Continuing Fitness to Practise Professional Liaison Group
15 January 2008

Workplan

Executive summary and recommendations

Introduction
The workplan for the group's work is attached.

A plan of activities is also appended.

Decision

This paper is to note. No decision is required.

Background information

None

Resource implications

None

Financial implications

None

Appendices

- Plan of activities

Date of paper

3 January 2008

Continuing fitness to practise Professional Liaison Group (PLG)

1. Introduction

This document sets out proposals for work on continuing fitness to practise. In particular, a Professional Liaison Group (PLG) is proposed to guide the project.

2. Background

A number of reviews and inquiries, including the Shipman Inquiry led by Dame Janet Smith, have made recommendations relating to measures to assure the continuing fitness to practise of registered professionals.

In 2000, the General Medical Council consulted on proposals for the revalidation of doctors, which they described as an 'up-to-date statement of each doctor's fitness to practise'. These proposals were subsequently criticised in the fifth report of the Shipman Inquiry.

The Department of Health in England's consultation document: 'The regulation of the non-medical healthcare professions' concluded that revalidation was necessary for all regulated healthcare professionals.

In its response to the document, the Council said:

'We do not believe that the case for revalidation of non-medical healthcare professionals has been made convincingly, either in this consultation document or elsewhere. We do not believe that there is evidence to show that developing a system for revalidation would add substantially to public safety.'

In particular, we noted that the following questions remained unanswered:

- What is the definition of revalidation?
- What risks does revalidation aim to minimise or mitigate?
- Against what standards should health professionals be assessed?
- By what means should this assessment be carried out?
- What is the outcome of the revalidation process?

In our response to the review, we also said:

'We believe that the consultation limits this topic to 'revalidation', which we find a problematic term with conflicting expectations behind it. We find it more helpful to consider revalidation as part of a wider debate around ongoing fitness to practise.'[1]

[1] Health Professions Council response to the Department of Health review of non-medical regulation (November 2006). http://www.hpc-uk.org/aboutus/consultations/external/index.asp?id=38

We said that work on this topic might include:

- dialogue and work with the public about their experiences and expectations;
- work with the professional bodies about their role in supporting professionals to undertake CPD; and
- research into the various post-registration and professional frameworks already in existence for certain professions.

3. Trust, Assurance and Safety – The regulation of Health Professionals in the 21st Century

The government white paper, published in February 2007, made a number of clear recommendations about revalidation. In summary, they were:

- Revalidation is necessary for all health professionals, but it needs to be risk based and proportionate
- The department of health will work closely with each regulator to discuss appropriate arrangements
- Each regulator should be responsible for approving the standards which registrants will be judged against (with CHRE acting in a co-ordinating and supervisory role across regulators)
- Appraisal, which should be both summative and formative, should be a central part of revalidation within the NHS
- For employees working within 'an approved body' (e.g. NHS) revalidation will be part of staff management and clinical governance systems, with employers making recommendations to regulators
- There will be three broad groups for revalidation:
    - For employees of an approved body, for example, nurse, dietitians or paramedics working in an NHS organisation or a licensed private or independent sector provider, evidence to support revalidation will be provided as part of the normal staff management and clinical governance systems, with employers providing recommendations to the professional regulators;
    - For those, including self employed contractors, performing services commissioned by NHS primary care organisations (such as dentists or optometrists) the revalidation processes will be carried out under the supervision of either the NHS commission organisation or, particular where it is necessary to take a overview of both NHS and private work, the regulatory body, but in either case with appropriate collaboration between the two bodies; and

- For all others, for example, osteopaths, their regulatory bodies will develop direct revalidation arrangements.'[2]

4. Rationale

This document sets out proposals for phase one of a project which will explore the issues raised in the white paper and in the other reviews.

This first phase should be focussed on the proposals in the white paper but should also more broadly examine the issues around continuing fitness to practise.

Although much has been written on revalidation and associated subjects, there is a lack of clear, analytical information available in one place which brings together the available evidence and the viewpoints of different stakeholders. In addition, almost all of the literature is focused on medical regulation.

This work would be a way of positively engaging in and moving forward the debate, and would be an important formative step in moving towards the development of the Council's own specific proposals.

5. Continuing fitness to practise

'Continuing fitness to practise' refers to all steps taken by regulators, employers, health professionals and others which are supportive of maintaining fitness to practise beyond the point of initial registration. This encompasses, but should not be limited to, 'revalidation'.

The General Medical Council's revalidation proposals include requirements to demonstrate that standards of good character and 'probity' have been met. One area of this work may be examining whether it is appropriate to talk of continuing fitness to practise rather than continuing competence.

The Professional Liaison Group (PLG) would be tasked with coming-up with appropriate terminology.

6. General aims of the work

There are a number of broad general aims of the work:

- To allow proper, evidence based, exploration of the issues relating to continuing fitness to practise.
- To examine the issues with particular focus on non-medical regulation and the professions regulated by the Council.
- To assist the Council in developing its position on a wide range of topics.

[2] Trust, Assurance and Safety – The regulation of Health Professional in the 21st Century (Februrary 2007), pp. 31-42.

- To benefit from the expertise of, and achieve ‘buy-in’ from, the Council’s stakeholders.
- To make recommendations for ways forward.

7. Phase one

This work should be undertaken in phases. This document covers phase one. However, the PLG will be asked to make recommendations about the next steps which will need to undertaken. This could include further analysis of the outcomes of the CPD audits which will commence in July 2008 or the start of a project to develop the operational detail and standards required for revalidation.

The PLG would be tasked with:

- defining continuing fitness to practise;
- identifying best practice in this area including the ways in which regulators, employers and others can be supportive of professionals’ continuing fitness to practise;
- reviewing the evidence base/ literature on continuing fitness to practise in a number of key areas; and
- exploring the issues raised by the white paper and making recommendations to the Council for next steps.

The PLG should consider information across different professions and across the different settings in which health professions work. However, where possible, the group should draw on information and examples relevant to the professions regulated by the Council.

8. Topics

The PLG should consider the following topics (this is not an exhaustive list):

- Revalidation – history, definitions, other models in the UK and elsewhere.
- Continuing professional development – review of practice across regulators and employers including whether a link can be made to continuing fitness to practise. This will include consideration of the outcomes of the first round of CPD audits.
- Appraisal and peer review – models of good practice, statistical reliability.
- Existing good practice amongst professions which we regulate, in both the statutory and non-statutory sectors, which might include:
    - Recertification of paramedics
    - Clinical supervision of arts therapists
    - Other objective ways in which registrants are/ can be/ might be periodically assessed.
- Standards for specialist practice.

9. Membership

The PLG should consist of 12 members, including 6 council members (both registrant and lay). There should be four home country representation.

The remainder of the membership should consist of representatives from a broad range of stakeholder groups which might include (this is not an exhaustive list):

- Employers or employment organisations (NHS and independent sector)
- Other regulators – medical and non-medical
- Patient groups
- Professional bodies

The PLG should be chaired by a member of Council (registrant or lay).

10. Stakeholder engagement

"Buy-in" from stakeholders is a key aim of the work – this includes both benefiting from the expertise of the Council's stakeholders and ensuring that stakeholders feel involved and engaged in the process. Commenting upon the GMC's revalidation proposals, Dame Janet Smith criticised the lack of buy-in to the proposals amongst doctors.

A discussion meeting will be held at an early stage of the work with representatives from professional bodies. This might be broadened to also include stakeholders from other non-medical professions.

During the course of its work, the PLG should also explore other ways of ensuring engagement. This might usefully include inviting professional bodies to contribute to the work with examples of good practice.

The Council will also draw upon the input of its stakeholders in the membership of the PLG.

11. Research

In addition to in-house research, there is scope during phase one to commission external research. This might include:

- A literature review – particularly around the evidence for links between CPD and competence
- Qualitative research to better establish current practice and its benefits and limitations (or this might be more meaningfully conducted in consultation with professional bodies).

12. Report to Council

The final outcome of the PLG should be a report to Council which will summarise the information considered, the breadth of discussion and viewpoints, and any recommendations to Council for the next stage. It should build upon the discussion / conclusions of the PLG and include:

- a clear explanation of the key issues;
- an analysis of the available evidence; and
- examples of current practice / good practice.

This document should be publicly available via the website and sent to our stakeholders.

13. Plan of activities

The detailed plan of activities will be devised by the member of staff supporting the PLG together with the members of the PLG.

The group should aim to meet five times. The group may also consider information electronically between meetings. At its last meeting the group will recommend its positions and conclusions to the Council.

14. Timescale

This draft timescale assumes that there will be sufficient time for research to be undertaken before and between meetings. It also assumes that the PLG does not conclude its work in less than five meetings:

July 2007

5th July 2007 Council meeting – consideration of workplan

October / November 2007

Discussion meeting with members from professional bodies.

January 2008

First meeting

March 2008

Second meeting

May 2008

Third Meeting

June 2008

Fourth Meeting

September 2008

Fifth meeting

October/ November 2008

Consideration by Council of the outcomes of the work and consideration of next steps

15. Costs

The proposal entails the establishment of a professional liaison group (PLG). The costs include:

- Attendance
- Travel expenses
- Venues for meetings
- Research

These financial implications are accounted for in the budget for 2007/08 and will be included in the budget for 2008/09.

16. Resources

The work is likely to be resource intensive. This includes the time of members of staff in researching the subjects, preparing papers for PLG, and writing the document reporting to Council.

17. Changes to the workplan

Any necessary changes to the workplan should be agreed by the chair and PLG members.

The work of the PLG may well be affected by the work of the UK Revalidation steering Group to be established by the Department of Health (England).

Appendix 1 – Plan of activities

The following is a draft plan of activities for future meetings. This is subject to revision in light of the group's ongoing work.

13 November 2007

- Discussion meeting with representatives from professional bodies
- Areas covered included the definition of revalidation; existing models and good practice; and the White Paper.

15 January 2008

Existing models and good practice (1)

- International revalidation

11 March 2008

Existing models and good practice (2)

- The GMC and GDC have been invited to present on their current revalidation proposals
- The group will also consider a paper examining more closely the models discussed at the last meeting, e.g.
    - Paramedic recertification
    - Clinical supervision

13 May 2008

The White Paper (1)

- Papers/discussion about the White Paper recommendations

17 June 2008

The White Paper (2)

- Papers/discussion about the White Paper recommendations

4 September 2008

- Finalisation of conclusions/ recommendations to the HPC Council