Continuing fitness to practise Professional Liaison Group (PLG)

The purpose of revalidation

Executive summary and recommendations

Introduction

This paper looks at the purpose of revalidation, in light of the group's discussions at the last meeting. It is intended to stimulate the group's discussion.

Decision

This paper is for discussion.

Background information

None

Resource implications

None

Financial implications

None

Appendices

- The GMC four layer model

Date of paper

30 April 2008

1.Introduction

At the last meeting, the group returned to the purpose of revalidation itself and said that at some stage there was a need 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?

It was suggested that it was only once the first two of these questions had been answered that we could begin to address the subsequent questions.

These questions echo the discussion at the group's discussion meeting in November 2007, where the wider group discussed possible definitions for revalidation and many participants questioned whether there was clear evidence that revalidation was necessary.

This paper makes no firm recommendations to the group. It is intended to bring together background information and information discussed previously by the group to provide a structure which might support the group in its discussion.

This paper is structured into four areas:

- Definitions of revalidation
- A summary of the White Paper recommendations and a summary of points previously raised by the HPC Council
- What is the problem to be solved?
- Existing HPC processes

2. Definitions

The following are definitions of revalidation:

- ‘The regular demonstration by registered doctors that they remain fit to practise in their chosen field(s).’
  Ensuring standards, securing the future – consultation document (GMC, 2000)

- ‘Revalidation is the process by which a regulated professional periodically has to demonstrate that he or she remains fit to practise.’
  The regulation of the non-medical healthcare professionals (DH, July 2006)

- ‘Revalidation is a mechanism that allows health professionals to demonstrate that they are up-to-date and fit to practise.’
  Trust, Assurance and Safety – The regulation of health professionals in the 21st century (February 2007)

In summary revalidation in the definitions above is:

- Regular.
- An assessment that a registrant is up-to-date.
- An assessment that a registrant is fit to practise.

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

At this meeting, the group is considering papers which look at costs, risk and the NHS Knowledge and Skills Framework, areas addressed in the White Paper recommendations. This section provides the group with a summary of the White Paper recommendations. The points raised by the Council in its response to the review of non-medical revalidation are also reproduced for the group's information.

Summary of White Paper recommendations

- 'Revalidation is necessary for all health professionals, but its intensity and frequency needs to be proportionate to the risks inherent in the work in which each practitioner is involved.' (paragraph 2.29)

- '…the regulatory body for each non-medical profession should be in charge of approving standards which registrants will need to meet to maintain their registration on a regular basis.' (paragraph 2.30)

- 'There are some non-medical professional staff, such as clinical scientists, who undertake higher specialist training and practise for most of their careers at a specialist autonomous level. The Department will work with the Devolved Administrations to establish a short-term working party to consider how regulation and revalidation should reflect this.' (paragraph 2.31)

- Three groups for revalidation:

    - Employees of an approved body – employers make recommendations to the professional regulators
    - Self-employed contractors and others performing commissioned activities - commissioning organisations or regulators make recommendations
    - Others – regulator develops direct revalidation requirements

- 'Information gathered under the Knowledge and Skills Framework should be used as far as possible as the basis of revalidation, with any additional requirements justified by risk analysis.' (paragraph 2.34).

- 'The Government will discuss with the Devolved Administrations and with public private and voluntary sector employers the development of an affordable and manageable timetable for the effective implementation of revalidation.'(paragraph 2.38).

Points raised in our response to the Review of the regulation of non-medical healthcare professionals

The Council said the following in its response to the Review of the regulation of non-medical healthcare professions ("the Foster review").

'The Council believes that:

- The case for revalidation of the non-medical healthcare professions has not yet been made.

- Crucial questions around the nature of revalidation in relation to non-medical healthcare professions remain unanswered:

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

- There may be a conflict between formative and summative assessment, which means one process cannot effectively cover both.

- The costs of revalidation are untested, and are likely to be significant.

- There is not sufficient evidence to show that the addition of revalidation to existing systems would add significantly to public safety, but that we would welcome any further research in this area.

- 'Revalidation' can more usefully be considered as part of a broader debate around ongoing fitness to practise, and we consider this is a more useful way forward.

- The regulation of currently unregulated groups should be a higher priority for legislative time and regulatory efforts.'[1]

1 Health Professions Council response to the Review of the regulation of non-medical healthcare professionals.
http://www.hpc-uk.org/assets/documents/100016F5HPC_response_review_non_medical_regulation.pdf

4. What is the problem that needs to be solved?

This section seeks to stimulate discussion on the questions: 'What is the problem that needs to be solved?' and 'What are we trying to achieve'?

Two 'possible problems' are outlined, with the aims of a revalidation process which would seek to resolve those problems. The 'comments' sections highlight possible areas for discussion.

The 'problems' identified are not intended to be exhaustive or exclusive of each other. There may be more than one 'problem' and revalidation might achieve more than one aim.

1. Identifying 'bad apples' (quality control)

Problem

- There are poorly performing registrants who are either not identified by the existing system or not identified early enough.

Aims

- Bring to the regulator's attention health professionals who are not fit to practise.

- Catch health professionals early before an incident has happened.

Comments

- There is a lack of evidence (see paper 'cost and risk') that there are a large number of HPC regulated health professionals who present a risk to the public, and who are not currently effectively dealt with either locally or at a regulatory level.

2. Public confidence and public expectations

Problem

- Low levels of public awareness of the regulatory system.

- The public expect that health professionals are checked in some way on a regular basis and this expectation is not met by the existing system.

- The public expect to be involved in the regulatory process.

Aim

- To provide a clear demonstration to members of the public that health professionals are fit to practise, thereby meeting public expectations and improving public confidence.

Comments

- Public awareness

Research was undertaken as part of the review of the regulation of non-medical healthcare professionals to gage attitudes of members of the public to the regulation of professionals other than doctors. The research concluded that there is very little public understanding of the existing system of health regulation.

The HPC recently commissioned research with the public and registrants about the views of the public, stakeholders and registrants of the HPC. The research found that around one in seven UK residents had heard of the HPC. Awareness of the functions and purpose of professional regulation was also low with 32% of the general public unable to identify what the role of a regulator of health professionals might be at all.[2]

- Public expectations

The DH research concluded that there was 'strong public support for regular checks being carried out on non-medical healthcare professionals'.[3] It could be argued, however, that current systems are appropriate given the low risk profile of the professions regulated by the HPC (in light of the available information) and, if the public were better aware of the existing system and the rationale behind it, they would be supportive.

A number of characteristics were highlighted by participants as important for trust and confidence in non-medical healthcare professionals:

- listening;
- giving the impression of caring/ showing concern;
- taking the time to speak to patients; and
- giving personal treatment/ treating patients as 'humans'.

Research has also shown that a key factor in achieving positive outcomes for patients is adequate exchange of information and willingness on the part of health professionals to share decision making.[4] The medical profession has invested significant resources in developing training in communication and listening skills amongst doctors, both at pre registration and post qualifying stages.

[2] Mori (Commissioned by the Health Professions Council), Health Professions Council – Public, Registrant and Stakeholder Views, December 2007

[3] Mori (commissioned by the Department of Health), Attitudes to Regulation of Non-medical Healthcare Professionals (September 2005)

[4] Elwyn, G; Edwards, A and Kinnersley, P (1999a) Shared decision making in primary care: the neglected second half of the consultation. *British Journal of General Practice, 49, 477-482*

Stewart, M. (1995) Studies of health outcomes and patient centred communication. In Stewart, M; Brown, J; Weston, W. et al (eds) *Patient Centred Medicine.* Sage, Thousand Oaks.

If these are the areas where public confidence is less strong, should regulatory bodies be focusing on raising standards and/or awareness of the importance of them amongst registrants?

The DH research concluded that there was a high level of satisfaction with non-medical healthcare professionals – 88% of participants reported that they were satisfied with their last contact with a non-medical healthcare professional. Existing public confidence in non-medical professionals is therefore still high, despite differences between public expectations and knowledge of the existing regulatory system.

- Public involvement

Public involvement in developing and monitoring healthcare professional practice is also a key influence on the current regulatory process, but there is limited public awareness of the nature and extent of this involvement.

At the HPC, lay council, committee members, lay panel members and patient groups as well as voluntary sector organisations are involved not only in the governance of the regulatory body itself, but also in the development and revision of standards, fitness to practice panels and in specific projects. For example, organisations representing disabled people were involved in developing guidance for disabled people considering becoming a health professional. In some areas of education, for example, in social care, there has been a move towards service user involvement in the development and delivery of undergraduate training.

Patient public involvement (PPI) is high on the agenda of the regulators and the HPC participates in the joint regulators PPI group. Patient and public involvement already plays an important part in quality control and quality improvement and this needs to be highlighted in the debate around revalidation.

4. Existing HPC processes

At previous meetings, the group has considered information about the HPC's existing processes.

Three processes which are integral to remaining up to date and fit to practise are summarised below:

1. Self certification

- Self-certification against standards of proficiency and standards of conduct, performance and ethics on admission, readmission, and renewal.

- Self-referral of health and character matters including criminal convictions and disciplinary action by employers.

2. Continuing Professional Development

- 5 CPD standards generic to all regulated professions.

- Registrants have to undertake CPD, record their CPD, seek to ensure that their CPD contributes to the quality of their practice and service delivery, and seek to ensure that it will benefit service users.

- No direct link is made between undertaking CPD and fitness to practise.

- Random audits to take place from July 2008, linked to renewal. 5% sample size for first two professions regulated.

- Information gathered under the NHS Knowledge and Skills Framework can be used in meeting the CPD standards.

3. Returners to practice requirements

- Requirements apply for readmission to the Register.

- Health professionals seeking readmission must undertake a period of updating of 30 days for between 2 and 5 years out of practice; and 60 days for five or more years out of practice.

- The updating period can consist of private study, formal study and supervised practice and has to be countersigned by a registrant from the same part of the Register who has been in registered for three years or more.

- Registrants who have not practised during the two years of their registration cycle will need to undertake an updating period as they will be unable to sign the professional declaration on renewal.

In addition, the fitness to practise process and the health and character process are quality control mechanisms that are used to ensure that the standards of proficiency and standards of conduct, performance and ethics are met.

We might conclude that, for our purposes, revalidation consists of the three processes identified on the previous page:

- Self certification against standards and self-declaration of important information demonstrates the registrant's commitment to maintaining standards, and maintaining fitness to practise.

- Compliance with CPD requirements demonstrates that a registrant is committed to remaining up to date and supports fitness to practise.

- Returners to practice requirements mitigate potential risks involved in returning to practice after a break, demonstrate that the registrant is up to date, and supports fitness to practise.

We might further conclude that these processes are appropriate and sufficient, given the wider environment in which they operate. At the last meeting, the group considered a paper which looked at models and practice that already exist. These models or practices are often not required by the regulatory body and are often complementary to the purpose of regulation. For example, for those in managed environments, the clinical governance agenda is an important part of the environment in which safe practice is encouraged and ensured.

There are then a number of steps we could take to explore whether changes to the existing system are necessary. For example, this might include research into the outcomes of the CPD audits due to commence next month, or further qualitative research into the data from our fitness to practise process.

We might alternatively conclude that whilst these processes contribute towards fitness to practise, they do not provide a positive affirmation of fitness to practise in the sense of a periodic or regular assessment against clear standards at a given point in time.

Appendix 1

The GMC Four Layer Model

At the last meeting, it was suggested that it might be helpful to map existing processes against the four layer model developed by the General Medical Council (GMC).

The definition of each layer, taken from the GMC website, is given below, together with an indication of how these layers may be accounted for by the existing regulatory system.

Personal regulation…reflects the way in which individual doctors regulate themselves, based upon their commitment to a common set of ethics, values and principles, which puts patients first.

- Self-regulation – demonstrated by, for example:
    - Acting within scope of practice and referring to another professional where appropriate (cf. HPC standards of conduct, performance and ethics)
    - Self-certification on admission, readmission and renewal (registrants make personal decisions about whether they continue to practise and continue to meet relevant standards)
    - Engaging in other activities which support ongoing fitness to practise (such as those discussed at the last meeting).

Team based regulation…reflects the increasing importance of team working and requires health professionals to take responsibility for the performance of the team and to act if a colleague's conduct, performance or health is placing patients at risk.

- Team working reflected in standards of proficiency
- Requirements to act in the best interests of service users and to report circumstances where a colleague may not be fit to practise (cf. HPC standards of conduct, performance and ethics).

Workplace regulation…reflects the responsibility that the NHS and other healthcare providers have for ensuring that their staff, and those who use their facilities, are fit for their roles.

- The responsibility of employers to ensure that health professionals are fit to practise and that the safety of service users is protected. For example:
    - Performance management
    - Clinical governance
    - Disciplinary procedures

Professional regulation…is undertaken by the GMC and other statutory health regulators and, for example, by medical Royal Colleges where appropriate. Professional regulation is expressed through work on standards, education, registration and licensing, including revalidation, and fitness to practise procedures.[5]

- National regulation by statutory regulators, including:
    - Development of standards, programme approval, registration, fitness to practise.
    - Professional regulation might be widened to include service regulation by organisations such as the Healthcare Commission and Healthcare Inspectorate Wales. This would mainly impact upon workplace regulation by employers, but can also indirectly affect the individual practice of registrants.

5 General Medical Council website
http://www.gmc-uk.org/about/reform/ebulletin/2005_09.asp