hcpc health & care professions council

Health and Care Professions Council – Tuesday 4 December 2012

Reports from Council representatives at external meetings

Executive Summary and Recommendations

Introduction
The following feedback has been received from Council Members reporting back from meetings at which they represented the HCPC:

Report on the 10th International Association of Medical Regulators (IAMRA) Conference, Ottowa - Anna van der Gaag, Eileen Thornton

Report on the Annual Care Conference for Wales - Arun Midha

Report on the Scottish Government Regulation Event – Keith Ross

Decision
The Council is requested to note the reports.

Background information
None

Resource implications
None

Financial implications
The cost for attendance at conferences/meetings has been incorporated into the Council annual budget.

Background papers
None

Appendices
Copies of feedback forms

Date of paper
22 November 2012

Report on the 10th International Association of Medical Regulators (IAMRA) Conference, Ottawa, October 2012

Medical Regulation in the Real World: Bringing evidence to bear

More than 200 delegates attended the 10th IAMRA conference from 34 countries. South American countries were represented for the first time. The three days provided a mix of plenary sessions, workshops and parallel sessions. It was particularly encouraging to see that evidence building has become a key theme in professional regulation in the global landscape.

Eileen Thornton, Marc Seale and I attended on behalf of HCPC. I gave a paper on professionalism, which was well attended. This report summarizes some of the presentations we attended and provides a summary of some discussion points for future reference.

1. **Continuing fitness to practice**
There were diverse views and approaches to assessing continuing fitness to practice. To some extent, this depended upon the culture and the resources available. There were some evidence-based differences, however. Canada takes a risk-based approach, arguing that resources should be targeted at the minority of poorly performing doctors rather than directed towards the majority. The papers below, one from the Quebec medical board, and the other the GMC, provide an illustration of these different approaches.

Marc Billiard, Medial Board of Quebec; Targeting 'dycompetent' physicians
This paper describes the Canadian model of assessing doctors' ongoing performance. The model concentrates resources on the poorly performing doctors, rather than on the majority.

Goulet et al (1996) has shown that 95% of doctors are 'good' doctors. A key question for regulators therefore is: How do we reach the 5%?

Methodology:
Randomly selected peer review process includes an initial short questionnaire to all doctors, followed up by structured interviews, observations, audit, and ultimately referring to the Inquiry division of the Board.
Register holds 18,000 doctors, 11% are overseas qualified (IMG).
1,764 reviews over the last 9 years, 160 peer reviews per year.
Results:
Older physicians are highly likely to be in the cohort of 'dyscompetent' doctors.
30% of doctors over 75 are practising 'adequately'
40% of doctors over 65years are practising 'adequately'
IMG- 25% are not practising 'adequately'
CPD - good CPD correlated with good scores overall

There tended to be a correlation between doctors over 65, not undertaking CPD.
Overseas qualified doctors also scored badly on CPD activity.
As a result of this search, the Medical Board are now sending a short questionnaire to all doctors over 70, using age as a marker of risk.
Started this process in January 2012 - to date this is being well received.

The Medical Board is investing in this as a preventive measure - to reduce complaints and disciplinary hearings. They are targeting the dyscompetent doctors rather than checking all doctors. A by-product of this programme is that they are also looking at location- the survey may find that there are particular hospitals that are not performing well, and there is therefore an 'indirect benefit' of doing these individual audits.

Doctors registration fee =$1,200 Canadian
Budget for the division $6.1 million p.a, employing 8 doctors, and 5 others delivering the remediation programme. Doctors have to pay for the remediation programme.

Principle: Find the physician before the lawyer does!

Prof Malcolm Lewis GMC
Delivering medical revalidation in the UK - the biggest change in regulation in 150 years?

Revalidation is part of a wider system of measures to improve safety and quality across all doctors:

- It is not a test or exam
- It is not a new way of raising concerns about a doctor
- It is about evidence from the real world

There is an expectation that doctors will do 6 things (in addition to whole practise appraisal):

1.Undertake CPD, but not prescriptive about amount
2.Undertake quality improvement activity
3.Record significant events
4.Gain colleague feedback
5.Gain patient feedback
6.Review of complaints and compliments.

The process:

Responsible Officer (ROs) makes a recommendation to GMC ie
- Revalidate
- Defer
- Failure to engage

Concerns about FtP must be raised when they arise. If there is insufficient information provided then this could be referred back. The system depends on robust local appraisal systems. It is estimated that the process will take about 5 years, with ROs and medical leaders going first in the first year.

2. Continuing Professional Development
There were a range of papers on CPD. DR Elizabeth Wenghofer presented particularly interesting papers on the relationship between CPD activity and complaints.

Dr Elizabeth Wenghofer Laurentian University, Canada

Effects of CPD on occurrence and type of complaints

Research Question: What is the relationship between CPD and incidents and types of complaints?

A comparative study:
Looked at CPD activities in the year prior to the complaint (grouped into self directed, group learning, and assessment related CPD eg they have been asked to participate in these as a result of some incident) as well as type of complaint.
Co-variants also looked at and multi variants analysis undertaken
N= 942 cases, 1850 controls.

Results:
Quality of care complaints constituted the largest number of complaints
CPD was the only predictor of quality of care complaints i.e. if CPD was undertaken then doctors were less likely to have a complaint made against them about quality of care.
Older doctors, number of patients seen, also predicted complaints,
Other co variants may also have an impact but this needs to be investigated further.

Conclusions:
Overall participation in CPD means doctors are less likely to have complaints made against them.
Doctors' participation in group CPD activities especially likely to be a predictor here.
Attitudes to lifelong learning likely a predictor too.

Not yet published, but submitted to Journal of the American Medical Association (JAMA).

3. Psychosocial aspects of performance
There were a number of papers on the psychosocial aspects of performance. Nick Brown's paper provides an illustration:

Dr Nick Brown *(NCAS)
The definition of insight - a challenge that matters for remediation

NCAS experience of working with poorly performing doctors over many years is that self awareness and insight are a key factor. Insight and self awareness are often used synonymously - they are key to improvement in performance. Lack of insight is frequently part of the reason for striking off doctors in the UK.

There are clinical and educational definitions of insight - self knowledge, paying attention to the observations and assessments made by others of ourselves. Also called 'private self consciousness' - internal self awareness
Questions remain about whether this is passive - should we seek out feedback?

Conte and Ratto 1997
High awareness individuals are interested in the meaning of their own and others behaviours, are sociable, assertive, low on rejections, more open to new ideas.
Curious, open, active listener,
Emotional intelligence (EI) is another way of conceptualising this - a skill in understanding and managing others. - understanding oneself and others, and their

feelings.

Common features of insight:

- Curiosity
- Focus on experience
- Reflection
- Intellectual and affective activity

Why does this matter?
The higher an individuals EI the better the work performance (Baron 2005)
Nelis (2010) training in EI works
Smith (2005) self awareness can be developed

Conclusions:
Insight is capable of change. Attention to EI and self awareness and motivation is of fundamental importance to CPD and the undergraduate curriculum.

4. International migration
Workforce migration is a widespread concern for many of the developing nations, who experience an exodus of skilled workers. We attended a number of papers on this.

Prof LesleyAnne Hawthorn, University of Melbourne
English language testing in Australia 2005-2011

Australia: 25% population are first generation migrants
Key trends:
The level of medical migration has accelerated and diversified in recent years. This is largely to do with the privatisation of migration. Migrants now go directly into medical practice. There is a preference for OECD economies. In contrast, government sponsored migrants are more likely to come from non-English speaking countries.

For permanent medical migrants, language testing is a condition of entry. The big hurdle is not the clinical exam but the test of English, which currently has a 52% pass rate.
The reality is that most people go to work immediately and with little support.

Policy challenges
IELTs level 7 is specified for medicine, it should be adopted as the gold standard for others.

Hawthorn recently conducted interviews with 7 other jurisdictions including HCPC. There was very little empirical evidence for decisions about language testing. Eg asking for IELTS passing in one sitting. This has had a catastrophic impact for some candidates. Eg 82% of nurses cannot get registration in Australia since the single sitting has been introduced.

The research evidence is very problematic - no certainty that there is a progression for example during education in non-English speakers. We lack the evidence base in this area.

These papers illustrate the wide variety of approaches taken by regulators. These presentations and many others are available on the website.

Shane Carmichael GMC
A look at a preventive approach in regulation
Supporting doctors treating people with learning disabilities

Mary Zulu
National healthcare Standards for Zambia: a pilot study

Aaron Young
Physician violations of online professionalism: a survey of State medical Boards in the US

Conclusions and possible discussion points for HCPC

1. There is now a strong consensus that regulators in the 21st century should be undertaking and commissioning research and sharing data. An effective regulator brings evidence to bear on all its activities.

2. Several papers referred to the correlation between CPD activity and good clinical practice/if CPD is undertaken there is less likelihood of complaints being made against a doctor

3. Research in regulation consistently reports that doctors in the older age group, overseas qualified are most 'at risk' of poor performance.

4. Several papers emphasized self-awareness and insight as a key competence of good practice. There should be more emphasis on teaching these skills and competencies during undergraduate education but also as part of CPD.

5. Some regulators are producing tools to assist registrants in areas where there are identified weaknesses e.g. GMC micro-site to support doctors treating patients with learning disabilities.

6. Andre Jacques, Quebec "find the doctor before the lawyer does! "
Eg risk based approach to CPD? Or Following up on poor CQC outcomes?

7. Involving the public -
The closing keynote speaker offered a challenge: How are you creating links with your community?
Guard against tokenistic gestures of inclusion - having a lay majority on Council doesn't cut it. Public members can become 'professional' regulators
More important - how do you link with the organisations who try to stop human trafficking? Is this an area HCPC might think about? Strengthening our links with voluntary organisations and asking them how we can raise public awareness of our work.

Some observations from **Professor Ron Paterson, keynote speaker**, Professor of

Law, Auckland NZ

‘Regulators must be watchdogs not guide dogs. Good watchdogs bark when they see harm. Simply sticking to the letter of the law is not enough. Regulators need to challenge, test evaluate, be proactive’.

‘The angry a buzz of a multitude is one of the bloodiest noises in the world’.

‘Lessons for regulators - do basic common sense checks well’.

‘When complaints are freely heard, deeply considered and speedily reformed, then this is the upmost bound of civil liberty attained that wise men look for”
John Milton 1644 Areopagitica

Visit http://www.buksa.com/IAMRA/program.htm to download and view handouts.

Anna van der Gaag
Eileen Thornton
November 2012

Name of Council Member	Arun Midha
Title of event	Annual care conference for Wales
Date of event	10th October 2012
Approximate attendance at event	100+

Issues of Relevance to HCPC

The conference focused on the long term care sector in Wales which is currently experiencing unprecedented change, creating a number of challenges to owners, operators and care professionals. The conference provided an update on legislation, training and also inspection.

Slightly disappointingly the Deputy Minister, Gwenda Thomas, was unable to attend. However, there were a number of interesting sessions. One focused on citizen focused regulation given by the Care and Social Services Inspectorate Wales and the use of a quality judgement tool. Hugh James solicitors provided a presentation on how employers can manage some of the more complex issues of employment including ensuring appropriately qualified staff, vetting and barring and registration as well as best practice on recruitment and performance management. A further session focused on the implications for Wales of the Health and Social Care Bill.

Key Decisions Taken

Name of Council Member	**Keith Ross**
Title of event	**Scottish Government Regulation Event**
Date of event	**6/11/12**
Approximate attendance at event	**200**

Issues of Relevance to HCPC

Whole conference was relevant to HCPC. Opening address was by Scottish Cabinet Secretary for Health. He reaffirmed commitment to UK wide regulation but hinted at need for change particularly in light of intent to integrate health and adult social care. This was followed by presentations on EU issues by an EU policy officer, and on public protection by the Commissioner for Public Law. There were parallel sessions on a wide variety of relevant issues. I attended sessions on the Law Commission Review, Voluntary Registers and Professionalism. The feedback to the Law Commission from a group of about sixty delegates was supportive of greater consistency and alignment between regulators. The session on voluntary registers highlighted the potential for confusion about voluntary versus statutory regulation, and the discussions on professionalism highlighted the perceived importance of mentors, coaches, peer review, leadership and immediate feedback on performance as critical factors. The closing address by Jim Martin Scottish Public Services Ombudsman challenged the delegates to think of regulation from the perspective of the consumer and asked regulators to consider if they were designing a system from scratch for health and social care regulation – would they come up with what we currently have.

On the whole a well-attended and thought provoking day with plenty of opportunity to network.

Key Decisions Taken

Not a decision making forum