CONFIDENTIAL

Revalidation task & finish group

Minutes of the meeting held on Wednesday 27 January 2016 at UKPHR
18c, Mclaren Building, 46, Priory Queensway, Birmingham B4 7LR

Present (personal attendance):
Anne McMillan, UKPHR's Registrar (AM)
Jeremy Hawker, UKPHR Board Director (JH)
Present (by telephone):
Sara Kovach Clark, GMC (SKC)
Angela Townsend, FPH (AT)
Nigel Woods, PHE (substituting for Imogen Stephens) (NW)
In attendance:
Pavenpreet Sull, Secretariat (PS)

Apologies:
Janet Collins, GDC
Sally James, Coordinator West Midlands practitioner registration
Helen Kirk, PHE Nursing & Midwifery Directorate
Caroline Linden, HR Directorate, PHE
Sue Lloyd, UKPHR's Registration Panel Chair
Em Rahman, Coordinator Wessex practitioner registration
Viv Speller, UKPHR Board Director
Imogen Stephens, Public Health England Revalidation Team

ACTION

1. Welcome, apologies for absence and declarations of interest

The Chair welcomed everyone to the third meeting of the revalidation task & finish group. Apologies for absence as stated above were received. There were no declarations of interest.

2. Minutes of the meeting held on 08 December 2015

The minutes of the meeting held on 8th December were agreed subject to confirmation from David Kidney that AT's amendments were noted. [Note: David Kidney's confirmation has been given].

PS

3. Matters arising from the minutes

None

4. Developing a revalidation scheme

The Chair referred to the draft scheme prepared by David Kidney and circulated to members of the group with the agenda. Members of the group that were unable to attend the meeting were encouraged to send in their comments prior to the meeting. The Chair had before her comments supplied by Viv Speller.

The Chair commented that discussion would revolve around the content of the draft policy rather than specifics in relation to house-keeping issues such as revalidation timetables.

The Chair took the group through the draft policy paper, page by page. No comments were received for page 1. With regard to page 2, the Chair commented that Good Medical Practice was an important source yet required interpretation for public health practice. The group was informed that Good Public Health Practice was at an advanced stage of revision and that David Kidney was working alongside Meradin Peachey. The new edition of the document was not yet signed off but it was hoped that the document would be ready by the implementation of revalidation. JH commented that the latest version could be assumed to be a near complete edition.

NW provided an alternative viewpoint with reference to paragraph 2 of page 3 in the draft policy. Discussion was stimulated around the difference in risk of harm by registered specialists and practitioners. NW commented that the perception around revalidation was that some groups were not high risk yet they all completed identical revalidation processes. JH stated that there was a difference between junior and senior doctors. SKC commented that the argument could be made for both views and when looking at this topic from a regulatory view it was important that it was looked at proportionately. The Chair concluded that whilst revalidation should be robust, a balance was sought between acting proportionately and fairly, and for UKPHR as a voluntary register, an important consideration was not to deter registrants.

The Chair invited comments in relation to appraisal (page 5 of the draft policy paper), in particular to the illustrative options 1A and 2A. The Chair reminded members that a key outcome was equivalence with medically qualified public health specialists . NW informed the group that PHE was bound by legislation to provide professional appraisal for medically qualified public health specialists and provided professional appraisal for multi-disclipinary specialists working for PHE free of cost as a good employer. The Chair commented that in order to achieve equivalence, UKPHR-registered specialists should have access to professional appraisal.

JH commented that revalidation with PHE required a responsible officer, which was provided at no cost. FPH also reported that it has a revalidation service which has a Responsible Officer attached. AT reported that FPH only charged to meet costs for those doctors using the FPH revalidation service. The group agreed that further debate was required around guidance to be issued regarding appraisal, including an approved format and trained appraisers.

Members of the group agreed that option 2A was preferrable. JH commented that it would be difficult to expect registered practitioners to immediately begin to produce professional appraisals and hence once every 5 years alongside yearly work appraisals was recommended.

The Chair sought views on page 6 of the draft policy paper. It was agreed that CPD monitoring was already robust through the FPH. The Chair reported on UKPHR's recent CPD audit for practitioners and that new guidance would be issued to recommend 15 credits per year alongside compulsory reflective notes for each CPD entry. JH commented that it may be useful to look at other CPD requirements for practitioners, such as from the CIEH. This would make it easier in the future for responsible officers with regard to revalidation.

The group was invited to feedback on evidence of quality of service and in particular the illustrative options 1B and 2B on pages 7 and 8 of the draft scheme. NW commented that PHE offered multi-source feedback to all those due for revalidation and it was not an appraisal requirement. As a matter of principle, this service could be offered to all but the tool costs on average between £70-100 including VAT and it would need to be considered whether the questions were relevant. AT commented that people appreciated guidance on what tools were preferrable from a range that are acceptable. The Chair commented that the tool should offer the opportunity for someone to reflect and it was the content of the tool that mattered rather than the type of tool.

NW commented that option 1B of multi-source feedback allowed anonomised comments to prevent people from consciously providing positive comments, which perhaps option 2B may lead to. SKC commented that the GMC's multi-source feedback tool was onorous and that option 2B would be preferred with the inclusion of multi-source feedback to supplement the other sources. It was agreed that there needed to be a balance within a mandatory set of statements. NW reported that PHE asked for a minimum of 12 with many supplying 15-20. As option 1B only required 8 statements as a minimum this would possibly pose the risk of losing the power of multi-source feedback.

With regard to multi-source feedback for practitioners, it was agreed that if a testimonial were to be required there should be one submitted from the registrant's employer and another from a UKPHR registrant. JH stated that this would disseminate the culture to all registrants that quality of service should be maintained and seen as a responsibility with UKPHR registration. AT agreed that as the multi-source feedback was once every 5 years for practitioners, it provided sufficient time to collect enough sources.

Group members agreed that the minimum number of statements for multi-source feedback should be less for practitioners and that testimonials should be structured and from defined groups, including at least 1 UKPHR registrant.

Confirmation of compliance for specialists and practitioners carrying out revalidation in the absence of a responsible officer was considered. The Chair noted that self-declarations will be requested for audit and quality assurance. SKC commented that at the GMC verification was carried out by responsible officers, however primary source verification was completed by random selection. JH suggested that further work was required to mirror the responsible officer for medically qualified specialists and extend to specialist and practitioner registrants. UKPHR should also study the NMC and CIEH requirements to ensure that UKPHR does not require more than they do.

The Chair reported that UKPHR accepted GMC revalidation to eliminate duplication of revalidation for dual registrants and if a registrant had undergone NMC revalidation, this should be accepted.

The Chair summarised the discussion as pointing towards a common requirement for professional appraisal, a process which should be annual for specialist registrants and once every 5 year years for practitioners, supplemented with yearly work appraisal. Some further thought was needed about appraisal guidance and possible templates. There was support for requiring feedback via multi-source feedback tools but further work is required to establish the feedback requirements for both specialists and practitioners.

5. Next steps

The Chair said that the issues debated by the group would be further considered at the next meeting. **All**

6. Updates

6.1 Good Public Health Practice revision

The Chair referred to the earlier update provided on Good Public Health Practice at the beginning of item 4.

6.2 Routes to registration

PS reported that UKPHR had established a task & finish group to review routes to registration for public health specialists. A consultation had been opened and would run until 29th February 2016. The consultation paper and a survey could be read on UKPHR's website and PS urged members to read the consultation and complete the survey. The consultation had so far received 83 responses and these would be considered by the group at the end of March/early April.

7. Communicating the work of the group

The Chair reported that in the interest of maximum transparency of the group's work, minutes and a report of the previous meeting were published on UKPHR's website. Minutes and a report of this meeting would similarly be published. **DK**

8. Any other business

None

10. Date of next meeting

The next meeting of the group is due to be held on Tuesday 15th March 2016 at UKPHR's Birmingham office. A further meeting has been timetabled for the 24th May. The Chair thanked all for their attendance. **DK**