



Revalidation for GP Locums

A Practical Guide



Introduction

Revalidation has started and Wessex LMCs are keen to offer support to GP locums with their preparation for revalidation. It has been acknowledged nationally that locum doctors may face additional practical challenges in obtaining their supporting information. We hope that this document will go some way to easing those challenges.

This document contains a range of practical suggestions that GP locums can use to add to their existing evidence for appraisal. It has been written by GP locums for GP locums.

The key message is that revalidation doesn't have to be difficult. If in doubt ask early – your Appraiser and your LMC will be happy to help.

You can read this document from start to finish or dip in and dip out again. We hope that you find it helpful



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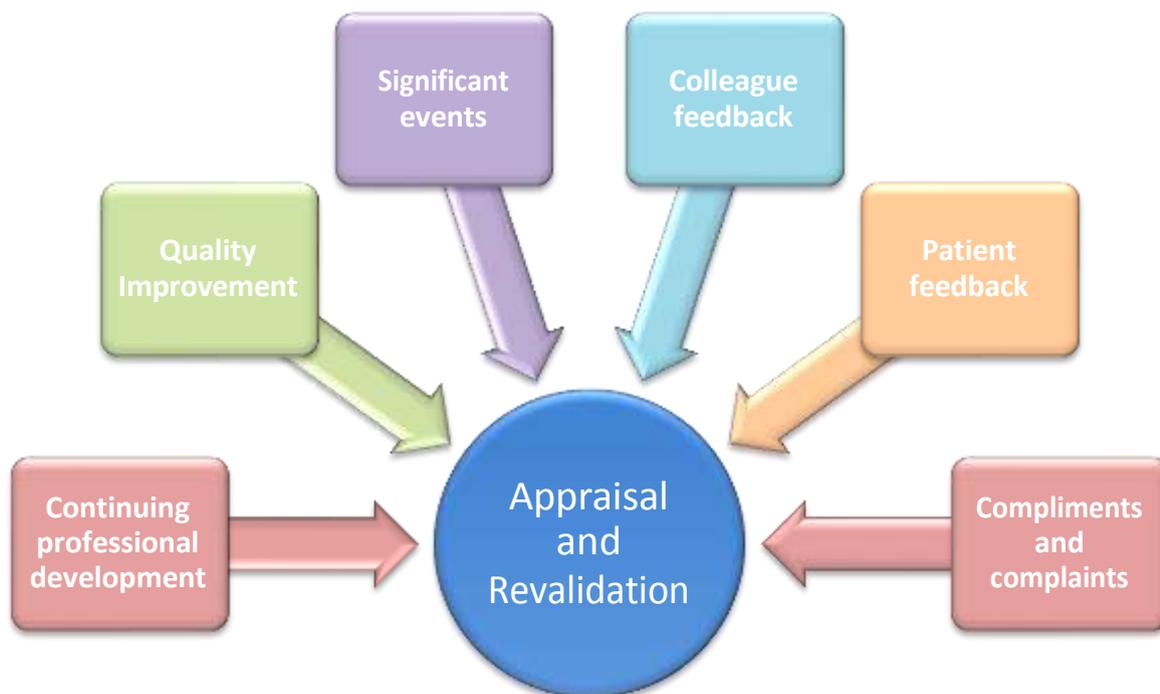
Wessex LMCS

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Where to start:

Important advice for locums about revalidation itself can be found on the website of the Revalidation Support Team. Click [here](#)

There is ample general information on the [Wessex LMCs website](#) about revalidation



The Six Areas for Revalidation

1. [Continuing professional development \(CPD\) - required annually](#)
2. [Significant events - required annually](#)
3. [Quality improvement activity - required annually](#)
4. [Feedback from colleagues - required once every 5 years](#)
5. [Feedback from patients - required once every 5 years](#)
6. [Review of complaints and compliments - required annually](#)

Clicking on the individual headings will take you directly to further information on each subject.

Under the section of quality improvement activity there is a range of examples to choose from.

Continuing professional development

Here is a summary of what you need to do:

Record on your personal learning

Needs based – why did I need to learn this?

Cover your whole scope of practice

Reflect on what you have done and what you have learnt

Outcome focused – how does it change my clinical care?

Discuss your CPD at each appraisal

CPD is the cornerstone of revalidation and will be discussed at each appraisal. CPD should be specified and undertaken as part of your personal development. You should identify your professional needs and competencies and should take account of the needs of patients and the healthcare system when planning your CPD. If you are unfamiliar with how to develop a PDP please find sample information via this [link](#). With the wide ranging breadth and depth that general practice covers there are several options to discover learning opportunities. A self- assessment can help and this can be done either via a knowledge check list [click here](#) (link to knowledge check list document), PEP self-assessment via **the [RCGP website](#)** or via [On-Examination](#) to test yourself with MRCGP-like questions.

The RCGP suggests that you are required to undertake a minimum of 50 credits of CPD per year to cover the breadth of the GP curriculum. The vast majority of GPs will undertake significantly more than this. The GMC does not define a specific number of hours or credits but does require you to engage, record and reflect on the activities you undertake, and do enough to demonstrate that you are up to date across the whole scope of your work.

You should complete a **variety** of learning events or actions, which could include:

- Attending an external lecture or conference
- Attending an internal practice based educational event e.g. significant event meeting, practice based education, try asking the Practice Manager at practices if you can link up with their activities
- Attending a small group based learning e.g. an action learning set, Problem Based Small Group Learning (PBSGL) with a formal or informal origin or done through a locum support group or chambers
- Reading a medical journal or book
- E-learning modules, podcasts, apps or websites
- Teaching and training
- Case based discussion
- Clinical audit
- Data collection and analysis
- Review of notes with a colleague

CPD is not only about filling gaps in knowledge but is also about maintaining your skills.

You will need to demonstrate you are keeping your skills and knowledge up-to-date in all aspects of your work especially where you have more than one role.

Keep a CPD log of what you have done during the year, why you have done it, how long you have spent doing it and recording brief reflections, focusing on the outcomes of your learning rather than providing vast sums of documents. It is the impact on your practice that matters. Your CPD can be recorded on any of the commercial toolkits, the RCGP portfolio, the MAG form or the Severn Deanery toolkit. There is also an Excel spread sheet available on the LMC Website. There is also a free learning log at www.mylmc.co.uk that can be exported as a PDF at the end of the year to any appraisal tool you wish.

Significant event review

The GMC definition of a significant event is not the same as the one that has been used in general practice (essentially a significant untoward incident). For clarification of the difference and its meaning for your appraisal please check the [LMC website](#).

All practices discuss significant events and practitioners should use these as quality improvement activities. What appraisers are looking for is your reflection and then any action that has been taken which will improve the quality and safety of care in your practice.

As a locum you should try to ensure that the places you work let you know if you have been involved in a significant event so that you can share the learning by getting the minutes, even if you can't always attend the meeting. You could stipulate this in your terms and conditions.



Feedback from colleagues

There are a number of feedback tools that are available to do this for you. They come at a variety of prices. You are free to choose whichever you wish, check beforehand that they match the GMC requirements.

The GMC states that all colleague and patient questionnaires must:

- be consistent with the principles, values and responsibilities set out in the GMC's core guidance, *Good Medical Practice*
- be piloted on the appropriate population, and demonstrate that they are reliable and valid
- reflect and measure the whole practice of the doctor
- be evaluated and administered **independently** from the doctor and appraiser to ensure an objective review of the information
- provide appropriate and useful information to the doctor that can be used in discussions with a supervisor or mentor, or through appraisal
- help the doctor reflect on his or her practice and identify opportunities for professional development and improvement.

'MyLMC' is a tailored service for GPs set up in conjunction with Wessex LMCs to reduce the stress around revalidation, colleague feedback and patient feedback as much as possible. The following link explains about feedback from colleagues and how to arrange your MSF via [MyLMC](#). There are a number of alternatives on the market including [CFEP Surveys](#), [Edgecumbe Doctor 360](#) and many others that can be found via an internet search engine.

If you are a portfolio GP try to anticipate that most of the questions are clinical in nature. It would be helpful, if you can, to try to select most colleagues whom you know from working in a clinical setting. Don't limit yourself to doctors. A receptionist working with you regularly would also get valuable feedback about your interpersonal skills from patients; this is also true for GPs working in the Out Of Hours service or as GPwSI in a secondary care setting.

If you work in a non clinical role there are MSF tools out there for you. For example MyLMC have a good dedicated colleague feedback questionnaire designed for managerial and leadership roles, and are developing one specifically for doctors involved in aviation medicine.

Feedback from patients

Patient feedback is intended to help doctors reflect on their practice by giving them the information about their work through the eyes of those they treat.

There are a number of organisations available to administrate this requirement for you. They can be found easily via search engines on the internet. They will vary in price. There may be an opportunity to purchase both a patient and colleague survey for a discount.

Whichever company you choose check that they will meet the GMC standards. The full guidance can be found [here](#) but are the same principles as for the colleague feedback surveys. Some suggestions of organisations include [myLMC](#) and [CFEP](#).

This needs to be completed at least once in every Revalidation 5 year cycle. If you have completed on in the last 3 years bring this to your next appraisal as this will be valid.

You must reflect on the results and discuss them with your appraiser.

The survey needs to be administered, collected and analysed independently of the GP.

The guidance is that you need to distribute 50 questionnaires (they do not have to be to consecutive patients) but they should not be given to selected patient (because you know they will give you positive feedback). You need 34 completed questionnaires to ensure the result is valid.

The diagram on the following page helps you avoid some of the pitfalls and make sure the process is as painless as possible.



Ensuring collecting your feedback is painless



Review of compliments and complaints

The GMC see complaints and compliments as a type of feedback.

Compliments: As important as complaints, we can always learn and share experiences. They can also help you to reflect on your strengths which are as important as your weaknesses.

Complaints: Each year at your appraisal you will be required to declare whether you have been named in a complaint and if so you will be expected to demonstrate that you have reflected on this, defined any lessons that have been learnt and most importantly discussed any outcomes in terms of change in clinical or managerial practice as a result of this.

This is not a second chance for the establishment to open up resolved complaints, but a chance for you to review them with the benefit of hindsight after it is all over. Unresolved complaints should be identified but would not be appropriate to discuss at any length until the appraisal after they have been resolved (although you may already have some lesson learned to discuss part way through an investigation).

Note: Do not provide patient identifiable information in any of your written supporting information, nor should you name colleagues or provide colleague identifiable information in your written supporting information.

Quality improvement activities

In the past GPs were told by the RCGP that once in every 5 year cycle they would need to complete a full clinical audit. This is now not a requirement as defined by the GMC, although the RCGP suggests that GPs should use this as part of their quality improvement activity.

At each appraisal you need to demonstrate that you are engaged in quality improvement activities and provide supporting information for this.

Examples of quality improvement are:

- Case based discussion
- Significant event reviews (as defined in QoF)
- A review of clinical outcome
- Audit and monitor / data collection and analysis
- Clinical audit
- PUNs and DENs
- Review of notes, referrals or prescribing with a colleague or small group

With the above headings in mind you find below a list of suggested options to use as quality improvement activities, like a menu card you can choose from. Please do not think you are expected to do them all, instead you are expected to keep your recording proportionate and reasonable.

The difference between CPD and QI

In the purest sense one might argue that any education leads to Quality Improvement. Being more pragmatic, CPD is education but may involve revision of an area and therefore could be argued that this is not always improving quality. The RCGP Revalidation Guidance suggests that the main two ways to demonstrate Quality Improvement (QI) is Significant Event Analysis (SEA) ('At least two for the 12-month period prior to your last appraisal before your revalidation date; any serious incident must be included') and also a cycle of clinical audit ('Evidence of regular participation in quality improvement activity relevant to your scope of work and discussed at your last appraisal before your revalidation recommendation' at least one full cycle per year'). There is a caveat though which says 'The RCGP has defined the significant event audit and clinical audit as the core information to be included under Review of Practice. However, a broader range of activities can be submitted including case discussions and briefer reviews of clinical and other work if SEA or clinical audit information is not appropriate given your circumstances'.

Within the RCGP revalidation guidance is a paragraph specifically aimed at addressing QI if you are a locum or OOH GP which contains one notable statement 'A locum or out-of-hours doctor may undertake an 'action audit' in which the care of presenting cases of a defined nature is continually reviewed against pre-set criteria and standards with continuous reflection and improvement recorded. One example might be keeping a log of all referrals and patients causing concern, and then following up the patient on return to the practice or clinic, and learning lessons from the outcomes'.

The last part of this statement implies that regularly reviewing the outcomes of your patients that you have concerns about, reflecting on it and learning lessons from it, is a form of QI.

Case based review or discussion

A documented account of interesting or challenging cases that a doctor has discussed with a peer, another specialist or within a multi-disciplinary team. You must record an outcome • you only need one line but will this discussion change your clinical practice for the better?

- A) Consider getting together regularly with two colleagues (or more) for case based reviews. Some groups even enhance their learning by acting out scenarios which can be an educationally rich experience and fun, especially without CSA related stress.

How to run a group scenario:

- 1) Write out a case scenario: one with patient information for the doctor to act out, one for the observer with additional background information about why this case proved to be an interesting or challenging scenario.
- 2) Act the case
- 3) Discuss the case together
- 4) Link the discussed topic to national guidance
- 5) Next time you see a similar or related patient – write down how the case based discussion influenced your clinical assessment and decision making
- 6) Write the above process up as a quality improvement activity

- B) Another form to discuss topics in a more structured format is the use of Practice Based Small Group Learning (PBSGL). Groups of 5-12 GPs/ practice nurses come together every 6-8 weeks for facilitated group work focussing on pre-prepared evidence based modules integrating recent guidelines reducing the gap between current and best practice. [Click here](#) for further information. It requires one person to be trained as a facilitator and carries with it an annual fee of around £120. An English branch of this Scottish organisation is currently [in development](#)

Review of clinical outcomes: where robust, attributable and validated data is available. This could include morbidity and mortality statistics or complication rates where these are routinely recorded for local or national reports. Again ensure you record the reflections and actions taken.

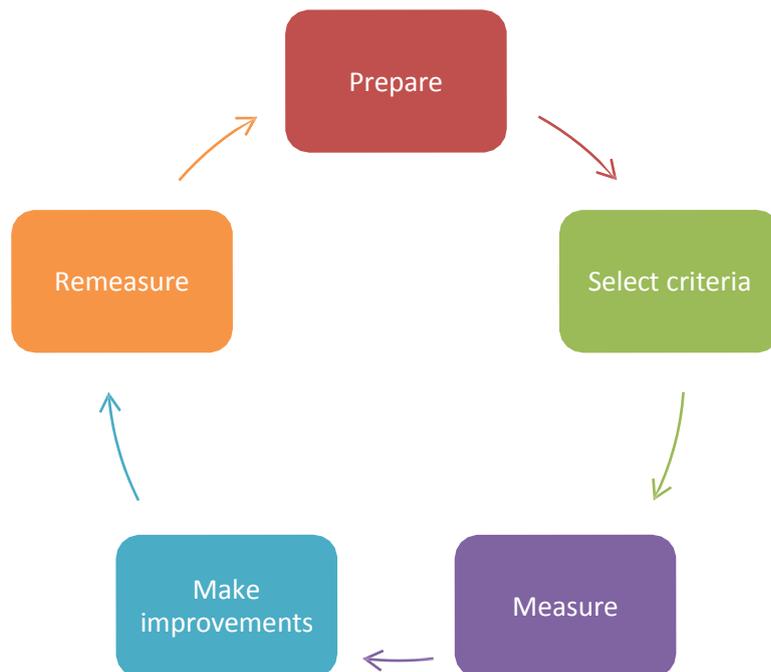
1. Retrospective reflection of your past clinic: in a practice where you have worked some months ago take a look at the outcome of the consultations you have had in one clinical session;
 - a. Diagnosis: Did the patient come back? Was your diagnosis reviewed and changed? What do you learn from this? Did you request the right investigations?
 - b. Referral: If you have referred a patient to secondary care – was the outcome what you expected? Does this change your decision in the future? Does this identify your learning need?
 - c. Quality of record keeping: Was the patient followed up according to your expectation? Did your notes indicate clearly a suggested plan of action for the patient and the next GP?
 - d. Safety-netting: Did you safety net patients at risk of significant disease safely? Is this clear from your notes? If your answer is no to these questions, how are you going to improve this? How did you communicate with the patient's own GP – paper based, intra-net based, via other staff?

You may want to use the template [appendix A](#) to record your findings.

Audit and Quality monitoring:

As we have stated there is no requirement for audits but you may choose to do this as one aspect of your quality improvement activity. Doing the measurement once could be seen as quality monitoring. In the following examples if the suggested areas are measured, reflected on and then repeated these would be audits that you could do as a locum.

Here as a refresher is the audit cycle:



1. Equipment: Do you have with you what you may need? [Appendix B](#) has a list of suggested equipment.
2. Emergency drugs
 - a. Do you have what is needed? Further information on emergency drugs can be found on the LMC website page '[The Emergency Doctors Bag](#)'
 - b. Do you keep your medication in date? Further information about how to look after your doctor's bag can be found [here](#)

3. Tracking expiry dates:
 - a. Do you have a system that tracks your expiry dates of your emergency drugs?
 - b. Drug name, formulation, dose, number held, manufacturer, LOT number, expiry date in spreadsheet
 - c. Copy and paste onto word document when needing to re-order

How to get your medication:

- i. Issue a private prescription to yourself with your name, title, GMC number. This is a business expense hence tax deductible.
 - ii. Consider carefully which drugs you have and any attached consequences. Do you store your drugs appropriately? Check out the LMC website on [storage of drugs and controlled drugs](#)
4. If you work for the Out Of Hours consider checking availability and working order (if appropriate) of the items listed. Do give feedback to the service about any missing items and record that you have done so. Can you make positive suggestions for improvement?
 - a. Emergency equipment
 - b. Emergency drugs – if stored in a cupboard are they ‘in date’?
 - c. Referral forms & envelopes
 - d. Prescription pads
 - e. Working order of laptop & phone
 - f. Ensuring patient ID and MSU specimen bottles are systematically written correctly (not on a loose piece of paper, but on the specimen bottle itself)

Clinical audit:

“Evidence of effective participation in clinical audit or an equivalent quality improvement exercise that measures the care with which an individual doctor has been directly involved.”

There are many examples of audits currently undertaken in most practices including:

- Minor surgery,
- Cervical smears,
- Monitoring of DMARDs,
- End of life care
- Cancer diagnosis
- Referrals and admissions
- Hypertension management
- Leg ulcer care
- Investigations and imaging

Practices may welcome their locum to attend their audit practice meeting or for a locum to get involved in one of their audits. You don't know if they are unless you ask. The following topics could be considered for your own audit and/ or monitoring.

Use of antibiotics – record your antibiotic prescribing for the next 30-50 prescriptions; study the local guidelines for antibiotics use and thereafter monitor your next 30-50 prescriptions.

For Hampshire based GPs there is an [antibiotic mobile phone app](#)

Web based information on antibiotic use in Hampshire and Wiltshire can found [here](#).



Use of antibiotics – C. difficile; you can use the same information about antibiotic prescribing from a different angle: trying to reduce C. difficile infection using links above by avoiding provoking antibiotics such as co-amoxiclav, ciprofloxacin, cephalosporins and clindamycin.

Review of referrals to secondary care – use of 2nd tier services;

As a group write down a set number of your referrals e.g. 20; during a group meeting ask the question: Are we using the most cost effective service for your patients? Is there any community service that could have been used rather than hospital based services? Compare notes, share knowledge about services.

Individual approach: For the next 30 referrals make a note of your intended referral route for a patient you are referring, prior to sending the referral check the surgery's GP locum pack whether an alternative service is available or ask a member of staff/ permanent GP for each of these referrals, write down whether you changed your referral route. Which additional services have you identified?

Compare above findings with the referral routes mentioned in Map of Medicine as a benchmark. Click [here](#) for more about Map of Medicine.

Review of hospital referrals and required preparatory actions: Have you added the right information to your referral? Have you done the needed investigations to accompany your referral?

Compare your actions with those suggested in [GPNotebook](#).

Compare a set of your referrals with [Map of Medicine](#)

Hypertension

Consider looking at the following aspects of your encounter with patients with hypertension during a pre-set time frame e.g. 1 or 2 months:

- i. Diagnosis: which method is being used or has been used to come to a diagnosis? ABPM, home monitoring or practice readings
- ii. CVD risk: which method is being used? Lifestyle counselling in place? Statin offered if indicated?
- iii. Investigations & end organ damage identification and/or monitoring
- iv. Treatment

See [appendix C](#) for an example of a template you can use.

- b. Compare your findings with the NICE guidelines 2011 – are there areas you can improve on?

Mental health:

- i. Have all the patients you see or diagnose with a mental health condition been offered bibliotherapy?
- ii. For a suggested bibliotherapy click [here](#).
- iii. What do patients tell you about their bibliotherapy? What is their take home message after reading?
- iv. How does this contribute to your professional view on bibliotherapy?
- v. Can you help patients getting more out of bibliotherapy?



Antiplatelet therapy: when you see a patient or prescription for antiplatelet therapy is the patient on the right drug? See [appendix D](#) for the different drug regimes.

Two Week Wait Referrals:

- a. Follow up of your 2WW referrals – ask a practice manager or GP partner before you leave whether they are happy to be contacted about the outcome e.g. 4 wks. later.
- b. Compare your conversion rate (the amount of people you have referred via the Two Week Wait who subsequently have been diagnosed with cancer) with the conversion rate at the practices where you work. These can be found at:

http://www.ncin.org.uk/cancer_information_tools/profiles/gp_profiles

- i. Click on your area e.g. 'South', select the CCG where you work, under rates/ ratios by practice you can find the conversion rate of all practices of a CCG.
- c. Do you know which symptoms prompt a Two Week Wait referral by heart? Write them out and compare your findings with:
http://www.macmillan.org.uk/Documents/AboutUs/Health_professionals/PCC/L/Rapidreferralguidelines.pdf
- d. Did you identify a link between your knowledge of NICE guidelines and your patient's diagnosis?

Review of same day hospital admissions – could you have avoided this admission by using rapid non-admission services (COAST, Rapid Assessment Service for the elderly, outreach services, rapid access to investigations, virtual clinics with community matron)?

End of Life – Please have a look at the interactive PDF about '[People's End Of Life Care Needs](#)' setting out the practical steps you can undertake as part of end of life care.

Auditing 'People's End Of Life Care Needs': are you assisting the practice in identifying patients who may need supportive and end of life care within the next 12 months?

- i. Within a set timeframe monitor how often do you identify a patient's need for supportive end of life care and initiate the first step of this care?
- ii. Compare your findings with the identifiable factors as mentioned in the link 'Identifying patients for supportive and palliative care' in the above document.
- iii. Within the same time frame as used initially see how often you identify a patient's need for end of life care using the described identifiable factors.
- iv. Compare your findings

Once patients are identified have the necessary steps been taken to support preparation and delivery of end of life care? For helpful steps see LMC 'Meeting People's End Of Life Care Needs'

Investigations: are you requesting the right investigations for the clinical scenario you encounter?

Compare with [GP Notebook](#)

N.B. Subscription to GPNotebook is free: click on 'Account Login' and register with Univadis for free subscription and limitless use of GPNotebook. Consider using GP Tracker pages to be able to proof which pages you have read over any time period. You can even compare your use against the average use of the same pages by other GPs to identify your further educational needs.

DVLA advice: write the main reason of contact with patients on a surgery list –

- Do any of them have a condition that is described by the DVLA?
- Did you take DVLA advice into account?
- Have you communicated DVLA advice to the patient including legal consequences of putting insurance at risk when ignoring medical advice?
- Did you record this in the medical record?

COPD / asthma: If you are not doing this already ask the following questions when a patient presents for medication review or acute exacerbation (you could use the template in [appendix E](#)):

- Which inhaler they are using in which situation?
- If any of the used approach works?
Check correct length of time and frequency of inhaler use; check against clinical records.
- If not helping check inhaler technique especially if using different devices?
- Spacer device needed?
- Consider stopping inhalers that do not add to improvement
- Think of occupational asthma
- Arrange follow-up – might a written care plan help in future?
- Reflect on what you have learnt from the above exercise: are there any communication issues that you could improve? Are care plans optimally used? What have you learnt about the use of inhalers by patients? How does this affect your future care?



PUNs and DENs

Patient Unmet Needs (PUNs) and Doctor's Educational Needs (DENs) are a way of identifying areas of learning during a surgery. For a full explanation of this method click [here](#).

If you are using GPnotebook during your consultations you could use their GPTracker system to identify your PUNs and DENs. At any time you can have decide to review your learning needs of a chosen period e.g. Feb-Oct last year. The pages that you have read on GPnotebook can be compared with the rate of use of the same pages by other GPs in your Personal Knowledge Graph (PKG). In this way you can identify a topic or specialty you may wish to update your knowledge in further via e-learning modules or other sources. E-learning modules can be found via BMJLearning, RCGP eLearning, GPnotebook Educational Modules, Doctors.net eCME (Continuous Medical Education) modules to name a few.

The benefit of working in small groups

Working as a locum can be professionally isolating. The feedback loops about your clinical actions are not the same as GPs who work in the same setting over a long period of time. However, there is no reason why this cannot be different. Working in small groups, two or more GPs or other health care professionals if you wish, coming together (bi) monthly creates a wide range of options to choose from:

- i. All the activities as mentioned above can be shared with your colleague(s). Remember working together can double your CPD credits by demonstrating the impact of your shared learning on what you and/or your colleagues do.
- ii. Share guidelines you have read. Consider sharing the work load by each summarising guidelines from 1 sources such as
 - a. NICE
 - b. SIGN
 - c. Essential Knowledge Updates from the RCGP
<http://www.elearning.rcgp.org.uk/course/category.php?id=2>
 - d. 'Guidelines' or on-line *eGuidelines* (with free downloadable app)
- iii. Share information about change of local services. Contact your local CCG and ask whether they produce a Newsletter or have a GP mailing list. Ask to be added to the GP mailing list. Share this information together. Many CCGs have GP locums working for them, you'll never know what this information may lead to.
- iv. Share medical news you have seen and discuss clinical implications;
 - a. BMJ
 - b. BJGP
 - c. For those registered with Doctors.net there is access to 'Journal Watch' (a round-up of relevant published research in different clinical areas. It is written by experts in the following specialties: diabetes, general internal medicine, general practice, haematology, HIV, oncology, psychiatry, respiratory medicine and rheumatology.) It provides quick and easy access to recently published topics.
 - d. Recent LMC news. Wessex LMCs send out very regular news to all GPs with both clinical and managerial information, especially from national sources. Ensure you have access to the same information as other GPs by putting your name on their mailing list.
- v. Share the learning of educational events you have attended (doubling your CPD credits).
- vi. If you see a patient after your meeting with a condition that you have discussed before, bring it to the next meeting. It is this kind of reflection and learning that is valuable for your appraisal.

- vii. Share new services or other information (indication for referral, referral form, telephone numbers) you have picked up from the locum pack of the surgery you have worked with your colleagues.
- viii. Discuss 'How to approach this scenario'.... with your colleagues. GP locums work in a wide variety of circumstances and are exposed to at times challenging situations. Ask colleagues what they would do if they were in your shoes in what proved to be a challenging situation for you. This reflection shows you are open for feedback and learning.

Do make sure you make a short report or minutes of your meeting, otherwise you cannot show your appraiser the great work you have done. You could add a summary of personal learning points for each meeting (for an example see [appendix F](#)).

Here are suggestions how to become part of a small group:

- a) Contact the GP-tutors in your area. They may run a sessional GP group already or know of other locums who want to set up a group. Their details are known by your local deanery.
- b) The National Association of Sessional GPs may have contact details of a locum group in your area.
- c) Contact your LMC and ask for local locum groups in your area
- d) Network via local educational events and meet other locums and ask them
- e) If you are within the first 5 years of qualifying consider the RCGP initiative First5. Contact details of First5 Leads in your area can be found on the [RCGP website](#)
- f) Small groups working together in the 'Practice-Based Small Group Learning' format can be found via www.pbsgl.co.uk

Appendix B: Your equipment for general consulting

Suggested list:

- stethoscope
- ophthalmoscope/otoscope
- blood pressure machine or manual sphygmomanometer
- tape measure
- thermometer
- glucometer
- pulse oximeter
- disposable ear probes for thermometer and otoscope
- pregnancy urine test kit (e.g. Clear Blue)
- British National Formulary (BNF)
- access to portable textbook via apps, on-line or paperback (e.g. Oxford Handbook of General Practice, GP notebook)
- desk aids – peak flow chart, Snellen chart, pregnancy calculator, BMI chart
- latex gloves
- urine dipsticks
- urine specimen bottle
- peak flow meter; adult and child range
- peak flow tubes
- Maglite AA torch with spare batteries
- lubricating jelly
- fluorescein eye drops
- A4 paper, envelopes, blood forms, X-ray forms
- swabs
- forms for biochemistry/haematology and microbiology
- If taking blood test specimens:
 - Tourniquet
 - Blood tubes
- needles and syringes
- butterfly needles
- sharp box
- gauze swabs, plasters and alcohol wipes
- vomit bowl
- clinical waste bags
- alcohol hand gel

Appendix C: Hypertension¹

Patient Age & sex	A Diagnosis; ABPM / Home readings – diagnosis threshold & number of readings	B CVD risk assessment	C End organ damage assessment/ monitoring: which investigations done?	D Treatment	Learning points

A Diagnosis:

1. Which method has been used to come to a diagnosis?
2. If home readings have been used has the first day of readings been discarded?
3. Which blood pressure threshold has been applied?
4. How many readings have been used to come to a diagnosis?

B CVD risk assessment:

- A. Has a CVD risk assessment been done?
- B. If over 20% -
 - a. Has life style counselling taken place?
 - b. Statin offered?
 - c. Consider discussion of role of aspirin - risk and benefits

C End organ damage assessment at time of diagnosis or medication review/annual review:

- i. ECG done / on medical records?
- ii. Bloods: Glu, U&E/eGFR, chol, HDL – is there a significant trend?
- iii. Urine: ACR, dipstick for haematuria – if abnormal, has it been investigated?
- iv. Fundi for hypertensive retinopathy – GP fundoscopy, annual optician check?

D Treatment: where is patient on treatment 'ladder'?

- I. ACE or CCB
- II. ACE + CCB (ARB in black people or if intolerant to ACE)
- III. ACE + CCB + thiazide (but not bendroflumethiazide) – suggested indapamide 2.5mg od
- IV. ACE + CCB + thiazide + (further diuretic or alpha blocker or beta blocker). Consider specialist referral

¹Based on NICE guidance, 2011 from GP Update Handbook 2012

Appendix D: Antiplatelet therapy

(Not applicable to (risk of) stroke associated AF or after carotid artery procedures)

	1 st line	2 nd line
Post-MI (based on NICE 2007, CG48 & NICE 2010, CG94)		
A) Non-ST elevation MI	Aspirin 75mg for life & Clopidogrel 75mg for 12m (local variation possible)	If aspirin contra-indicated, use clopidogrel alone for life
B) ST-elevation MI	Aspirin 75mg for life & Clopidogrel 75mg daily for: 1m if no intervention/bare metal stent 12m if drug-eluting stent	
Occlusive vascular disease (based on NICE 2010, TA210)		
C) TIA	Aspirin 75mg daily for life & Dipyridamole MR 200mg bd for life	If unable to take one of these drugs, use the other drug alone
D) Ischaemic stroke	Clopidogrel 75mg daily for life	Aspirin 75mg daily for life & Dipyridamole MR 200mg bd for life (or either separately if one is not tolerated)
E) Peripheral arterial disease	Clopidogrel 75mg daily for life	If unable to take clopidogrel, take 75mg aspirin for life
F) Multivascular disease (CVD at more than one site e.g. MI& PAD, CVA & MI)	Clopidogrel 75mg daily for life	If unable to take clopidogrel, take 75mg aspirin for life

Table taken from: The GP Update Handbook 2012. Prior to using this table check any changes in use of above medication since time of publication.

Appendix E: COPD/asthma: systematic medication review or exacerbation assessment

Patient age and sex	Which inhaler in which situation: does it work?	How are inhalers used – freq & length of time?	If not helping check inhaler technique	Spacer device needed?	Consider stopping inhalers that do not improve symptoms	?Occupational asthma	Written care plan in place?

Appendix F: Summary of personal learning points attached to minutes of group meeting

PERSONAL LEARNING POINTS:
POSSIBLE CHANGES TO PRACTICE:
RESULTS:

Appendix G: Knowledge self-assessment

The following checklist is derived from the toolkit developed by Primary Care Education in South Essex.

Beware! Studies have shown that we are not very good at filling these in; we tend to over-estimate our knowledge!

See: **The validity of general practitioners' self-assessment of knowledge: cross sectional study** *BMJ* 1997; 315:1426-1428 (29 November)

NORTH THAMES EAST CURRICULUM CHECK LIST

(Revised P Outen, Feb 2000)

<http://myweb.tiscali.co.uk/bedpgme/Personal%20Development%20Plans/checklist%20for%20learning%20needs%20assessment.pdf>

This list of topics is not comprehensive - no list of GP subjects could be. It aims to provide a fairly general spread to act as a prompt. Some things are difficult to place and there is occasional duplication. As the list is intended for registrars as well as principals it contains certain basis elements required for summative assessment.