Reviewer's report

Title: Can GPs working in secure environments in England re-license using the Royal College of General Practitioners revalidation proposals?

Version: 2 Date: 25 September 2012

Reviewer: Martin Wilkinson

Reviewer's report:

On the whole a good paper. Important area but could be written in a simpler style to improve impact.

Major Compulsory Revisions

• What do they mean by “community” and “prison GPs”. Different terminology is used to refer to this group and they should try and be consistent throughout the paper. The data is presented as “prison GPs, “security hospital GPs”, and “forensic physicians”. Are the latter GPs? Also they refer to IRC and custody suites. So some clarity on definitions for the reader would be helpful as they will not be familiar with the territory.

• The discussion could be usefully rewritten to pull out the key themes and not to repeat the results. Some sentences are not well constructed e.g. first two sentences of the second paragraph.

Minor Essential Revisions

• In the background information 4th paragraph there is a typo confusing “principle” with “principal”

• Second paragraph page two first sentence does not make sense “the majority…. work full-time or part-time” – who are the minority?

Discretionary Revisions

BACKGROUND

This article describes some of the suggested tools for revalidation of GPs prior to the introduction of revalidation. The interest is with GPs working in secure environments. The authors neglect to mention that to work in a secure environment doctors are now required to be a GMC registered GP, and on the Medical Performers List. (In the past anyone could do this work). The local PCT commissions the prison health service, which is considered an extension of the NHS and should have similar standards of practice. It is this comparison with NHS practice that puts the NHS GP peer appraiser in a good position to judge.

• It is a pity no GP from a secure environment is included as an author to ground the potential conclusions in reality.

• There is some confusion for the reader in that the GMC is responsible for
revalidation yet the GP specialist college is recommending the tools for collecting
the evidence using their own online eportfolio which is not at present, nor is
proposed, to be compulsory for revalidation. International readers might need
some clarity on this issue.

• One piece of evidence is a “statement of extended practice” and it is not clear if
this is a description (as on the current eportfolio) or a statement signed-off by a
peer in a secure environment specific appraisal or peer-to-peer appraisal. The
GP NHS appraisal is in itself a peer-to-peer appraisal although the appraiser
might not mirror the extended practice of the appraisee.

• The hypothesis is that this group of doctors will experience difficulties collecting
the supporting information, and this would affect their ability to relicense. So
they’re presuming a problem before the research but this is informed by earlier
work by the same authors.

• Some paragraph - This paragraph is not referenced. What does “scattered
geographically” mean?

• What the secure GPs were asked to collect was evidence in all 11 areas, which
under revalidation they would have 5 years to collect. Hence they will find this
study onerous.

METHODS

• Participants worked 50% or more of their time in secure environments. The
reason for this decision is not justified. I presume to get a reasonable and
representative sample.

• They state there was no sampling frame yet they have described this working
group in the background. I do believe there are no national figures but would be
interesting if this data exists or not.

• The study was by the use of small focus groups, telephone survey and
structured interview. Transcribed and analysed.

• In addition participants shared evidence collected and a simple count was made
and no attempt to look at quality of the information.

• A GP issues log was designed and used in the study.

• Ethical approval gained.

RESULTS

• The participants should be clearly placed in well defined groups for the results
(prison GPs, forensic etc). We have GPs working in prisons and “community GPs
with an extended role”. I think they mean some of the GPs did not have a
community placement, but in the tables no mention of these “community GPs”.

• I am afraid I got lost in the first paragraph which needs displaying as a table or
simplifying.

• From the focus groups it appears there are worries with a patient survey &
undertaking audit, how the appraiser will interpret the evidence, and lack of
support from the PCT commissioners.
• 40% submitted evidence. We have no information why 60% did not submit evidence, was this because it was too difficult or declined to take part? It is a very small group that is then subdivided.

• Between them all areas were submitted but very few submitted all areas.

• It is clear the GMC unvalidated patient survey tools did not work in this environment nor did the colleague feedback.

• Audit was a struggle for many.

• Complaints were different to those received in clinical practice and not always included.

• As the statement of competence for extended practice roles was not fully explained it is difficult to interpret the data on this section, but there appears to be a lack of any organisational feedback on their performance.

• The collection of evidence was time consuming.

**DISCUSSION**

• The authors do not appear to grasp the poor CPD structures within secure environments – they are not set up as learning environments. Very few of these GPs have study leave, protected learning, clinical meetings etc. A culture of audit does not exist. Doing audits, patient surveys and analysing complaints is virgin territory and as such should be embraced, kindled and used to promote learning. A reference on this issue might be helpful. This is part of the national agenda of improving offender health.

• They miss the point that they were using draft tools from the GMC that were not fully validated. It might be quite useful to design tools for this environment. Use of smiley and unhappy faces as an example. Setting up clinical audit, and CPD meetings at the sub-regional level would also help.

• I think the discussion does miss out by not having a jobbing secure environment GP involved in the discussion.

• They introduce the term “portfolio GP” and “GPwSI” with no explanation in an international journal.

• I am not sure this group wants accreditation as GPwSIs rather than time for CPD within their contracts. The point about spending a day in community general practice probably is the key for me.

• They don’t pick up the issue that it was a pilot, not compulsory, they collected all areas of information normally to be collected over 5 years, and none of the tools were approved at that stage.

• What benefit did the GPs get from collecting this information? Was it helpful to them?

**Level of interest:** An article of importance in its field

**Quality of written English:** Acceptable
**Statistical review:** No, the manuscript does not need to be seen by a statistician.

**Declaration of competing interests:**

I declare I have no competing interests