**Helen and Douglas House Hospices for children and young adults, Oxford**

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**Summary**

Small designated body (voluntary sector hospice), in a small subspecialty, employing 7 doctors, just 3 of them ‘connected’ to the hospice for revalidation purposes. The case study is an illustration of how we are working creatively to make the very best of opportunities for formative whole practice appraisal of ‘hard to reach’ doctors in a challenging setting, in partnership with a supportive external Responsible Officer, in order to implement the Responsible Officer regulations. **In particular we have capitalised on the opportunity of the 5 year revalidation cycle, to provide varied appraisal input (internal and external, subspecialty specific, and generalist), for our connected doctors.**

**Background**

Our setting is a small Designated Body, a children’s and young adults’ hospice, employing 7 doctors with diverse portfolio roles straddling hospital, hospice and general practice. 3 of these are directly ‘connected’ to the hospice and to its Responsible Officer for revalidation. Paediatric palliative care is a small and recently established subspecialty.

**Objectives**

1. *To enable our ‘connected’ doctors to revalidate successfully.*
2. *To maintain relevant, formative specialty-specific appraisal, complemented by more generalist, usually external appraisal to provide assurance and benchmarking.*
3. *To obtain useful individualised patient / patient proxy feedback, without over-burdening patients and families in a ‘hard to reach’ setting.*
4. *To support our hospice-employed doctors in collecting relevant supporting information for their portfolios.*

**Key Challenges**

1. To understand the Responsible Officer regulations and interpret them constructively and appropriately for our small voluntary sector hospice and the members of its medical team.
2. To identify and work with an appropriate external Responsible Officer (we decided that it would be both inefficient and inappropriate for one of our 3 connected doctors to also act as Responsible Officer).
3. To agree appropriate procedures for appraisal and revalidation that would continue a positive tradition of formative appraisal, taking account of both subspecialty expertise and internal review, whilst also providing external assurance and benchmarking.

**How it works (including benefits)?**

1. *Appointing an External Responsible Officer*: We realised that as a small voluntary sector designated body with only 3 ‘connected’ doctors, it was likely to be both inefficient and ineffective to appoint an internal Responsible Officer, and would be difficult to assure the processes. Building on historically constructive relationships, we entered discussions with both our Area Team and our local NHS Hospital Trust, to consider the practicalities around either of them providing us with Responsible Officer services. We are technically a community service, but our connected doctors also provide hospital inreach and have hospital honorary contracts, so either would be relevant and appropriate. Pleasingly, both were willing in principle, and we appointed the Area Team Responsible Officer.
2. In discussion with our visionary and supportive External Responsible Officer, we agreed a novel, but we believe optimised, system for whole practice appraisal for our ‘connected’ doctors, ***using the whole 5 year revalidation cycle creatively*** to provide an optimal mix of appraisers for each doctor. This allows for a mix of both external appraisal at least twice in 5 years (to provide objectivity and benchmarking), and a speciality-specific appraiser in other years (this could be internal or external as the subspecialty is so small). The default is for external appraisal, with either appraisee or appraiser able to suggest this every year (important in a small organisation). External appraisals are informed by an earlier internal review, which further optimises formative aspects of the process. This also helps to provide organisational and specialty-specific context for a generic external appraiser who is unlikely to be unfamiliar with the subspecialty.

We keep our Responsible Officer informed of the appraisers we would like to utilise for our connected doctors each year, and welcome suggestions from the Area Team. Our ‘internal’ appraiser is also an experienced Area Team appraiser which further helps ensure consistency and benchmarking. In tandem with this agreement, we have also established a short list of appraisers regionally and nationally with relevant subspecialty-specific expertise. We use a memorandum of understanding for provision of appraisal services by each appraiser.

1. *Obtaining personalised supporting information, in particular patient / patient proxy feedback* has been a challenge and required development of new systems. The organisation has good, proactive and reflective clinical governance processes, and for appraisal, doctors use the Clarity ATK or MAG form. However, the interdisciplinary team approach to care, means that most of the data collected previously has been about the clinical service as a whole, not specific to the medical team, and not specific to individual doctors.

We are a ‘hard to reach’ setting, with a relatively small number of patients, mostly inpatients in fragile health, more than half being under 18, and /or non verbal, but have managed to obtain feedback meeting GMC criteria. We devised a patient feedback questionnaire, adapted for our setting, based closely on the GMC model questionnaire but with more scope for freetext comments. (We also have separate questionnaires available for children and for patients with a learning disability).

We ran an (unsuccessful) pilot whereby care team would hand out questionnaires to patients or parents after a doctor had seen them on admission. After a 3 month trial very few had been returned (average just 1 per doctor). We therefore moved to a system whereby each doctor keeps a record of patients / parents seen, giving the list to an administrator who selects which families to send questionnaires to, enclosing an SAE (ensuring the same families aren’t asked repeatedly, as we are seeing evidence of ‘feedback fatigue’). Despite this being postal and retrospective, over 50% have been completed and returned overall. The administrator collates the feedback which is shared at the doctor’s internal review (and uploaded to inform their ‘revalidation’ appraisal). We think this system is probably now optimised for our setting.

Collection of *other supporting information* is now enhanced by having standing items at monthly clinical governance meetings, to review incidents, complaints and compliments, with key points also being discussed at the medical team meeting. The organisational intranet now includes a folder of supporting information for doctors (including relevant audits, incidents etc). The monthly medical team meetings now also include a standing item about appraisal and revalidation. Half the meeting is designated as ‘professional development’ (including case discussion, review of deaths, learning from incidents, topic based teaching, journal club, clinical supervision), further aiding collection of robust supporting information for appraisal.

**Lessons learned**

1. There is great value in using the **5 year revalidation cycle** creatively (particularly for doctors in atypical settings, small subspecialties, or with portfolio careers), in order to achieve a mix of internal (within hospice), and external appraisal, with speciality-specific input at least twice in 5 years. This can optimise the formative opportunity in appraisal, providing specialty specific relevance without sacrificing external assurance. Further assurance is provided for a small Designated Body by having an external Responsible Officer.
2. **Relevant patient / patient proxy feedback** can be obtained (and in line with GMC guidance) in ‘hard to reach’ settings such as a children’s hospice, with some careful thought, adaptation of a standardised questionnaire, and development of systems to support it.
3. By having ‘**appraisal and revalidation’ as a brief standing item at monthly medical team meetings**, and including at least half the meeting as documented professional development activity, we ensure that we have documented regular team-based learning, all the team are prompted to think about their own appraisals in timely fashion, queries are addressed, and we inform continuing development of organisational systems to support appraisal and revalidation.
4. Although a lot of time, thought, and discussion has been needed to develop and report on processes initially, both internally and in discussion with Area Team, we hope it will not be over-burdensome in the longer term.

**Next steps:**

1. We will collate our individualised doctor feedback from patients and parents/ carers, in order to provide collated feedback for the organisation as a whole.
2. With the merging of Area Teams we will need to finalise / revise our hospice in-house policies and procedures to ensure governance mechanisms dovetail with those of the new organisation.
3. We will collaborate with the new merged organisation, particularly to develop systems for quality assurance, (to include a site visit from Area Team), and to review what is working well and what could be improved.

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