RCGP: the current situation

The RCGP “Guide to the Revalidation of General Practitioners” (henceforth referred to as the “Guide”) states that “When revalidation is fully established, a GP’s revalidation portfolio will be expected to contain appropriate evidence of auditing”. This will normally be two full-cycle (initial audit, change implemented, reaudit to demonstrate improvement) clinical audits during the revalidation period.”

The Guide continues: “Locums will have less infrastructure/practice support than practice-based GPs to facilitate clinical audits. Practices will be encouraged to facilitate access to clinical records for audits by locums, and the Department of Health will be encouraged to ensure that all prescribing is identified to the prescribing doctor. Guidance on audit topics suitable for sessional doctors, especially locums, will be drawn up, and a list of suggested topics may include:

- antibiotic prescribing
- investigation and imaging
- prescribing for pain
- referrals
- cancer diagnosis, e.g. breast/lung/prostate
- depression case handling
- medication reviewing
- hypertension management.”

A briefing paper prepared for sessional GPs by Professor Mike Pringle has already outlined some of the problems with this requirement. He writes:

“Some general practices record locum activity on their computer systems under a generic “Doctor locum” or put salaried doctor prescribing into the prescribing of a practice partner (distorting that partner’s prescribing data and making computer analysis of the sessional doctor’s prescribing impossible). Some practices use one smart card for all locums. These problems are soluble if the practices adopt best practice and the Departments of Health insisted that software can attribute prescribing to individuals. There are plans in Scotland to move to the GMC number being the identifier for all GP’s.”

The proposed action is:

<table>
<thead>
<tr>
<th>Proposed action</th>
<th>Lead Organisation</th>
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<tbody>
<tr>
<td>The Department of Health should be urged to resolve the issue of computer recording of prescribing against the prescribing doctor</td>
<td>BMA</td>
</tr>
<tr>
<td>A list of clinical audits suitable for locums and OOH doctors should be drawn up, with collection sheets and example outcomes</td>
<td>NES, NASGP, BMA and RCGP</td>
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</table>
Fundamental issues

Why are we doing this? We need to be clear about why clinical audit has been included in revalidation, for all GPs and not necessarily just GP locums. As we will demonstrate in this paper, so far as locums are concerned it will not improve quality of care.

The questions that need an answer include

- Is there any evidence to suggest audit can work for GP locums?
- Is the clinical data relating to a locum’s practice reliable?
- Can reliable data be gleaned from patients’ records?

Problems with the requirement for locum audit

Even if the measures in table 1 are put in place it would remain extremely difficult, if not impossible, for locum GPs to do a full audit cycle on any of the topics listed above, let alone to get reliable data from which meaningful conclusions can be drawn.

Even if the data on GP clinical systems were reliable, there are major problems for locums trying to collect data. Locum work is unpredictable by nature and changes constantly. A practice that employs a particular locum regularly for a few months may well find that its financial or other circumstances then change and that it no longer needs to use locums. This could prevent a locum from completing an audit cycle and therefore from being revalidated, leading to loss of livelihood. Would locums be expected to pool data from all, many or just a few of the practices in which they have worked? Locums need guidance on how many patients need to be included in an audit for it to be sufficiently “powered”.

The word “encouraged” which appears twice in paragraph 2 of the introduction is nowhere near strong enough. Peoples’ livelihoods are at stake. If a practice or the Department of Health decide not to follow this “advice”, GPs (and especially locums) will not be able to do audit. This word needs changing to “must”, and it must be enforceable.

General practice is a team effort and no doctor works entirely in isolation. There will always be team influences, practice guidelines and formularies which impact on the quality of care provided, and locums will be subject to these different influences when they work in a practice. Audits should always be seen in the context of the situation in which it was conducted.

Some of the problems below apply to any GP, not just to locums.

General Problems for all GPs

The quality of data on GP systems

This is variable at best and there are many problems to be overcome if data quality is to improve. I think it would be a mistake to make judgements about a doctor’s performance on the basis of crude data.

Skewing of data

Many factors beyond the doctor’s control influence clinical data. These include, for example:

- Demographics of a population. Practices with a large elderly population are likely to appropriately prescribe more analgesia and more antibiotics
A doctor doing the weekly ward round at the cottage hospital or nursing home is likely to have higher prescribing of analgesia and antibiotics

**Lack of searchable data**
Many entries for investigations requested are entered on the computer in free text rather than in code, so they are not searchable.

**Poor search facilities in GP systems**
Anecdotal experience suggests IT systems are, on the whole, very poor at giving reliable search outcomes. No research has been done to ascertain the reliability and effectiveness of different IT systems and no national standards exist for data entry or output.

**Problems for locums**

**Lack of identification of the locum**
Most practices use a generic log-in for locums – despite guidance to the contrary from the GMC and Medical Protection Society, so it is not possible to search for data entered by them. Locums generally use the stamp of a regular practice doctor on request forms, or sticky labels bearing the name of the registered GP. Referrals are usually stored on the computer as “referral by Dr A locum” or similar, and some practice secretaries substitute the locum’s name with that of a regular practice doctor at the foot of the letter. Therefore, referrals are not searchable either.

**Other problems for locums**
There are simply more locums than there used to be, having to spread themselves across wider areas in order to work. Practices are less likely to appoint new partners, and anecdotal evidence suggests, because of the “credit crunch” are less likely to recruit salaried GPs and instead rely on ad-hoc locums. A recent NASGP survey suggests 55% of locums work in more than 5 practices a year; 25% work in more that 10.

The locum is often not around to view the results of investigations ordered or to examine the outcomes of referrals.

To go around to all the practices in which one has worked to find out results or outcomes or to perform computer searches for other data would be prohibitively time consuming. Assuming the locum could organise a suitable time between surgeries, at a time suitable to the practice with an available member of staff and free computer, the data obtained would be poor and useless in any event.

**NHS Infrastructure and the realities of a busy job**
Preparing the NHS for a situation where reliable data on prescribing, referrals and requests for laboratory tests and imaging could be obtained would be a bureaucratic nightmare. Just some of the things that would need to be put in place would be:

- Smart cards for all locums, to be set up by the practice manager (if available) at the beginning of every single locum session, and closed down at the end of the session. This process involves the practice manager making a ‘phone call to the PCT before a session to register the card to that practice, and then ’phoning back at the end to “de-
register” This is precisely why practices do not make use of locum smart cards, even if locums possess them. Moreover, in reality, often only a receptionist is available.

- Practice managers setting up individual profiles on the computer for every locum working in the practice. This can amount to many dozens of locums and would be a most onerous task
- Prescribing numbers for every locum
- Reliable coding of every referral and investigation (laboratory, imaging)
- Fully reliable search facilities in GP computer systems

Does the quality and usefulness of the data obtained justify the considerable use of time and financial resources?

**What audits can locums realistically do?**

Some examples of surveys that locums have performed:

- A survey of 50 consecutive patients seen, looking to see how they fared after the consultation.
- A survey of 20 consecutive referrals and admissions to observe outcomes and to look for evidence about the appropriateness (or otherwise) of management.

There was very little to learn and neither of these surveys would be classed as an audit anyway, since there was no local or national standard with which to compare performance. Nor would such surveys be acceptable anyway under the rules set out in the “Guide”, since there was no full audit cycle.
Appendix
What, exactly, would one audit in the examples listed in the introduction?

Referrals and investigation (laboratory, imaging)
How exactly could one audit appropriateness of a referral or investigation? These concepts are not measurable.

Referrals, requests for investigations (for example laboratory, imaging) are usually not coded and cannot be reliably searched. Some practices review all locum referrals and modify (or even cancel) them, according to their wishes. This makes any analysis unreliable.

A locum could certainly build up his own database of referrals and investigations as he made them, and could later look up the results of investigations and the outcomes of referrals in a few practices in which he worked regularly. However, for investigations this would be immensely bureaucratic and would not be at all helpful in terms of professional development, since one would not learn anything about the appropriateness or otherwise of the investigation when viewing the result.

It is difficult for a doctor to assess the appropriateness or otherwise of a referral when reading a letter after the patient has been seen by the person referred to. Who would judge whether an original referral was appropriate anyway? Hospital consultants are not best placed to do this since they are not experienced in the realities of being a primary care physician.

How would one convert any of this into a full audit cycle in any case?

Hypertension
How could a locum audit hypertension management when, in reality, the locum is only one of perhaps a handful of doctors involved in the management of a particular patient’s hypertension. The locum is the doctor who is least likely to impact on the management and is likely to only initiate a new drug, stop an old drug or change a dose once before the care returns to the regular practice doctor.

Prescribing
Prescribing data is notoriously unreliable. It is affected so much by repeat prescribing systems and by so many practice variables that the data is meaningful only at practice level. The name at the bottom of the script often bears no resemblance to the doctor who prescribed one particular item on the script and if a repeat prescription contains 10 items, it is perfectly possible that they were all initiated by different doctors. Moreover, patients often ask for a repeat prescription for several items while another medication is being initiated in the consultation. All the items may appear on the same script, perhaps giving the appearance that the consulting doctor initiated them all. Many practices now show the registered doctor (and hence the prescribing doctor) as “salaried pool” or similar. It is impossible to get reliable data on an individual doctor’s prescribing and any attempt to do so would represent “Big Brother is watching you” at its very worst. The same concern applies to just about every other requirement in the “Guide”

Data on generic prescribing is now virtually meaningless since so many PCTs are now instructing doctors to prescribe the cheapest branded products rather than a generic drug, and most GP surgeries now have facilities to advise on prescribing, including a local pharmacist,
a PCT prescribing adviser and software such as “Script switch”. Some drugs should be prescribed as a branded product because of pharmacokinetic considerations, for example.

**Cancer diagnosis**

What exactly would a cancer diagnosis audit be expected to detect? The number of cancers diagnosed? GPs rarely diagnose cancer themselves but they do arrange investigations or make referrals that subsequently result in a cancer diagnosis being made. How would one audit cancers “missed” or get any reliable information about whether the investigations requested or the referrals made were appropriate, regardless of whether the patient subsequently proved to have cancer or not? This sort of information is not measurable.

**Depression case handling and Medication Reviews**

As discussed above, the data quality on GP systems is unreliable and no meaningful conclusions about quality of care can be drawn from audits of numbers of PHQ9 scores recorded or of codes for “Medication Review done”. In the past I have either noticed the following or they have been reported to me:

- A PHQ9 score of 0 entered in every case by a number of doctors
- Doctors admitting that they make up the scores for each question based on their own gut feelings, or make up the total score without even itemising the component questions
- No documentary evidence that a PHQ9 score had actually been done
- A code for “medication review done” entered on the computer when there was no evidence that the medication had been properly reviewed, or evidence that it had not (eg items last issued in 1996 still in repeat scripts).

These findings are most unlikely to be peculiar to a single practice. Together with inadequate search facilities, they mean that any audit of these two areas would yield totally unreliable results, from which no conclusions can be drawn at all. I don’t need to waste my time doing audits/searches for this data when, for example, I know for a fact that I ask 2 screening questions and/or do a full PHQ9 score on every patient who may possibly have depression. However, the value of even doing a PHQ9 score is uncertain because there is some evidence that PHQ9 scores over-diagnose depression.

Dr John Pike

**References**
