

Continuing fitness to practise Professional Liaison Group (PLG)

Cost and risk

Executive summary and recommendations

Introduction

The attached paper looks at the areas of cost and risk.

Decision

This paper is for discussion.

Background information

None

Resource implications

None

Financial implications

None

Appendices

Appendix 1: Risk table reproduced from Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st century

Date of paper

30 April 2008

Cost and risk

Introduction

During the group's discussions, two key issues have been raised.

- The likely or potential costs of any revalidation system.
- The risks or potential risks posed by the health professionals registered by the HPC.

This paper briefly looks at each of these areas, highlighting some of the issues which the group may wish to consider.

The group is asked to consider two broad questions:

Are the risks posed by HPC regulated professionals proportionate to the likely costs of revalidation?

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

1. Costs

The costs of revalidation have not been easy to obtain.

The Executive is working to try and obtain more information from UK and overseas regulators about the actual and estimated costs of revalidation and hopes that this information might be tabled at the group's meeting, or else considered as part of the group's report to the Council. The Executive is also working on estimating the costs for different potential models of revalidation.

In the absence of this information, information is provided below about the costs of two HPC processes, and the estimated assessment costs of one of the models looked at previously by the group. Any costing would inevitably rely on key assumptions about the number of registrants, the frequency of revalidation and the mechanism of the revalidation process.

- **International Registration Assessment**

The international and grandparenting department handles applications for registration from applicants who trained outside of the UK.

This is a paper based process – each applicant completes an application form providing full details about their education, training and experience. Each application is assessed by two registration assessors from the relevant profession and a recommendation made about whether we can register the applicant.

In 2006, an external auditing exercise put the costs of our international application process, including assessment, administration costs, and overheads, at **£354** per applicant.

- **Continuing Professional Development (CPD)**

The CPD audits will begin this year, with chiropodists and podiatrists and operating department practitioners due to be audited in July and October.

Registrants selected for audit will be asked to submit a written profile which demonstrates how the standards have met. Each profile will be assessed by two CPD assessors and a decision reached. The fee agreed per profile assessment is £20.

The first two audits will be a 5% audit sample; depending on the results of these audits, the sample size may be dropped to 2.5%. Registrants are randomly selected for audit when they renew their registration every two years.

The estimated cost of assessing CPD profiles is £77.27 per profile. This includes fees, administrative costs and overheads. It does not include development costs (standards development, literature, training CPD assessors and other associated costs).

This is based on:

- 50% of profiles assessed remotely by assessors; 50% of profiles assessed centrally, at a meeting of assessors.
- Each profile is assessed by two assessors.
- Assessment (£20 per profile), travel, room hire and stationery costs are included.
- Budget of £83,451 for the assessment of 1080 profiles in the 2008/2009 financial year.

- **Site assessment**

At its meeting on 11 January 2008, the group considered a paper looking at models of revalidation elsewhere in the world. One of those models was the quality assurance program of the College of Physiotherapists of Ontario.

This model involved:

- Structured CPD
- Assessment of competence of each registrant by a peer assessor every 5 to 10 years
- Remediation programme for those registrants failing the assessment

Figures on the costs of this process are not available. However, we might estimate the possible costs of the assessment stage, based on HPC's existing costs for partners that sit on fitness to practise panels.

The total cost per assessment is estimated at £490. This is based on:

- A Daily fee of £130
- Travel costs of £200
- Accommodation costs of £130
- Subsistence costs of £30

Total: £490 per assessment

This does not include other costs such as the cost of administering the process, and the costs of the CPD and remediation stages.

(We are currently seeking information from the College on the costs of their arrangements and hope to update the group with this information shortly).

Conclusions

- Examples of existing HPC processes suggest that the cost of periodic assessment of each registrant, site based or paper based, is likely to be substantial.
- The costings given on the previous page do not include other costs which would be associated with the development of an additional assessment process – including standards development, consultation, communications activity, additional staff required to administer the system, and so on.

2. Risk

Trust, Assurance and Safety – The regulation of health professionals in the 21st century

The White Paper said the following regarding risk:

‘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...Working closely with the Devolved Administrations, the Department will discuss with each regulator the most appropriate arrangements that are proportionate to the risk that each profession may pose to patients.’¹

○ **A risk model?**

The White Paper included a table which highlighted some areas which might indicate whether a registrant was higher or lower risk (reproduced in appendix 1). There are a number of observations we could make about this model of risk. In particular, we might point to a lack of empirical evidence, particularly in the professions regulated by the HPC, which supports the risk profile identified in the table.

We might conclude that the table has some intuitive basis in that we might expect the practice of registrants in team based work environments, with developed governance structures, to be of lower ‘risk’ than registrants working in environments where that isn’t the case. However, we might conclude that this assumption would need to be backed up by clear evidence.

We might also observe that the table suggests a certain degree of homogeneity of environment which may not exist. For example, within managed environments there might be a huge variation in the degree of direct employer-employee contact which might affect our perception of ‘risk’ – for example, registrants who are employed but who undertake independent domiciliary visits without regular contact with management or supervision. Further, it is important to note that the chart is not exhaustive. For example, there is some evidence to suggest that there might be some correlation between the age of a practitioner and risk. For example, an analysis of data from referrals to the National Clinical Assessment Service revealed that the rate of referral to NCAS increases with age and rises steeply after 60 amongst general medical practitioners. The data further indicated that women are referred less frequently than would be expected from a profile of the workforce.²

Other research has examined gender differences against fitness to practise data. In one US study, Taragin found that male doctors were three times more likely to have malpractice claims against them than their female counterparts.³ Conduct and drug dependency related concerns about doctors are also predominantly

¹ Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century (Paragraph 2.29).

² National Clinical Assessment Service, Analysis of the first four years referral data (July 2006).

³ Taragin, M Wilczek, A et al (1992) Physician demographics and the risk of medical malpractice. American Medical Journal, 93, pp.535-42.

found amongst male doctors. Firth-Cozens observes that ‘ the less favourable tail of the normal distribution curve is populated more by men, as it is in many other areas of life such as addiction, delinquency and risky behaviour’.⁴ She goes on to observe that womens’ communication skills and emotional intelligence ‘may make them forge better relationships with patients and make them less likely to be the subject of complaints’.

76% of the total HPC registrant population are women. From the research evidence available, we might conclude that women from these professions present a lower risk than their male counterparts.⁵

The table says: ‘Registrants who are not practising should not be required to revalidate.’ Our definition of practise says that a registrant practises their profession when they draw on their professional skills and experience in some way during the course of their work. This definition is deliberately broad to encompass registrants who are engaged in roles in which they draw on their professional skills and experience, roles which may not involve patient or client contact, but nonetheless bring registrants into contact with service users such as students.

In the review of the regulation of the non-medical healthcare professionals we also raised important concerns regarding a risk-based model of revalidation. In particular, we highlighted that although we might support a risk based approach in principle, any such approach would rely on the ability to easily identify those registrants who posed the highest risk. We highlighted a number of possible obstacles including:

- The logistical difficulties of capturing reliable information about the nature of the practice of registrants.
- The possible impact of a risk-based approach upon health professionals in that it could discourage movement into areas which might be flagged as ‘high risk’.

General Dental Council

At the last meeting, the General Dental Council presented on their revalidation proposals. In particular, they explained that they divided risk into two areas:

- static group risk; and
- static individual risk.

The first of these relates to the risk which a group of practitioners might attract because of the nature of their practice (e.g. undertaking invasive procedures).

The second relates to risks which are personal to the individual registrant – i.e. those which might be identified through previous adverse fitness to practise findings.

⁴ Firth-Cozens, Jenny, ‘Effects of gender on performance in medicines’, British Medical Journal (2008), pp.731-2.

⁵ Health Professions Council Annual Report
http://www.hpc-uk.org/assets/documents/100021B3HPC_Annual_Report_2007.pdf

The GDC's approach is to avoid static group risk, partly due to a lack of robust evidence; instead the ownership of risk resides with the individual registrant.

The GDC's three stage model of revalidation might seem to be 'risk based' in that all registrants enter the first stage, following which only registrants for whom concerns are identified need undertake further, more in-depth assessment. The intensity of the check increases as the proportion of registrants involved decreases.

Fitness to practise

The group has discussed on several occasions whether data from the fitness to practise process might provide evidence of risk indicators (as well as evidence which might support a rationale for revalidation).

In 2006-07, 0.18% of registrants were subject to a complaint via our fitness to practise process.

The vast majority of cases are about misconduct or convictions/ cautions, with small numbers of lack of competence cases and an even smaller number of health cases considered each year.

Table 1: Reproduced from HPC Fitness to Practise Annual Report 2007

Profession	Number of complaints	% of total complaints	Number of registrants	% of total number on Register	Total % of registrants with complaints
AS	4	1.2	2344	1.3	0.17
BS	18	5.6	22533	12.7	0.08
CH	38	11.8	12671	7.1	0.30
CS	2	0.6	4251	2.4	0.05
DT	6	1.9	6281	3.5	0.10
ODP	22	6.8	8830	5	0.25
OR	1	0.3	1289	0.7	0.08
OT	40	12.4	28794	16.2	0.14
PA	81	25.2	13210	7.4	0.61
PH	52	16.1	40670	22.9	0.13
PO	3	0.9	855	0.5	0.35
RA	14	13.7	24316	13.7	0.18
SL	11	3.4	11487	6.5	0.10
Total	322	100	177531	100	0.18

The table above shows that there is some variation in complaints patterns between professions. The rate of complaints is higher for chiropodists and podiatrists, operating department practitioners, paramedics, and prosthetists and orthotists, than might be expected by the proportion of these professions on the Register.

Paramedics accounted for 25.2% of complaints, but made up 7.2% of the total number on the Register. We might conclude that this figure reflects the nature of paramedic practice in that paramedics frequently have direct contact with the

public and are therefore more likely to be subject to complaint. In comparison, biomedical scientists, for example, have little contact with patients and have a lower rate of complaint compared to their proportion on the Register. These figures could reflect a higher likelihood of complaint, rather than suggesting that some professions are 'higher risk'. There may also be other factors which we could take into account, for example, 76% of paramedics are men, compared to 24% of the total number of registrants. However, further analysis of such data would be needed to draw any firm conclusions.

Anecdotally, the experience of our fitness to practise process so far does not suggest that private practising registrants are more likely to appear before our fitness to practise panels than registrants who work in managed environments. However, the HPC does not routinely collect data from registrants on the environment in which they practice, and this information is not routinely recorded as part of fitness to practise data collection.

We might suggest other areas of risk which could be specific to the nature of each of each profession. These might concern areas such as the use of ionising radiation (for radiographers) and prescribing or administration of medicines.

In 2006/2007, we considered one case in which a radiographer had administered 85 times the safe dose of radiation to a patient. However, the types of allegations received in this profession were varied, and many concerned misconduct unrelated to direct clinical interventions.

In 2006/2007, we considered a number of cases which concerned the misuse of drugs – including the theft and self-administration of drugs. These normally concerned registrants who work in professions and environments in which there is ready access to drugs. In the past, we have considered a small amount of cases which have concerned the competence or conduct of registrants in administering medicines to patients.

(Please note that although our annual report gives an indication of the allegations we receive, cases frequently involve a number of issues, and we do not currently classify cases in a way which could provide more readily available quantitative information about these areas).

Table 2: Complaints received by regulators per 1000 registrants in 2006⁶

GMC	GDC	RPSGB	GCC	HPC	GOsC	GOC	PSNI	NMC
23.7	20.7	17.4	17.3	1.8	9.1	6.7	3.5	2.0

The table above shows that the HPC currently receives the lowest number of complaints per thousand registrants compared to the other eight regulators of healthcare professionals.

⁶ Council for Healthcare Regulatory Excellence (CHRE) Annual Report 2006/2007
http://www.chre.org.uk/_img/docs/HC699%20Web%20Optimised%20PDF%20050907.pdf

A recent scoping exercise commissioned by the HPC concluded that there is very little published research on complaints against the professions regulated by the HPC. Amongst the available research, a recent study of complaints in the National Health Service (NHS) found that 60% of complaints related to nursing and medical staff, compared to 5% for 'professions allied to medicine'.⁷

⁷ Jackie Gulland, Scoping report on existing research on complaints mechanisms, January 2008
<http://www.hpc-uk.org/assets/documents/100021EB230408-enclosure4-Complaintsreview.pdf>

Conclusions

- There is little evidence to support the proposed risk factors for HPC registrants as outlined in the White Paper.
- Further research is needed to explore the application of a risk based approach to revalidation for these professions
- Risk might be considered in two ways:
 1. Risks posed by particular groups of registrants or attracted by particular interventions.
 - How risky are the professions regulated by the HPC?
 - What would a revalidation approach based on such 'group risk' look like?
 - How could registrants who posed the greatest risk be identified?
 2. An approach which itself takes account of 'risk'
 - A staged approach to revalidation in which the proportion of registrants involved decreases, as the intensity of the check increases, for example.
- We might suggest possible areas of risk in the practise of HPC regulated professionals. They might include:

Broad areas:

- The consequences of an error in undertaking a particular intervention (i.e. likely to be higher in professions where the intervention is invasive).
- Direct patient contact.
- Work environment (i.e. sole practitioner versus multi-professional team).

More specific areas:

- Use of ionising radiation – risks association with over exposure, for example.
- Prescribing of medicines – risks associated with adverse reactions, for example.

However, a strong evidence base would be needed to support the identification of such areas of risk. There is a lack of quantitative and qualitative evidence to support identifying such areas, with specific reference to the professions regulated by the HPC, at this time.

- Data from the fitness to practise process does not suggest that certain areas of practice or certain types of registrant are risky than others; however, further qualitative analysis of fitness to practise data could be useful in the future.

- Analysis of the outcomes of the CPD audits due to start in July this year could, in the future, provide some useful information on possible patterns of risk. Such analysis might consider whether certain groups of registrants (as defined by profession, age, gender, practice area, type of environment etc) are more likely to experience difficulties in meeting the standards, and why this occurs.

Appendix 1

Higher	Lower
High level of responsibility for patient safety inherent in scope of practice	Low level of responsibility for patient safety inherent in scope of practice.
Leaders of clinical teams	Team members
People who practise outside managed environments such as a hospital or clinic	People who practice within such environments
People whose working environment is not subject to NHS standards of clinical governance	People whose working environment is subject to NHS standards of clinical governance
Practitioners who are frequently alone with patients/clients (including in their homes)	Practitioners who always work in a team/do not work face to face with patients/clients
Unsupervised practitioners/post	Supervised practitioners/posts
People in their first few years of registration (and possibly also their last few, according to some evidence)	Registrants in mid (or late?) career
Recent adverse finding by a regulator	Clean regulatory record
Recent appraisals show concern about performance	Good performance record
People who are in current practice	People who are not practising (some regulators have proposed a scheme where non-practising registrants need not revalidate at all) Those who are not practising should not be required to revalidate as there is no risk to the public. This does however have implications for re-entry to the register.
People using invasive, high-risk interventions	People using lower-risk interventions