



Royal College of  
General Practitioners

**A Joint RCGP/Specialist Organisation (BAD)  
Approach to a Replacement Process for the  
Accreditation and Re-Accreditation of General  
Practitioners with a Special Interest (GPwSI): A  
Report of a Pilot Study in Assessing GPs with  
Extended Roles in Dermatology and Skin Surgery**

# **A Report of a Pilot Study in Assessing GPs with Extended Roles in Dermatology and Skin Surgery**

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**Report Reviewed by RCGP Council and BAD Officers March – May 2015**

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## Foreword

GPs who undertake 'extended roles', i.e. roles outside the scope of the GP curriculum, make an important contribution to the health service, particularly in terms of bridging the gap between primary and secondary care and enabling patients to receive high quality care in a community setting.

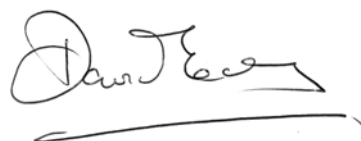
The Royal College of General Practitioners (RCGP) and the British Association of Dermatologists (BAD) have worked closely in collaboration to ensure that appropriate standards exist for GPs undertaking extended scopes of practice in Dermatology. The restructure of primary care in England, the introduction of revalidation for UK-licensed doctors and the move towards a system of 'credentialing' for roles over and above core roles for all medical practitioners, present an opportunity to introduce more consistent processes to ensure that GPs who are practising outside the scope of the GP curriculum are doing so safely and effectively, with appropriate local support and the right level of integration with secondary care. The pilot has identified a number of current issues, which the RCGP and BAD will seek to address through discussion with NHS England and other relevant stakeholders. However, in the longer term it will also inform the development of credentialing models and thinking about new models of care.

Whilst GPs with Special Interests (GPwSI) were the initial focus of the pilot, the pilot team recognised the need to consider how the processes to be evaluated in the pilot would sit with credentialing as a developing policy, having been given impetus by the Shape of Medical Training (SoT) review. Since the pilot was commissioned the RCGP adopted the term "GPs with Extended roles" (GPwER) to describe all general practitioners who undertake activities that are beyond the scope of GP training and the MRCGP examination including, as a subset, GPs who are commissioned to perform specialised clinical services in a community or hospital setting as an extended scope of practice. This report needs to be set in the context of this change of terminology in terms of informing our future planning.

We would like to note the significant contribution of the pilot participants, and give our thanks to the pilot team, who under the effective leadership of Dr Julia Schofield, have produced an exceptional piece of work that will guide us in future strategies.



Maureen Baker  
Chair,  
Royal College of General Practitioners



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# Executive Summary

Historically, GPwSIs have been defined as GPs who continue their core generalist role, but have demonstrated additional skills and knowledge in particular clinical areas, so that they can deliver extra services for patients in addition to their core services. They work unsupervised, usually in community settings and take referrals from colleagues.<sup>1</sup>

The role was described in 2000, and soon after this the Royal College of General Practitioners (RCGP) and the Department of Health (DH) decided that a form of accreditation would be necessary to ensure that the quality of care for a patient seen by a GPwSI would be the same as that provided by a specialist service.

Since 2003, generic and specialty specific guidance for GPwSIs has been published across 17 specialities. In 2007 the DH published generic guidance for GPwSIs setting out the requirements for accreditation by PCTs of GPwSI services, and of facilities and individuals working within the services.

The restructure of primary care in England, the introduction of revalidation for UK-licensed doctors and move towards a system of ‘credentialing’ for roles over and above core roles, for all medical practitioners, present an opportunity to introduce more consistent processes to ensure that GPs who are practising outside the scope of the MRCGP curriculum are doing so safely and effectively.

NHS England approached the RCGP to design a new process of assessment that would be undertaken by the RCGP and the relevant specialty. With a mutual interest in this area, the British Association of Dermatologists (BAD) agreed to fund a small-scale pilot, the purpose of which was to test and evaluate a new process for the assessment and reassessment of GPs wishing to work with extended roles in dermatology and skin surgery, to evaluate how this will sit with the GMC processes of credentialing and revalidation and to understand the resource implications and any significant risks for the professional organisations involved. Existing guidance for GPwSI accreditation was used as a starting point to map the process.

The pilot evaluated two models of assessment/re-assessment: remote assessment of a portfolio only and assessment of a portfolio with face-to-face interview. Each model included a mixture of ‘new’ and ‘re assessment’ candidates who submitted evidence across three standards (diagnosis and management of skin disease, skin surgery and skin lesions and community skin cancer) using an application form structured around the 2007 generic guidance and the curriculum and competency based assessment tools in the 2011 dermatology and skin surgery GPwSI guidance.

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<sup>1</sup> This is the current DH definition of a GPwSI. In February 2014 the RCGP adopted the term “GPs with extended roles” (GPwER) to describe general practitioners who undertake activities that are beyond the scope of GP training and the GP curriculum, and cannot be carried out without further training, undertaken within a contract or setting that distinguishes them from standard general practice, or offered for a fee outside of care to the registered practice population (teaching, training, research, occupational medicals, medico-legal reports, cosmetic procedures, etc). The requirements for supervision would vary depending on the nature of the role.

A panel of assessors was recruited based on the assessment panels in the 2007 generic guidance. This included a lay member, a consultant dermatologist and a general practitioner. A panel was also established to support the evaluation of the project (the evaluation panel).

Candidate portfolios were reviewed individually by panel members and then assessed by the panel together, either remotely (i.e. teleconference) or by face-to-face panel interview with the candidate.

A range of evaluation tools were developed. These included toolkits for the assessment of the applications and the evaluation of the assessment process. A range of on-line questionnaires were developed for the assessment panel, the participants, their referees and the appraisers of the reassessment group.

The pilot team received 52 applications from candidates wishing to take part in the project and 24 candidates were invited to participate. Of these 19 portfolio submissions were considered across a range of assessment areas, of which 18 were accepted. The submissions were of varying quality with nine meeting the requirements in terms of the structure and evidence requirements. Two candidates submitted large amounts of evidence but not in the required format, and the remaining seven portfolios were submitted in the correct format but lacked documentary evidence across a range of areas.

The pilot evaluation identified the need for a national process to ensure consistency of standards. This would be supported by local supervision and mentorship, and would involve a central portfolio assessment, conducted remotely in most circumstances, by the RCGP and BAD to determine whether a doctor's portfolio demonstrates that they have the appropriate skills and competences to practise in an extended role.

It was identified that the reassessment process (formally known as 're-accreditation') of GPs with extended scopes of practice should occur as part of the appraisal and revalidation process, but that because it is the role of appraisal to overview a doctor's performance in all their roles, it is unlikely that an appraiser would be able to make an assessment of a doctor's ability to practise in an extended scope of work, unless they are an expert in that field.

The pilot team therefore identified the need for a secondary appraisal and portfolio relating to an extended scope of practice to feed into a doctor's main appraisal, the specialist supervisor's report being integral to the extended scope of practice portfolio.

## Key Findings

The pilot has identified the following in relation to GPs with extended practice in dermatology, which are likely to have applicability to other areas of extended practice.

- A national approach, based on local supervision and mentorship and central portfolio assessment by the RCGP and BAD, would help ensure consistent standards of patient care.
- For extended roles in dermatology, the 2007 generic guidance and the 2011 speciality specific guidance, which includes a range of workplace based assessment tools, could be used as the basis to develop a new framework.
- In such a new framework, candidates would be presented with a number of appropriate options to demonstrate competency.
- Where an assessment panel has identified that a portfolio is borderline, or further clarity is required, a face-to-face interview with the candidate may be necessary.
- Appropriate tools need to be developed to support the collection of evidence and submission process, including a structured format to submit supporting information relating specifically to the extended scope of practice (e.g. an e-portfolio or interactive PDF).
- The integration of extended role practitioners in the local dermatology service needs to be promoted.
- The reassessment ('re-accreditation') of GPs with an extended dermatology role could take place as part of the five yearly appraisal and revalidation cycle, supported by a second separate dermatology-focussed appraisal to provide assurance to the responsible officer that the doctor remains up to date and fit to practise in their extended scope of practice.
- The concept of provisional 'accreditation' might be explored to ensure that those in the process of collecting the required evidence are able to practise, with appropriate limitations.
- There is the opportunity to propose a specific scope of extended dermatology to the GMC as an area to credential in the future.
- Costs for assessment and re-assessment would most likely be borne by the GP and appropriate cost / income models would need to be developed by the RCGP and BAD, and opportunities for setup funding explored.
- Engagement with commissioners would help inform the RCGP and BAD's understanding of the likely drivers behind uptake of assessment.

# Full Report

## Background to the Project

Historically, GPwSIs have been defined as GPs who continue their core generalist role, but have demonstrated additional skills and knowledge in particular clinical areas, so that they can deliver extra services for patients in addition to their core services.

They work unsupervised, usually in community settings and take referrals from colleagues. Usually GPwSIs provide services for specific patient groups and their role is different from, and in addition to, specialists (consultants). GPwSIs will usually be part of an integrated dermatology service.

The role was described in 2000<sup>2</sup>, and soon after this the Royal College of General Practitioners (RCGP) and the Department of Health (DH) decided that a form of accreditation would be necessary. Such accreditation was designed to ensure that the quality of care for a patient seen by a GPwSI would be the same as that provided by a specialist service. Since 2003, generic and specialty specific guidance for GPwSIs has been published across 17 specialities.<sup>3</sup>

In 2005, an audit of the dermatology GPwSI framework showed a lack of knowledge of the DH framework with nearly half of respondents having not completed the accreditation process. In 2007, partly in response to the 2005 audit, the DH published a suite of documents which outlined generic guidance for GPwSIs. This 2007 guidance set out clearly the requirements for accreditation by PCTs of GPwSI services, and of facilities and individuals working within the services. The guidance was supported by a formal direction for PCTs to undertake this process.

Key developments have presented an opportunity to introduce a more consistent process to ensure that GPs who are practising outside the scope of the MRCGP curriculum are doing so safely and effectively. Such “extended roles” would include, but are not restricted to, commissioned roles such as GPwSIs.

- The restructuring of the NHS in England, and the disbanding of PCTs in April 2013, presents a need for a new approach in England which could be replicated in the other countries of the UK
- Revalidation for UK-licensed doctors was introduced in December 2012. Revalidation is designed to reassure the public, the NHS and the profession that doctors are up to date and fit to practise across the whole scope of their practice, which in the case of GPs includes extended and special interest roles

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<sup>2</sup> Department of Health (2000) *The NHS Plan: A Plan for Investment, A Plan for Reform*.

<sup>3</sup> *GP with a Special Interest Accreditation*. RCGP, 2015. Available from: [www.rcgp.org.uk/clinical-and-research/clinical-resources/gp-with-a-special-interest-gpws-i-accreditation.aspx](http://www.rcgp.org.uk/clinical-and-research/clinical-resources/gp-with-a-special-interest-gpws-i-accreditation.aspx)



- The General Medical Council is moving towards a system of ‘credentialing’ for roles over and above core roles, for all medical practitioners.

There is broad agreement that the development of standards of competency for extended or credentialed roles must be professionally led i.e. the RCGP working in collaboration with the relevant specialty college, faculty or association. This pilot project evaluated whether the RCGP, working in collaboration with the relevant specialty, could effectively assess the knowledge, skills and competences of a GP in an extended area of practice through the assessment of a portfolio of supporting information, with or without a face to face interview. It is envisaged that the commissioning organisation e.g. the CCG in England, would consider the educational assessment made by the RCGP and relevant specialty organisation when commissioning and appointing a GP to deliver a specific service. Such an arrangement has been proposed by NHS England. The pilot also considered the suitability of appraisal and revalidation as a means to re-assess a GP with an extended role, exploring a potential interface between an educational assessment carried out by professional bodies and the appraisal process.

This particular pilot project considered the process of assessment of portfolios, with or without face to face interview, of GPs wishing to undertake extended roles in dermatology that map to the GPwSI roles in the 2011 dermatology GPwSI and skin surgery guidance. The starting point for the assessment process used the generic process of accreditation from the 2007 guidance in combination with the requirements specified in the dermatology guidance. To this end, the project used the following documentation:

- The 2007 generic GPwSI guidance which includes a model application form for candidates<sup>4</sup>
- The 2011 dermatology and skin surgery speciality specific guidance<sup>5</sup> which includes a curriculum, a range of required work place based assessment tools (previously developed with the support and input of the RCGP) and requirements about ongoing continuing professional development.

A key part of the project was to assess whether this documentation and the assessment tools were fit for purpose.

The current GPwSI accreditation process recommends a face to face interview as part of the process and the pilot evaluated the importance of this in assessing candidates’ competency.

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<sup>4</sup> Department of Health (2007) *Implementing Care Closer to Home: Convenient Quality Care for Patients. Part 3: The Accreditation of GPs and Pharmacists with Special Interests*. London: Department of Health.

<sup>5</sup> NHS Primary Care Contracting (2011) *Revised Guidance and Competences for the Provision of Services using GPs with Special Interests (GPwSI) Dermatology and Skin Surgery*.

## Aims and Objectives

- To test and evaluate a new process for the assessment and reassessment of GPs wishing to work with extended roles in dermatology and skin surgery
- To evaluate how this will sit with the GMC processes of credentialing and revalidation
- To understand the resource implications for the professional organisations involved in the new process measured against projected benefits and any significant risks involved.

## Methodology

### Ethics

The National Research Ethics Service (NRES) was contacted and confirmed that ethics approval for the project was not required.

### Preparatory Work

Other pilot work in this area was reviewed, such as the GMC musculoskeletal<sup>6</sup> and forensic medicine<sup>7</sup> credentialing pilots. Lessons learnt from the RCGP revalidation pilots were incorporated in the pilot design. Discussions took place with the GMC about how the pilot might relate to credentialing and the terminology to be used for the process in the medium to longer term.

### Documentation and Submission of Applications

- The current documentation relating to generic GPwSI accreditation was used. Pilot application checklists for new and reassessment candidates are included as Appendices 1 and 2.
- A central administrator was appointed and a secure file sharing site created to enable the panel and evaluators to access the applications remotely.

### Panel

A panel of assessors was recruited based on the assessment panels in the 2007 generic guidance including the following representation:

- Lay member: Helen MacAteer, Chief Executive of the Psoriasis Association
- Consultant dermatologist: Dr Anshoo Sahota, also Honorary Secretary of the British Association of Dermatologists
- General Practitioner: Dr Carol Blow, RCGP

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<sup>6</sup> British Institute of Musculoskeletal Medicine. Report to the GMC on the Musculoskeletal Credentialing Pilot (2012).

<sup>7</sup> Faculty of Forensic and Legal Medicine. Report to the GMC on the FFLM credentialing pilot (2012)

Panel members were required to participate in the following activities:

- A panel briefing teleconference (1-2 hours)
- A preparatory review of the applicant portfolios (1 day)
- Panel assessment of the portfolios of the 12 applicants not being interviewed by teleconference, requiring a maximum of 6 hours divided up over two sessions
- Panel interviews of 12 candidates face to face; requiring 1.5 days
- Evaluation interviews of panel members for their views on the process; no more than 0.5 days

A budget for travel and clinical backfill, where required, was agreed for the panel.

### **Evaluators**

The evaluators of the project were agreed as follows:

- Dr Julia Schofield, consultant dermatologist, pilot project lead
- Professor Nigel Sparrow, RCGP Medical Director for Revalidation
- Dr Jonathan Botting, general practitioner, RCGP clinical champion minor surgery

The expectations of the evaluators were as follows:

- Involvement in the panel briefing teleconference
- Project lead to assess and evaluate submissions in preparation for panel assessments
- Involvement in non-face to face assessments if possible
- Attendance at face to face interviews
- Involvement in panel evaluation interviews.

### **Recruitment Participants**

The project aimed to recruit 24 GPs wishing to undertake extended roles (i.e. dermatology and skin surgery practice beyond the scope of the MRCGP curriculum) for the first time and some that wished to be reassessed. The candidates would be assessed either by portfolio only (n=12) or by portfolio and interview (n=12).

### **Terminology and Assessment Groups**

It was agreed that the terms accreditation and reaccreditation would not be used for the pilot project, instead participants would apply for either 'new assessment' or 'reassessment'. Assessment standards were agreed as follows:

- Assessment Standard 1: Diagnosis and management of skin disease
- Assessment Standard 2: Skin surgery
- Assessment Standard 3: Skin lesions and community skin cancer

A summative approach was then used to map to the current GPwSI roles which are defined in the 2007 dermatology speciality specific guidance, recognising that the term GPwSI will be replaced and the models may need to change after evaluation of the pilot. Participants were asked to present evidence as follows:

- *Group 1 GPwSIs: Diagnosis and management of skin disease* presented evidence in relation to Assessment Standard 1
- *Group 2 GPwSIs: Dermatology and skin surgery: diagnosis and management of skin disease and benign skin surgery* presented evidence in relation to Assessment Standards 1 and 2
- *Group 3 GPwSIs: Dermatology, skin surgery and skin cancer: diagnosis and management of skin disease, skin surgery including skin cancer community services* presented evidence in relation to Assessment Standards 1,2 and 3
- *Skin lesion GPwSIs Skin lesions and skin surgery including skin cancer community services* presented evidence in relation to Assessment Standard 3
- Extended role skin surgeons presented evidence in relation to Assessment Standard 2.

From the 24 participants, the aim was to recruit a mix of candidates requiring different assessments with some candidates being assessed across more than one assessment group.

### **Specific Issues Relating to Reassessment Candidates (*formerly known as reaccreditation*)**

In addition to portfolio review by the panel +/- a face to face interview, the reassessment participants were required to have had an appraisal during the pilot period and the support of the local appraiser was required. This was so that an evaluation could be made of whether the local appraiser can reasonably be expected to assess the dermatology specific evidence provided, to make a decision on the competency of the clinician to continue in the extended role. The project team aimed to collect feedback from the 12 appraisers of the reassessment candidates in order to complete this evaluation.

### **Recruitment Process and Timeframes**

Invitations to participate in the project were circulated widely via the Primary Care Dermatology Society website, the British Association of Dermatologists and other informal contacts including a drug company database of dermatology GPwSIs. Detailed information about the project was provided and applicants were given six weeks to submit their evidence electronically using the model documentation provided, based on the 2007 generic GPwSI guidance.

Some flexibility was introduced where candidates were unable to submit in time. These candidates were offered a later submission date and attendance at face to face interview as the face to face assessments were held four weeks after the non-face to face assessments.

### **Evaluation Tools**

Tools to evaluate the project were developed, using the work undertaken by the RCGP to pilot revalidation process for GPs prior to its introduction and specifically designed questionnaires. This included the following:

- A toolkit for assessment of the applications and evaluation of the assessment process
- A range of on-line questionnaires for the assessment panel, the participants, their referees and the appraisers of the reassessment group.

### **Panel Assessment**

Submitted portfolios were either assessed through remote, non-face to face assessment (an assessment panel teleconference chaired by the lay member of the panel and attended by the project lead as evaluator) or candidate interview (attended in person by the candidate,

assessment and evaluation panels). Prior to the assessments the panel reviewed candidate portfolios individually and uploaded comments to the file sharing site. Each assessment was followed by a de-briefing in which the pilot team judged on whether the candidate had met the requisite criteria. The panel were then asked to evaluate the assessment process and answer the following questions:

- Q1. Was the evidence provided adequate to enable the candidate's fitness to practise in the new extended role to be determined?
- Q2. Were the assessments (when provided) appropriate and of the requisite standard to ensure fitness to practise in the extended role?
- Q3. Would it have been helpful to interview the candidate?
- Q4. How long did it take you to assess the application?
- Q5. For reassessment candidates ONLY, do you think that the local GP appraiser would be able to assess and make judgement on the application?
  - *If you think that a local specialist dermatology appraiser would be able to assess and make judgement on the application, please indicate whether you think this needs to be a Consultant Dermatologist or a GPwSI.*
  - *Do you consider that this function could be undertaken by a central national dermatology appraiser (BAD/ RCGP approved, Extended Role Practitioner or Dermatologist)?*

### **Candidate, Appraiser and Referee Questionnaires**

Following the assessments the GP candidates were invited to provide their feedback on the process via an online questionnaire. They were offered feedback on their submission and issued with a certificate of participation.

With prior consent from relevant parties, the appraisers of participants seeking re-assessment were contacted and asked to complete an on-line questionnaire to gather their views on the extent to which they could make a judgement of the participant's continued fitness to practise in their extended role in dermatology on the basis of the supporting information presented at appraisal. The pilot team subsequently felt it would be beneficial to invite feedback from candidate referees by electronic survey, where the candidate had given their consent.

### **Data Collection and Evaluation**

The data collected was reviewed by the project team and the information collated in MS Excel spreadsheets for evaluation purposes. The results presented are a mix of the following:

- Quantitative data related to the applications and submissions received
- Qualitative data from the panel, candidates assessed, their referees and appraisers.

## Applications

Applications were received from 52 prospective candidates across the range of assessment groups. Of these, 33 were considered suitable for the project. Four candidates were excluded at the request of the BAD because of concerns relating to the clinical governance arrangements of their local GPwSI service. In total 29 candidates were invited to participate of whom eight declined with four giving no explanation for their decision, others indicated that there was either insufficient time to collate and submit their evidence or there was a lack of consultant dermatologist support in meeting the deadline. Of the remaining 21 candidates two subsequently withdrew indicating an inability to meet the deadline for evidence submission. In total 19 applications were considered across the following assessment areas as demonstrated in Table 1:

Table 1: Candidate portfolio submissions

Candidate	F2F*	Non F2F*	New assessment	Re-assessment	Standard 1	Standard 2	Standard 3
F2F1				√	√	√	√
F2F2	√		√		√	√	√
F2F3	√		√		√		
F2F4	√		√		√	√	
F2F5	√		√		√	√	√
F2F6	√			√	√	√	
F2F7	√			√	√	√	√
F2F8	√			√	√	√	√
F2F9	√			√	√	√	√
F2F10	√		√			√	
F2F11	√			√	√	√	√
NF2F1		√	√		√	√	√
NF2F2		√	√		√	√	
NF2F3		√		√	√	√	
NF2F4		√	√		√		
NF2F5		√	√			√	√
NF2F6		√		√	√	√	√
NF2F7		√		√	√		
NF2F8		√	√			√	

\*F2F indicates candidates attended for interview

\*NonF2F indicates portfolio assessment only and no interview

## Quality of Submissions

The portfolio of one candidate (NF2F1) was considered but rejected because the candidate had failed to submit sufficient evidence in the appropriate format. The quality of the remaining 18 portfolio submissions was variable with nine meeting the requirements in terms of the structure and evidence requirements. Two candidates submitted large amounts of evidence but not in the required format, requiring the project lead to collate the evidence appropriately for the panel's consideration. The remaining seven portfolios were submitted in the correct format but lacked documentary evidence across a range of areas including the following:

- Robust audit data, particularly in relation to skin surgery, inclusion of surveys rather than audits of clinical practice
- Missing evidence of competency based assessments (such as mini-CEX or DOPS for minor surgery)
- Incorrect submissions in relation to the assessment considerations applied for
- Caseload and outcome data
- Patient experience information
- Missing or variable quality of reference provided by a specialist dermatologist.

### **Panel Evaluation of Submissions**

The panel used a questionnaire to note their comments in relation to their evaluation of the assessment process. This section considers the panel responses to the questionnaire.

### **General Comments**

The panel all agreed that separating the relevant information out from the submissions was often difficult for the following reasons:

- Some candidates included much of their dermatology related information in their NHS GP appraisal and identifying key issues such as CPD from the extensive GP appraisal documentation was difficult.
- Other candidates submitted information relating to a whole dermatology service rather than their own individual data. This was particularly the case in relation to patient experience, casemix and outcome data, which often reflected the service rather than the applicant.
- Candidates submitted local accreditation documentation which did not map to the requested documentation.
- Even though the project lead had reordered some of the applications, they were cumbersome to consider because of the inclusion of large amounts of unnecessary information that had not been requested (e.g. PowerPoint presentations of lectures).
- Several candidates were working predominantly in dermatology, undertaking very little general practice, and the panel were concerned that the process being piloted was not appropriate for this group.

### **Q1. Was the evidence provided adequate to enable the candidate's fitness to practise in the new extended role to be determined?**

Following assessment of the portfolio, the panel felt that sufficient evidence of a good enough quality to assess candidates as fit to practise an extended dermatology role was demonstrated in nine of the 19 applications. A further 3/19 portfolios were considered to be partially adequate and 7/19 portfolios did not provide enough of the required evidence to enable a judgement to be made. Reasons for this differed according to whether the applications were new or reassessments and were as follows:

### ■ **New Applications**

In all four of the new applications, that were considered inadequate, the competency based assessment tools were missing (mini CEX, DOPS) as was the log diary and no clinical audits were provided. None of these candidates were working as part of an integrated dermatology service. One candidate had applied to work as a community cancer clinician but had not provided evidence to meet the requirements for this role.

### ■ **Reassessment Applications**

Reasons that the evidence submission were inadequate to assess fitness to practise in this group included the following:

- No audits completed or submitted, and where audits were submitted they were often surveys rather than audits
- No outcome data
- Missing evidence in relation to community cancer standards and the NICE 2010 guidance
- A lack of patient experience data
- Missing or inadequate reference.

## **Q2. Were the assessments (when provided) appropriate and of the requisite standard to ensure fitness to practise in the extended role?**

The assessment tools for new extended role practitioners are contained within the 2011 dermatology and skin surgery guidance and include the following work place based assessments:

- Mini-CEX across a range of skin conditions.
- DOPS for skin surgery.

Additionally candidates are expected to demonstrate that they have kept a log diary which includes learning actions and reflection and completed case based discussions. The GP and dermatologist on the panel felt that, where provided, this range of assessment tools covered the curriculum and were appropriate to provide evidence of the requisite standard to ensure fitness to practise in the extended role. The lay member of the panel did not feel able to comment on this. There was discussion about the workplace based assessor and the skill set required to perform this role. Work place based assessments were performed by either consultant dermatologists or by experienced GPwSIs.

## **Q3. Would it have been helpful to interview the candidate?**

### ■ **Non Face to Face Applications**

Of the eight candidates whose portfolios were reviewed, without a face to face interview, it was felt that an interview would have been unhelpful and that missing information could have been obtained by a robust administrative process prior to panel evaluation.

### ■ **Face to Face Applications**

For the 11 candidates that attended for interview, the interview was felt to be of limited benefit for five. Three of these candidates were experienced GPwSIs working within an integrated dermatology service. Of the remaining two, one was being newly assessed and had submitted a good application with supporting evidence, the other had not submitted



any work place based assessments and could have been excluded at an early screening stage. For five candidates the interview was felt to be helpful for the candidates rather than the assessors as they were able to describe the difficulties they were encountering in working with the local dermatology service and sought the advice of the panel. This, however, was not the intended purpose of the interview. One candidate, an experienced GPwSI, had recently relocated and the interview was helpful for the panel to understand the candidate's application better.

#### **Q4. How long did it take you to assess the application?**

Data on 18 candidates was considered and the overall average time to review the portfolio applications was 60 minutes (range 30-105 minutes). There was variation between panel members, with the GP and lay member taking an average assessment time of 72 minutes, twice as long as the consultant dermatologist (36 minutes). There was no difference in the average portfolio review times when comparing new and reassessment candidates or face to face versus non face to face candidates.

The reasons for variation in the time taken to review the applications included the following:

- Dermatology information contained within the NHS GP appraisal.
- Muddled submissions, with difficulty extracting the information to make a careful assessment.
- Submission of irrelevant/superfluous information.

#### **Q5. For reassessment candidates ONLY, do you think that the local GP appraiser would be able to assess and make judgement on the application?**

The panel did not believe that a local GP appraiser would be able to assess and make judgement on the capability of the GP to undertake an extended role in dermatology. The panel were asked to comment on a range of other options that might be used to assess the competence of established extended role practitioners to continue in this role:

- **Do you think that a local specialist dermatology appraiser would be able to assess and make judgement on the application?**

The panel felt that for all except one of the candidates, a local specialist dermatologist would be well suited to considering the application. In the one case where this was not felt to be the case, the candidate had recently relocated so the need for a central assessment panel was considered to be of value in this situation.

- **If you think that a local specialist dermatology appraiser would be able to assess and make judgement on the application, please indicate whether you think this needs to be a consultant dermatologist or a GPwSI.**

Views about this were mixed and depended on the specialist experience of the candidate:

- For experienced extended role practitioners, seeking reassessment, it was felt that a consultant dermatologist should be involved in the process, as a less experienced colleague would not necessarily be able to make a judgement of the clinician's ongoing competency
- For extended role practitioners seeking reassessment, with less experience (the period of 'less experience' would need to be defined), more experienced extended role colleagues could be involved in the reassessment process, provided they had been appropriately assessed themselves.
- **Do you consider that this function could be undertaken by a central national dermatology appraiser (BAD/ RCGP approved, extended role practitioner or dermatologist)?**

The panel felt that this function could be undertaken by a central national dermatology appraiser.

#### **Other Comments:**

#### *Assessment/Reassessment and Integration of Services*

The panel discussed the importance of integration with local dermatology services in the context of assessment of competency:

- For the six candidates where the extended role practitioner was working as part of an integrated dermatology service with support and mentoring from the local specialist dermatology service, it was felt that local assessment by a specialist (either consultant or experienced extended role practitioner) would be acceptable
- For the six candidates working independently of the local specialist dermatology service with no evidence of any integration (usually private providers) the panel were concerned that there could be a problem of conflict of interest if non-local specialists, either consultants or experienced extended role practitioners, were responsible for assessing local candidates and that an external national review of the application would be more appropriate. This external review could be by either a consultant dermatologist or an experienced extended role practitioner
- For the remaining candidates where there was evidence of some limited integration with local services it was felt that a mix of local and national input to the assessment might be helpful.

#### *Role of the NHS Appraisal in the Assessment of Ongoing Fitness to Practise for Extended Role Practitioners*

The panel and evaluators were asked for their comments about the role of the NHS appraisal in the assessment of ongoing fitness to practise in an extended role. The following comments were made:

- Identifying the relevant dermatology evidence from the NHS appraisal was difficult.
- If the NHS appraisal process is to be used for assessment of ongoing fitness to practise in an extended role, the panel felt that a separate portfolio of appraisal evidence should be collected specifically relating to the extended role.
- The collation of evidence is time consuming and the panel felt that the use of an e-portfolio to collect ongoing evidence relating to the extended role could be helpful.
- The detailed structured reference was found to be very helpful and it was felt that the process would benefit from extended role practitioners being able to demonstrate ongoing links and support from an appropriate clinical supervisor.

#### *The Need for a Face to Face Interview*

Eleven candidates attended for formal face to face interview whilst seven did not. The panel felt that, provided a central administrative function checked that all applications were completed and submitted correctly, face to face interviews were unnecessary and did not add anything to the assessment process. The interviews were felt to be of value to the candidates, particularly where there were problems of integration with local services and issues of mentoring and support. This, however, was not the purpose of the interview.

#### *The Role of a National Assessment Process for New Applicants for Extended Roles*

The panel felt that all of the new assessment candidates could have been assessed satisfactorily using a national assessment process and the assessment tools in the current guidance.

#### *New Applications: Provisional Status*

For some candidates, it was felt that provisional status might be considered, particularly those aspiring to deliver community cancer services where there is a need to be delivering the services in order to collect the evidence to demonstrate competency ('catch 22').

#### *Skin Surgery*

Candidates regularly performing skin surgery had been required to submit evidence to other organisations to be able to deliver this service. It was felt important that candidates should not need to duplicate evidence submissions.

### **GP Candidate Surveys**

The group received nine responses (82% return) from candidates assessed by portfolio and interview (F2F candidates) and eight responses (100% return) from candidates appraised by portfolio alone (NF2F candidates), including candidate NF2F8 whose portfolio was rejected). F2F candidates were asked to complete some additional questions relating to the interview process.

#### *Application Process and Ease of use Feedback*

Candidates were asked to provide their feedback on the application process in detail. The applications were divided into several categories and candidates asked if they had experienced any issues completing applications sections as follows:

- *Section A (Application, GMC Registrations Screenshot, Personal Details)*
  - 14 (82.3%) candidates indicated they had no issues
  - 3 (17.6%) candidates indicated they had an issue

Few issues were noted in the comments, but one candidate noted technical problems completing the application in comments here and in other sections. This was not reflected across the other candidates.

- *Section B (Current and new role)*
  - 15 (88.2%) of candidates indicated they had no issues
  - 2 (11.8%) candidates indicated they had issues

Two candidates commented on some confusion over whether to give detail about the specialist portion of their role.

- *Section C (Portfolio of evidence for current and extended role)*
  - 8 (47%) candidates indicated they had no issues
  - 9 (53%) candidates indicated they had an issue

Candidates commenting on issues with this section felt that the process was lengthy and complex. Many found it laborious to 'cut and paste' information from other documents on to the given form in the required format. Several noted technical problems such as being unable to make a zip file, or compatibility problems between different versions of Adobe Acrobat. Several commented that information requested appeared to be duplicated in other sections.

- *Section D (Planned or completed audits)*
  - 10 (58.8%) candidates indicated they had no issues
  - 6 (35.3%) candidates indicated they had an issue
  - 1 (5.9) candidate did not answer the question

Candidates who commented all felt the frequency of audits was overly time consuming and some felt it unnecessary. One noted that an ongoing tender process had made gathering the information and meeting the submission deadline difficult.

- *Section E (Consultant specialist reference)*
  - 11 (64.7%) candidates indicated they had no issues
  - 5 (29.4%) candidates indicated they had an issue
  - 1 (5.9) candidate did not answer the question

Of the comments given by candidates, the common issue experienced was a difficulty gaining a consultant specialist reference. For one candidate this was simply a matter of lack of time, but for another there were "political/trust policy issues" that meant they could not gather an endorsement.

- *Section F (Resus, Basic Life Support, Immunisations)*
  - 12 (70.6%) candidates indicated they had no issues
  - 5 (29.4%) candidates indicated they had an issue

No significant issues were raised in gathering the information, but several candidates felt this was unnecessary and/or duplicated in other sections of their application. One candidate asked “Are these more employer, CQC and occupational health issues?”

### **Q1. How long did your application take to complete?**

Candidates were given a free text response to the question, of 16 replies the responses were as follows:

- 5 candidates gave responses of between two hours to a day
- 5 candidates gave responses of several days
- 4 candidates gave responses of between two to three weeks
- 1 candidate did not give a set amount of time, but complained that they had to repeat processes due to technical issues.

### **Q2. With regard to the submission process, how do you think this can be improved (for example let us know about any systems you have used for your GP appraisal or CPD that might be of use to support this type of application)?**

Fourteen candidates gave a response to this query, some quite lengthy. However a common theme was that an online submission system for the applications would be preferable due to increased ease of use. Several candidates complained of duplication of information between their appraisal processes and this application and clearly felt that some integration of the processes would make the application easier.

Specific suggestions included:

- An online portal
- An online appraisal tool - Clarity toolkit, RCGP e-portfolio, and the MAG form were mentioned

### ***Responsibility for Assessment Type and Frequency of Assessment***

The candidates were asked for feedback on the organisations who would be best placed to make an assessment of a doctor’s ability to practise in an extended role.

### **Q3. Do you think it is the role of the RCGP and the relevant specialty/specialty association (e.g. the British Association of Dermatologists) to make an initial assessment of a doctor’s ability to practise in an extended role?**

- 13 (76.5%) answered YES
- 2 (11.8%) answered NO
- 1 (5.9%) answered DON’T KNOW
- 1 (5.9%) did not provide a response

Responses to the question were overwhelmingly positive. Of the two candidates to answer in the negative both contextualised their response with comments “However, [the RCGP and the relevant specialty/specialty association (e.g. The British Association of Dermatologists)] should help set the benchmark for those accrediting” and “just RCGP”. The candidate who gave a ‘don’t know’ response added “I think they need to set a standard but

not necessarily make the judgment, they should suggest who is qualified to do this. Perhaps trained/recognised appraisers”.

**Q4. Do you think it is the role of the RCGP and the relevant specialty/specialty association (e.g. the British Association of Dermatologists) to re-assess a doctor’s ability to practise in an extended role at regular intervals?**

- 13 (76.5%) answered YES
- 3 (17.6%) answered NO
- 1 (5.9%) did not provide a response

Again responses were positive but the accompanying comments from those who replied ‘yes’ were slightly more guarded, of the three candidates to respond in the negative, one did not offer a comment, but one other repeated their previous comment “just RCGP” the other was more negative “probably not -maybe the CCG clinical lead in that area”.

**Q5. Do you think it is appropriate for the local GP appraiser to make a judgement on a doctor’s ability to practise in an extended role?**

- 3 (17.6%) answered YES
- 11 (64.7%) answered NO
- 2 (11.8%) answered DON’T KNOW
- 1 (5.9%) did not provide a response

The majority opinion was that a local GP appraiser lacked the necessary specialist knowledge. One delegate who answered ‘no’ identified themselves as a GP appraiser and noted that they found specialist portfolio appraisals difficult. Of those who did reply with ‘yes’ comments qualified this with the caveat that specialist knowledge should be required.

**Q6. The revalidation cycle is five years. Do you think that a similar five year cycle would be appropriate for the re-assessment of extended roles?**

- 14 (82.3%) answered YES
- 1 (5.9%) answered NO
- 0 (0%) answered DON’T KNOW
- 2 (11.8%) did not provide a response

While the response was largely positive, one ‘yes’ was accompanied by an ironic comment about bureaucracy, another added a caveat “of an annual appraisal by one’s consultant/experienced GPwSI mentor which is part of the submission process to ensure one is staying on track and keeping up to date”.

**Q7. Do you consider a review of a portfolio by an assessment panel (without face-to-face interview) to be a reliable method of determining whether a doctor has the necessary skills and competences to practise in an extended role?**

- 14 candidates answered the question and two skipped, of those:
- 7 (41.2%) answered YES
- 5 (29.4%) answered NO
- 3 (17.6%) answered DON'T KNOW
- 2 (11.8%) did not provide a response

This was a more mixed response, with candidates from the interviewed group being slightly more inclined to remark on an interview being necessary. However, there was a general consensus among the free text comments that a review of a portfolio alone should at least be accompanied by endorsements and subject to interview in cases where there were doubts over the portfolio.

**Q8. Who do you think should sit on the assessment panel?**

Candidates were given a free text box to respond to the question, so a variety of suggestions were made. The most popular choice was a consultant (12 mentions), and most made clear this should be one with the appropriate specialist knowledge. Almost as popular (11 mentions) was a GPwSI, and again in the appropriate specialism.

Other suggestions received fewer votes and included:

- An RCGP representative, for example a clinical lead, champion, senior fellow, GPwSI member (five mentions)
- A lay person/patient representative (four mentions)
- A BAD representative (two mentions)
- NHS England representative (one mention)
- An external representative, i.e. from the GMC (one mention)
- A GP appraiser (one mention)

**Q9. If you think an interview is important, please explain why.**

Candidates were given a free text box to respond to the question, and 13 candidates provided comments. While many felt that an interview was important to give an accurate overview of a doctor's knowledge and skills, some felt that while important it was not necessary in all cases, or would only apply to the assessment of surgical skills. One candidate commented that assessment by portfolio alone should suffice in the majority of cases.

**Q10. How do you think we can ensure that assessments are fair, consistent and reliable?**

Candidates were given a free text box to respond to the question, and 13 candidates provided comments. The consensus was that assessments be based on sound and robust processes and assessment accompanied by thorough guidance for candidates. Several

candidates stressed the importance of an assessment interview. One candidate responded critically regarding the pilot assessment process.

**Q11. What would you expect as confirmation that you have been judged fit to practise in an extended role?**

Candidates were given three options: certificate; e-mail; entry on GMC register. They could select all three. The following was the total votes for each option:

- Certificate - 12 votes
- E-mail - 6 votes
- Entry on GMC register - 14 votes

**Candidates Invited to Interview Answered the Following Additional Questions:**

**Q1. Based on your experience with the interview panel do you think that a face to face interview should be a necessary part of the process for candidates applying to be assessed as a NEW dermatology extended role practitioner?**

Candidates responded unanimously in the positive.

**Q2. Based on your experience with the interview panel do you think that a face to face interview should be a necessary part of the process for candidates applying to be RE-ASSESSED as a dermatology extended role practitioner?**

Four candidates responded 'yes', three candidates 'no', and two 'don't know'.

**Q3. Please provide feedback on the interview process below if you wish.**

Six candidates provided comments, four were broadly positive, one felt an interview was unnecessary for most cases, and one referred to previous comments critical of the pilot processes and in particular their feeling that the panel was not fully briefed on their case.

***Final Comments from both Candidate Groups***

Candidates (both F2F and NF2F) were given the opportunity to leave any further comment that they wished. Thirteen comments were received, although seven of these were either simple thanks or statements that there was no comment they wished to leave. Some comments suggested a small number of candidates had not properly understood that this was a pilot survey and not a formal accreditation process.

**Appraiser Surveys**

For practical reasons and to ensure consistency across the pilot, the pilot team invited feedback from appraisers via online survey rather than structured telephone interview. Four GP appraisers participated in supplying feedback to the follow questions. Due to the low response rate (the project team had aimed to collect feedback from the 12 appraisers of the reassessment candidates), we cannot assume that the data is representative. Additionally, one of the appraisers was also a pilot candidate (F2F7).



**Q1. How easy was it for you to interpret the dermatology related supporting information submitted by the candidate? Were there any areas you were unclear about?**

Three appraisers responded 'yes' and one 'no', the latter stating that they were not 'in a position to appraise the specialty side of a doctors appraisal.'

**Q1a. Were there any areas you were unclear about?**

Appraisers responded as above, with the appraiser who responded 'no' stating that 'they were not in a position to provide opinion on the evidence produced for the dermatology speciality and assist with the new Personal Development Plan.'

**Q2. Did you review and discuss the dermatology related supporting information in detail or did you look for assurance from another individual /organisation that the candidate had attained/maintained their skills in that area?**

Two appraisers answered 'yes' and two answered 'no'.

**Q2b. Was the supporting information provided sufficient to show that the candidate had attained/maintained their skills in the dermatology extended (GPwSI) role?**

Two appraisers answered 'yes' and two answered 'no'. Of the two appraisers who responded 'no', one stated that this was because the doctor was studying for a diploma and not yet working as a GPwSI in dermatology, and the other reiterated that it was outside their capacity as a GP appraiser to provide opinion on speciality side of doctor's development, suggesting that a hospital consultant should appraise the extended dermatology elements of the doctor's practice.

**Q3. Did you look for assurance from another individual/organisation that the candidate had attained/maintained their skills in the dermatology extended (GPwSI) role?**

Three respondents answered 'no' and one 'yes'.

**Q3b. What individual/organisation provided you with supporting information about the dermatology extended role (GPwSI)?**

The respondent who answered 'yes' to the above stated that they sought specialist dermatology advice to appraise this element of the doctor's practice.

**Q4. Did the fact that the candidate's scope of practice include a GPwSI role have an impact on the amount of time it took you to prepare and conduct the appraisal?**

Two respondents answered 'yes', two 'no'.

**Q4b. If you have answered YES please give further details.**

One respondent reported that they had discussed training, future plans and GPwSI guidance in detail, also highlighting that prior knowledge of the guidance was helpful. The second respondent highlighted that they had to review evidence for gross misconduct as per GMC Good Medical practice, then discuss the doctor's future plans with regards to GPwSI accreditation

**Q5. Do you think it is possible to separate the 'Generalist' and GPwSI elements of a doctor's appraisal portfolio?**

Respondents answered unanimously 'yes'. One respondent highlighted that the candidate's evidence was predominantly dermatology based in the current year because they were studying for a diploma, and expressed concern that the doctor's learning was not 'generalist enough' for their GP work. The other respondent suggested that GPwSI accreditation should be undertaken by a speciality doctor while the GP appraiser will 'overview doctor's performance in all roles.'

**Q6. Do you think it is appropriate for a GP appraiser to make an assessment of a GP's skills and competences in an extended scope of practice? If not who might do this?**

Two respondents answered 'yes' and two 'no'.

**Q6b. If you have answered NO then please suggest who might be better placed to do this.**

One respondent suggested that it would have been difficult for them to assess the extended dermatology element of the doctor's work if they had not been working as a GPwSI in dermatology themselves, adding that they believed the GPwSI's role should also be appraised either by their consultant mentor (ideally based as working alongside the GP) or an experienced GPwSI who is already aware of the guidance for that particular role. The second respondent suggested that the assessment should be undertaken by the specialist organisation or the RCGP.

**Q7. Do you think that the Initial assessment of a GP's skills and competences to undertake an extended scope of practice (GPwSI role) should be a service that the RCGP and specialist organisations should provide?**

Respondents answered unanimously 'yes'.

**Q8. Do you consider that the 'Re-accreditation' of a GP's extended scope of practice should occur as part of the revalidation process?**

Respondents answered unanimously 'yes'. However, one respondent included the caveat that a separate annual appraisal is conducted via the consultant/GPwSI mentor to help the responsible officer prior to the revalidation process submission.

## Referee Survey

Although not in the original scope of the study, it was decided that a survey of candidates' referees would add value to the pilot. Only one referee responded so this data is considered unrepresentative and not included.

## Resource Implications

Based on the experience of the pilot, resource estimates are provided below for two models of assessment on the assumption that (for both models) a panel would assess six portfolios per day, which the pilot would suggest is a manageable number. These models assume that a lay person would review portfolios and attend assessment sessions, but the benefits of this were questioned by the pilot team and require further discussion. Costs would be divided accordingly between the RCGP and the relevant specialty organisation, the BAD in this case. Each organisation would apply their own clinical, staff and lay input rates, overhead costs and travel/subsistence rates where applicable.

### Remote Assessment – per Assessment Day plus Preparation (6 Portfolios)

GP panel member:	1 day (review of portfolios) 1 day (participation in assessment teleconference)
Dermatologist:	1 day (review of portfolios) 1 day (participation in assessment teleconference)
Lay person:	1 day (review of portfolios) 1 day (participation in assessment teleconference)
Project support:	0.5 days (processing submissions) 1 day (supporting teleconference assessment session)
Manager:	0.25 days (providing general oversight and coordination)
Teleconference:	Per hour / per person

### Face-to-Face Interview – per Assessment Day plus Preparation (6 Portfolios)

GP panel member:	1 day (review of portfolios) 1 day (participation in assessment teleconference) Travel x 1 journey Subsistence
Dermatologist:	1 day (review of portfolios) 1 day (participation in assessment teleconference) Travel x 1 journey Subsistence

Lay person:	1 day (review of portfolios) 1 day (participation in assessment teleconference) Travel x 1 journey Subsistence
Project support:	0.5 days (processing submissions) 1 day (supporting teleconference assessment session)
Manager:	0.25 days (providing general oversight and coordination)
Other:	Lunch Tea / coffee Room hire

For indicative purposes, it would be likely to cost the organisations undertaking assessment approximately £450 to assess **an individual portfolio** via remote assessment and £500 by interview, if:

- Costs are based at RCGP rates
- Portfolios are submitted in a suitable format (hence can be administered and assessed efficiently)
- Six portfolios are assessed in a one day session
- Candidates cover their travel costs and other expenses
- VAT is not included

### **Additional Costs**

The cost of providing a portfolio assessment function would not be limited that incurred through the assessment process. There would be additional costs associated with the development and maintenance of an assessment service, including:

#### **Setup Costs**

- Assessment framework development (and periodic review)
- Portfolio / interactive PDF development
- Assessor recruitment and training
- Staff time to establish operational process

#### **Ongoing Costs**

- Assessor recruitment, training and calibration
- Quality assurance
- Governance
- Legal advice / insurance / indemnity
- Management and administration
- Materials
- Marketing
- IT support
- Publishing

The above costs would need to be shared across the two organisations and factored into any pricing structure developed.

## Key Themes, Findings and Further Questions

The availability of funding did not permit a large scale project and it was never envisaged that the pilot would draw reliable conclusions on the basis of its statistical data. Nevertheless, participants were represented across a range of assessment areas and the pilot evaluation has identified a number of findings and further questions that will help the RCGP and relevant partners design an appropriate model of assessment. These are detailed below:

### Definition and Scope of an Extended Role Practitioner

The pilot team identified the need to define an extended role (where it ‘starts and ends’), including how much time should be spent as a generalist to be an extended role practitioner, if such a requirement should be specified. Noting that it is a doctor’s responsibility to work within the limits of their competence and the role of appraisal to consider whether they are doing that, the team did not feel that it would be realistic for a doctor to demonstrate competence in all aspects of an extended area of practice e.g. dermatology to gain accreditation. Looking forwards to credentialing, the concept of ‘granular’ credentials was considered, but it is understood that credentials will cover broad areas of practice and a granular approach will not be adopted by the GMC, partly for administrative reasons. Credentials will be outside existing specialty curricula and skin surgery is already in the dermatology GPwSI curriculum. Therefore, the RCGP and BAD may wish to recommend a defined area of activity such as “skin surgery in primary care” as a credential to the GMC.

### The Importance of a National Process

National standardisation is a key requirement to ensure patients receive safe and effective care. It will also help doctors who relocate or work in different parts of the country. Whilst there is scope for local assessment, there is clearly a need for a central check and balance function, particularly where local supervision is weak or whether there are local conflicts of interest (e.g. around private providers delivering care). Clear systems of local support were identified in a number of the stronger candidates submissions.

### The Role of the Central Panel

The panel would judge whether a doctor’s portfolio demonstrates that they have the appropriate skills and competences to practise in an extended role rather than make clinical assessments, its judgement being objective and based upon the portfolio of evidence rather than local intelligence. It was acknowledged, however, that local knowledge may be helpful in some cases in order to understand the doctor’s evidence, but there would be a risk of local knowledge undermining the panel’s objectivity.

## Composition of the Panel

The panel would need to include a consultant dermatologist, nominated by the BAD, and a GP with experience in extended dermatology, nominated by the RCGP. It is not clear whether there is benefit in routinely including a lay member on the panel. Nevertheless, the pilot team agreed that lay input is required in the wider process, including quality assurance.

## How to Demonstrate Competence

There is a need to present a range of options to demonstrate competence. Whilst demonstration of acquisition of knowledge through post-graduate study can be important, the panel felt that work place based assessment tools used to demonstrate competency were of paramount importance, in combination with a structured reference from a specialist. The doctor should provide demonstration of both quality and on-going mentoring as follows:

### Competence

- For new candidates, the competency based tools included in the 2011 guidance are appropriate
- For reassessment candidates, audit of outcomes using audit, 360 MSF (dermatology), case note review and DOPS for procedures would seem appropriate
- A structured reference from a suitable specialist (s) – using a standard reference pro-forma for new and reassessment candidates

### Mentoring (life-long learning)

This would be covered via the following using the annual appraisal process:

- Personal Development Plan
- Arrangements for ongoing mentoring
- Continuing Professional Development

The group considered whether a knowledge test should be a requirement for new candidates and had mixed views about this.

### Ongoing Clinical Specialist Secondary Care Supervision

Local clinical supervision was identified as key and there is a need to define who should provide this supervision, what form it should take and whether there should be different arrangements for new and experienced extended role practitioners. The pilot team considered the concept of a supervisor's report, a structured document based on Good Medical Practice. The supervisor's report is described in more detail in **Appendix 3**.

### Quality Assurance

The pilot team agreed the need for clear assessment criteria to ensure transparency and to meet any challenges effectively. The team considered whether external scrutiny of the panel decision would be required. This model adopted for the RCGP Membership by Assessment of Performance (MAP) process, whereby recommendations for College membership are scrutinised by an additional panel, is one option.

### *The Role of the Lay Person*

The pilot team agreed that lay input was required in the process, but this may not be used most effectively through routine representation on the panel. The team considered how removed from the medical profession a lay person would need to be – e.g. a retired doctor may not provide a sufficiently external view. Impact on patients would need to be a clear assessment criterion.

### *Interview Process*

The pilot team considered the overarching question of whether a face-to-face interview adds value to the process. Whilst an interview panel may be important for an applicant who has changed roles, for borderline applicants or where clarification of evidence is required, the pilot team questioned whether routine use applicant interview would add value to the process. A number of candidates gave personal information in the interview, or used the interview as an opportunity to obtain career advice, thus diverting the interview from its intended purpose. Structured telephone conversations with candidates may be appropriate in some circumstances. The pilot team were concerned that a face-to-face interview may introduce unconscious bias.

### *Whole Service vs Individual Contribution?*

Many candidates submitted evidence relating to their service rather than specifically about their own contribution to it. The pilot team consider that the focus should be on the individual and the one to one patient experience. Nevertheless, it was considered not always possible to separate the individual and the service.

### *Fixed Point Assessment or Ongoing Demonstration of Competence?*

The pilot team identified a ‘catch 22’ situation whereby candidates would be required to demonstrate experience to achieve initial ‘accreditation’, but may not be able to gain this experience unless they are ‘accredited’. It might therefore be necessary to provide ‘provisional accreditation’ subject to certain conditions until accreditation has been gained. A patient view on this would be welcomed. It was noted that it will not be a (GMC) requirement for a doctor to hold a credential to practise in a particular field – the credential will demonstrate that they have attained competence in that field.

### *Length of Accreditation*

The pilot team considered how long an ‘accreditation’ should be valid. It would make sense to align the process with the revalidation cycle, but should a doctor, for example, be accredited before taking a break from practice? Might there be legal issues to consider?

### *The Role of Appraisal*

The pilot identified that, unless they have specialist expertise in the relevant field, the local GP appraiser is unlikely to be able to make an assessment of a GP’s extended role dermatology activity, the role of appraisal being to overview the doctor’s performance across the full spectrum of their clinical practice. However, a high quality dermatology appraisal could assure an appraiser that a GP is up-to-date and fit to practise in an extended scope of practice. If this is the case, an appraiser could ‘sign off’ the doctor in an extended role via their main appraisal. The pilot team considered what might happen if a GP has ‘failed’ in the dermatology element of their role and whether the appraiser would have a

mandate to tell the doctor that they cannot practise in that area. Due to a risk that doctors may be unable to get a dermatology appraisal, the pilot team considered whether it should be incumbent on the provider of a dermatology service to offer an appraisal, or whether it might be possible to establish regional appraisal and assessment centres.

### *Submission Process*

An appropriate electronic format (e.g. e-portfolio or interactive PDF) would be necessary for a doctor to submit evidence relating specifically to their extended role. This would make the evidence requirements clear and allow administrators and panellists to access the information they need quickly. Detailed supporting information relating to the doctor's extended scope of practice would be uploaded separately to that submitted for their main appraisal, but would be accessible to the doctor's appraiser, perhaps as a PDF summary in the extended roles section of their e-portfolio. There would not be a need to capture basic information e.g. GMC registration status in the extended roles portfolio because this is already included in the appraisal portfolio. However, because the doctor's appraisal is concerned with their full scope of practice, it would not be appropriate to exclude certain items of information relating to their extended role e.g. SUIs from their appraisal portfolio.

### *Resource Requirements*

It is important to note that two areas of work with resource implications were not included in this pilot – the background work to agree the standards for assessment, which requires curriculum review, stakeholder agreement, and clear articulation for the purpose of application to practice. The other area not evaluated here is the cost of running a service to host and disseminate the standards – e.g. providing information to CCGs or individual practitioners, answering queries, and keeping documentation up to date. There would also be costs associated with the recruitment, training and calibration of a pool of assessors, as well as ongoing administrative and managerial support. To set up and sustain an accreditation service (or 'credential') would need to take these aspects into account.

These above costs are likely to be significant and would need to be recuperated with an income model. The RCGP would need to consider how it might support a process potentially covering several extended roles. Appropriate cost / income models would need to be produced and drivers for uptake of extended roles would need to be understood. There are also a number of operational considerations to factor into service design, including indemnity and how the organisations supporting the process would meet data protection and equality and diversity obligations.

### *Isotretinoin*

The pilot team identified the need for clarity on the conditions when an extended role practitioner is authorised to prescribe Isotretinoin.



## Next Steps

The pilot findings will be taken forward within the context of credentialing. The RCGP will develop an internal business case to support credentialing, informed by the findings of the pilot. Subject to the approval of that business case, it is anticipated that the RCGP will work with relevant partners, including the BAD, to develop credentialing proposals in a small number of priority areas for submission to the GMC in late 2015. In the interim, the RCGP and the BAD will engage with NHS England to agree ways to promote the implementation of existing national GPwSI accreditation and reaccreditation guidance to address current inconsistencies in the implementation of the generic and speciality specific frameworks.

## References

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## Acknowledgements

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The RCGP and the BAD would particularly like to thank the pilot team, the GPs and appraisers who participated in the project, as well as the organisations who supported the recruitment process by raising awareness of the pilot.

# Appendices

## Appendix 1: DERMATOLOGY AND SKIN SURGERY EXTENDED ROLES APPLICATION FOR FIRST ASSESSMENT

### *SUMMARY CHECKLIST OF REQUIRED DOCUMENTATION*

All applicants should complete the application for assessment indicating their required assessments, complete in the word document and include an electronic signature.

Sections A: Complete in the word document

- Application for assessment (signed and dated).
- Screenshot of GMC GP Registration.
- Personal Details

Section B: Complete in the word document

- Your current role and the new role – timetable.

Section C:

- Portfolio of summary evidence relating to core role.
- Portfolio of evidence relating to extended role, in particular log diary, case based discussions, mini-CEXs and DOPS.
- Appropriate appraisal documentation.

Section D:

- Examples of planned or completed audit projects.

Section E:

- Signed, dated, reference from consultant specialist.
- Where appropriate, this should make reference to involvement with the skin cancer MDT

Section F:

- Evidence of resuscitation update, basic life support certificate and immunisations.

**Applicants should provide the evidence as follows**

- Completed word document under Sections A and B
- Portfolio of evidence to support Sections C, D, E, F.
- All documentation should be organised under the designated sections (A-F) using the 'section dividers' attached.
- All documentation must be scanned as **one** PDF file.

Please note: any questions regarding the application process and documentary evidence should be directed to Anna Tong by emailing [anna@bad.org.uk](mailto:anna@bad.org.uk)

## Appendix 2: DERMATOLOGY AND SKIN SURGERY EXTENDED ROLES APPLICATION FOR RE-ASSESSMENT

### *SUMMARY CHECKLIST OF REQUIRED DOCUMENTATION*

All applicants should complete the application for assessment indicating their required assessments, complete in the word document and include an electronic signature.

- Sections A: Complete in the word document
  - Application for assessment (signed and dated).
  - Screenshot of GMC GP Registration.
  - Personal Details
- Section B: Complete in the word document
  - Your current role and your extended role – timetable.
- Section C:
  - Portfolio of summary evidence relating to core role
  - Portfolio of evidence relating to extended role
  - Appropriate appraisal documentation
- Section D:
  - Examples of planned or completed audit projects
- Section E:
  - Signed, dated, reference from specialist
  - Where appropriate, this should make reference to involvement with the skin cancer MDT
- Section F:
  - Evidence of resuscitation update, basic life support certificate and immunisations

#### **Applicants should provide the evidence as follows:**

- Completed word document under Sections A and B
- Documentary evidence to support Sections C, D, E, F.
- All documentation should be organised under the designated sections (A-F) using the 'section dividers' attached.
- All documentation must be scanned as **one** PDF file.

Please note: any questions regarding the application process and documentary evidence should be directed to Anna Tong by emailing [anna@bad.org.uk](mailto:anna@bad.org.uk)

### **Appendix 3: THE CONCEPT OF A CLINICAL SUPERVISOR'S REPORT (INITIAL IDEAS)**

The clinical supervisor's report would be structured like an appraisal document and based on Good Medical Practice. The clinical supervisor could be a consultant or an experienced, re-accredited extended roles GP belonging to an approved list. The doctor providing the report could be non-local if there was no local dermatology service or the local dermatologist preferred to devolve this supervisory role to another dermatologist. In this situation, a national review of the application would be very important to ensure standardisation. The pilot team were of the view that the DOPS or mini CEX could be carried out by someone other than the clinical supervisor.

The pilot team's thoughts on the supervisor's report were as follows:

- This would include the range of evidence
- Modelled on the SpRs report
- Summary sheet of CPD completed with reflection
- Summary sheet of DOPS/mini CEX/ CBD (varying dependent on whether new or reassessment) rather than masses of forms
- Not a one off process but ongoing collection of data in form that could then be collated and submitted more easily (e portfolio?)
- Assessment tools and DOPS/mini CEX/ CBD feel much more important than certificates of attendance at meetings
- Reference less helpful perhaps than a local dermatology appraisal with supervisor (s)
- Not all boxes ticked in the curriculum lists, how do we deal with this? Flexibility essential. Key may be to identify core conditions that need to be seen and managed and another level relating to the rarities
- Prospective/ongoing audit must be part of the submission. Not acceptable to have ideas about projects
- Peer review of notes considered an excellent tool: who does the peer review, again? Mix of GPwSI and specialist review. Logically would form part of the supervisors report
- Table to summarise dermatology CPD and PDP programme