Association for Paediatric Palliative Medicine

Dear Palliative care doctors and Children's hospice CEOs and Directors of Care,

Medical Revalidation update: September 2012

Processes for revalidation of doctors have developed rapidly in the last few months, with the expectation that revalidation will begin in December. On behalf of APPM, I have continued to advocate for the particular issues pertaining to doctors working in children's hospices and children's palliative care more broadlyand to respond to queries from individual hospices and doctors. I also contribute to the South of England Revalidation Delivery Board, and regional Responsible Officer Network,and supported the 2 recent national revalidation days for hospices

Timescale:
Responsible Officers have now submitted to the GMC a suggested revalidation timetable for all their doctors: in early December the GMC will start to tell doctors when they will be revalidating.
Assuming the Secretary of state gives the anticipated go-ahead for revalidation to proceed, the first doctors (mainly Responsible Officers) will revalidate in 'Year 0' (Dec 2012 to March 2013). 20% of doctors will then revalidate in April 2013-March 2014, Year 1 (these will be mainly medical leaders and appraisers plus others as selected by their Responsible Officers). 40% will revalidate in each of years 2 and 3 so that virtually all current doctors will have revalidated by April 2016.
Action*: Any doctor could be randomly allocated for revalidation in Year 1 (2013-4) and could therefore be revalidated on the basis of this year's (2012-13) appraisal so we need to have supporting information in place* ***now****.*

Issues for hospices and their doctors:
It is acknowledged that revalidation is less straightforward for hospices and their doctors, being small non NHS organisations with small numbers of doctors, in a small specialty, often with portfolio careers, and with patients who can't readily give us doctor-specific feedback. In response to these concerns, there have therefore been 2 national hospice-specific revalidation events this summer, organised by the Revalidation Support Team (RST), with input from APM, APPM and Help the Hospices. These were opportunities for hospice representatives to find out more about the process, share good practice, raise concerns with the national GMC and RST representatives, and identify some ways forwards. Hospices that are also 'Designated Bodies' for revalidation purposes should now be making rapid progress towards 'revalidation readiness' and any medical appraisals conducted this year should be by appraisers trained to the enhanced 'revalidation –ready' standards.

Action:
If your hospice is not a Designated Body, the main new responsibility of hospices, hospitals and doctors will be to ensure that all doctors have ***'whole practice' appraisal***, covering all their areas of practice.

Action: for hospice boards and their doctors. Hospices have a responsibility for the revalidation of their doctors, so they should be working in partnership with doctors to develop processes.
For hospices that are Designated Bodies, by December they will also need to

- *have identified and contracted with (if external to the hospice)a trained Responsible Officer*
- *have a policy for medical appraisal in place*
- *have sufficient trained medical appraisers (with letters of agreement for appraisers employed external to the hospice)*
- *have a system to monitor and investigate fitness to practice*
- *have a policy for remediation, rehabilitation and re-skilling (likely to rely on resources from the larger statutory organisations)*
- *have a means to make relevant hospice and doctor-specific supporting information available to their doctors*

In some cases, it may be simplest for hospices to come under the policies of their local hospital or community Trust, with an agreement as to how these policies would be applied in the hospice setting.

Revalidation continues to present a positive opportunity for both employing organisations and their doctors to ensure that high quality appraisal and professional development opportunities are resourced and accessed, and systems developed to ensure appropriate supporting information is readily available. Time invested to develop good systems now, will optimise the benefits and reduce the burdens of medical revalidation over the longer term.

There is still much debate about how to retain the best of formative appraisal (likely to be optimised by a site-specific and specialty-specific appraisal), whilst still retaining an external element for objectivity and fairness. I have suggested using the 5 year revalidation cycle to preserve and balance both these aspects over the 5 years, and although this takes some organisation, this suggestion is now being taken up positively by some Responsible Officers. It is worth considering this in your local area.

Action: for Feedback please (to slapwood@helenanddouglas.org.uk)

1. *Are you a revalidation-ready trained appraiser? If so, would you be willing to have your details on a database of doctors willing to offer appraisal in paediatric palliative care (any specific arrangements and agreement for funding to be between the doctor's employing organisation and the appraiser).*
2. *What provision does your hospice have to release doctors for paediatric palliative care study and updating?*

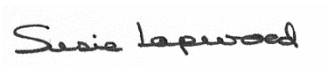
Supporting information:
The GMC has issued a minimum acceptable list of supporting information for the first cycle of revalidation, acknowledging that some doctors won't have had long to develop systems and collect a full set of supporting information.http://www.gmc-uk.org/static/documents/content/Meeting_our_requirements_in_the_first_cycle.pdf
The emphasis is on doctor-specific supporting information, and on personal reflection and learning from it.

Patient feedback questionnaires are a particular challenge for children's hospices. For most doctors, these will probably only be required once in a five year revalidation cycle, in the early years, although doctors may do this more often. The ideal is doctor-specific patient feedback using a validated questionnaire that meets GMC guidance (see link below), and we should be seeking ways to obtain this (*Very few hospices have achieved this as yet*, so *please share any ideas that are working for you*). However, GMC has indicated that if this is not possible in our context (for example because the only feedback available is to the whole team), the important element is for the individual doctor to demonstratein their supporting information their own reflection and learning from the feedback with a view to improving their practice. It is left to the discretion of the Responsible Officer as to what sources of feedback will be acceptable in this first cycle, so it is worth discussing this with your RO ahead of time.

Action: for feedback please:
Please share any methods you have used to obtain patient (or patient proxy) feedback in children's palliative care settings, with your experience and recommendations.

There will be further changes as revalidation gets under way. I am facilitating a short Revalidation Question Time at the APPM study day on 16 November, and will also be giving some input on revalidation at the Together for Short Lives 'Leaders of Care' day on 12 December, when there will be opportunity for further discussion and sharing of good practice. Do get in touch meanwhile, with any queries or examples of good practice. Hoping this helps.

With best wishes,



Dr Susie Lapwood

Co-chair, APPM Education and Training Working Party
Member, South of England Delivery Board for Revalidation
Head of Research, Education and Professional development, Helen and Douglas House Hospices, Oxford
(Tel 01865 794749) e-mail slapwood@helenanddouglas.org.uk

Other resources:
The GMC and Revalidation Support Team websites have a wealth of useful information, including template agreements on the RST site. They are worth visiting for the current versions of documents as they are being updated frequently. Some current links are below,all updated / checked Sept 2012.

- Updated specialty-specific guidance about supporting information was issued this year and is available at:

  http://www.aomrc.org.uk/revalidation/revalidation-publications-and-documents/speciality-guidance.html
- This complements the broad statutory guidance issued by GMC in April 2011 and updated in March 2012: http://www.gmc-uk.org/Supporting_information100212.pdf_47783371.pdf
- The GMC requirements for supporting information in the first revalidation cycle includes guidance on currency and relevance and is at:http://www.gmc-uk.org/static/documents/content/Meeting_our_requirements_in_the_first_cycle.pdf
- General GMC guidance for doctors on getting ready for revalidation is here: http://www.gmc-uk.org/doctors/revalidation/9622.asp
- The Revalidation Support Team has produced a definitive version of the 'Medical Appraisal Guide' (version 3), available at: http://www.revalidationsupport.nhs.uk/CubeCore/.uploads/RSTMAGforReval0312.pdf
- The Revalidation Support Team website has a wealth of other useful information, and template agreements for Responsible Officer services etc.www.revalidationsupport.nhs.uk
- The APPM website also has a revalidation section at: www.act.org/appm
- GMC: Guidance on colleague and patient questionnaires (revised April 2011) is at:http://www.gmc-uk.org/Colleague_and_patient_questionnaires.pdf_44702599.pdf
- RCGP Revalidation guide for GPs v 7 (June 2012) is at: http://www.rcgp.org.uk/PDF/Guide%20to%20Revalidation%20for%20GPs%20Version%207%20FINAL_.pdf
- https://appraisals.clarity.co.uk/for an updated revalidation-ready Appraisal toolkit and electronic forms etc. This site includes a proforma 'Structured Reflective Template' (SRT) for each section in the supporting tools. (Note new website address from 21.5.11)