Council, 2 July 2014

Research briefs

Executive summary and recommendations

Introduction

Three research briefs are attached which appeared on the agenda of the Education and Training Committee at its meeting on 5 June 2014. They are as follows.

- The Department of Health invitation to tender document looking at the costs and benefits of the HCPC's approach to continuing fitness to practise. The Council has been previously advised of this project. This is a Department of Heath funded project.

- Interprofessional education. This research forms part of the forthcoming review of the standards of education and training.

- Perceptions and experiences of the HCPC's approach to CPD standards and audits. This research forms part of the on-going work to consider issues around continuing fitness to practise.

The Committee approved the briefs listed at the second and third bullet points above, subject to minor editing amendments.

Decision

This paper is to note.

Background information

The full papers considered by the Committee on 5 June 2014 are available here. http://www.hcpc-uk.org/aboutus/committees/educationandtraining/

Resource implications

Resource implications include commissioning the research and supporting the appointed research team. These are accounted for in planning for 2014-2015 and will be included in planning for 2015-2016.

Financial implications

The financial implications are the cost of the HCPC research projects. These are accounted for in budgeting for 2014-2015 and will be included in budgeting for 2015-2016.

Appendices

As described.

Date of paper

18 June 2014

Invitation to tender

Department of Health Policy research programme

An examination of the costs and benefits of a regulatory approach to the assessment of continuing fitness to practise of health and care professionals

Introduction

1. The Department of Health invites full applications for a single project to gather evidence on the costs, outputs, outcomes, benefits and impact of a system designed to assure the continuing fitness to practise[1] of health and care professionals. The research will examine the system put in place by the Health and Care Professions Council (HCPC), a regulator of 16 professions across health and social care.

2. There will be a single stage tender process. Funds of up to £175,000 are available to support this work.

Background – continuing fitness to practise

3. 'Revalidation' has been used to describe the process by which health and care professionals are required to demonstrate periodically that they are fit to practise and should remain registered. The debate about 'revalidation', particularly in the medical profession, has had a long history. The more recent history relevant to the regulation of the health and care professions is outlined here.

4. In 2007, 'Trust, Assurance and Safety – The regulation of Health Professionals in the 21st Century' set out proposals for the revalidation of the medical profession. The following conclusion was reached about the 'non-medical healthcare professions'.

   '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.' (Paragraph 2.29, page 41) [2]

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[1] Continuing fitness to practise is used here and throughout this document to refer to the outcomes of activities used by regulators to periodically assure themselves that their registrants continue to meet their standards beyond their initial registration. This term is used by the Professional Standards Authority to describe the outcome that revalidation and other activities seek to achieve. http://www.professionalstandards.org.uk/docs/psa-library/november-2012---right-touch-continuing-fitness-to-practise.pdf

[2] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/228847/7013.pdf

5. In 2011, 'Enabling excellence' set out the Government's policy on professional regulation. The paper said that the Government retained an 'open mind' on the issue of revalidation for professions other than medicine – 'additional central regulatory effort on revalidation' would be considered where there is 'evidence to suggest significant added value in terms of increased safely or quality of care for users of health care services' (paragraph 5.3, page 19).

6. In 2013 medical revalidation was introduced. The system involves doctors undertaking appraisal in the workplace and maintaining a portfolio of evidence including evidence of CPD and quality improvement activity. This informs the recommendations of a network of 'responsible officers' in the workplace. The General Medical Council (GMC) then makes the final decision about whether to renew a doctor's licence to practice.[3] An evaluation of the benefits and impact of medical revalidation is being taken forward in separate research.

7. Most recently, the report of the Mid Staffordshire NHS Foundation Trust made the following recommendation with reference to the Nursing and Midwifery Council (NMC).

   'It is highly desirable that the NMC introduces a system of revalidation similar to that of the GMC, as a means of reinforcing the status and competence of registered nurses, as well as providing additional protection to the public.' (Recommendation 229)[4]

8. Across the regulators of health and care professions, there have been a variety of different approaches to the range of policy initiatives on continuing fitness to practise, with different starting points as to the systems already in place. They have included undertaking research to gather evidence to inform their proposals, particularly around the risks involved in particular professions; introducing auditing of continuing professional development; and augmenting existing systems to introduce, for example, a greater role for peer review and other forms of third party feedback.

9. The Professional Standards Authority's 2012 report on continuing fitness to practise noted this variation in approach across the regulatory bodies, concluding that there are 'many possible responses to the challenge of fitness to practise' (paragraph 6.1; page 19). The PSA conclude that revalidation is one approach to continuing fitness to practise, concluding that assurance of continuing fitness to practise 'can and, in most cases, should be achieved by means other than formal revalidation' (paragraph 3.4; page 5). A risk-based continuum is suggested, with revalidation at one end, and 'self-reported CPD' at the other.

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[3] http://www.gmc-uk.org/doctors/revalidation.asp

[4] http://www.midstaffspublicinquiry.com/report

Background – the Health and Care Professions Council (HCPC)

10. The Health and Care Professions Council (HCPC) is an independent professional regulator set up to protect the public. The HCPC sets standards; approves education and training programmes which meet those standards; registers those who pass those programmes; and holds its registrants to account via its fitness to practise process. It registers the members of 16 different health and care professions (c. 320,000 registrants), including, for example, biomedical scientists, practitioner psychologists and speech and language therapists. The professions are regulated on a UK-wide basis, with the exception of social workers who are regulated by the HCPC in England only.

11. The HCPC's existing approach to continuing fitness to practise is based around its CPD standards and ongoing independent audits of registrants' CPD activities. The CPD standards were introduced in 2006. The standards are generic across all the professions. Registrants have to undertake a range of CPD activities; keep a record of their CPD; ensure that it benefits their practice and their service users; and participate in an audit if asked to. All the regulated professions have been audited at least once, with the exception of social workers in England where the first audit is due to take place from September 2014.

12. Audits to check compliance with the standards have taken place since 2008. Each profession renews its registration at a fixed point in a two year cycle. At point of renewal, a sample of each profession (currently 2.5%) is audited at random. Registrants selected are required to submit a written profile setting out how they have met the CPD standards. This is assessed by HCPC CPD assessors, who are recruited against competences and are from the same part of the Register as those who are audited. If a registrant fails to participate in an audit, or does not meet the standards, they are administratively removed from the Register. Analysis of audit outcomes to date has revealed that relatively few registrants participating in an audit have failed to meet the requirements. Those administratively removed from the Register during an audit process typically either voluntarily request to be de-registered, or fail to participate in the process.

13. The HCPC has been carrying out a programme of research to build the evidence base for any enhancement to its approach to continuing fitness to practise. This has included reviewing approaches put in place by regulators in Canada; exploring the potential value of tools designed to collect the feedback of service users on professional practice; and a multi-variant analysis of the outcomes of fitness to practise proceedings.

14. A full list of previous HCPC research and other relevant documents is given in Annex A.

Purpose and scope of the research

15. This research will enable the DH to assess the effectiveness of its current policy on professional standards in relation to the continuing fitness to practise of health and care professions.

16. This research will be of interest to a wide range of stakeholders including the nine regulators of health and care professionals, service user advocacy groups, professional bodies, the NHS in England and the Departments of Health in the devolved administrations.

17. The research will contribute towards building the evidence base in this area, in particular given an identified lack of evidence about the impact of different approaches to monitoring of health and care professionals' continuing fitness to practise.

18. There is some research about the role of CPD in contributing to improved professional practice, but this largely concerns the medical profession and has been undertaken outside the UK. For example, Rosner *et al* (1994) reviewed remedial retraining programmes for doctors in Canada and the US and concluded that CPD played an essential role on the improvement of doctors clinical performance. It was considered important that the CPD was personalised to met the specific needs of individual doctors

19. Wenghofer *et al* (2012; in press) found a correlation between CPD activity and complaints against doctors. If CPD had been undertaken, complaints were less likely. Group based CPD activities was the most likely to have an effect. Other predictors included age, attitude to lifelong learning, number of patients seen. Wenghofer and colleagues have also identified a relationship between CPD activity and clinical peer assessed performance. Doctors who reported participating in CPD activities were significantly more likely to have satisfactory assessments compared with those who did not. Goulet *et al* (2013) found that the three most important factors influencing the quality of clinical practice in doctors were age, location of practice, and quantity and quality of CPD activities. Little or no CPD, private practice and older age were found to have a significant impact on quality of practice scores. There have been no UK studies to date which allow comparisons between, the impact of different regulatory approaches in this area or across health and care professions.

20. The research seeks to gather evidence on the costs and perceived benefits of the HCPC's system of assuring the continuing fitness to practise of health and care professionals it registers. Specific questions include the following:

- What has been the impact of the HCPC's CPD standards and audits on health and care professionals?
- What are the perceived benefits, and disadvantages, of this approach?
- What risks are being mitigated by the CPD standards and audits?
- What improvements could be made?
- What are the costs to the regulator; to employers; and to registrants?

Outline of research required

21. To answer the questions set out above, research is required with the following elements:

- a focussed review of existing relevant evidence. This should inform the conduct of the other components of the research required.

- collection of additional data from CPD profile submissions. The HCPC has audited in excess of 11,500 registrants since 2008. Applicants should collect additional data from the profile submissions made by registrants to assist in identifying and describing trends in the content of profiles, as well as the characteristics of registrants submitting profiles. Data to be collected may include for example, evidence from annual appraisal; feedback from service users and colleagues; audits of significant events; and whether the registrant works in a managed environment or in independent practice. Applicants should develop a systematic framework for collecting this data across the whole of the audit data-set.

- analysis of CPD audit data. This will include analysis of the data referred to above, alongside analysis of existing data, which includes, for example, registrants' length of time on the Register, route to registration, area of practice, part time/full time status, gender and the outcomes of CPD audits. The main questions that will drive analysis are set out in paragraph 20 above, but applicants may wish to suggest further questions relevant to fitness to practice, which can be answered using this data-set.

- interviews with HCPC registered health and care professionals, and with employers, to explore in depth their views on questions including the impact of the CPD standards and audits in practice; the type and amount of CPD undertaken pre and post introduction of the HCPC's CPD requirements; and collection of self-reported data such as time taken to complete the audit

- analysis of costs, including regulatory costs and reported employer and practitioner costs will be undertaken.

Research timetable

22. The research should commence in early **2015**, with a final report to be delivered within a year of the start of the project. Emerging findings should be (for example on the initial review of evidence) should be shared with the DH and HCPC on a regular basis. Proposals will be favoured which enable a timely start.

Oversight

23. An advisory group will be appointed by DH, to include the HCPC, supported by the successful research team. This will offer a sounding board for the researchers and take receipt of an interim report at the half way mark of the research.

Standard information for applicants

24. The Policy Research Programme (PRP) is a national programme of research dedicated to providing an evidence base for policy-making in the Department of Health (DH). It provides information to the Secretary of State for Health and his Ministers directly and through policy directorates in the Department and covers all aspects of the Department's policy-making activity.

25. Applications will be considered from other UK countries provided they address the priority areas in a way that is relevant to the needs of the Department of Health (England) and meet all other selection criteria.

Governance issues

26. Day-to-day management of this research will be provided by the principal investigator. They and their employers should ensure that they identify, and are able to discharge effectively, their respective responsibilities under the Department of Health Research Governance Framework for Health and Social Care[5], which sets out the broad principles of good research governance.

27. All successful research involving National Health Service (NHS) and adult social care users, carers, staff, data and/or premises must be approved by the appropriate research ethics committee (REC) or social care research ethics committee (SCREC). For further information on RECs, please visit the National Research Ethics Service website: http://www.nres.nhs.uk/

28. The successful research team must adhere to the Data Protection Act (1998) and the Freedom of Information Act (2000). Effective security management, and ensuring personal information and assessment data are kept secure, will be essential. In particular:

- the research team shall, at all times, be responsible for ensuring that data (including data in any electronic format) are stored securely. The research team shall take appropriate measures to ensure the security of such data, and guard against unauthorised access thereto, disclosure thereof, or loss or destruction while in its custody.

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[5] Department of Health. Research governance framework for health and social care [Online]. 2nd Ed. London: HMSO; 2005 [cited 2008 March 26]; https://www.gov.uk/government/publications/research-governance-framework-for-health-and-social-care-second-edition

- personal data shall not be made available to anyone other than those employed directly on the project by the research team, to the extent that they need access to such information for the performance of their duties.

Risk management

29. Applicants should submit, as part of their application, a summary explaining what they believe will be the key risks to delivering their research, and what contingencies they will put in place to deal with them. Please ensure this is detailed in the Management and Governance section of the online application form.

30. A risk is defined as any factor which may delay, disrupt or prevent the full achievement of a project objective. All risks should be identified. The summary should include an assessment of each risk, together with a rating of the risks likelihood and its impact on a project objective (using a high, medium or low classification for both). The risk assessment should also identify appropriate actions that would reduce or eliminate each risk, or its impact.

31. Typical areas of risk for an evaluation study might include ethical approval, site variation in data gathering, staffing, resource constraints, technical constraints, data access and quality, timing, management and operational issues; however, please note this is not an exhaustive list.

Patient and public involvement (PPI)

32. The Policy Research Programme expects the active involvement of patients and the public (e.g. service users and carers) in the research that it supports where appropriate. However, it is accepted that the nature and extent of patient and public involvement (PPI) is likely to vary depending on the context of the study. Applicants should describe how the issue of PPI will be addressed throughout the research process. For example, this could include patient and public involvement in refining research questions, designing research instruments, advising on approaches to recruitment, assisting in the collection and analysis of data, participation or chairing advisory and steering groups, and in the dissemination of research findings.

33. Applicants are required to describe what active involvement is planned, how it will benefit the research and the rationale for their approach. PPI needs to be undertaken in a manner that acknowledges that some people may need additional support, or to acquire new knowledge or skills to enable them to become involved effectively (see INVOLVE publications for guides for researchers). Applicants should therefore provide information on arrangements for training and support. In addition, applicants should ensure that a budget line for the costs of PPI is included in the finance form. Where no PPI is proposed, a rationale for this decision must be given.

34. For further information and guidance about PPI, please visit the INVOLVE website: http://www.invo.org.uk/

Research outputs

35. The research team will be expected to submit written progress reports over the lifetime of the research and will be provided with a standard template to complete at regular quarterly intervals, with occasional ad hoc reports in between. In addition to describing progress, these reports will allow researchers to indicate any significant changes to the agreed protocol, as well as setting down milestones for the next reporting period, giving an update on PPI and also any publications or other outputs. Information on emergent findings that can feed more immediately into policy development will be encouraged and should be made available as appropriate.

36. A final report on the research, with an accessible executive summary, will be required within one month following completion of the research. The report will be peer reviewed and circulated to policy-makers in the Department of Health. Once your study is complete, a summary of your final report will be placed in the public domain, on the Department of Health Policy Research Programme Central Commissioning Facility (CCF) website. This is where the outputs resulting from expenditure of public funds are made available for public scrutiny so it is important that the summary of your final report is easily accessible to the lay reader.

37. Research contractors are obliged to give at least 28 days notice before submission of any publication arising from research funded by the Department of Health Policy Research Programme. In this instance, 'publication' concerns any presentation, paper, press release, report or other output for public dissemination arising from a research project funded by the PRP. There is no time limit to this provision and research contractors remain under an obligation to provide notice even after the contract has ended. Publication of PRP-commissioned research is subject to prior consent of the Secretary of State, which will not be held unreasonably and cannot be withheld for more than three months from the time the publication is submitted.

Dissemination

38. Applicants should describe how the research findings could be disseminated most effectively, ensuring that results of this research impact on policy and practice in the NHS, DH and system partner organisations.

39. Publication of scientifically robust research results is encouraged. This could include plans to submit papers to peer reviewed journals, national and regional conferences aimed at service providers, professional bodies and professional leaders. It might also include distribution of executive summaries and newsletters. Less traditional dissemination routes are also welcomed for consideration.

Budget

40. The amount available for this research is approximately £175,000. Costings can include **up to 100% full economic costs** (FEC) but should **exclude output VAT**. Applicants are advised that value for money is a key criterion that peer reviewers and Commissioning Panel members will consider when assessing applications.

41. Funding to the level stated will only be available if there are suitable high quality and relevant studies.

42. Notification of outcome is expected to be given by late **November 2014.** All applications are expected to start as soon as possible and no later than within 6 months of funding being agreed.

Transparency

43. In line with the government's transparency agenda, any contract resulting from this tender may be published in its entirety to the general public. Further information on the transparency agenda is at: http://transparency.number10.gov.uk/

44. If you wish to view the standard terms and conditions of the Policy Research Programme contract, please go to: www.prp-ccf.org.uk
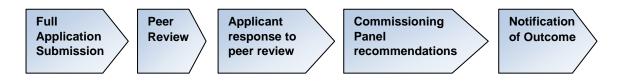
Application process

45. To access the research specification and application form, please visit the Policy Research Programme Central Commissioning Facility (PRP CCF) website at www.prp-ccf.org.uk

46. The Central Commissioning Facility (CCF) runs an online application process and all applications must be submitted electronically. No applications will be accepted that are submitted by any means other than the online process. **Deadlines for the submission of research applications occur at 1pm on the day indicated and no applications can be accepted after this deadline.** We strongly recommend that you submit your application well before deadline.

47. Once the 1pm deadline passes, the system shuts down automatically and CCF Programme Managers are unable to re-open it. If you are experiencing any technical difficulties submitting your application, please contact the CCF on 0208 843 8027 in good time, before 1pm on a closing date.

48. This is a single stage tender and a full application must be submitted online by **1pm on 02 July 2014.**

49. Applicants are expected, before submitting applications, to have discussed their applications with their own and any other body whose co-operation will be required in conducting the research. The **declarations and signatures page** must be printed off and signed by an administrative or finance officer for the host (contracting) institution to confirm that the financial details of the application are correct and that the host institution agrees to administer the award if made. This is the only part of the form required in hard copy.

50. The hard copy of the declaration and signatures page should be submitted within one week of the closing date to:

> PRP Commissioning Round 10
> **Fitness to Practise**
> PRP CCF
> Grange House
> 15 Church Street
> Twickenham
> TW1 3NL

51. The standard PRP application process

| Full Application Submission | Peer Review | Applicant response to peer review | Commissioning Panel recommendations | Notification of Outcome |

52. In standard one stage commissioning, all full applications submitted to the PRP will be peer-reviewed by both stakeholder and independent academic referees. Wherever time permits, applicants will be given one week to respond to the peer reviewers' comments.

53. Applications, peer reviewers' comments and any responses to those comments will then be considered by the Commissioning Panel, which is comprised of independent experts (possibly with observers from other government departments and executive agencies), who will advise the Department of Health on which applications are most suited to receive funding. The Panel will be informed by the reviewers' comments and any responses made to these comments by the researchers. However, it is ultimately the responsibility of the Panel to make any funding recommendations to the Department of Health.

Selection criteria

54. Criteria used by peer reviewers and members of the Commissioning Panel to assess applications for funding from the PRP include:

- **RELEVANCE** of the proposed research to the research specification
- **QUALITY** of the research design
- **QUALITY** of the work plan and proposed management arrangements
- **STRENGTH** of the research team
- **IMPACT** of the proposed work
- **VALUE** for money (justification of the proposed costs)
- **INVOLVEMENT** of patients and the public

Timetable

55. It is anticipated that commissioning of this research will adhere to the following approximate timetable:

- Issue of invitation to tender: **06 May 2014**
- Deadline for receipt of full applications: **02 July 2014**
- Peer review to be completed: **28 July 2014**
- Notification of outcome: **Late November 2014**
- Award of contract: **December 2014** (subject to pre-contract negotiations)

56. In order to maximise the benefit from the findings, the research will need to commence as soon as possible following selection of the successful bid and placing of a contract. Capability to start promptly will be a definite advantage.

Contacts

57. General enquiries regarding the application and commissioning process can be directed to the PRP CCF Help Desk by telephone at 0208 843 8027 or by email to prp@prp-ccf.org.uk

References and Key Documents

Department of Health. Research governance framework for health and social care [Online]. 2nd Ed. London: HMSO; 2005 [cited 2008 March 26]; URL: https://www.gov.uk/government/publications/research-governance-framework-for-health-and-social-care-second-edition

Annex A:

Bloom B (2005). Effects of CME on improving physician clinical care and patient health: a review of systematic reviews. Int J Technol Assess Health Care 274 (9) 700-705.

Goulet, F. (2013). Effects of cpd on clinical performance. Canadian Family Physician, 59:518-25.

Goulet, F., Jacques, A., Gagnon, R. et al (2007). Assessment of family physicians performance using patient charts: inter-rater reliability and concordance with chart stimulated recall interview. Evaluation and the Health Professions, 30(4), 376-92.

Rosner, F., Balint, J., Stein, R. (2004) Remedial medical education. Archives of Internal Medicine 154: 274-9.

Wenghofer, E. (2012) Effects of CPD on occurrence and types of complaints

IAMRA, Ottawa, October 2012

Wenghofer, E., Marlow, B.,Campbell, C. et al (In press) Relationship between physician participation in CPD programmes and Physician in practice peer assessments. Academic Medicine, 2014

HCPC (2009). Continuing fitness to practise – Towards an evidence based approach to revalidation.

HCPC (2011). Professionalism in healthcare professions.

Picker Institute (2011). Service user feedback tools – an evidence review and Delphi consultation for the Health Professions Council.

HCPC (2012). Revalidation – update and PSA report. HCPC Council, 9 May 2013.

INVITATION FOR RESEARCH PROPOSALS

Interprofessional education (IPE) in education and training programmes approved by the Health and Care Professions Council (HCPC).

1. Purpose and research aims

1.1 This project is about exploring interprofessional education (IPE) in programmes approved by the Health and Care Professions Council (HCPC). The purpose is to assist the HCPC in reaching conclusions about making a positive requirement for IPE as part of the HCPC's standards of education and training.

1.2 The research aims are as follows.

- To draw on learning from the relevant literature on IPE.

- To gain improved understanding of the extent and nature of IPE in the education and training programmes approved by the HCPC.

- To identify and analyse the different types of IPE activities undertaken by approved education providers.

1.3 We expect as core components that the research will include the following.

- A literature review.

- Research with HCPC approved education providers.

- A final report analysing the findings of the research and providing recommendations about possible changes to the standards and supporting guidance.

1.4 A budget of up to **£30,000** is available for this work (depending on the scope of the research). The deadline for proposals is **8 August 2014**.

2.   About the HCPC

2.1   The Health and Care Professions Council (HCPC) is an independent professional regulator set up to protect the public. We register the members of 16 different professions. We set and maintain standards which cover education and training, behaviour, professional skills and health; approve and monitor educational programmes which lead to registration; maintain a register of people that successfully pass those programmes; and take action if a registrant's fitness to practise falls below our standards.

2.2   We were set up in 2002 and now regulate 16 health and care professions (c. 320,000 registrants), including, for example, dietitians, practitioner psychologists and speech and language therapists. 15 of these professions are regulated UK-wide. Social workers are regulated on an England only basis, with separate regulators in the other UK countries.

3. Our role in quality assurance of education and training programmes

3.1   We currently approve 966 programmes delivered by 150 education providers.[1] Although most programmes are delivered or validated by a Higher Education Institution (HEI), we also approve programmes delivered by other providers including by employers and professional bodies.

3.2   The majority of approved programmes are pre-registration programmes and are approved against our standards of education and training, which are common across all the professions that we register. These standards cover areas such as admissions; curricula; programme management and resources; and assessment.

3.3   We assess programmes against the standards of education and training at approval visits. The assessment is carried out by 'visitors', registrants in each of the professions we regulate, who make recommendations about approval to our Education and Training Committee. (In the near future, visit teams will also include lay people.) This may include recommending that certain conditions should be set before approval is granted. We grant open-ended approval subject to on-going checks to ensure that our standards continue to be met through the 'Annual monitoring' and 'Major change' processes.

3.4   A programme that successfully meets the standards of education and training will allow a student by completion to meet the standards of proficiency, the threshold standards for safe and effective practice in each profession. If a student successfully completes an approved programme they are eligible to apply for registration, subject to health and character checks and payment of the registration fee.

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[1] Figures correct as of 30 April 2014

3.5 We also approve a small number of post-registration programmes, some of which lead to an entry in the Register being 'annotated' (marked). These include programmes which allow certain professions to train to act as supplementary and independent prescribers. We also approve programmes which allow certain professions to train to become Approved Mental Health Professionals (AMHP).

3.6 We publish separate standards for use in approving these programmes. These standards are not directly within the scope of this research. However, the findings of this research may nonetheless inform future changes to these standards.

4. Interprofessional education (IPE)

4.1   This section provides background information which informs the context of the research.

Terminology

4.2   A variety of different terms are sometimes used to refer to students from different programmes and professions learning with, from and about each other. The existing standard of education and training which is relevant to this area uses the term 'interprofessional learning'. This brief uses the term 'interprofessional education' and adopts the definition put forward by the Centre for the Advancement of Inter-professional Education (CAIPE).

'Interprofessional Education occurs when two or more professions learn with, from and about each other to improve collaboration and the quality of care.' (CAIPE 2002, cited in CAIPE 2012, p.3)

Review of the standards of education and training

4.3   This research forms part of a forthcoming review of the HCPC's standards of education and training. The standards of education and training were last re-published in 2009 and are reviewed approximately every five years to ensure that they remain up-to-date and fit for purpose. The scope, content and timetable for the forthcoming review are currently under discussion.

4.4   In 2013, we agreed that we would introduce from the 2014-2015 academic year a new standard which requires education providers to involve service users and carers in their programmes. This decision was informed by commissioned research conducted by Kingston University and St George's University of London (Chambers and Hickey 2012) and a public consultation. We anticipate that this research will similarly inform proposals to amend the standards of education and training, but as one part of a more thorough periodic review.

Existing standard

4.5   The topic of IPE was the subject of debate by the working group (known as a 'Professional Liaison Group' (PLG)) convened when the standards of education and training were last reviewed. At that time, the Group agreed to strengthen the guidance that supports the standards to be more positive about the value of 'interprofessional learning'.

4.6   However, the Group considered that it would not be appropriate to go beyond encouragement to mandate interprofessional learning in approved programmes, principally owing to concerns about whether all approved programmes could meet such a requirement.

4.7 The existing standard sits within the curriculum standards. The following gives the standard, and an excerpt of the supporting guidance.

SET 4.9: When there is interprofessional learning the profession-specific skills and knowledge of each professional group must be adequately addressed.

'Successful interprofessional learning can develop students' ability to communicate and work with other professionals, potentially improving the environment for service users and professionals, Where you provide interprofessional learning, you must make sure that it does not prevent each professional group from learning skills and knowledge specific to their profession.

We appreciate that you may not be able to offer interprofessional learning because of factors beyond your direct control. As a result, we do not make it a requirement. However, interprofessional working is included in the standards of proficiency and the standards of conduct, performance and ethics.'

4.8 As noted above, although they are not directly the subject of this research, the HCPC's other standards have content which is relevant to interprofessional working. The standards of proficiency for each profession in particular include a number of standards which relate to working effectively as part of a multi-disciplinary team and in partnership with service users, professionals and others.

4.9 We recently held a workshop to inform the planning of the review of the standards of education and training, which was attended by our education stakeholders. This identified a number of potential points for consideration when the existing IPE standard is reviewed. They included the following views from participants.

- A more positive and encouraging position on interprofessional learning is required.

- The standard needs to reflect that professions no longer work in isolation and that interprofessional learning is important and necessary.

- The standard and guidance need to be realigned so language and intent is the same.

- There is a need to acknowledge the difficulties in organising interprofessional learning.

- The emphasis needs to be on learning to work interprofesionally, as opposed to learning about the work of other professions.

- There is a need to be sure of the outcomes. How does interprofessional learning enhance practice and benefit the service user?

Other standards and reference points

4.10 Amongst the other UK regulators of health and care professions, interprofessional education is often a specific requirement for programme approval. For example:

'Medical schools must ensure that students work with and learn from other health and social care professions and students.' (General Medical Council, 2009)

'Programme providers must ensure that students have the opportunity to learn with, and from, other health and social care professionals.' (Nursing and Midwifery Council, 2010)

4.11 A number of different organisations have advanced what they see as the benefits of IPE. For example:

CAIPE has published a set of recommendations for commissioners and regulators of education, setting out what it considers are the conditions for effective IPE, which they argue : '…develops and reinforces collaborative competence, employing interactive learning methods to enhance mutual understanding of each other's roles and responsibilities. Students explore wyas in which their professions can work together to respond more fully, more effectively and more economically to the multiple and complex needs presented by individuals, families and communities in contemporary society.' (CAIPE 2012)

The World Health Professions Alliance (WHPA) has published a statement on inteprofessional collaborative practice (ICP). The statement argues that in order to achieve collaborative practice between different professional groups, education providers should 'adopt a philosophy of ICP and include opportunities for joint and person-centred, problem-oriented learning and professional socialisation, in both clinical and academic environments.' They argue that this should be supported through arrangements for the accreditation of education (WHPA 2013).

5. Scope of proposed research

5.1 This section outlines the scope of the proposed research.

5.2 The existing standard is 'negatively framed' in that it currently focuses on ensuring that IPE does not take place to the detriment of profession-specific skills. There is no standard that requires in absolute terms that IPE must take place. The guidance is positive about the benefits of these activities but this is not currently the focus of the standard itself.

5.3 Our initial view (subject to future public consultation) is that it is appropriate to consider amending this standard to make a much more positive requirement for IPE in approved programmes.[2] The purpose of this research is therefore to understand more about what the literature says about effective IPE, and about the nature and extent of IPE on HCPC approved programmes, in order to inform the text of the standard that should be required in the future, and its supporting guidance.

5.4 We welcome all proposals which will meet the research aims outlined in this brief. We expect the research will include, but will not necessarily be limited to, the following.

Literature review

5.5 The literature review will inform the primary data collection. We anticipate that this is likely to include (but may not be limited to) the following content.

- Types of IPE.

- 'Good practice' in achieving effective IPE.

- Appropriate terminology in this area.

- Benefits of IPE for professionals and service users, including the impact of IPE in producing students who are capable of safe and effective practice.

5.6 Although we anticipate that most literature is likely to concern IPE in health and social care education in relation to other professions, or more generally, we would particularly be interested in any literature which specifically pertains to the professions regulated by the HCPC and / or to the regulation or external quality assurance of education.

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[2] For the avoidance of any doubt, IPE on approved programmes need not be confined only to learning with, from and about HCPC regulated professions.

Research with education providers

5.7   We anticipate that the research with education providers will include both qualitative and quantitative data collection. We would be particularly interested in the following.

- The frequency and types of activities undertaken by education providers.

- Examples of particularly 'good' or 'notable' practice (i.e. in order to provide illustrative examples / vignettes).

- The drivers and rationale for existing IPE activities.

- The (perceived) benefits and impact of IPE.

- The (potential) limitations of or barriers to IPE.

- Any trends within or between different professions and different models of education delivery.

5.8   This phase of the research should ensure that all the 16 professions regulated by the HCPC are included in some way.

5.9   We will work with the appointed researcher(s) / research team to facilitate the research with education providers as necessary (e.g. by sending out information to programme leaders).

Research governance

5.10   We expect the appointed researcher(s) / research team to convene a research advisory board or its equivalent, with representation from the HCPC, to oversee the conduct of the work.

5.11   We expect that all relevant stakeholders, such as service users and carers, should be involved in the conduct of HCPC commissioned research, wherever appropriate. We recognise, however, that the nature and extent of involvement may vary depending on the context of the research. Proposals should clearly outline how the involvement of relevant stakeholders will be addressed during the research process.

Final report

5.12   The report of the completed research will be used by the HCPC to consider changes to the standards of education and training and supporting guidance.

5.13 The final report is likely to include the following.

- Information about the research methodologies adopted.

- Findings from the literature review and research with education providers.

- Advice and recommendations to the HCPC in light of the research findings.

5.14 The researcher(s) / research team will be required to present their findings to the HCPC's Education and Training Committee in June 2015 (date TBC).

6. Next steps and anticipated timescale

6.1   Proposals for this work should be submitted by email to Nicole Casey, Policy Manager, by no later than **8 August 2014**.

Email: nicole.casey@hcpc-uk.org

Tel: 020 7840 9168

6.2   There is no prescribed format for submitting research proposals. However, they should include the following.

- A proposal for how the research would be conducted.

- An outline timescale including key milestones.

- Any ethical considerations or approval needed.

- Arrangements for research governance, including the involvement of relevant stakeholders.

- Information about the experience of the organisation involved to deliver the project (if applicable).

- The researcher(s) CV(s).

- A breakdown of costs.

6.3   We anticipate the following timescales for this work. Please note, in the event that the number of proposals received delays the process of appointing the researcher(s) / research team to carry out this work, these dates may change.

Action	Timetable
Invitation for proposals issued	16 June 2014
Deadline for proposals	8 August 2014
Shortlisting	By 29 August 2014
Interviews / meetings with shortlisted researcher(s) / research team(s) (if required)	By 12 September 2014
Researcher(s) / research team appointed	By 19 September 2014
Deadline for final report	Target date for completion is **8 May 2015** (with a draft report available for comment prior to this date). Deadline will be agreed with the appointed researcher(s) / research team based on what is considered to be feasible.

6.4 We anticipate a budget of up to **£30,000** (depending on the scope of the research). This budget is inclusive of all costs, including VAT (if applicable).

Shortlisting criteria

6.5 Our decision to shortlist or appoint will be based on the research brief, and on an overall assessment of how far the proposal has addressed the HCPC's needs. We will particularly assess research proposals as to the extent to which they meet or exceed the following indicative criteria.

- The proposal demonstrates understanding of the role of the HCPC as a regulator.

- The proposal demonstrates understanding of the stated research aims and the purpose of the HCPC's standards and guidance.

- The proposal describes an appropriate methodology which is consistent with the research aims.

- The scope of the proposed research includes an appropriate range of HCPC regulated professions.

- The proposal demonstrates that the researcher(s) / research team have proven experience and expertise in fields relevant to the subject of the research.

- The proposal represents value for money.

7. References

Approval of education and training programmes

Health and Care Professions Council (2013). Approval criteria for approved mental health professional (AMHP) programmes.
http://www.hcpc-uk.org/publications/standards/index.asp?id=690

Health and Care Professions Council (2013). Standards for prescribing.
http://www.hcpc-uk.org/publications/standards/index.asp?id=692

Health Professions Council (2009; reprinted 2012), Standards of education and training and Standards of education and training guidance
http://www.hcpc-uk.org/aboutregistration/standards/sets/

Health Professions Council (2009), Standards of education and training and guidance – Responses to our consultation
http://www.hpc-uk.org/aboutus/consultations/closed/index.asp?id=70

Further information about the HCPC's approval process is available here:
http://www.hpc-uk.org/education/downloads/

Other references

Centre for Advancement of Interprofessional Education (2012). Interprofessional education in pre-registration courses. A CAIPE guide for commissioners and regulators of education. (Prepared by Hugh Barr and Helena Low).
http://caipe.org.uk/news/interprofessional-education-in-preregistration-courses-a-caipe--guide-for-commissioners-and-regulators-of-education---/

Chambers, M. and Hickey, G. (2012). Service user involvement in the design and delivery of education and training programmes leading to registration with the Health Professions Council.
http://www.hcpc-uk.org/publications/research/index.asp?id=550

General Medical Council (2009). Tomorrow's doctors.
http://www.gmc-uk.org/education/undergraduate/tomorrows_doctors.asp

Health and Care Professions Council (2013). Consultation on service user involvement in education and training programmes approved by the Health and Care Professions Council (HCPC). Summary of responses to the consultation and our decisions as a result
http://www.hcpc-uk.org/aboutus/consultations/closed/index.asp?id=150

Nursing and Midwifery Council (2010). Standards for pre-registration nursing education
http://standards.nmc-uk.org/PublishedDocuments/Standards%20for%20pre-registration%20nursing%20education%2016082010.pdf

World Health Professions Alliance (2013). WHPA statement on interprofessional collaborative practice.
http://www.whpa.org/WHPA_Statement_collaborative_practice.pdf

INVITATION FOR RESEARCH PROPOSALS

Perceptions and experiences of the HCPC's approach to continuing professional development standards and audits

1. Purpose and research aims

1.1   This project will explore the perceptions and experiences of the HCPC's approach to continuing professional development (CPD), including its standards for CPD and CPD audits. The outcomes of the research could inform any future changes to the CPD standards; audit process; and supporting communications materials.

1.2   This research forms part of wider work looking at 'continuing fitness to practise' – a term which refers to the range of possible approaches implemented by regulators to assure themselves that their registrants continue to be fit to practise beyond the point of initial registration.

1.3   The research aims are as follows.

- To gather feedback from stakeholders on their perceptions and experiences of the HCPC's approach to CPD, including (but not necessarily limited to) the following.
    - The CPD standards.
    - The audit process.
    - Supporting materials such as guidance.

1.4   We expect as core components that the research will include the following.

- Interviews and/or focus groups with registrants and with other key stakeholders including professional bodies and employers.

- A final report analysing the findings of the research and providing recommendations about possible changes to the standards, audit process and communication materials.

1.5   A budget of up to **£40,000** is available for this work (depending on the scope of the research). The deadline for proposals is **22 August 2014**.

2.   About the HCPC

2.1   The Health and Care Professions Council (HCPC) is an independent professional regulator set up to protect the public. We register the members of 16 different professions. We set and maintain standards which cover education and training, behaviour, professional skills and health; approve and monitor educational programmes which lead to registration; maintain a register of people that successfully pass those programmes; and take action if a registrant's fitness to practise falls below our standards.

2.2   We were set up in 2002 and now regulate 16 health and care professions (c. 320,000 registrants), including, for example, biomedical scientists, operating department practitioners and radiographers. 15 of these professions are regulated UK-wide. Social workers are regulated on an England only basis, with separate regulators in the other UK countries.

3. Our role in continuing professional development (CPD)

3.1   We first published standards for CPD in 2006, following an extensive period of engagement with stakeholders. A minor amendment to one of the standards was made after consultation in 2009. However, the standards have not been formally reviewed since their publication.

3.2   There are five CPD standards which apply to all the regulated professions. A registrant must:

- o   maintain a continuous, up-to-date and accurate record of their CPD activities;
- o   demonstrate that their CPD activities are a mixture of learning activities relevant to current or future practice;
- o   seek to ensure that their CPD has contributed to the quality of their practice and service delivery;
- o   seek to ensure that their CPD benefits the service user; and
- o   upon request, present a written profile (which must be their own work and supported by evidence) explaining how they have met the standards for CPD.

3.3   We do not set any 'points' or 'hours' requirements or endorse any CPD activities or providers. Instead the standards above are focussed on the outcomes of a registrant's learning and how this has benefited them and others.

3.4   Audits to check compliance with the standards have taken place since 2008. At the time of writing, all of the regulated professions have been audited at least once, with the exception of social workers in England who are due to be audited for the first time from September 2014.

3.5   Each profession renews its registration at a fixed point in a two year cycle. At point of renewal, a sample of each profession (currently 2.5%) is audited at random. Registrants selected are required to submit a written profile setting out how they have met the CPD standards. This is assessed by HCPC CPD assessors, who are recruited against competencies and are from the same profession as those who are being audited.

3.6   CPD is linked to registration, so if a registrant fails to participate in an audit, or does not meet the standards, they are administratively removed from the Register. The process has been designed, however, to allow registrants who are audited a fair opportunity to meet the standards. This includes the opportunity to request further information from the registrant. A registrant who has participated in the audit in good faith but is struggling to meet the standards might be given an additional three months to complete a new profile or to undertake more CPD, with guidance from the assessors.

3.7   Analysis of audit outcomes to date has revealed that relatively few registrants participating in an audit have failed to meet the standards. Those administratively removed from the Register during an audit process typically either voluntarily request to be de-registered, or fail to participate in the process at all.

3.8   A range of materials have been published to explain the CPD standards and audit process to registrants and to support them in meeting the standards. They have included the following.

- o   Published guidance such as 'Continuing professional development and your registration'.
- o   Sample CPD profiles produced in collaboration with the professional bodies representing our registrants.
- o   Audio-visual presentations.

3.9   This has been supported by other activities such as undertaking presentations on request and at HCPC events with registrants and employers.

Continuing fitness to practise

3.10   This research forms part of a wider programme of work exploring continuing fitness to practise.

3.11   'Revalidation' is a term that has been commonly used to describe the process by which health and care professionals are required to demonstrate periodically that they are fit to practise and should remain registered. The debate about 'revalidation', particularly in the medical profession, has had a long history. The more recent history relevant to the regulation of the health and care professions is outlined here.

3.12   In 2007, 'Trust, Assurance and Safety – The regulation of Health Professionals in the 21st Century' set out proposals for the revalidation of the medical profession. The following conclusion was reached about the 'non-medical healthcare professions'.

'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.' (Paragraph 2.29, page 41)

3.13   In 2011, 'Enabling excellence' set out the Government's policy on professional regulation. The paper said that the Government retained an 'open mind' on the issue of revalidation for professions other than medicine – 'additional central regulatory effort on revalidation' would be considered where there is 'evidence to suggest significant added value in terms of increased safety or quality of care for users of health care services' (paragraph 5.3, page 19).

3.14   In 2013 medical revalidation was introduced. The system involves doctors undertaking appraisal in the workplace and maintaining a portfolio of evidence including evidence of CPD and quality improvement activity. This informs the recommendations of a network of 'responsible officers' in the workplace. The General Medical Council (GMC) then makes the final decision about whether to renew a doctor's licence to practice.

3.15   Across the regulators of health and care professions, there have been a variety of different approaches to the range of policy initiatives on continuing fitness to practise, with different starting points as to the systems already in place. They have included undertaking research to gather evidence to inform their proposals, particularly around the risks involved in particular professions; introducing auditing of continuing professional development; and augmenting existing systems to introduce, for example, a greater role for peer review and other forms of third party feedback.

3.16   The Professional Standards Authority's 2012 report on continuing fitness to practise noted this variation in approach across the regulatory bodies, concluding that there are 'many possible responses to the challenge of fitness to practise' (paragraph 6.1; page 19). The PSA conclude that revalidation is one approach to continuing fitness to practise, concluding that assurance of continuing fitness to practise 'can and, in most cases, should be achieved by means other than formal revalidation' (paragraph 3.4; page 5). A risk-based continuum is suggested, with revalidation at one end, and 'self-reported CPD' at the other.

3.17   Our existing approach to continuing fitness to practise is based around our CPD standards and audits. We have been carrying out a programme of research to build the evidence base for any enhancement to our approach to

continuing fitness to practise (HCPC 2012c). This has included, for example, research on the potential value of multi-source feedback tools designed to collect feedback from service users, including looking at their potential role in the CPD standards or process (Chisolm and Sheldon 2011).

3.18 More recently, the Department of Health has issued an invitation to tender for a research study which will look at the costs and benefits of the HCPC's approach to CPD standards and audits. This will include collecting additional data from CPD audit submissions and interviews with registrants about the impact of the CPD standards and audits in practice; the type and amount of CPD undertaken pre and post introduction of the HCPC's CPD requirements; and collection of self-reported data such as time taken to complete the audit. This research project is therefore complementary to that work, with a strong focus on the perceptions and experiences of registrants and others of the CPD standards and audit process.

4. Scope of proposed research

4.1   This section outlines the scope of the proposed research.

Key questions to be addressed in the research

4.2   The purpose of the research is to explore the perceptions and experiences of the HCPC's standards for CPD and audit process. We anticipate that the research will address the following areas. Some example questions are given below – they not intended to be exhaustive of all the possible questions which might be addressed in the research.

- The CPD standards
    - How well understood are the CPD standards?
    - How effective are the CPD standards considered to be?
    - Should the CPD standards be strengthened in any way?
    - How do the CPD standards impact on practice?
    - Do they serve to reinforce reflective practice?

- The audits and audit process
    - What is the purpose and value of the audit process?
    - What have been registrants' experiences of the audit process?
    - What impact do the audits have?
    - How might the (experience of the) audit process be improved?

- Supporting communication materials
    - What are stakeholder views of the existing guidance and other communication materials?
    - What improvements could we make to help registrants understand the standards and to support them in meeting them?

Qualitative research

4.3   We welcome all proposals which will meet the research aims outlined in this brief. However, we anticipate that the research is likely to include (but might not be limited to) interviews and/or focus groups with a range of groups including the following.

Registrants

4.4   The research should include both registrants who have been audited for their CPD and those who have not. We would also expect the successful researcher(s) / research team to have regard to the need to include the following.

- Registrants drawn from the range of HCPC regulated professions and from across the UK.

- Registrants selected for CPD audit but with different audit outcomes including those accepted on first submission; those asked for further information; and those given extra time to complete the audit process.

- Registrants with different lengths of time in practice.

- Registrants drawn from different practice settings, for example managed environments such as the NHS; private practice; management; and education.

Key stakeholders

4.5 This should include professional bodies representing the professions regulated by the HCPC and employers (and/or representative bodies of employers) of HCPC registrants.

4.6 We will work with the appointed researcher(s) / research team to facilitate the research with registrants and key stakeholders as necessary (e.g. by providing data).

Research governance

4.7 We expect the appointed researcher(s) / research team to meet with the HCPC on a regular basis and to provide progress reports on a regular basis.

Final report

4.8 The report of the completed research will be used by the HCPC to consider any possible future changes to the CPD standards; audit process; and supporting communication materials.

4.9 The final report is likely to include the following.

- Information about the research methodologies adopted.

- Findings from the qualitative research.

- Advice and recommendations to the HCPC in light of the research findings.

4.10 The researcher(s) / research team will be required to present their findings to the HCPC's Education and Training Committee at a date to be confirmed.

5. Next steps and anticipated timescale

5.1   Proposals for this work should be submitted by email to Michael Guthrie, Director of Policy and Standards by no later than **22 August 2014**.

Email: michael.guthrie@hcpc-uk.org

Tel: 020 7840 9768

5.2   There is no prescribed format for submitting research proposals. However, they should include the following.

- A proposal for how the research would be conducted.

- An outline timescale including key milestones.

- Any ethical considerations or approval needed.

- Arrangements for research governance.

- Information about the experience of the organisation involved to deliver the project (if applicable).

- The researcher(s) CV(s).

- A breakdown of costs.

5.3   We anticipate the following timescales for this work. Please note, in the event that the number of proposals received delays the process of appointing the researcher(s) / research team to carry out this work, these dates may change.

Action	Timetable
Invitation for proposals issued	23 June 2014
Deadline for proposals	22 August 2014
Shortlisting	By 12 September 2014
Interviews / meetings with shortlisted researcher(s) / research team(s) (if required)	By 26 September 2014
Researcher(s) / research team appointed	By 10 October 2014
Deadline for final report	Target date for completion is **30 June 2015** (with a draft report available for comment prior to this date). Deadline will be agreed with the appointed researcher(s) / research team based on what is considered to be feasible.

5.4   We anticipate a budget of up to **£40,000** (depending on the scope of the research). This budget is inclusive of all costs, including VAT (if applicable).

Shortlisting criteria

5.5   Our decision to shortlist or appoint will be based on the research brief, and on an overall assessment of how far the proposal has addressed the HCPC's needs. We will particularly assess research proposals as to the extent to which they meet or exceed the following indicative criteria.

- The proposal demonstrates understanding of the role of the HCPC as a regulator.

- The proposal demonstrates understanding of the stated research aims and the purpose of the HCPC's standards and processes.

- The proposal describes an appropriate methodology which is consistent with the research aims.

- The scope of the proposed research includes an appropriate range of HCPC regulated professions.

- The proposal demonstrates that the researcher(s) / research team have proven experience and expertise in social / market research.

- The proposal represents value for money.

6. References

Continuing professional development

HCPC (2012a). Continuing professional development audit report.
http://www.hcpc-uk.org/assets/documents/10003B0CContinuingprofessionaldevelopmentauditreport.pdf

HCPC (2012b; updated 2014). Continuing professional development and your registration
http://www.hcpc-uk.org/assets/documents/10001314CPD_and_your_registration.pdf

More information about the CPD standards and audits is available here:
http://www.hcpc-uk.org/registrants/cpd/

Continuing fitness to practise

Chisolm, A., and Sheldon, H. (2011). Service user feedback tools – an evidence review and Delphi consultation for the Health Professions Council. Picker Institute.
http://www.hcpc-uk.org/publications/research/index.asp?id=669

Department of Health (2007). Trust, Assurance and Safety – The regulation of health professionals in the 21st century
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/228847/7013.pdf

Department of Health (2011). Enabling excellence – Autonomy and accountability for healthcare workers, social workers and social care workers
https://www.gov.uk/government/publications/enabling-excellence-autonomy-and-accountability-for-health-and-social-care-staff

HCPC (2009). Continuing fitness to practise – Towards an evidence based approach to revalidation.
http://www.hcpc-uk.org/publications/research/index.asp?id=207

HCPC (2012c). Revalidation – update and PSA report. HCPC Council, 9 May 2013.
http://www.hpc-uk.org/aboutus/committees/archive/index.asp?id=635 (enclosure 06)

Professional Standards Authority (2012). An approach to assuring continuing fitness to practise based on right-touch regulation principles.
http://professionalstandards.org.uk/library/document-detail?id=69393f02-d5a3-4ae0-a1bb-a7b437dc3485