CONFIRMED

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MINUTES of the second meeting of the Professional Liaison Group on Continuing Fitness to Practice held on **Tuesday 15 January 2008** at Park House, 184 Kennington Park Road, London SE11 4BU.

Present:

Anna Van Der Gaag (Chair)
Keith Ross
Christine Farrell
Mark Woolcock
Morag MacKellar
Mary Clarke-Glass
Eileen Thornton
Lynn Smith
Thelma Harvey
Ruth Crowder
Vince Cullen

In attendance:

Michael Guthrie, Policy Manager
Niamh O'Sullivan, Secretary to Council
Steve Rayner Secretary to the PLG
Nina Blunck Public Affairs Manager

Item 1 - 08/1 Apologies for absence, welcome and introduction

1.1 Apologies for absence were received from Audrey Cowie and Charles Shaw.

1.2 The Chair welcomed everyone to the meeting and began by inviting each member to update the group on any new developments or thoughts since the last meeting.

1.3 The following points were made:

- The revalidation debate is often framed as being about quality control versus quality improvement. The solution should include both, but these two do not necessarily need to be intrinsically linked.

- The link between revalidation processes and accreditation processes should also be explored.

- There are clear parallels, and should be closer coordination, with the work of the Knowledge and Skills Framework (KSF) which has many shared objectives in maintaining Continuing Fitness to Practise. There is a research proposal to look at KSF as a tool for revalidation in more detail, led by the KSF Development Group.

- There is a lack of rigorous research in this area of policy formulation.

- The contribution of professional bodies around standards should be strengthened.

- Consideration should be given to the implications of punitive aspects of the current approach to continuing fitness to practise (CFtP).

- It might be useful to look at concerns around the grandparenting process and see what lessons can be learned.

- Resource and risk implications and cost-benefit analysis should be fundamental parts of the process, along with ensuring the appropriate skill set of people involved. Using people without these appropriate skills will undermine results and perceptions.

- Other CFtP schemes should be researched thoroughly as a solution may already have been tested and successful. This should include analysis of European and other UK health sector approaches.

- The message must be that HPC employs a light touch approach, but is effective, and that CFtP is not simply the route to fitness to practice (FtP) investigations. Continued Professional Development (CPD) is about internal scrutiny and revalidation is about external scrutiny.

- Concerns about the papers all presenting uniprofessional models, and all are clinician based systems and therefore not readily applicable. They are also mostly about CPD and no revalidation. If HPC were to pursue a remedial role it would need to work closely with others – professional bodies and employers

- Practitioners can have an excellent CPD portfolio and still not be fit to practice

- We need to promote a culture of accountability, and work in partnership with others, such as the professional bodies.

- There may be useful examples from the other European Union (EU) countries for example Holland

- Consideration should still be given to not implementing any further checks on CFtP if the cost and effort outweigh the benefits

- Focus should be retained on the role of HPC to ensure public safety. Does a change of approach to CFtP change the role of HPC? Would it therefore be better placed with another body, or should HPC consider changing it's role? Does the current shape and direction of HPC dictate the structure of the project?

- Policy has been developed at a high level – with little consideration of the practicalities. Revalidation must not be tokenistic. We don't know enough about what patients want and we need to look at this aspect further. Could the Consumer Association be involved? Could patient involvement come through the Healthcare Commission, Healthcare Inspectorate Wales, the General Social Care Council (GSCC)– as they have a lot of experience in this area.

- There is already a process for revalidation – it is called fitness to practise. However we need to look at whether there is any need for further scrutiny – perhaps by asking employers periodically whether they have any cause for concern

Item 2 - 08/2 Minutes of discussion meeting of 13 November

2.1 The Group approved the minutes as an accurate record of the last meeting.

Item 3 - 08/3 International Revalidation

3.1 Michael Guthrie outlined how the discussion on international validation fitted into the workplan. At the next meeting there will be presentations by the General Medical Council (GMC) and the General Dental Council (GDC) on their systems of revalidation.

3.2 Michael outlined paper 03/08 explaining that the main focus had been on Canada because of the high level of well established CFtP schemes In use there.

3.3 Michael took the group through the analysis part of the paper, focussing on commonality between approaches and the high costs of these approaches, and underlining the importance of measuring different approaches against risk and proportionality.

3.4 The group were asked to discuss the following:

- What are we revalidating?
- Is it possible to revalidate CFtP?
- Is it possible to do achieve quality control and quality improvement?

3.5 The following points were made:

- One option for CFtP would be to require registrants to undergo a peer "MOT" review at regular intervals. This could lead to FtP investigations with three possible outcomes:

    - Punitive
    - Conditions of Practice
    - Retraining

  The cost of this option would be minimal, and could be built into registrants own business planning processes. This option would also have the effect of distancing HPC/FtP from the CFtP process, and be easier for registrants to buy in to. It would also provide an opportunity and the motivation for standards to be revised before CFtP.

- The underlying perception is that FtP is a purely punitive mechanism. This hampers its success.

- Any proposal should be measured against tested approaches from outside health. Do examples from outside health include assessing the necessary soft skills as well as technical skills?

- If CFtP is seen as a learning tool, what criteria would we use to identify failure to learn? If we could identify this, it would help to move the perception from that of a system of punishment, to that of quality improvement.

- Is it worth investigating conditions during which bad practice exists as a method of understanding the issues?

- What is the reason for the disparity in the levels of investigations between GMC/Nursing and Midwifery Council (NMC) and HPC? Is this adequately explained by the difference in contact time and social position between groups of registrants?

- What is the reason for the disparity in the levels of investigations and the levels of conduct investigations brought before HPC?

- Does HPC need to ask the question of how do we define performance and competence?

- Is the remedial element of the FTP mechanism being adequately used? Analysis of the competency investigations could be fed into CPD to improve standards.

- The use of a large hammer (FtP) to crack a nut probably acts as a deterrent to people reporting minor competence infringements via this route. Employers and managers may be aware of competence issues but they do not report them to the HPC.

- Clear definitive terminology will be important in order to get the message across to registrants about the nature and value of CFtP i.e. an MOT is understood to be a clear measurement of safety on the day it is issued.

- There is scope for the group to make its own conclusions. With a lack of research and best practice, there is an opportunity for HPC to step into a void and influence thinking.

- Work looking at complaints from other health sector professions show very different trends:

  NHS 60% Complaints about Doctors/Nurses vs 5% Allied Health Professionals

  NHS 23 Complaints per 1000 registrants[1]
  HPC 1.8 Complaints per 1000 registrants

  Why are these results so different?
  Should this have an impact on policy development?

- We should not assume that there is a genuine desire for improvement amongst the public. A solution should be pragmatic.

- Evidence that professions would benefit from this approach would make the development more robust.

3.6 The Chair drew the discussion to a close, summarising that the following should be taken forwards for the next discussion:

  - Costs of models
  - Risk factors

[1] Figures from CHRE Annual Report 2006/7, Section 6.1.6

- European models
- Partnerships

Item 4 - 08/4 Work Plan

4.1 The group noted the work plan.

Item 5 - 08/5 Definitions

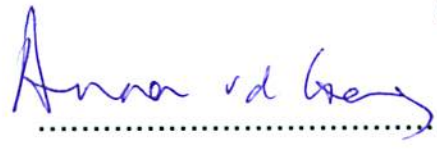
5.1 The group noted the definitions paper.

Item 6 - 08/6 Date and time of next meeting

6.1 The next meeting of the Group would be held at 10.30 am on Tuesday 11 March 2008. Vince Cullen will be unable to attend.

6.2 The subsequent meeting will be held at 11.00 am on Tuesday 13 May

Chair



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Date

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