Council, 26 March 2009

Response to the Department of Health 'Principles for Revalidation – Report of the Working Group for Non-Medical Revalidation'

Executive summary and recommendations

Introduction

At its meeting on 1 October 2008, the Council approved the report of the Continuing Fitness to Practise Professional Liaison Group (PLG).

The Department of Health Working Group for Non-Medical Revalidation (on which the Council is represented by the President) published its report in November 2008. The Department of Health subsequently asked each regulator to outline their proposals on revalidation, describing how their approach would meet the principles for non-medical revalidation.

A copy of the HPC's response to the Department of Health in February 2009 is attached. This was based around the report of the PLG and the document makes in-text references to this report (please see background information for a link to this paper).

A copy of the report of the Department of Health Working Group for Non-Medical Revalidation is appended.

The Executive will keep the Council updated with any developments in this area.

Decision

The Council is invited to note the attached documents; no decision is required.

Background information

The report of the Continuing Fitness to Practise Professional Liaison Group was considered by the Council at its meeting on 1 October 2008. This is not appended but is available on the HPC website:
http://www.hpc-uk.org/aboutus/council/councilmeetings_archive/index.asp?id=412

Resource implications

None

Financial implications

None

Appendices

- Principles for Revalidation - Report of the Working Group for non-Medical Revalidation

Date of paper

16 March 2009

February 2009

Health Professions Council (HPC) response to 'Principles for Revalidation – Report of the Working Group for Non-Medical Revalidation'

1. Introduction

1.1 The nine UK Health regulators have been asked by the Department of Health to respond to the report of the Working Group for Non-Medical Revalidation, outlining their current work and proposals around revalidation, and setting out how they meet the principles for revalidation.

1.2 In this document, a summary is provided of the HPC's work on this subject to date. The document then outlines how the HPC's planned approach is consistent with the twelve principles outlined in the Report.

2. The HPC's approach to revalidation

2.1 The Health Professions Council's thinking on revalidation has been informed by the work of the Professional Liaison Group (PLG) on Continuing Fitness to Practise. This group met five times between November 2007 and September 2008 and also benefited from a meeting with a wider group of representatives of organisations representing the professionals we regulate.

2.2 The Group made its report and recommendations to the HPC Council in October 2008. A copy of the report is appended and cross references are given in this document.

2.3 The Group considered revalidation in the wider context of 'continuing fitness to practise' which we broadly defined as 'all those steps taken by regulators, employers, health professionals and others which support the maintenance of fitness to practise beyond the point of initial registration'. In its work the Group considered, amongst other topics:

- the existing mechanisms for assuring continuing fitness to practise (including existing regulatory systems and those in place outside of professional regulation);
- the evidence of the risk posed by the professions regulated by the HPC;
- the likely costs and resources of any additional layer of inspection; and
- the opinions and expectations of members of the public.

2.4 The Group concluded (sections 1 and 10 of the report):

- Revalidation is but one part of the process of assuring continuing fitness to practise.

- The current evidence suggests that the risk posed by the professions regulated by the HPC overall is low. However, this area merits further exploration, in particular, conduct was identified as an area of greater risk than competence.

- Public trust in the health professions regulated by the HPC is high. However, further work on ways to increase public involvement in regulation is merited.

- The potential costs of additional regulatory systems are likely to be significant and as such must be clearly justified, balancing the costs against demonstrable benefits.

- In the light of these findings, existing regulatory systems are currently appropriate and sufficient when considered in the context of the wider environment in which they operate and the risk of harm posed by the professions regulated by the HPC.

2.5 The Group made the following recommendations for further work (section 10):

- Analysis of fitness to practise data to explore correlations between age, location of practice and fitness to practise (section 6).

- Analysis of the outcomes of the CPD audits currently being conducted (section 5.1, paragraphs 13-17).

- A retrospective study to explore whether registrants from a particular profession who have undergone fitness to practise action are more likely to have been involved in disciplinary procedures or to demonstrate a poor record in professional behaviour during training (section 6.3).

- A prospective study piloting the use of a professionalism tool with education and training providers for two different professions and track progress of students over five years (section 6.3).

- Depending upon the outcome from these studies, wider use of this tool in education and training programmes for other professions may be recommended (section 6.3).

- In parallel, explore further the teaching of ‘professionalism’ on pre-registration programmes across the 13 professions and look at ways of promoting this further, for example, via the standards of education and training (section 6.3).

- A prospective study looking at the application of a patient feedback tool with a random sample of registrants and students (section 8).

2.6 In summary, we intend to take a systematic, evidence based approach to revalidation, in light of our assessment of the risk profile of the professions we regulate.

The Europe Economics research commissioned by the Department of Health concluded that any assessment of revalidation would need to recognise existing regulatory systems and how they identify registrants performing at a below-standard level, and take these into account in forming a view of the incremental costs and benefits a new policy would bring (A1.12). We have considered our existing systems in our work on this topic and conclude that the totality of these existing systems (including self-certification, CPD standards and audit and returners to practice requirements), when seen in the broader context in which they operate, are currently sufficient in assuring continuing fitness to practise. Put another way, revalidation for our purposes consists of the combination of these systems (see section 5.1).

We believe that further work is merited in the areas outlined in paragraph 2.5. In particular, we will focus our efforts in the area of conduct, identified as the area of greatest risk for the professionals we register. To that end, we are preparing to commission research on the links between poor conduct during education and training and subsequent fitness to practise action.

3. Principles for Revalidation

In this section, we have outlined how our approach to revalidation meets the non-medical revalidation principles.

3.1 Transparency

Principle 1 (Consistency) *Models should be consistent with the Better Regulation Executive's five principles of good regulation.*

Our approach to revalidation outlined in section two of this document is consistent with the Better Regulation Executive's principles of good regulation. In particular, our approach is proportionate and targeted in that it is based on our assessment of the overall risk profile of the professions regulated by the HPC, and targeted in the areas we consider merit further attention. In particular, our proposed work on the link between pre-registration education and training and subsequent fitness to practise action is based on the assessment that, for our professions, conduct is more frequently an issue post-registration than competence and therefore requires further scrutiny.

Please also see our response to principle 5 on our proportionate approach to auditing compliance with our standards for continuing professional development.

Principle 2 (Professional standards) *The regulatory body for each profession should at all times set out the contemporary professional standards which registrants will have to meet in order to maintain registration.*

Registrants are required to renew their registration every two years, and sign a declaration to confirm that they continue to meet the standards of proficiency; that there have been no changes to their health or relating to their good character which they have not advised the HPC about and which would affect the safe and effective practice of their profession; and that they continue to meet standards for CPD. We are clear that registrants need to continue to meet those standards of proficiency that are relevant to their scope of practice.

Principle 3 (Remediation) *Where revalidation systems highlight performance concerns there should be scope for remediation of the professional but measures to secure public safety must remain paramount.*

The professions we regulate do not have the infrastructure necessary to support a robust system package of remediation. In the medical profession, this infrastructure is available in the form of the work of organisations such as the National Clinical Assessment Service and the Postgraduate Medical Deanaries. This is an area that we would wish to explore further in the future.

Our CPD audit process demonstrates an approach consistent with the principle of remediation (please see principle 5). The audit process has been designed to provide registrants who struggle to meet the standards with support to do so. If from a CPD profile it is unclear that the required standards have been met, we can ask a registrant for further information, highlighting the areas in which the standards have not been met. If a registrant has not met the standards fully but there is a demonstrable commitment to CPD, they can be given an extra three months to go away, with the benefit of clear guidance, and undertake more CPD

and/or rewrite their CPD profile. In summary, we have designed a process that provides registrants with the support necessary to meet the standards and maintain their registration. Analysis of the outcomes of the CPD audits will help us to assess the effectiveness of this approach and how that might be extended to other systems that we develop.

3.2 Accountable

Principle 4 (Patient and Public Involvement) *A successful revalidation process must have the confidence of the public that it is appropriate, relevant and fit for purpose.*

The principle says that the public and service users must be involved in and seen to be involved in the design and delivery of the revalidation systems.

The expectations of patients and public are central to our approach to revalidation. Research has shown that public awareness of the HPC (and the other regulators overall) is low. However, we believe that this needs to be seen in the overall context of high levels of trust in health professionals and low levels of complaint against the professions regulated by the HPC. Research has also identified that the main areas of patients' concern about the practice of health professionals are most frequently 'soft skills' around communication, respect and involvement – all of which are aspects of practice that may be far harder to revalidate or assess in a meaningful way.

Further, we believe that any additional regulation must be meaningful, easy to communicate with members of the public and avoid tokenism which might have the effect of providing false reassurance to the public, and would be counter-productive in terms of public safety and maintaining public trust and confidence.

The CPD standards and audit process is deliberately focused on the benefits of registrants' learning to 'service users' - i.e. those who use or are affected by their practice. However, service user feedback, which might be helpful in terms of providing feedback on 'soft skills' is not currently integrated within the CPD standards or CPD process, although many practitioners are choosing to submit this feedback as evidence. In the light of the conclusions from a similar ongoing study in the field of medical revalidation, we intend to undertake a prospective study looking at the application of a patient feedback tool with a random sample of registrants and students. A patient feedback measure could have the potential to provide structured, regular, external input and verification, which is currently missing from the existing HPC systems. The outcomes of this study might lead to changes to the HPC's existing systems. For example, we might consider whether such a tool would provide a helpful way for registrants to reflect on their practice and identify their CPD needs as a result (section 9, paragraphs 2 to 8).

Principle 5 (Continuing Professional Development) (CPD) *This is the process by which individual registrants keep themselves up to date with healthcare developments in order to maintain the highest standards of professional practice.*

The principles set out that CPD may provide a source of evidence for revalidation; must be relevant to the practitioner's scope of practice; and should be based on outcomes.

The CPD standards and audits are one part of the systems that we believe collectively assure the fitness to practise of registrants.

We set standards for CPD that are outcomes based and relevant to the practitioner's scope of practice. Registrants are required to:

- maintain a continuous, up-to-date and accurate record of their CPD activities;
- demonstrate that their CPD activities are a mixture of learning activities relevant to current or future practice;
- seek to ensure that their CPD has contributed to the quality of their practice and service delivery;
- seek to ensure that their CPD benefits the service user; and
- present a written profile containing evidence of their CPD upon request.'

CPD audits to check registrant compliance with the standards started in May 2008 with a 5% sample of registrants from the first two professions being audited. We are reviewing the sample size in light of the outcomes of the first two audits.

The outcome of a failure to meet the standards is administrative removal from the Register.

The outcomes of the CPD audits are likely to help further in the development of risk indicators for the regulated professions and we will undertake further analysis as the audits progress.

Principle 6 (Quality Assurance) *Quality assurance mechanisms must be built into revalidation systems.*

Robust quality assurance mechanisms are built in to our existing systems. We will ensure robust quality assurance systems in any amendments to our existing systems or additional systems which are indicated as a result of our planned research programme.

In the area of CPD, registrant profile submissions are considered at meetings of CPD assessors, professionals from each of the professions on our register who assess profiles on our behalf. Profiles are assessed against clear criteria and using clear documentation.

Such meetings allow assessors to share their views of profiles, ensuring greater consistency in decision making. The quality of decisions and reasoning for these decisions is also checked administratively to ensure consistency of approach and so that any potential problems are identified. Profiles can also be moderated by a third assessor, if necessary, in borderline cases or where there is disagreement amongst assessors. Decisions are also subject to a clear appeals process.

The CPD process and our other systems are also subject to regular internal audit, and external audit as part of our registration with the BSI to ISO9001 standards.

3.3 Consistent

Principle 7 (Equality) *Equality and diversity considerations must be evident in the development of all systems and systems.*

The HPC publishes an equality and diversity scheme which explains how it takes account of equality and diversity considerations in all aspects of its work. Reporting on the implications for equality and diversity will form part of our commissions for research and thorough equality and diversity impact assessment will form part of any subsequent proposals.

Principle 8 (Integration) *The implementation of clinical governance frameworks yields information on professionals' performance and practice. Where appropriate, effective connections need to be made between them and the system of revalidation.*

We agree that the role that clinical governance frameworks and other local appraisal systems play in assuring the continuing fitness to practise of registrants, and in generating information that might demonstrate that fitness to practise, should be taken into account in any revalidation proposals.

Within our existing systems, we also seek to ensure that there is integration with other systems where possible in order to avoid duplication of effort. For example, information gained from participation in the National Health Service (NHS) Knowledge and Skills Framework (KSF) could be used by a registrant to demonstrate that they have met our standards for continuing professional development. Further, many of the CPD schemes set up by professional bodies to support their members in undertaking CPD make explicit links between these local appraisal systems and HPC's CPD standards, helping to minimise duplication.

Principle 9 (UK-wide) *Revalidation arrangements should be consistent in outcome across the United Kingdom.*

We agree that any systems should be UK-wide and we will take into account differences between the four countries in the research we intend to undertake.

We already have well established mechanisms for dialogue with stakeholders across the four home countries, including regular meetings with the devolved administrations.

3.4 Proportionate and Targeted

Principle 10 (Demonstrating Benefits – effective in confirming fitness to practise) *The structures and systems of revalidation should be effective in confirming fitness to practise.*

The principle says that the structures and systems of revalidation should 'knit together in a coherent, unbureaucratic and proportionate manner to ensure that the resources invested yield valid and reliable outcomes, together with the anticipated benefits to service users and health professionals'.

In paragraphs 2.4, 2.5 and 2.6 we outline our approach to revalidation and how we intend to take a systematic, evidence-based approach, informed by our evolving assessment of the risk profile of the professions we regulate. We believe that the totality of our existing systems, when seen in the wider environment in which they operate, are effective in confirming fitness to practise. However, we have identified a number of pieces of further work, to further develop our understanding of risk, which can be used in considering whether we should introduce any additional structures or systems.

Our approach to revalidation closely mirrors the requirements of this principle; our focus is on ensuring that revalidation is meaningful for practitioners and members of the public; is targeted in the area or areas of greatest risk; avoids tokenism; and is clearly beneficial in addition to existing systems.

In addition to our responses to principles 5, 8 and 11 (which provide more information about our standards for continuing professional development, our approach to risk and our desire to ensure integration of systems), we have outlined our existing systems below in order to demonstrate how we are meeting this principle. We have also outlined how our proposed research is focused on the salient issues around fitness to practise for our registrants.

Existing systems for assuring continuing fitness to practise
Our proposals outlined in paragraph 2.5 are made in light of our existing systems and the wider environment in which they operate. We believe that the assessment of the effectiveness of systems which exist within and outside the professional regulatory environment is important to in order to help assess the extent to which an additional layer of regulation is necessary at the professional regulatory level.

Our existing systems include:

- Self certification (section 5.1, paragraphs 7 to 12)

Applicants for admission and readmission to the Register make a declaration that they have read and will comply with the standards of proficiency, conduct, performance and ethics and that they have read and will comply with the standards for CPD. Applicants are also required to declare any convictions or cautions or determinations of other regulators responsible for licensing a health or social care profession, as part of the application process.

Every two years when they renew their registration, registrants are required to sign a declaration to confirm that they continue to meet the standards of proficiency which apply to their practice; that there have been no changes to their health or relating to their good character which they not advised the HPC about and which would affect the safe and effective practice of their profession; and that they continue to meet the standards for CPD.

The self-certification process is supported by the health and character process. If a registrant declares an issue relevant to their good character on application or renewal (e.g. a caution or conviction), a health reference raises possible concern, or a registrant makes a self-referral during their registration cycle, this will be considered by a registration panel. The panel determines whether the applicant should be admitted to the Register or permitted to renew their registration. Or, in the case of a self-referral, the panel decides whether the matter should be referred into the fitness to practise process.

Self-certification and self-referral of important information demonstrates the registrant's commitment to maintain their fitness to practise. It also demonstrates behaviours commensurate with professionalism.

- CPD standards and audit

We set standards for CPD that are outcomes based. Registrants are required to undertake CPD, record their CPD, ensure that their CPD contributes to the quality of their practice and service delivery, and ensure that it will benefit service users. We also audit to check compliance with the CPD standards and a failure to meet the standards is administrative removal from the Register (please see our response to principle five).

- Returners to practice

Health professionals seeking readmission to the Register who have been out of practice must undertake an updating period of 30 days for between two and five years out of practice and 60 days for five or more years out of practice.

The updating period can consist of private study, formal study and supervised practice and has to be countersigned by a registrant from the same part of the Register who has been in regulated practice for three years or more.

The returners to practice requirements are primarily a quality control mechanism aimed at mitigating the potential risks involved in returning to practise after a break, demonstrating that the returner is up to date and supporting fitness to practise. The returners to practice requirements are threshold requirements which may be exceeded by the requirements of others, such as employers.

These systems sit alongside other systems such as the fitness to practise process and the role of regulators in assuring standards in pre-registration education and training.

They also exist in an environment that includes other systems and structures that exist outside of professional regulation but which nonetheless are an important part of the picture of ensuring continuing fitness to practise.

We believe that the consideration of any additional system of regulation needs to consider this wider environment and how systems, both within and outside of regulation, collectively serve to ensure the continuing fitness to practise of registrants.

Research
The benefits of any additional inspection must be clear in order to justify the likely costs. We conclude that at present, in light of our assessment, the benefits to public protection and public confidence are unclear.

The Europe Economics research said of the existing evidence base: 'The pre-existing data sources focused upon the issue of revalidation are limited, and uniformly silent with regards to quantifying the benefits of the policy.' (A1.27) In this document (and in the appended report) we have outlined an approach to build the evidence base in this area, in order to make informed, evidence based decisions that would ensure that any refinements to our existing systems or additional systems are coherent, proportionate and clearly beneficial to service users and health professionals. In particular:

- Our proposed research into the links between pre-registration education and training and fitness to practise will help to further identify the area of greatest risk, the nature of that risk and the best way of mitigating that risk.

- Further analysis of the outcomes of the CPD audits and fitness to practise data will help to build our assessment of risk.

- A study looking at the application of a patient feedback tool might identify where service user feedback might be better incorporated into existing systems, for the benefit of both members of the public and health professionals.

We have appended an outline timetable for the delivery of this work.

Principle 11 (Information) *The nature of the information required by each regulatory body will be based on their risk profiling of their registrant groups.*

The principle says that: '…the nature of the information required will be based on the regulator's risk profiling of their registrant groups. The frequency and breadth/ depth of evidence each regulator requires information on and the evaluation / assessment methods will be based on the assessed potential risk posed by practitioners to patients and the public.'

We believe that any revalidation system must be proportionate to the assessment of the risk posed in order for it to be meaningful.

We have considered data from our fitness to practise cases (section 6.1) and, in summary, have made the following findings and conclusions:

- The numbers of registrants involved in the fitness to practise process are small relative to the numbers on the Register and compared to other regulators. In 2007/2008, 0.24% of registrants were subject to a complaint via our fitness to practise process.

- The majority of complaints considered were about misconduct / convictions and cautions; only 10% of cases in 2006/2007 were purely about competence matters.

- The available data is limited and as such it is not possible at this time to revalidate on the basis of risk – in the sense of treating registrants differently dependent upon a pre-determined assessment of the risk that their practice attracts.

- The data suggests that, for the professions we regulate, conduct is a higher area of risk or more frequently an issue than competence. As conduct is associated with the attitudes and values which influence behaviour (intangible aspects of practice that are difficult to identify and measure) it is better to focus regulatory effort in this area.

- Further analysis of the outcomes of fitness to practise cases may be helpful in developing our assessment of risk.

We are proposing further research in order to further develop our risk profile, in particular, to focus on the area of conduct.

Principle 12 (Introduction) *The introduction of revalidation should be incremental.*

We agree that the introduction of any additional systems should be incremental. We are proposing an evidence-based approach as we believe this is necessary to ensure that any additional system is robust and meaningful.

We believe that such an approach is necessary in order to command the confidence of stakeholders including registrants and members of the public.

Principles for Revalidation

Report of the Working Group for non-Medical Revalidation

Professional Regulation and Patient Safety Programme

DH INFORMATION READER BOX

Policy	Estates
HR / Workforce	Commissioning
Management	IM & T
Planning / Performance	Finance
Clinical	Social Care / Partnership Working

Document Purpose	Policy
Gateway Reference	10535
Title	Principles for Revalidation
Author	DH/Workforce Division/Professional Regulation
Publication Date	20 November 2008
Target Audience	PCT CEs, NHS Trust CEs, SHA CEs, Care Trust CEs, Foundation Trust CEs, Medical Directors, Directors of PH, Directors of Nursing, Directors of Adult SSs, PCT PEC Chairs, NHS Trust Board Chairs, Special HA CEs, Directors of HR, Allied Health Professionals, GPs, Communications Leads, Directors of Children's SSs, Health Professionals Regulators
Circulation List	PCT CEs, NHS Trust CEs, SHA CEs, Care Trust CEs, Foundation Trust CEs, Medical Directors, Directors of PH, Directors of Nursing, Directors of Adult SSs, PCT PEC Chairs, NHS Trust Board Chairs, Special HA CEs, Directors of HR, Allied Health Professionals, GPs, Communications Leads, Emergency Care Leads, Directors of Children's SSs, Voluntary Organisations/NDPBs
Description	The paper sets out the key principles which the non-medical health professions regulators will now use to develop proposals on the systems and processes for revalidation for their professional groups and outline piloting required.
Cross Ref	N/A
Superseded Docs	N/A
Action Required	N/A
Timing	**N/A**
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For Recipient's Use	

http://www.dh.gov.uk/publications

Revalidation Principles

This report from the non-medical revalidation working group outlines the principles that regulatory bodies will consider when preparing proposals for the revalidation of their professional groups.

Gavin Larner, Chair of the Working group on Non-Medical Revalidation

Contents

Annexes

Executive Summary

Revalidation is a mechanism that allows health professionals to demonstrate that they remain up-to-date and can demonstrate that they continue to meet the requirements of their professional regulator. Revalidation confirms that the registrant is practising in accordance their regulators professional standards and will identify for further investigation, and remediation, poor practice where local systems are not robust enough to do this or do not exist.

The White Paper *Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century* (February 2007), set out our proposals to ensure that all the statutorily regulated health professions have arrangements in place for the revalidation of their professional registration through which they can periodically demonstrate their continued fitness to practise. We continue to support the principle of revalidation and will develop a timetable for ensuring the process will encompass all health professionals over the next five years.

The White Paper endorsed the recommendations of the review led by Andrew Foster on '*The regulation of the non-medical healthcare professions*'. We agree that the regulatory body for each non-medical profession should develop the professional standards that the registrant will need to meet and demonstrate by provision of evidence to maintain their registration. It will be important that those standards and arrangements for assessment are proportionate to the risk that each profession may pose to the public.

The non-medical revalidation in developing this key principles paper, took account of the five principles[2] for good regulation as identified in the Better Regulation Task Force report *Regulation – Less is More: Reducing Burdens, Improving Outcomes.* The key principles for the development of non-medical revalidation proposals are summarised in table one on page 6.

[2] Better Regulation Taskforce (March 2005) Regulation –Less is More – Reducing Burdens, Improving Outcomes.
http://archive.cabinetoffice.gov.uk/brc/
http://www.berr.gov.uk/bre/reviewing-regulation/commission/page44086.html
The Better Regulation Executive (BRE) is part of the Department for Business, Enterprise and Regulatory Reform (BERR) and leads this regulatory reform agenda across government

Table 1
Key Principles

Principle	Theme	Summary Description
Principle 1	Consistency	Models should be consistent with the Better Regulation Executive's five principles of good regulation.
Principle 2	Professional Standards	The regulatory body for each profession should set out the contemporary professional standards, which registrants will have to meet in order to maintain registration.
Principle 3	Remediation	Where revalidation processes highlight performance concerns there should be scope for remediation of the professional but measures to secure public safety must remain paramount.
Principle 4	Patient and public involvement	A successful revalidation process must have the confidence of the public that it is appropriate, relevant and fit for purpose
Principle 5	Continuing Professional Development (CPD)	This is the process by which individual registrants keep themselves up to date in order to maintain the highest standards of professional practice.
Principle 6	Quality Assurance	Quality assurance mechanisms must be built into revalidation processes.
Principle 7	Equality	Equality and diversity considerations must be evident in the development of systems and processes for revalidation.
Principle 8	Integration	Clinical governance frameworks yield information on professionals' performance and practice. Where appropriate, effective connections need to be made between them and the system of revalidation.
Principle 9	UK-wide	Revalidation arrangements should be consistent in outcome across the United Kingdom.
Principle 10	Demonstrating Benefits	The structures and processes of revalidation should be effective in confirming fitness to practise.
Principle 11	Information	The nature of the information required by each regulatory body will be based on their risk profiling of their registrant groups.
Principle 12	Incremental Introduction	The introduction of revalidation should be incremental

1. Introduction

1.1 The UK Government White Paper *Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century*[2] endorsed the findings of the Foster Review *The Regulation of the Non-Medical Healthcare Professions*[3] that revalidation is necessary for all health professionals (see Annex A for the relevant extract from the White Paper). The White Paper set out the key principles that will underpin the regulation of health professionals over the next decade. It also acknowledged that professional regulation should be as much about sustaining, improving and assuring the professional standards of the overwhelming majority of health professionals as it is about identifying and addressing poor practice or inappropriate behaviour.

1.2 The primary purpose of revalidation is to enhance public protection by ensuring that health professionals in clinical practice are up to date and demonstrate that they continue to meet the requirements of their professional regulator. Revalidation confirms that the registrant is practising in accordance their regulators standards and will identify for further investigation, and remediation, poor practice where local systems are not robust enough to do this or do not exist.

1.3 The Government agrees that the regulatory body for each non-medical profession should approve the standards that registrants will need to meet to maintain and renew their registration on a regular basis. Where appropriate, common standards and systems should be developed across professional groups where this would benefit patient safety.

1.4 Revalidation is necessary for all health professionals in clinical practice, 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 of Health will discuss with each regulator the most appropriate arrangements that are proportionate to the risk that each profession may pose to patients.

1.5 In order to support delivery against the actions identified above, this paper sets out the high-level principles that will guide the development of models of revalidation for the non-medical professions by the following healthcare professional regulatory bodies:

- General Chiropractic Council;
- General Dental Council;
- General Optical Council;
- General Osteopathic Council;
- Health Professions Council;
- Nursing and Midwifery Council;
- Pharmaceutical Society of Northern Ireland and
- Royal Pharmaceutical Society of Great Britain.

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[2] *Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century* (2007) Cm7013 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_065946

[2] *The Regulation of the Non-Medical Healthcare Professions(2006) COI DH http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4137239*

1.6 The Non-Medical Revalidation Working Group was one of seven working groups established to take forward the recommendations in the 2007 White Paper, *Trust, Assurance and Safety - The Regulation of Health Professionals in the 21st Century*. The working group was chaired by Professor Jim Smith in 2007 and latterly by Gavin Larner, Director Professional Regulation, Department of Health. This paper draws upon discussions held within the working group. The Council for Healthcare Regulatory Excellence convened and provided secretariat services to the group's meetings. The report from the medical revalidation working group was published on the 23rd July 2008 and charted the way forward for medicine.

1.7 The group's primary objective was to set out the way forward to implement the White Paper's intention to introduce a new model of revalidation for non-medical health professions. The group's members had been invited both as the leaders of key organisations and for their personal practical experience of the issues. The group met between July 2007 and July 2008. The meetings were used to discuss and refine the key components of revalidation and to examine and resolve concerns and potential problems, in order to identify practical steps that would support the development of an implementation strategy by the key stakeholders.

2. Background

2.1 In preparing this paper, the Group took account of the five principles[4] for good regulation as identified in the Better Regulation Task Force report *Regulation – Less is More Reducing Burdens, Improving outcomes.* The Legislative and Regulatory Reform Act (2006) came into force[5] in January of 2007 to underpin the principles. These principles were put in place to ensure regulatory activities are carried out in such a way that they are:

- Transparent;
- Accountable;
- Proportionate;
- Consistent; and
- Targeted where action is needed.

2.3 It was acknowledged by the group that these principles will help the regulatory bodies for non-medical healthcare professionals develop proposals for revalidation including the systems and processes and to provide advice on the piloting required. The UK Government, working in partnership with the Devolved Administrations, agreed in the White Paper that each

[4] Better Regulation Taskforce (March 2005) Regulation –Less is More – Reducing Burdens, Improving Outcomes.
http://archive.cabinetoffice.gov.uk/brc/
http://www.berr.gov.uk/bre/reviewing-regulation/commission/page44086.html
The Better Regulation Executive (BRE) is part of the Department for Business, Enterprise and Regulatory Reform (BERR) and leads this regulatory reform agenda across government

[5] Legislative & Regulatory Reform Act (2006) LRRA - . This Act included powers to remove or reduce regulatory burdens[5] (the definition of burden includes financial, administrative, an obstacle to efficiency, productivity or profitability or a sanction which affects the carrying out of an lawful activity) and a power to promote regulatory principles where a Minister of the Crown may, by Order, make any provision that would ensure that regulatory functions are exercised so as to comply with the principles listed above. NB parts of this Act vary in Scotland, Ireland and Wales.

statutory professional regulator would be responsible for approving the standards that registrants would need to reach and maintain to secure their initial and continuing registration (full text at Annex A).

The twelve principles agreed on by the group have been cross-referenced to the five principles from the Better Regulation Executive.

2.4 Definition of terms used in this document:

- Patient: a person who receives care or treatment from a healthcare professional
- Service User: a person who receives care or treatment from a healthcare professional, clinical support staff or support from administration and reception staff.
- Carers: Carers provide care by looking after an ill, frail or disabled family member, friend or partner.
- Employers: persons or organisations who directly employ health professionals and other staff who come into contact with the patient and in some circumstances organise and commission services.

3. Definition Statement

3.1 The purpose of revalidation is to ensure that health professionals remain up to date and continue to demonstrate that they continue to meet the requirements of their professional regulator. The professional standard against which each is judged is the contemporary standard[6] required to be on the register, and not the standard at the point at which the individual may have first registered.

4. Revalidation Principles

4.1 Following the deliberations of the UK Non-Medical Revalidation Working Group, it was agreed that the principles of revalidation should be made explicit so that the regulatory bodies could use them to guide the development of models of revalidation. These twelve key principles reflect further discussions held with the regulatory bodies and are set out below. The principles are consistent with the Legislative and Regulatory Reform Act. Under each principle are further points for consideration when exploring how the principle is to be enacted.

Transparency

Principle 1 (Consistency) Models should be consistent with the Better Regulation Executive's five principles of good regulation**.**

Principle 2 (Professional Standards) The regulatory body for each profession should at all times set out the contemporary professional standards or competence, which registrants will have to meet in order to maintain registration. The standards or competence will determine the

[6] Contemporary standard – The standard that demonstrates that a practitioner is up to date in their specialty in order to be fit to practise within a contemporary healthcare setting. This is the fundamental standard necessary for public protection.

evidence that the regulator requires in order to decide whether a registrant meets it. Individual registrants will be responsible for submitting this evidence in order that a revalidation decision can be made. The regulatory body will determine the frequency of revalidation.

Issues for consideration:

- The need to ensure sufficient flexibility in standard setting to facilitate working across the diversity of employment environments within the UK;
- The need to develop guidance and clarity on the role of both the contracting body, employer and the individual in revalidation;
- In order to ensure equity for all registrants, the needs of those practitioners who do not practise within recognised employment frameworks such as the self-employed, need to be fully considered so they are still able to be revalidated;
- The need to decide how members of the profession not in active clinical practice should be revalidated (e.g. educationalists, policy advisors);
- The need to decide on what evidence registrants will be expected to provide in order to demonstrate that they meet the contemporary standard plus any relevant to their current scope of practise e.g. higher level practise where this is clearly defined;
- Whether issues such as declaration of cautions and convictions and vetting checks are a matter for on going registration rather than revalidation but also may be linked.

Principle 3 (Remediation) Where revalidation processes highlight performance concerns there should be scope for remediation of the professional but measures to secure public safety must remain paramount. Proposals should also reflect a common sense approach to supporting practitioners who return to practice after prolonged periods of sick leave, maternity leave, sabbaticals or who change sector of practice.

Issues for consideration:

- Proposals should define clearly what would happen if a registrant failed to meet the required standards in the revalidation cycle (because of prolonged absence or lack of competence) with the next steps for individuals and employers clearly stated. Clarity around when it would be appropriate for the regulator to intervene should be encompassed within this;
- Standards and guidance for employers will be required. It will be essential to have the employer's support for remediation where this is appropriate;
- Support related to the self-employed in accessing remediation;
- The need for a transparent assessment tool that will determine the nature of remediation and ensure that the practitioner understands clearly the areas in which they are deficient, the evidence that led to these decisions and the action required to address the deficiencies;
- If remediation fails, regulators need to be clear on next steps in relation to formal fitness to practise procedures;
- Models for revalidation need to take account of existing best practice for remediation and to accommodate this.

Accountable

Principle 4 (Patient and Public Involvement) A successful revalidation process must have the confidence of the public that it is appropriate, relevant and fit for purpose. The public and service users must be involved in and seen to be involved in the design and delivery of revalidation processes.

Patients and the public want to be treated by competent, skilled, up to date professionals. The involvement of patients and the public will greatly enhance the quality of the process of revalidation and help promote public confidence in healthcare professions. Patients and members of the general public need to be able to easily access the standards set by the regulators so that they know what to expect of the healthcare professionals looking after them. Patient feedback on practitioner performance is recommended where possible as it enables reflective care, and should be integral to good practice and revalidation as a part of a range of sources of evidence.

Patients and carers have a vital role to play in helping to define what counts as good healthcare, in identifying good professional practice and in drawing attention to unacceptable standards of care[7].

Issues for Consideration

- Lay input should develop patient and public confidence in the quality assurance of revalidation processes and the quality of information on which the process is based;
- The standards set must be understandable to the public, and as patients increasingly have care delivered by multiprofessional teams, consistency of standards will enhance confidence in the process. Example of standards applying across professional groups are:
    I. communication skills (listening, informing and explaining);
    II. involving patients in treatment decisions and patient consent;
    III. treating patients with dignity and respect.

Revalidation should routinely include feedback from patients and information from complaints systems.

Principle 5 (Continuing Professional Development) (CPD) This is the process by which individual registrants keep themselves up to date with healthcare developments in order to maintain the highest standards of professional practice. It should be seen as an integral part of revalidation and may provide supporting evidence that a practitioner submits to the regulatory

[7] Medical revalidation report
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_086430

body for consideration at the time of revalidation judgement. CPD needs to be relevant to the practitioner's scope of practise, where such scope has been defined.

Issues for consideration:

- The role of CPD should be made clear in terms of its contribution to a regulatory body's decision on whether or not the practitioner meets the contemporary standard for continued registration;
- The CPD system should not be based on a process (points collection, number of hours etc.) but on outcome measurement together with some audit of the adequacy/relevancy of the individual's programme.

Principle 6 (Quality Assurance) Quality assurance mechanisms must be built into revalidation processes.

Issues for consideration:

- Patient and public involvement and lay input should be incorporated into all aspects of quality assurance; it must be clear to the public how their input will be evaluated. Wherever possible, existing lay input mechanisms should be incorporated into this process;

- The ability to demonstrate on an ongoing basis that revalidation processes are valid, reliable and fit for purpose.

- Whether the role of employers in the system should be quality assured and accredited and if so at what level;

- When an employer is found not to have a satisfactory internal process to support revalidation requirements then alternative approaches must be introduced and an appeals mechanism identified;

- Consider agreed principles for quality assurance across all regulators.

Consistent

Principle 7 (Equality) Equality and diversity considerations must be evident in the development of all systems and processes.

Issues for consideration

- While equality and diversity considerations will inform the work and policy development of regulators generally, specific consideration will need to be given to how they will be brought to bear in development of revalidation processes. Impact Assessments (IA) should include specific consideration of equality and diversity (see Principle 12);

- The Disability Discrimination Act 2005,[8] reflects the need to acknowledge that some individuals may need to be treated/supported differently so that the desired outcome is achieved. Demonstration of equality of opportunity will be key. Revalidation processes may highlight a poor response to the legislative requirements to 'make reasonable adjustments' within practice.

Principle 8 (Integration) The implementation of clinical governance frameworks yields information on professionals' performance and practice. Where appropriate, effective connections need to be made between them and the system of revalidation. Appraisal processes, Knowledge and Skills Framework (KSF) development reviews - where these are available – and other evaluation systems should be seen as a parallel process to revalidation, carried out for different purposes. Information from these parallel processes may provide evidence that contributes to the regulatory body's decision on revalidation, but may also highlight a practitioner who is not practising at the required level and therefore allow early intervention before it becomes a fitness to practise issue.

Issues for consideration:

- KSF development reviews are only available to staff employed in the NHS and are linked to the current role and scope of practice of the practitioner. The group has therefore commissioned a feasibility study on the potential use of a model such as the KSF in revalidation both within and outside of the NHS;

- The potential use of the KSF development review model is currently being explored in the independent sector. However, consideration needs to be given to the alternatives to formal development reviews for those not employed in the NHS e.g. in the corporate healthcare sector or other managed environments or for the self-employed or those who move around frequently, i.e. temporary staff;

- Whether such alternatives should have common frameworks across the regulators;

- The need to acknowledge that not all appraisal systems are aligned with revalidation for example where they are concerned with achievement of commercial targets;

- Whether appraisal should be considered a cornerstone of good employment practice;

- The need for revalidation models must work across all employment situations.

Principle 9 (UK-wide) Revalidation arrangements should be consistent in outcome across the United Kingdom and required by all who work in the UK thus providing a basic standard of assurance for the public anywhere in the UK.

Issues for consideration:

- Under European legislation on recognition of professional qualifications (Directive 2005/36/EC), a qualification listed in one of the annexes to the Directive should be automatically recognised by other member states who have listed an equivalent

[8] http://www.opsi.gov.uk/Acts/acts2005/ukpga_20050013_en_1

qualification. The requirement for CPD or revalidation cannot be made a condition for recognising the qualification. Once the person is registered as a UK registrant they can however be expected to meet the same conditions as other registrants for staying on the register, so can be obliged to do whatever their UK peers have to do to stay on the register. The development of revalidation schemes in the UK needs to be communicated to competent authorities in other jurisdictions in order to facilitate increasing mutual recognition of qualifications for a more mobile professional population serving a correspondingly mobile patient base.

Proportionate and Targeted

Principle 10 (Demonstrating Benefits – effective in confirming fitness to practise) The structures and processes surrounding revalidation should knit together in a coherent, unbureaucratic and proportionate manner to ensure that resources invested yield valid and reliable outcomes together with the anticipated benefits to service users and health professionals.

Issues for consideration:

- Models for piloting recommendations should be developed by the regulator(s) and should include proposals for evaluation of the pilot at relevant stages of the process if required;

- Whether analysis of data on the benefits to service users could be used or whether the numbers of successful/unsuccessful practitioners through revalidation would be a more practical measure;

- Whether the analysis and evaluation should be based on the risk from the specific profession or be on an agreed quality assurance framework across regulators.

Principle 11 (Information) The nature of the information required by each regulatory body will be based on their risk profiling of their registrant groups and should be undertaken systematically. The frequency and breadth/depth of evidence each regulator requires information on and the evaluation/assessment methods used will be based on the assessed potential risk posed by practitioners to patients and the public. Regulators should work towards valid and robust risk profiling of their registrant groups to inform this process. The nature of the information required will depend on the value the information adds when making an assessment against standards and in reaching revalidation decisions that are just and defensible.

Issues for consideration:

- Consideration should be given to those groups who undertake elements of advanced practice as to whether they have additional revalidation requirements placed on them. Advanced practice is discussed in more detail at paragraph 5.3;

- How should intensity be defined? Is it meant to indicate that some professions, or indeed subsections of professions, may require a full performance assessment in order to revalidate and others will rely on a knowledge test or self-certification and others will rely solely on appraisal?

- Clarity on the accountability and responsibility of employers and contracting organisations is required;

- Clarity on the accountability and responsibilities of professionals is required.

Principle 12 (Introduction) The introduction of revalidation should be incremental. This will enable proper piloting and effective preparation and will avoid overburdening regulatory bodies, professionals and employers with the process of implementation. The timetable for comprehensive implementation should be known at the outset.

Issues for consideration

- Piloting should be with a representative sample of registrants and not focus solely on areas/sectors where revalidation would be easiest;

- An impact assessment will be required from the regulatory bodies[9]

5. General themes for consideration.

5.1 Harmonisation

- Where appropriate, common standards and systems should be developed across professional groups. In particular, this should encompass common and shared competences relating to specific aspects of direct care delivery e.g. prescribing, as well as common systems and standards for regulators such as those described on page 10, communication skills, involving patient in treatment decisions and treating patient with respect and dignity.

- The extent to which attempts are made to harmonise high-level principles should be determined by the principles of regulation. To ensure public protection, there will be areas/occasions where harmonisation is not appropriate;

- Whether CPD requirements should be standardised across regulators.

[9] Guidance on impact assessment to be found http://www.berr.gov.uk/bre/policy/scrutinising-new-regulations/preparing-impact-assessments/page44077.html

5.2 Impact of multidisciplinary teams

- Care is increasingly being delivered in multiprofessional teams and team members will be contributing to each other's revalidation processes through the use of team performance data. This will not be prevalent in professions like osteopathy for example where practitioners are mainly engaged with patients on an individual basis in private practice.

- There is increasing patient awareness that treatment is delivered by teams and of the benefits of this rather than sole professionals. There is a need to ensure that regulation allows the standards of teams to be set and understood by patients.

5.3 Advanced practice

- There is currently no agreed definition of advanced practice that applies across professions. This was recognised by the recent report *A High Quality Workforce – NHS Next Stage Review,* which proposed work with CHRE and the professional regulators "to ensure a consistent definition of advanced practice across the health professions"[10]. It is recommended that the observations in the following bullet points are taken into account in that work;

- If a level of "advanced practice" is recognised by a regulatory body, this must be on the grounds of public protection alone and not for professional recognition/enhancement;

- Systems surrounding the sign-off process (i.e. who signs off, how is the process structured, how are uni-professional considerations resolved if harmonisation of processes, as well as principles is the aim) need to be agreed;

- How will revalidation link to the recognition of advanced practitioners by employers who are not recognised as advanced by the regulator (e.g. practitioners with special interests or those carrying out expanded scopes of practice)?

- Where a practitioner for example practises against a set of standards that are normally associated with the primary practice of another professional group e.g. a nurse who practises endoscopy or a podiatrist who practises foot surgery, then the distributed model of regulation could apply if implemented. What implications would this have for revalidation? Would the nurse or podiatrist be required to meet the standards and revalidation requirements set by the lead regulatory body for the original profession? Would regulatory bodies accept the standards of others?

5.4 General point

- Regulators should identify any legislative constraints related to the introduction of revalidation for their registrants and discuss with UK-wide Health Departments at the earliest opportunity.

[10] A High Quality Workforce – NHS Next Stage Review, Department of Health, June 2008, para 54.

6. Challenges to implementation

6.1 There are six main areas that could challenge implementation as referenced in the medical revalidation report[7]:

Logistic: large numbers of healthcare professionals need to be covered by the revalidation schemes, which need to encompass a great diversity of groups, roles and practice settings. The numbers involved in non-medical revalidation will be greater than one million and the scope of practice varies significantly even within discrete professional groups.

Methodological: valid, reliable, proportionate and fair systems still need to be designed in all areas to set standards and to assess practice against them. Proportionality is essential and a one-size fits all approach should be avoided.

Connections: many systems and organisations examine the quality of healthcare in the NHS and throw light on professionals' performance and practice. Where appropriate, effective connections need to be made between them and the system of revalidation.

Information: high quality data is vital to effective assessment of practice and although these may have been lacking in the past in some areas they must be developed. This might be outcome data or other measures could be used.

Cultural: revalidation should be seen primarily as supportive, focussed on raising standards, not a disciplinary mechanism to deal with the small proportion of health professionals who may cause concern. The involvement of patients and the public at all stages will greatly enhance the quality of the process of revalidation and help promote public confidence in the profession itself. Careful consideration needs to be given to how patients and the public can be involved meaningfully.

Resources: revalidation will require considerable investment to develop, including potentially advanced expertise in assessment. There may be an adverse reaction from both professional groups and employers if packages of revalidation are resource intensive. Implications for registration fees would need to be handled carefully in such circumstances. To what extent will employers be able to provide additional resources for non-medical revalidation and in particular remediation? In the case of contractor professions, what funding will be needed by the primary care groups to ensure revalidation can be taken up?

7. Next Steps

7.1 The council's of the regulatory bodies will consider the report now that the non-medical working group has completed the work on the high level principles that will guide the

[7] Medical revalidation report
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_086430

work. The regulatory bodies will develop models of revalidation that both meet the needs of the profession and the public and will report in January 2009. This work will be influenced by the two pieces of commissioned research outlined below.

7.2 The commissioned research on the use of a model such as the KSF will be completed and the outcomes circulated to the regulators and those working in non-NHS settings for consideration.

7.3 The commissioned research on decision-making based on risk and proportionality will be circulated to the regulatory bodies for their consideration.

7.4 The regulatory bodies will come back with proposed models for piloting including recommendations and early discussion of evaluation in order to get robust baseline data prior to piloting any new systems. Proposals will need to work for health professionals in non-NHS sectors, research, teaching and private sector health provides.

7.5 These high-level principles will now be shared with the Working Group for Medical Revalidation with a view to cross-professional endorsement.

7.6 As proposed by *A High Quality Workforce – NHS Next Stage Review,* The Council for Healthcare Regulatory Excellence will be asked to work with the Department of Health, the Regulatory Bodies, the Devolved Administrations and other key stakeholders to agree on the definition and criteria for recognition of advanced practice.

Annex A – Trust, Assurance & Safety

EXTRACT FROM TRUST, ASSURANCE AND SAFETY – THE REGULATION OF HEALTH PROFESSIONALS IN THE 21ST CENTURY
(Chapter 2, pp 37 – 41)

Revalidation for the non-medical healthcare professions

2.29 'The regulation of the non-medical healthcare professions' review endorsed the principle of revalidation for these professional groups as well. **The Government endorses the recommendations in this review.** 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.**

2.30 **The Government agrees that the regulatory body for each non-medical profession should be in charge of approving the standards which registrants will need to meet to maintain their registration on a regular basis. Where appropriate, common standards and systems should be developed across professional groups where this would benefit patient safety. The Department will ask the Council for Healthcare Regulatory Excellence (CHRE) to work with regulators, the professions and those working on European and international standards to support this work. This will encompass the development of standards for higher levels of practice, particularly for advanced practice in nursing, AHPs and healthcare scientists The Department will discuss with the Nursing and Midwifery Council the outcome of their consultation on advanced nursing practice to agree next steps.**

2.31 There are some non-medical professional staff, such as clinical scientists, who undertake higher specialist training and practise for most of their careers at a specialist autonomous level. **The Department will work with the Devolved Administrations to establish a short-term working party to consider how regulation and revalidation should reflect this**

2.32 Professionals will fall broadly into one of three groups for revalidation in England:

- **for employees of an approved body, for example, nurses, dietitians or paramedics working in an NHS organisation or a licensed private or independent sector provider, evidence to support revalidation will be provided as part of the normal staff management and clinical governance systems, with employers providing recommendations to the professional regulators;**

- **for those, including self-employed contractors, performing services commissioned by NHS primary care organisations (such as dentists or optometrists), the revalidation processes will be carried out under the supervision of either the NHS commissioning organisation or, particularly where it is necessary to take an overview of both NHS and private work, the regulatory**

body, but in either case with appropriate collaboration between the two bodies; and

- **for all others, for example, osteopaths, their regulatory bodies will develop direct revalidation arrangements.**

2.33 **The responsibility for revalidation arrangements for professionals directly employed by primary care contractors, for example practice nurses or dental hygienists, will be discussed with the relevant professions and regulators.**

2.34 **The Government agrees that the appraisal process within the NHS, which will be a central component of revalidation, should be both formative and summative, to ensure objectively that required standards are met. Information gathered under the Knowledge and Skills Framework should be used as far as possible as the basis of revalidation, with any additional requirements justified by risk analysis. As these measures will require the introduction of summative elements to assessment, the Department will discuss these proposals with the Devolved Administrations, the relevant regulators, NHS employers, trades unions and others with an interest to ensure this is proportionate, fair and appropriate.** As far as possible, the agreement of such arrangements should be professionally led, provided that they secure adequate objective assurance to patients and the public that they give appropriate safeguards to the maintenance of high professional and clinical standards. Scotland, Wales and Northern Ireland will consider how they wish to take this forward within their particular contexts.

Ensuring effective systems for revalidation

2.35 For all health professionals, including doctors, it will be important to ensure that the organisations, whether providers or commissioners, responsible for their revalidation are doing so in a sufficiently rigorous and fair manner to ensure patient safety and fair treatment of health professionals. **In England, the Department will include the capacity of organisations to carry out this role as a core component of the standards against which organisations are judged when they are granted their licence to operate by the new national system regulator (Care Quality Commission).** As with the current arrangements, this is likely to be based on evidence-based self-assessment, validated through risk-based audit and investigation where concerns are identified. The Devolved Administrations will consider how to address this within their particular contexts.

Introducing revalidation

2.36 The Secretary of State commissioned CHRE to provide advice on the issues that needed to be considered in implementing revalidation arrangements for health professionals. Their main findings are that:

- there is general support for the concept of revalidation, and the most important issue is how to implement it;

- the Department needs to consider carefully the additional responsibilities placed on local organisations, to avoid overloading them; and

- the implementation of revalidation should be sufficiently flexible to take account of the diversity of employment environments across the UK.

2.37 The Department welcomes this advice. The introduction of a new appraisal and revalidation system covering all health professionals in the UK needs to be piloted thoroughly, managed carefully and phased in over time to ensure that it works well, that it works fairly and that it enables employers and commissioners to put in place the capacity and capability needed to make it work well. The setting of standards by the professions themselves will take time, thought, piloting and consultation. The Government is resolved that these changes should be introduced, but is equally determined that they should be introduced in a way that does not place unmanageable burdens on employers, staff or resources.

2.38 **The Government will discuss with the Devolved Administrations and with public, private and voluntary sector employers the development of an affordable and manageable timetable for the effective implementation of revalidation.** This will reflect the state of readiness of each profession to deliver robust revalidation processes; the impact revalidation would have on diverting frontline staff from direct patient care; the capacity of regulators and employers for each professional group; the level of public concern about professional standards within each professional group; the risks inherent in the care provided by each professional group; the numbers of professionals working in each professional group, including the proportion of self-employed; the ability of practitioners taking career breaks, maternity leave and other absences from practice to engage with these processes; and the particular circumstances in Scotland, Wales and Northern Ireland.

Conclusion

2.39 The measures set out in this chapter will provide the objective assurance that the public now expect to underpin their trust in health professionals. The measures are framed in a way that is proportionate to the risk inherent in each professional group and designed to assure patient safety in relation to that risk. The Department believes that revalidation should be professionally led and proportionate and will work with the regulators for each profession to ensure that this is the case. It will be a complex undertaking to create workable and appropriate detailed arrangements for each profession involved and it will be important to develop and adapt these proposals to ensure effective implementation. **Therefore, a United Kingdom Revalidation Steering Group will be established to develop and co-ordinate this work.**

Annex B - Group Membership

NON-MEDICAL REVALIDATION UK WORKING GROUP MEMBERS

Organisation represented		Name	Title
1	University of Sunderland Department of Health	Professor Jim Smith Gavin Larner	Chair (2007); Professor of Pharmacy Practice and Policy, University of Sunderland Chair (2008); Director of Professional Regulation, DH
2	General Chiropractic Council	Margaret Coats	Chief Executive and Registrar
3	General Dental Council	Carol Varlaam	Lay Member; Chair, Revalidation Working Group
4	General Medical Council	Una Lane	Assistant Director, Revalidation
5	General Optical Council	Jon Levett	Director of Standards
6	General Osteopathic Council	• Vince Cullen • Evlynne Gilvarry	Head of Development Chief Executive and Registrar
7	Health Professions Council	Anna van der Gaag	President
8	Nursing and Midwifery Council	• Kathy George • David Hutton	Director of Standards and Registration Professional Adviser, Revalidation
9	Royal Pharmaceutical Society of Great Britain	• Dr Peter Wilson • Andreas Hasman	Head of Post Registration Division Policy Coordinator
10	Pharmaceutical Society of Northern Ireland	• Brendan Kerr • Dr Deirdre McAree	Registrar and Head of Professional Services Post Registration Facilitator (2008) PSNI lead for Revalidation
11	Dept. Health (England)	Sue Hill	Chief Scientific Officer
12	Dept. Health (England)	Karen Middleton	Chief Health Professions Officer
13	NHS Employers	Alastair Henderson	Deputy Director
14	NHS Staff Council,KSF Group	Gary Theobald	Employer Side Chair, KSF Group of the NHS Staff Council
15	Prime R&D Ltd	Lindsay Mitchell	Consultant
16	Council of Deans for Nursing and AHPS	Paul Turner	Chief Executive
17	SHA Workforce Lead	Peter Blythin	Director of Nursing and Workforce
18	Independent Healthcare Advisory Services	Sally Taber	Chief Executive
19	Public/patients representation	Kate Webb	Senior Policy Analyst, CHRE (Principal Policy Adviser, Which?, to June 2008)
20	Public/patients representation	Judy Wilson	Independent Consultant
21	Scottish CNO	Paul Martin	Scottish CNO
22	Scotland	Audrey Cowie	Professional Adviser

	Organisation represented	Name	Title
23	Wales	• Barbara Bale • Mary Gilbert	Head of Workforce Policy Development and Commissioning Regulation and Education Project Lead
24	Northern Ireland	Joyce Cairns	Deputy Director HR
25	MOD	Jerry Tuck	Defence Medical Services
26	BDA	Graham Brown	Chair, Education Committee
27	RCM	Louise Silverton	Deputy Secretary General
28	Federation of Ophthalmic and Dispensing Opticians	Paul Carroll	Director of Professional Services
29	Allied Health Professionals Federation	Ralph Graham	Chair, Allied Health Professionals Federation
30	CHRE	Douglas Bilton	Project Manager

Annex C – Terms of Reference

To consider the recommendations in *Trust, Assurance and Safety* on non-medical revalidation and to develop proposals for the timely, effective and affordable introduction of a revalidation system for these groups. Working closely with the medical revalidation and education-working group, Chaired by the Chief Medical officer, the group will, in particular, consider and make recommendations on:

- A clear definition of revalidation across medical and non-medical working groups to ensure commonality of understanding and language
- The scope, structure and processes for revalidation for all statutorily regulated non-medical health professionals, paying particular attention to how these interact with existing clinical governance/ risk systems
- What revalidation will mean in terms of post-registration (advanced or higher level practice)
- A process for establishing common standards across the regulators and clarifying where this is not appropriate
- The use of information systems to collect data that might be used for appraisal and revalidation, and how to overcome problems around confidentiality and data protection issues
- Effective appraisal processes (both formative and summative) and clarifying the role of the Knowledge and Skills Framework in revalidation
- Revalidation and appraisal processes for health professionals working in non-NHS sectors, e.g., research, teaching and private sector health providers
- Models for Continuing Professional Development and demonstrating how they fit in with formative and summative processes for appraisal
- Models for piloting recommendations made by the group and early discussion of evaluation in order to get robust baseline data prior to piloting any new systems
- The consequences of failed revalidation in terms of systems and support and how this would work with fitness to practise procedures
- The timetable for the introduction of new processes within the 5 year window

The group will liaise with other working groups and establish its own sub-groups where appropriate to examine matters in more detail.

Appendix: Prospective timetable for completion of the recommendations

2009/2010 and ongoing – Further analysis of fitness to practise data to explore correlations between age, gender, location of practice and fitness to practise.

2009/2010 and ongoing – Analysis of the outcomes of the CPD audits currently being conducted.

2009-2011 – Retrospective study: fitness to practise and student conduct.

2009-2014 – Prospective study: pilot of professionalism tool.

2010-2012 – Prospective study: pilot of patient feedback tool.