doctors were community GPs (29%, n = 11) employed in an extended practice role in prisons (n = 7), secure hospitals (n = 2) and in immigration removal centres (n = 1) and as a forensic physician (n = 1).
- They were predominantly male (79% n = 30/38) and had received their primary medical qualification in the UK (88%, n = 28/32). The median length of years since first GMC qualification was 19 (range 6 -37 years) with a median of 4.5 years experience of working in secure settings (ranging from under 1 year – 27 years).
- Nearly one-fifth of GPs were clinically employed only in secure environments (18%, n = 8).
- Just over one-third had two or more extended practice roles (37%, n = 14).

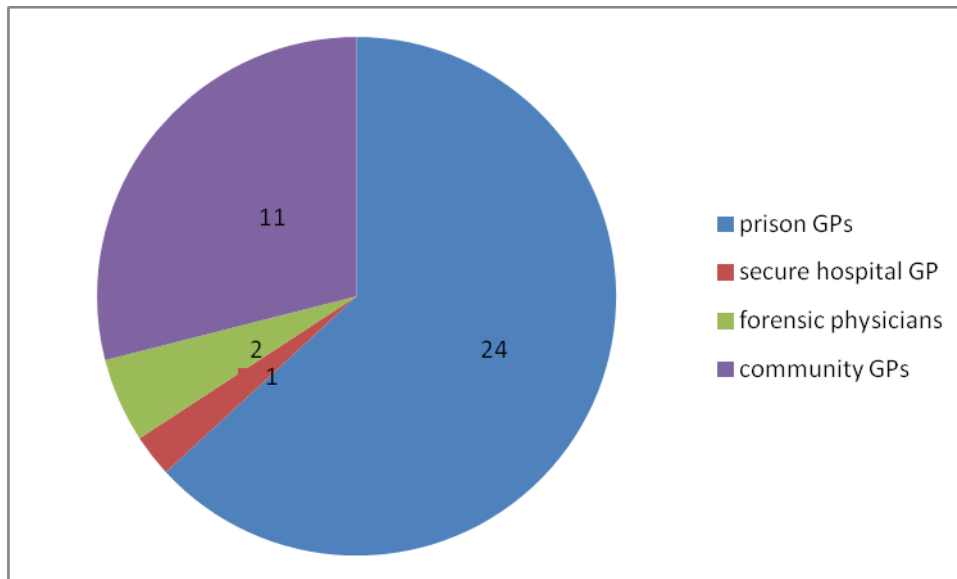


Figure 1 Initial GP interviewees by secure environment medical role (n = 38)

After analysis their views fell into four main areas/themes:

- General opinions about revalidation.
- Secure environment appraisals.
- Individual GP supporting information.
- Ability to change clinical practice.

### (i) General opinions about revalidation

The GPs considered that, in principle, revalidation was a good idea as it would encourage them to keep up to date as practitioners and reassure the public of their fitness to practise. However, they believed it could become a time consuming and onerous tick box exercise that may not improve GPs' practice or stop another Shipman. They felt that their practice already received considerable scrutiny from external agencies.

It's just something else taking up my time, and there's lots of time in compiling all the stuff that you need to do, to tick the boxes to do your appraisal. (9)

Above average performing doctors will be OK. Low performing doctors will spend bit of time fudging together evidence rather than addressing the issues. (26)

If we really didn't have any respect for some of these processes, we could get round them, very, very easily. (41)

...in a sector where we have no shortage of external agencies that we have to prove ourselves to...which is very questionable as to what benefits actually derive from those processes... (41)

It was considered relatively easy for newly qualified GPs to become engaged with the revalidation process, whereas GPs nearing retirement age might seriously contemplate leaving the profession.

...certainly when I was a registrar and you're putting all the evidence together and reflecting and things.... (13)

Young GPs will be able to sail through it and the elderly doctors would leave. (20)

Some of the GPs were concerned about their ability to 'fit' the proposed GP revalidation model which they saw as an easier process for community GPs to engage with.

People like myself do not fit into a neat box. (8)

While GP partners and many GPs who work sessionally within partnerships, because they've got support mechanisms inherent in the practice, and the practice having to produce things, they engage with appraisal and by extension, I guess, it's going to swing over to revalidation relatively quickly. (20)

## **(ii) Secure environment appraisals**

The pilot doctors participated in GP annual appraisals. However, they reiterated the concerns about who would appraise for revalidation, though currently there are also problems with appraisers knowing about the secure environment work.

Before any appraisal first, I invite them into the prison. They don't all come in, its only happened once, and that was useful for the appraiser to understand it. But other appraisers don't come in. (12)

When you are doing forensic work, you have to be appraised by somebody in that professional sphere who understands what your role is and be able to appraise you appropriately, so I don't understand how they are going to use general GPs to appraise prison GPs. (27)

But for those doctors who considered the self-improvement role of appraisal, the issue of who appraises is not that relevant. There was an element of realism surrounding availability of GP appraisers with this specialty knowledge and the need to use community general practice as a benchmark.

It's a process that you go through and it's about self-reflection so you need someone who's good at enabling you to self reflect. (41)

It would be nice to have somebody who is more familiar with it and all that, but I think, I'm not sure how practical that would be to get somebody in secure settings because they might not be as trained at being an appraiser, I guess. (13)

An outside look is quite valuable, benchmark against the community. (8)

However, many GPs were concerned about negative interpretation of their revalidation supporting information by non secure environment appraisers and ROs regarding patient feedback surveys and complaints.

I didn't give them medication that they wanted... now that is so common, you know, that's our daily bread and butter, and you know that they're then going to say, 'Poor' and I think that's why GP's worry about doing these questionnaires, because I don't know, maybe I'm wrong, but in the community, I never got a poor and no one ever said 'Poor', whereas in this environment they're never backwards in coming forwards

to say 'You're poor' and they [GPs] worry that they are going to be compared. (8)

Moreover, GPs who worked exclusively in secure settings and had little or no recent experience in community general practice were very concerned that they would not be able to be appraised and remain on the PCT performer's list. GPs without a community GP session in their employment contract did GP community practice in their own time to ensure they maintained their core GP skills.

It's a lady doctor and she, her appraiser has insisted that she do a session which she is having to do with her current job. That the appraiser has said, that in order to be appraised as a GP, she has to do this extra work so she is having to do it in her spare time.... (41)

As a full time doctor who works within prisons I still do not have this [community general practice session] as part of my contract and currently this fundamental part of my skill set is being neglected. This will obviously ultimately cause problems (arguably unfairly) with my revalidation. I am aware of one doctor who works within prisons who has already been informed that he should expect a referral to the RO if he does not get some GP experience. (12)

GPs reported feeling professionally isolated from their medical colleagues. Organisational support and communication was stronger for some groups of GPs than others, which was not related to type of custodial setting.

There's usually only one doctor at any time in the prison. (6)

I've receive nothing at all from the PCT, to invite me to any meetings, I am not on any communication feed... It is very isolated... (29)

### **(iii) Individual GP supporting information**

#### **Patient satisfaction survey**

The GPs were more anxious about producing this item of supporting information than any other for revalidation. As practitioners working with an incarcerated client group with higher rates of psychiatric and physical illness and lower levels of English literacy than the population as a whole, they questioned the validity of this evidence.

My concerns are, I mean, one is the actual client group you're dealing with [prison population], are not overly responsive to giving feedback whether negative or positive, they don't tend, I mean you're dealing with a group of people who probably a lot of them are illiterate, a lot of them have learning difficulties, mental health problems, foreign nationals, so usually they would only give feedback in a negative way... (34)

Some [secure hospital patients] might be having a bad day (35)

Most [custody suite detainees] are able to do it and others could be sent sheet later but not remember [having] been in custody. (48)

Poor feedback could occur due to lack of patient continuity through high turnover and patient needs as opposed to demands being met.



If you're talking about [name of immigration removal centre], anywhere between ten or 15, I think our peak was 23 new receptions a night, and some of these will be out, catching the plane eight to 12 hours after they are bought in. (6)

There's a rapid turnover in some of these prisons, especially the remand and local prisons, is so high that you sort of change the whole prison population within 10 weeks. (6)

Not appropriate as [forensic physician] clients traumatized ... no time to build up relationship with clients. (2)

If you certainly give them a survey like this and ask how was the doctor, polite or and so on, they would say 'No, he was absolutely awful because I wanted my Tramadol and he didn't give it to me'. (6)

There was a lack of assistance from the other teams of contracted staff in custodial settings to administer the questionnaires, which necessitated the doctors to administer their own questionnaires that could reduce the objectivity of the process.

I was thinking cynically though, then being targeted at, would have plenty of scope for intercepting the negative ones and putting forward the good ones. (41)

GPs' suggestions for more representative feedback included:

- paying someone to administer the survey, perhaps a patient champion.
- administering higher numbers of questionnaires to reduce patient outliers.
- design a shorter (national) questionnaire with easy to understand questions perhaps using smile faces.
- translate questionnaire into various languages.
- do not ask patient gender (prisons are single sex establishments) for secure environment.
- auditing of a GP's patient medical notes.
- direct clinical observation.
- compare survey results with peers as well as GPs generally.
- use information from internal and external organisations that monitor secure environments.

## **Clinical audits**

GPs were also concerned about producing clinical audits for a revalidation portfolio as they perceive custodial organisations are not essentially set up to collate clinical audit information with IT facilities varying from institution to institution. The population is dynamic with data difficult to source for new patients and the electronic data of relocating prisoners may not be read coded.

Yes, when they come in... you have to get consent from the patient to contact the GP and then wait awhile.... (13)

It's quite tricky because we have just changed our [IT prison record] system to System One...people are not read coding things, it's hard to get information and I've got about 1000 patients... and at the moment we don't do any prescribing, so none of the medication, you can't search by medication. (13)

With multi-providers in custodial environments, GPs tend to search for information themselves but sometimes have to ask other professionals to source patient data.

I know when the audit I've been doing, one of the doctors that's in a regular GP's practice when I was sat doing some of it, was amazed at how much I was doing that he would just have, he would have delegated to a member of his practice team to go and do for him, but I was just taken for granted (10).

Normally you would just do a search yourself and come up with all these people, yeah, but you're going to ask other [staff] to do that. (13)

Some forensic physicians commented that they were obliged to handover their hand written patient medical notes to their employers at the end of the week. One forensic physician suggested auditing the doctor's notes against in-house protocols as an alternative to an electronic audit.

The inability to remove data from the environment for security reasons and the sessional working pattern of these medical practitioners meant these practitioners had to source the information in their own time. However, access to audit data could be more difficult for GP locums in custodial environment.

I need to get information back to home, which I can't take. (10)

Well, I'm contracted to do two sessions a week, those two sessions are full... then you come out of your [morning] clinic and you have to go to your 12.00 pm meeting... (24)

If you're locum... well, even if you're doing regular sessions, when you're asked the opportunity to do an audit, it's hard on them to give you the prison clearance, give you the time, give you an office, give you a computer. (28)

### **Colleague survey feedback**

GPs working in prisons and secure hospitals said they have a variety of colleagues who could fill in the MSF from the other health provider groups, but forensic physicians stated they may have difficulty acquiring this information as they were relatively isolated practitioners.

Yes, well, we've got lots of nurses.. a few of those, yes, with the mental health team and drugs team...optician, x-ray, everybody, so that's fine. (13)

You are lone workers... police personnel different each time. (2)

Online MSFs might not be applicable in custodial settings as access to the internet varies between institutions.

### **Complaints**

GPs working in prisons receive more complaints than their counterparts in the community.

If you took my 15 years as a GP in the community, compared with my six years as a GP in a prison, in 15 years, I've probably had a couple and they didn't go anywhere,

whereas I've done six years as a, I've probably had a dozen or more in the six years here probably. (34)

They will complain at the drop of a hat. (24)

I think in prison, yes, a lot of people do complain about things generally, so there is a set system and it does seem to work... (13)

How complaints are processed also varies between organisations.

Complaints are looked at by the organisation, and put together thematically and fed back to them. (29)

If we get a complaint from either a police officer, from a patient or whoever makes the complaint, a solicitor, that something wasn't done properly or the doctor had a poor attitude.... it gets categorized as a complaint....sent to the doctor ..concerned to answer... (34)

### **Learning credits**

GPs working in secure hospitals reported they have sufficient CPD opportunities. Forensic physicians suggested there was a dearth of material for them to engage with while prison GPs would like more online material and access to ethical and security based learning programmes. GPs reported feeling isolated in their workplace even though they made strenuous efforts to keep in touch with both community and secure environment communities; they would appreciate some support and national leadership for their specialty practice.

It is very difficult to know about local events/meetings if you work mainly in prison as you do not get invitations for local events or you cannot attend them if you work in different locations. I have to fall back mainly on national events/meetings which involves a lot of money and time. I miss an organisation which would offer affordable meetings for prison GPs and which would also provide updates in other areas. This would give prison GPs also the chance to meet peers.

### **Extended practice**

Although GPs' PDP and learning credits demonstrated they were up to date and fit to practise in their extended role it was not always clear to the GPs who would sign the proposed extended practice statement and whether that individual should be a clinician.

I would have to make a further attempt to contact an appropriate person. I suppose there must be a senior consultant...or someone on the panel... (24)

Moreover, if the GP's workload was more or less equally weighted commitment and time-wise, they wondered whether it was right that GPs produced the majority of evidence for one role and only a statement for the other half of their job.

That would certainly be my question, so who would sign that and on what basis and after what sort of assessment, because it seems rather bizarre to say, say for arguments sake, you've got a three day two day split, for your three days you might have to do all this and for your two days, someone just comes along and signs it 'Oh

yes, he seems alright' and signs a form... because you could then go through your whole life working quite a large chunk of your life in a secure environment and not have to produce any formal evidence at all, which seems rather peculiar. (8)

Many GPs were already participating in mini appraisals in secondary clinical areas in which they spent a significant proportion of their workload. However, mini appraisals for specialist practice in the commercial sector might be problematic.

We would seek a mini appraisal of our own with a peer who is working in that particular sector. Now the problem is, it's quite a competitive sector...and for us to find somebody actually we aren't in competition with, can be a bit of a struggle. (41)

#### **(iv) Ability to change practice**

The ability to make direct changes in clinical practice following reflection of their supporting information varied between institutions. Some GPs said they were able to change medical organisational clinical practice relatively easily, but for others it was more difficult, and support to implement change was dependent on engagement with others within the organisation.

...if we change any protocols within the prison, with the work that we do.....you have to have them approved by the prison governors and everything. It takes ages to get anything through because... of the legal consequences... you can be legally challenged very easily... (7)

You have different providers providing different services and you can't influence all of them. I mean, I am lucky at the moment, we, in one of the prisons we have a very co-operative health care manger and she also is also very interested in developing the service and we are now starting to move things around a little bit. (6)

### 5.1.3 GPs' portfolios of supporting information

Twenty GPs submitted a pilot portfolio. Known reasons for GP non submission of supporting evidence included short length of pilot data collection period and commercial and personal sensitivity of their evidence.

#### (i) GP demographics

- Two-thirds of the participants were predominantly employed in secure environments (75%, n = 15/20). The majority of these were prison GPs, including two GPs who specialised in substance abuse (65%, n = 13/20). One prison GP had an extended practice role as a forensic physician. The remaining two GPs worked in a secure hospital (5%) and as a forensic physician (5%). This included 1 GP locum.
- The other five participants were community GPs (25%, n = 5/20), three employed in prisons, one in a secure hospital and one as a forensic physician in an extended practice role.
- These doctors were predominantly male (65% n = 13/20) and had received their primary medical qualification in the UK (80%, n = 16/20). The median length of years since first GMC qualification was 20 years (range 6 - 37 years) with a median of 3 years experience of working in secure settings (ranging from under 1 year – 27 years).
- One-fifth of GPs were clinically employed only in secure environments (n = 4).
- Nearly half of GPs had two or more extended practice roles (45%, n = 9).

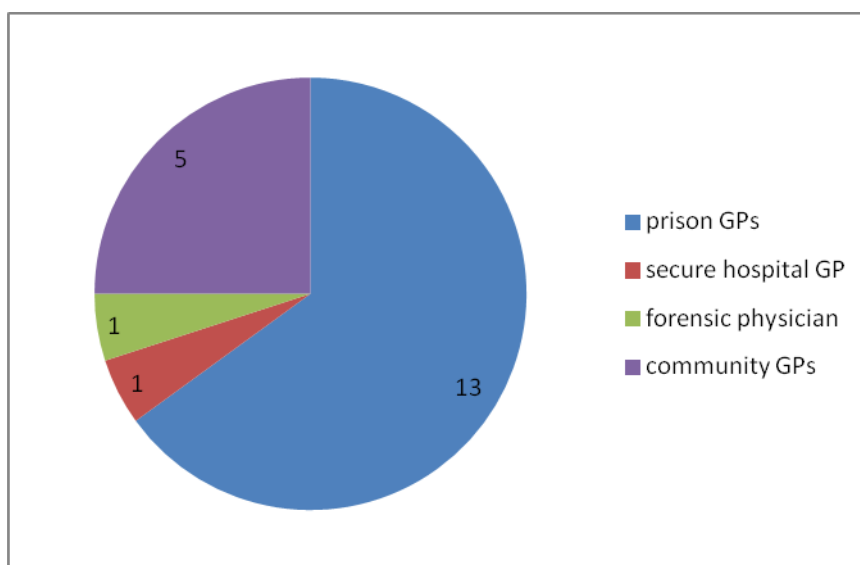


Figure 2 GPs who submitted supporting information by secure environment medical role (n = 20)

#### (ii) Items of supporting information submitted in GP portfolios

The GPs submitted between one item of supporting information and one year's worth of supporting information to the research team. Altogether between all the participants, predominantly prison GPs, they collected evidence for the four generic evidence categories. Fifty per cent of the GPs submitted evidence for five out of the 11 types of supporting information. Around one-third (35%, n = 7) of the GPs produced evidence of colleague and patient feedback and one-quarter produced clinical audits (figure 3).

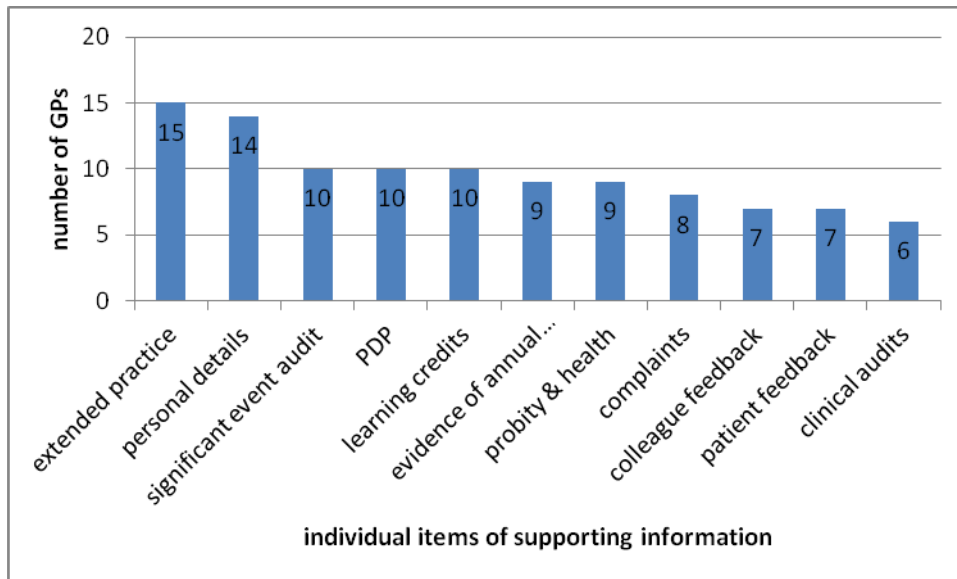


Figure 3 Evidence submitted in GP portfolios by individual item of supporting information

(iii) Ease with which GPs had collected items of supporting information over the past 12 months

Seventy percent of GPs self-reported it was 'very easy' or 'fairly easy' to collect evidence for a statement of probity and health, a learning credits log, PDP and colleague feedback. They stated it was most difficult to provide evidence for complaints, significant event audits and a patient feedback survey.

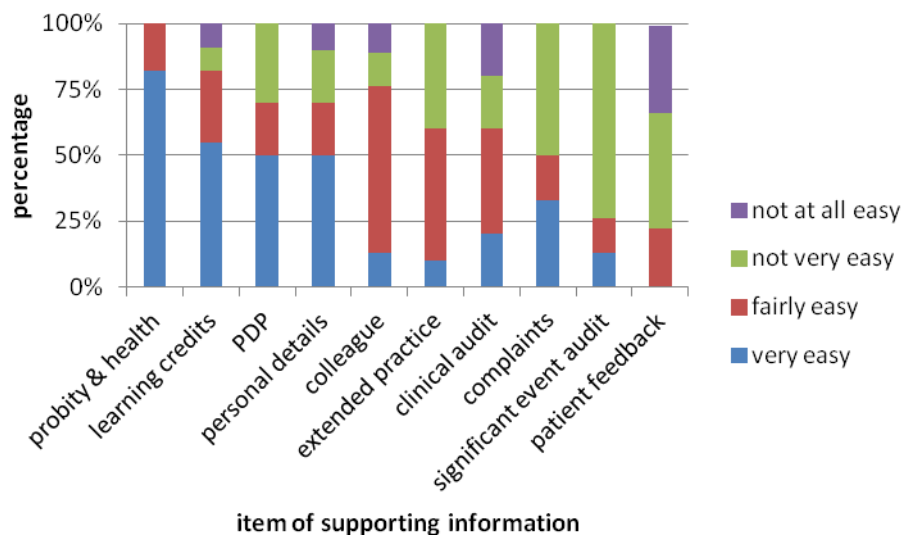


Figure 3 Ease with which GPs collected items of supporting information over the past 12 months (n = 14)

Although the GP locum submitted 10 out of the 11 items of supporting information (no clinical audit), s/he found it 'not very easy' to collate this data. The doctor would have appreciated organisational assistance with sourcing an appropriate ePortfolio, colleague and patient questionnaires and guidance with significant event analysis, clinical audits and feedback on complaints.

#### **5.1.4 GP follow-up interviews**

Nine GPs participated in a face to face (n = 4) or telephone interview (n = 5). The remaining GPs forwarded their comments on the pilot's issues log (n = 17) or via email to the research team.

##### **(i) Time**

The GPs felt that collecting the proposed revalidation supporting information was time consuming, beginning with understanding the type of information they were expected to produce and then sourcing and completing the appropriate templates; time they would rather spend with the patient.

I find all this very time consuming, and I think this time should be counted as personal development time because I have to do this, and I am spending time on thinking how to count the credits, how to write reflections, how to record an impact (there are a few types of impact according to guidelines), what is significant event, what is whole audit cycle, how to find proper templates and how to fill in them and all this other things. This is so much paper work and I have to learn how to do this properly. I really would prefer to spend this time on clinical activities and clinical learning. (3)

##### **(ii) Individual supporting information**

###### **Patient feedback survey**

Five GPs (25%) successfully carried out a patient survey. These surveys were mostly carried out in routine clinics. However, the majority of these participants administered the questionnaires themselves as clinic staff were not always available to assist them, although they appreciated this produced a self-selected sample.

Oh no, I wouldn't do it for that [reception clinic], but this was just in our routine, routine GP clinics. (8)

No one was available to give it out and collect when they finished it, which I appreciate is the more honest recommended way of doing it. (9)

They found that a significant percentage of patients were unable to understand the questionnaire and response rates could be low.

Over a third needed help filling in the form because they can't read or understand it... so they can either read a bit, seeing a form like that... it's just scary... I think how you get round it, is that someone actually has to sit there and do it with them (8).

Sluggish return of questionnaires... (6)

They suggested that a significant number of patients in foreign national prisons and immigration removal centres might not understand a patient feedback questionnaire in the English language. In 40 consecutive consultations, one GP noted:

Fifteen out of 40 prisoners in this foreign national prison would not have the English language skills to complete the survey. These 15 people spoke ten different languages. (5)

There was little time after the consultation to administer these questionnaires and it was preferable they were completed under the observation of staff.

Not helped by prison staff who were keen to get inmates back to the wing and out of Healthcare, so did not allow them time to complete the forms. (24)

If they take the paper back to their cells, are they going to use that bit of paper for other things than writing on? I'd absolutely have to have agreement or not off the prisoner governors for that sort of thing. (7)

Patient feedback was good except for a few cases where the GPs thought maybe the patients' treatment and general wants were not met.

You see the two negative [feedback], I didn't give them the medication that they wanted... (8)

Sometimes with a lot of ranting, complaints and items not related to my work but to the healthcare system in the prison. (6)

The GPs felt quite strongly that all patients, both in their main role and extended roles, should have the opportunity to complete a patient questionnaire in an accessible format. Several GPs suggested a short and simple national validated patient questionnaire should specifically be developed for secure environments.

### **Clinical audit**

The six GPs that submitted a clinical audit appeared to have access to electronic medical records and maybe focused on a relatively stable prison population. Most GPs currently carry out audits in their own time, undertaking data collection at the prison in hope that a prison shutdown does not occur.

Yes, easy access to records because they're all computerized... I literally went into the records of 120 people...it was time consuming, to do a really valuable audit... I mean...you can actually do very quick and easy audits that are valuable. (8)

But I had to do it within the prison, I had to do it really in my own time, I have to go and do it at a time separate from my clinic. The only limitations would be if there was some problem within the prison, they shut, you know, you could not move around. (7)

### **Colleague feedback.**

A mix of clinical and non-clinical staff completed the GPs' colleague feedback surveys in prisons, one secure hospital and one custody suite. However, response rates could be quite poor.

I only got six responses... I probably sent out about 15 or 20. (8)



## **Extended practice role**

The GPs were able to demonstrate they were up to date and fit to practise in their extended practice roles through their PDP and learning credits log entries, but not one participant produced a competence statement. Some employment agencies produce negative /or and organisational GP feedback to their out of hours (OOH) GPs, but not individual doctor feedback.

I am also a salaried GP in out of hours services and as a quality requirement for that service they undertake patient satisfaction surveys and they do it monthly. I have been asking for many years to have this information collated in a doctor specific way so that it would assist appraisal. It still does not happen and this is a separate service. It seems to be a problem of salaried GPs working in orphan services generally. (12)

There was not always a clinician to provide a statement of competence. Clarity is needed by the GPs as to whether the statement for an extended role has to be produced by medical clinician for a clinical extended role or the GP can be signed-off by a non-medical practitioner.

## **5.2 GP appraisers – interpretation of GPs’ portfolio supporting information**

### **5.2.1 GP appraiser participants**

Three community GPs – two with community general practice experience in a mixed urban/rural PCT and one with community and secure environment general practice experience in an inner city PCT - interpreted the contents of the 20 pilot GPs’ portfolios for the purpose of medical appraisal and revalidation. Their experience as GP appraisers ranged from 18 months to eight years.

### **5.2.2 GP appraiser interpretation of GP supporting information session**

At the beginning of the one day session, a short training session was led by the pilot lead and research assistant and comprised a recap on the pilot’s aims and objectives and the pilot GP appraiser’s role, explanation of the GP feedback form and response to the community GPs’ request for a brief description of secure environments in England. Each GP portfolio was looked at by at least one appraiser with 16 portfolios double rated. The appraisers completed a feedback form for each GP’s portfolio they rated. On these forms, they were asked to assess if there was evidence of an item of supporting information collected in a secure environment; if the response was ‘yes’, they were then asked to rate how easy it was to interpret for revalidation. Analysis of the completed feedback forms revealed that the three appraisers rated the GPs’ supporting information as ‘very easy’ or ‘fairly easy’ to interpret for the purposes for medical appraisal and revalidation, except for a ‘not very easy’ for extended practice evidence on three occasions.

### **5.2.3 GP appraiser interpretation of GP supporting information session discussion summary**

#### *(i) Secure environment specific*

- GPs who work in prisons need to be aware of the characteristics of this custodial patient group and have knowledge of appropriate clinical treatments (i.e. appropriate prescribing habits.) This cannot be learned entirely through CPD/studying.
- GPs who work in secure settings predominantly care for males with substance abuse problems. However, GPs require a broad health care knowledge of women and children as well to stay on performer’s list. The Department of Health recommends GPs hold at least one surgery per week in a community practice.

#### *(ii) Multiple roles*

- Working in custodial environments is extremely challenging, so GPs may limit their number of weekly sessions in a particular secure setting clinical role. These GPs, therefore, tend to have multiple practice roles, which require revalidation evidence for each role.
- GP with special interest (GPwSI) status have accreditation for their specialised clinical role. This provides evidence to GP appraisers that the GP is up-to-date and

fit to practice in this speciality area of practice. GPs working in secure environments do not have this status, therefore would benefit from an appraisal in their secure environment to provide evidence they are fit to practice in that clinical area.

- GP appraisers provide evidence that a GP is fit to practise in extended GP practice role.
- The legality of GPs who don't 'fit anywhere' revalidation-wise due to their multiple roles needs further investigation. Perhaps a special GP appraiser for GPs with multiple clinical/non-clinical roles is needed.
- Patient feedback:
  - validity of patient feedback may be questioned in a secure setting
  - may be influenced by patients' wants as opposed to needs being met (ie medical and non-medical).
  - GP locums and salaried GPs could experience difficulties collecting this information.

*(iii) General comments on revalidation*

- Need a revalidation toolkit that encourages GPs to document all relevant supporting information to provide contextual background/details for RO who looks at portfolio but might not personally know the individual GP.
- Time is required to complete this supporting information. GPs, especially jobbing GPs, have busy workloads, lots of paperwork and may be too tired at end of long working day to produce revalidation material. Scanners can facilitate collation of evidence for this process.
- Concerns were expressed that the introduction of revalidation might encourage GPs nearing retirement age to leave the profession to the detriment of the profession and patients.
- More experienced GPs rely on their wealth of experience as much as learning.

#### **5.2.4 GP appraiser follow-up interviews**

One community appraiser and the secure environment experienced appraiser participated in an end of session focus group of 45 minutes duration and the second community appraiser participated in a semi-structured interview of 30 minutes duration post session.

Analysis grouped the comments into the following 8 themes:

- General thoughts on medical appraisal.
- Interpretation of GP supporting information.
- Constraints for GPs collecting supporting information in secure environments.
- Interpreting GPs' evidence within the context of the secure environment.
- Clarification of GP evidence needed for extended practice.
- Maintaining GP core skills.
- Community versus sub-specialty GP appraisers.
- GP remediation.

### **(i) General thoughts on medical appraisal**

Although the appraisers accept revalidation is good in principle they were not so sure that all GPs were ready and willing to engage in this process which is quite rigorous and time consuming and may encourage those nearing retirement to leave the profession.

Currently being a GP appraiser and seeing people's appraisal folders prior to the appraisal interview, very few of the GP's really have collected the necessary amount of information that you might quantify as adequate for an appraisal, and I think it's not because of a lack of enthusiasm, I think it's purely a lack of time. It's yet another task that GP's will have to incorporate into their already very busy day. (1)

The doctors coming towards the end of their career will say, 'I've had enough.' (2)

### **(ii) Interpretation of GP supporting information**

The appraisers did not find interpreting the GPs' supporting information for revalidation difficult except maybe for complaints.

I don't think I have any difficulty interpreting the secure environment evidence... I feel that revalidation is pretty much at the moment, certainly a tick box exercise, or the proposals, so if you've got evidence of multi source feedback, if you've got evidence of patient satisfaction, if you've got evidence of audit, evidence of significant events, why do I need to have specialist knowledge of them working in a secure environment? Either you've got the satisfaction scores or you haven't. I am capable of reading other peoples stuff and understanding and interpreting and making a valued judgment on it. (2)

I think that was the one area that I did find difficult to interpret, not having any background in secure environments, because I can see that there is a huge potential for what you might call frivolous complaints in a secure environment. So when I read, I can't remember which one it was now, but there was one complaint, where I thought, this sounds almost as though it's been made up, you know, for a sort of semi political purpose or something. (2)

### **(iii) Constraints for GPs collecting supporting information in secure environments**

The GP appraiser with secure environment experience highlighted the difficulties GPs working in secure environments might encounter collecting supporting information and that they differed between secure environments.

...if you work in that environment there definitely are lots of constraining factors that make it that much more difficult to obtain that data... there are specific issues relating to things in secure environments that perhaps you don't come across otherwise, to do with obtaining data. You know, even simple things, not having computerised records to be able to produce prescribing information... when you are trying to do an audit, you aren't allowed to take any data off the premises.... I think it's more an issue with being able to produce the data. (3)

I think there are a lot of logistical issues and it will be different for each secure environment. (1)

They considered these practitioners might require some creative thinking to produce their supporting information.

Yes, you have to be a bit more creative. (3)

#### **(iv) Interpreting GPs' evidence within the context of the secure environment**

They were mindful of the need to interpret the GPs' supporting information within the context of the secure environment, particularly patient feedback surveys and complaints.

...the meaningfulness of that evidence might be different and a good example would be this patient satisfaction questionnaire, the PSQ. Because, and this is something that I've learned, GPs who see patients in a secure environment, those patients may make demands on the GP, such as wanting substances, opiates, whatever, and the GP might say, 'Well, that's not appropriate', and therefore, that patient will not have that high level of satisfaction or not rate highly that GP so, the actual collecting of evidence, there's a lot of similarities, there's a lot of overlap, but the meaningfulness of that evidence and therefore the appropriateness of aspects of the process, would be different. (1)

...maybe you would attract a lot of complaints than somebody like myself [a community GP] and it might [appear] superficially worse, even though, actually you're not... (2)

#### **(v) Clarification of GP evidence needed for extended practice**

The appraisers were concerned that GPs working in secure environment had to produce supporting information to illustrate the quality of their practice in secure environments and general practice, the amount of which had not yet been clarified.

I think the difficulty will come in people producing, if they've got multiple roles, producing sufficient evidence to meet all the roles. (2)

#### **(vi) Maintaining GP core skills**

However, their main concern was whether, given the specialist nature of some areas of secure environments, the doctors still possessed general practice skills.

... is it appropriate for GP appraisers to appraise prison doctors? In the sense of, if their role, if they don't have these generalist skills of a GP, we can still understand their work, but should they remain on the performers list? Do they have a sufficient general experience to remain on the performer's list because if they ever stopped working in a prison, and decided to go back to general practice, would they be OK as a GP? That's the main dilemma which seems to come out of what we've talked about today. (2)

#### **(vii) Community versus sub-specialty GP appraisers**

One of the community GPs suggested that they might be more confident in their role of appraising GPs from this specialty, perhaps through discussion with a GP appraiser with

experience in this field or participating in a joint appraisal with the specialist practitioner and community appraiser.

From my limited knowledge of secure environment's, I think the working day is so fundamentally different to a GP working in a non secure environment in community environment, that it will be truthfully difficult for a GP appraiser to very objectively appraise that data, that evidence. And a GP who themselves works in a secure environment, I think will be better informed to make judgments, if there are judgments required to be made on the quality of the reflection, I think that GP would working in a secure environment as an appraiser would be in a much better position to do it. (1)

**(viii) GP remediation**

The GPs appraisers were unaware of the revalidation GP remediation process.

Well, nobody's said what remediation is, nobody has said who will do it, nobody has said who will fund it, nobody has said at what level are you expected to undertake it, whether you work while you're doing it, there is a total dearth of information about remediation... (2)

### **5.3 Acting responsible officers – interpretation of GPs’ portfolio supporting Information**

#### **5.3.1 Acting responsible officer participants**

Two senior GPs - one a very experienced PCT lead appraiser and one very experienced in working within secure environments, interpreted the contents of a selection of pilot GP portfolios.

#### **5.3.2 Acting responsible officer interpretation of GP supporting information**

The two acting ROs interpreted the GPs’ portfolios in individual sessions. At the beginning of the session, a recap of the pilot’s aims and objectives, the pilot RO’s role and explanation of the GP feedback form was given by a senior researcher or the research assistant. The first RO selected six of the 20 GP portfolios at random to interpret their contents for medical appraisal and revalidation; the second RO interpreted the same portfolios for quality assurance purposes. The appraisers completed a feedback form for each GP’s portfolio they rated. On these forms, they were asked to assess if there was evidence of an item of supporting information collected in a secure environment; if the response was ‘yes’, they were then asked to rate how easy it was to interpret for revalidation. Analysis of the completed feedback forms revealed that the two ROs rated the GPs’ supporting information as ‘very easy’ or ‘fairly easy’ to interpret for the purposes for medical appraisal and revalidation, except for a handful of ‘not very easy’ and ‘not at all easy’ responses.

#### **5.3.3 Acting RO interpretation of GP supporting information session discussion summary**

##### *(i) Local as opposed to standardised national revalidation system*

- Revalidation is to be managed at a local level, with organisations creating their own methods of data collection and retrieval
- Colleague and patient feedback questionnaires do not have to be GMC approved.

##### *(ii) GP extended practice role*

- Evidence for extended role provided in GP’s PDPs, learning credits and a statement.
- GP appraisers provide evidence that a GP is fit to practise in extended GP role. The primary care trust (PCT) can provide a statement for GPwSIs’ extended roles.
- Forensic physicians require skills different to those practiced in traditional general practice work and therefore GPs working in this field will require sign-off/ appraisal in this area.
- GPs’ evidence should reflect all areas of their practice (e.g. if a GP practices predominantly in a secure environment and works two sessions per week in OOH, their supporting evidence should reflect practice in both roles over five years).

*(iii) Same sub-specialty GP appraisers*

- The non-secure environment acting RO supported GPs working in non-traditional practice becoming GP appraisers - secure environment GPs, salaried GPs, locum GPs - so any potential differences in medical appraisal and revalidation can be acknowledged and addressed.
- The non-secure environment acting RO suggested that community GP appraisers could become aware of the barriers and facilitators for GPs working in secure environments to collating supporting information through discussion of these issues with secure environment GP appraisers prior to undertaking medical appraisals with these specialty GPs.
- The secure environment acting RO suggested the establishment of a national network of secure environment experienced GP appraisers and ROs to revalidate GPs working in custodial settings.

*(iv) Performer's list*

- GPs are required to be registered on a PCT performer's list to practise in NHS commissioned services.
- Concerns were expressed by the acting ROs that GPs who practise solely in secure environments might have insufficient evidence to convince their GP appraiser that they possess sufficient generalist core skills to remain on a performer's list.
- The secure environment acting RO put forward a suggestion that GPs whose practice is solely in secure settings could apply for a restricted license to work within their specific secure environment only.

*(v) General*

- GPs are responsible for collecting their own supporting information.
- GP appraisers can give guidance to GPs regarding the type and quality of evidence they are expected to produce for medical appraisal and revalidation.
- Difficulties potentially experienced by GPs working in secure settings regarding revalidation may be similar to those experienced by single-handed GPs.



### **5.3.4 Acting RO follow-up interviews**

These appraisers each participated in an end of session semi-structured face-to-face interview of between 20 - 40 minutes duration.

Their views were captured in four main areas/themes:

- Interpretation of GP supporting information.
- Community versus sub-specialty GP appraisers.
- Extended practice statement.
- GP remediation.

#### **(i) Interpretation of GP supporting information**

The acting responsible officers were both able to interpret the GPs' supporting information. Even though the GPs worked in a different environment from community practice, the information produced was similar to general practice.

I think it's fairly understandable in the terms of the types of data that was provided; it was not dissimilar to what you would get from general practice. So for example, significant event analysis, complaint management, learning logs, PDPs. There's no, it's not different even though the working environment is certainly different, that has its restrictions. There is still a lot of stuff that you can still take out of that environment that is very similar to general practice. (1)

The community RO viewed the GPs' supporting information as one component of medical appraisal, but more important was the interaction between the appraisee and GP appraiser at the appraisal meeting.

Tell me now, when you have reflected on it, what changes has it brought about? I think that is the difficulty with just looking at the documentation without being in an appraisal situation. It's not the documentation that reflects everything necessarily. It's the conversation that's held... you can get an understanding what lies behind the piece of paper. (1)

Further, this acting RO said that the written summary of the appraisal meeting along with local clinical governance knowledge was key to recommendation for re-licensing.

That summary should be giving an indication of what the essence of the conversations were, so I would have expected the appraiser to have had a good discussion say around a significant event and Form 4 saying have discussed significant event and we will go forward and do this differently in the future. (1)

#### **(ii) Community versus sub-specialty GP appraisers**

There was a difference of opinion about whether the GP appraiser and RO were required to have a direct knowledge of secure environments or an awareness of the needs of a sub-specialty GPs to effectively perform these roles and whether there would be sufficient secure environment GP appraisers to revalidate their specialist peers.

I think that we need to develop a national database of appraisers who work and know about the environment and I think we need ROs nationally who know and understand about the environment to really do this well. (2)

It would be nice if we had some appraisers coming from that [secure] environment because, again, it would support some of the other appraisers through the training sessions we hold with the appraisers to get a good understanding, so we can share their experience. It was useful to have another [peer] as they can bring a perspective that says 'Yeah, OK, we know that doesn't work. You don't do audit, but there are other ways you can look at it' and therefore reflect that as part as your role. So you've got that affinity. So it's really helpful, so I think it will be really helpful to have some of those if your cadre.... of appraisers because they would be able to support learning by the appraisers. (1)

But we will never have enough of each individual type of practitioner to be able to appraise the same people by the same people. (1)

In addition, the independence of the RO in a private organisation was questioned.

It is crucial the RO do not play any part in employing you. If you work for a private company... you RO must not be that medical director... not only do they control your registration but your pay...so those doctors have to have an independent RO out of that organisation. (2)

### **(iii) GPs who do not practice outside the secure environment**

There was discussion around the issue of re-licensing of GPs who had chosen to work solely in secure environments and a possible solution.

Doctors who only work in a secure environment and no other primary care setting, they are very anxious about how this [revalidation] process is proceeding. And some have taken a career decision, they only want to work in a psychiatric hospital... or they only want to work in a prison. They do not want to do core general practice. And we're going to think very carefully how they are licensed and relicensed in the future... they could just be licensed, relicensed as a GP to work, but in [secure] hospital only, or to work in [name of] prison only. (2)

### **(iv) Extended practice statement**

Providing a competence statement of extended practice raised issues about who should sign the statement, whether the appraisee was comfortable with the person in authority signing the form and conversely, if the person who was being asked to sign the form was comfortable with signing this statement.

I don't think it has to be a clinical lead. I don't know why it can't be the Chief Constable or custody sergeant who works with you regularly, a respected figure within the establishment who is prepared to say [GP] is an excellent FME [forensic medical examiner] and we have no concerns about his/her practice... literally a three or four line statement...say relationship to appraisee...signed and dated. (2)

You do not like the manager, you might not be getting on with them, you may be reluctant to give him the piece of [statement] paper to sign. (2)

Some [approached to complete the statement] might refuse to do, rather than write something negative about you, they might prefer not to do anything with it. (2)

## **(v) GP remediation**

GP remediation remains unclear for these acting ROs.

Remediation issues are still being debated nationally, but the way forward seems to be the intention is to have a definition of different levels of concern in the first instance. (1)

What happens around remediation; that needs to be clarified. (2)

### **5.3.5 Quality assurance**

A random selection of doctors working in secure environments' portfolios of supporting information were examined independently by an experienced GP appraisal lead (EE). Assessment and comments made by the RO without secure environment knowledge and two GP appraisers suggested were virtually identical suggesting good concordance and a similar if not identical standardised approach to evaluation of the portfolios. There was considerable variation around the responses to the four statements (the four statements were originally used in the RO pilot study for revalidation). However, this may have been due to difficulties in responding to the questions as many of the portfolios were incomplete.

There was less concordance in evaluation responses when the GP appraisal lead's evaluation of portfolios was compared to those reviewed by a 'RO' with secure environment experience. The RO in this case was not a trained appraiser, which may be why there was variation in responses. Responses varied mostly around interpretation of the quality of the evidence with the GP lead appraiser and the other appraisers being more rigorous in their evaluation. Less appraiser experience on the part of the RO with secure environment experience was possibly evident in areas such as CPD and learning credits, audit and scope of personal practice. There was no disagreement between the appraisers, ROs and lead appraiser regarding the actual submission of evidence by the doctors working in secure environments, which is encouraging.

## 6. Discussion

Revalidation is the process through which UK doctors will demonstrate to the GMC that they are up to date and fit to practise. The RCGP, on behalf of the GMC, is charged with proposing the criteria and standards of revalidation for GPs. The College has commissioned a series of pilots, running concurrently with the National Pathfinder Pilots, to investigate if their revalidation proposals are fair, accessible and achievable for all GPs in whatever capacity they are employed in the UK. The RCGP identified GPs working in custodial settings as requiring further investigation to ensure the viability of their revalidation proposals for this group of practitioners. These GPs are principally employed as sessional doctors in prisons, secure hospitals, immigration removal centres and custody suites.

The main purpose of this qualitative project was to explore the feasibility of GPs working in secure environments in England to collect supporting information under the criteria and standards proposed by the RCGP for a revalidation portfolio and the ability of GP appraisers, ROs and RCGP quality assurers to interpret the GPs' evidence for the proposed revalidation process. In addition, the impact of the RCGP proposals on organisational systems and processes was explored.

### *GP participants*

50 GPs, 35 of whom predominantly worked in secure settings and a sub-cohort of 15 community GPs who worked in an extended practice role in these settings, consented to participate in our study. Of these 50 pilot GPs, 38 participated in either an initial focus group or individual face to face interview or telephone interview. The interviewees were drawn from the study's four secure environment settings, predominantly from the prison sector. These participants were experienced both as medical practitioners (median years since first GMC qualification was 19 (range 6 - 37 years)) and as GPs within secure environments (median of 4.5 years experience of working in secure settings (ranging from under 1 year – 27 years)). They were predominantly male (79% n = 30/38) and had received their primary medical qualification in the UK (86%, n = 28/32). Nearly one-fifth of GPs were clinically employed only in secure environments (21%, n = 8) and just over one-third had two or more extended practice roles (37%, n = 14). No sampling frame of GPs working in secure environments exists, but as with all self-selected study participants, these GPs were very motivated individuals and may not be representative of their peers concerning the ability to collate good quality supporting information and enthusiasm for the revalidation process.

### *Initial GP interview feedback*

Generally speaking, the GPs agreed revalidation was good in principle but considered it was be time consuming to collate the proposed revalidation supporting information, the outcome of which may not raise the bar of practice amongst their fellow colleagues and had the potential to drive GPs nearing retirement out of the profession. Those working predominantly in secure environments, who would be required to collate their revalidation supporting information in a secure setting, expressed concerns about successful re-licensing through the collation of supporting information in an organisation whose first priority was security and undergoing medical appraisal with a GP appraiser who lacked knowledge of their specialist medical practice.

These GPs believed that the patient feedback survey and clinical audit would be the most difficult items of supporting information to collect. GPs were concerned that incarcerated patients with low levels of English skills in typically high population turnover custodial

institutions will not provide patient feedback that will compare favorably with those of indigenous community patients who have choice and continuity of GP services. Sourcing data for clinical audits was perceived to be difficult due to a lack of access to up-to-date read coded patient data for this unstable patient population and the variety of medical patient data storage arrangements (paper/electronic data housed with a variety of health professionals) within a significant number of these establishments.

#### *Submission of GP items of supporting information*

Twenty GPs submitted items of supporting information for the four generic categories. The items of supporting information that were submitted in greater numbers were those that had been collected for a previous purpose (e.g. annual appraisal, clinical governance) with less evidence for items of supporting information that were novel and required colleague collaboration and/or organisational structure. The only GP locum who submitted supporting information did not find it very easy to collate this data without organisational support. The ease with which these practitioners reported they collected their data diminished with the increase in the groups of people involved and organisational support required to produce this information. These findings corroborate those of the English and Welsh GP revalidation pilot.

The GPs felt that collecting the proposed revalidation supporting information was time consuming, beginning with understanding the type of information they were expected to produce and then sourcing and completing the appropriate templates; time they would rather spend with the patient.

A handful of GPs submitted patient questionnaires. The patient feedback was good except for a couple of instances that appeared to be directly related to patients wants as opposed to treatment needs being unmet. However, these questionnaires were doctor administered in routine prison clinics only. The number of pilot patient surveys carried out could have been higher if an independent person had been available to administrate the GPs' questionnaires and analysis the patient feedback. In the English and Welsh revalidation community GP pilot, the principle GPs' employees performed this task.<sup>12</sup> A significant proportion of the GPs' prisoners did not have the English skills to complete the questionnaire, which possibly reflected the high percentage of detainees with learning difficulties (20 – 30% of the prison population) and foreign national detainees (13% of the prison population) in England and Wales.<sup>16</sup> There is a resource issue for carrying out a patient feedback survey, but only once in five years for each GP. Facilitation of this process would be independent administration of a short and simple questionnaire, translatable into various languages as required. The results of these GPs' patient surveys should be compared with those of their peers as well as GPs in general. An alternative to identifying doctor specific information could be through routine internal and external agencies service questionnaires. Another alternative is peer review of a random selection of patient consultations.

Likewise, a handful of GPs submitted a clinical audit. The GPs that submitted a clinical audit appeared to have access to electronic medical records and maybe focused on a relatively stable prison population. Most GPs currently carry out audits in their own time, undertaking data collection at the custodial setting. Data collection appeared to be facilitated for small and/or personal practice audits on a stable patient population. An alternative to clinical audits would be to present cases of a defined nature against pre-set criteria and standards with continuous reflection and improvement recorded.

GPs reported that organisational structures existed for GPs to produce significant events and review complaints, although they stated that they found it 'not very easy' to collate

evidence for this supporting information; possibly because these processes were designed to meet organisational, not individual practitioner needs. For complaints, individual doctor feedback was not automatic in some custodial institutions; slight modification to the complaint system might resolve this issue. For revalidation, GPs would benefit from organisational assistance with sourcing appropriate colleague and patient questionnaires and an ePortfolio to store their supporting information for revalidation. The availability of electronic read coded prescribing and patient records, administration support for completing a patient survey and protected time to collate revalidation supporting information would be welcomed. In the pilot it was observed that organisational support varied (NHS and non-NHS) between providers. Medical revalidation may have a financial cost for organisations that employ GPs who predominantly work as their employees in secure environments.

Similarities in the difficulties in collating supporting information for revalidation exist between sessional GPs in secure environments and community. They are both 'visitors' in the host organisation and do not have certain access to patient data and have a lack of patient continuity. The support received from co-workers varies and is dependent on personal relationships ('good favour and charm') within the individual environment.<sup>12</sup> However, the community clients might be less challenging than custodial patients and practice is not constrained by security issues peculiar to a custodial environment. One secure environment GP commented that s/he felt isolated in the GP surgery as a salaried GP where they held their weekly community session. Similarities also exist between secure environment and single-handed GPs regarding professional isolation to discuss professional practice. The pilot GPs reduced professional isolation through networking with secure environment peers at local and regional meetings and community peers at local surgery meetings and participating in PCT activities, on top of their busy workloads. Medical student secure environment placements could also reduce professional isolation within the secure environment workplace.

GPs employed in long stay prisons and secure hospitals might find it easier to collect patient feedback and clinical audit data than GPs working in local and remand prisons, immigration removal centres and custody suites.

#### *Community versus sub-specialty GP appraisers*

Many GPs were concerned about negative interpretation of their revalidation evidence by non-secure environment appraisers and responsible officers at medical appraisal. Some of the GPs had experienced appraisal with GP appraisers who lacked knowledge of secure environments and had felt these appraisers might not be aware of the difficulties they may face collecting their revalidation supporting information. The pilot GP appraisers were able to interpret supporting information collected by the secure environment GPs within the context of a custodial setting, but the appraiser with secure environment experience highlighted the potential difficulties that a GP might encounter collecting this supporting information. The acting ROs were aware of the difficulties GPs might face collecting their supporting information, but suggested different strategies to ameliorate this situation. The community acting RO, who believed that there were insufficient same sub-specialty GP appraisers, recommended that GP appraisers with secure environment experience shared this knowledge with their colleagues to raise the awareness of the barriers and facilitators of GPs working in this specialty to collect the supporting information. Another strategy could be to encourage these GPs to be GP appraisers, which would also reduce their sense of professional isolation. The secure environment experienced acting RO suggested these specialist GPs should have access to a network of GP appraisers and ROs with knowledge and experience of secure settings.

### *GPs who worked predominantly or solely in secure environments on performer's lists*

GPs who worked exclusively in secure settings and had little or no recent experience in community general practice were very concerned that they would not be able to be appraised and remain on the PCT performer's list. This issue was also raised by the pilot GP appraisers and acting ROs and expressed as a concern. The pilot acting RO with experience in secure environments suggested that maybe these GPs could be licensed to practice in specific custodial institutions.

### *Extended practice statement and multiple work roles*

The pilot GPs were able to demonstrate their fitness to practise in extended practice through their PDP and learning credits but not one participant produced a competence statement. It was unclear to the GPs, GP appraisers and acting ROs what was an appropriate format for this statement and the status of the person who should produce this statement (ie medical or non-medical manager). Also, whether the appraisee would be comfortable with the person in authority signing the form and conversely, if the person who was being asked to sign the form was comfortable with signing this competence statement.

In an area of medical practice where the practitioners might have equal time commitments in each practice role, producing evidence in a GP's main role may not reflect their professional skills in another field of practice (eg 50/50 workload community GP and forensic physician). One pilot RO suggested that the GPs' evidence should reflect their entire practice. A mini appraisal in the GP's specialist role could provide professional support for that practitioner and a statement of extended practice for the community GP appraiser to refer to.

### *Quality assurance*

Assessment and comments made by the acting RO without secure environment knowledge and two GP Appraisers suggested were virtually identical suggesting good concordance and a similar if not identical standardised approach to evaluation of the portfolios.

### *GP remediation*

As this topic is currently being debated at a national level, there is a lack of clarity concerning GP remediation at the present time.

## Recommendations

1. To incorporate the following into the commissioner's health care providers' contract to assist secure environment GPs to collect supporting information for medical appraisal and revalidation:
  - a. To promote accessible sources of data (e.g. electronic read coded patient medical data for clinical audits, individual doctor feedback on complaints).
  - b. To promote appropriate data collection tools (e.g. short and simple patient feedback questionnaire translated into several languages).
  - c. To provide staff support to collect information (e.g. administration of patient questionnaires, perhaps assistance to draw off audit data).
  - d. To recommend GP supporting information templates for medical appraisal and revalidation.
  - e. To promote awareness of the time element involved with GPs collecting their supporting information.
  - f. To promote awareness of the benefit to GPs working full-time in secure environments to undertake a weekly community general practice session to maintain the core generalist practitioner skills necessary for GP re-licensing.
2. To ensure GPs have access to a clinician within their specialty to provide support and mini-appraisals.
3. To ensure secure environment GPs can gain support from, and undertake annual appraisals with appraisers who have an appropriate level of insight into the secure environment context, and the challenges associated with collecting supporting information within custodial institutions.
4. To encourage secure environment GP appraisers to share their knowledge of this specialty with other appraisers who may undertake medical appraisal with practitioners working in custodial settings.
5. To encourage GPs working in secure environments to become GP appraisers and ROs themselves to enhance the cadre of supporters available for GPs working in this setting.
6. To clarify the type and amount of supporting information needed for GPs with multiple work roles, including secure environments, within a portfolio career.



## 8. Conclusion

Forty of the 50 pilot GPs participated in a focus group and/or a face to face interview. Twenty of these – 15 GPs who worked predominantly in secure environments and five community GPs who worked in an extended practice role in this setting - submitted items of supporting information collected over the past 12 months guided by criteria and standards as detailed in the RCGP Revalidation Guide for the four generic evidence categories with variable ease.

These GPs expressed concern with sourcing and collating supporting information in a custodial organisation whose first priority was security. In addition, a significant proportion of these doctors were apprehensive of undergoing medical appraisal with a GP appraiser and responsible officer who may lack knowledge of their specialist medical practice for re-licensing.

These GPs believed that the patient feedback survey and clinical audit would be the most difficult items of supporting information to collect. The ease of collecting patient feedback was dependent on the stability of the client population, assistance with administration of the questionnaires and ability of the patients to understand the patient questionnaire. The ease of sourcing clinical data was dependent on the stability of the population, standard of information systems that varied between secure settings, and time outside sessions to complete this task. Time to collect their evidence was an issue for these GPs. Supporting information was considered to be easier to source in prisons and security hospitals than immigration removal centres and custody suites. Organisational support was reported to vary between the individual secure settings, with implications for revalidation.

The GPs submitted items of information with variable ease for the four generic supporting information categories. The GP locum commented that it was 'not very easy' to collate this data without organisational support. However, the successful patient feedback surveys were predominantly doctor administered, which reduced the validity of the surveys. Independent administration of questionnaires and a simple user-friendly patient questionnaire are recommended to obtain valid feedback from this challenging patient group. Alternatives to patient feedback surveys could be peer review of a random selection of patient consultations, follow-up patient questionnaires and evidence of patients' views from internal and external agency reports that identify individual doctor practice. Small and meaningful clinical audits that are practiced based as opposed to population based may be more appropriate for GPs in secure settings to undertake.

The community and secure environment experienced pilot appraisers reported they were able to interpret the GPs' supporting information for medical appraisal within the context of the practitioners' setting and ROs to make a decision for re-licensing. The appraisers suggested that secure environment GPs would benefit for undertaking medical appraisal with a GP appraiser who had knowledge of the barriers and facilitators of collecting evidence in a custodial setting. Issues that were raised in the pilot that may require further discussion are the re-licensing of GPs who solely practise in secure setting, the constituents of the extended role statement and the appropriateness of collecting the majority of evidence in one practitioner role for portfolio GPs.

## 9. References

1. RCGP. *RCGP Guide to Revalidation of General Practitioners*. Version:5.0 London: RCGP, 2011.  
Available at: [http://www.rcgp.org.uk/PDF/PDS\\_Guide\\_to\\_Revalidation\\_for\\_GPs.pdf](http://www.rcgp.org.uk/PDF/PDS_Guide_to_Revalidation_for_GPs.pdf) (accessed January 2011).
2. [http://www.gmcuk.org/GMP\\_framework\\_for\\_appraisal\\_and\\_revalidation.pdf\\_41326960.pdf](http://www.gmcuk.org/GMP_framework_for_appraisal_and_revalidation.pdf_41326960.pdf) (accessed September 2011).
3. RCGP. *RCGP Guide to Revalidation of General Practitioners*. Version:6.0.London: RCGP, 2011.  
Available at:  
[http://www.rcgp.org.uk/pdf/Guide%20to%20Revalidation%20for%20GPs\\_sixth\\_edn\\_210911.pdf](http://www.rcgp.org.uk/pdf/Guide%20to%20Revalidation%20for%20GPs_sixth_edn_210911.pdf) (accessed October 2011).
4. <http://www.justice.gov.uk/about/noms> (accessed September 2011).
5. M Rutherford. Duggan S. *Forensic Mental Health Services. Facts and figures on current provision*. London: The Sainsbury Centre for Mental health, 2007.  
Available at:  
[http://www.centreformentalhealth.org.uk/news/2007\\_secure\\_hospital\\_population\\_at\\_record\\_high.aspx](http://www.centreformentalhealth.org.uk/news/2007_secure_hospital_population_at_record_high.aspx) (accessed September 2011).
6. Home Office UK Border Agency.  
<http://www.ukba.homeoffice.gov.uk/aboutus/organisation/immigrationremovalcentres/> (accessed September 2011).
7. Home Office Statistical Bulletin. *Police Service Strength, England and Wales, 30 September 2010*. London: Home Office.  
Available at:  
<http://webarchive.nationalarchives.gov.uk/20110218135832/http://rds.homeoffice.gov.uk/rds/pdfs11/hosb0311.pdf> (accessed February 2011).
8. Ministry of Justice. *Offender management statistics quarterly bulletin January to March 2011, England and Wales*.  
Available at: <http://www.justice.gov.uk/downloads/publications/statistics-and-data/mojstats/omsq-q1-2011-bulletin.pdf> (accessed September 2011).
9. Ministry of Justice. *Statistics of mentally disordered offenders England and Wales*. December 2008.  
Available at: <http://www.justice.gov.uk/publications/docs/mentally-disordered-offenders-2008.pdf> (accessed September 2011).
10. Pearce S, Gray A, Marks L. *Training needs analysis to identify primary care skills and competences for doctors working in prisons*. Final report to Prison Health Group. London: Department of Health, 2004.

11. Department of Health. *Report of the Working Group on Doctors Working in Prisons*. London: Department of Health, 2001.  
Available at:  
[http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/documents/digitalasset/dh\\_4034220.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4034220.pdf)
12. Charlton R, Thistlethwaite, Coomber J. *RCGP revalidation pilots: England and Wales*. RCGP:London, 2010.  
Available at:  
[http://www.rcgp.org.uk/PDF/Revalidation\\_Warwick\\_Pilot\\_final\\_report\\_18\\_June\\_2010.pdf](http://www.rcgp.org.uk/PDF/Revalidation_Warwick_Pilot_final_report_18_June_2010.pdf) (accessed September 2011).
13. Jelley D, Morrow G, Kergon C, Burford B, Wright P, Illing J. *Revalidation processes for sessional GPs; A feasibility study to pilot current proposals*. London: RCGP, 2010.  
Available at:  
[http://www.rcgp.org.uk/PDF/Revalidation\\_Sessional\\_Doctors\\_Final\\_report\\_18\\_June\\_2010.pdf](http://www.rcgp.org.uk/PDF/Revalidation_Sessional_Doctors_Final_report_18_June_2010.pdf) (accessed September 2010).
14. [http://www.gmc-uk.org/Draft\\_GMC\\_Colleague\\_Questionnaire.pdf\\_28205215.pdf](http://www.gmc-uk.org/Draft_GMC_Colleague_Questionnaire.pdf_28205215.pdf) (accessed October 2010).
15. [http://www.gmc-uk.org/Draft\\_GMC\\_Patient\\_Questionnaire.pdf\\_28195071.pdf](http://www.gmc-uk.org/Draft_GMC_Patient_Questionnaire.pdf_28195071.pdf) (accessed October 2010).
16. Prison Reform Trust. *Bromley Briefings Prison Factfile*. London: Prison Reform Trust, 2010.  
Available at:  
<http://www.prisonreformtrust.org.uk/Portals/0/Documents/FactfileDec10small.pdf> (accessed June 2011).

### Acknowledgement

We would like to offer our thanks to the GPs who kindly gave up their time to participate in the study and collect supporting information.

## APPENDIX 1

### Four domains and 12 attributes of the GMC *Good Medical Practice*

Domain 1: Knowledge, skills & performance

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

Domain 2: Safety and quality

- Put into effect systems to protect patients and improve care
- Respond to risks to safety
- Protect patients and colleagues from any risk posed by your health

Domain 3: Communication, partnership and teamwork

- Communicate effectively
- Work constructively with colleagues and delegate effectively
- Establish and maintain partnerships with patients

Domain 4: Maintaining trust

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

## APPENDIX 2

### Pilot snapshot of the commissioning, delivery and GPs' working patterns in English secure environments

#### GP secure environment settings

The pilot secure environment GPs were employed as sessional doctors in prisons, secure hospitals, immigration removals centres and in custody suites in England.

English custodial institutions include 129 prisons,<sup>4</sup> secure hospitals (high and medium facilities),<sup>5</sup> 12 immigration removal centres<sup>6</sup> and custody suites in each of the 39 police forces.<sup>7</sup> Prisons comprise juvenile centres, youth offender institutes, adult (predominantly male) and high security prisons with different categories of offenders.

#### Commissioners of health care and health care providers

Detainee health care was commissioned by the NHS for prisons and secure hospitals and the Home Office for the immigration removal centres and custody suites.

The commissioners contracted a variety of NHS and non-NHS providers who employed health professionals to deliver the service.

*Prisons* - PCTs commissioned medical care in state run prisons. The ten private run English prisons were responsible for medical care provision for their detainees.<sup>16</sup>

*Secure hospitals* – 800 high security beds were managed by NHS Trusts and the 3 500 medium secure beds managed by both NHS and the independent sector (the latter provide 35% of the medium secure capacity).<sup>9</sup>

*Immigration removal centres* – Contracts were awarded to the independent sector to manage these centres and these companies employed GPs from local practices and prisons as well as private providers to provide medical services on a sessional basis in these establishments.

*Forensic physicians* – It appeared that police forces employed GPs directly on a self-employed basis or through an independent provider to provide forensic physician services. The commissioning for these services was in the process of moving from the police to the Strategic Health Authorities. Fifty-three per cent of forensic medical services in English and Welsh police custody suites were outsourced to private commercial providers in 2008.<sup>1</sup>

#### GP working patterns

##### *Prisons*

In our pilot the GPs were employed full-time and part-time in prisons across the NHS and non-NHS sector supported by a mix of health care officers and nurses. Some specialist (eg substance abuse specialists) undertook one or two weekly sessions in a cluster of prisons. These practitioners were employed individually either directly by the PCT, from local GP practices and through independent companies. Some PCTs provided contracted weekly community practice sessions for their prison GPs, but other PCTs did not, although the Department of Health recommends this practice to reduce professional isolation and

promote integration of community and secure environment service. Prison GPs without contacted community sessions undertook OOH and locum work to maintain their core GP skills.

#### *Security hospitals*

The pilot doctors worked sessionally in these settings alongside psychiatrists and non-medical support staff.

#### *Immigration removal centres*

GPs from local practices and prisons as well as private providers provided medical services on a sessional basis in these establishments.

#### *Forensic physicians*

GPs worked on an on-call basis in custody suites in addition to their GP secure environment and/or community practice. In the West Midlands there were about 10 GP forensic physicians per police force. Doctors with other specialist backgrounds were also employed as forensic physicians (eg psychiatrists).

#### *Substance misuse specialists*

These specialist GPs worked on a sessional basis in a cluster of prisons (and in the community) or as community GPs coming into their local prison.

#### *Professional isolation*

GPs who practised predominantly in secure environment were professionally isolated from their secure setting colleagues and community colleagues as well as medical students. GPs working in secure environments were usually sole medical practitioners who have to arrange to see their secure environment colleagues (if they know who they are!) outside their busy clinics or communicate electronically. They felt distanced from their community colleagues physically and in type of practice (eg prescribing habits). Traditionally, medical students do not have placements in this medical speciality due to security restrictions.

Some GPs experienced more organisational support than others. For example, in a same site prison area, a PCT prison GP manager was employed on-site; this manager undertook mini-appraisals with the prison GPs. Other PCTs provided a regional liaison GP. The quality of organisational support was not related to NHS or private status of the employer.

The pilot GPs made much effort to network with GPs within their own secure environment speciality (eg. Regional offender network meetings, Offender Health Research Network RCGP Secure Environment Group and national conferences) and keep up to date with core generalist skills through community sessional practice, attending local surgery meetings, National Association of Sessional GPs membership, PCT employment and being a GP appraiser. This networking was on top of the GPs work and family commitments, and due to the small population of these specialists, the meetings were regional as opposed to local, which are quite time consuming travel wise and once you have undergone security checks to move in and out of the secure environment.

1. Payne-James JJ, Anderson WR, Green PG, Johnston. *Provision of forensic medical services to police custody suites in England and Wales: Current practice*. Journal of Forensic and Legal medicine. 2009; 16: 189-195.

## **APPENDIX 4 GPs' follow-up focus group topic guide**

### **University of Warwick and RCGP revalidation pilot for doctors working in secure environments**

#### **GPs' follow-up focus group topic guide**

1. General feedback of experience of collecting supporting information
2. Barriers experienced by doctors to collecting supporting information according to the criteria and standards of RCGP revalidation proposals
3. Facilitators for improving the revalidation process for doctors working in secure environments and suggestions for alternative documentation
4. Training required by doctors to facilitate them to present the supporting information
5. Suitable processes of remediation for doctors working in secure settings.

**APPENDIX 5 GP supporting information feedback form**

RCGP secure environment revalidation pilot

**GP supporting information feedback form**

GP ID number .....

Please place a tick in the appropriate box.

Supporting information	Evidence of secure environment related supporting information			If yes, how easy was this evidence to interpret for revalidation?					Comments
	Yes	No	Not sure	Very easy	Fairly easy	Not very easy	Not at all easy	Not sure	
General information									
Personal details									
Scope of practice including extended practice									
Record of annual appraisal									
Personal Development Plan & review									
Statement on probity and health									
Keeping up to date									
Learning credits									
<b>Review of practice</b>									
Clinical audits									
Significant event audits									
Feedback on practice									
Colleague feedback									



Feedback from patients									
Review of complaints & compliments									

### Post appraisal: The Four Statements

The appraiser will, at the end of every appraisal, be able to make a statement that indicates

	Yes	No	Unsure
Presence or absence of immediate concerns about the doctor's fitness to practise. If concerns exist the statement will specify in which attribute(s) concern exists.			
Whether there is sufficient supporting information recorded to demonstrate the doctor is making satisfactory progress towards revalidation			
Whether there has been satisfactory progress with key elements in the previous year's Personal Development Plan			
Agreement with the Personal Development Plan that derives from the current year's appraisal discussion to demonstrate the doctor is making satisfactory progress towards revalidation and that key priorities for development have been included in the plan.			

## **APPENDIX 6 Appraisers' follow-up focus group topic guide**

### **University of Warwick and RCGP revalidation pilot for doctors working in secure environments**

#### **Appraisers' follow-up focus group topic guide**

1. Appraisers' perceptions of the appraiser's role in RCGP revalidation proposals.
2. Ability of appraisers to interpret portfolios of doctors in secure environments.
3. Appraisers' training needs for undertaking strengthened appraisal.
4. Alternative methods of presenting supporting information for doctors working in secure environments.
5. Suitable processes of supporting doctors experiencing difficulties in the appraisal process.

## **APPENDIX 7 Acting Responsible Officers' follow-up focus group topic guide**

### **University of Warwick and RCGP revalidation pilot for doctors working in secure environments**

#### **Acting Responsible Officers' follow-up focus group topic guide**

1. Nominated ROs' perceptions of the RO role in RCGP revalidation proposals
2. Ability of ROs to make a fair, consistent and informed revalidation recommendation for doctors in secure environments with the supporting information presented
3. ROs' training needs for undertaking this process
4. Alternative methods of presenting evidence for doctors working in secure environments
5. Suitable processes of supporting doctors experiencing difficulties in the appraisal process

## APPENDIX 8 Pilot ethical approval letter

20 October 2010

Dr Rodger Charlton  
Associate Clinical Professor in Medical Education &  
Lead for GP Specialty Teaching  
Warwick Medical School  
University of Warwick  
CV4 7AL

Dear Rodger

*Substantial amendment:  
The University of Warwick and the Royal College of General Practitioners Revalidation  
Pilots for General Practitioners*

---

Thank you for submitting your request for a substantial amendment to the above-named project which was approved in July 2010 by the University of Warwick Biomedical Research Ethics Sub-Committee for Chair's Approval.

I am pleased to confirm that the revised documentation meets the required standard and that the study may continue in accordance with the submitted amendments.

I take this opportunity to remind you any further substantial amendments require approval from the committee. The committee would also welcome an End of Project Report.

Yours sincerely,

Professor Jane Barlow  
Chair  
Biomedical Research  
Ethics Sub-Committee

