CONFIDENTIAL

Revalidation task & finish group

Minutes of the meeting held on Tuesday 20 September 2016 at UKPHR
18c, Mclaren Building, 46, Priory Queensway, Birmingham B4 7LR

Present (personal attendance):
Anne McMillan, UKPHR's Registrar (Chair)
David Kidney, UKPHR (Secretariat) (DK)
Present (by telephone):
Em Rahman, Coordinator Wessex practitioner registration (ER)
Rhian Rajaratnam, GMC (RR)
Imogen Stephens, PHE (IS)
Angela Townsend, FPH (AT)
Also in attendance:
Ulrike Harrower

Apologies:
Janet Collins, GDC
Jeremy Hawker, UKPHR Board Director
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
Viv Speller, UKPHR Board Director

ACTION

1. Welcome, apologies for absence and declarations of interest

The Chair welcomed everyone to the fifth meeting of the revalidation task & finish group. IS explained that Ulrike Harrower was shadowing her for the day. Apologies for absence as stated above were received. There were no declarations of interest.

2. Minutes of the meeting held on 15 March 2016

The minutes of the meeting held on 15th March 2016 were agreed.

DK

3. Matters arising from the minutes

None.

4. Further development of UKPHR`s revalidation scheme

4.1 The Chair referred to DK`s report of consultation responses and proposed that the group consider the report page by page.

Page 3: The group agreed with the commentary.

Page 4: The group agreed the commentary with the proviso that only revalidation by the GMC should be referred to.

Page 5: The group agreed with the commentary. Regarding the two options in the commentary the group preferred that revalidation should first be required 5 years after first registration as a specialist.

Page 6 & 7: The group agreed the need to address the confusion that was evident regarding the difference between work-based appraisal and professional appraisal. The group recommended that UKPHR`s formal revalidation scheme ought not to concern itself directly with work-based appraisal although there were obvious linkages which guidance which would have to be addressed including links to personal development planning, professional appraisal and third party confirmation. The group agreed that the scheme and guidance would need to be clearer as to how registrants who were working independently would be expected to comply with the revalidation requirements. The group was supportive of a Responsible Officer role in revalidation but accepted that without legal backing UKPHR could not have recourse to a system of Responsible Officers. In view of this, the group was of the view that UKPHR would need to engage with and provide clear guidance for employing bodies regarding the revalidation requirements that would apply to their employees. Regarding equivalence of treatment for specialist registrants RR described lessons learned by the GMC: doctors valued professional appraisal; reflection is an important part of the process and doctors without a connection to a Responsible Officer have a responsibility to arrange their professional appraisal by a licensed practitioner. IS described the history of the development of revalidation and said that a key feature for revalidation to be successful is professional appraisal by reference to clear professional standards. She said it was only in public health that line management and work-based appraisal was so prevalent. Overlap arose between these arrangements and professional appraisal through, for example, personal development planning. AT suggested that perhaps the overlap could be accommodated through production of work-based appraisal material in the professional appraisal. The group agreed to concentrate UKPHR`s revalidation scheme on professional appraisal.

Page 8 & 9: AT said that the FPH agreed that the lower risk involved in practitioners` practice merited fewer revalidation requirements but felt that professional appraisal should be more regular than the proposed once per 5 years but simplified. ER said that practitioners might appreciate an annual process if it were to reduce the burden of the once-every 5 years revalidation requirements. AM pointed out that UKPHR had refined its CPD guidance for practitioners to advise that the 5-yearly CPD requirement of 75 hours was best met by achieving 15 hours a year. DK said that some annual requirement in respect of feedback and reflection was justifiable by reference to the consultation responses received.

Page 10: The group agreed the commentary.

Page 11: The group agreed the commentary.

Pages 12-15: IS said that PHE did not use the GMC questionnaire for the collection of feedback because it did not regard it as sufficiently specific. She referred to tools that were available for use for this purpose although these tools were variable. Validated tools should be specified by UKPHR. PHE required clinical specialists to produce multi-sourced feedback (MSF) using a validated tool once per 5 years. PHE advises specialists to seek 10-20 raters. PHE also appraises new MSF tools. RR said that direct patient feedback as part of the requirements for revalidation had beenrelatively new for doctors whereas elements such as CPD, personal development and involvement in dealing with complaints and significant incidents was more established. GMC decided to help doctors by publishing case studies on how to collect patient patient feedback in addition to guidance. IS said that MSF could also be useful in personal development terms. Research should disclose availability of simpler MSF tools suitable for use by practitioners. The group agreed that whether or not tools were available objectivity in the feedback process was an important feature.

Page 16: The group agreed the commentaries to Questions 9 & 10.

Page 17: The group agreed the commentary.

Page 18: The group agreed the commentary.

Page 19: IS said that there was a growing culture of public health people getting used to giving ratings for MSF tools.

Pages 20 & 21: On policy, RR said that remediation should happen independently of revalidation anyway and for that reason the GMC had decided not to include remediation as part of its revalidation model per se (although it was referred to in guidance). On implementation and securing compliance, the availability of appraisers was discussed. IS said that PHE provided half-day training for appraisers and that in Scotland appraisers were paid. RR said that doctors overseas were still required to complete all revalidation requirements.

4.2 The group asked DK to redraft the revalidation scheme to take account of the group`s discussion and decisions and circulate the new version to all group members by email for comment. **DK**

4.3 DK described UKPHR`s further processes in relation to settling and implementing its revalidation scheme including Board meetings on 29 September and 22 November. The group agreed that it would be

willing for the report on consultation responses to be published by UKPHR but recommended removal of names of individuals and organisations. **DK**

5. Indicative timetable

The group had been provided with an indicative timetable which the group approved with the proviso that the timeline would need to be extended if group members were subsequently to decide that a further meeting of the group was required. As to implementation, RR said that the GMC had introduced revalidation over a 3-year period with 20 per cent of doctors selected randomly in the first year, a further 40 per cent selected in the second year and the remaining 40 per cent included in the third year.

6. Updates

6.1 Public Health Skills & Knowledge Framework revision

DK reported that the revised Framework had now been published with a "soft launch" and reactions to using the Framework were invited to be submitted. A formal launch was planned for 15th November 2016.

6.2 Routes to registration

DK reported that UKPHR's task & finish group had engaged a contractor to assist in developing the standards for a new, single route by way of retrospective portfolio assessment.

6.3 Practitioner registration task & finish group

DK reported thatUKPHR had established this new task & finish group to review practitioner registration 5 years after UKPHR had first started to operate practitioner registration.

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.

8. Any other business

None

10. Date of next meeting

The group did not set a date for another meeting but intended to review DK`s next draft of the revalidation scheme by email and tracked changes electronically. **DK**