

would it discourage patients from seeking help and put them at risk of harm? Would this just increase GP workload even more? Could it be that patient education, instead of charging, is the way to reduce unnecessary attendances? Are charges of this kind becoming inevitable in the NHS?

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Quality assurance of appraisal summaries

Objective assessment of whether doctors meet the General Medical Council (GMC) standards for revalidation^{1,2} is a new challenge. In Hertfordshire GP senior appraisers started to quality assure appraisals in January 2013 with the aim of ensuring that they were up to sufficient standard to enable the responsible officer to base revalidation recommendations on their outcomes. A quality assurance form was developed, and all appraisal summaries were allocated to one of seven senior appraisers to be checked against the form. After 3 months the senior appraisers were sent (without knowing it) the same appraisal summary to ascertain whether this process was accurate and objective. The results showed surprising lack of unanimity.

In some areas there was total agreement, for example: whether last year's personal development plan had been reviewed; whether it covered the scope of the doctors work; whether a balance of different types of educational activity was maintained; and whether patient and colleague surveys with reflection were present. However there were complete splits on issues that we had expected to be cut and dried. There were 5:2 splits on whether learning credits were discussed and verified, whether complaints/audits with review and reflection were present, and whether statements were objective and supported by evidence. There were 3:4 splits on whether last year's appraisal summary had been reviewed and discussed, and whether two significant events were present with reflection and learning points.

This is a work in progress. We have discussed these results and revised the wording and the statements on the QA form. Furthermore this is a tiny sample, of one appraisal summary and seven senior appraisers' views of it. However, revalidation is now with us, and our findings suggest that application of the GMC minimum standards for revalidation decisions may be problematic.

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REFERENCES

1. General Medical Council. *Supporting information for appraisal and revalidation*. London: GMC, 2012. http://www.gmc-uk.org/doctors/revalidation/revalidation_information.asp [accessed 26 Jun 2013].
2. Royal College of General Practitioners. *Guide to the revalidation of general practitioners*. London: RCGP, 2012.

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The Wow test in quality

There is usually a Wow factor in the very highest quality. But there is often a Wow factor in the poorest quality. An editorial¹ that suggests that the RCGP first started to define excellence in 2008, focuses on a process of remuneration (the Quality and Outcome Framework) as the current zenith of quality measurement and wants more research so that the concepts of quality should be tested until a consensus emerges of the key domains of components, passes the Wow test.

In 1985 the RCGP *What Sort of Doctor* report was published. This followed 4 years of developing systems to assess the quality of care by matching individual performance against defined and agreed criteria of competence. In the same year, the College published a major policy document *Quality in General Practice*. Subsequently, and for the last 20 years, other RCGP quality schemes with evolving measures of

quality like the Fellowship of the RCGP by Assessment, the Quality Practice Award, and the Practice Accreditation Scheme have continued to do all that is suggested in this new paradigm. It was good idea in 1985 but it's not a new idea in 2013. All that remains is to convince government to reward these schemes that have 30 years experience trying to 'capture general practice quality in all its richness and complexity'.

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REFERENCE

1. Kordowicz M, Ashworth M. Capturing general practice quality: a new paradigm? *Br J Gen Pract* 2013; **63**(611): 288–289.

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Measles targets and herd immunity

Measles epidemics occur in populations with sufficient numbers of susceptible individuals for each infected person to meet and pass on the virus to one or more other susceptible individuals. Herd immunity suggests that if enough people are rendered immune such meetings will be rare enough for the virus not to be passed on and the whole population to be protected. If immunisation rates for the population were high enough we should therefore prevent epidemics such as the current one in south Wales. So if general practice can and does deliver high measles immunisation rates from ages 2–5 years, why do we currently have a problem?

Unfortunately both the model of herd immunity and our immunisation rate markers are flawed. Human communities do not consist of randomly moving particles bumping into each other by chance, they cluster in social groupings. Equally just because 90–95% of 5-year-olds are immunised over a 10-year period does not mean that 95% of people under 15 have been protected. If unimmunised people move into a community the coverage will drop. Moreover if the newcomers cluster together they will form a subgroup at high risk of an outbreak.

In our small inner-city practice in an area of high turnover and immigration,