CONFIRMED
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MINUTES of the fourth meeting of the Professional Liaison Group on Continuing Fitness to Practice held on **Tuesday 13 May 2008** at Park House, 184 Kennington Park Road, London SE11 4BU.

Present:
Dr A Van Der Gaag, HPC President (Chair)
Ms A Cowie, Scottish Government Health Directorates
Mr V Cullen, General Osteopathic Council
Ms C Farrell, HPC Council member
Dr S Gosling, Allied Health Professionals Forum
Ms T Harvey, Knowledge and Skills Framework
Miss M MacKellar, HPC Council Member
Ms S Prout, UNISON
Mr K Ross, HPC Council member
Dr C D Shaw, Independent health care advisor
Ms L Smith, Regulation Council for Clinical Physiologists
Miss E Thornton, HPC Council Member
Mr M Woolcock, HPC Council member

In attendance:
Mr M Guthrie, Policy Manager
Ms N O'Sullivan, Secretary to Council
Mr S Rayner, Secretary to the PLG

Item 1.08/13 Apologies for absence

1.1 Apologies were received from Mrs M Clark-Glass, HPC Council member and from Mrs R Crowder of the Allied Health Professionals Forum (AHPF). The AHPF was represented by Dr S Gosling.

Item 2.08/14 Approval of the agenda

2.1 The Group approved the agenda.

Item 3.08/15 Minutes of the third PLG

3.1 The minutes of the third meeting of the Group were accepted as a true record subject to the following amendments:

Attendees: Mr Frances Garrett should read Ms Frances Garrett.

3.2.08/09 "It was envisaged that they would be assessed by GMC appointed 'responsible officers'" to be replaced by "The responsible officer would make sure that the appraisal would take place".

3.5.08/09 Second sentence to read: "This raised the question of whether professionals working within well managed, apparently low risk, environments should be subject to less scrutiny".

4.2.08/10 Fourth sentence to read: "Technically the Health Care Commission had the power to inspect dental practices in England, but this did not happen".

Item 4.08/16 Matters arising from the third PLG

4.1 The Group agreed that the matters arising, which regarded liaison work with the General Medical Council and the General Dental Council over data, would be addressed as part of the item on cost and risk.

Item 5.08/17 Cost and risk

5.1 The Group received a paper from the Executive. The paper was an attempt to capture ideas developed around cost and risk from previous discussions. The Group were asked to consider:

Were the risks posed by HPC regulated professionals proportionate to the likely cost of revalidation?

Were the costs proportionate to the likely/possible benefits of an additional layer of inspection?

5.2 The Group noted that the research had been hampered by extremely limited information around costs. Cost assessments had been carried out by the General Medical Council but these had been designed to support research carried out in 2001 to a significantly different portfolio. The Group noted that the GMC's estimated cost of revalidation at that time was £7.85m per annum. The Group noted that the total budget of HPC was £12.5m per annum.

5.3 The Executive were looking to develop a costing model for HPC purposes if no other costing model became available

5.4 The Group noted that the rate of complaints against HPC registrants was significantly lower than that of other regulators. The Group noted that this might have been due to factors such as local complaints mechanisms or the level of public awareness about the role of the regulator.

5.5 The Group noted that data being collected by the Fitness to Practise Department was being used in the research for the Group's work but some of these data had to be approached with caution. There were some inconsistencies between data collected from existing registrants and new registrants. There had also not been any data collected about managed environments to date.

The Group noted that the upcoming FtP annual report would contain more data on complaints. The data would also be broken down along diversity lines. This would feed into ongoing work into barriers to complaining

5.6 The Group held a discussion based around the themes of cost and risk in which the following points were made:

<u>Cost</u>

5.6.1 If introducing a system of revalidation, the Council would need to keep its own position of liability under review. Ultimate responsibility for the competencies was significant. If the process stated that all professionals are competent, did that make the Council corporately liable for the actions of registrants?

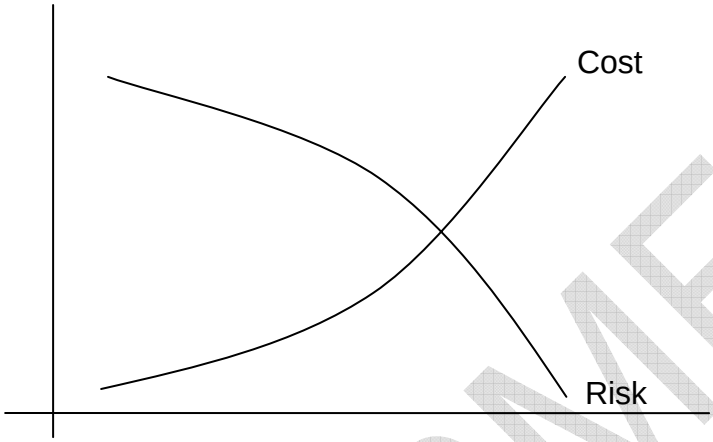
5.6.2 Despite the availability of professional liability insurance for practitioners and businesses, there was no legal requirement to hold insurance in many of the professions regulated by the HPC.

5.6.3 As insurance premiums were based on actuarial risk, professional liability could be used as a proxy for risk. Data held by insurance companies could be useful in investigating a risk-based approach to revalidation.

Action: MG to investigate risk criteria carried by insurance firms

5.6.4 The cost of a system based on self declaration at re registration was low, but it could mean that the 'risk' was more substantial.

5.6.5 Balance of cost and risk



Risk

5.6.6 The assumption that complaints and allegation levels are a reflection of the experience of the public could be challenged. Of the fitness to practice cases, which cases could have been mitigated by a revalidation process? Conversely, if we examine existing fitness to practice cases, are we measuring the already established safety net and if so, how does this add value? Is HPC registration itself sufficient to mitigate risk?

5.6.7 Professional bodies and employers may have additional information on risk factors that could be used in correlational analysis from their disciplinary work. It might be useful to look at the correlations between different types of risk – clinical risk, conduct and competence.

5.6.8 The emphasis of discussion up to this point was on "bad apples" rather than a focus on the presumption of "good practice apples". A different approach might be to focus on measuring good practice. .

5.6.9 Analyses of adverse events in healthcare suggested that the majority of risks are around systems not individuals. It may therefore be a better solution to identify 'risky' environments and 'revalidate the post not the person

5.6.10 Registrants could be then provided with a self test kit along the lines of:

- Do you have peers?
- Do you do CPD?
- Do you work in a managed environment?

5.6.11 There were lone practitioners who worked outside managed structures who use that position and isolation as an excuse for poor practice. These were unlikely to seek out revalidation and would need more external checks.

5.6.12 There was no evidence that quality improvement, complaints mechanisms or customer service procedures had any impact on clinical outcomes.

5.6.13 Public expectations of risk should be managed. With any system, clear boundaries of accountability are necessary and whistle-blowing needs to be encouraged, but there has to be an acceptance that there is some risk involved in healthcare.

5.6.14 With a body of 200,000 registrants even a light touch revalidation process would be logistically difficult, and reasonably expensive, for HPC unless another agency is involved.

5.6.15 The Group also noted the Department of Health's work for the extending professional regulation working group. The working group will be approving a research specification to commission work on risk. It was clear from the evidence that context was a key issue and that technical skills were not the main risk factor – conduct could present a risk if the context allows.

5.6.16 There was little if any evidence that an additional form of inspection would add anything to existing systems.

5.6.17 Could the Group discuss a risk based approach when there is no clear data on risk?

5.6.18 Context was also an issue as Allied Health Professionals undertake new roles that may require new standards. New roles are likely to have a continuing impact on the context of practice issues.

5.7 In summary the Group noted that the following themes should be incorporated into the final report:

- Risk
- Cost
- Our own data
- Data from the wider field

- Correlational analysis
- NAPSA research
- Question of focus - how much is any system affirmative

Item 6.08/18 The purpose of revalidation

6.1 The Group received a paper from the Executive. The paper drew together discussions from previous meetings and research to discuss the purpose of validation. The group were asked to focus on the following questions:

Was the aim to look at people who weren't captured by the current system?

What was the significance of the public interest (or what should be the level of focus on public expectation)? Within this:

- What were the elements which define public expectation?
- How could revalidation address this expectation?
- What had others done?

Of existing HPC processes:

- What was missing?
- Were they sufficient?
- What should be added?

6.2 The Group held a discussion based around the theme of the purpose of revalidation in which the following points were made:

6.2.1 Three issues were discussed:

<u>Political will for change</u>

- Need to ensure that any change was consistent with HPC remit

<u>Finding 'bad apples'</u>

- Was there a gap to be filled?
- With research and by documenting systems this could be done

<u>Public Expectations</u>

- Public expectations and public confidence were different.

6.2.2 HPC could be in a position to put forward a different position on revalidation to that of other regulators to demonstrate that the public can have confidence in the regulated professions. The issue of public expectation is more complex

6.2.3 The impact of Education, how HPC ensures standards through visits, approvals and accreditation, should be included in the report as it was very effective.

6.2.4 If the Group was satisfied that the current system protected the public, work should be done to raise public awareness.

6.2.5 The Group had not seen compelling evidence that the HPC FtP process was not already highly effective.

6.2.6 Lay people may find self certification difficult to accept as an adequate test of competence.

6.3 The Chair drew the discussion to a close, asking that the Group return to the subject of what is missing from the current picture of non medical revalidation after the discussion on the Knowledge and Skills Framework.

Item 7.08/19 NHS Knowledge and Skills Framework links to regulation and revalidation

7.1 The Group received a paper from Ms T Harvey providing a briefing on the NHS Knowledge and Skills Framework (KSF) and its links to regulation and revalidation.

7.2 The Group noted that the KSF outlined for practitioners what they should be expected to do at different stages of their careers, with two main thresholds:

1. Foundation Gateway (usually after one Year)
2. Full outline of post (fulfilling every part of the evidence base for professional development for that post)

Assessment against the KSF would be through the yearly annual review process. KSF was about CPD, an external quality control mechanism.

7.3 The Group noted that both Managers and Staff needed comprehensive training in order to make the system work. A fully working KSF could contribute to revalidation, but it was not ready to do so yet.

7.4 The Group noted that KSF had been developed with the support of staff and as a result was seen positively.

7.5 The Group noted that the KSF core skills clearly mapped onto the HPC standards of proficiency as well as the national standards of education and training. The Group noted that the NHS KSF Group had put a proposal to

the Department of Health to work with HPC and other health regulators to see how KSF could be used in the revalidation process.

7.6 The Group noted that KSF was not originally intended to be used for revalidation or by regulatory bodies but as a development tool.

7.7 The Group held a discussion on the NHS KSF in which the following points were made:

7.7.1 Anything which placed non-NHS practitioners as "outside the norm" would also be problematic to implement.

7.7.2 Assuming KSF was comprehensively implemented; the Group must decide whether it could be used as evidence to support self declaration or evidence to support an employer's declaration.

7.7.3 The similarity of KSF to the Continuing Professional Development framework was a reasonable argument that HPC already conducts a form of revalidation.

7.7.4 KSF was seen as an important part of the portfolio of evidence

7.8 The Group noted that useful data on the performance of professionals under KSF could be available in 2010.

Item 8.08/20 Non-Medical Revalidation Framework

8.1 The Group received a paper from the Executive presenting the Non-Medical Revalidation Framework produced by the Department of Health Non-Medical Revalidation working group. The Framework was still in draft form, and is due to be revised and discussed at a further meeting of the working group.

8.2 The Group were invited to consider the following:

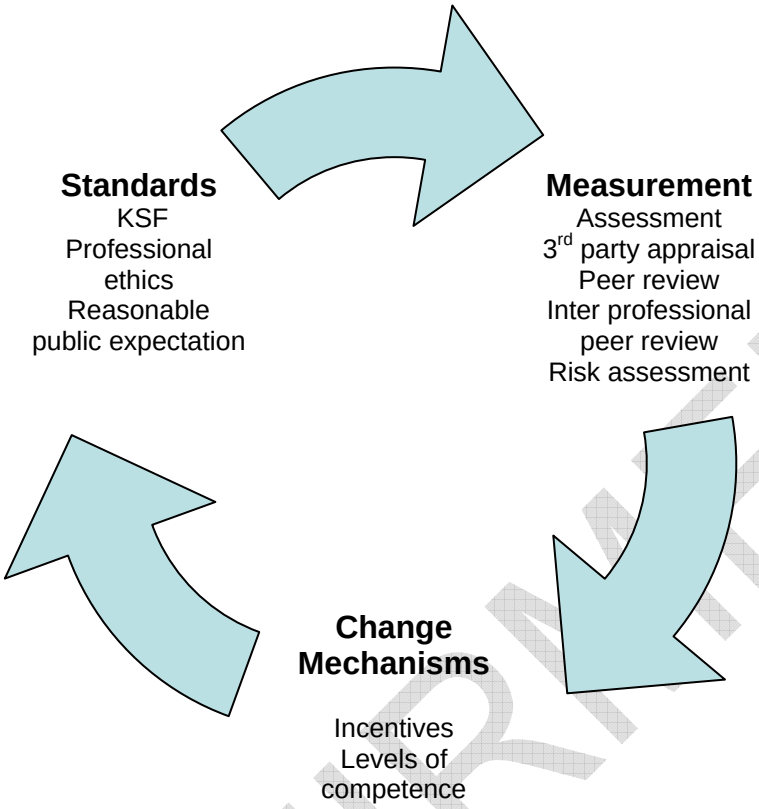
What was missing from the approach?

Were there any comments on the Framework?

8.3 The Group held a discussion on what is missing from the current approach to revalidation in which the following points were made:

8.3.1 Revalidation should be a cycle:

<u>The cycle of revalidation</u>



8.3.2 Statistical data collection was very important for the above to work.

8.3.3 Should the amount or volume of practice be taken into account? Was there a link between the amount of work a practitioner undertook and the quality of the outcomes of that work? How many hours a week should a practitioner undertake in order to remain competent?

8.4 The Group noted that the regulators would work to determine the specific relationship of each organisation with the framework over the next couple of months. Mr Guthrie would report back to the Group following the final meeting in June.

8.5 The Group noted that all of the possible mechanisms for revalidation so far considered appeared compatible with the proposed DH framework.

Item 6.08/12 Date and time of next meeting and further work

6.1 The Group agreed that Mr Guthrie should produce a draft report reflecting the research and discussions undertaken and making recommendations for further steps and research.

6.2 The Group noted that the above report would take more than a month to write, and agreed that Mr Guthrie should return to the September meeting with a first draft.

6.3 The Group agreed that the meeting scheduled for 17 June 2008 should be cancelled.

6.4 The next meeting of the Group will be held at:

10.30am Thursday 4 September 2008

Chair

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Date

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