*Revalidation*

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

e 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.

**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](http://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.revalidationsupport.nhs.uk/files/ORSA_2010-11_v1.0.pdf>

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1. ***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.
2. ***Think about how you will collect supporting information*** through the year:
3. *What? Note the generic GMC requirements, and keep in touch with requirements for your own college which are out for consultation e.g. RCGP, RCPCH, 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.
4. *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).
5. *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*](http://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*

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