Council, 29 March 2012

Revalidation

Executive summary and recommendations

Introduction
At its meeting in December 2011, the Council discussed the outcomes of one of the revalidation research projects. An appendix was also included with that paper which provided a brief update about the revalidation programme of work. The appendix said that a further report would be brought to the Council 'drawing together the completed research reports, and reflecting on changes in the policy environment since the programme of work was agreed'.

Whilst no specific decisions are required, the purpose of this paper is to bring to the Council's attention the revalidation policy context; to highlight the on-going work; and to stimulate discussion about this area.

Decision
The Council is invited to discuss the attached document. No specific decision is required.

Background information

- 'Revalidation: Service user involvement, Council meeting, 6 December 2011
  http://www.hpc-uk.org/aboutus/committees/archive/index.asp?id=537

Resource implications
None as a result of this paper.

Financial implications
None as a result of this paper.

Appendices
None

Date of paper
19 March 2012

Revalidation

1. Introduction

1.1 Revalidation is the concept that registered professionals should be subject to some kind of periodic check to ensure that they continue to remain fit to practise beyond the point of initial registration.

1.2 This paper provides the Council with a more detailed update about the HPC's programme of work looking at revalidation.

1.3 This paper includes:

- a summary of the policy context to revalidation; and
- a summary of the outputs and outcomes of the work to date.

2. Background and context

2.1 The question of how regulators should best ensure the on-going fitness to practise of their registrants has been on the policy agenda for some time. This section provides a short summary of some key areas.

- In 2006, the government published the outcomes of a review of the regulation of 'non-medical professions'. This concluded that revalidation was necessary for all professionals; that it should be both formative and summative; build on existing clinical governance systems for those employed in managed environments; and be proportionate and risk-based.[1]
- In 2007, the government published the White Paper 'Trust, Assurance and Safety – The regulation of health professionals in the 21st Century' which said that revalidation was necessary for all health professionals but that 'its intensity and frequency need to be proportionate to the risk inherent in the work in which each practitioner is involved' (paragraph 2.29).[2]
- In response to the publication of the White Paper, the Continuing Fitness to Practise Professional Liaison Group (PLG) was established to explore and make recommendations in this area. The conclusions reached were as follows.[3]

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[1] Department of Health (2006). The regulation of the non-medical healthcare professions. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4137239

[2] Department of Health (2007). Trust, assurance and safety – The regulation of health professionals in the 21st century http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_065946

[3] Health Professions Council (2009). Continuing Fitness to Practise: Towards an evidence based approach to revalidation. http://www.hpc-uk.org/publications/research/index.asp?id=207

- 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.

- Alongside the PLG's work, the HPC was represented on a Department of Health working group looking at the implementation of 'non-medical revalidation'. In 2008, the DH published a set of principles for revalidation based on the group's discussion. The Executive produced a document outlining how the HPC's existing systems met those principles.[4]

- The Command Paper 'Enabling excellence' outlined the government's continued support for medical revalidation, but for other professions said that it had an 'open mind', acknowledging that there was a 'wider spectrum of risk' and that therefore a 'one-size fits all' approach would not be appropriate. The cost of revalidation was also acknowledged. The regulators were to continue to develop the evidence base for their revalidation proposals. The government would agree next steps for implementation 'where there is evidence to suggest significant added value in terms of increased safety or quality of care for users of healthcare services'. [5]

- In 2011, the General Chiropractic Council (GCC) concluded that, having undertaken a consultation on a proposed revalidation model, it could not demonstrate 'significant added value'. 'In reaching this decision, the GCC took into consideration evidence that the practice of chiropractic is low risk in terms of potential harm, and the majority of the fitness to practise concerns considered by the GCC concern misconduct by chiropractors rather their lack of competence in chiropractic and therefore would not be

[4] http://www.hpc-uk.org/aboutus/committees/archive/index.asp?id=415 (enclosure 16)
[5] Department of Health (2011). Enabling excellence: Autonomy and accountability for healthcare workers, social workers and social care workers. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_124359

undertaking any further work on revalidation.'[6] The GCC has since discussed this with the DH who have: '…made it clear that it expects regulators to be able to assure themselves, members of the public and patients, that registrants are fit to practise and up to date. This means setting-up a process that measures 'outcomes' and is not based on self-assessment.'[7]

- The Law Commission's on-going consultation on the regulation of health and social care professionals proposes that the regulators should be given discretionary rule making powers for revalidation, subject to impact assessment and consultation.

[6] CHRE performance review 2010/2011
http://www.chre.org.uk/satellite/402
[7] General Chiropractic Council (2011). News from the GSCC, August 2011.
http://www.gcc-uk.org/page.cfm

3. HPC's programme of work on revalidation[8]

3.1 In 2009, the HPC was awarded a grant of £360,000 to undertake further work to explore the evidence which will inform any revalidation system and to explore the potential feasibility of possible models of revalidation. The funding was not to be used to pilot, introduce or maintain a revalidation process.

3.2 The programme of work which would be delivered using the Department of Health grant was outlined in detail in a Council paper in December 2009. The work was based on the recommendations for further research outlined in the Continuing Fitness to Practise report. The areas for further research outlined in that report were as follows.

- 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 preregistration 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).

3.3 Our understanding from discussion with the Department of Health at that time was that they wished to be assured that any processes the HPC has or will put in place:

- represent a positive affirmation of fitness to practise, supported by appropriate external verification;

- command public confidence and demonstrate benefit to members of the public; and

[8] http://www.hpc-uk.org/aboutregistration/revalidation/

- are proportionate to the available evidence of risk.

3.4 The specific projects proposed in December 2009 were focused either on a) increasing understanding of the different levels of **risk** posed by our registrants and the robustness of our current systems; or b) exploring the **feasibility** and **costs** of different processes.

3.5 Sections 4 to10 outlines each project describing the rationale for the project; and the key findings, observations and/or conclusions as a result. (Please note: some projects have been removed and others have changed in scope since the Council agreed the programme of work in December 2009. This has previously been reported to the Council.)

4. Review of existing revalidation processes that have been implemented by international regulators

4.1 In 2010, a visit was undertaken to Ontario, Canada to find out more about the 'quality assurance (QA) programmes' put in place by five regulatory colleges regulating professions within the HPC's remit. These arrangements were similar to what has been proposed for revalidation but were aimed at improving standards.

4.2 These programmes typically involves a three stage process which is risk-based and proportionate in that the level of scrutiny increased, and the number of registrants decreased, at each stage. They typically included the following.

- Professional development. This included requirements to maintain a CPD portfolio including completing self-assessments and professional development plan to identify strengths, weaknesses and learning and development needs. They sometimes included specific tests; reflection tools; and/or compulsory CPD subjects or modules.

- Practice assessment. This included a sample of registrants undergoing specific tests of professional skills or peer assessments at an assessment centre or by peer assessors in the workplace.

- Practice enhancement. This included arrangements for remediating registrants who did not meet the requirements in practice assessment.

Key findings, observations and conclusions

- The arrangements in Canada were focused on 'quality improvement' – enhancing and improving the practice of all registrants. This raised the question of whether, for the HPC, the aim of revalidation should be ensuring that threshold standards are met; and/or increasing the standard of all registrants.

- In their evaluation of their QA programmes, the Canadian regulators had found general support amongst registrants. There was limited evidence to support a definitive link between the programmes and the outcomes of improved public protection or improved patient experience. However, we

acknowledged that this limitation applied to other aspects of regulators' activities, and that arguably the benefits may not be clear until piloting is undertaken.

- The costs associated with these approaches to revalidation could be significant – amongst the regulators studied, the QA programmes accounted for about 10% of operational costs. We estimated development and implementation costs of £500-£800,000 if we introduced similar processes and on-going costs of upwards of £500,000; considerably more if a practice-based assessment was introduced.

- A number of other areas were identified which might be considered further, including the following.

    - Sampling techniques to check compliance with CPD requirements.
    - Compulsory or prescribed CPD subjects.
    - Multi-source feedback tools as a way for registrant's to identify their learning needs.

5. Review of existing revalidation processes that have been implemented or are being developed by other UK regulators.

5.1 This project involved reporting on the existing revalidation processes that have been implemented or are being developed by other UK regulators.

5.2 Overall, there were a variety of different approaches being adopted by the different regulators. The regulators were also at different stages – with some conducting further research; some piloting proposals; and others nearing implementation. A report was produced which described the activities of the regulators up to the end of August 2011.

Key findings, observations and conclusions

- The regulators had conceptualised risk differently. This included risks associated with individuals (e.g. relative inexperience in a particular area) and situations (e.g. lone working). One regulator concluded that the risk of harm from practice was low, focussing instead on 'sub-optimal outcomes' – situations where the outcome for a service user is not the best outcome.

- A variety of different approaches were adopted in research examining risk including economic modelling; literature reviews; surveys of registrants; and analysis of complaints data. For most regulators, the research was based on reasonably homogenous practice in a single or small number of similar professions.

- In the proposed revalidation schemes, the outcome of revalidation was linked to continued registration – failure or a failure to participate would lead to removal from the register. For most regulators the anticipated approach to regulation was to be based on the threshold standards required for entry to the Register.

- Most of the regulators were proposing a phased revalidation process by which the level of scrutiny of registrants increased at each stage.

- All of the regulators are considering the role that CPD plays in revalidation. For some regulators, enhancements to their CPD requirements form a central part in their revalidation proposals.

- Some of the regulators have explored whether they can use appraisal systems already in place to support revalidation, with different conclusions reached dependent on how developed appraisal is within a given profession.

- Professionalism and conduct, as well as matters related to technical competence, feature in some of the revalidation proposals.

6. Professionalism in healthcare professions - qualitative study undertaken by Durham University

6.1 This study looked at three professions across four different education providers: paramedics (2); occupational therapists (1); podiatrists (1). The research sought to explore what is perceived as professionalism by both students and educators and why and how professionalism and lack of professionalism may be identified. This involved focus group research. 20 focus groups were held with 112 participants.

6.2 The research was precipitated by the observation in the Continuing Fitness to Practise report that, based on fitness to practise data, conduct appeared to be a greater risk than competence. It was further observed that there was some evidence in the medical profession that confirmed a link between conduct during pre-registration education and training and subsequent fitness to practise action. It was suggested that ‘a clearer understanding of the potential link between poor conduct during pre-registration education and training and subsequent fitness to practise action would be helpful here in directing our efforts to the area of greatest risk’.

Key findings, observations and conclusions

- The term professionalism was ‘not easy to define’. Participants’ interpretation of professionalism was varied and was conceived as both a holistic concept (‘doing the job well’) and as a multi-dimensional, multi-faceted concept covering aspects such as professional identity, professional attitudes and professional behaviour. This covered things such as communication and appearance.

- Regulation was seen as providing basic guidance, providing a baseline for behaviour rather than a specification.

- Professionalism had a basis in individual characteristics and values, but was defined by context including factors such as the following.

    - Organisational support.
    - The workplace.
    - Expectations of others (including role modelling).
    - Specifics of each service user / patient encounter.

- Views of participants did not diverge widely in the study, regardless of professional group, training route or status as a student or educator.

- Participants saw professionalism or professional behaviour as being the result of interaction of practitioner, service user and context, requiring situational judgement. Rather than a set of discrete skills, professionalism is instead a 'meta skill', knowing about what is most appropriate in a specific situation, drawing on appropriate technical and practical skills.

- The research suggests that one approach to the lack of a clear definition of professionalism may be to recode professionalism simply as using 'appropriate behaviour' in relevant communication and technical skills. It is suggested that educators might focus on professionalism by seeking to raise awareness of and increase students' capacity for making professional judgements.

7. Service user feedback tools - literature review and Delphi consultation exercise undertaken by the Picker Institute Europe

7.1 This study involved a literature review to explore 'standardised instruments' developed to gather service user feedback for the professional groups regulated by the HPC. A Delphi consultation was also undertaken to identify areas of consensus on the use of service user feedback between individuals from professional bodies representing the professions regulated by the HPC.

7.2 This project was precipitated by the observation in the Continuing Fitness to Practise report that multi-source feedback from patients and colleagues was being trialled as a source of evidence for the General Medical Council's revalidation proposals. It was also observed that some kind of patient feedback measure 'could have the potential to provide structured, regular, external input and verification, which is currently missing from the existing HPC processes'. This project was therefore about the feasibility of such a tool as part of a revalidation process.

Key findings, observations and conclusions

- There were relatively few instruments found relating to HPC professions. They looked at areas of practice such as communication and respect for privacy.

- Further evidence of the validity and reliability of standardised instruments is needed. Some evidence from the use of feedback instruments for doctors highlights some challenges in applying the instruments.

- Any approach to obtaining feedback for HPC professions must be tailored to the professional group and, where appropriate, sub-sets of the professional group, and be designed according to judgements about the capacity and willingness of a particular service user group to respond to a particular form of assessment.

- Existing instruments such as the CARE measure should be built upon.

- There was limited evidence of a clear link between the standardised instruments identified in the research and improved professional practice. More needs to be known about the long-term effectiveness of the feedback process and mechanisms for effective formative feedback.

- The Delphi consultation revealed support for the proposition that service users could have a valuable perspective on professional practice, and, with the caveat that good systems were in place, could be useful to inform developments in professional feedback. There was less consensus on the proposition that benchmarking against peers was helpful.

- The overall conclusion was that although the case for measuring service user feedback is 'strong, the systems to do so are as yet imperfect and must continue to be developed in ways that accommodate the wide variety of contexts and service user groups encountered by HPC registrants'.

8. Professionalism tool - quantitative study undertaken by Durham University to measure professionalism and track students after graduation

8.1 This project is related to the qualitative study: 'Professionalism in healthcare professions.' This is five year study concluding at the end of 2014/2015. An annual progress report will be a paper to note at a future Council meeting.

9. Fitness to practise multi-variant analysis – data analysis undertaken by a researcher at Oxford Brookes University

9.1 This study is looking at data from registrants who have reached a final fitness to practise hearing and where a sanction has been applied. It is a multi-variant analysis – looking at the characteristics of registrants reaching final hearings and whether there are relationships with variables such as age, gender and route to registration.

9.2 The analysis is nearing completion and we anticipate presenting a paper to the Council's meeting in May 2012.

10. CPD audit analysis – data analysis undertaken by a researcher at Oxford Brookes University

10.1 This study is looking at multi-variant analysis of CPD audit data looking at correlations between outcomes and variables such as age, gender and place of registration. This also includes collecting data from CPD profiles on location of practice to examine whether there is a link with outcomes. The analysis is being undertaken by a researcher at Oxford Brookes University.

10.2 This analysis has yet to commence as further work was necessary to gather and fulfil data requirements for the fitness to practise analysis. We are currently undertaking work to check whether our data requirements can be fulfilled through existing reporting.

11. Discussion

11.1 This paper aims to update the Council and to stimulate discussion on the on-going programme of work exploring revalidation, in particular, any emerging conclusions and whether there are any additional areas of research that should be considered.

11.2 The following are some observations based on the findings and conclusions summarised in this paper. They are not intended to be exhaustive.

- The external policy context has changed since the programme of work was commenced. The government has set out its overall commitment for revalidation but with an 'open mind' and a focus on evidence of 'significant added value'. The revalidation proposals of the General Medical Council and Nursing Midwifery Council (NMC) have recently been scrutinised and criticised in some areas by the Health Select Committee.[9]

- The HPC has registered two new groups since the Continuing Fitness to Practise report was published in 2008 (practitioner psychologists and hearing aid dispensers) and social workers in England will shortly become HPC registered.

- A key question continues to be the purpose of revalidation – namely whether it is aimed at quality control (identifying poorly performing registrants who are not being identified through the fitness to practise process); at quality improvement (improving the standard of practice for all); or a combination of both. This has implications for the standards that would be set and used for any revalidation process.

- The Continuing Fitness to Practise report noted (in a similar fashion to the GCC) that conduct issues were far more prevalent in fitness to practise cases, questioning whether it would be possible to revalidate this area. The professionalism research seems to support this in that professionalism was revealed to be a complex 'holistic concept' which was the product of the interaction of many different variables, of which the individual was just one.

- Where data is available, the costs involved in establishing and maintaining a system of revalidation appear to have the potential to be significant (although this would be dependent on the exact detail of any proposed scheme).

- The place of CPD in any revalidation system is still under debate across the regulators and, for some regulators, introducing mandatory

[9] http://www.parliament.uk/business/committees/committees-a-z/commons-select/health-committee/news/11-07-26-nmcreportpublished/

CPD or enhancing the CPD requirements already in place forms the basis for revalidation. The CHRE noted this in their 2010/2011 performance review, saying that this may be a ‘proportionate and cost-effective approach’ but that: ‘Current CPD arrangements are not equivalent to revalidation and do not provide the same level of assurance to the public.’

11.3 The Council is not invited to reach any definitive conclusions on the substance of revalidation at this meeting and a further paper will be brought to the Council on the conclusion of the two remaining research projects.