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Briefing from the APPM chair

As the APPM continues to grow and develop, we are keen to ensure that we are aware of, and responsive to, the views and support needs of our members. You will find the results of our first ever APPM survey in this issue. Many thanks to all of you that responded.

There are many exciting developments in paediatric palliative medicine both in the UK and internationally. One of the key roles of the APPM is to ensure that our members are fully informed and able to participate.

APPM executive

This autumn two longstanding members of the APPM, Dr Richard Hain and Dr Ann Wallace will be standing down. We would like to thank them both for their enormous contribution to the work of the APPM and previously the BSPPM. Richard in particular has worked tirelessly over the last decade to champion the cause of paediatric palliative medicine including establishing paediatric palliative medicine as a paediatric speciality, chairing the CSAC for Paediatric Palliative Medicine, and previously the BSPPM and the CCLG Palliative Care Research Group.

With Ann and Richard standing down we have **vacancies for two new doctors from any background to join the APPM executive**. If you are interested in joining the APPM Executive please contact me via email (Lynda.Brook@Alderhey.NHS.UK) or telephone (0151 252 5187) before the end of October. In the event of more than two nominations a ballot will be held at the AGM on 25th November.

We are continuing our efforts to actively engage with **General Practitioners who are working both in General Practice and Children's Palliative Care**. We would be particularly interested in hearing from GPs with an interest in paediatric palliative medicine and currently working in general practice who would be interested in becoming a member of the APPM executive.

APPM subscriptions

The APPM member survey has identified important priorities for APPM in order to meet the needs of APPM members. In response to our member survey we will be looking specifically at what we can do to support children's palliative care networks as this is an area where APPM has previously not been particularly active. We will continue to grow and develop our portfolio of expert publications in response to members identified needs. We will also consider how we can begin to develop guides and standards for paediatric palliative care that could eventually be used for benchmarking or audit. Unfortunately, all this comes at a price and we will **propose an increase in the annual subscription to £50 per year at the AGM in November.** The subscription fee has not changed since the foundation of the BSPPM over 10 years ago. We feel that the increase in subscription fee is still very competitive compared with other comparable organisations and will allow us to continue to develop and respond to our members' needs.

Other project work

The first edition of the **APPM Children's Palliative Care Master Formulary** is now available on the APPM www.act.org.uk/appm. The APPM Children's Palliative Care Master Formulary provides information on indications, routes and standardised doses for paediatric palliative medicine based on systematic literature review and appraisal of available research evidence together with expert consensus opinion where there is insufficient research evidence.

The Children's Palliative Care Master Formulary Team is now beginning the second phase of the project. This involves identifying areas of greatest concern for doctors prescribing in paediatric palliative care because of insufficient evidence and an options appraisal to identify the most appropriate way of ensuring that the Children's Palliative Care master formulary remains appropriate and up to date. **Your views are vital and we would like to ask you to complete a simple on line survey** at www.surveymonkey.com/s/L3NGM3R

Other current APPM activities include:

Support for **appraisal and revalidation** particularly for doctors working in paediatric palliative medicine outside the NHS

Development of **standards for education and training in paediatric palliative medicine** for those not eligible for CCST via RCPCH.

Quality assurance and validation of **Specialist Training in Paediatric Palliative Medicine** via the RCPCH Paediatric Palliative Medicine CSAC. The CSAC sits formally under the RCPCH and is affiliated to the APPM. More information is available via the RCPCH website.

Dr Lynda Brook – Chair Association for Paediatric Palliative Medicine

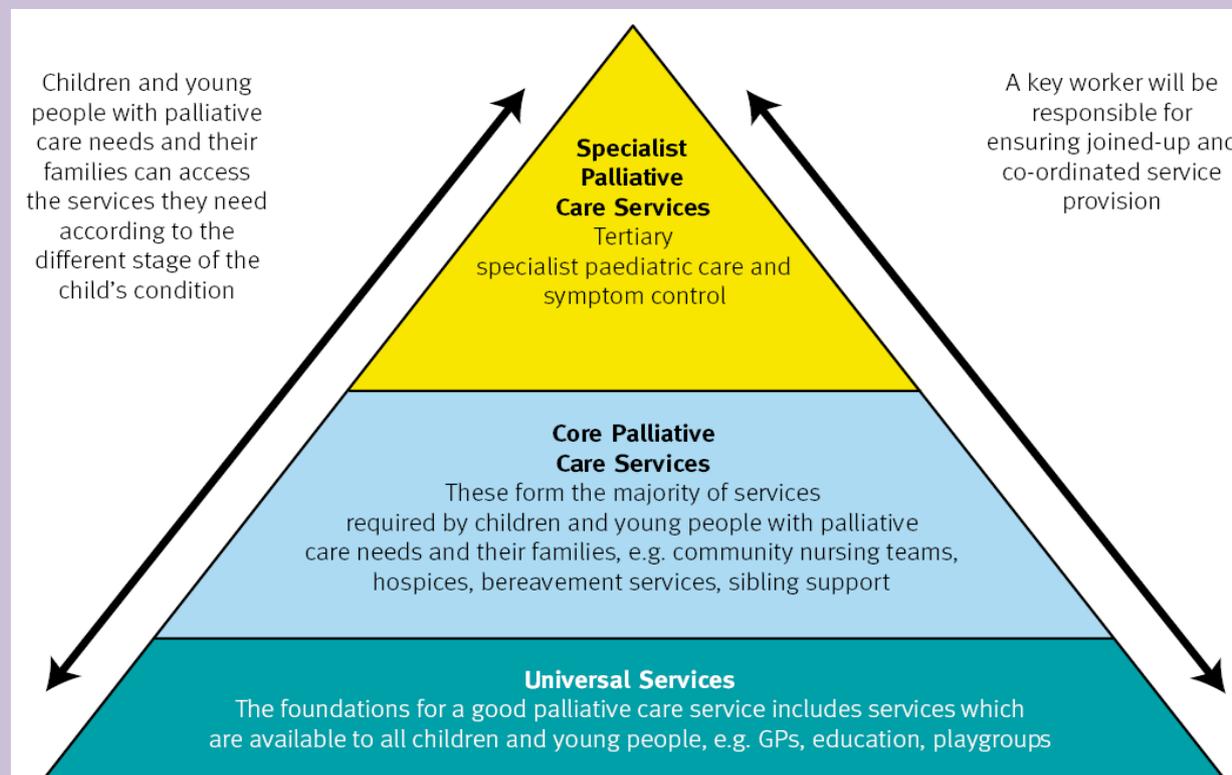
Lynda.Brook@alderhey.nhs.uk

Palliative Care Funding Review Lynda Brook August 2011

Tom Hughes-Hallett, Professor Sir Alan Craft, Catherine Davies, Isla Mackay, Tilde Nielsson

The Palliative Care Funding Review was published in July 2011. The aims of the Review were:

- To review the current funding mechanisms for dedicated palliative care for adults and children in England.
- To consider and quantify the impact of changes in funding mechanisms, based on an NHS tariff to meet NHS responsibilities, regardless of the choice of provider, on a per-patient basis.
- To make recommendations on a funding mechanism which:
 - Is fair to all sectors, including the voluntary sector
 - Encourages the development of community-based palliative care services
 - Supports the exercise of choice by care users of provider and of location of palliative care provision



Evidence was collected from a wide range of stakeholders across England including service users, providers from voluntary and statutory sector and commissioners

What stakeholders want

Patients and families	Commissioners	Providers
<ul style="list-style-type: none"> ▪ A comprehensive needs assessment ▪ A coordinator/ keyworker ▪ High quality services as needed including medical/nursing care, social care, rehabilitation support, respite care and bereavement support ▪ Support to be cared for and die where they wish ▪ Appropriate spiritual support 	<ul style="list-style-type: none"> ▪ Clarity on core services to commission against ▪ Levers to ensure that services are of a high quality ▪ Clear outcome measures ▪ Clear reporting requirements 	<ul style="list-style-type: none"> ▪ A clear, fair funding structure ▪ Payment in full for core services ▪ Clear outcome measures ▪ Clear reporting requirements ▪ Clarity on education and training requirements and funding

What were the key recommendations of the Palliative Care Funding Review?

Ensuring availability of palliative care in hospital and community settings, and supporting early referral to palliative care, could potentially lead to significant cost savings for the NHS on hospital costs in the last year of life. QIPP estimate of £3,000 per hospital death, this would translate to a potential reduction in hospital costs of £180m per annum.

The most important recommendations were:

- Implementation of a **per-patient funding model** using a **classification system** based on age, phase of illness and a measure of complexity
- An **end of life locality register** maintained by every commissioning locality group, to support the capture, storage and sharing of electronic patient records.
- A **palliative care needs assessment** undertaken by an appropriately skilled practitioner which then informs palliative care provision including coordination of care, clinical care needs of the patient and social care needs of the patient at the end of life

Palliative Care Classification System

The classification criteria proposed for children includes

- Age (0 – 1 years; 2 – 13 years; 14 – 25 years)
- Phase of illness (stable, deteriorating, unstable, dying)
- Problem severity (Simple, complex)

The classification criteria proposed for adults includes

- Age
- Phase of illness
- Provider type
- Problem severity
- Functional status

The review team recommends that the age cut offs between the adult and children's classification systems should be used in a flexible way, to best suit the needs of the patient.

- *There is a need to consider exactly how the proposed classification system for phase of illness and problem severity would translate into paediatric palliative care*

Per patient funding system

There is a proposed funding system where payments are made for each phase of illness, This allows a new episode of care to start when it is clinically meaningful. These would be set as national tariffs, but commissioned and delivered locally. Palliative care services for children would be commissioned on a population basis of up to 1.5 million.

- *There is a need to consider how these commissioning populations would work most effectively for children and the appropriate commissioning structure including consideration of footprints or other*
- *Reference costing will be needed in order to set the national tariffs for both adults and children.*

End of life register

Every Clinical Commissioning Group (or at commissioning network level) should be required to hold an end of life locality register. When a patient is put onto the end of life locality register the NHS will meet all their needs (both health and social care). A patient can only be put onto the register after:

- Informed consent has been obtained
- An assessment of their needs has been undertaken and a care plan has been drawn up

There is a need to consider what this national minimum dataset should contain for children

The review recommends that five pilot sites are selected to test implementation of the new model over a two year period.

- *There is a need to identify appropriate paediatric pilot site*
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Palliative care needs assessment

A holistic palliative care needs assessment should be undertaken by an appropriately skilled practitioner which then informs palliative care provision including coordination of care, clinical care needs of the patient and social care needs of the patient at the end of life.

The assessment should be followed by the development of a care plan

Reassessments should be undertaken in response to a change in the level of need of the patient

- *There is a need to consider who would be appropriately skilled and qualified to provide a holistic palliative care needs assessment for children and to ensure the appropriate balance between skills and access to such an assessment*

What elements of care will be funded by the proposed palliative care tariff?

- Assessment of the patient
- Coordination of the care of the patient
- All clinical and supporting care needs of the patient, irrespective of the setting of the provider.
- Social care needs of the patient at the end of life
- Pre-bereavement evaluation
- Short breaks which represent planned in-patient and/or community care for symptom management

What elements of care will not be funded by the proposed palliative care tariff?

- Complementary therapies
- Bereavement support
- Drugs and pharmacy services (which will continue to be funded by the NHS as now).
- Short breaks which provide respite for the carers and families of children requiring palliative care
- Respite care for adults
- Spiritual support

Other recommendations

- **A statement by the Government** describing the palliative care support and services that patients, families and carers can receive, if they need them, from the NHS.
- **A lead provider for palliative care** in every Clinical Commissioning Group, to coordinate all palliative care services, including those not funded by the NHS.
- **Outcome measures** that are supported by the newly created dataset for the tariff and the NHS outcomes framework.
- **A standard contract** for commissioning NHS palliative care services
- Community services, to provide **24/7 access to community care** across the country.
- **Palliative care education and training** for NHS professionals should be funded by the NHS Commissioning Board. All other professionals should be trained to standards which should be outlined in the standard contract for commissioning NHS palliative care services and should be funded by the provider organisation.

Revalidation and Appraisal Update for doctors working in paediatric palliative care—with special reference to children's hospice doctors

The APPM is keen to support its members in achieving relevant 'whole practice' appraisal, and in ensuring that revalidation is as straightforward as possible for all doctors working in paediatric palliative care in Great Britain. To this end, we are writing to all children's hospice CEOs and Directors of Care, alerting them to their hospice's responsibility for their doctors being able to revalidate successfully, and giving some suggestions about how to proceed. This briefing for doctors is intended to provide updated advice and information to support those processes.

Guidelines and procedures for revalidation have changed rapidly in the last few months and continue to do so, so an update seems timely.

NB New GMC guidance has been issued (April 2011) re the revalidation framework and supporting information. There are 2 useful new documents, about supporting information, and about overall framework:

http://www.gmc-uk.org/doctors/revalidation/revalidation_gmp_framework.asp

http://www.gmc-uk.org/doctors/revalidation/supporting_information.asp

Overall supporting Information requirements from GMC are now more flexible and less demanding than initially proposed. In response to this, proposed new specialty-specific requirements have just been released (consultation periods ending mid September), and are hopefully becoming more equivalent between specialties. <http://aomrc.org.uk/introduction/news-a-publications/208-speciality-frameworks-and-speciality-guidance-.html>

General points:

1. A reminder that it is expected to be a **single process to revalidate**: relicensing as a doctor (based on current role(s), *not* recertifying as a specialist too, as originally proposed). Normally revalidation would involve 5 satisfactorily completed annual appraisals, (covering all roles, with appropriate supporting information collected over the 5 year cycle), signed off by that doctor's Responsible Officer (RO) who makes recommendation to the GMC to revalidate the doctor. (RO s have recently been appointed in each SHA).
 2. Doctors must **revalidate through NHS links** if they have one (e.g. through a salaried or honorary NHS contract) even if not your main role. But *appraisal(s) should reflect whole practice* (may mean more than one appraisal, with information from other posts including non NHS ones informing the NHS appraisal. If you have multiple roles, you may need to vary the background of your appraiser across the 5 year cycle, to reflect whole practice if you can't access a single appraiser who can cover all your roles.
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3. **Toolkits:** Various toolkits are available to support appraisal. Some PCTs and trusts specify the toolkit to be used. Appraisals Toolkit team have been accommodating in arranging access for some children's hospice doctors so do ask, if it would be helpful. <https://appraisals.clarity.co.uk/> is the new web address from 21.5.11 (not www.appraisals.nhs.uk). There will be one or more 'Revalidation toolkits' in due course, still under development. I recommend storing supporting information covering all your medical roles in off-line folders as a backup during this transition phase so that it is future-proof and can be uploaded to any suitable toolkit.

4. **GP guidance** (August 2011 draft for consultation)

In the draft guidance, Significant Event Analyses (SEAs) now need to be 2 a year on average, not 1 a year over 5 years. 1 not 2 of Patient Satisfaction Questionnaire (PSQ), Multi Source Feedback (MSF), and audit in 5 years (but PSQ and MSF should be done in 1st 2 years of cycle). Outcome measures or case reviews may be acceptable alternatives to audit.

Note: GMC website has guidance on developing MSF and PSQ processes and will shortly release recommended questionnaires with suggestions about feedback for those not able to answer for themselves. <http://www.gmc-uk.org/doctors/revalidation/9575.asp>

5. It seems likely that the first revalidation folders will be submitted in early **2013**, based mainly on supporting information collected from 1.4.12 (but also incorporating significant information from earlier years). This year's (2011-12) supporting information will be increasingly relevant as we prepare for revalidation: there is increasing focus on this being *personalised* where possible, and on our demonstrating *personal reflection* on it, and the *impact* of any learning. We are all being encouraged to be more rigorous in collecting and reviewing supporting information in order to be best prepared for revalidation, which will mean providing it for appraisers at least a fortnight before the appraisal.

What can you do now?

1. **Think about what appraisal model may suit you** this year and next in preparation for revalidation. This needs to reflect whole practice ie an element of paediatric palliative care appraisal as well as a more generic medical appraisal for those with combined roles. This could be achieved with one appraisal if suitable appraiser available, or through 2 appraisals (the hospice performance appraisal probably feeding information into an NHS one). Guidance suggests maximum 2 of 5 years with same appraiser. *The APPM has several GP members experienced in paediatric palliative care who are also trained appraisers, so with your PCT agreement could offer 'whole practice' appraisal for some GPs working in children's hospices where practical.*
2. **Work out who your responsible officer will be for revalidation (see 'who is my Responsible Officer? link in p13 of Dept of Health Responsible Officer Guidance below** http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_119418.pdf). This is important to establish. If unclear, talk to your hospice NOW as it is their responsibility that their doctors can revalidate. Hospices employing doctors may need to be 'Designated Bodies' for revalidation purposes if any of their employed doctors have no obvious route to a responsible officer and NHS revalidation. These hospices will also need to appoint a Responsible Officer (RO) for such doctors (e.g. the PCT or local hospital NHS trust RO). Ask your hospice to consider doing an 'Organisational Readiness for Revalidation' self assessment exercise: this would be essential for any that will need to be a designated body, but Sections 3 and 4 in particular would be useful for *all* hospices to consider what preparation / information may be needed to support all their doctors in being able to revalidate. http://www.revalidation.support.nhs.uk/files/ORSA_2010-11_v1.0.pdf

- 3 Cultivate any NHS links** you have, to maintain opportunity for revalidation through NHS where possible e.g. Honorary NHS contracts where doctors are providing a service for the NHS. This also helps with governance, indemnity, library access etc for that work. You would normally revalidate through your main role, but any NHS role (including honorary contracts) will give you an NHS route to revalidate even if not your main role.
- 4. Think about how you will collect supporting information** through the year:
- What?* Note the generic GMC requirements, and keep in touch with requirements for your own college which are out for consultation e.g. RCGP, RCPC, RCP e.g. professional development activity plus reflections, Significant event analyses (SEA) personalised. Engage in dialogue with your hospice to make supporting information accessible and available for you. Collect it as you go through the year. This is still an overly cumbersome element of appraisal and revalidation, especially for doctors with multiple or non NHS roles. This information needs to cover all your professional roles as a doctor.
 - Where?* Either on a Toolkit (Appraisals toolkit, RCGP toolkit etc) and/ or as off-line personal document folders to upload at the end of year. On the Toolkit only you and your current appraiser (once you've signed it off) can see it (with introduction of revalidation your Responsible Officer may see it too).
 - How?* Needs to be electronic, either scanned or typed. Include *personal reflections* as you go e.g. reflective learning sheet to type or scan in, and/or log reflections on Toolkit as you go. Remove personal identifiers.

NB Think about how the information demonstrates the GMC 'domains and attributes'.

Once we have confirmation of the latest recommendations about revalidation, you will be able to find the information in this article, together with useful weblinks, a summary of the new GMC guidance, and a suggested action plan for children's hospices, all on the APPM 'education and training' pages on the ACT website: www.act.org.uk. I will endeavour to keep this up to date with significant developments as the processes evolve and will provide another update and question time at the APPM study day in November. Meanwhile, do keep an eye on the Revalidation Support website for continuing updates and drafts of the new Medical Appraisal Guide. <http://www.revalidationsupport.nhs.uk>

My hope is that appraisal will remain supportive and developmental, and that as plans evolve and simplify, revalidation will be straightforward for the vast majority of doctors. If you have suggestions as to how APPM could further support its members in this area, do let me know. I am very keen to hear from any individuals for whom revalidation processes may be problematic, but am also happy to be contacted about any individual queries or concerns in relation to revalidation as the new processes evolve.

Dr Susie Lapwood 7 September 2011

Co-chair, APPM Education and Training working party. GP appraiser. Member of South Central Strategic Health Authority Project Board for Revalidation. slapwood@helenanddouglas.org.uk

Trainee Perspective

Michelle Hillis spR GOSH

Having now been in a Paediatric Palliative Medicine Grid post for a year, (albeit part time) I would like to share my experiences of being a trainee at Great Ormond Street Hospital. Hopefully this will help potential trainees know what they are letting themselves in for and let those working in the field have greater understanding of training needs and fears.

Starting my grid post in paediatric palliative medicine was a reality shock. Having been a confident competent general registrar with an interest in palliative medicine, I became the junior member of a highly specialised team, aware of my lack of knowledge and understanding of paediatric palliative care. Consultants from other hospitals would call up for advice and I felt a fraud, collecting information and then asking my consultant.

The role is fundamentally different from anything previously done in my training. I have been given 'supervised' autonomy to manage my own patient caseload. Patients include children with a wide range of life-limiting and life-threatening conditions (including malignant, cardiac, neurological and metabolic conditions), at a variety of stages along their disease trajectory. I visit patients wherever they are, whether in GOSH, other hospitals, hospices, schools or at home. We have no inpatient palliative care beds at GOSH and do not run clinics.

My role is wide, but focuses on assessing, anticipating and managing symptoms, facilitating end of life care planning and liaising with other professionals to ensure quality multi-disciplinary care. I support children and their families and help construct symptom management and emergency care plans. I have observed and then helped to manage withdrawal of intensive care of patients in PICU and supported families in the withdrawal of ventilation in their own home and at the hospice. I participate in an on-call rota where we offer a 24/7 telephone advice service to families and professionals, which although initially terrifying, is now one of the most interesting and satisfying learning experiences. I have been encouraged to study towards a Postgraduate Diploma in Palliative Medicine and participate in audit and teaching. I also do some haematology/oncology shifts and attend specialist clinics and ward rounds to broaden my experience

The most important learning points for me have been to constantly ask myself:

- Is this patient actively dying or not? - as it significantly alters management.
- What are they dying from? What is causing their symptoms? - as without thinking through the physiology I cannot work out how best to treat them.
- What does the patient/family want? - how can I best manage and meet expectations?

The learning curve has been steep and there is a long way to go but it has been an enjoyable year which has absolutely confirmed my desire to specialise in this field. Paediatric palliative medicine is a young, developing specialty and there are few trainees. We need both enthusiastic trainees and trainers who recognise challenges faced and provide experience, knowledge and support.

Training Information Update

December saw the second round of interviews for national grid training posts in paediatric palliative medicine. Although we have largely navigated the rocky shoals of the transition between the old system and the new, this has not been without its casualties. Frustratingly, we have not been able (as we had hoped and expected to be able to do) to offer retrospective recognition of training to those who had had experience in paediatric palliative medicine prior to its becoming a sub specialty. Even those who had spent time in the two posts that subsequently became recognised as grid training posts did not find it easy to gain official recognition.

The explanation for this is probably that while we have been trying to develop training in paediatric palliative care, there has been a revolution quietly taking place in the structure of accountability with respect to training. Training is now directly coordinated by The General Medical Council, rather than being delegated to the Postgraduate Medical Education and Training Board. Whereas, in the past, there seemed to be some leeway, so that a CCT could be awarded on the recommendation of the relevant Specialist Advisory Committee, this discretion seems now to have disappeared. It has become clear that currently the only route to obtaining a CCT in paediatric palliative medicine is to be appointed to and complete one of the national grid training posts.

This raises the question as to whether the existing two posts are enough. There are competing influences here. The number of trainees anxious to specialise in paediatric palliative medicine is increasing. At the same time, there is no obvious increase in the number of consultant posts to which they could be appointed. On balance, our feeling is that the recent flurry of Department of Health activity makes it likely that new posts will appear. With that in mind, we are tentatively looking to add a third national grid training post over the next year or so. The location of the post will depend on a number of factors, including the availability of a suitable trainer and funding.

In the meantime, advertisements for most consultant posts in paediatric palliative medicine will ask for certification in the sub specialty 'or its equivalent'. Whether training is considered equivalent is usually decided at the time of interview by the interview panel, which will usually include an advisor from the Royal College. The SAC in PPM is always happy to assess training informally with a view to writing a letter confirming that, in our view, it is considered 'equivalent' to completing a national grid post. This is entirely informal, and is NOT necessary in order to be appointed. But for those who feel it might stack the odds in their favour a little more, do contact me to ask about this possibility.

Dr Richard Hain
CSAC Chair

The first annual APPM study day at BMA house

Well... the team organising this event had planned for 40-50 delegates and dreamed of 80 (maximum room size) but we got 110 delegates! The BMA House were very helpful in accommodating our increased numbers and moved us the day before to bigger rooms. For some the room was still felt to be too cramped; though some may say cosy and intimate!?

The day started with Myra Bluebond-Langner, the True colours chair for Paediatric Palliative care, who set the tone for a very interactive, packed programme. Feedback on the day was overwhelmingly complementary and supportive of the day being an annual event.

Costs were kept down to encourage attendance and we will endeavour to keep the costs the same £80 for member and £100 for non-member for this year. Though, we will look to have a bigger room this year.

For the study day 2011 we have attempted to address the feedback from last year's delegates including starting later and finishing earlier to enable people travelling from afar to try and do the journey in a day. Unfortunately we have had so much to fit into the day that despite our best efforts we have ended up with at least 9-5 filled. Closer to the time, for those travelling up the day before, we will organise a local meal.

Delegates requested more time to network and more case –based discussion to generate debate and discussion around challenging cases experienced. This has been incorporated into the programme as short case presentations with a longer 'open to the floor' discussion. To consolidate on a successful first attempt at an annual study day, the event will be held again this year in London but after that we will look to have it held elsewhere in the UK in 2012.

Delegate participation on the day was fantastic, your enthusiasm and commitment to the field was palpable and made the day what it was. Feedback from the day was invaluable to enable us to plan this year's study day. As the organisers we are always happy to hear from people with ideas of great speakers or interesting cases that could be shared.

Hope to see you on the 25th Nov 2011.

AK, Mike and Pat

Research Meetings and Study Days

APPM Study Day in London on Friday 25th November 2011, Full details and booking at www.act.org.uk/landing.asp?section=385

We have an exciting programme including a keynote address on movement disorders by Dr Charlie Fairhurst and a range of workshop options including getting in and out of PICU, assessing risk for bereaved parents and providing a GPs service in a children's hospice. **The APPM AGM will also be held at this meeting.** There will also be an **opportunity to display posters** related to paediatric palliative care research and development activities including the £30 Million for Paediatric Palliative Care funded projects.

Research Meetings and Study days

Our aim to network with other palliative care organisations has led to the planned collaboration with the **Adult Association for Palliative Medicine (APM) at the 9th Palliative Care Congress, 14th – 16th March 2012, the Sage Conference Centre, Newcastle Upon Tyne, www.apmonline.org. There will be a range of paediatric palliative care oral presentations, poster presentations and guest speakers with the abstracts closing date 23rd September 2011.**

RCPCH Conference Glasgow 22-24 May 2012. There will be a joint session at the RCPCH congress in Glasgow 2012 between Palliative Care and Ethics & Law. call for abstracts is now open until 21st November, particularly interested in papers relating to:

- compassionate extubation,
- refusal of treatment, including the advance refusal of care
- resource issues related to place of care
- Maintaining the confidentiality of children and young people whilst also meeting our obligations to their parents.

7th World Research Congress, European Association of Palliative Care [EAPC]. Trondheim, Norway 7-9th June 2012. Abstracts to be submitted by 15th October 2011

Cardiff International Conference In Paediatric Palliative Care 10-13th July 2012 Despite the fact that this will be the sixth annual international Cardiff Conference, which unbelievably means I have been doing it for well over a decade, I am still always taken by surprise when I realise it is time to start thinking about the theme for the next conference. The dates have now been decided, and we have even fixed a venue and – most important – begun to consider the social programme. It only remains for us to decide what the conference should be about.

The conference is done in collaboration with the International Children's Palliative Care Network (ICPCN). I will be looking soon for willing participants as speakers, members of the academic/scientific panel (helping select abstracts and chairing sessions), and of course, delegates.

I hope to see you all there. Richard

Editorial Change.

The members of the executive would like to thank AK for all her hard work over the last few years with the newsletter. She has been doing this as well as organising the study days. As of this edition the newsletter will be edited by Heather McCluggage, if you wish to submit an article please contact me at, heather.mccluggage@westerntrust.hscni.net