Continuing Fitness to Practise PLG – Discussion meeting
13 November 2007

Meeting Room 1, The Evangelical Alliance, Whitefield House, 186 Kennington Park Road, London SE11 4BT, London

Notes of discussions

Meeting chaired by Dr Anna van der Gaag

Michael Guthrie (HPC Policy Manager) and Niamh O'Sullivan, (HPC Secretary to Council) in attendance

What is revalidation?

Group 1

Mark Woolcock (feedback)
Richard Davis
Gail Stephenson
Val Huet
Sherran Milton
Derek Pearson

The Group did not reach a consensus but noted that they did not agree with the definition of revalidation in the White Paper.

The Group raised the following questions;

- was the assessment for revalidation consistent with the threshold standards or was it higher?
- what did fitness to practise mean (in the context of revalidation)?
- what was the end point of non-revalidation? Would it mean coming off the register?
- what about those who were University based who were likely to be up-to-date academically but not clinically?
- was revalidation about making poor practitioners become good ones?

Group 2

Eileen Thornton (feedback)
Audrey Cowie
Gordon Sutehall
John Martin
Wilfred Foxe
Jo Partington

The Group agreed that the revalidation was not a helpful term and that the starting point for a definition should be validation, not revalidation. Entry to the register was a statement that the practitioner was competent to minimum standards.

The Group agreed on the following definition. 'Revalidation is a periodic reaffirmation of performance against standards which reflects contemporary practice and scope of practice'.

Continuing Professional Development (CPD) was a tool which was a part of the revalidation process.

Most of the material written about revalidation was addressed to the practitioner working with patients rather than the practitioner working in management.

There was also the issue of whether the process was a measurement against threshold standards or against the standards to which the health professional had developed in the course of their practice.

Group 3

Mary Clark-Glass (feedback)
Sharon Prout
Christine Farrell
Ruth Crowder
Madeline Anderson-Warren
Vince Cullen

The Group asked the following questions;

- what should be included in a definition of revalidation?
- did it unpack the purpose? White Paper was a good start but did not set down the purpose of revalidation.

- it was easier to say what revalidation was not. It was not an MOT once a year. It had to be continuous. It had to look at the risk posed.

- should we approach revalidation from a Fitness to Practise purpose?

The Group noted the following points;

- revalidation should be a system of enhancing the quality of patient care.

- revalidation should be holistic, multifaceted, and should encourage peer review.

- should inform practitioners of their CPD needs and their risk of burn-out, should also maintain self-respect

- must contain a strong element of self-assessment

- must be positive and have registrant buy-in, not a way of catching registrants out. It was not a policing tool, should not be an MOT

- could be seen as enhanced CPD with additional ingredient of feedback from a variety of sources

- must bear in mind that a significant proportion of registrants are not employed in the NHS.

- It must be seen as positive by the professionals

Possible definitions of revalidation

1. A system to enhance the quality of patient care provided by a health professional. It should be proportionate, targeted and based on relevant risk assessment.

2. A tool to ensure safe practice, an evaluation which is holistic. It should inform the registrants CPD needs highlighting future needs e.g. risks to patients, risks to practitioners such as burn-out.

3. Revalidation should enable registrants to give best service to patients in a safe environment. It should enable registrants to enhance their professional self-respect.

4. An individual route where the practitioner identifies his/her on-going professional needs. The primary criteria is the assessment then reducing risk.

5. A re-affirmation of fitness to practise.

The Group noted that it would be useful to keep the developments in Scotland under review.

Group 4

Keith Ross (feedback)
Barbara Arora
Robert Beattie
Christina Freeman
Vince Clark
Thelma Harvey

The Group agreed that revalidation was more than being up-to-date and avoiding Fitness to Practise proceedings.

The Group noted that there were dangers if practitioners worked on their own. Such practitioners needed support.

Revalidation is not about catching practitioners who were doing wrong but about helping practitioners to improve their practice. The Group asked whether revalidation was about minimum standards or about role development and who was responsible for this?

The Group asked what the roles of the professional bodies and managers were in this process.

Group 5

Rachel Tripp (feedback)
Morag Mackellar
Charles Shaw
Sally Gosling
Christina Docchar
Kamini Gadhok

The Group asked the following questions;

- is revalidation focussed on bad apples or should it aim to engage with the majority of registrants moving practitioners from unsafe to safe practice or from safe to safer?

- does the term revalidation have any meaning?

- what was the role of the regulator?

- could revalidation be more bottom-up?

- what was the relationship between CPD standards and revalidation – noting that CPD was one aspect of revalidation?

General comments

There needed to be clarification on whether revalidation was about coming off or staying on the register. There was a need to clarify what the end point of revalidation was. Was revalidation about quality control and quality improvement? If revalidation was not about quality improvement then who was responsible for this? There was a need for clarity in the definition of revalidation.

There was an agreement that any system needed professional 'buy in'.

There was an acknowledgement of the need for greater understanding of public perceptions and expectations.

The role of other stakeholders (professional bodies, employers) needed to be explored further.

There was a need to communicate the HPC's position on revalidation/continuing fitness to practise carefully and to inform the public and registrants about the reasoning behind our position on this.

There could be lessons to be learned from other sectors.

There was a need to bear in mind that some failures on the part of registrants were as a result of failures in the system whereby registrants were being asked to undertake tasks which could put their practice at risk.

Existing models and good practice

Group 1

Mark Woolcock (feedback)
Richard Davis
Gail Stephenson
Val Huet
Sherran Milton
Derek Pearson

The Group noted that there were a variety of CPD systems across the register. In some parts of the register it was usual practice to belong to a professional body and in other parts membership of a professional body was low.

The Group had discussed whether it would be possible for a registrant to falsely complete and submit a CPD profile but noted that such a registrant could be liable to have an allegation made against them under the HPC's Fitness to Practise proceedings if they behaved in this way.

Various models were discussed – from supervision in practice to the paramedic 'sheep dip' approach.

The low percentage of fitness to practise cases suggested that the current system is working.

Group 2

Eileen Thornton (feedback)
Audrey Cowie
Gordon Sutehall
John Martin
Wilfred Foxe
Jo Partington

The Group discussed the complexities of the different issues faced by registrants working in the NHS and those working in independent practice.

The Group discussed whether revalidation could be fitted into the annual appraisal system and the Knowledge and Skills Framework (KSF). Links between the KSF and the HPC standards had proved useful.

The Group noted that a multisource feedback model for GPs had been piloted in Wales and discussed whether this would be acceptable to regulators.

The Group also noted that there was the Flying Start system for newly qualified practitioners in Scotland but that there were no plans to extend this beyond the system as it was in its current form. Valuable lessons could be learned from this project.

The Group was aware that there were statutory supervision systems for midwives, the Certified Ophthalmic Technician (COT) post qualifying framework, and team assessment for practitioners working in laboratories.

The Group noted that HPC was an example of good practice in that practitioners self-certified that they continued to meet the standards set by HPC each time they renewed their registration.

Group 3

Mary Clark-Glass (feedback)
Sharon Prout
Christine Farrell
Ruth Crowder
Madeline Anderson-Warren
Vince Cullen

The Group discussed a number of examples of revalidation.
The Group noted the importance of a symbiotic relationship between the regulator and the professional bodies on the issue of continuing fitness to practise.

The issues regarding CPD and revalidation needed to be separated out but there were aspects of CPD which would from part of revalidation.

Patient feedback was seen as an important element of good practice.

Group 4

Keith Ross (feedback)
Barbara Arora
Robert Beattie
Christina Freeman
Vince Clark
Thelma Harvey

The Group considered all the systems which interacted with a registrant's fitness to practice e.g. complaints systems, disciplinary systems, performance targets, CPD audits, accreditation schemes, membership of professional bodies, appraisal processes, the Knowledge and Skills Framework (KSF), mentoring, clinical audit, risk management, insurance schemes, the Healthcare Commission, personal professional networking and peer review. Many of these were run by the employer and therefore had less impact on sole practitioners, and therefore sole practitioners possibly a higher risk group. There was not much formal evidence of the impact of these systems but the fact that the number of allegations against practitioners was very low provided some evidence that the systems were working. More integration between all these systems would be helpful.

Group 5

Morag Mackellar
Charles Shaw
Sally Gosling
Christina Docchar
Kamini Gadhok (arriving from 12)
Rachel Tripp (feedback)

The Group noted that the British Association of Counselling and Psychotherapy (BACP) had a mandatory system of supervision. This was a useful way to counterbalance the isolation of practitioners who worked alone. In some cases allegations under the BACP Fitness to Practice procedures came though this system – allegations against supervisor as well as supervisee

The Group noted that there were a variety of systems- Chartered Society of Physiotherapy (CSP), the Royal College of Speech and Language Therapy (RCSLT) and the British Dietic Association (BDA) all had systems in place to support ongoing fitness to practice. The Group were unclear of the extent to which local systems existed.

The Group agreed that in order to be successful revalidation had to be continuous rather than 'one off.'

The Group acknowledged that in addition to the NHS there were other employers and also that not all practitioners worked in a managed environment.

The patient safety agenda was also important – who writes the standards for systems? Who develops the local safety standards and who has input into these?

Important not to forget the European agenda and its impact on UK registrants.

General comments

There were a variety of systems which aimed to measure the performance of organisations and individual registrants.

There were differences within managed environments and between managed environments and private practitioners.

Registrants needed to be clear about where the scope of their practice and responsibility and the role of the employer in providing support for this.

The White Paper

Group 1

Mark Woolcock (feedback)
Richard Davis
Gail Stephenson
Val Huet
Sherran Milton
Derek Pearson

The Group noted that revalidation was felt to be a disproportionate response to the issues which had led to the publication of the White Paper.

There was agreement that the KSF was not fit for purpose. The professions had no feeling of ownership of KSF.

The Group were unsure whether the appraisal system actually led to an improvement in practitioners' performance. The lack of appraisal did not appear to have a negative effect on the independent sector.

It would be useful to look more closely at the data on this – for example in relation to paramedics; what was the failure rate? Was there any relationship between failure and subsequent fitness to practice hearings?

Group 2

Eileen Thornton (feedback)
Audrey Cowie
Gordon Sutehall
John Martin
Wilfred Foxe
Jo Partington

The Group asked the question; if it was possible for a regulator to make a valid assessment of the risk posed by a practitioner beyond the assessment made to bring registrants on to the register?

The Group had reservations about the risks as outlined in the White Paper and noted that in a managed environment a practitioner who posed a risk to patients was likely to be identified earlier. Risk was likely to be context driven, rather than related to categories of staff. The 6 risks outlined by the National Patient Safety Agency (NPSA) were seen as useful. The Group questioned whether further assessment was really necessary

The Group noted that the KSF could be used as one of the tools for revalidation in addition to the HPC standards as a tool against which registrants could self assess their practice.

Group 3

Mary Clark-Glass (feedback)
Sharon Prout
Christine Farrell
Ruth Crowder
Madeline Anderson-Warren
Vince Cullen

The Group noted that there was a power imbalance in the relationship between practitioner and patient. The relationship was one of trust. The Group noted that the relationship between a sole practitioner and the patient was very intense, even in a managed environment. Adequate ongoing supervision was the key to both clinical and managerial good practice.

The Group noted that sometimes registrants needed support in dealing with requests from their employer to practice outside their scope of practice. It was sometimes difficult to know where professional responsibility began and ended, if practitioners were being asked to do things beyond their scope of practice by managers.

The Group noted that management tools and tools for assisting registrants in reflecting and improving on their practice were important, but not all tools could be applied across all contexts e.g. KSF

The Group recognised the importance of the forthcoming HPC CPD audit in providing greater understanding. .

Group 4

Keith Ross (feedback)
Barbara Arora
Robert Beattie
Christina Freeman
Vince Clark
Thelma Harvey

The Group considered the question of who would undertake a risk assessment of practice. The regulator would need the input of the professional body, the

Council for Healthcare Regulatory Excellence (CHRE), and employers in undertaking this.

Risks differed according to the environment and the nature of the practice of the registrant. There were different risks – managed environments versus non managed ones, prescribing drugs, radiography, direct contact with patients, consequences of an error and work context. Risks varied within professionals and between professionals. There were therefore huge challenges with defining risk.

The Group noted that appraisal systems such at KSF were not embedded throughout the NHS. The current systems were formative rather than summative.

The competence of managers to assess was very variable

The issue of independent practitioners was considered and the place for peer review and a mentoring system. The main issue for those working alone was who would undertake the assessment and how would it be made.

Human rights issues should not be overlooked.

Portfolios of evidence certainly had a role to play.

Group 5

Rachel Tripp (feedback)
Morag Mackellar
Charles Shaw
Sally Gosling
Christina Docchar
Kamini Gadhok

The Group discussed whether there was any evidence that there were high risks at all. What was the evidence from insurers, NHS, ombudsman and criminal record checks.

Evidence from CSP suggested that lone practitioners were more likely to come before Fitness to Practice Panels.

The professional bodies had a key role to play in providing support and networking and in promoting understanding of the concept of self regulation.

There was a danger that inspection regimes could undermine this.

Work was on-going in Scotland on risk assessment and care pathways. – useful to follow this up with Quality Improvement Scotland (QIS).

The Group noted the importance of peers in providing scrutiny.

It was important to use what is there and to understand the relationship between appraisal and regulation – how were they linked?

The Group noted that there were many existing systems which could form part of a revalidation process.

General comments

The Group noted that the General Osteopathic Council had undertaken a grandparenting exercise, which involved individual assessment of practitioners including some practice assessments, when it first opened its register. This had cost in the region of £2 million for 3000 osteopaths and was therefore not something which could be undertaken on an ongoing basis.