Policy for the Recruitment, Training and Accreditation of GPs and Practitioners with Special Interests
(including governance checks for practitioners who intend to deliver services in a primary care setting as part of a commissioned contract)

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<td>Claire Darbyshire, Senior Quality &amp; Engagement Manager</td>
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Policy for the Recruitment, Training and Accreditation of GPs and Practitioners with Special interests

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Policy for the Recruitment, Training and Accreditation of GPs and Practitioners with Special interests

Policy Statement

Background
This policy describes the underpinning principles for Practitioners with Special Interests from different professions and groups of NHS specialist staff who may be commissioned to provide care closer to home, taking into account The Accreditation of General Practitioners and Pharmacists with Special Interests' Directions 2007.

It has been updated in consideration of extended transitional arrangements with NHS England Lincolnshire & Leicestershire Area Team since April 2013 and in lieu of further guidance anticipated in 2014 from the Department of Health in collaboration with the Royal College of General Practitioners and the Association of Surgeons in Primary Care.

Statement
Commissioners are redesigning the patient pathway to provide planned care episodes in a different way and practitioners have a key role to play in the delivery of services in a local and convenient setting for patients.

NHS England (UK) implemented an interim guidance document via the Royal College of GPs in February 2014. The guidance did not extend to other qualified providers, or consider local primary care surgical schemes.

A business case is due to be presented to the RCGP Council at the end of 2014 which will include timelines for the development and implementation of the new GPsWI accreditation and re-accreditation system.

This policy is specific to Lincolnshire CCGs and reflects the current arrangement with NHS England Lincolnshire & Leicestershire Local Area Team.

Responsibilities
Lincolnshire West CCG has a duty for the provision of a Quality Service to help provide assurance on the quality of care for patients on behalf of Lincolnshire CCGs.

Clinicians must be suitably qualified, accredited and performance managed under this policy framework.

"Clinicians" within this policy is inclusive of all clinicians providing an extended service outside their normal role, or
within their normal acute sector role in a primary care setting.

Any transitional arrangements are to be managed to secure delivery of safe and appropriate patient care.

**Training**

Continuing Professional Development and training must be carried out in line with this policy guidance.

**Dissemination**

Quality & Patient Experience Committees of the x 4 Lincolnshire CCGs
CCG Council
NHS England
CCG Websites and intranets
LWCCG Intranet (GP Team Net)

**Resource implication**

The full cost of implementing the accreditation scheme includes the funding of an accreditation panel and the costs of an appropriately qualified project manager on a sessional basis.
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- Appendix B Governance Checks Process (Other Practitioners) | 20 |
1. Introduction

The appointment of GPs and Practitioners with Special Interests is an important part of all Lincolnshire Clinical Commissioning Group’s strategies to enable faster access to services and to subsequently meet waiting and access times. Shorter waiting times and a convenient, community-based service mean that patients receive the necessary care in the most appropriate location. Staff also benefit from the opportunity to develop their specialist abilities and undertake a greater variety of work.

GPs and Practitioners with Special Interests supplement their core generalist role by delivering an additional high quality service to meet the needs of their patients. Working principally in the community they deliver a clinical service beyond the scope of their core professional role or the role for which they are monitored within their core NHS contract.

The introduction of local commissioning in March 2013 has led to an increase in providers from secondary care, delivering services independently of their core employer or contract in a primary care setting. This has created a need for healthcare organisations to communicate about the governance arrangements around those individuals to secure service quality and safety.

2. Purpose

The purpose of the policy is to ensure there are robust processes around recruitment of practitioners and development of services to ensure that a quality, safe and efficient service is provided to patients. The process of accreditation should assure patients and commissioners that they operate within a coherent and quality assured clinical pathway and they maintain the highest possible standards of clinical governance.

This document sets out a framework for assuring the quality and standards of individual performers which arise in the design of new services. As such it can be used as a check list for clinicians and managers working to develop these services. The principles addressed within this policy are transferable to policy formulation for all practitioners with a specialist interest.

This framework/policy is also good practice when redesigning other services which may require groups of practitioners to undertake specific work on behalf of other practices (relative specialisation), e.g. practice based commissioning, local enhanced services that involve contracting with clinicians.

3. Objectives

The policy will be used to ensure that all new and existing services requiring the skills of a specialised practitioner are safely delivered.

4. Definition of GPs and Practitioners with Special Interest (GPwSI/PwSIs)

A GP or Practitioner with Special Interest supplements their core generalist role by delivering an additional high quality service to meet the needs of the patients. Working principally in the community, they deliver a clinical service beyond the scope of their core professional role or may undertake advanced interventions not normally undertaken by
their peers. They will have demonstrated appropriate skills and competencies to deliver those services without direct supervision.

5. Other Practitioners operating within primary care outside of their core NHS contract

The growth of care provided closer to home has attracted consultants in secondary care to enter into contracts with primary care commissioners to deliver what might previously have been considered secondary care services in primary care premises.

In order to secure care quality and patient safety, the Federated Accreditation Team undertake a basic governance check on all contract applicants to ascertain the following details:

- Evidence of professional registration with appropriate body
- Details of other healthcare employers
- Details of any limitations, or conditions on professional registration.
- Notification of any current, pending or recent investigations, concerns or complaints with current employer(s)
- Date of revalidation (Doctors/Surgeons)
- Date of latest appraisal
- Responsible Officer (Doctors/Surgeons)
- Agreement with the Practitioner and their responsible officer and /or employer(s), that should the status of any of the above indicators change, that the Federated Accreditation Team will be informed.

These details are held securely on behalf of the Commissioner by the Federated Accreditation Team. This is not considered to be a part of the accreditation process as described by the Department of Health 2007 Guidance, but it an important adjunct to the process to provide assurance to Commissioners on the individual practitioner’s competence and professional status.

The process is demonstrated within Appendix C of this document.

5. Recruitment, Application Process and Validation

5.1 Recruitment and Selection

The knowledge and skills and formal qualifications required for each post will be defined for each contract type individually, this may include:

- Formal Medical qualifications and full registration with the appropriate professional body and any additional relevant qualifications.
- Clinical assistant post for at least 6 months duration in the chosen specialty within the last 12 months. This should include at least one session per week within the specialty under the supervision of an appropriate practitioner i.e. Consultant.
• A reference which details suitability for the post from a Consultant in the named specialty or where more appropriate a PwSI whose governance arrangements and subsequent monitoring supports their status as a suitable mentor.

• The reference must be from an individual who has supervised the PwSI within the last 12 months and can vouch for their competence. It should also detail the type of supervision.

• A DBS check within the last 12 months.

The contract type is defined by the Commissioner, and that process is recorded by the procurement and contracting teams to ensure that it fulfils the requirements of procurement law. Applications from service providers are required to include the practitioners and the procedures/ services that they will be providing.

Once the provider has completed this process and the preferred providers have been selected, the contract management team contact the accreditation team to arrange local accreditation for each practitioner. From this point the practitioner and the accreditation team liaise directly.

5.2 Application Process

Applications will only be accepted from GPs who have been qualified and practicing continuously for more than three years.

Applications to become a Practitioner with a Special Interest will include:

• Description of the service — the applicant will provide a detailed description of how their role is to be defined with the service.

• Education, training and Development — submission of evidence to include mandatory training i.e. resuscitation, courses attended and personal development plans aligned to the role.

• Clinical governance and quality activities — a minimum of one service improvement project/audit to be submitted annually to demonstrate patients' safety and focusing on clinical and cost-effectiveness of the service to be delivered.

• Demonstration of clinical mentorship — proforma to be completed by supporting clinician.

Each practitioner completes their own application. The process and timescale for this application can be seen at Appendix B of this document.

5.3 Membership requirement

Membership of the appropriate Royal College and/or Professional Body as appropriate to the role.

5.4 Accreditation Decision by Specialist Panel
If the candidate satisfies the above criteria an accreditation panel will be convened which will formally assess the candidates' knowledge, skill and understanding, evidence of continuous professional development and also their organisational and managerial competence.

The Panel will be drawn from:

- An Independent Professional Clinical Advisor as most suitable to the role applied for, this individual will be a senior clinical lead from within the relevant speciality.
- A senior commissioner from a CCG independent of the General Practitioner where applicable
- A senior professional representative from the Local Medical, Optometry or Pharmacy Committee;
- A lay person from the executive body of the CCG commissioning the service
- The accreditation programme manager or deputy

The Candidate must demonstrate within evidence submitted for consideration of the panel:

- Appropriate and necessary levels of skill and competence to fulfil the role described;
- A clear understanding of the role that they are being asked to fulfil;
- Demonstrate knowledge of the appropriate local clinical pathway;
- Set out commitment to ongoing training, updates and education through appraisal and use of Personal Development Plans:
- Make appropriate peer review and mentoring arrangement with references or reports from clinical assessors.

The panel may elect to make a decision on the accreditation of the candidate based on their submitted evidence supplemented with appropriate photo ID which is verified by the accreditation team.

5.5 Service Visit

Where the GPwSI/PwSI service is dependent upon premises and equipment, such as the Primary Care Surgical Scheme (PCSS), an inspection and infection control visit will be undertaken as part of the contracting process. Commissioners may also choose to visit the service, as part of the contractual review or quality monitoring process.

5.6 Professional Indemnity

Evidence of current professional indemnity insurance acknowledging the GPwSI/PwSI role will be required. Additionally, this will be included as part of the contract for the service.

6. Service Contracts

All service contract quality schedules for GPwSi and PwSi will include details to maintain patient safety, ensure quality of health care and minimise the risks to Lincolnshire CCGs of contracting with inappropriately qualified practitioners. The appropriate specialist clinical
advisor will provide advice to the panel e.g. on number or type of supervision sessions, and who would be appropriate to provide supervision, or the type of Continuing Professional Development.

6.1 Value for Money Review

Value for money review is included within the contracting procedures for practitioners who provide services under an Any Qualified Provider (AQP) contract. Contracts outside of AQP procedures are considered within commissioning procurement panels which are governed outside of this policy.

7. Assessment Guidance and Training

In preparation for the role of specialised practitioner clinicians would need to have demonstrated, prior to submitting their application, that they are competent in the role as follows:

- The content of the assessment will be based on areas of known best practice;
- The overall assessment system must be fit for a range of purposes;
- The individual components used will be selected in the light of the purpose and content of that component of the assessment framework.

7.1 Method of Competency Assessment

Practitioners, prior to applying for the role, will previously have been assessed by an appropriate specialist/specialist body and will be able to provide evidence of this assessment.

Practitioners are not entitled to see patients unsupervised for the procedures applied for until they are accredited for the specific role. The assessment should take place under the direct supervision of a suitably qualified and accredited independent assessor.

7.2 Self-Assessment as part of re-accreditation process

Accreditors must ensure the GPwSI/PwSI has prepared a self-assessment that includes:

- statistical summary of service provided;
- clinical audit data and resultant actions of follow up;
- audits of patients' experience in their care;
- critical re-appraisal of how service could be further improved considering a cross-section of structure, process, outcome and patient experience;
- a strategy for further improving the quality of the service;
- participate in at least one service quality and governance project;
- annually providing a minimum of three such projects over a three-year period;
- additional training or development requirements
- critical incident review reports

Self-assessment may become part of the service providers quality schedule return, individual practitioners are responsible for ensuring that they provide this self-assessment
to the contract holder for review and in order to support the providers quality schedule submission.

### 7.4 Continuing Professional Development

Continuing Professional Development will include regular professional updates appropriate to both the core professional role and any relevant extended role. The practitioner is responsible for ensuring this takes place. Training programmes must be prior approved and accredited by an appropriate body. The GPwSI and PwSI must satisfy the criteria that this has been done prior to appointment and that it will continue after appointment.

The GP/practitioner must undergo annual appraisal with a trained appraiser in each specialty area for each extended service that they provide. Specifically for example, practitioners working in the community to treat low risk basal cell carcinomas (BCC) should refer to the training guidelines example identified in Appendix A.

### 7.6 Clinical Support

The practitioner must detail the named clinical mentor support and any peer support mechanisms and keep records of interactions.

### 8. Governance

The function of accreditation is to ensure 'fitness for purpose' through a process of obtaining assurance of the skills and competencies of the individual practitioners working within primary care commissioned services.

In order to avoid conflicts of interest in the provision of services, there is clear accountability of the Lincolnshire West Federated Accreditation Team to the Lincolnshire CCGs through the Lincolnshire West Governing Body and the governing bodies of the other Lincolnshire CCGs.

Lincolnshire West CCG will set up and manage a locally held list of accredited GPwSIs and PwSIs to include length and dates of accreditation, details of speciality and ensure it is made available for public inspection.

#### 8.1 Role of responsible officer, appraisal and revalidation

GMC registered applicants are required to provide details of their responsible officer and any other employers through the application process. The accreditation team will make contact with the applicant’s responsible officer and with the HR departments of other employers to ensure that professional appraisers and revalidating officers are aware of the extended role of the clinician and are able to consider this within their own processes.

Responsible officers as defined within the guidance provided by the British Medical Association:
The specific responsibilities of an RO are:

- Ensuring that effective systems to support revalidation are in place (including appraisal and clinical governance systems)
- Evaluating the fitness to practice of all doctors with whom the designated body has a prescribed connection and making a recommendation to the GMC regarding revalidation
- Identifying and investigating concerns about doctors’ conduct or performance
- Ensuring that support and remediation is provided where a doctors practice falls below the required standard
- Overseeing doctors whose practice is supervised or limited under conditions imposed by the GMC

The accreditation team will contact responsible officers at the time of application for accreditation or re-accreditation of a GPwSI to confirm the scope of the practitioners role, and ensure that a positive recommendation for revalidation has been made, that the Doctor has been considered fit to practice in their core role, that there are no active concerns about a doctors conduct and performance and that no limitations or conditions have been imposed by the GMC.

It is the responsibility of the practitioner to notify the accreditation team of any changes in their employment or contracts. Notifiable changes include:

- Change in employer
- Suspension from any other contract either pending or following investigation
- Conditions/ limitations being placed upon any contracts including GMC imposed conditions and limitations
- Sickness absence necessitating a period of leave longer than 14 days
- Disclosure of new convictions not already considered within DBS certificate provided as part of the application process.

The process of managing concerns raised about the service is outlined in section 9.5 of this document.

8.2 Re-accreditation

Re-accreditation will take place every three years. Re-accreditation will follow a formal process and must be related to the service to be delivered. The applicant will provide a detailed description of how their role is to be defined within the proposed service.

The GPwSI/PwSI application should be submitted at least one month before re-accreditation is required.

If the GPwSIs/PwSIs work is discontinued, or the individual is unable to use their enhanced skills for a period longer than twelve months, they must be re-accredited before they can work again as a GPwSI/PwSI.

8.3 Service Accreditation

GPwSI/PwSI services are safe and effective only if delivered within a working environment that is properly resourced and properly clinically governed, therefore, the services within which GPwSIs and PwSis work are also required to be accredited.
The Care Quality Commission (CQC) defines the standards required of all providers of NHS services, including reference to appropriate premises requirements, information technology, etc. However, Lincolnshire West CCG will also refer to the specialty-specific guidance to identify any requirements relating to specific services they are developing or accrediting.

The procurement process details service accreditation which includes evidence of CQC registration, information governance arrangements and financial checks.

All premises must be accredited prior to the commencement of the service and providers will be expected to comply with Lincolnshire CCGs Infection Control Policy. Contracts cannot be issued until this process is complete and compliance is demonstrated. Within six months of starting the contract, the Quality Team may wish to visit the service and will give a minimum of 24 hours notice. If there is an indication at any time that patient safety is at risk contract management procedures may be initiated.

8.4 Addition of further procedures (Primary Care Surgical Scheme)

Where primary care surgery is accredited, practitioners may develop further surgical skills as part of their continuing professional development, and wish to add additional procedures to their portfolio. In this case, the panel will consider each additional procedure as a new application on the instruction of the Commissioner, if a demand for the procedure has been established. The instruction to commence accreditation procedures will come from the Commissioner and be followed by an application from the practitioner.

9. Patient Safety

9.1 Risk Management

Patient safety is enhanced by the use of healthcare processes, working practices and systematic activities that prevent and reduce the risk of harm to patients, service users and staff alike. The CQC define the standards required of all providers of NHS services and GPwSI/PwSIs would be required, as a minimum, to meet these standards together with any specialty-specific guidance identified within the contract.

9.2 Incident Reporting

The GPwSI and PwSI will be required to identify, report and learn from all patient safety incidents and to meet the requirements set out by the CQC in accordance with Essential standards of quality and safety. All serious incidents must be reported to the Federated Clinical Risk & Compliance Team hosted by Lincolnshire West CCG in line with their reporting requirements.

9.3 Record Keeping

Accurate, contemporaneous and comprehensive information is essential for high quality patient care. Information about the clinical care of patients is recorded in their clinical records and includes presenting symptoms, diagnosis and records of treatment documenting each episode of care for future reference. Records also serve the wider purposes of teaching,
research and clinical audit as well as providing evidence in the event of litigation. They are also a vital source of statistical and managerial information for the day to day running and future planning of the NHS. GPwSI and PwSIs are required to work in line with best practice standards for record keeping published by their professional body (GMC, GOC etc).

9.4 Complaints

The GPwSI/PwSI, must ensure that a full and positive response is provided to all complainants, whether their complaint was made verbally or in writing. It is important to satisfy the complainant that his/her concerns have been listened to, an apology offered and/or an explanation provided as appropriate. The service provider will aim to investigate all complaints thoroughly and impartially and to provide a prompt and positive response. The practitioner must participate fully with the complaints procedure.

All GPwSI/PwSI will investigate and manage complaints in line with the service providers complaints and reporting procedures or NHS England reporting procedures, or the Commissioners complaints procedure, whichever route is most appropriate to the nature and origin of the complaint.

Complaints as part of the service improvement programme will be viewed as valuable feedback and must be reported to the Commissioner by the service provider as part of the Quality Schedule within each contract.

9.5 Concerns

The term “Concerns” covers all intelligence received from or about the service, which either relate to process and systems or to an individual practitioner, and which pose a potential risk to the service, patients, the public, staff and the individual practitioner providing the service.

A concern can be raised in a variety of ways, including for example through a complaint, or an incident report, or as a result of the service quality monitoring schedule results, though audit or as a result of declarations or disclosures from the service provider, the individual providing the service, or their peers.

All concerns will be investigated by the accreditation team in collaboration with the Lincolnshire West Executive Lead Nurse and Chief Clinical Officer who will be responsible for deciding on appropriate levels of information sharing in relation to the concern raised.

Concerns are treated as highly confidential, the arrangements for information sharing and storage of relevant data are described in the Information Sharing Policy for Accreditation.

Appropriate actions will be taken by the LWCCG Chief Clinical Officer and Executive Lead Nurse or their appointed deputies in order to secure the safety of all involved.

These actions will be shared with other agencies as appropriate and necessary, in line with the information sharing policy (accreditation), which has been devised with the objective of securing patient safety and clinical quality, and to ensure that personal and/or sensitive information is being processed securely, fairly and lawfully and proportionately.
10. Audit and Monitoring

Evaluation of the programme under which the GPwSI/PwSI is operating is built into the service contract. In addition to this the practitioner him/herself must produce at least one audit per year which relates to their clinical activity within the service e.g against best practice guidance and in consideration of the scope of the service. This includes the dissemination of the results to others to ensure learning from outcomes. The sample should be statistically representative of the patients seen by the individual practitioner.

Quality monitoring will be undertaken by the Federated Quality Team in line with the service contract. Individual practitioners under the contract (GPwSIs/PwSIs) should be able to demonstrate their participation with these processes and their personal impact on quality improvement.

11. Service Governance & Information Storage

The Lincolnshire West Federated Accreditation Service is governed by the Lincolnshire West Executive Lead Nurse in collaboration with the Executive/Chief Nurses of all 4 Lincolnshire CCGs.

Quarterly reports are published to each CCG in relation to their activity.

Conflict of interest is managed between the CCGs, by ensuring that panel members declare interests in involvement with applicants, and where potential conflicts of interests are highlighted, the application is processed by alternative staff. The CCG Commissioner representative on the panel will from a CCG not affiliated to the GP Member being accredited.

Records of this are kept by the programme manager.

Information is stored in line with the Data Protection Act (1998).

12. References and Further Reading

- Implementing a Scheme for General practitioners with Special Interests (DH and RCGP, April 2002) [www.dh.dov.uk/pricare/gp-specialists/gpwsiframework.pdf](http://www.dh.dov.uk/pricare/gp-specialists/gpwsiframework.pdf)
- Implementing a scheme for Nurses with special Interests in Primary Care (DH April 2003) [http://www.dh.00v.uk/assetRoot/04/06/60/13/04066013.pdf](http://www.dh.00v.uk/assetRoot/04/06/60/13/04066013.pdf)
- Implementing a scheme for Allied health professionals with Special Interests (DH April 2007) [http://www.dh.gov.uk/assetRoot/04/06/60/14/04066014.pdf](http://www.dh.gov.uk/assetRoot/04/06/60/14/04066014.pdf)
- Implementing Care Closer to Home: Convenient Quality Care for Patients: accreditation of
- GPs and Pharmacists with Specialist Interests (DH: April 2007) [www.dh.qov.uk](http://www.dh.qov.uk)
- Heart of Birmingham Teaching NHS PCT, Recruitment and Accreditation of General Practitioners with a Specialist Interest, Policy HR1014: July 2007
13. Related CCG Policies and Procedures

- Information Sharing Policy (Accreditation)
- Risk Management Strategy and Policy
- Policy for the Reporting and Handling of Serious Untoward Incidents
- Records Management Policy
- Complaints Policy
- Equality and Diversity Employment Policy
- Recruitment Policy
- Management of Employee Performance and Capability
Appendix A

Accreditation, Governance and Training Guidelines for Level 1 Practitioners

Level 1 practitioners are GPs working in the community, offering a service to treat low risk BCC.

NICE published guidance on skin cancers in February 2006. This stated that all skin cancers, except low risk BCC, should be treated in secondary care. Low risk BCC maybe treated by accredited GP’s working independently in primary care.

Accreditation is through a committee formed by Lincolnshire West CCG.

Dr Neill Hepburn, Consultant Dermatologist, United Lincolnshire Hospital Trust, is the recognised Multi Disciplinary Team (MDT) training lead.

Accreditation will work at two levels, firstly assessment and, if necessary, training of experienced GPs and, secondly, training and assessment of inexperienced GPs. It is assumed an experienced GP will have at least 12 months experience working in a Dermatology or Plastic Surgery Department. In both cases the GP should have been involved in the care of skin cancer patients. GPs with at least 2 years experience operating on skin cancers, prior to October 2008, maybe exempt from the accreditation process, if the Clinical Lead of the MDT feels they have sufficient experience. Normally the 2 years experience will have been gained in a Dermatology or Plastic Surgery Department. GPs will be introduced to how the MDT works and the importance of their role in the MDT stressed. At all points training and assessment will be tailored against the individual's needs.

Experienced GPs

Clinical skills:

- Recognise benign and malignant tumours
- Identify common sub-types of BCC
- Divide BCCs in to high and low risk
- Thorough knowledge of and willingness to work with NICE guidance on skin cancers

Treatment:

- Knowledge of treatment options for BCCs in a given situation
- Experience of using cryotherapy, topical 5-Flurouracil, Imiquimod, Topical Diclofenac
- Consent
- Assessment e.g. anti-platelet agents
- Correct use of histology forms and interpretation of histology reports
- Surgical skills: Marking margins; local anaesthesia; aseptic techniques; biopsy techniques; excision techniques; haemostasis; subcutaneous sutures; surface sutures; post op advice and care.
Other

- GPs wishing to be accredited will attend MDTs

Assessment will be through a combination of mini-clinical evaluation exercise (mini-CEX), direct observation procedural skills (DOP) and 360 degree appraisal by a senior member of the MDT.

**Inexperienced GPs**

GPs in this group will require a period of training to attain the skills listed above. It is anticipated the GP will need to attend 40 sessions. They should attend a surgical course, such as that offered by the British Society for Dermatological Surgeons. In addition, the trainee will be expected to be involved in the MDT and operational meetings. The length of training will be tailored to individual needs. Assessment will be via personal log, mini-CEX, DOP, 360 degree appraisal by a senior member of the MDT, review of cases and audit of histology (to be presented at an operational meeting).

Individuals will be signed off when they can demonstrate the skills necessary to work independently in the community and within the MDT.

**Re-accreditation requirements**

The practitioner will be required to:

- Maintain an operations log for suspected low risk BCC and be expected to carry out 40 procedures per year.
- Be part of the MDT and must work with the MDT.
- Attend one clinic per year, usually with the Clinical Lead of the MDT.
- Audit their excisions, including tumour type and completeness of excision, this information needs to be presented at one of the bi-annual operational meetings.
- Attend 15 hours Continuing Professional Development (CPD) per year.
- Document all activity in a portfolio updated annually.
- Be re-accredited annually.

*This guidance has been approved by the East Midlands Cancer Network, Network Site Specific Group (NSSG) and should be read in conjunction with the Policy for Community Skin Cancer Service in Lincolnshire. The policy was written and approved by the Skin Cancer MDT Lead, Dr Khalid Hussain, Consultant Dermatologist, United Lincolnshire Hospital Trust*
Practitioner Governance Check Process

Other Practitioners operating within primary care outside of their core NHS contract

1. Email to Federated Accreditation Team by Contract Team or Commissioner
2. Accreditation Team contact practitioner & core employer(s)
3. Components of governance check completed, any further evidence requested of applicant
4. Outcome sent to practitioner and Commissioner
5. Recorded on accreditation record, appraisal and revalidation undertaken monitored

Status with Professional Body (suspensions/conditions on contract)
Status with other current healthcare employers (active investigations/suspensions/conditions on contract)
Confirmation of appraisal in relation to relevant commissioned services
Responsible officer contact (Doctors/Surgeons)
Agreement to disclose change to status of any of the above
Appendix C – Accreditation Process

RECEIPT OF APPLICATION

Confirmation of receipt of application to applicant and appropriate professional advisor

Primary assessment of application – response to applicant

Evidence incomplete
Evidence complete*

Notify applicant and await resubmission

Convene Accreditation Panel and agree format

Confirm date in writing to all parties

Send application evidence to all panel members at least one week prior to panel meeting

Keep detailed records of panel decisions and communications

Draft response to applicant regarding decision

Notify applicant of decision

Notify appropriate Commissioning Teams

Notify Finance Team (payments)

Application Accepted
Application declined

Add to reaccreditation process
Add to unsuccessful applicants folder

END PROCESS

PANEL MEETING

Professional advisor reviews evidence

Evidence incomplete
Evidence Acceptable

Securely receive and review applicant evidence
Direct questions/requests for further evidence to applicant via programme manager

Consider evidence at panel meeting as a group.
Ask appropriate questions of applicant
Clearly communicate reasons for decision made to enable appropriate feedback to be provided to the applicant after the meeting

Professional Advisor and senior commissioner sign letter/certificate on behalf of the Accreditation Panel

*evidence may go to professional advisor for review prior to being complete, at the discretion of the programme manager

Aug 2014
Appendix D - Re-Accreditation Process

**RECEIPT OF APPLICATION**
Confirmation of receipt of application to applicant and relevant professional clinical advisor

**Primary assessment of application by programme manager - response to applicant**

**Clinical advisor reviews evidence & primary assessment**

**Notify applicant and await resubmission/additional submission**

**Evidence Acceptable**

**Application accepted**

**Application declined**

**Notify applicant of decision**

**Issue certificate**

**Update PCSS contacts group**

**Notify Commissioning Team**

**Notify Finance Team (payments)**

**Add to reaccreditation process**

**Archived evidence & communication**

**END PROCESS**

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**MAP**

**Send application form by letter and email to practitioner (programme manager)**

**Not returned**

**Returned**

**Reminder letter and email to practitioner (programme manager)**

**Not returned**

**Returned**

**Letter to practitioner and Commissioning CCG**

**Not returned**

**Returned**

**Letter to Commissioning CCG advising that practitioner is no longer accredited to provide the service.**

**Liaise with relevant CCG Contracting Team to issue remedial notice**

**Relevant CCG Contracting Team issue contract termination notice.**

**Notify NHS England**

**Archive evidence & communication**

**LINCOLNSHIRE WEST**

**Clinical Commissioning Group**

**August 2014**