Continuing Fitness to Practise Professional Liaison Group (PLG)
15 January 2008

International revalidation

Executive summary and recommendations

Introduction

The attached paper looks at some existing models of 'revalidation' in place in Canada, the United States, New Zealand and Australia.

At the next meeting, the group will consider a further paper looking at the UK-based based models and practices identified and discussed at the last meeting. In addition, the General Medical Council and General Dental Council will be attending the group's meeting on 11 March 2008 to present on their existing proposals.

Decision

The group is invited to discuss the attached paper.

The group is particularly invited to identify any areas which might be explored further at subsequent meetings.

Background information

None

Resource implications

None

Financial implications

None

Appendices

None

Date of paper

4 January 2008

International revalidation

Introduction

This paper examines some models of revalidation in place outside of the UK. The paper particularly focuses on models in place in North America, but also briefly outlines models in place elsewhere.

At the end, common features and areas of interest are identified, together with some key areas for discussion.

It should be noted that the term 'revalidation' is often not used in the models examined in this paper. The group identified at the last meeting that there was, in any event, a lack of clarity or agreement around the meaning of revalidation. Other regulatory terminology also varies (e.g. licence rather registration). The term relevant to each particular model is used in this paper.

The models outlined in this paper, however, can easily sit within the definition of 'continuing fitness to practise' put forward in the group's workplan:

'*Continuing fitness to practise' refers to all steps taken by regulators, employers, health professionals and others which are supportive of maintaining fitness to practise beyond the point of initial registration. This encompasses, but should not be limited to, 'revalidation'.*'

In addition, it should be noted that the structure of regulation varies elsewhere in the world. Whilst there are often clear parallels with arrangements in the UK, sometimes functions performed by regulators in the UK are performed by a number of different organisations.

Canada

In Canada, health professions are regulated by profession-specific provincial colleges. Practice varies between states, but most colleges have mandated requirements for 'quality improvement'. At present, the additional focus on practice or site assessment is something which has been adopted in British Columbia and Ontario.

Discussion with the co-ordinator of the 'Continuing Competence Program' at the College of Physical Therapists of Alberta has identified the following drivers behind the development of 'continuing competence' programs in Canada:

- 'Profession driven' – the Alliance of Physiotherapy Regulators developed a framework for continuing competence programmes in 1999.[1] Many of the physiotherapy regulatory bodies in the provinces have voluntarily implemented arrangements and are moving towards, or have implemented, compulsory arrangements.
- The reports of the Pew healthcare commission in the United States in the early 1990s (see page 9).

[1] Canadian Alliance of Physiotherapy Regulators, National Framework for Assuring the Continuing Competence of Physiotherapists in Canada (October 2000). http://www.alliancept.org/

- Provincial legislation mandating continuing competence programs (driven by discussion about the meaning of licensure).

Most colleges have different types of registration which differentiate between registrants in patient-facing roles and others who work in academic or other environments. 'Independent registration' normally refers to registrants working in a clinical, patient-facing environment. Some colleges do not require the participation in the quality programmes of registrants who practice in 'non-clinical' environments.

1. College of Physiotherapists of Ontario[2]

The College of Physiotherapists of Ontario run a 'Quality Management Program' to 'promote quality practice and support registrants in their ongoing efforts in applying knowledge, skills, attitudes and judgement, and to ensure the competence of physiotherapists in Ontario'. There are approximately 6000 registered physiotherapists in Ontario.

The programme does not include information from, or provide information to, employers. However, from discussion with the Director of Quality Management, anecdotally, employers are generally supportive of the process and some incorporate the quality management tools into employment requirements.

- *Competency reflection and integration*

The goal of this stage is to 'promote registrant self-assessment, professional accountability and practice reflection to continuously improve the quality of professional performance'.

All registrants (regardless of whether they are not in clinical practice) are mandatorily required to create and maintain a professional portfolio. The portfolio is designed as an opportunity for registrants to reflect on their practice and learning and is designed to be developmental. Portfolios will contain information such as information relating to learning and CPD and may include feedback from patients or colleagues.

The College does not make points or hours requirements for continuing professional development and no preference is given to certain types of learning. However, the College provides a template for the completion of profiles and guidance to registrants about setting learning goals and reflecting on their practice.

The College may ask to see a portfolio if a registrant is selected to participate in competency assessment and use it to give feedback and to set developmental goals. However, otherwise, compliance is not routinely checked; registrants have to sign a declaration to confirm that they meet the requirements when they renew their registration.

- *Competency assessment*

[2] Information from www.collegept.org/

The goal of this stage is to ‘allow registrants to demonstrate competency whilst providing a positive learning experience’.

Each registrant is subject to onsite assessment by a peer assessor every five to ten years. Assessment through the quality management process is scope of practice led – physiotherapists are only expected to demonstrate competence within the role that they perform. The onsite assessment takes place in the workplace and lasts for approximately four hours, using pre-determined tools.

The assessor provides positive and developmental feedback to the registrant during the assessment and submits a report to the Quality Management Committee. If the Committee feels that concerns have been identified they may set conditions for the registrant to bring their knowledge, skills and judgement up to the required level.

The results of the assessment are ‘ring-fenced’ from other parts of the College. The results of the assessment cannot be shared with another Committee unless the following conditions apply.

- The registrant has committed an act of professional misconduct or may be incompetent or incapacitated; and
- The Committee feels that this can not be remedied via the quality management process; or
- The registrant has provided false information to the Committee or to an assessor.

Only the name and allegations, but not the full assessment findings, can be disclosed to the Executive Committee. The College is keen to emphasise this fact and sees this as key in ensuring that the programme is viewed as a developmental process.

- *Competency improvement*

This section is a remediation programme which is designed to ‘assist registrants who have competency challenges to meet the standards’. Registrants participate as needed and are assisted by a one to one remediator.

Registrants required to participate in this section are those where an assessment has raised performance concerns or where an investigation has raised concerns. The results of competency assessment are used to develop goals and a plan to address the deficiencies that have been identified.

The College undertook an evaluation of the programme between 1997 to 2001 which looked at aspects such as communication with registrants and the validity of the tools used in the programme.

Over the five year period, approximately 10% of the registrants participated in the program. Six (1%) of 553 participants over the last five years were required to complete a period of remediation. The report concluded: ‘Registrants identified as being below minimal competence are in fact far below. One-to-one mentorship appears critical to improving competence; however, even with one-to-one mentorship there are some cases where the registrant is so far below minimal

competence that he or she is unable to improve enough to become minimally competent.'[3]

Discussion with staff at the College indicates that individuals who are identified to be struggling to meet the required standard are provided with feedback throughout, and, in light of this feedback, some choose to voluntarily remove themselves from the Register.

2. College of Occupational Therapists of Ontario[4]

The College of Occupational Therapists of Ontario has a very similar 'Quality Assurance Program'. The aim of the programme is to protect the public – the programme is designed to:

- 'assist all registrants to maintain and improve their professional competence';
- 'identify when an individual registrants competence falls below the essential competencies for the profession'; and
- 'assist those registrants to improve their competence to an acceptable level'.

The programme has three sections, which are similar in content to that of the College of Physiotherapists of Ontario.

- *Competency enhancement* has three mandatory tools:

- Prescribed regulatory education program modules (self-directed).
- Self-assessment tool.
- Professional portfolio.

- *Competency review and evaluation*

Registrants are randomly selected to enter the second component of the programme. The number of registrants who are required to participate is not given on the College's website.

Most registrants who are selected participate in competency review, which is a screening process. Registrants submit the mandatory competency enhancement tools from their portfolios and also provide the names of colleagues and clients who have knowledge of their practice. The College sends feedback surveys to these individuals.

Following this stage, most registrants do not need to move on to the next stage. However, a small number of registrants may be asked to undergo competency evaluation, if competency review has suggested that there may be areas of their practice which demand further investigation. Referral to competency evaluation may also be made from other College processes (e.g. from an investigation).

[3] College of Physiotherapists of Ontario, Quality Management Program Evaluation Report (June 2003),www.collegept.org/
[4] Information from www.coto.org/

Competency evaluation consists of an in-depth formal assessment by peer assessors, who provide a report to the Quality Assurance Committee.

- *Competency improvement*

This is a remediation stage for registrants where deficiencies have been identified in competency evaluation. This process is similar to the same stage in the College of Physiotherapists of Ontario procedures.

Similar models exist in Ontario for other professions which HPC regulates.

3. College of Physical Therapists of Alberta[5]

The College of Physical Therapists of Alberta has a 'Continuing Competence Program' which is mandated by the Health Professions Act. The Act says that Colleges must establish continuing competence programmes that 'provide for members to maintain competence' and 'enhance the provision of professional services.' The programme is currently in place on a voluntarily basis but will soon be mandated by provincial legislation.

The programme does not include site visits or remediation but licensees are required to submit information when they renew their licence.

The programme requires physical therapists to develop a professional portfolio. A professional portfolio is described as 'a collection of information that illustrates in a structured format, a physical therapist's reflection on practice, continuous professional growth, professional history and achievements'. The professional portfolio has four components:

- *Competency assessment questionnaire*

Licensees have to complete a questionnaire to assist them in reflecting on and evaluating the 'attitudes, knowledge, skills and tasks considered essential for safe, ethical and effective physical therapy practice'.

- *Practice enhancement plan*

This tool is designed to help licensees to define practice-related learning goals and develop strategies and timelines for meeting those goals.

- *Competence maintenance log*

A record of professional activities which support the advancement of physical therapy competencies (e.g. CPD).

- *Practice information folder*

This contains information relating to the activities in the competence maintenance log.

[5] Information from www.cpta.ab.ca

The College's website says that the programme will become mandatory at some point in 2007. When the programme becomes mandatory, licensees will have to submit their portfolio when they submit their practice permit renewal form. However, how these portfolios will be assessed is unclear.

4. College of Physicians and Surgeons of Ontario[6]

The College of Physicians and Surgeons of Ontario has a developed a 'revalidation' program which builds upon existing processes such as their peer assessment program. The revalidation system is focussed on licensees with an independent practice certificate (i.e. those in clinical practice with direct patient contact) and is based on a five year cycle.

Employers are not directly involved in the revalidation program. In Ontario, most doctors are likely to have 'privileges' with an institution, and are not in an employer-employee relationship. However, some hospitals do make use of the tools in order to decide whether to grant or renew hospital privileges.

The program has three components:

- *Self reflection and needs assessment, multisource feedback and CPD*.

Each doctor fills in a practice information questionnaire about their practice, work pattern and the resources available to them. The College provides feedback to the doctor – the doctor also receives the results of other doctors who practice in similar areas to allow for comparison.

Doctors also receive feedback from patients and peers. They provide the names of patients and colleagues to the college who administers a feedback process. Feedback is sent back to the doctor with opportunities for improvement identified so that the doctor can set CPD goals.

Doctors are also required to undertake CPD to meet the needs identified.

The College says: '…the philosophy behind component 1 is to raise the bar across the process with respect to ongoing competence and practice performance, giving individual doctors a perspective of where they fit relative to their colleagues.'

- *Peer assessment*

A peer assessment program has been in place in Ontario since 1972.

Doctors are randomly selected to participate in peer assessment. The selection is also partly risk based – doctors over 70 who have not been assessed in the previous five years are automatically assessed.

Peer assessment involves assessment by another doctor, including a site visit and report. The assessor reviews the doctor's medical records and discusses the doctor's practice with the doctor.

[6] Information from www.cpso.on.ca

The College says: ‘Each year, almost 90% of doctors who participate in a peer assessment are found to be practising in a satisfactory manner and receive useful feedback from their assessor, a practising colleague. If it is identified that a physician needs to make improvements in any particular area of practice, the College will assist the physician in developing an educational plan to address identified areas for improvement.’

The effectiveness of this part of the programme was reviewed in 1998. A research study concluded that peer assessment produced a short term improvement in practice in the bottom 10-15% of all physicians assessed, which was sustained for more than six years.[7]

- *PREP and SAP evaluations*

Two remediation programmes are currently in place which deal with doctors whose practice has been questioned following a disciplinary investigation or the results of peer assessment. The ‘Physician Review Program’ (PREP) assesses general practitioners; the ‘Specialists Assessment Program’ (SAP) assesses other specialists.

As with the other models in Canada, doctors stay within the revalidation system unless they refuse to co-operate or demonstrate a serious risk to patient safety. The results of the assessment findings cannot be used in disciplinary proceedings.

[7] P Norton, E Dunn, Roy Beckett, Dan Faulkner, ‘Long -Term Follow-up in the Peer Assessment Program for Nonspecialist Physicians in Ontario, Canada’, Joint Commission Journal on Quality Improvement (Vol 4, number 6, June 1998).

United States

In the US, health professions are regulated in each state by state boards. In some professions a 'federation' organisation exists to foster consistency and good practice sharing between boards.

Whilst boards grant licensees, other organisations are often concerned with (re)certification. Certification is confirmation that an individual has the required knowledge and skills in a particular area, often to agreed national standards.

It is also interesting to note that many US boards have had in place for some time remediation programs which assist licensees where investigatory/ disciplinary procedures have identified failings. Many also have assistance and monitoring procedures in place for licensees with substance abuse or other health problems which may be affecting their practice.

'Revalidation' or 'continuing competence' is a key topic in regulation in the US. In the 1989, the Pew Health Professions Commission was established by the Pew charitable trusts. The Commission made recommendations relating to the education and regulation of health professionals. The drivers behind the recommendations seem to be a desire that professional regulation should demonstrate clearly that it serves the public interest, and a suggestion that, in a market economy where cost is all important, regulators need to ensure that high quality care is delivered. The Commission concluded that:

'*…states should require that their regulated health care professionals demonstrate their competence in the knowledge, judgement, technical skills and interpersonal skills relevant to their jobs throughout their careers*.'[8]

In 2004, The Citizen Advocacy Center (CAC), an organisation representing public members serving on health regulatory boards, produced a 'Road Map to Continuing Competency Assurance'.[9] The CAC argue that regulatory boards should assure continuing competence because of patient expectations that professionals are competent to practice, and in light of a rapidly changing healthcare environment.

In keeping with the Canadian model, the CAC argue that quality should be the purpose of any 'effort to assurance patient safety and improve the quality of health care practice'. They conclude: 'Continuing competence assessment and assurance is not designed for finding "bad apples" amongst practitioners.'

[8] Pew Health Professions Commission, 'Strengthening Consumer Protection: Priorities for Health Care Workforce Regulation' (October, 1998), p.56.
www.futurehealth.ucsf.edu/pubs.html

[9] Citizen Advocacy Center, Maintaining and Improving Health Professional Competence: The Citizen Advocacy Center Road Map to Continuing Competency Assurance (April, 2004).
www.cacenter.org

A five step model is suggested: ‘Its purpose is to enable clinicians to practice safe, quality health care, and to support their efforts as lifelong learners, not to punish or burden professional practice.’

- *Step 1: Routine periodic assessment*

The purpose of such assessment would be to identify the knowledge gaps of individual licensees in order that these gaps can be filled by continuing education or other professional development activity.

The assessment could be some type of self assessment, or a third party assessment of knowledge, understanding and skills, or a combination of self and third party assessment.

The CAC argue that an absence of concern is insufficient in order to demonstrate high performance and enhanced quality of care. They further argue that targeting only those licensees who have experienced problems in the past would be counter-productive by undermining the positive value of assessing continuing competence. They conclude: ‘ To be seen as positive and non-punitive, continuing competency assessment must apply to everyone.’

- *Step 2: Develop a personal plan*

Licensees develop a personal plan based on the outcomes of the assessment – i.e. they identify the steps they will take to develop their knowledge/ practice in light of the assessment findings.

- *Step 3: Implement the personal plan*

Implement the actions identified above (e.g. undertake education).

- *Step 4: Documentation*

Documentation to support the three steps above.

- *Step 5: Demonstrate/evaluate competence*

The CAC suggests that boards should develop clear standards and criteria to evaluate competency, and work to evaluate the effectiveness of continuing competency programs over time.

The CAC suggest that continuing education (CE) should become more evidence based and involve formal assessment, in order to ensure that knowledge is being applied.

1. State Medical Board of Ohio[10]

The State Medical Board of Ohio regulates a number of different professions including doctors, podiatrists and physician assistants.

From discussion with the Executive Staff Co-ordinator at the Board, it does not appear that any of the state boards have yet moved towards the Canadian model of regular periodic assessment of doctors.

Like the majority of state boards, Ohio does not make any 'revalidation' or 'continuing competency' requirements of its licensees.

The Board requires doctors to achieve 100 Continuing Medical Education (CME) credits every two years in order to renew their licenses. Of those 100 hours, a minimum of 40 credit hours has to be traditional formal learning, whilst 60 credit hours can come from other forms of learning, such as reading professional journals, and so on.

Licensees are asked to declare on renewal that they have met the CME requirements. A random audit of 2% of doctors is carried out to verify compliance. Every year approximately 5 to 10 doctors have a disciplinary sanction or non-compliance with the CME requirement.

Separate, not for profit organisations, similar in role to the Royal Medical Colleges, issue certificates in medical specialities. These organisations often have re-certification requirements. For example, the American Board of Internal Medicine requires that specialists in internal medicine re-certify every ten years – the requirements involve continuing education, self-evaluation and an examination in their particular area of expertise.[11]

2. National Commission on Certification of Physician Assistants[12]

This organisation sits alongside the respective boards which regulate physician assistants in each state. The National Commission on Certification of Physician Assistants (NCCPA) runs a system of certification. Certification from NCCPA is one of the criteria to become a licensed physician assistant in each of the states.

Graduates from courses accredited by the Accreditation Review Commission on Education for the Physician Assistant can take a certification exam. The exam is multiple-choice and assesses basic medical and surgical knowledge. If the exam is passed, certification is granted, normally for two years.

Re-certification happens in six year cycles. Every two years, 100 hours of continuing medical education (CME) must be undertaken, logged and a renewal fee paid. By the end of the six year, a recertification exam must also be passed which covers general medical surgical knowledge. An alternative, web based examination may be undertaken instead, but extra CME requirements apply.

[10] Information from med.ohio.gov
[11] Information from www.abim.org
[12] Information from www.nccpa.net

Not all state boards require NACCP re-certification in order to renew licenses (e.g. this is not a requirement for licence renewal in California).

3. National Registry of Emergency Medical Technicians[13]

The National Registry of Emergency Medical Technicians (NREMT) is a similar body to the NCCP and registers emergency medical technicians, first responders, paramedics and others.

The requirements for certification include a current CPR certificate and successful completion of the NREMT-Paramedic cognitive and practical examinations.

72 hours of continuing education over two years are required to re-register. This requirement can be met via a combination of a paramedic refresher course (48 hours) and 24 further hours of continuing education. Alternatively, the registrant can undertake continuing education which covers the content and hours requirement for the refresher course.

The refresher course is specific as to hours and subjects – mandatory subjects include airway, breathing and cardiology, medical emergencies, trauma and obstetrics and paediatrics.

Registration with the NREMT is not a right to practice – a licence is still required in each state. Registration with NREMT can be used to meet the requirements of licensure. However, state boards do not always require current NREMT registration in order to become re-registered.

In New Zealand, the Accident and Medical Practice Authority runs a similar recertification system.

New Zealand

Health professionals in New Zealand are regulated by separate, national boards.

1. New Zealand Occupational Therapy Board[14]

The New Zealand Occupational Therapy Board has requirements for recertification which are similar to those in Canada.

Registrants with an annual practising certificate are required to develop a competence plan, set objectives, record activities (e.g. CPD), and keep a log of professional supervision they receive. Registrants complete a self declaration, countersigned by another registrant, confirming that they have met the requirements.

Samples of up to 20% of practitioners are audited each year and practitioners for whom competence concerns are raised can be referred to competence review for remediation.

[13] Information from www.naemt.org
[14] Information from www.otboard.org.nz

However, not all professional regulatory boards have such requirements.

Australia

Health professionals are regulated in Australia by state boards.

1. Nursing Board of Tasmania[15]

Registrants with an annual practising certificate have to self-declare that they are currently practising and that they have no criminal convictions or health problems which would affect their fitness.

Some applications are randomly audited to ensure competence to practise. Individuals have to provide:

- evidence of peer review process or other documentary evidence which the applicant believes demonstrates their maintenance of competence completed within the preceding 12 months (Professional Portfolio); or
- if currently practising, a satisfactory workplace performance appraisal confirming the applicant's ability to meet the Australian Nursing and Midwifery Council (ANMC) National Competency Standards; or
- a statutory declaration, made by the applicant's employer or immediate supervisor, attesting to the applicants demonstration of the ANMC National Competency Standards in their practice.

(The Australia Nursing and Midwifery Council is an umbrella organisation which works with the state boards to facilitate a common approach to regulation.)

Renewals can be rejected if insufficient information is provided (after one request to the individual for additional information) or if an application is false or misleading

The nursing boards for the central territories and northern territories have similar requirements.

[15] Information from www.nursingboardtas.org.au

Analysis

The group is invited to discuss the existing models outlined in this paper, in particular their benefits, weaknesses and transferability to the UK.

The following analysis highlights some key features of the models, and then highlights some potential questions for discussion.

The group's discussion will be used to inform the analysis of further, UK-based models at the next meeting, and also to help shape the development of a framework which could help us evaluate the various different models.

1. Common features

The models considered in this paper vary in terms of content. However, a number of features which are common to some, if not all of the models, can be identified:

- **Self-certification**
  Individual registrants sign to confirm that they met the regulator's requirements.
- **Compulsory Continuing Professional Development (CPD) requirements**
  These requirements are often linked to the renewal of registration or non-compliance is linked with a disciplinary process. CPD is often firmly linked to ongoing competence, even in those models which do not involve a competency assessment stage.
- **Structured reflection and the identification of learning needs**
  The use of structured portfolios, feedback and/or other tools in order to reflect on practice and to set learning needs.
- **Periodic assessment and/or monitoring of compliance**
  Periodic assessment/ monitoring of compliance against standards or using a variety of different techniques. Assessment takes many different forms e.g. assessment of portfolio information to provide feedback; site visits; formal examinations. Checks are periodic – varying between two years and ten years.
- **Remediation or other sanctions**
  Supportive measures to remedy identified shortfalls or, in some limited circumstances, referral into disciplinary procedures.

Please see figure one for a summary of the key features of each of the models.

2. Risk and proportionality

The White Paper said: '*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*.'[16]

We can scrutinise the models examined in this paper to some extent by thinking about concepts of risk and proportionality.

[16] Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century (February 2007), p.37.

Most models require that CPD requirements have to be met. Although these requirements vary as to points or hours requirements and the way in which information is collected, compliance is generally monitored via an audit sample of registrants. In the Ontario models, this is supplemented by a periodic competency assessment, which, if problems are identified, can lead to remediation.

We might view this as a risk-based and proportionate approach which is analogous to the Council's existing arrangements for CPD. All registrants are required to meet the requirements, and to self-certify that they have met them, but only a random sample of the Register is audited to check compliance.

The approach in Ontario resembles a 'funnel' (see figure 2) in that the proportion of registrants involved decreases greatly at each stage, as the 'scrutiny' or thoroughness of the check increases. In this way, we might conclude that most resources are targeted at those registrants who have been identified as potentially presenting a greater degree of risk – i.e. those for whom a competence assessment has identified shortfalls in the standards expected.

It is also notable that in Ontario doctors over the age of 70 who have not been assessed in the five years are automatically invited to peer assessment. In the UK, an analysis of data from referrals to the National Clinical Assessment Service (NCAS) revealed that the rate of referral to NCAS increases with age and rises steeply after 60 amongst general medical practitioners.[17] However, similar data does not seem to exist for other professional groups. This could be a area which the group will wish to consider further.

3. 'Enhanced' CPD

In the models examined, a link is often made between undertaking continuing professional development and the competence of the practitioner. In some models studied, what is termed a quality or continuing competence programme consists entirely of CPD requirements.

When the Council developed its own requirements, it was keen to make clear that CPD was about ongoing learning and development and that no assumptions were made about the competence of a registrant on the basis of their CPD.

At the last meeting, many of the discussion groups discussed whether CPD could be seen as part of revalidation, the basis of revalidation or a tool for revalidation.

In many of the models examined in this paper, the activities might be termed 'enhanced' CPD. In some examples, assessment, structured self-assessment and peer feedback are used in order to assist the practitioner in identifying learning needs which might be fulfilled via CPD and other professional development.

[17] National Clinical Assessment Service, Analysis of the first four years referral data (July 2006). http://www.ncas.npsa.nhs.uk/

The structured way of developing learning goals put forward in some of these models could be seen as similar to existing CPD schemes run by the professional bodies. These schemes often provide not only access to CPD activities, but also provide guidance and a way of recording CPD which assists in reflection and the setting of developmental goals.

Analysis of the outcomes of the CPD audits due to commence in July 2008 may highlight whether a more structured approach would be necessary or helpful.

4. Fitness to practise?

Many of the models studied are focussed on quality or competence; the term fitness to practise is not used and, beyond self-certification at renewal, no additional requirements are made relating to health and character.

This raises the issue of whether it is possible to revalidate to ensure that someone remains 'fit to practise'. The White paper definition of revalidation figures it as a combination of remaining up-to-date with current professional practice, and remaining fit to practise.

HPC defines fitness to practise in the following terms: 'When we say that someone is fit to practise, we mean that they have the skills, knowledge, character and health to practise their profession safely and effectively.'[18]

5. Costs and resources

A number of cost and resource issues are raised by the models outlined.

In the Ontario models, regular, periodic, one to one assessment of a registrant's practice occurs. This would be costly in terms of the recruiting, training and time of the assessors involved, in addition to costs and resources associated with administering such arrangements.

When someone who has trained outside of the UK applies to HPC to become registered, their application is assessed by two members of their profession (known as 'registration assessors'). The registration assessors consider, on a documentary basis, whether the applicant's skills, knowledge and experience meet the standards required for registration. A recent costing exercise carried out for the Council by an external audit company identified the costs of our current international assessment process at around £354 per applicant.[19] We might therefore assume that the costs of conducting an individual site assessment would be considerably higher.

The models which include feedback, particularly those that administer a 360 degree feedback process, would involve considerable resources to administer.

[18] Health Professions Council, Managing fitness to practise: a guide for registrants and employers, p.2 www.hpc-uk.org/assets/documents/10001344Managingfitnesstopractise.pdf

[19] The Health Professions Council's response to the Department of Health's review of the regulation of the non-medical healthcare professions (November 2006). http://www.hpc-uk.org/assets/documents/100016F5HPC_response_review_non_medical_regulation.pdf

6. Purpose

The drivers behind the models outlined seem similar to the UK. They often concern arguments that existing systems based on exception reporting are outdated and that a firm assurance of ongoing competence is necessary.

The purpose of many of the models studied is firmly developmental – to improve the quality of practice. This is reinforced by the structure of many of the models, which separates the 'quality assurance' or 'quality management' processes from fitness to practise or disciplinary process.

This compares sharply to how revalidation has so far been conceived in the UK – that there should be a direct link between revalidation and the retention of registration and between revalidation and the regulators' fitness to practise processes.

Instead, the models studied, particularly in Canada, and the arguments put forward for similar arrangements in the US, are based on a supportive approach which aims to 'shift the bell curve' of professional practice over time.

At the last meeting, the group discussed whether revalidation should be focused on 'catching the bad apples', or whether it should instead aim to engage with the majority of practitioners. A dichotomy was suggested, between quality control and quality improvement. Figure 3 has been adapted from a diagram provided by Charles Shaw (a PLG member) and highlights the comparison between quality control (compliance with threshold standards) and quality improvement (a shift has occurred and practitioners at each level have increased competence).

Throughout the research into these models, the importance of professional buy-in has been emphasised. A quality improvement approach, with outcomes which clearly separate disciplinary matters, it is argued, is necessary in order to ensure full engagement with the process. At the last meeting, one group discussed whether revalidation should be bottom up (led by the professional bodies) rather than top down (led by government and regulators).

It is noteworthy that some of the models developed in Canada were run on a voluntary basis before becoming mandated by law.

The regulation of the non-medical healthcare professionals noted:
'*For regulation to motivate and engage with the majority who always aim to practise safely, it must aim for improvement, not mere compliance*.'[20]

[20] Department of Health, The Regulation of the Non-medical Healthcare Professionals (July 2006) p. 11.

7. Some discussion points

The following are some questions which may assist the group in its discussion.

- Risk and proportionality

How does the approach undertaken in Canada help us to think about risk and proportionality in revalidation?

The group may wish to consider whether the approach to risk and proportionality in the models identified are helpful in drawing any conclusions. In particular, the group might wish to consider the models in light of the White Paper's recommendation that the frequency and intensity of revalidation should depend on the nature of the individual registrant's practice.

- Enhanced CPD

What are the merits or weaknesses of an 'enhanced CPD' approach?
Can 'enhanced CPD' achieve the aims of improving quality and assuring continued competence?

- Fitness to practise? / Competence?

Is it possible to revalidate fitness to practise?

The group may wish to consider whether it is possible to devise a system of revalidation which could positively assure the fitness to practise of registrants. Competence is one facet of 'fitness to practise'.

In the GMC proposals, it has been put forward that doctors would be asked to prove their good conduct by way of a probity declaration, and a declaration from their employer that any concerns about their fitness to practise had been satisfactorily resolved. In 2003, Dame Janet Smith said that this would provide only a 'negative assurance' of fitness to practise.[21]

- Costs and resources

Are the likely cost and resource implications of the models examined proportionate to the likely or suggested benefits?

- Purpose

Is it appropriate for regulators to be involved in 'quality improvement'?

In the existing system, regulators set threshold standards for entry to professional registers and then ensure that those standards are met (e.g. via approving courses and fitness to practise procedures).

Whilst regulators focus on compliance with threshold standards, other organisations are often concerned with developing and encouraging good

[21] The Shipman Enquiry, The Fifth Report, Chapter Twenty Six – Revalidation, 26.136.

practice and improving the quality of services and practice over time. For example, government and sector skills councils may be involved in raising the bar of professional practice by involvement in workforce planning and ‘up-skilling’ of staff at different levels. Professional bodies might also be seen to have a role in this area in their role of promoting and developing the professions.

The models studied in this paper move away from an approach focused on threshold standards and suggest a role for the regulator in supporting registrants not only to meet those standards, but also to exceed them. Such an approach could potentially be seen as controversial, moving away from the ‘core aims’ or ‘core functions’ of regulators into an area which has traditionally been occupied by other organisations.

Regulators in the UK do make CPD requirements, but this is often focused at keeping ‘up-to-date’; a direct line between CPD and improved outcomes or improved competence is normally not drawn.

However, we could suggest some possible benefits from the quality improvement approaches outlined in this paper. Such an approach could, potentially, not only benefit the bottom percentile needing some help to reach the required standards, but all registrants, in providing developmental feedback. Such an approach might also be more effective in achieving professional buy-in by avoiding the perception that the purpose was to ‘catch out’ registrants and remove them from the Register. In this way, a focus on quality improvement could potentially be figured as a more pro-active way of achieving the goal of protecting public safety.

The group may further wish to explore the issues of self-regulation and trust in light of the models examined, particularly in light of the movement in some of the models, from voluntary arrangements, to compulsion.

Figure 1

	Self-certification	CPD	Portfolio/ tools	Periodic Assessment	Remediation
Canada					
Physiotherapists (Ontario)	✓	✓	✓	✓	✓
Occupational Therapists (Ontario)	✓	✓	✓	✓	✓
Physical therapists (Alberta)	✓	✓	✓	X	X
Physicians and Surgeons (Ontario)	✓	✓	✓	✓	✓
United States					
Doctors (Ohio)	✓	✓	✓	✓	✓
Physician Assistants (Certification)	✓	✓	X	X	X
Emergency Medical Technicians (Certification)	✓	✓	X	X	X
New Zealand					
Occupational Therapists	✓	✓	✓	✓	✓
Australia					
Nurses (Tasmania)	✓	✓	✓	X	X