REVALIDATION AND APPRAISAL FOR DOCTORS

Joint guidance from Help the Hospices and the Association for Palliative Medicine of Great Britain and Ireland (APM)

What is this guidance about?

Over the next few years, the General Medical Council (GMC) will change the way doctors in the UK are regulated to practise medicine. In 2009, the GMC introduced licences to practise. This means that all doctors are required by law to hold a licence if they wish to exercise the privileges currently reserved for registered medical practitioners.

After licensing, a new system called revalidation will begin, which will require doctors to renew their licence to practise every five years. Revalidation will provide assurance for patients, doctors and employers that licensed doctors are practising to appropriate professional standards, and that systems of appraisal and clinical governance are consistent across the UK.

This change in legislation has major implications for doctors working in all settings including independent hospices. This guidance aims to help hospices and their staff prepare for the change.

Who needs to read it?

This guidance is aimed at chief executives, medical directors, responsible officers, human resources managers and doctors working in independent hospices anywhere in the UK.

Why now?

Revalidation is set to begin in Autumn 2012 so all doctors and their employers need to start preparing now. The secretary of state for health will assess the readiness of organisations to implement this new process in summer 2012 before confirming the start date. It is anticipated that the majority of recommendations will take place in 2013 and 2014.

What is the process for revalidation?

The new regulations require organisations deemed to be 'designated bodies' to nominate or appoint a responsible officer (RO). In reality, most healthcare organisations that employ or contract with doctors are designated bodies, so virtually all independent hospices will be classed as such.

The link between an organisation and a doctor is called a 'prescribed connection'. Each doctor can only have one prescribed connection and only one RO and so where a doctor is employed in more than one organisation, special rules apply. In the majority of circumstances, the prescribed connection is where the doctor does most of his/her clinical work, but there are exceptions:

- If a hospice employs a doctor who is a GP on a performers list, that doctor's prescribed connection is to the primary care trust (PCT), irrespective of how much time they spend in the hospice. If the GP resigns from the performers list but continues to work for the hospice, then that doctor's prescribed connection will be to the hospice, and the hospice must appoint an RO for that doctor.
- If a hospice contracts with a doctor employed by the local NHS trust on a sessional basis, the doctor's prescribed connection is likely to be with that NHS trust; the hospice should assure itself that this is the case.

The RO must be medically qualified and trained in his/her role. Any RO must:

- have been on the GMC register for five years
- have managerial experience that enables him/her to set up appropriate appraisal and clinical governance systems
- respond appropriately to issues of poor practice, and
- have a good working knowledge of risk management.

The RO's own responsible officer is at the local strategic health authority (SHA).

Each doctor must participate in an annual medical appraisal, carried out by a trained medical appraiser. Such an appraisal will be in addition to any other appraisal or performance review offered by a non-medical manager such as the hospice chief executive or a non-medical clinical lead.

There is an explicit set of evidence that must be used to inform each appraisal, some on an annual basis, others on a five-year cycle (see page four for details).

The RO recommends revalidation of each doctor on a five-year cycle or refers the doctor on if there is cause for concern.

The processes for dealing with doctors who cause concern should mirror the best of current practice and should ensure fairness and equality. It is important that consistent thresholds for investigation and intervention are applied, and work on this is being planned through local RO networks. In the case of palliative medicine, the Royal College of Physicians and palliative medicine as a specialty will be involved.

How should hospices organise the responsible officer function?

As a designated body, each independent hospice must nominate an RO for each of its doctors. We recommend one of the following options:

a. approach the local NHS trust or PCT to undertake this responsibility

b. cluster with other local independent hospices, so that one senior doctor takes on the role of the RO for all doctors in the hospices.

There are already examples of independent hospices adopting these approaches. For further information contact the national clinical lead at Help the Hospices (h.richardson@helpthehospices.org.uk) or the APM secretariat (sabine.tuck@apmonline.org).

If a hospice 'outsources' its RO function to another organisation a service level agreement (SLA) is required to make explicit the hospice's expectations of the RO, including standards of conduct. Guidance for a model SLA agreement is currently being written by the NHS Revalidation Support Team.

Whatever the chosen approach, it is suggested that, wherever possible, independent hospices seek honorary contracts with their local NHS trust for their doctors. There is evidence that this enhances local links and gives doctors increased access to continuing professional development activity and other professional support within their local trust.

Who can help hospices get this right?

Every SHA in England has an RO with whom local ROs link. Similar RO arrangements are being put in place by the health boards in Wales, Scotland and Northern Ireland. The ROs at SHA and health board level can offer local ROs information regarding related training as well as local networks, communication, regular newsletters and other forms of support.

What are the cost implications?

It has been widely suggested that where the RO function is being provided outside the organisation, the sum of £500 to £1,000 per doctor per annum is a realistic and sensible fee for hospices to expect to pay.

The RO should expect to have adequate support from his/her organisation to carry out this function. He/she must have robust systems in place to make sure that each doctor has a satisfactory annual appraisal and that those whose appraisals are not satisfactory are managed in a fair way.

What evidence is required for the annual appraisal?

The following evidence will need to be collected:

Annually:

- general information including scope of the doctor's work, probity and health
- evidence of continuing professional development activity
- review of previous professional development plan (PDP) and agreement of new PDP
- review of significant events
- reflections on complaints and compliments

Every five years:

- structured colleague feedback
- evidence of quality improvement activity
- structured patient feedback.

Whose responsibility is it to collect evidence for the appraisal?

It is the individual doctor's responsibility to collect and present the evidence for his/her appraisal. However, organisations must support the doctor in doing so, by providing adequate preparation time, systems for collecting relevant data, the data itself and the support necessary to fulfil the required activities, eg continuing professional development, clinical audit, etc. Even where the doctor's prescribed connection is to another organisation, the hospice has a responsibility to provide the doctor with the information, data and support he/she requires for his/her appraisal.

What is the timeline?

Right now, hospices need to make sure that:

- an RO has been nominated or appointed for doctors working in the hospice
- every doctor within its organisation is having an annual medical appraisal with an appropriately trained appraiser
- there are enough doctors locally who have been trained in conducting medical appraisals to meet local need
- resources have been identified to make sure the RO is able to carry out the responsibilities of the role.

In spring 2012, each hospice, as a designated body, will be required to complete an organisational readiness self assessment tool (available through the NHS Revalidation Support Team website), in conjunction with the RO for their doctors. The regulations required to 'switch on' revalidation will come into force by winter 2012, and revalidation will then begin to be rolled out.

What other sources of advice exist to help hospices get this right?

The Association for Palliative Medicine of Great Britain and Ireland
sabine.tuck@apmonline.org
www.apmonline.org

General Medical Council
www.gmc-uk.org/doctors/revalidation/9547.asp

Help the Hospices
h.richardson@helpthehospices.org.uk

The NHS Revalidation Support Team
www.revalidationsupport.nhs.uk

Revalidation in Scotland
www.scotland.gov.uk/Topics/Health/NHS-Scotland/paper/Revalidation

Royal College of Physicians
www.rcplondon.ac.uk/resources/revalidation

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