CONFIRMED
The Health Professions Council

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MINUTES of the third meeting of the Professional Liaison Group on Continuing Fitness to Practice held on **Tuesday 11 March 2008** at Park House, 184 Kennington Park Road, London SE11 4BU.

Present:
Dr Anna Van Der Gaag, HPC President (Chair)
Mrs Mary Clark-Glass, HPC Council member
Ms Audrey Cowie, Scottish Government Health Directorates
Mrs Ruth Crowder, Allied Health Professionals Forum
Ms Christine Farrell, HPC Council member
Ms Thelma Harvey, Knowledge and Skills Framework
Ms Nadia Miszczanyn, UNISON
Mr Keith Ross, HPC Council member
Dr Charles D Shaw, Independent health care advisor
Mr Mark Woolcock, HPC Council member

Mr Frances Garrett, General Dental Council (Item 4)
Ms Moragh Loose, General Dental Council (Item 4)
Mr Richard Marchant, General Medical Council (Items 1-3)

In attendance:
Mr David Hutton, Nursing and Midwifery Council
Mr Michael Guthrie, Policy Manager
Ms Sherran Milton, Association for Perioperative Practice
Mr Steve Rayner, Secretary to the PLG
Charlotte Urwin, Policy Officer

Item 1 - 08/07 APOLOGIES FOR ABSENCE, WELCOME AND INTRODUCTION

1.1 Apologies were received from Council members Miss Eileen Thornton and Mrs Morag MacKellar, Mr Vince Cullen of the General Osteopathic Council

and Lynne Smith of the Regulation Council for Clinical Physiologists. Ms Nadia Miszczanyn attended in place of Ms Sharon Prout on behalf of UNISON.

Item 2 - 08/08 MINUTES OF THE DISCUSSION GROUP OF 15 JANUARY 2008

2.1 The minutes of the Second meeting of the Group on 15 January 2008 were accepted as a true record subject to the following amendments:

08/01-1.1 Audrie Cowie should read Audrey Cowie, Kieth Ross should read Keith Ross

08/03-3.5 The figure of 21 complaints per 1000 registrants relates to GMC registrants and is taken from section 6.1.6 of the CHRE annual report 2006/7.

Item 3 - 08/09 GENERAL MEDICAL COUNCIL APPROACH TO REVALIDATION

3.1 The group received a presentation on medical revalidation from Mr R Marchant, of the General Medical Council (GMC).

3.2 The group noted that the GMC approach focussed on registrants operating in team or otherwise managed environments and asked how it proposed to deal with independent practitioners.

It was assumed that independent doctors would still operate in environments capable of producing evidence which could be assessed to determine their continuing fitness to practise. It was envisaged that they would be assessed by GMC appointed 'responsible officers'. Patient questionnaires were expected to play an important role in these assessments and GMC were currently piloting multi source feedback questionnaires with the Penninsula University. Policy on this question and other questions were still at a developmental stage.

3.3 The group noted that GMC registrants failing the revalidation process would be subject to a full fitness to practise investigation and asked how GMC intended to deal with registrants who did not cooperate with the process. These individuals would have their license to practise removed.

3.4 The group asked whether GMC had made estimations of the cost of the revalidation process. Estimates had been made for the Regulatory Impact Assessment for the Health and Social Care Bill.

Action MG: to liaise with GMC over estimates (ongoing)

3.5 Developing a GMC approach to risk based regulation had highlighted the difficulty in generating evidence that certain groups were higher risk than others. This raised the question of whether well managed, apparently low risk, environments should be subject to less scrutiny. At present, GMC was carrying out piloting in this area focussing first on assessing localities with a strong track record in appraisal. It would be happy to share the details of this, and work done on risk, with the group. The information would also be useful to the Non Medical Revalidation Working Group and the Extending Professional Regulation Working Group.

Action MG: To liaise with GMC over work on risk (ongoing)

3.6 The group noted the concept of low risk, well managed, environments and asked whether guidance on this was available that supported CPD and potentially revalidation. GMC drew the concept of an 'approved working environment' from guidance from clinical governance support teams. It was agreed that standards for approved working environments constituted a potential area for a common approach between health regulators. The group noted that there was a need to look at the wider environment and to identify ways of measuring a 'good' environment in partnership with other agencies involved in quality assurance

3.7 The group found the presentation very helpful and thanked Mr Marchant for attending the meeting.

Item 4 - 08/10 GENERAL DENTAL COUNCIL APPROACH TO REVALIDATION

4.1 The group received a presentation on revalidation from Ms F Garrett, from the General Dental Council (GDC).

4.2 The group asked whether there was a process for licensing independent dental practices. NHS practices were subject to primary care inspections, but this varied from trust to trust and tended to focus on equipment. Private dental practices were not subject to any regulation. Technically the Health Care Commission had the power to inspect dental practices but this did not happen.

4.3 The group noted that the GDC approach was much 'lighter touch' than the GMC approach.

4.4 The group noted that the concept of introducing a validation process to establish a baseline standard for registrants on initial registration and asked whether there was evidence that this had an effect. Evidence suggested that this did have an impact.

4.4 The group noted that GDC did not currently intend to use Fitness to Practise procedures to deal with all registrants who failed revalidation. GDC explained that the burden of proof would have been on the registrant to display their fitness to practise through revalidation. If a registrant failed to provide the necessary evidence for revalidation, the GDC would remove them from the register via an administrative process. In fitness to practice cases, the burden of proof would be reversed, and would be on the regulator not the registrant to evidence unfitness to practise.

4.5 The group asked how GDC considered the interface between national standards and local appraisal systems. It also asked about post registration standards and revalidation. Specialist registrants would revalidate against the standards for their specialism. All other registrants would revalidate against generic standards.

4.6 The group asked whether GDC had developed costings on the impact of the new system on registrants. GDC were currently using estimates from similar systems in Canada as a baseline which it would be happy to share with the group.

Action MG: To liaise with GDC over estimates (Ongoing)

Item 5 - 08/11 EXISTING MODELS AND GOOD PRACTICE

5.1 The group received a paper from the Executive drawing together observations from the study of different models and practices including supervision, periodic assessment, mentorship and induction, professional body initiatives, and examples from other regulatory fields.

5.2 The group agreed that it had not seen a stand alone system to date which would deliver appropriate revalidation within an HPC context. There was therefore an opportunity to design a system, if this was required

5.3 There were of course other models that had not been considered fully to date. For example, the process undertaken by Physician Assistants in the United States, where registrants are potentially subject to a full revalidation process, being required to re-take exams every six years. Ms Cowie agreed to supply further information for interest.

5.4 The group held a discussion with following points and questions:

- The group agreed that there was a need at some stage to answer the following questions: What was the problem to be solved? What are we trying to achieve? What are the options? What mechanisms could be used?

- Evidence given to the review of non-medical revalidation had highlighted that the public assume that there is more scrutiny of healthcare professionals than is currently the case.

- It was still not clear what additional mechanisms for revalidation would achieve for the professions regulated by HPC. There was no clear evidence of a problem in relation to the continuing fitness to practice of practitioners, for example.

- Should a revalidation model be linked to the fitness to practise process or should it be separate from it?

- Should patient feedback be captured?

- If risk based regulation was adopted, it would potentially lean in the direction of professions in which there were higher complaint levels.

- The GMC "Good Medical Practice" framework, with attributes and associated standards is a model that could work for any group.

- At best, Revalidation should provide a positive affirmation from the majority of registrants and a mechanism to capture early incompetence and misconduct in the few.

- To date, HPC had followed a developmental approach and this had proved effective in relation to CPD.

- A number of building blocks for revalidation already existed, including self-declaration against the proficiency standards and the Code. Another tier of scrutiny may not be necessary at this stage.

- If revalidation was the decision of the regulator to allow a registrant to remain on a register, what evidence should inform that decision?

- Based on current knowledge of registrants, what was a reasonable amount of evidence required to support revalidation of fitness to practise? Did the current two year declaration or CPD process do this already? Did these elements need to be augmented by other forms of inspection?

- These issues have been of concern for a considerable time in the UK. The Alment Report 1978 established a "need for systematic revalidation"

- The real challenge was to stimulate registrants to take responsibility for their own continuing fitness to practice, as the CDP standards were

designed to do. .Work could be done to see the value in peer review for independent practitioners.

- There continued to be an issue with awareness of the standards Mori polling indicated that registrants did not look at the standards, despite self certifying against them every two years.

- Amongst the things that the group would have liked revalidation to achieve were; accountability to the public, public safety and the driving up of standards.

5.5 It was important that the group looked at the role played by different accreditation systems. The next session would include details on the accreditation of Radiology services and work from Ganesh Shah of the UK Accreditation Forum into the register of accreditation systems and their applicability to HPC registrants.

5.6 The group discussed the two systems that had been presented and offered thoughts.

5.7 <u>GMC model</u>

- 4 (5) stage model was thorough as a description of regulatory mechanisms currently in place at both local and national levels.

- The split between relicensing and recertification could be problematic but may not be necessary for HPC registrants.

- There was value in the concept of patient feedback questionnaires and this should be explored further.

5.8 <u>GDC Model</u>

- The three-stage process with a screening approach could be a cost effective model.

- The process was semi flexible, and could accommodate different groups of professionals.

5.9 The group agreed that a full cost benefits analysis and further reference to the impact assessment should be undertaken.

5.10 The Chair concluded that the meeting had once again offered the opportunity for varied and complex discussions, all of which would contribute to the final recommendations in the report.

Item 6 - 08/12 DATE AND TIME OF NEXT MEETING

6.1 The next meeting of the Group will be held at 11.00 am on Tuesday 13 May

Chair

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Date

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