This report details the findings of a study commissioned by the Pharmaceutical Society of Northern Ireland to review approaches to assuring the continuing fitness to practise of practitioners that have been adopted by regulators of healthcare professions in the UK, by a sample of pharmacy regulators in other countries, and by a sample of other professions.
Acknowledgments

The project was commissioned and funded by the Pharmaceutical Society of Northern Ireland. We would like to express our thanks to Michelle McCorry, Post-Registration Lead for her ongoing support and encouragement throughout this work.

We would also like to thank:

- officers in the UK healthcare professional regulators and the Pharmaceutical Society of Ireland for checking the accuracy of our descriptions about their approaches to assuring continuing fitness to practise
- individuals in the pharmaceutical regulatory bodies across the world who provided confirmation or clarification of points of detail by email.

Any errors or omissions are the responsibility of Prime Research and Development Ltd.
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EXECUTIVE SUMMARY

INTRODUCTION
The Pharmaceutical Society of Northern Ireland (PSNI) is seeking an overview of the continuing fitness to practise processes of other professions in the UK and the pharmacy profession worldwide as, like other healthcare regulators in the UK, it is actively considering how it can assure the continuing fitness to practise of its registrants.

The aims of this report are to:

1. identify and analyse the available literature on models of continuing fitness to practise
2. summarise and compare the different models used by other regulators in the UK and beyond to build an increased understanding of the nature, scale and effectiveness of different approaches to managing continuing fitness to practise
3. make recommendations on a possible way forward in the context of the PSA’s standards of good regulation and the principles of ‘right-touch regulation’
4. contribute to PSNI’s future decisions about the most effective and appropriate means of assuring the continuing fitness to practise of registrants.

The work was commissioned on 11 September 2013 and was mainly undertaken between 16 September and 10 November 2013. Subsequent to this, the content relating to the UK health regulators and the Pharmaceutical Society of Ireland was checked with the organisations concerned resulting in some minor modifications.

The UK Government set out its interest in the revalidation of healthcare practitioners in the White Paper Trust, Assurance and Safety (2007). Immediately following this, the Department of Health set up a Non-Medical Revalidation Working Group which produced a set of principles for non-medical revalidation (DH, 2008).

All of the healthcare profession regulators in the UK are overseen and scrutinised by the Professional Standards Authority (PSA) with their performance being reviewed on an annual basis. The PSA encourages the regulators to adopt a ‘right-touch’ approach to regulation using the six principles of: proportionality, consistency, targeted, transparency, accountability and agility. In its proposals for the approaches that regulators might adopt in assuring the continuing fitness to practise of their registrants, the PSA emphasises the importance of adopting a thoughtful and flexible approach to risk mitigation, implying that there is no single solution applicable to all professions (PSA, 2012).

The main areas that the PSA is seeking in relation to a right-touch approach to assuring continuing fitness to practise can be summarised as:

a. reaffirming that registrants continue to meet the core standards of competence and behaviour (ie conduct and competence)
b. having a clear understanding of what professionals (registrants) do and the context in which they do it
c. identifying the severity and prevalence of risks relating to continuing fitness to practise to guide decision-making and the approaches used (including whether these differ for different registrant groups or in different areas of practice)
d. making use of existing mechanisms whether national or local, or of the regulator or other organisations, providing they are fit for purpose
e. ensuring that the assessments made are sufficiently valid and reliable for the risks identified
f. transparency and accountability – being clear about the reasons for these forms of assurance being used and making explicit and public the levels of assurance that the approaches provide.

These areas have been used as a basis to identify good practice in this report.

Chapter 1 concludes with an overview of the PSNI’s recent development of a mandatory CPD scheme, and also an account of the methodology used to produce this report.

The approaches of UK healthcare profession regulators
Chapter 2 reviews the approaches used or under development by the other UK healthcare profession regulators to assure continuing fitness to practise. It summarises the current systems of mandatory CPD that all the UK healthcare profession regulators have in place as well as considering their more recent developments in assuring continuing fitness to practise.

It is evident that the term ‘assuring continuing fitness to practise’ is now widely used by UK healthcare profession regulators and for a number this term has replaced the earlier focus they had on ‘revalidation’ (eg GOC, GOsC, GPhC), whilst for the HCPC ‘assuring continuing fitness to practise’ has always been the concept that has driven its work in this area. The GMC is the only UK healthcare profession regulator in the UK (and possibly in the world) to have implemented a system of revalidation. The NMC has announced plans to introduce revalidation in 2015 although it has not as yet published detailed proposals.

Amongst the non-medical regulators there is a growing interest in enhancing CPD as a more proportionate and effective means of assuring the continuing fitness to practise of registrants. For the GOC this conclusion was reached following detailed work on the risks posed in optical practice and by identifying the most cost-effective means of addressing those risks. For the GOsC it is a result of the outcomes of an extensive pilot, whilst for the GDC the focus has shifted to reviewing and improving its CPD scheme as a fundamental step on the path to a possible future revalidation system. More recently the GPhC has agreed to develop a framework based on CPD, peer review and external performance measures – the first two of which are common to the GOC and GOsC.

Chapter 2 also reviews the development work that each of the regulators has undertaken and compares this with the areas of good practice identified by the PSA. This comparison reveals a number of examples of good practice in a number of the areas.

The approaches of pharmacy regulators in other countries
Chapter 3 reviews the approaches adopted by pharmacy regulators in other countries to assure continuing fitness to practise. Regulators outside the UK do not use the concept of ‘continuing fitness to practise’ as an organising principle. The term ‘fitness to practise’ tends to be confined to matters associated with professional conduct and discipline. Similarly, the term ‘revalidation’ has yet
to achieve currency in pharmacy regulation in the countries reviewed. However these concepts can be inferred from the widespread adoption of regulatory measures to promote continuing competence through continuing education and professional development, affirmed through processes of periodic re-registration.

Periodic re-registration is the principal means by which pharmacists are obliged to declare and/or to demonstrate that they continue to meet expectations regarding competence and conduct. Pharmacists in all but one of the jurisdictions reviewed are required to renew their registration periodically and to declare that they continue to meet registration standards, and usually also to confirm or to provide evidence of having undertaken continuing education or professional development.

Maintaining competence and keeping up-to-date is a professional obligation promulgated by all the regulators reviewed – an obligation that appears in statutes, regulations, rules, codes of conduct and policies. In some cases it is cast primarily as an ethical duty and in others as a legal requirement. A mandatory requirement to complete a specified number of hours, credits or units of learning or to follow a continuing professional development cycle during the registration period have been adopted widely as a means of regulating what would otherwise be a matter for registrant discretion.

A distinction can be drawn between the more permissive schemes (that allow pharmacists to determine how best to satisfy their continuing education and professional development needs) and the more tightly specified schemes (that require completion of accredited continuing education and/or the acquisition of a specified number of accredited hours or units of learning). The distinction appears to reflect differences of underlying philosophy about purpose and methods.

The more permissive schemes place greater emphasis on explaining why they are structured as they are, emphasising among other things that pharmacists learn in different ways, work in different settings, have different needs at different points in their careers, are likely to benefit most from access to the widest range of learning opportunities and activities, and that greater flexibility in what is to count as acceptable CPD is more likely to result in practice and services improvements.

It is not uncommon for continuing education to be formally assessed, enabling participants to claim credits without equivocation. Of those reviewed only Canadian regulators select a sample of registrants to undertake a formal, invigilated, knowledge assessment. Ontario is alone among these in subjecting a small minority of randomly selected registrants to an assessment in which a peer reviewer observes and rates several dimensions of performance during a registrant interview with a patient in a standardised scenario. Peers are also involved subsequently in supporting and advising pharmacists who fall below the required standard.

The evidence required at registration renewal to demonstrate that continuing education (CE) or CPD requirements have been met varies among regulators. All require pharmacists to keep adequate records and to make a self-declaration of compliance. Most offer an online facility to log learning activities and provide a range of guidance, development cycle templates, portfolio proforma and other forms of support.

The policy to audit a sample of registrant declarations and associated evidence is commonplace but few regulators provide details of how this is done, by whom, or against what standards.
There is an apparent absence of information about the costs of operating the various schemes described. We found no direct evidence of Government funding for measures to assure the continuing fitness to practise of pharmacists (although this may have occurred as initial pump priming) and have inferred from annual reports that most schemes are accounted for in general operating expenditure, funded from registrant fees and other established income streams.

There is a paucity of published information reporting any risk-assessments, cost-benefit analyses or business cases that may have been undertaken or developed to inform policy decisions leading to the adoption of the models described. It seems reasonable to assume that if analyses of this sort had been undertaken committees would probably have considered them *in camera*.

There are no regulatory blueprints to assure continuing fitness to practise or to validate continuing competence suitable for evaluation as a potential model for consideration by the PSNI. However elements of some of the schemes reported provide potentially helpful pointers regarding specific measures that might be adopted.

**The approaches of other, non-health profession regulators**

Chapter 4 examines how three non-health professions – accountancy, aviation and teaching – assure continuing fitness to practise.

The occupation of ‘accountant’ does not have protection of function or title in UK law. However certain financial functions are regulated and can only be undertaken by qualified accountants. In the absence of a single regulatory body there are no universal registration or membership standards against which continuing fitness to practise can be assessed and assured.

There are a number of professional accountancy associations. Membership is voluntary and is usually qualification, experience and fee dependent. The incentive of members to comply with standards rests on the benefits that accrue from belonging to an organisation of standing in the professional community and among employers, and whose qualifications are respected.

The absence of exclusive rights to regulate an occupational function or title means that these associations have only limited scope to make demands on their members in terms of assuring continuing fitness to practise. The predominant approach is to specify expectations in respect of continuing professional development and to demand a declaration of compliance upon (usually annual) renewal of membership. Byelaws permit these bodies to discipline, decline or refuse to renew membership to individuals who do not comply with the CPD standard, but the absence of occupational exclusivity means that debarred members are not prohibited from working as an accountant.

Many regulatory bodies for teachers have policies for periodic re-registration but few are associated with formal requirements to demonstrate continuing competence or fitness to teach. Where renewal of registration is linked to a requirement to undertake continuing education this is usually expressed as a professional obligation in a Code of Conduct. In some cases professional leaders are required to endorse registrant declarations and to confirm their own assessments of the registrant’s continuing ‘fitness to teach’. There is evidence of an increasing use of regular (both professionally-led and employer-led) teacher appraisal and direct observation of teaching practice as a means of
assuring continuing fitness to teach, and also of a strengthening of development and performance review to underpin ‘reaccreditation’.

Procedures to deal with poor teacher performance are usually independent of employer appraisal schemes. Those jurisdictions that have professional-self regulation tend also to have established systems of professional conduct and discipline, providing a retrospective measure of assurance of continuing fitness to teach by responding to complaints and notifications of misconduct or incompetence.

Standards of safety in civil aviation are regulated by national and supra-national bodies. The regulation of pilots and other safety-critical aviation personnel is by license, not registration. In contrast to the registration approach typically adopted by the health professions, aviation authorities use licensing as the means to assess initial competence and to admit individuals to regulated and tightly defined occupational roles, and then through periodic but regular checks to revalidate an individual’s competence and fitness to operate (quite literally in the case of regular medical examinations) against the initial licensure standards.

There are detailed regulations that specify a schedule of requirements for each type of license. For any particular type this might involve an annual proficiency check for some elements (ratings) and less frequent revalidation of others. Failure to demonstrate competency in a proficiency check results in withdrawal of the privilege and can mean retraining and demonstration of competence through the knowledge and skills assessments used to determine competence for initial licensure. Arguably, this ‘live’ approach to licensure provides a greater level of assurance about continuing fitness to practise than is achieved in most other professions.

**Chapter 5 Conclusions and recommendations**

Chapter 5 draws together information on the approaches that UK healthcare profession regulators, pharmacy regulators in different areas of the world and regulators for three other professions use in assuring the continuing fitness to practise of the practitioners they regulate.

It shows that the term ‘assuring continuing fitness to practise’ is a relatively recent addition to discussions about regulation in the UK and is concentrated in healthcare. The concept implies a proactive approach to assuring that practitioners continue to meet standards of conduct, behaviour and competence, in contrast to the more reactive systems that are in place to deal retrospectively with conduct, behaviour or competence when something has gone wrong, also referred to under the rubric of ‘fitness to practise’. The term is not widely used by pharmacy regulators elsewhere in the world where the focus tends to be on renewal of registration linked to continuing professional development. Statutory regulation and/or protection of title, which are commonplace among the health professions, are not privileges extended to every profession; some other professions have to rely on the regulation of certain of their activities as the basis of standard setting and policing.

Periodic renewal of registration (or licensing) and an associated requirement to undertake continuing professional development are the most commonly adopted regulatory measures to assure continuing fitness to practise among the professions studied. In the UK the approach tends to be at the more permissive end of the spectrum inasmuch as it is usually based on an adult learning cycle in which practitioners are viewed as best placed to identify their learning and development needs, to select and undertake appropriate continuing education and professional development,
and to produce evidence of having done so. Most of the pharmacy regulators in other countries reviewed for this study, and the GOC in the UK, operate more tightly specified schemes which require completion of accredited continuing education, and which can also have some form of assessment linked to them. The rigour that regulators apply to confirmation of compliance can also be seen on a spectrum. Most regulators refer to auditing a sample of registrant declarations and associated evidence but not all regulators provide details of sample size and frequency, how this is done, by whom, or against what standards.

The term ‘assuring continuing fitness to practise’ is now widely used by UK healthcare profession regulators and for a number it has replaced an earlier focus on revalidation. To date the GMC is the only UK healthcare profession regulator to have implemented a revalidation system. There is a growing interest amongst the non-medical regulators in enhancing CPD as a more proportionate and effective means of assuring continuing fitness to practise or in introducing what might be termed ‘CPD Plus’.

It is unrealistic in a study of this sort to make judgements about best practice because each regulator has to develop measures that are most appropriate and proportionate to the risks posed by their registrants. We believe direct comparisons are problematic and not especially helpful. We have therefore used the areas that the PSA identify as characteristic of a right-touch approach to assuring continuing fitness to practise as a basis to identify good practice. These are summarised below:

1. **Core standards of competence and behaviour (ie conduct and competence)**

   All of the regulators have standards of conduct and competence although the extent to which they are integrated, how they are presented and how they have been used in developing approaches to the assurance of continuing fitness to practise varies.

2. **A clear understanding of what professionals (registrants) do and the context in which they do it**

   Given the time and resources available for this project, it has proved difficult to establish how clear an understanding each regulator has of what their registrants do, although examples of such understandings can be inferred. One example of research commissioned specifically for this purpose is that commissioned by the GOsC to understand how its registrants practise and feeding into its understanding of risk.

3. **Severity and prevalence of risks relating to continuing fitness to practise guiding decision-making and the approaches used**

   The development of a risk-based approach is one of the fundamental principles to regulation that has emerged over the last few years in the UK. A number of the healthcare profession regulators have undertaken detailed risk assessments (beyond an analysis of their fitness to practise case data) although these differ in approach and coverage. Some focus on the risks in the activity of the professions concerned (eg the GCC), others consider both the activity and the context (eg GOC) and some the context alone (eg the GPhC). The GOsC has undertaken a number of studies to explore different areas and perceptions of risk. However not all UK healthcare profession regulators have undertaken / published studies on risk (eg GMC and NMC).
Information on risks, and the benefits and costs associated with addressing those risks, is clearest in the work undertaken by the GOC, where it is possible to see a clear path through from risk assessment, to potential ways of addressing those risks, a costing of the different ways to a decision on the final approach to be used.

4. Use of existing mechanisms

There are various examples of the UK regulators using existing mechanisms to assure continuing fitness to practise, either those already in place within the regulator (eg the GOC’s use of CET) or in healthcare organisations (such as the use of annual appraisals in medical revalidation). Where devolved systems are used, the main costs of the assurance system appear to be covered by the state through NHS funding. Recent developments by the non-medical regulators (GDC, GOsC and the GPhC) suggest that increasingly they are following the path taken by the GOC, viewing CPD enhancement as the most cost-effective way to proceed for areas of practice where there is low risk.

5. Assessments made are sufficiently valid and reliable for the risks identified

The predominant themes that emerge in relation to assessment are:

- concerns about relying solely on self-assessment as the basis of the assurance process (eg GOsC) and for driving practitioner improvements
- the benefits of peer review that is structured to provide a measure of objectivity (eg GMC, GOC, GPhC and GOsC)
- the use of feedback from patients and service users (eg GMC, GOsC and HCPC).

Another key theme to emerge from the work of a number of regulators is the active engagement of practitioners in the process of assuring continuing fitness to practise. There appears to be no appetite for one-off assessments of practice of healthcare professionals (as with licensing in the aviation industry) to determine whether an individual is competent to remain on the register.

6. Transparency and accountability - the reasons for these forms of assurance being used and the levels of assurance that the approaches provide are made explicit and public

This report illustrates the level of availability and accessibility of information on regulator websites. A number of regulators make explicit the range of research they have commissioned and the decisions and actions they have taken as a result (eg the GDC, GOC, GOsC). There is a wealth of information on the GMC’s website but the genesis and development of medical revalidation is more difficult to track due to the numerous partners involved and the direct involvement of the UK government. There is however no published risk analysis of medical practice or any assessment of whether the current system of medical revalidation is the most appropriate response to the risks that exist. Regulators will not be in a position to provide publicly accessible information about the level of assurance delivered by the approaches to assuring fitness to practise they have proposed until after implementation.

This project also sought information on business cases and time frames.
**Business cases** - little public information is available on business cases developed in support of particular approaches for assuring continuing fitness to practice although costs and benefits have been presented for medical revalidation (DH, 2012), for the initial revalidation scheme proposed by the GOsC (KPMG, 2013b), and for enhanced CET by the GOC (Europe Economics, 2012). As well as costs each regulator needs to consider its capacity to deliver such systems in terms of human and capital resources.

**Time frames** - the time frames for implementation of measures to assure continuing fitness to practise vary. Some regulators (the GMC and GOC) have started implementation, others have plans to implement their approaches within the next two years (NMC and GDC) subject to legislation, while the GPhC is looking to 2018. Other regulators have yet to commit to a firm date whilst the HCPC appears to retain its original position that it has not established a need for any new or enhanced mechanisms. For all regulators the outcomes of the Law Commission review may affect decisions on timing and approach.

**Recommendations**

Four options have been identified as possible ways forward for the PSNI from the approaches to assuring continuing fitness to practise that were surveyed. The options are:

1. **do nothing**
2. develop a revalidation model from first principles
3. import and adopt (wholesale or adapted) an established revalidation model from another regulator (ie the regulator of another health profession, a pharmacy regulator in another country, the GPhC or the regulator of another profession)
4. strengthen existing PSNI regulatory policies and procedures to improve the assurance of continuing fitness to practise of registrants.

Each of the options has been reviewed for its strengths and weaknesses and from this the fourth option, which has the most advantages and fewest disadvantages, is recommended as potentially the most productive way forward. Given this, we recommend:

1. the PSNI does **not** develop a revalidation scheme for pharmacists in NI, either from first principles or through adapting another existing scheme
2. the PSNI seeks to strengthen its existing regulatory policies and procedures to improve the assurance of continuing fitness to practise of pharmacists in NI, building on the work undertaken to implement a comprehensive scheme of mandatory CPD.
3. in seeking to strengthen its existing regulatory policies and procedures, the PSNI evaluates the GPhC’s recent proposals and their applicability to pharmacy practice in NI so that a UK-wide approach is facilitated. This should specifically include evaluating the potential of three key components:
   a. incorporating a peer review process
   b. how reviews of individual registrant’s CPD might be improved
   c. using external performance indicators related to the registrant’s scope of practice

   and learning from the developments being undertaken by the GPhC as they proceed.
4. in this work, and in addition to the components of the GPhC model, the PSNI also:
a. specifies standards against which continuing competence and performance can be assessed (which might be the current registration performance standards or competencies developed for the purpose)
b. identifies ways in which practitioners can be actively engaged in understanding standards of conduct and practice and enabled to see the value of assuring continuing fitness to practise
c. evaluates whether some forms of CPD are required to facilitate improvements in practice
d. evaluates whether current proposals for remediation in response to non-compliance with CPD standards are sufficient to deal with a failure to meet continuing fitness to practise standards, and if not, what system of support would be fair and appropriate whilst also protecting patients
e. develops a business case for enhancing its regulatory policies linked to the risks of pharmacy practice in Northern Ireland that such enhancements seek to address.

5. in the context that research and development funding has been afforded to other healthcare profession regulators in the UK through the Department of Health, the PSNI seeks development funding from the NI Government for taking forward policies to assure the continuing fitness to practise of pharmacists in Northern Ireland.
CHAPTER 1: INTRODUCTION, BACKGROUND & METHODOLOGY

INTRODUCTION
The Pharmaceutical Society of Northern Ireland (PSNI) is seeking an overview of the continuing fitness to practise processes of other professions in the UK and the pharmacy profession worldwide.

The aims of this report are to:

1. identify and analyse the available literature on models of continuing fitness to practise
2. summarise and compare the different models used by other regulators in the UK and beyond to build an increased understanding of the nature, scale and effectiveness of different approaches to managing continuing fitness to practise
3. make recommendations on a possible way forward in the context of the PSA’s standards of good regulation and the principles of ‘right-touch regulation’
4. contribute to PSNI’s future decisions about the most effective and appropriate means of assuring the continuing fitness to practise of registrants.

The work was commissioned on 11 September 2013 and was mainly undertaken between 16 September and 10 November 2013. Following this the content relating to the UK health regulators and the Pharmaceutical Society of Ireland was checked with the organisations concerned and some minor modifications made.

BACKGROUND
UK context
The PSNI, like other healthcare profession regulators in the UK, is in the process of actively considering how it can assure the continuing fitness to practise of its registrants. This consideration is a result of Government interest in the revalidation of healthcare practitioners as set out the White Paper \textit{Trust, Assurance and Safety} (2007). Immediately following the publication of the White Paper, the Department of Health set up a Non-Medical Revalidation Working Group\footnote{Medical revalidation was taken forward separately from the other regulated healthcare professions.} which produced a set of principles for non-medical revalidation (DH, 2008). These principles are:

1. Consistency - with the Better Regulation Executive’s five principles of good regulation.
2. Professional standards - regulatory bodies should set out the contemporary professional standards that registrants have to meet to maintain registration.
3. Remediation - where processes highlight performance concerns there should be scope for remediation of the professional although public safety must remain paramount.
4. Patient and public involvement - the process must have the confidence of the public that it is appropriate, relevant and fit for purpose.
5. Continuing professional development - the process by which individual registrants keep themselves up to date in order to maintain the highest standards of professional practice.
6. Quality assurance mechanisms must be built into revalidation processes.
7. Equality - equality and diversity considerations must be evident in the development of revalidation systems and processes.
8. Integration – effective connections should be made with clinical governance frameworks and information about individual professionals made use of in revalidation.


10. Demonstrating benefits - structures and processes should be effective in confirming fitness to practise.

11. Information - required by each regulator to be based on risk profiling of their registrant group(s).

12. Incremental introduction.

Following the production of the principles of non-medical revalidation, each of the non-medical regulators which covered England put in bids to the Department of Health for grant monies to take forward research and development work in this area of Government policy. This was unusual for the regulators who are normally self-funding but was in recognition of the additional developments that the Government wanted taken forward as part of its health policy. We understand that each regulator made bids for and received grants of approximately £250,000 for development work between 2009 and 2013.

The House of Commons Health Select Committee, which has taken an interest in the development of revalidation policies and processes, defined revalidation as:

“a broad term used to refer to the policy of proactively ensuring that practitioners who are registered to practise are still safe and competent to do so. This contrasts with the policy of investigating competence only when complaints are made or concerns are raised.” (House of Commons Select Committee, 2010-12)

In 2011, the Coalition Government published its Command Paper Enabling Excellence (DH, 2011). This confirmed that despite a change of Government, regulators were still asked to:

“continue to develop the evidence base that will inform their proposals for revalidation over the next year. For those professions where there is evidence to suggest significant added value in terms of increased safety or quality of care for users of health care services from additional central regulatory effort on revalidation, the Government will agree with the relevant regulators, the Devolved Administrations, employers and the relevant professions the next steps for implementation.” (DH, 2011)

All of the healthcare regulators in the UK are overseen and scrutinised by the Professional Standards Authority (PSA) and their performance is reviewed on an annual basis². The PSA also audits the initial stages of regulators’ fitness to practise processes and reviews their final decisions to evaluate whether the decisions taken protect the interests of service users and the public.

For the annual performance review process, the regulators are asked to provide evidence as to how they are meeting the PSA’s Standards of Good Regulation (PSA, 2010a) on each of the four core regulatory functions: guidance and standards, education and training, registration, and fitness to practise. The PSA evaluates the evidence provided by the regulators with information collected from other sources. The PSA reports the outcomes of the process in its annual report to the four UK governments – the last report covered the period 2012-2013 (PSA, 2013).

² The PSA was originally named the CHRE – Council for Healthcare Regulatory Excellence. Its name changed and its role was extended in 2012.
The specific standard that relates to continuing fitness to practise comes under the education and training section and states:

“Through the regulator’s continuing professional development/revalidation systems, registrants maintain the standards required to stay fit to practise” (PSA, 2010a, para 4.2.2).

The most recent version of the Performance Review noted that neither the PSNI or the Nursing and Midwifery Council (NMC) were currently meeting this standard, and that the PSNI was awaiting legislation to implement a mandatory scheme of continuing professional development (CPD). The PSA also noted that all of the regulators were at different stages of implementing schemes to provide assurance of the continuing fitness to practise of registrants (PSA, 2013). The PSA recommended that other regulators take note of the actions that the General Medical Council (GMC) took to launch medical revalidation. It also identified the use of peer review within the General Optical Council’s scheme as an example of good practice.

The PSA encourages the regulators to adopt a ‘right-touch’ approach to regulation adding to the Better Regulation Executive’s principles of good regulation (proportionate, consistent, targeted, transparent, accountable (BRE, 2000)) a sixth principle of agility, which is anticipating change rather than seeking to prevent the last crisis happening again. It describes this as:

“always asking what risk we are trying to regulate, being proportionate and targeted in regulating that risk or finding ways other than regulation to promote good practice and high quality healthcare. It is the minimum regulatory force required to achieve the desired result” (PSA, 2010b).

The PSA summarises the elements that sit at the heart of right touch regulation as:

- “identify the problem before the solution
- quantify the risks
- get as close to the problem as possible
- focus on the outcome
- use regulation only when necessary
- keep it simple
- check for unintended consequences
- review and respond to change” (PSA, 2010b).

The PSA continues its theme of right-tough regulation in its proposals for the approaches that regulators might adopt in assuring the continuing fitness to practise of their registrants (PSA, 2012). This emphasises the need for regulators to develop approaches that mitigate the risks posed by the practitioners they regulate and to do so in a thoughtful and flexible way. This message from the PSA is clear in that it suggests there is no one way for regulators to take forward the assurance of continuing fitness to practise with different approaches needed to address different risks. As the document states:

“Revalidation will not be an appropriate response for all professions, but for high-risk professions it may be. We find it helpful to think of the regulatory responses as sitting on a risk-based continuum, with revalidation at one end, and the auditing of self-reported, input
based continuing professional development (CPD) at the other. What should be common to all responses is the monitoring of their effectiveness and of the transparency around these arrangements – over time regulators will need to be able to demonstrate that these mechanisms are achieving what they set out to achieve” (PSA, 2012, para 2.4).

“The primary (though not necessary only) role of continuing fitness to practise should be that of reaffirming that registrants continue to meet the core standards of competence and behaviour”. (PSA, 2012, para 3.12). The development of “ways of assuring continuing fitness to practise that are proportionate and effective at mitigating risks will require a clear understanding of what professionals do, and of the context in which they do it”.

The PSA classifies risk into two broad groups:

- context – variables related to the practitioner’s employment, education and training
- activity – the risks related to the tasks and actions that the practitioner undertakes.

The risk factors identified by the PSA are shown in full in table 1.1 below.

**Table 1.1: Risk factors associated with continuing fitness to practise**

<table>
<thead>
<tr>
<th>Source</th>
<th>Risk factors</th>
<th>Description of factor by PSA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Context</strong></td>
<td>Effectiveness of clinical governance (or equivalent) mechanisms (GOC)</td>
<td>What measures are in place to manage risk and learn from mistakes</td>
</tr>
<tr>
<td></td>
<td>Effectiveness of qualifying training (HPC)</td>
<td>How well the course has taught skills, knowledge and professionalism</td>
</tr>
<tr>
<td></td>
<td>Frequency of practice (PSNI, TAS)</td>
<td>If practitioner is well-versed in his/her field (eg returners to practice, practitioners in predominantly management roles)</td>
</tr>
<tr>
<td></td>
<td>Level of autonomy (TAS)</td>
<td>Extent to which practice is monitored and practitioners are able to practise independently</td>
</tr>
<tr>
<td></td>
<td>Level of isolation (GOC)</td>
<td>Level of interaction with other practitioners (linked to practice context)</td>
</tr>
<tr>
<td></td>
<td>Level of support (PSNI)</td>
<td>Quantity and quality of appraisals, learning opportunities etc to which registrant has access</td>
</tr>
<tr>
<td></td>
<td>Practice context (GOC, NCAS, TAS)</td>
<td>Whether practising in private practice, NHS or non-NHS managed environments or domiciliary</td>
</tr>
<tr>
<td></td>
<td>Time since qualification (GOC, NCAS, TAS)</td>
<td>Length of time since practitioner qualified (linked to age)</td>
</tr>
<tr>
<td></td>
<td>Workload (PSNI)</td>
<td>Pressure on practitioners to be more efficient; increased stress</td>
</tr>
<tr>
<td><strong>Activity</strong></td>
<td>Complexity of task (GOC, TAS)</td>
<td>Complexity of diagnosis, procedure or treatment; including the management of issues related to the service user such as compliance with treatment</td>
</tr>
<tr>
<td></td>
<td>Emotional and psychological engagement (CHRE)</td>
<td>Extent to which intervention poses an emotional / psychological risk to the service user</td>
</tr>
<tr>
<td></td>
<td>Level of responsibility for service user safety (TAS)</td>
<td>Whether responsible for service user safety, how many responsible for; vulnerability and/or severity of condition</td>
</tr>
</tbody>
</table>
The severity and prevalence of any risks relating to practitioners continuing to be fit to practise should strongly influence the approaches that regulators take. They should also inform where those approaches are on a risk-based continuum allowing regulators to focus on those groups of practitioners and/or those areas of work that they undertake which present the greatest risks. The use of existing appropriate local or national mechanisms is also encouraged providing that they are fit for purpose. Regulators are also asked to consider how reliable their assessments need to be based on the risk being addressed.

The main areas that the PSA is seeking in relation to a right-touch approach to provide assurances of the continuing fitness to practise of registrants are closely aligned to the principles of non-medical revalidation. They can be summarised as:

a. reaffirming that registrants continue to meet the core standards of competence and behaviour (ie conduct and competence)
b. having a clear understanding of what professionals (registrants) do and the context in which they do it
c. identifying the severity and prevalence of risks relating to continuing fitness to practise to guide decision-making and the approaches used (including whether these differ for different registrant groups or in different areas of practice)
d. making use of existing mechanisms whether national or local, of the regulator or other organisations, providing they are fit for purpose
e. ensuring that the assessments made are sufficiently valid and reliable for the risks identified
f. transparency and accountability – making clear the reasons for these forms of assurance being used and making explicit and public the levels of assurance that the approaches provide.

We have used these principles, which are themselves drawn from the principles of better regulation, as the basis to identify good practice in this report.

Firstly, we provide an overview of the current state of play as we understand it in terms of the PSNI’s developments related to assuring the continuing fitness to practise of its registrants. We then describe how we undertook the work that forms the remainder of this report.

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3 The acronyms used in the table, which are not referred to elsewhere in the document, are as follows: NCAS – National Clinical Assessment Service; TAS – Trust, Assurance and Safety White Paper (HM Government 2007). The reports from which the data was drawn for the table can be found at: http://www.chre.org.uk/_img/pics/library/121102_Right_Touch_CfP_-_FINAL_1.pdf
PSNI

Given this UK context, the PSNI is seeking an overview of the continuing fitness to practise processes of other professions in the UK and a sample of pharmacy profession regulators worldwide to inform its thinking on how it might be appropriate to proceed.

As one of the smallest regulators within the UK with 2,111 pharmacists on its register (as at 31 May 2013) and confined to regulating the profession within one country of the UK, the PSNI has the same challenges as other UK regulators but limited resources (PSNI, 2013a). It is also in the unique position of there being another regulator that regulates the same profession – pharmacy – in the remainder of the UK.

The PSNI has also seen some major changes over the last few months with the enactment of the Pharmacy (NI) Order 1976 (Amendment) Order (NI) 2012 and associated regulations. This has led to changes in its structures, powers and activities, specifically by giving additional sanctions to Fitness to Practice Committees and making Continuing Professional Development (CPD) mandatory (PSNI, 2013b).

The PSNI sets standards and offers guidance to its registrants on a number of matters, including professional conduct and ethics (PSNI, 2009), pre-registration training (PSNI, 2012a), internet pharmacy services (PSNI, 2012b), pharmacist prescribers (PSNI, 2013c) and raising concerns (PSNI, 2012c).

In 2010, the Society commissioned research to investigate the risks in pharmacy practice in Northern Ireland. Phipps et al (2011) surveyed PSNI registrants (n = 543) and sought to measure practice risk factors (safety climate, job characteristics, psychological health and risk behaviour) to give an indication of their extent among pharmacists in Northern Ireland. Whilst the researchers found that in many respects the NI pharmacists were comparable to pharmacists and other healthcare professionals in Great Britain, there appeared to be increased risks in relation to pharmacists in patient-facing roles and those returning to practice after a career break (Phipps et al, 2010). There was evidence of the impact of the work context on individual pharmacists such as those where there is high work pressure with low levels of support and a requirement to work long hours. Phipps et al also interviewed registrants who had recently returned to practice after a career break, changed sector or managed an individual who had done one of these things (n = 18). The interviews indicated that there were variable levels of support offered and also different interpretations of whose role it is to offer such support. Both of these factors lead to increased potential risk.

Phipps et al also conducted a stakeholder workshop on revalidation during which it was suggested that revalidation might provide a means of managing risk in the sense of assessing practice in the work environment against common standards of practice; risk being viewed as part of the environment as well as being related to the individual. Phipps et al use two models to show how risk-based revalidation might be undertaken: one which is based on CPD and the other using CPD together with assessments of competence. They recommended that: the PSNI should develop explicit standards of practice, consider aligning the CPD scheme to the standards, support registrants in the development of CPD portfolios, determine which model would best address risk focusing on registrants in patient-facing roles and those returning to practice, and provide further support to registrants returning to practice or changing sectors and to their employers.
CPD has been a professional requirement of registration with the PSNI since 2005 and became mandatory from 1 June 2013. Following consultation, a new CPD framework was produced so that registrants would know the mandatory requirements they have to meet and patients and the public would understand what pharmacists are required to do (PSNI, 2013b). The CPD framework is based on an adult learning cycle of reflection, planning, action and evaluation with registrants being responsible for their own personal learning and development. Registrants must:

1. keep a legible record of their CPD (electronically or on paper) in the form and manner specified
2. complete a minimum of 30 hours of CPD learning annually and allowing 5 hours for documenting the learning (except where there are extenuating circumstances)
3. complete a minimum of four CPD cycle entries per year relevant to the safe and effective practice of pharmacy and to their scope of practice, maintaining appropriate evidence of participating in CPD
4. develop a reflective approach to learning with the majority of learning having been planned and where prior learning needs have been identified
5. ensure their record of CPD in their portfolio complies with the PSNI’s recording format and essential assessment criteria
6. record if their CPD is relevant to the safe and effective practice of pharmacy and to their scope of practice
7. submit their CPD portfolio record annually to the PSNI by the published deadline (currently 31 May each year) (PSNI, 2013b).

The CPD requirement is linked to annual retention of registration and individuals must make a declaration on their renewal of registration form that they have complied with the CPD standards. If a registrant does not submit their CPD portfolio in time this can lead to removal from the register. Individuals who are seeking to return to the register after a period of more than 12 months have to submit a personal development plan.

The PSNI will sample a minimum of 10% of the CPD portfolios submitted annually to confirm that the information is correct and that the registrants are meeting the CPD standards. Sampling will be undertaken on a random and targeted basis. Targeting will cover such areas as: change of sector during the year, restoration to practice, a predominance of unscheduled learning activities in the portfolio, and having been subject to fitness to practise processes. Assessment of the portfolios is against the assessment criteria and undertaken by trained assessors appointed by the PSNI. The quality of the assessors’ work is monitored. Registrants who have had their portfolios assessed will be given feedback on the percentage of CPD cycle entries that have met the standard. CPD portfolios are retained for five years by the Society.

In October 2012, the Council of the PSNI considered a position paper on revalidation outlining the progress that other UK regulators were making (PSNI, 2012d). The new Council remains committed to progressing the agenda relating to assuring continuing fitness to practise and this report forms one strand of its work in this regard.

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4 Principle 6 in the PSNI Code of Ethics.
METHODOLOGY

As requested in the research brief, the report updates and extends the Pharmaceutical Society of Ireland’s review of international CPD models undertaken by PA Consulting (PSI, 2010). An exact replication of that study has not been possible because the PSI report does not contain a detailed account of the methodology that was adopted and does not cite all the policy and other sources that we believe must have been consulted to inform its findings.  

For the purposes of this research we adopted a broad interpretation of what might constitute systems and approaches to assure continuing fitness to practise – one of which is CPD. Whilst policies and procedures to deal with complaints about registrants may also be construed as a measure to assure continuing fitness to practise – or at least to identify and take action in respect of those whose fitness to practise is called into question – professional discipline is not addressed in this report. The disciplinary function of fitness to practise is a universal regulatory function focused on reacting when things have gone wrong and a complaint has been made. We have followed convention and conceptualised it separately from the more proactive assurance of fitness to practise that may be provided through CPD and revalidation.

For most jurisdictions we have therefore taken a zero-based approach. In an effort to build a picture of the models adopted to assure continuing fitness to practise we have identified and used contemporary primary sources: that is statutes, policies and guidelines accessible on or via regulator websites. In some cases we have sought confirmation or clarification of points of detail from regulators by email.

The methodology and the report are constrained by:

- the approaches used by the regulators reviewed and the way in which they conceptualise the assurance of continuing fitness to practise (if indeed they do at all)
- the extent to which regulators publish the research and analyses that have informed their policies, and the time these sources remain accessible
- the construction of regulators’ websites and the search facilities they offer
- the point in time at which the work was undertaken.

Where sufficient information has been available to make it possible, we have adopted a common format to present findings for each regulator and country to aid comparison. Most sections conclude with a summary table that also extends the narrative by including additional information about incentives, penalties and funding.

SUMMARY

The PSNI is seeking to understand the approaches that other regulators use to assure the continuing fitness to practise of their registrants both in the UK and beyond. A more proactive assurance of
fitness to practise has been on the UK Government’s agenda for healthcare professions for a number of years, mainly in response to a range of serious cases affecting patient safety within the National Health Service (NHS). The initial focus was that each healthcare regulator should develop a system of revalidation for its registrants and the Department of Health in England gave grants to all of the non-medical healthcare regulators (which covered England) to take forward development work to advance its policy objectives. Medical revalidation was taken forward with a range of other funding from, and the active involvement of, the health departments in each of the four UK countries and came into effect in December 2012.

Informed by the development work undertaken by the non-medical regulators and in the context of right-touch regulation, the focus of developments has shifted in the UK from a focus on revalidation to the potential for a wider range of approaches to assure the continuing fitness to practise of registrants – hence the focus of this report.

This report:

- sets out the approaches that the UK healthcare profession regulators are currently using or have under development for assuring the continuing fitness to practise of their registrants – chapter 2
- sets out the approaches used within pharmacy regulation in a number of other countries (principally those examined by the PSI report) – chapter 3
- considers the approaches used by three other professions – accountancy, aviation and teaching – chapter 4
- draws conclusions from the work and offers recommendations to the PSNI on possible ways forward – chapter 5.
CHAPTER 2: APPROACHES TO ASSURING THE CONTINUING FITNESS TO PRACTISE OF HEALTH PROFESSIONALS REGULATED IN THE UNITED KINGDOM

INTRODUCTION
This chapter provides an overview of approaches to continuing fitness to practise used by the other UK healthcare regulators and looks at the developments they have underway in this area.

The following regulators have been included and are considered in alphabetical order:

GCC – General Chiropractic Council
GDC – General Dental Council
GMC – General Medical Council
GOC – General Optical Council
GOsC – General Osteopathic Council
GPhC – General Pharmaceutical Council
HCPC – Health and Care Professions Council
NMC – Nursing and Midwifery Council.

The chapter draws on the information presented in chapter 1 as to the policy context in which the UK healthcare profession regulators are working in relation to the assurance of the continuing fitness to practise of healthcare practitioners. It looks at:

- the role of each of the regulators and their size
- how each of the regulators currently describe their approaches to continuing fitness to practise
- the approaches they currently use or have under development
- the research and development work undertaken to inform these approaches
- their future plans.

In writing this report we have been conscious that there are a number of different aspects that also affect the work that each of the regulators undertakes such as: their history and context, other challenges (eg changing role, changing governance structures, taking on new registrant groups), their freedom of action within their current legislation, the review of all healthcare professional regulation being undertaken by the Law Commission, and the wider political and social environment. Given the scale of this work, it has not been possible to address these wider issues in this report.

The chapter concludes by comparing the different models and summarising the findings.
GENERAL CHIROPRACTIC COUNCIL

Role and size
The General Chiropractic Council (GCC) is the statutory regulatory body for chiropractors. It was established under the Chiropractors Act (1994) and has three main duties:

1. “to protect the public by establishing and operating a scheme of statutory regulation for chiropractors, similar to the arrangements that cover other health professionals
2. to set the standards of chiropractic education, conduct and practice
3. to ensure the development of the profession of chiropractic, using a model of continuous improvement in practice”.

At 30 December 2011, there were 2,700 chiropractors on the register (GCC, 2011a). The GCC has two categories of registration – practising and non-practising (although it was not possible to find a description of the categories).

Continuing fitness to practise approaches
The GCC has a mandatory system of CPD which is defined as: “the process whereby chiropractors take responsibility for their own learning and development and apply it to improve their practice in the interests of patients and the development of the profession” (GCC, 2003). Whilst the original CPD guidance (2003) does not relate CPD to continuing fitness to practise, more recent guidance states: “CPD helps chiropractors to stay up to date and fit to practise, with the aim of maintaining and improving the standards of practice for the benefit of patients and the public” (GCC, 2012, page 4).

The GCC has been undertaking work on the development of a system of revalidation for chiropractors since 2008 (when the principles of non-medical revalidation were published). Revalidation is described as: “the way in which, in the future, registrants will demonstrate to the GCC that they continue to have the knowledge and skills to continue to practise, in accordance with the Code of Practice and Standards of Proficiency, in order to remain registered”.

The purpose of revalidation is described as providing “additional assurance to patients that their chiropractor continues to meet the profession’s standards”.

The GCC has consulted twice on a proposed system of revalidation - in 2010-11 and then with a revised proposal between 1 December 2012 and 28 February 2013. The Council considered the outcomes of the revalidation at its meeting in June 2013. The consultation proposals no longer appear on the GCC’s website. However a news release from the Council states that the Council had commissioned a review of its Code of Practice and Standard of Proficiency (CoP and SoP) and also:

“decided to make significant improvements to the proposed system. In particular, the assessment of continuing fitness to practise, which is fundamental to the scheme, will be less complex and relate more directly to the Code of Practice and Standard of Proficiency. ... we plan to pilot the proposed revalidation system in early 2014. The results of that pilot will help

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8 Information obtained from same website page - http://www.gcc-uk.org/page.cfm?page_id=1837
us to finalise the system that we plan to introduce from January 2016 subject to the necessary legislation being in place. Account will be taken of the review of the CoP and SoP” (GCC, 2013a).

The Council Bulletin in October 2013 states: “Council received an update on progress ... and the current work that is in train with the Professional Associations and Royal College. Council will discuss the specification for the pilot and assessment system including assessment criteria and themes at its December meeting” (GCC, 2013b). The Bulletin from the December 2013 Council meeting states: “Council noted the developments in the approaches being taken by the other Healthcare Regulators to their continuing assurance of fitness to practise schemes and in particular the latest decisions by the GOsC and the GPHC to build on their existing CPD schemes. The GCC therefore decided to delay its pilot, and will be further considering the development of its scheme at its February meeting” (GCC, 2013c).

In November 2011, the GCC announced in its 2012 – 2014 strategic plan a review of its CPD scheme (GCC, 2011b). This was described as including: a questionnaire to registrants, an opportunity for stakeholders to provide input and a review of research undertaken on CPD by other healthcare regulators, following which the next steps in the review would be decided. The CPD review is also to be informed by a system of revalidation under development. It is noted that changes to the CPD scheme before the end of 2013 are unlikely.9 The recommendations presented to the Council meeting in June 2013 by its Revalidation Working Group state that: “further consideration should be given to the relationship between the proposed system of revalidation and CPD with specific regard to CPD’s contribution to evidence and whether or not there should be required element(s) of CPD relating to revalidation”.10 There appears to be no further information on developments in the CPD scheme on the GCC’s website and it is not referred to as a separate activity in an update on delivering key activities in the Council’s strategic plan considered by the Council in August 2013.11 However in the light of the message in the December Council bulletin referred to above, CPD developments in 2014 will be contingent on discussions regarding the next steps on assuring continuing fitness to practise.

**Current CPD system**

Table 2.1 below summarises the GCC’s current system for assuring the fitness to practise of its registrants. Further information on the GCC’s CPD system is provided in Appendix 1.

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10 Consultation on revalidation proposals: overview of outcomes and recommendations – paper for the GCC Council meeting 3 June 2013. Quote from page 28 of Council papers, page 14 of the paper. Available at: [http://www.gcc-uk.org/files/link_file/OPEN%20papers%202003.06.13%20UPDATED.pdf](http://www.gcc-uk.org/files/link_file/OPEN%20papers%202003.06.13%20UPDATED.pdf) Accessed at: 08/10/13. Agreed minutes of that meeting were not on the website at that date.

Table 2.1: Summary of current measures to assure continuing fitness to practise used by the GCC - CPD

| **Approach** | CPD mandatory for all registrants whether practising or non-practising. All registrants have to complete a CPD summary sheet each year. Based on a learning cycle with chiropractors identifying their own learning needs and interests and how to meet these. Each registrant must report annually (via a CPD summary sheet): one complete learning cycle and at least 30 hours of learning activities of which at least 15 hours is learning with others plus declare the content of the summary sheet is a valid reflection of their CPD. |
| **Standards** | Code of Practice and Standard of Proficiency include a standard D2 ‘you must maintain and improve your professional knowledge, skills and performance in keeping with the requirements set out by the GCC’ – hence providing a link to CPD. CPD guidance sets out requirements which are in the CPD Rules. |
| **Accreditation** | The GCC does not approve or accredit CPD learning activities or providers. Registrants have the responsibility of assessing the quality of the learning available. |
| **Assessment** | Chiropractors self-assess their own learning needs and interests and determine how to meet these and then evaluate the learning undertaken. GCC monitors summary sheets to ensure that requirements have been met. It also audits a sample of CPD returns each year to verify the content and to identify general lessons for the future. |
| **Incentives & penalties** | The scheme is mandatory and reflects the professional obligation to maintain professional competence expressed in the Code of Practice and Standard of Proficiency. Failure to meet the CPD requirements can result in removal from the register. |
| **Funding** | Funding of the GCC’s activities is through the income raised from registrants’ annual registration fees – £800 for practising registrants and £100 for non-practising registrants for 2014 registration year\(^\text{12}\). Registrants must fund their own CPD activities – few chiropractors are employed so CPD will generally be funded by individual registrants direct. |

**Research and development**

The GCC’s earlier phase of work on revalidation included the commissioning of a project to identify the risks of chiropractic and a business case for revalidation through determining the counterfactual against which the costs and benefits of revalidation could be measured (ie the forecast of what would happen over a set period of time on the assumption of unchanged policies) (Europe Economics, 2010a). The researchers used two aspects that might be addressed through revalidation to develop the counterfactual:

- adverse events – based on a categorisation of risk as either a violation (deviations from safe operating practices, procedures, standards or rules) or an error (Reason, 2001), and
- sub-optimal outcomes – the proportion of patients who could have had a better outcome if their care was managed differently.

The latter was given the highest monetary value and seen to be the most costly risk. We understand however that the concept of sub-optimal outcomes was challenged in the consultation that followed this work and on which a proposed approach to revalidation was developed. However, as the history of the GCC’s developments does not appear on its website and no reference is made to this work on risk, it is not possible to ascertain the extent to which it is influencing the GCC’s current work.

The GCC also commissioned research into patients’ views and expectations of chiropractic care (Firefly, 2013). Its purpose is to “place a proposed form of revalidation within the context of patients’ views of chiropractic” and “to demonstrate that ... the GCC has taken specific account of chiropractic in its work on revalidation”. In a background note to the research, the GCC states it has “recognised that the over-riding message from patients and the public is that they have assumed that regular checks are made on healthcare professionals to assess that they are fit to practise”. The outcomes of the research were used in developing the consultation proposals in 2012 (referred to above) specifically in relation to:

- “supporting the concept that the focus of revalidation should be on conduct and behaviour as well as competence
- the revalidation system being based on trusting chiropractors to self-report the evidence they have gathered on a five year basis
- the role of patients providing feedback to practitioners so that they can improve their practice”.

**Future plans**

A Council bulletin noted that the Council would consider plans for piloting revalidation in December 2013 with a pilot scheduled for 2014. However following the December Council meeting a statement was released to the effect that the pilot had been put on hold whilst further consideration was given to the approaches being developed by the other Healthcare Regulators to their continuing assurance of fitness to practise schemes, specifically the latest decisions by the GOsC and the GPHC to build on their existing CPD schemes. Further consideration to this area will be given at its February 2014 meeting.

**Summary**

The GCC has been undertaking a programme of development work in relation to how it assures the continuing fitness to practise of its registrants since about 2008. This has included:

- research into the assessment of risk in chiropractic practice and the development of a business case
- research into patients’ expectations of chiropractic care
- two consultations on draft proposals for revalidation.

The Council reported earlier in 2013 that further development work was needed on the proposals although the public information on this is limited as are the use it is making of the research undertaken and its developments in relation to reviewing its CPD scheme. The GCC is currently in the process of reviewing its Code of Practice and Standard of Proficiency as this is reviewed on a five-

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yearly cycle. Any scheme of assuring the continuing fitness to practise of registrants will be based on the CoP & SoP.
GENERAL DENTAL COUNCIL

Role and size
The General Dental Council (GDC) regulates dentists and dental care professionals – clinical dental technicians, dental hygienists, dental nurses, dental technicians, dental therapists and orthodontic therapists - in the UK. At September 2013, there were 100,903 GDC registrants – 40,157 dentists and 60,746 dental care professionals (GDC, September 2013a). The GDC also holds 13 specialist registers for dentists such as: dental public health, oral surgery. Only dentists on a specialist list are able to call themselves ‘a specialist’ in an area.

The GDC is a statutory corporation established under the Dentists Act 1984 and which has been amended several times since. The work that the GDC carries out is governed by a number of statutory instruments, rules and regulations covering a number of areas including: registration, education, continuing professional development and fitness to practise14.

Continuing fitness to practise approaches
The GDC state ‘the purpose of revalidation is to introduce an approach to providing continuing assurance for patients and the public that those on our register continue to be up to date and fit to practise’, revalidation being ‘the general name for procedures that enable health professionals to demonstrate to their professional regulator that they continue to have the knowledge and skills required to practise, and ‘continuing assurance is the outcome policies and procedures in this area should aim to achieve’15. The GDC sees CPD as an important part of assuring continuing fitness to practise as it helps registrants stay up-to-date and fit to practise to the standards required.

The GDC introduced mandatory system of CPD for dentists in 2002 and for dental care professionals in 2008. CPD is defined by the GDC as: “lectures, seminars, courses, individual study and other activities, that can be included in (your) CPD record if it can be reasonably expected to advance your professional development as a dentist or dental care professional and is relevant to your practice or intended practice” (GDC, 2012a).

A report from the GDC’s Revalidation Working Group (RWG) usefully provides a history of the developments that the GDC has undertaken in relation to the assurance of continuing fitness to practise16. Initial research focused on understanding the patients’ perspective in revalidation (Ipsos Mori, 2009), a feasibility study of the then proposed stage 1 of revalidation (George Street Research, 2009), and exploring patient and public attitudes to standards for dental professionals (George Street Research, 2010) - all of which fed into the development of a proposed revalidation system for dentists.

14 The legislation and the related statutory instruments, rules and regulations are available at: http://www.gdc-uk.org/Aboutus/Thecouncil/Pages/governancemanual.aspx
15 Revalidation page of GDC website – available at: http://www.gdc-uk.org/Aboutus/policy/Pages/policyitem.aspx?AspXPage=g%5F382DFC47F60D4C7FA30F9851641648E4-%2540Title%3DRevalidation - last accessed at 08/10/11.
16 The GDC’s Corporate Strategy 2013 – 15 refers to reviewing the CPD scheme and supplementing it with a system of revalidation for dentists (section 2). The Business Plan 2013 (section 7) refers to greater scrutiny of registrants’ CPD as a means of demonstrating fitness to practise, the review of CPD and continuing to prepare for a three-stage model of revalidation.
In late 2010, the GDC undertook its public consultation on a proposed three-stage model of revalidation for dentists related to the four domains of practice as set out in the learning outcomes for registration (GDC, undated b)\(^{17}\) and consisting of the stages of: compliance, remediation and in-depth assessment. The Council’s post-consultation statement included:

- a commitment to developing a workable, proportionate and cost-effective model of revalidation that avoids unnecessary duplication and uses, where possible, existing methods of performance management, quality assurance and regulation
- using evidence and research to inform developments
- further developing the three-stage model of revalidation
- ensuring that revalidation is free from unfair bias and workable across all forms of dentistry and workplaces through piloting and testing
- exploring how patients and the public can contribute to and shape revalidation (GDC, 2011).

In July 2012, the GDC’s revalidation group was given revised terms of reference and its purpose changed to ‘oversee and scrutinise the development of an enhanced model of mandatory CPD for registrants, as a core component of assuring continuing fitness to practise and to continue to develop proposals for a system of revalidation initially for dentists’ (GDC, 2013b, page 5). With an enhanced form of CPD being seen as part of the journey to fuller revalidation and an important precursor to it, the GDC’s, and hence its RWG’s, focus shifted to taking forward CPD developments.

In 2011, the GDC commissioned a literature review on the effectiveness of CPD. Eaton et al (2011) reported that:

- there were no high quality studies demonstrating the overall effectiveness of CPD for particular purposes (such as performance, competence, public satisfaction or safety) although some elements of CPD were found to be effective, including sustained, repeated, or longer term CPD activities. The literature highlighted the importance of personal development planning, self-directed learning and reflection
- overall there is a lack of evidence on how CPD activity can be effectively measured. There are some indications that a mix of input and outcomes measures focused on an individual’s practice might be useful (such as looking for a range of different learning activities - blended learning - and assessment of competence related to patients and assessed by peers), although it is not possible to find clear evidence of this
- a range of benefits for regulation from CPD are identified in the literature related to areas such as public expectations and perceptions, although there was no firm evidence for this improving the quality of care or increasing standards
- the factors that motivate individuals to undertake CPD are personal as well as context driven and include aspects such as: perceptions, the working environment, employment setting as well as cost, time and ease of access
- there was no literature to show that CPD participation is a valid indicator of professional competence or performance, mainly because of the difficulty in showing cause and effect in this area

\(^{17}\) The four domains are: clinical, communication, professionalism, management and leadership.
- literature from medicine suggests that there is a link between undertaking CPD activities and enhancing performance, particularly if the learning is focused on areas highlighted in personal development plans and appraisal.

In 2012 a further research study was commissioned on registrant and CPD provider perspectives of CPD. ERS (2012) reported, among other things, that:

- more than half of registrants undertook CPD outside of normal working hours and the majority (70%) paid for it themselves
- just under half of registrants reported finding it easy to find appropriate CPD learning activities, although other stakeholders expressed concern about the quality of some CPD that was available
- time and cost were the most frequently cited barriers to undertaking CPD with distance also an issue.

The researchers concluded that the GDC should:

- retain the five-year CPD cycle but place more emphasis on monitoring during it
- retain the core topics but allow for more flexibility in certain areas (such as specialisms)
- consider accreditation of CPD suppliers for quality purposes
- change the balance between verifiable and general CPD increasing the focus on the former
- further consider recording outcomes of CPD as well as inputs, such as asking registrants to reflect on the learning they had undertaken.

In April 2012, the GDC issued a discussion document *Maintaining quality and impact of CPD in dentistry* which set out the areas that the GDC was exploring in CPD, and focused on supporting registrants in undertaking CPD and ensuring that learning and development has a positive impact on individuals’ practice (GDC, 2012a). The areas that were noted as being of interest for further exploration were:

- ways of embedding personal development planning in CPD
- ways of ensuring that registrants are supported to undertake CPD that is appropriate for them and the work they do and how registrants can best capture this
- methods of introducing an outcomes-based approach into CPD
- whether a five-year CPD cycle is appropriate
- how registrants can best be supported in the CPD cycle and how this links to sharing information with the regulator
- how to reduce the amount of paperwork related to CPD
- the potential of using mandatory CPD.

Following the discussion document, the GDC issued a consultation document on CPD in late 2012 (GDC, 2012b) and reported on the outcomes of the consultation in 2013 (GDC, 2013c). 387 responses were received to the consultation of which between 67 - 87% agreed with the proposals made including: introducing annual mandatory CPD declarations, the introduction of annual personal development plan (PDP) declarations, the retention of core and recommended topics with a number wishing these to be made mandatory, linking CPD learning outcomes with the GDC
standards, a two-month grace period for non-compliance, and the use of an improved online CPD recording system.

As the consultation also revealed concerns about the quality of CPD that was on offer, support for enabling registrants to undertake effective personal development planning, reflection and keeping CPD records, and concerns that any new system should be proportionate and link to what is already in place in other systems, the GDC called on:

- CPD providers to quality assure their learning provision and registrants to be mindful of the CPD they selected to undertake
- support to be provided to dental professionals in developing reflection and personal development planning and undertaking appropriate CPD
- all registrants to think about their development needs in the context of their scope of practice and the expectations set out in the standards
- employers of dental professionals to support their staff to effectively meet the CPD requirements as a part of professional regulation.

It was noted that any new requirements for CPD would not be in place before September 2014 at the earliest (due to the need to amend the CPD rules) and a period of notice would be given to all concerned before implementation. A consultation on the proposed draft Rules was issued in December 2013 with a closing date of 21 March 2014 (GDC, 2013d).

The GDC’s current proposals on enhanced CPD emphasise that registrants should:

- make good decisions about their CPD based on effective planning and reflection
- undertake CPD that achieves learning outcomes reflecting the standards required
- embed CPD into their professional life
- provide the GDC with regular assurance of their CPD activity in order to reassure the public.\(^{18}\)

In November 2013, research commissioned by the GDC to improve understanding about the supply of CPD products and services in UK dentistry reported that the supply of CPD in dentistry was large, varied, involved organisations with national and international reach, on the increase and with an estimated annual value of over £57 million (ICF GHK, 2013). The majority of CPD was focused on General Dental Practitioners with only a small proportion of CPD available for dental nurses given their size as a group. The majority of CPD offered focused on verifiable CPD (as described by the GDC). The researchers concluded that the quality of CPD was of interest to providers as well as the GDC and would benefit from further research, as would the mix of CPD undertaken by different registrants (ICF GHK, 2013).

Current CPD system
Table 2.2 below summarises the GDC’s current system for assuring the fitness to practise of its...

\(^{18}\) Information available on the GDC web page on the CPD review – available at: [http://www.gdc-uk.org/Aboutus/policy/Pages/policyitem.aspx?AspXPage=g_382DFC47F60D4C7FA30F9851641648E4:%2540Title%3DContinuing%2520Professional%2520Development%2520review](http://www.gdc-uk.org/Aboutus/policy/Pages/policyitem.aspx?AspXPage=g_382DFC47F60D4C7FA30F9851641648E4:%2540Title%3DContinuing%2520Professional%2520Development%2520review)
registrants. Further information on the GDC’s CPD system is provided in Appendix 2.

**Table 2.2: Summary of current measures to assure continuing fitness to practise used by the GDC - CPD**

| Approach | CPD is defined as ‘lectures, seminars, courses, individual study and other activities, that can be included in (your) CPD record if it can be reasonably expected to advance your professional development as a dentist or dental care professional and is relevant to your practice or intended practice’. Dentists are required to undertake a minimum of 250 hours of CPD over five years of which 75 hours must be verifiable. Dental Care Professionals need to undertake a minimum of 150 hours of CPD over five years of which 50 hours must be verifiable. Verifiable CPD is learning activity that meets the definition of CPD for which it possible to obtain documentary evidence of the activity and which has concise educational aims and objectives, clear anticipated outcomes and quality controls. There is an expectation that the CPD chosen will enable registrants to practise consistently with the Standards for the Dental Team. Registrants are encouraged to use a Personal Development Plan (PDP) to inform the decisions they make about CPD. Certain topics related to patient safety are recommended to registrants to consider for their verifiable CPD. |

| Standards | Standards for the Dental Team sets out the standards of conduct, performance and ethics that govern all dental professionals related to what patients can expect from their dental professionals. Principle 7 of the standards is: ‘maintain, develop and work within your professional knowledge and skills’. CPD requirements are set out in CPD Rules supported by CPD guidance. The CPD cycle is five-years (January – December) and based on the January following the date at which an individual entered the register. Recently revised guidance includes the need for registrants to update their CPD records on a more regular basis (ie every year). CPD has been mandatory for dentists since 2002 and for dental care professionals since 2008. |

| Accreditation | Neither CPD providers nor learning activities are accredited. Registrants need to decide relevant CPD activities and obtain documentary evidence for verifiable CPD. |

| Assessment | CPD submissions are checked on return that they meet the requirements. Audits are carried out on a sample (percentage not given) to confirm that the CPD return is capable of being supported by documentary evidence, specifically the verifiable component. |

| Incentives & penalties | There is a two-month period of grace for fulfilling the requirements. If a return does not meet the requirements, then the individual may be removed from the register. There is a right of appeal. Individuals need to fulfil the CPD requirements before being restored to the register. |

| Funding | Funding of the GDC’s activities is through the income raised from the fees paid by registrants. The fees paid depend on the profession and for initial registration when the application is made in the calendar year. For dentists initial registration and the annual retention fee is £576 for a complete calendar year and £120 for dental care professionals. Specialism fees for dentists are £345 for initial specialist registration and then £120 for annual retention. A study undertaken for the GDC showed that more than half of registrants undertook CPD outside of normal working hours and the majority (70%) paid for it themselves (ERS, 2012). |
**Research and development**

In 2012 and following the consultation on revalidation, the GDC commissioned a study evaluating the suitability of a range of potential evidence types for the first stage of a revalidation scheme for dentists (Chisholm et al, 2012). Using a mixed-method research approach, Chisholm et al (2012) grouped the processes of gaining evidence in revalidation into three main types:

- evidence of participation in quality improvement or assurance systems (including CPD, audit, PDP, peer review)
- direct assessment of practice, performance, skills or knowledge (including the use of multi-source feedback (MSF), patient feedback and direct observation)
- data gathered for payment or monitoring purposes (such as for NHS contracts).

The research showed variation in the extent to which the different processes were used both overall and in relation to other factors, such as geography and workplace arrangements. The surveys undertaken also revealed different views on whether the evidence should be used for formative or summative assessment purposes, its proportionality and the relationship between these different aspects. An example noted is that whilst multi-source feedback is perceived as being difficult to obtain, it is seen to have value in improving dentists’ communication skills. There was some evidence to suggest that participation in performance management and quality assurance processes shows that individuals are engaged and there is more likely to be improvements in practice as a result.

From their work, Chisholm et al recommended that it would not be appropriate to use peer review and direct observation in stage one of the revalidation process but that there was a role for: CPD; personal development planning; review of significant events, complaints and compliments; case-based discussion/assessment; multi-source feedback and feedback from patients, and these would be most valuable in supportive professional and/or organisational frameworks. They recommended that referral of an individual to stage two of the revalidation process should take into account all of the evidence presented as well as the individual’s “capacity to reflect on what the evidence tells them about their practice and how they could develop it”. They also emphasised the need for consistency, transparency and fairness in the revalidation assessment process, including the need to interpret evidence in the context in which it has been generated.

In 2013, the GDC commissioned two further research studies. The first aims to identify the risk in dentistry and is due to report in November 2013, and the second is a comparative analysis of CPD audit methods used by regulators or professional associations, where CPD is a requirement of registration or membership.

**Future plans**

The GDC has announced its plans to commission an independent assessment of the economic costs of introducing enhanced CPD. A further study will follow on the costs of introducing revalidation once the Council has developed fuller proposals in this area.
Summary

There has been ongoing work on the development of a revalidation scheme, particularly for dentists, over the last ten years. In 2012, the work was broadened out to include the development of an enhanced model of mandatory CPD for registrants, as a core component of assuring continuing fitness to practise, with an enhanced form of CPD being seen as part of the journey to fuller revalidation. The GDC is currently working with the Department of Health on the development of Rules to introduce an enhanced system of CPD and has issued a consultation on the proposed Rules for doing this – the earliest the enhanced system will be in place is 2014. At the time of writing, there is no further information on plans to develop revalidation.
GENERAL MEDICAL COUNCIL

Role and size
The General Medical Council (GMC) registers doctors to practise in the UK. Its purpose is to ‘protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine’ with its main functions set out by the Medical Act 1983\(^1\). The GMC was initially established under the Medical Act in 1858 and is a registered charity.

In order to practise medicine in the UK doctors need to be registered with the GMC and have a license to practise.

At 9 October 2013, there were 259,815 doctors on the List of Registered Medical Practitioners of whom 201,224 (77.45%) had full registration (with the remainder having a form of registration linked to education and training or temporary registration)\(^2\).

Continuing fitness to practise approaches
The GMC’s principle means of assuring the continuing fitness to practise of doctors is through a system of revalidation “the process by which licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practise. Revalidation aims to give extra confidence to patients that their doctor is being regularly checked by their employer and the GMC”\(^3\). Revalidation is based on the standards set out by the GMC in Good Medical Practice and is principally implemented through regular appraisals between a doctor and their employer.

In November 2009, the GMC introduced the requirement for any doctor who wished to practise medicine in the UK to hold a licence to practice (GMC, undated). The introduction of licensing was seen as the first step towards introducing revalidation, which came into effect in December 2012. The purpose of re-licensing was to demonstrate that the GMC was assured that the doctor continued to practise in accordance with its generic standards. A licence to practise replaced the previous scheme that was solely based on the registration of doctors conferring the same legal privileges – now doctors in the UK need to be both registered and licensed to practise medicine. Doctors who hold a licence to practise are subject to the requirements of revalidation. It is possible for some doctors to remain registered without being licensed but only if they are not practising medicine.

CPD is seen as an integral aspect of revalidation and doctors are required to take along a summary of their CPD activities to their annual appraisal to contribute to meeting the requirements of revalidation. Revalidation and CPD are described in more detail below.

Standards and approach
In 2004, the GMC set out its thinking on the different levels of regulation and how each is important in promoting patient safety and protecting the public (GMC, 2004). The levels of regulation are:

1. the individual – personal regulation
2. the team – team-based regulation

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\(^1\) Available at: [http://www.gmc-uk.org/about/role.asp](http://www.gmc-uk.org/about/role.asp)


\(^3\) Quote from web page: [http://www.gmc-uk.org/doctors/revalidation.asp](http://www.gmc-uk.org/doctors/revalidation.asp) Last accessed 12/10/13
3. the organisation – workplace regulation
4. across a whole profession – national regulation.

These different regulatory levels, and the responsibilities of different parties inherent in each, can be seen in the work that the GMC has taken forward over the last ten years.

The principle standards for doctors are set out in *Good Medical Practice* (GMC, 2013a). The standards are grouped into four areas: knowledge, skills and performance; safety and quality; communication, partnership and teamwork; and maintaining trust. The area relating to knowledge, skills and performance contains requirements relating to: keeping professional knowledge and skills up-to-date, regularly taking part in activities to maintain and develop competence and performance, and being willing to take part in structured support opportunities offered by employers or contracting organisations. The standards are also available through a series of more than 60 scenarios to enable registrants to see ethical guidance in action and test their own knowledge 22.

Revalidation is an evaluation of whether doctors are fit to practise and is based on a continuing evaluation of their performance in the workplace (GMC, 2012a). It is based on a devolved model of regular appraisals of individual doctors being undertaken by their employing / contracting organisation and reported to a responsible officer in a designated body (a UK organisation). The devolved body is responsible for supporting doctors during appraisal and revalidation, and ensuring that doctors work in an environment that monitors and improves the quality of its services. Responsible officers in devolved bodies have the responsibility of making a recommendation to the GMC every five years that an individual doctor is up-to-date, fit to practise and should be revalidated. Responsible officers can make three forms of recommendation:

1. a positive recommendation (ie that the individual should be revalidated as the evidence the officer has obtained shows that the person is up-to-date and fit to practise)
2. request a deferral because more information is needed to make a recommendation about an individual doctor
3. notify that an individual doctor has failed to engage with any of the local systems that support revalidation (GMC, 2012b).

The GMC will act on the basis of the recommendation from a responsible officer.

Revalidation began to be rolled out in December 2012 starting with medical leaders and responsible officers and then being rolled out to other doctors with responsible officers asked to schedule the doctors for whom they are responsible.

The *Good Medical Practice Framework for appraisal and revalidation* sets out the broad areas that should be covered during the appraisal of doctors and hence the areas on which revalidation recommendations will be based (GMC, 2013b). The GMC does not prescribe the form that appraisals of doctors should take due to the range of practice that they undertake and the variety of organisations in which they work. The framework document is designed to form the basis of a standard approach to appraisals so that they can then be used for revalidation. Individual doctors are expected to provide supporting evidence that they are continuing to meet the standards in Good Medical Practice and discuss their practice and performance with their appraiser.

22 Available at: [http://www.gmc-uk.org/gmpinaction/](http://www.gmc-uk.org/gmpinaction/)
In producing the framework for appraisal and revalidation, the GMC has used the domains and standards set out in Good Medical Practice and then described each by three key attributes designed to capture the scope and purpose of each domain. The 12 attributes that comprise the whole appraisal and revalidation framework are illustrated by more detailed descriptions in Good Medical Practice. The domains and attributes are:

<table>
<thead>
<tr>
<th>GMP Domain</th>
<th>Attribute identified for appraisal and revalidation</th>
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| 1 Knowledge, skills and performance | 1.1 Maintain your professional performance  
1.2 Apply knowledge and experience to practice  
1.3 Ensure that all documentation (including clinical records) formally recording your work is clear, accurate and legible |
| 2 Safety and quality                | 2.1 Contribute to and comply with systems to protect patients  
2.2 Respond to risks to safety  
2.3 Protect patients and colleagues from any risks posed by your health |
| 3 Communication, partnership and teamwork | 3.1 Communicate effectively  
3.2 Work constructively with colleagues and delegate effectively  
3.3 Establish and maintain partnerships with patients |
| 4 Maintaining trust                 | 4.1 Show respect for patients  
4.2 Treat patients and colleagues fairly and without discrimination  
4.3 Act with honesty and integrity |

Individual doctors are expected to develop and maintain a portfolio of supporting information that demonstrates they are continuing to meet these attributes. Whilst individuals (doctors and appraisers) might prefer to structure the information formally against the attributes, it is not a specific requirement as discussing and reflecting on the information over the course of the revalidation cycle (ie five annual appraisals) is thought to help ensure that all of the 12 attributes are covered.

The information that individual doctors are expected to use in their appraisals to show they are continuing to meet the principles and values set out in Good Medical Practice is described under the four broad headings of:

- General information – to provide the context of the work that the individual undertakes
- Keeping up-to-date – how they maintain and enhance the quality of all aspects of their work
- Review of practice – evaluating the quality of their professional work
- Feedback on practice – how others perceive the quality of their work (GMC, 2012c).

There are also six types of supporting information broadly relating to the headings that individual doctors are expected to provide and discuss at least once in a revalidation cycle, which are:
1. Continuing professional development (CPD) – to be discussed at every appraisal meeting
2. Quality improvement activity – at least once every revalidation cycle
3. Significant events – emphasis on those that have led to a specific change in practice or show learning
4. Feedback from colleagues – at least once every revalidation cycle
5. Feedback from patients – at least once every revalidation cycle
6. Review of complaints and compliments – focus is on how an individual deals with a complaint not the number.

Doctors are not only asked to collect and retain this information in their revalidation portfolio but also to state what they did as a result of having gained the information (ie how they used it to reflect on and develop their practice). The GMC has provided a number of case studies and online tools to help doctors with revalidation and specifically aimed at those who are unsure of their designated body.23

There is no accreditation of bodies or programmes for revalidation. Individual doctors are linked to designated bodies which are broadly bodies responsible for medical education and training in an area (such as Local Education and Training Boards in England, NHS Education Scotland and postgraduate deaneries in Wales and Northern Ireland).

Doctors collect and organise into a portfolio (paper and electronic) supporting information for consideration during their appraisal meetings. The portfolio contains: personal details, scope of work, record of annual appraisals, personal development plans and review, a statement of probity, a statement of health, and then the six types of supporting information outlined above. The responsible officer considers all of the information available on an individual doctor (ie from the doctor themselves and contained within clinical governance systems in their employing / contracting organisation) and makes recommendations to the GMC.

When the GMC receives a revalidation recommendation from a responsible officer it carries out a series of checks to ensure there are no other concerns about that doctor. If there are no such concerns then the doctor is revalidated and hence can continue to hold a licence to practise.

As medical revalidation relies on the active participation of local organisations and officers within those organisations, the GMC has developed a governance framework in which medical revalidation should take place and issued guidance on the role of employers in the system, including the development of appraisal and the provision of training for appraisers.24

Effective governance to support medical revalidation (produced by the GMC working with its partners) describes the joint responsibilities of organisations providing healthcare and of individual professionals in the delivery of high quality and safe services (Care Quality Commission et al, 2013). It emphasises that the introduction of medical revalidation reinforces the duty of organisations to provide an environment in which doctors can meet their professional obligations and in turn doctors to take part in organisational processes. The principles on which the guidance is built are:

24 See: http://www.gmc-uk.org/doctors/revalidation/revalidation_gmp_Framework.asp
- organisations that provide healthcare services are primarily responsible for the quality and safety of their services and the professionals that work within them
- healthcare providers should put in place effective governance systems to promote and protect the interests of patients, and so that professionals can meet their obligations
- healthcare professionals should comply with their profession’s values and principles and participate fully in organisational systems and processes
- the purpose of quality improvement, government procurement and regulatory bodies is to help improve the quality of care through activities such as: monitoring and enforcing compliance, sharing information and intelligence, driving improvement and acting decisively to protect the public (Care Quality Commission et al, 2013, page 4).

Revalidation does not replace or create a new system for raising or addressing concerns about a doctor. These should still be identified as early as possible and addressed through local human resource or clinical governance systems and be escalated to the GMC as a fitness to practise issue when necessary.

The management and implementation of medical revalidation has been complex and involved a number of partners including: the medical royal colleges, employers in the NHS and the independent sector, revalidation support teams in each of the four UK countries as well as national revalidation boards to make sure that revalidation was implemented. These organisations were also involved in research and development activities that fed into the design and implementation of medical revalidation, including pilot studies and pathfinder projects. There is ongoing research work related to the implementation of medical revalidation such as on measuring the costs, benefits and impact of medical revalidation in 2013-14 and patient and public involvement.

At the end of March the GMC reported that it had completed its first year zero of its five year plan to implement revalidation and had received recommendations on 3,500 doctors (100% of those scheduled for that year), mainly in senior roles, with recommendations expected on 44,000 doctors in the next year (GMC, 2013d).

Table 2.3 below summarises the GMC’s current system for assuring the fitness to practise of its registrants. Further information on the GMC’s CPD system is provided in Appendix 3.

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### Table 2.3: Summary of current measures to assure continuing fitness to practice used by the GMC – revalidation (including CPD)

| **Approach** | Medical revalidation was introduced in December 2012 being rolled out to include all doctors over the next five years – the medical revalidation cycle.  
Revalidation is an evaluation of whether doctors are fit to practise and is based on a continuing evaluation of their performance in the workplace through the use of annual appraisals and reported to a responsible officer in a UK designated body, which is responsible for supporting doctors during appraisal and revalidation. Responsible officers make a recommendation to the GMC every five years that an individual doctor is up-to-date, fit to practise and should be revalidated, request a deferral or notify that a doctor has failed to engage. The GMC acts on the basis of the recommendation. |
| **Standards** | Standards for doctors are set out in *Good Medical Practice*. The standards are grouped into four areas: knowledge, skills and performance; safety and quality; communication, partnership and teamwork; and maintaining trust.  
The *Good Medical Practice Framework* for appraisal and revalidation sets out the broad areas that should be covered during the appraisal of doctors and hence the areas on which revalidation recommendations will be based. Based on Good Medical Practice domains three attributes in each of the four domains (12 in total) form the basis of the appraisal discussion. Individual doctors are expected to develop and maintain a portfolio of supporting information that demonstrates they are continuing to meet these attributes. Supporting information includes: CPD, quality improvement activity, significant events, feedback from colleagues and patients, and review of complaints and compliments. |
| **Accreditation** | There is no accreditation of bodies or programmes for revalidation and the GMC does not accredit particular CPD activities, hold lists of CPD providers or award points or credits for learning activities. |
| **Assessment** | Assessment is devolved in that it is undertaken during the appraisals by the appraiser in discussion with the individual doctor who has also self-assessed and reflected on the supporting information. The responsible officer evaluates the information from the doctor and the organisation to make the recommendation to the GMC. When the GMC receives a revalidation recommendation from a responsible officer it carries out a series of checks to ensure there are no other concerns about that doctor. |
| **Incentives & penalties** | Appraisal is built into medical contracts within the NHS. The incentives and penalties are that if a doctor does not engage with revalidation then they can ultimately be referred into fitness to practise processes, lose their licence to practice and be taken off the GMC register. |
| **Funding** | Much of the funding of medical revalidation is borne by doctors themselves or their employing or contracting organisation.  
The costs for the time of responsible officers are given as £54.5 million over a ten year time period in the DH cost-benefit analysis for England for a three-year roll-out and £43.5 million for a five-year rollout. We assume that as responsible officers are placed in NHS infrastructure organisations the funding for their time comes from NHS funding.  
The GMC business plan 2013 gives a budget of £12,144,000 for the registration and revalidation directorate. GMC funding will be from the doctors it registers (GMC, 2013c). Current registration costs include: full registration with a licence to practise and annual retention fee - £390; full registration following provisional registration - £185; plus various certification fees and specialist registration fees. |
**Research and development**

We understand that an analysis of the risks of medical practice was undertaken by the Department of Health in about 2011 but we are not aware that it has been made public.

A cost benefit analysis of medical revalidation in England identified that revalidation for doctors had two main broad sets of costs: those associated with appraisals and those with making revalidation decisions with the first being considerably larger than the second and including that of doctors collecting supporting information for the appraisal discussion (DH, 2012a). It notes that as appraisal has been an NHS contractual responsibility for doctors since 2001 it should already have been largely in place and hence additional costs should be small in nature and be incurred in relation to the few doctors for whom appraisal was not taking place. The second set of costs related to responsible officers making revalidation decisions and the GMC and taking place on a five yearly basis were estimated to be relatively low.

Testing and piloting suggested a total estimated cost of £97 million per year for the first 10 years from 2013 with the majority of this being opportunity costs in terms of doctors’ time in collecting supporting information and reflecting on this. It was proposed that revalidation would enable this time to be spent more effectively than previously due to the use of the revalidation and appraisal framework.

The benefits that were noted as a result of revalidation related to:

- “increased public trust and confidence in doctors
- improved patient safety, outcomes and quality of care
- a reduction in the costs of support for the minority of doctors whose medical practice is poor, through earlier identification of performance issues
- a reduction in malpractice and litigation costs
- improvement in the quality of information about medical care; and
- supporting positive cultural change in the medical profession” (DH, 2012a, page 3).

Overall, the Department concluded that the benefits outweighed the costs and that revalidation was a cost-effective means of achieving the policy objectives of providing a proactive system of assuring that doctors are fit to practise and meet the requirements of Good Medical Practice.

The Department also published an equality analysis of medical revalidation (DH, 2012b). This concluded that in principle revalidation would “help to address underlying problems and ensure that all doctors, irrespective of gender, race, age or other equality characteristics, have a fair and equal chance to demonstrate their skills and to receive support in addressing any potential concerns over their performance and conduct”. Patients would be able to provide feedback and comment. Reasonable adjustments would help make sure that revalidation was proportionate and non-discriminatory.

**Summary**

Revalidation is an evaluation of whether doctors are fit to practise and is based on a continuing evaluation of their performance in the workplace. It is based on a devolved model of regular
appraisals of individual doctors being undertaken by their employing / contracting organisation and reported to a responsible officer in a designated body (a UK organisation). Responsible officers have the responsibility of making a recommendation to the GMC every five years that an individual doctor is up-to-date, fit to practise and should be revalidated. Responsible officers can make three forms of recommendation: recommend revalidation, request a deferral to gain more information or notification of failure to engage in local processes to support revalidation. The GMC acts on the basis of the recommendation from a responsible officer. CPD is one integral aspect of medical revalidation and relates to the actions that a doctor takes and reports in their annual appraisal.

The GMC is in the process of implementing revalidation for doctors in the UK with 100% of the doctors planned for revalidation (3,500 doctors in total) having gone through the system in what was described as year zero to end of March 2013 and another 44,000 planned in the next 12 months.

The development of medical revalidation was undertaken by the GMC with a large number of partners and with the active involvement of the four UK health departments’ revalidation support teams. Many of these partners remain involved in the implementation of medical revalidation. A cost-benefit analysis of medical revalidation was undertaken by the Department of Health although it is interesting to note that a risk assessment of medical practice and a business case does not appear to have been published (if developed).
GENERAL OPTICAL COUNCIL

Role and size
The General Optical Council (GOC) is the statutory regulator for the optical profession and from December 2012 has been a registered charity (GOC, 2013a). It currently registers approximately 26,000 optometrists, dispensing opticians, student opticians and optical businesses. Its statutory function is to ‘protect, promote and maintain the health and safety of members of the public’ (GOC, 2013a). The GOC was set up under the Opticians Act 1958 with later amendments to the legislation made in 1989 and 2005, the latter introducing mandatory Continuing Education and Training (CET) for full registrants - optometrists and dispensing opticians.

Continuing fitness to practise approaches
The GOC introduced an enhanced Continuing Education and Training (CET) scheme from January 2013 following a programme of research investigating the development of revalidation for its registrants including: an assessment of risk (Europe Economics, 2010b); the use of appraisals (Moore, 2011); gaining feedback from patients, registrants and other stakeholders (GOC, 2010c and GOC, 2009b); and analysis of data from the previous two CET cycles. Peer review was introduced into the CET scheme as a result of the research on risks that the GOC commissioned, which highlighted the risk of potential isolation (GOC, 2013b). Evaluation of the previous CET cycles showed that registrants tended to choose their CET because of their personal interests or the availability / location of the learning. This did not provide assurance of continuing fitness to practise across the scope of practice that is possible through registration with the GOC.

The GOC enhanced the CET scheme as a direct result of the research undertaken and to address the risks identified. It states:

“with these changes we are satisfied that the Enhanced CET Scheme will provide an effective mechanism for us to ensure our registrants continued fitness to practise” (GOC, 2013b, page 2).

As part of the decision making to introduce an enhanced CET, the GOC commissioned a cost-benefit analysis to:

“enable Council to satisfy itself that enhancements to our planned new CET Scheme will effectively address the risks associated with optometric practise and assess the potential costs and benefits of introducing a clinical skills assessment as part of any future requirements” (GOC, 2012b).

The GOC concluded that:

“the enhancements to the CET scheme do provide an appropriate and proportionate mechanism to address the risks identified in the earlier Risk Research ... (and) establishes the cost associated with establishing a system to assess the clinical skills of registrants and evaluates the benefits that such a requirement would offer beyond those already gained from the enhancements to CET. The research concludes that the additional benefits gained

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29 Available at: http://www.optical.org/en/about_us/mission_and_values/index.cfm

30 This was identified as an example of good practice by the PSA in its 2012-2013 performance review.
would be very limited and would not justify the huge costs associated with establishing such a requirement. The introduction of a six yearly clinical skills assessment would not therefore be proportionate for GOC registrants” (GOC, 2012b).

**Enhanced CET**

**Overview**

CET can be characterised as a structured system of CPD and a statutory requirement for all registrants who are qualified optometrists and dispensing opticians. The CET scheme was enhanced for the cycle starting in January 2013 and focuses on:

- “the maintenance and development of the knowledge and skills currently required to be a registered professional, and
- the mitigation of the risks associated with being a registered professional” (GOC, 2012a).

The GOC state that enhanced CET:

- must have a clear focus on current practice and developments within it
- support improved standards of patient care
- support the clinical decision making process and reduce the risk of professional isolation
- encourage registrants to reflect on their own and others’ practice (GOC, 2012a).

New entrants to the register do not have to undertake enhanced CET.

**Standards and approach**

The GOC sets standards in two areas: performance and knowledge, and behaviour. The standards of performance and knowledge are set out in core competencies in four areas of practice: optometry (split into stage 1 and stage 2) (GOC, 2011 a&b), dispensing optics (GOC, 2011c), contact lenses (for dispensing opticians) (GOC, 2011d) and therapeutic prescribing (for optometrists) (GOC, 2009a). To gain a qualification in these areas individuals have to demonstrate that they can meet the core competencies.

The GOC Code of Conduct applies to optometrists, dispensing opticians and students (who also need to be registered with the GOC) (GOC, 2010a). Business registrants have their own Code of Conduct which sets out a framework for all bodies corporate carrying on a business as an optometrist, dispensing optician or both (GOC, 2010b). The GOC does not issue any guidance beyond the Codes of Conduct. However it reviews and refers registrants to the guidance offered by professional and optical bodies (eg the College of Optometrists and Association of British Dispensing Opticians) and states that registrants should familiarise themselves with such guidance. The guidance that the College of Optometrists produces, for example, is quite extensive covering some 46 different areas in some depth (eg infection control, the patient-practitioner relationship)31. The Code of Conduct for individual registrants requires them to “keep professional knowledge and skills up to date” (GOC, 2010a, page 5 no: 8).

CET is a points-based system that runs over a three-year cycle during which registrants must earn a minimum number of CET points to remain on the register. The CET cycle is the same for all registrants (ie it is a set period of time currently 1 January 2013 – 31 December 2015).

Registrants are required to undertake CET activity across the three-year cycle and obtain a minimum of six CET points per year (GOC, 2013b). They report this through an electronic system known as MyGOC, which also offers an online retention facility. CET points reflect the level of engagement that the learning has with peers or experts and the extent to which the learning supports reflection (this is in contrast to the earlier CET system that related to learning hours). At least 50% (18 of the 36 CET points in a three-year cycle) must be achieved through interactive learning, including electronic interaction. Interactive learning involves: physical attendance at events such as lectures, workshops or peer review; or distance learning with an interactive element (such as participation in a web-based discussion forum, provision of personalised feedback from a tutor).

The 36 CET points that an individual gains need to cover all of the competency units for the area of practice (ie optometry or dispensing optics) and for optometrists at least one point must have been obtained from participation in a peer review group or peer discussion event. If a dispensing optician is also a contact lens optician, then in a CET cycle they need to gain half their CET points relating to that speciality and half in the general CET as well as covering all of the units (ie both dispensing optics and contact lens speciality) as well as participate in at least one peer review session using contact lens cases. For therapeutic specialist optometrists, there is a requirement to cover all of the general competency units for optometrists, all of the speciality competency units, participate in at least one peer review session using therapeutic cases in a CET cycle and gain 18 additional CET points in the speciality with a minimum of six per year (meaning they need to undertake 54 CET points over the three years). One CET activity can cover more than one competency unit.

The online CET portfolio has a facility to help registrants track the competencies they have covered and those on which they still need to focus. It does this by using an icon system for different competency units and colour coding those completed. It also shows how many interactive points an individual needs, whether the annual six points target has been met and whether the peer review has been completed. Registrants can also register their own peer review group, apply for scheduled overseas events to be awarded CET points, notify the GOC of exceptional circumstances, search for CET events in different ways, and set notification preferences.

Peer review is intended to help registrants to share their own learning and practice with others and also learn from what others do. Three types of peer review have been identified:

- registrant-led peer review groups of between four and ten registrants who meet to discuss their own real cases
- peer discussion events led by CET providers where cases or topics are provided and set in advance
- online peer review via online real-time audio and video services.

Following peer review, registrants must complete a reflection statement demonstrating their learning through completing a template within their CET portfolio.
Registrants have to submit their CET returns by the end of the CET period (ie 31 December in a given year). The Registrar is able to consider exceptional circumstances that prevented individuals undertaking CET, however there is no automatic shortfall period that registrants can use when they have not completed the requirements in time. Registrants are expected to proactively alert the GOC when they are experiencing difficulties in meeting their CET requirements so that this can be taken into account during annual monitoring.

To retain their registration, registrants must be able to show they have achieved at least 12 CET points in the 12-month period up to the point of re-registration and have no missing CET points for the preceding CET cycle. Anyone who is removed from the register and then applies for readmission needs to show they have covered all of the competencies relevant to their registrant group and interacted with their peers.

Accreditation

All CET provision must be approved in advance. Approved CET activity must last for a minimum of one hour. The GOC approves training and education providers to deliver enhanced CET with CET points attached to it. Approved CET providers must agree to follow the CET provider Code of conduct and performance (GOC, 2013c).

To gain approval for a specific CET activity, a provider must be registered with the GOC as an enhanced CET provider and submit proposals for the activity to the GOC via the enhanced CET platform. This is reviewed by a trained panel of approvers appointed by the GOC against set criteria and a decision is made within 10 days to approve, not approve or request further information. Approved enhanced CET is CET provision that is relevant to professional competency frameworks and standards. The approval period is 12 months, which can be extended for a further 12 months if the content and method of delivery have not changed and the content is still valid. Providers are responsible for ensuring that only approved CET activity is offered to registrants.

Once an enhanced CET activity is accepted it is entered onto the online CET directory and through this made available to registrants to access. Providers need to deliver the education and training activity consistent with the approval submission, identify those registrants that have successfully completed the learning objectives of the activity and tell the GOC the names and registration numbers of the registrants that have successfully completed the activity. Registrants are also responsible for confirming they have completed the CET provision.

Providers who have developed a proven track record of three years or more can apply to become an accredited enhanced CET provider. Accredited providers can appoint their own trained CET approvers. Accredited CET providers are required to report annually to the GOC, using a set template and summarising their enhanced CET activity, the feedback they have received on it, improvements made to their processes and the activities and plans they have for the next 12 months.

The GOC has the ability to gain feedback from registrants who have used specific CET activities and carry out random or targeted audits on the delivery of CET provision and the processes of CET providers to ensure that they match the specification and are at the required standard. All CET providers must allow the GOC to access their activities, events and records for audit purposes. Audit
can be either desk-based focusing on the materials and records or a visit so that the event being delivered can be reviewed against the submission. The GOC may make recommendations to CET providers as a result of audit activity. Audit activity is confidential between the GOC and the CET provider.

The GOC is working with CET providers to help make sure that all registrants can access CET in their areas and specialities.

**Records**

Registrants record their CET online using the interactive CET portfolio on MyGOC. Much of the portfolio is automated in that approved CET activities can be searched using the same platform and their details transferred to individuals’ records. Registrants use the same system to reflect on their learning for the peer review components. The GOC uses the system to monitor registrants’ progress annually as well as check CET returns at the end of the CET cycle.

**Assessment and audit**

The GOC reviews registrants’ CET activity every year in enhanced CET to confirm that every individual is undertaking CET regularly. If registrants have not recorded six CET points in a year they will be asked to explain why this has not been done. Such information will also be taken into account during an individual’s application for retention of registration.

The GOC will audit 10% of registrants’ reflection statements that are made each year by comparing the content to the learning objectives that were specified when the approval was given for that CET activity.

The online system enables the GOC to review all CET returns for compliance to confirm that: the minimum hours have been completed, all of the competencies have been covered, the required modes of learning have been covered and peer review undertaken.

The Registrar has the power to remove from the Register registrants who have not met the enhanced CET requirements by the last day of the three-year CET cycle.

A summary of the GOC’s enhanced CET scheme is given in table 2.4.

| **Approach** | Continuing Education and Training (CET) is a statutory requirement for all registrants who are qualified optometrists and dispensing opticians. CET was enhanced for the three-year cycle starting in January 2013 and focuses on maintaining and developing required knowledge and skills and the mitigation of the risks. New entrants to the register do not have to undertake enhanced CET.

CET is a points-based system that runs over a three-year cycle during which registrants must earn a minimum number of CET points to remain on the register. The CET cycle is the same for all registrants (ie it is a set period of time currently 1 January 2013 – 31 December 2015). Registrants are required to gain 36 CET points across the three year cycle with a minimum of six CET points per year and report this through an online system – MyGOC. CET points reflect the level of engagement that the learning has with peers or experts and the extent to which the learning supports reflection. At least 50% must be achieved through interactive learning, including electronic interaction. The CET points |
| --- | --- |
| **Table 2.4: Summary of current measures to assure continuing fitness to practice used by the GOC – enhanced CET** | **Approach** | Continuing Education and Training (CET) is a statutory requirement for all registrants who are qualified optometrists and dispensing opticians. CET was enhanced for the three-year cycle starting in January 2013 and focuses on maintaining and developing required knowledge and skills and the mitigation of the risks. New entrants to the register do not have to undertake enhanced CET.

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also need to cover all of the competency units for the area of practice and registrants must also engage in at least one peer review activity per CET cycle. One CET activity can cover more than one competency unit.

<table>
<thead>
<tr>
<th>Standards</th>
<th>The GOC sets standards in two areas for individual professional registrants: performance and knowledge (competencies), and behaviour (Code of Conduct).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accreditation</td>
<td>All CET provision must be approved in advance. The GOC approves training and education providers to deliver enhanced CET with CET points attached to it. To gain approval for a specific CET activity, a provider must be registered with the GOC as an enhanced CET provider and submit proposals for the activity to the GOC. Proposals are reviewed by a trained panel of approvers appointed by the GOC against set criteria. Approved enhanced CET is provision that is relevant to professional competency frameworks and standards. The approval period is 12 months which can be extended for a further 12 months if the content and method of delivery have not changed and the content is still valid. Providers who have developed a proven track record of three years or more can apply to become an accredited enhanced CET provider and they can then appoint their own trained CET approvers reporting annually to the GOC, using a set template and summarising their enhanced CET activity, the feedback they have received on it, improvements made to their processes and the activities and plans they have for the next 12 months. The GOC carries out random or targeted audits on the delivery of CET provision using desk-based processes or a visit. Audit activity is confidential between the GOC and the CET provider.</td>
</tr>
<tr>
<td>Assessment</td>
<td>Registrants record their CET online using the interactive CET portfolio. The GOC reviews registrants’ CET activity every year to confirm that every individual is meeting their annual requirements. A 10% audit of registrants’ reflection statements is made each year by comparing the content to the learning objectives that were specified when the approval was given for that CET activity. The GOC checks that every registrant has met their CET requirements at the end of the CET three-year cycle.</td>
</tr>
<tr>
<td>Incentives &amp; penalties</td>
<td>If registrants have not recorded six CET points in a year they will be asked to explain why this has not been done. Such information will also be taken into account during an individual’s application for retention of registration. Registrants who have not met the enhanced CET requirements by the last day of the three-year CET cycle will be removed from the Register by the Registrar. A grace period used to be allowed but this has now been abolished and registrants are responsible for proactively alerting the GOC if they are unlikely to meet their CET requirements due to exceptional circumstances. The Registrar reviews these on a case by case basis.</td>
</tr>
<tr>
<td>Funding</td>
<td>The GOC is mainly funded via registrants’ fees. Application for, and retention of, registration as an optometrist or dispensing optician for all of the year from 1/4/12 – 31/3/13 is £260 and for low income earners £160. In its annual report for 2012/13 it showed a budget of £233,111 for all of its education and standards support costs including the enhanced CET scheme (although it appears not to include staff costs). It also reported the use of a grant from the Department of Health for developing revalidation, which led to the enhancement of the CET scheme, of £40,801 in 2012/13 and £88,072 in 2011/12.</td>
</tr>
</tbody>
</table>
Research and development

The development of the GOC’s enhanced Continuing Education and Training scheme is evidently the result of the programme of research that it undertook in relation to developing a risk-based approach to regulation by assessing the risks associated with optometric practice and the costs and benefits of addressing these risks through an enhanced CET scheme or through a system that might be seen to be more like revalidation – a clinical skills assessment.

The risk assessment, which used a combination of literature review, analysis of available data and discussions with stakeholders, highlighted a numbers of areas of risk in optical practice (Europe Economics, 2010a). These were categorised into two broad groups:

- adverse events – areas of competency which with clinical risks present a risk for patient health and safety (eg misdiagnosis of mismanagement of: glaucoma, retinal detachment, diabetic conditions, macular degeneration; spectacle non-tolerance; contact lenses; management of children)
- contextual factors – which make the risks more or less likely and increase or decrease the effects of the risks (eg length of time in practice, locums, isolated practice).

Europe Economics (2010b) concluded that there were no major risks in the optical profession.

“The types of risk identified are limited to practitioners not conducting all appropriate eye health tests or not eliciting full patient symptoms, and issues around communication. There is no evidence of high risk due to gross mismanagement or misdiagnosis of eye health conditions. That said, there are some clinical areas that should receive more attention through revalidation. These are those areas where a high clinical risk is combined with some degree of practitioner risk. These include glaucoma, retinal detachments, macular degeneration and diabetic eye conditions. There are a number of lesser risks that involve both a lower clinical and practitioner risk. These include contact lens fitting, child care and communication skills. No contextual factors were identified as being of particularly high risk, although there is some risk associated with isolated or disengaged practitioners, those who have been qualified a long time, and locums” (page 11).

They consequently concluded:

“Revalidation could usefully focus on improving decision-making in the higher risk areas (glaucoma etc). This could be done through training that focuses on both decision making skills and the handling of the specific conditions. Any accreditation or tests to ensure practitioner competence could fall within the training framework. The areas of lower risk could be usefully addressed through an enhanced CET scheme, for example by requiring all optometrists to undertake a certain proportion of CET points in these areas to ensure that they keep up to date. Revalidation could also consist of a requirement to attain a proportion of CET points through an interactive mode (such a peer review or workshops) to address the problems associated with disengaged or isolated practice” (page 11).

They also noted that there were a number of arguments against basing revalidation on a detailed profiling of the risks associated with individual registrants related to their scope of practice or the
context in which they work as this would introduce new issues such as requirements to stipulate where individuals can work.

The GOC redesigned its CET scheme – enhanced CET – to address the risks identified and also considered the possibility of introducing an assessment of a practitioner’s clinical skills every six years. The approach to cost benefit analysis included:

- detailing the elements contained in the scheme
- setting out the benefits of the changes and the scale of the change
- the costs for the different parties involved (i.e., registrants, CET providers (employers, associations and commercial) and the GOC
- a risk mapping of the scheme – type of risk, description of risk and how the risk is addressed in the scheme (Europe Economics, 2012).

The total additional cost for introducing an enhanced CET scheme, which had as its main enhanced element peer review, was estimated at approximately £3.97 million. This was based on a semi-formal model of peer review and assumptions about registrants retaining certain CET preferences within the scheme. Of this amount, the additional costs per registrant were estimated at £176 (£3,341,862 in total for registrants), for providers £584,731 and for the GOC £39,439.

In relation to introducing a clinical skills assessment, Europe Economics was in the fortunate position of being able to draw from the costs of a one-off Scottish assessment system that was used in 2006 to assess whether practitioners met the requirements of a new NHS contract. Using this as a basis they calculated the costs of applying such an assessment to registrants in England of whom there are more than 13 times as many as in Scotland. The costs included: running an assessment centre, providing one-to-one tutoring and reassessment for failed registrants, the costs incurred by registrants to prepare for and attend the assessment centre, and the costs of training assessors. Based on this an estimate for implementing such a system in England was calculated at approximately £4.67 million.

The researchers then used a tipping point analysis for both of the risks that would be addressed by this assessment (glaucoma and retinal detachment) to assess whether “the benefits of a clinical assessment scheme, measured by the avoidance of harm a failed practitioner may cause should he/she remain in practice, outweigh the costs of implementing such a scheme” (Europe Economics, 2012 page 17). This identified that the proportion of practitioners that would need to be removed to make the assessment beneficial would be between 11 – 17% for the benefits to be at least as great as the costs. Another means of organising the assessment was also considered (i.e., using assessors visiting practices) but this turned out to be costlier (approximately £6 million).

Europe Economics (2012) concluded that the scheme would require significant resources to roll out and the benefits would be unlikely to offset the costs due to the number of registrants who would need to be found incompetent and the ability of the assessment to identify poor practice. They concluded:

“The results of our previous risk assessment work show that the main, overarching risks in the optical profession relate to decision making, which refers to the whole process of seeing a patient, determining appropriate tests to conduct, identifying any conditions, deciding on
the next steps and deciding on the most appropriate treatment and who to administer it. The consequences of poor decision making would be most serious in the case of a severe eye condition or disease, but are also very relevant to all other areas of optical practice. Other types of assessment, currently provided for under the new CET scheme, are likely to provide equal, if not greater benefits, than a practical assessment. This includes in particular peer review. Diagnostic procedures and identification of conditions would also be successfully tested through good interactive audio or videobased distance learning.” (Europe Economics, 2012 page 18)

Summary
The GOC has been running a structured form of CPD – known as CET – for a number of years. This is based on a points system related to specific forms of training and development and linked to GOC competencies for specific areas of practice.

The GOC took forward a number of research and development projects to investigate how best to assure the continuing fitness to practise of its registrants. These included: assessing the risks in optical practice, the potential use of appraisal in revalidation, consultations on licensing and revalidation, and a cost-benefit analysis of two ways of addressing the risks identified. It concluded that, given the risks in optical practice were low, the most cost-effective and proportionate approach would be to enhance its CET scheme to better address the risks identified.

The new scheme – known as enhanced CET – was introduced in January 2013 for the next three-year cycle of 2013 – 2016. Registrants are required to gain 36 CET points across the three year cycle with a minimum of six CET points per year. CET points reflect the level of engagement that the learning has with peers or experts and the extent to which the learning supports reflection. At least 50% of CET must be achieved through interactive learning, including electronic interaction. Individual practitioners must cover all of the competency units for their area of practice in the three years and also engage in at least one peer review activity per CET cycle.
GENERAL OSTEOPATHIC COUNCIL

Role and size
The General Osteopathic Council (GOsC) is the statutory regulator for osteopaths in the UK being established by the Osteopaths Act 1983. The role of the Council and those of its statutory committees are governed by the Act and a number of pieces of secondary legislation. The GOsC’s purpose is to protect the public by ensuring high standards of education, practice and conduct among osteopaths.

As at 11 October 2013, there were 4,810 osteopaths on the Register.

The GOsC’s main income is from registration fees giving £3,024,357 in 2011-12 and representing 94% of income in that year. The level of the registration fee has not changed since May 2000, although the top-level registration fee was reduced by 10% in 2012 as the GOsC cost-reduction programme took effect.

Continuing fitness to practise approaches
Osteopaths are required to re-register every year, described as renewing their licence to practise. As part of this process the GOsC checks individuals have current professional indemnity insurance, remain in good health and of good character and have met the mandatory requirements of CPD. CPD is the main way in which the GOsC currently confirms that osteopaths are up-to-date and hence likely to be fit to practise.

The GOsC has been active in taking forward the development of a system of revalidation in conjunction with considering its system of CPD. The GOsC describes revalidation as ‘a new process which will require osteopaths to show, at regular intervals, that they remain up to date and fit to practise’.

The GOsC set up three working groups to advise its Council on the development of revalidation for osteopaths: the Revalidation Standards and Assessment Working Group, the Revalidation Patient and Public Involvement Group and the Research Working Group. The papers and minutes of the Revalidation Standards and Assessment Working Group from February 2010 – June 2012 are available on the website.

A consultation on draft proposals for a revalidation scheme for osteopaths (GOsC, 2009) was held in the early part of 2009 and a summary of the outcomes was published at the end of December 2009 (Masterson & O’Hanlon, 2009). Following this the GOsC further developed the proposed scheme and commissioned research to support the development and introduction of revalidation. This included studies investigating:

- how osteopaths practise (KPMG, 2011)
- the work undertaken by other regulators to outline costs, benefits, financial and regulatory risks (KPMG, 2010).

• patients’ expectations of osteopathic care (Leach et al, 2011)
• the clinical risks of osteopathy (Vogel et al, 2012).

The GOsC’s draft proposals for revalidation broadly consisted of a four stage process as follows:

1. self-assessment completed by all osteopaths focusing on clinical interaction with patients and based on the practice standards
2. request for further information to clarify responses at stage 1
3. peer review of practice as a result of any concerns at stage 2 either reviewing documentary evidence, evidence of practice or via an interview
4. a formal assessment of clinical performance.

A pilot of the proposed revalidation scheme was held from September 2011 – September 2012. All of the osteopaths taking part in the pilot received a Revalidation Pilot Participation Manual consisting of three parts: (1) about the pilot (2) guidelines for osteopaths seeking revalidation (revalidation pilot), and (3) osteopathic practice standards. Participants were offered training workshops in the first two months of the pilot and support was also provided via an online learning area.

The standards of assessment for revalidation were based on the Osteopathic Practice Standards (GOsC, 2011a) with revalidation assessment criteria developed in the four broad areas used in the practice standards. The Osteopathic Practice Standards cover both the Standard of Proficiency and Code of Practice as defined in the Osteopaths Act. They are described as “all the standards of conduct and competence required of osteopaths to promote patients’ health and wellbeing and to protect them from harm” (GOsC, 2011a, page 3). The standards are grouped into four themes:

• communication and patient partnership
• knowledge, skills and performance
• safety and quality in practice
• professionalism.

The evaluation of the pilot (KMPG, 2013a) focused on ‘assessing the implementation of the scheme and whether participants, assessors and the GOsC consider whether and to what extent the model as piloted is fit for purpose’ (page 3). 484 registrants signed up for the pilot of whom 54% successfully completed it (i.e., provided a self-assessment of their practice demonstrating their compliance with the revalidation assessment themes and criteria through submitting a portfolio of evidence mapped to the criteria). 81% of those completing the pilot provided a completed self-assessment form and 43% of all completed portfolios were judged to have met all of the criteria through providing sufficient evidence. The researchers suggest that this challenges the basic assumption made about the scheme being based on self-assessment as this relies by its nature on accurate returns being made.

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36 This area includes a requirement for osteopaths to keep their professional knowledge and skills up to date (statement B4) and 'committing to and undertaking CPD’ and ‘monitoring the quality of osteopathic care you deliver and acting on the findings’.
75% of pilot participants reported that the pilot meant that they reflected more on their practice and there was a consistent finding throughout the duration of the pilot that there was a beneficial effect on patients. The majority reported that the purposeful review of the practice standards was beneficial. However quantifying the pilot and putting a monetary value on it – both costs and benefits – was reported as difficult with many of the benefits being relatively intangible (eg increased public confidence).

There was little evidence to suggest that any groups of practitioners (such as those who work part-time) were disadvantaged by the pilot, although the apparent complexity of some of the paperwork was noted as being a potential issue for people with dyslexia. However the apparent complexity of the scheme and the time that registrants had to give to it appears to have been an issue in retention. Average time to complete the pilot was reported as 53 hours over the year (roughly an hour a week).

The evaluators reported variation in the degree to which osteopaths were able to reflect on the feedback received (eg from patients) and apply this to their practice leading to a conclusion that more would need to be done in this area to gain improvements in practice.

The researchers also produced an impact assessment of the revalidation pilot scheme using the Impact Assessment Toolkit published by the Department for Business Innovation and Skills (KPMG, 2013b). Using this toolkit, KPMG advised that putting a value on the scale of the impacts by monetising the effects was appropriate to the stage of development, the data available, the anticipated timescale and likely changes to the scheme prior to implementation. The researchers identified a number of benefits and costs to the scheme including the measures that could be used. These included:

- direct costs such as: portfolio production time (osteopaths, and colleagues and patients in providing feedback), training costs (registrants and assessors), self-assessment and portfolio review time
- indirect / unintended costs such as: reduction in time spent on CPD by registrants, reduction in available time for GOsC, increase in the number of registrants leaving the register.

Further information is then provided on running different aspects of the pilot giving an estimated overall cost for the pilot as £1,558,989 and including: pilot consumable costs, GOsC administration time, participant training opportunity costs, participant participation time opportunity costs and GOsC pilot evaluation. The figure does not include a number of costs such as: patient time to complete surveys, GOsC administration time pre and post pilot nor possible differences between opportunity costs for assessors. KPMG then proceed to detail the different aspects that would need to be taken into account to develop costs and benefits for rolling out the scheme and the different ways in which this might be done. However they did not proceed to do this due to the outcomes of the pilot, possible changes to the scheme itself and the focus of the pilot being solely on stage one of the then four-stage proposed scheme.

As well as taking forward the revalidation pilot, the GOsC issued a discussion document in 2011 on CPD looking at the purpose and structure of the current scheme, the challenges inherent in it and possible ways in which it would be improved (GOsC, 2011b). The CPD discussion document was designed to generate debate about CPD at the same time as the GOsC were taking forward the
revalidation pilot. This was to allow the outcomes of the different strands to be considered together enabling the Council to decide how to take forward the assurance of continuing fitness to practise.

An independent report of the outcomes of the CPD discussion concluded that, whilst there appeared to be strong support for the current system of CPD:

- the profession as a whole appeared to have development needs related to undertaking audit and measuring the effectiveness of practice
- there would be benefit in developing further guidance on the current system, particularly on identifying learning needs and appropriate types of learning to meet those needs (Masterson & O’Hanlon, 2013).

The key findings reported on the GOsC website relate to: limited support for learning cycles, slightly more support for core CPD; support for feedback on CPD to individual registrants and considerable support for the current system. The GOsC noted that it would take time to consider these outcomes along with the outcomes of the revalidation pilot with a view to publishing revised proposals in autumn 2013.

At the meeting of its Council held on 17 October 2013, the GOsC considered a paper on Continuing Fitness to Practise (item 10) that bought together all of the work undertaken to that point in time. This emphasised the need for capacity building in the profession – individual osteopaths and the profession as a whole – before the objectives of a full revalidation scheme could be realised. The paper proposed a revised continuing to practise framework essentially based on a model of enhanced CPD and running over a three-year time period. Its main components are:

- annual hours requirement (as before)
- majority of CPD self-directed
- requirement for CPD in the four domains of the practice standards
- at least one defined activity related to consent and communication
- one of four set types of activity at the start of a three-year cycle
- quality assurance.

It was also proposed that the Council should discuss this broad framework with key groups prior to more detailed guidance being developed and consulted on in 2014. The Council agreed the proposal and is now in the process of sharing it more widely with a view to developing guidance on how it might work in practice and consulting further in 2014.

**Current CPD system**

Table 2.5 below summarises the GOsC’s current system for assuring the fitness to practise of its registrants – its extant CPD scheme. Further information on the GOsC’s CPD system is provided in Appendix 4.

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39 Personal communication with an officer at the GOsC.
Table 2.5: Summary of current measures to assure continuing fitness to practice used by the GOsC - CPD

| Approach | There is a mandatory scheme of CPD for osteopaths registered with the GOsC. New osteopathic graduates do not have to meet the CPD requirements for the first 10 months of registration providing that they apply for registration within three months of qualifying. CPD is described as ‘activities undertaken to maintain, enhance and develop existing knowledge and skills following the completion of a professional qualification’. Osteopaths have to undertake at least 30 hours of CPD each year of which 15 hours must be learning with others - any relevant learning activity that involves interaction with osteopaths, healthcare practitioners or other professionals. A registrant’s CPD year is two months prior to that of their registration year. Registrants have to complete a CPD annual summary form at the end of the year reporting on the CPD activities undertaken that year. They also need to compile a CPD Record Folder containing information on the CPD activities undertaken (eg articles read and their evaluation of them) and are advised to add in other relevant materials (eg copy of the summary form, learning plans, evaluations of learning). CPD records need to be retained for five years. |
| Standards | The Osteopathic Practice Standards are the standards of conduct and competence required of osteopaths. The Continuing Professional Development guidelines for osteopaths set out the details of mandatory scheme which is specified in CPD Rules. |
| Accreditation | The GOsC does not accredit CPD activities and does not itself evaluate the quality of CPD, because it sees this as complex and resource intensive with the potential of limiting availability and raising costs. |
| Assessment | The GOsC checks the CPD annual summary forms to confirm that the CPD requirements have been met and this information is then used towards the annual renewal of registration. Every year the GOsC samples a number of CPD record folders to verify their contents against the statements made by the individual on their CPD annual summary form |
| Incentives & penalties | Failure to meet CPD requirements may result in removal from the register not unless there is evidence of mitigating circumstances. Outstanding CPD requirements need to be met prior to any restoration of registration. |
| Funding | Funding of the GOsC’s activities is mainly through the income raised from registrants’ annual registration fees – £340 in the first year on the register, £455 in the second year and £610 a year in subsequent years. Registrants must fund their own CPD activities – few osteopaths are employed so CPD is generally funded by individual registrants direct. |

Research and development
The GOsC has undertaken a range of research to inform the development of its approaches to assuring the continuing fitness to practise of registrants. These are outlined below.

1. An investigation of how osteopaths practise used a survey approach of a stratified sample of 940 osteopaths (KPMG, 2011). From the 267 who responded (28%) KPMG found that: more than half of osteopaths usually practise alone and hence are usually alone with patients, with about 20% of osteopaths practising from their own home, 15% practise in managed
environments (such as hospitals), formal appraisal of performance is rare, approximately 22% undertake examination of intimate areas and of these about 12% never offer a chaperone, and about 50% practise less than 30 hours per week. The researchers noted that these factors have implications for risk in osteopathic practice and hence also for the system of revalidation that might be appropriate.

2. Research into the work undertaken by other regulators to outline costs, benefits, financial and regulatory risks (KPMG, 2010). Whilst this report is limited by reporting progress at a specific point in time - three years ago (2010), it is interesting to note that at that point most Councils were developing similar approaches and identifying the evidence for their business cases. In relation to cost, KPMG noted that the affordability of revalidation was seen as significant by all regulators either in terms of feasibility of roll-out or buy-in from registrants. Cost was also related to the effectiveness of other regulatory mechanisms such as appraisal, clinical governance and CPD. At that point in time regulators had not sufficiently developed their schemes to be able to accurately forecast costs.

3. Research into patients’ expectations of osteopathic care in order to identify the specific aspects of osteopathic practice about which patients have expectations and to what extent patients perceive their expectations are fulfilled or not (Leach et al, 2011).

4. An investigation of the clinical risks of osteopathy - this concluded that whilst osteopathy might be regarded as a low risk intervention major events can occur although they are rare (Vogel et al, 2012).

More recently, the GOsC has commissioned research into adverse events in osteopathic practice to further develop understanding of risk and contribute to decisions about the proportionality of approaches taken. It is also undertaking work with partners to develop a common classification system of coding complaints and claims about osteopaths to inform the areas in which future regulatory action might be needed.40

**Future plans**

As described briefly above, the GOsC has recently agreed to engage with key groups around a proposed new approach to assuring the continuing fitness to practise of osteopaths. This approach can be seen to essentially be a form of enhanced CPD reflecting the learning from piloting the first stage of its previously proposed revalidation scheme. The GOsC plans to develop more detailed guidance and consult on this approach in 2014.

**Summary**

The GOsC has commissioned a range of research and development activities related to continuing fitness to practise including studies of: risk, patient expectations, how osteopaths practise and the approaches taken by other regulators. It has also run and evaluated a pilot revalidation scheme and obtained an impact assessment. The evaluation of the pilot questioned some of the fundamental principles on which the model had been based such as the ability of practitioners to validly self-assess their own practice, reflect and to effectively improve their practice.

The costs of the pilot were estimated at more than £1.5 million including: pilot consumable costs, GOsC administration time, participant training opportunity costs, participant participation time

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opportunity costs and the evaluation of the pilot, but not including costs of: patient time to complete surveys, GOsC administration time pre and post pilot nor possible differences between opportunity costs for assessors.

The GOsC has recently agreed to take forward developments on assuring the continued fitness of its registrants using what might best be described as an enhanced CPD model which would run over a three year cycle (as compared with the current annual CPD cycle). This consists of a number of components including: the majority of CPD being self-directed, a requirement for CPD in the four domains of the practice standards, at least one defined activity related to consent and communication, a set activity at the start of a three-year cycle and quality assurance.
GENERAL PHARMACEUTICAL COUNCIL

Role and size
The General Pharmaceutical Council (GPhC) is the statutory regulator for pharmacists, pharmacy technicians and pharmacy premises in Great Britain. The GPhC’s role is set out in the Pharmacy Order 2010 and in other legislation (e.g. the Medicines Act).

Its principal functions include:

- “approving qualifications for pharmacists and pharmacy technicians and accrediting education and training providers
- maintaining a register of pharmacists, pharmacy technicians and pharmacy premises
- setting standards for conduct, ethics, proficiency, education and training, and continuing professional development (CPD);
- establishing and promoting standards for the safe and effective practice of pharmacy at registered pharmacies;
- establishing fitness to practise requirements, monitoring pharmacy professionals’ fitness to practise and dealing fairly and proportionately with complaints and concerns”.

There were more than 47,407 pharmacists, 21,824 pharmacy technicians and 14,186 pharmacy premises registered with the GPhC in England, Scotland and Wales as at March 2013 (GPhC, 2013a). All GPhC registrants must renew their registration each year and declare they meet all of the GPhC’s professional, fitness to practise and ethical standards.

Continuing fitness to practise approaches
The CPD framework came into force on 2 July 2011 (GPhC, 2011b) and sets out in detail what pharmacy professionals must do in order to meet the CPD standards. This framework sets out five CPD standards related to the recording of CPD and submission of CPD records and by implication the nature of the CPD that GPhC registrants have to undertake. Registrants are required to structure their CPD records against a CPD cycle with evaluation seen as the most important stage of the cycle. At the point of annual renewal of registration, a pharmacy professional is required to declare that they will comply with the CPD framework. Failure to comply can put an individual’s registration at risk.

In January 2012, following a report from its Revalidation Task and Finish Group (GPhC, 2012b) the Council of the GPhC agreed a draft definition of revalidation as:

“The process by which assurance of continuing fitness to practise of registrants is provided and in a way which is aimed primarily at supporting and enhancing professional practice”.

It also agreed seven revalidation principles. These included: the focus of revalidation being on continuing fitness to practise and not based on assessment at one point in time, although it was recognised that some form of assessment would be required against a standard; the standard being

41 Information on the About Us section of the GPhC website at: http://www.pharmacyregulation.org/about-us
Accessed on 15/10/13
the Standards of Conduct, Ethics and Performance which is applicable to all registrants; and more than one source of information being used. The principles also included the fact that the model developed should be consistent with the generic principles developed by the Department of Health’s Non-Medical Revalidation Working Group (DH, 2008), be cognisant of the structure of the pharmacy workforce, be costed and subject to testing.

In July 2012, a revalidation stakeholders meeting was held under the Chatham House Rule to assist the GPhC in developing revalidation policy (GPhC, 2012c). The report does not make clear the type of person who was counted as a stakeholder in the group (eg pharmacy professional, other professionals, other regulators, patients, members of the public). The report notes that the event was helpful in providing insights into key issues which will inform future research, development and stakeholder engagement, and notes that the Council is working towards finalising implementation plans in 2015 consistent with its corporate plan. In the GPhC’s strategic plan the work is described as: ‘Confirm our policy with respect to further strengthening of the assurance / revalidation of continuing fitness to practise of GPhC registrants, and finalise our plans for implementing new policy in this area’ (GPhC, undated).

The November 2013 meeting of the GPhC Council considered a paper on Developing a framework for assuring the continuing fitness to practice of pharmacy professionals. This sought the Council’s agreement to the development of a draft framework for assuring continuing fitness to practice, a timetable for doing this and a related review of the current CPD ‘call and review’ process. A press release following the Council meeting stated that the Council had agreed the framework should be developed.

The paper notes:

“The terms ‘revalidation’ and ‘continuing fitness to practise’ are subtly different. In the GPhC’s view ‘revalidation’ implies a fixed point assessment whereas ‘continuing fitness to practise’ suggests a review of practice viewed on a continuum. The latter better describes the thinking outlined in this proposal, so that term will be used from now on” (GPhC, 2013b, page 3 of 6 of the paper, page 75 of total Council papers).

Given the two different professional groups that the GPhC registers (pharmacists and pharmacy technicians) and the range of sectors in which their registrants work, a framework is considered to be more appropriate for development than a set model to allow sufficient flexibility.

As the GPhC’s Standards for Conduct, Ethics and Performance set out the standards of conduct, ethics and performance that all pharmacy professionals must follow (ie pharmacists and technicians), these standards will be used as the basis for assuring continuing fitness to practise (GPhC, 2012a). The standards are organised under seven broad principles that the pharmacy professional must undertake as follows:

1. “Make patients your first concern

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2. Use your professional judgement in the interests of patients and the public
3. Show respect for others
4. Encourage patients and the public to participate in decisions about their care
5. Develop your professional knowledge and competence
6. Be honest and trustworthy
7. Take responsibility for your working practices” (GPhC, 2012a, page 6)

The standards are due for review in 2014 and the development of a framework for continuing fitness to practise will be considered within the review and additional advice and guidance will be developed in relation to this.

The proposed agreed framework has three components:

1. a peer review process conducted by a professional peer and based on a registrant’s scope of practice as defined by the registrant and verified by the peer in the process. Organisations will be accredited by the GPhC to run peer appraisal with the intention of building on existing systems (such as appraisal)
2. CPD review – the call and review process which is currently primarily quantitative in nature will include a focus on the relevance of CPD to the registrant’s scope of practice
3. external performance indicators – a review of external performance indicators related to the registrant’s scope of practice developed in consultation with the profession.

The broad timetable for taking the work forward is:

2013 – agree development of framework and approach
2014 – review Standards, develop framework and review CPD call and review process, start testing components of framework
2015 - pilot the framework
2016 - evaluate the pilot and report to Council
2017 - launch full consultation on the framework and consider outcomes
2018 – continuing fitness to practise framework starts.

The paper concludes by noting that:

• a governance and project management structure will need to be agreed and put in place which is likely to include: an oversight group, a management group and in due course implementation boards in each of the three UK countries that the GPhC covers
• clear communication will be essential throughout
• the proposals will need to be subject to a full equality impact assessment
• resources are not currently available and will need to be put in place

45 These are the same principles that are used by the GCC to structure its Code of Practice and were originally developed by an inter-regulator working group looking at the principles they had in common.
assuring continuing fitness to practise is unlikely to be cost-neutral and this will need to be kept under review.

**Current CPD system**

Table 2.6 below summarises the GPhC’s current system for assuring the fitness to practise of its registrants – its CPD scheme. Further information on the GPhC’s CPD system is provided in Appendix 5.

| Approach | The CPD framework that supports the CPD standards for pharmacy professionals came into force on 2 July 2011. Amongst other things, registrants are required to record against the CPD cycle a minimum of nine CPD entries per year reflecting the context and scope of practice their CPD and say how it has contributed to the quality or development of their practice. Failure to comply with the CPD standards can put an individual’s registration at risk. When a pharmacy professional annually renews their registration they are required to declare that they will comply with the CPD framework. |
| Standards | The GPhC’s Standards for Conduct, Ethics and Performance (GPhC, 2012) set out the standards of conduct, ethics and performance that pharmacists and pharmacy technicians must follow (ie principle 5 is ‘develop your professional knowledge and competence’).

The GPhC’s standards for Continuing Professional Development ‘ensure that pharmacy professionals maintain their knowledge and skills and remain up to date with practice’. This is supported by a CPD framework and guidance entitled Plan and record. |
| Accreditation | There is no mention of accredited or approved CPD activities or providers in the GPhC documentation. |
| Assessment | The GPhC monitors registrants’ CPD records usually every five years but can call them for review at any time on the basis of risk. The review covers the five year period prior to the date of review and the outcomes of every review are retained on the Council’s registration database.

The reviews are undertaken by a trained CPD reviewer (pharmacy professionals and people who are not from the profession) appointed by the GPhC. Appointment is on the basis of ‘ability to review information objectively against the review criteria’. The quality of each reviewers’ work is assessed.

During the review process, registrants can be asked to provide supplementary information for verification purposes. Registrants are informed of the outcome of the review and feedback is given on their performance against the review criteria. They can also access a more detailed feedback report. |
| Incentives & penalties | The GPhC’s CPD Rules set out a number of ways in which registrants may have failed to comply with the CPD requirements and hence have not complied with the CPD framework and the procedures that the GPhC will follow if this happens. Registration can be cancelled if there are significant deficiencies. Any instances of potential fraud or dishonesty in CPD are dealt with through the GPhC’s fitness to practise procedures. |
| Funding | It is assumed that registrants pay for their own CPD although some may be subsidised by their employer or be able to use opportunities provided by the employer. The GPhC does not distinguish the costs of CPD separately from the costs of education. |
The majority of the GPhC’s funding comes from registrants’ fees. Annual renewal fees are: £240 for pharmacists and £108 for pharmacy technicians.

Research and development

The predecessor body to the GPhC, the Royal Pharmaceutical Society of Great Britain (RPSGB), established a short-term Revalidation Advisory Group. This ran in parallel with the Department of Health’s Non-Medical Revalidation Working Group and undertook some initial work on different revalidation options. With funding from the Department of Health, the RPSGB set up a revalidation research programme looking at the risks within pharmacy practice (Phipps et al, 2010), potential sources of evidence for revalidation including appraisals (Schafheutle et al, 2010) and CPD (Donyai et al, 2010), and potential structures for the delivery of revalidation (Boak et al, 2010). The programme of research was transferred to the GPhC in September 2010 and the outcomes appear on the research section of its website46. The November 2013 Council paper states that the research fed into the thinking of the GPhC’s Revalidation Task and Finish Group.

Future plans

In mid-November 2013, the GPhC agreed a way forward on the development of a framework to assure the continuing fitness to practise of its registrants. This will involve a development, testing, costing, communication and consultation programme between 2013 – 2017 with an anticipated implementation date of 2018.

Summary

The GPhC implemented a system of CPD for pharmacists and pharmacy technicians in Great Britain in 2011. It also drew on a programme of development work related to revalidation undertaken by its predecessor body, the RPSGB, to inform the development of seven principles of revalidation.

The GPhC Council has recently agreed the development of a framework for continuing fitness to practise related to a review of practice viewed on a continuum, as compared with revalidation, which is seen to imply a fixed point assessment. The standards to be used are the GPhC’s Standards for Conduct, Ethics and Performance, which will be reviewed during the development of the framework. The proposals suggest three methods of reviewing a practitioner’s practice: professional peer review, CPD review and the use of external performance measures.

HEALTH AND CARE PROFESSIONS COUNCIL

Role and size
The Health and Care Professions Council (HCPC) was established under the Health and Social Work Professions Order 2001 under Section 260 of the Health Act 1999. The HCPC currently regulates the following professions: arts therapists, biomedical scientists, chiropodists / podiatrists, clinical scientists, dietitians, hearing aid dispensers, occupational therapists, operating department practitioners, orthoptists, paramedics, physiotherapists, practitioner psychologists, prosthetists / orthotists, radiographers, social workers in England and speech and language therapists. As of 1 November 2013, there were 319,637 individuals on the HCPC register (HCPC, 2013). The largest group on the HCPC register is social workers in England (86,603) and the smallest is prosthetists / orthotists (937).

The Health and Social Work Professions Order 2001 gives the HCPC powers to recommend to the Secretary of State for Health and to Scottish Ministers the regulation of other professions and occupations although the final decision is made by Government. With the publication of the White Paper Enabling Excellence (DH, 2011) the Government made clear that further statutory regulation of groups of healthcare professionals will only be considered in ‘exceptional circumstances’ and when there is a ‘compelling case’.

The HCPC run a two-yearly registration cycle and the renewal of registration fee of £152 applies to all registrants except for new graduates for whom there is a 50% reduction. Since 2005, CPD has been seen as an important part of continuing registration.

Continuing fitness to practise approaches
The HCPC sets Standards of Conduct, Performance and Ethics which are applicable to all registrants and set the ethical framework within which they must work (HCPC, 2012a). Standard 5 is ‘you must keep your professional knowledge and skills up to date’ and the guidance makes reference to the fact that the standards for CPD link learning and development to continued registration.

The Standards for Continuing Professional Development define CPD as ‘a range of learning activities through which health and care professionals maintain and develop throughout their career to ensure that they retain their capacity to be able to practise safely, effectively and legally, within their evolving scope of practice’ (HCPC, 2012b).

The HCPC describes revalidation as ‘a process by which a regulated professional periodically has to demonstrate that he or she remains fit to practise’. In 2007, the HPC established a Professional Liaison Group on continuing fitness to practise – the group met five times between November 2007 and September 2008 and produced a report entitled Continuing Fitness to Practise: Towards an evidence-based approach to revalidation (HPC, 2009). The report considered: existing mechanisms for assuring continuing fitness to practise, national and local mechanisms, international mechanisms, developments in the UK related to revalidation, risk (as evidenced by fitness to practise cases),

47 Before the inclusion of social workers in England on to the register, the HCPC was known as the Health Professions Council. Both HCPC and HPC are used as acronyms in this section reflecting the time at which the work was undertaken. The name formally changed on 1 August 2012.
systemic risks, professionalism, costs and resources, public perceptions and options for further work. It concluded that “existing regulatory process are currently appropriate and sufficient when considered in the context of the wider environment in which they operate and the risk of harm posed by the professions regulated by the HPC” (HCPC 2009). However the HPC agreed to undertake a programme of research to build the evidence base further with, we understand, a grant from the Department of Health. This programme of work is described briefly in the research and development section below.

**Current CPD system**

Table 2.7 below summarises the HCPC’s current system for assuring the fitness to practise of its registrants – its CPD scheme linked to renewal of registration. Further information on the HCPC’s CPD system is provided in Appendix 6.

| **Approach** | The HCPC run a two-yearly registration cycle and CPD is seen as an important part of continuing registration. During the renewal of registration individuals need to declare they have met the CPD standards. CPD is defined as ‘a range of learning activities through which health and care professionals maintain and develop throughout their career to ensure that they retain their capacity to be able to practise safely, effectively and legally, within their evolving scope of practice’. |
| **Standards** | The HCPC sets Standards of Conduct, Performance and Ethics – these set the ethical framework in which all registrants must work. There are also Standards of Proficiency for each profession based on a generic model. The Standards for Continuing Professional Development state registrants must: 1. maintain a continuous, up-to-date and accurate record of their CPD activities 2. demonstrate that their CPD activities are a mixture of learning activities relevant to current or future practice 3. seek to ensure that their CPD has contributed to the quality of their practice and service delivery 4. seek to ensure that their CPD benefits the service user; and 5. upon request, present a written profile explaining how they have met the standards for CPD. |
| **Accreditation** | The HCPC does not approve CPD activities. |
| **Assessment** | The HCPC audits a random sample of registrants who have been registered for more than two years and are renewing their registration to make sure the standards are being met – sample size 2.5%. Those to be audited are required to complete a CPD profile showing how their CPD meets the CPD standards. CPD assessors assess the CPD profiles received against assessment criteria based on a spectrum from ‘not met, partly met and met’. CPD assessors are senior members of the professions regulated by the HCPC and contracted as partners. Each profession’s CPD audit is assessed by two HCPC partners, at least one of which (though usually both) will be from the relevant profession. They are selected and trained for the CPD assessment and their performance reviewed. Further information can be sought from the registrant. |
### Incentives & penalties

The outcomes of the assessment are: met & the individual remains on the register; the profile does not meet all the standards & the individual is offered three months to meet the CPD standards; or not met and they are removed from the register. In 2009-10, 16 of the 4377 registrants selected for the CPD audit were removed from the register either because they failed to submit a CPD profile or were assessed as not meeting the CPD standards.

### Funding

The majority of the HCPC’s continuing income is from registrants’ fees - renewal of registration fee of £152 applies to all registrants except for new graduates for whom there is a 50% reduction. The published accounts do not provide any information on the costs of running the CPD scheme or undertaking the CPD audit.

### Research and development

The HPC’s Professional Liaison Group on continuing fitness to practise proposed that there would be benefit in taking forward work in a number of areas as follows:

- “Analysis of fitness to practice data to explore correlations between age, location of practice and fitness to practice.
- Analysis of the outcomes of the CPD audits currently being conducted.
- A retrospective study to explore whether registrants from a particular profession who have undergone fitness to practise action are more likely to have been involved in disciplinary procedures or to demonstrate a poor record in professional behaviour during training.
- A prospective study piloting the use of a professionalism tool with education and training providers for two different professions and track the progress of students over five years. Depending on the outcome from these studies, a wider use of this tool in education and training programmes for other professions may be recommended.
- In parallel to the above recommendation, further explore the teaching of ‘professionalism’ on pre-registration programmes across the 13 professions and look at ways of promoting this further, for example, via the standards of education and training.
- A prospective study looking at the application of a patient feedback tool with a random sample of registrants and students.” (HPC, 2009)

The outcomes of five of these studies have been reported to date.

*Analysis of fitness to practise data* – Smith (2012) undertook a multi-variant analysis of the HCPC’s fitness to practise data to identify predictors and outcomes with the aim of building on annual fitness to practise reports. Using a case control study approach, comparing two data sets of registrants: one group had fitness to practise allegations and received a sanction from a final hearing whilst the second group was a control data set that were similar on important variables except for the key variable of having received a fitness to practise allegation. The report, as well as finding some historic issues with registration data, found that male gender and accessing the register via the grandparenting application route were found to be significant independent predictors with the strongest relationship to case outcomes. Overall the HCPC concluded that the outcomes of the study were not as successful as anticipated but have value in confirming annual descriptive statistics.
Professionalism - Morrow et al (2011) sought to increase understanding of professionalism within three of the professions regulated by the HCPC - chiropodists / podiatrists, occupational therapists and paramedics. Using a focus group approach (20 groups involving a total of 112 participants) they explored how students and educators perceive professionalism or lack of it. They found that participants’ interpretation of professionalism included a wide range of different aspects of behaviour, communication and appearance as well as being perceived as a more holistic concept in its own right. Professionalism is also seen to be part of an individual’s character and values but to be influenced by context with standards and regulations acting as a baseline for what is acceptable. The suggested that perhaps professionalism was best described as a ‘meta skill’ consisting of an awareness of context and judgment in that context. ‘The true skill of professionalism may be not so much in knowing what to do, but when to do it’ (page 3). The role of employers and regulators in enabling professionalism was noted. Burford et al (2011) reported on the first 12 months of a five-year study to develop measures of professionalism for paramedics. Two quantitative measures have been developed to date: two versions of a ‘conscientiousness index’ using routinely-collected organisational data (and adapted from previous work with medics); and a questionnaire to measure respondents’ self-perceptions of professionalism. At the time of the progress report no data had been collected using either tool.

International comparisons - The HCPC undertook a study visit to Ontario, Canada to explore the well established quality assurance programmes of its professional regulators (HPC, 2011a). The report notes that the primary purpose of the Ontario systems is to improve quality rather than to identify practice that is falling below the required level, although this may be an outcome, and this in itself would be a change in legislative approach. The HPC concluded that there would need to be clarity as to whether, if it introduced a system of revalidation, this was primarily to raise the practising standards of its registrants (a quality improvement approach) or to identify practitioners that are failing to meet the standards (a quality control approach). Other outcomes of the study visit were reported as registrant engagement and sampling approaches in quality assurance programmes.

Work of other regulators - In 2011 the HCPC reviewed the progress other regulators were making on developing systems of revalidation and noted the themes emerging at that stage were: use of feedback from patients and service users, thinking about conduct as well as competence and a range of approaches to assessing risk (HPC, 2011b).

Service user feedback - Related to the work on revalidation emerging from other regulators, the HPC commissioned a study to:

“examine available evidence regarding the use and impact of service user feedback tools in healthcare, and explore the views of people within the professional bodies of those professions regulated by the HPC on the use of service user feedback with a view to informing decisions about its introduction to the practice, appraisal, CPD, regulation and/or revalidation of the HPC’s registrants” (Chisholm and Sheldon, 2011).
Using a literature review and a Delphi consultation \(^{49}\), Chisholm and Sheldon identified twelve standardised instruments across ten professional groups and covering different areas of practice (Chisholm and Sheldon, 2011). They reported that whilst it is difficult to achieve absolute consistency in methods, which is known to affect comparability in scores, work on evaluating the validity and reliability of the different instruments is underway and could be used in the future. Qualitative approaches to gaining patient feedback which present issues in comparing individuals over time, have the benefits of enabling a greater range of service users to provide feedback and might be of use for individual practitioners. They also noted that there was no evidence that the use of the instruments would in themselves contribute to improvements in professionals’ practice, partly because no such evidence appears to have been sought to date. Overall Chisholm and Sheldon concluded that whilst the case for including service user feedback is strong more research needs to be undertaken to find the best ways of using this feedback in professionals’ ongoing development and hence improve practice.

Information on the HCPC website does not indicate whether the other proposed studies have been conducted or if the HCPC has further developed its thinking as a result of the research undertaken or in the context of registering a greater number of professional groups.

**Summary**

The HCPC has a mandatory system of CPD for all its registrants based on a two year registration cycle. In 2009, the HPC concluded that their current regulatory measures were sufficient to manage the risk of the professions they regulated. A programme of research work was commissioned to gain further evidence which has focused on understanding the risk posed by HCPC registrants, the development and measurement of professionalism, reviewing the approaches taken by other regulators in the UK and Ontario, and investigating the use of patient feedback tools.

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\(^{49}\) Delphi approaches are used as a means of gaining consensus across a group about a particular subject using a staged approach to consensus building.
NURSING AND MIDWIFERY COUNCIL

Role and size
The Nursing and Midwifery Council (NMC) regulates nurses and midwives in the UK and the islands. It was established under the Nursing and Midwifery Order 2001 under Section 260 of the Health Act 1999 and came into being on 1 April 2002. There were a number of predecessor bodies.

Its purpose is to: safeguard the health and wellbeing of the public; set standards of education, training, conduct and performance; ensure that nurses and midwives keep their skills and knowledge up to date and uphold professional standards; and to investigate nurses and midwives who fall short of their standards.

In July 2012, the PSA published a strategic review making several recommendations as to how the NMC should improve its regulatory functions (CHRE, 2012). In its response the NMC accepted the recommendations and agreed that it would need to make improvements. In this context the NMC is working to take forward a number of major development strands.

There are 673,567 nurses and midwives on the NMC register (as at 31 March 2013) making it by far the largest regulator in the UK (NMC, 2013a). The annual registration fee is £100 from 2013.

Continuing fitness to practise approaches
At present, nurses and midwives are required to meet the NMC’s Post-Registration Education and Practice (PREP) standards to remain on the NMC register. Renewal of registration takes place on a three year cycle and includes a requirement for individuals to sign a notification of practice form declaring they have met the PREP requirements and their health and character are sufficiently good to enable them to practise safely and effectively. The two PREP requirements that nurses and midwives have to meet to retain their registration are:

- the Prep (practice) standard – individuals must have worked for at least 450 hours in the previous three years as a result of their nursing or midwifery qualification (or completed an approved return to practice course)
- the Prep (CPD) standard – individuals must have undertaken and recorded at least 35 hours of CPD over the three years prior to their renewal of registration (NMC, 2011).

For midwives, there has been a model of midwifery supervision for a number of years. This is a statutory responsibility that aims to both support and guide every midwife practising in the UK as well as offer protection to women and babies through the active promotion of a safe standard of midwifery practice (NMC, 2009b). Midwives must meet at least annually with their midwifery supervisor, who is external to organisational management structures. These regular supervisory review sessions are intended to evaluate practice and identify areas for development.

The Francis Report – the report of the public inquiry into failings at Mid Staffordshire NHS Foundation Trust – recommended that the NMC should:

“introduce 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

51 At that time the Council for Healthcare Regulatory Excellence.
public. It is essential that the NMC has the resources and the administrative and leadership skills to ensure that this does not detract from its existing core function of regulating fitness to practise” (Francis Report, 2013, Executive Summary page 77 para 1.189).

The NMC has identified the implementation of “a model for ensuring that nurses and midwives continue to be fit to practise” as one of its six key work streams in the next three years and is reviewing its policy on standards and guidance to ensure they are in line with the principles of right-touch regulation. The review of the standards for the preparation of supervisors of midwives will continue and will be subject to consultation during 2013 (NMC, 2013a).

In 2012, a sample of compliance with the Prep standards was undertaken, which showed that from an audit of a random stratified sample of 100 registrants “the Prep standards are not fit for purpose in that they do not provide adequate assurance of registrants’ continuing fitness to practise”52.

The NMC describes the primary purpose of revalidation as: “to provide greater assurance that nurses and midwives on our register remain fit to practise and capable of safe and effective practice”. At its Council meeting in March 2013, the NMC considered a number of papers on revalidation, reviewed the way forward and agreed that assuring continuing fitness to practise remained an important priority for the Council and the work to develop a revalidation process would continue (NMC, 2013b). The NMC made a commitment to “introduce a proportionate and effective system of revalidation which enhances public protection by the end of 2015”. It is proposed that nurses and midwives will gather and reflect on evidence, including feedback from patients and colleagues, against the code and standards. They will then need to gain third party confirmation (eg an employer or a manager) that they are fit to practise and are complying with the code and standards.

Revalidation will occur at the same time as renewal of registration. Monitoring of revalidation submissions will be on a random and risk basis informed by other regulators and the NMC’s fitness to practise processes (NMC, 2013c). Failure to revalidate will result in the registrant lapsing from the register.

There will be various strands to the development work including:

- reviewing the current CPD hours requirement and clarifying what is meant by a CPD activity
- reviewing and revising the Code and Standards to make sure they are compatible with revalidation – launched by the end of 2014
- developing guidance on revalidation.

On 6 January 2014, the NMC launched the first part of a two part, six month consultation (January – June 2014). The consultation process focuses on revising the current Code (NMC, 2008) and implementing revalidation53. The online survey for the first part of the consultation asks questions on the main proposed components of revalidation as set out in the proposals for the September 2013 Council meeting (see above). The consultation will be used to gather information to draft a revised Code and develop guidance for revalidation. The NMC’s aim is to launch the revised Code and standards by the end of 2014 and to introduce revalidation by the end of 2015.

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The NMC is planning further research and analysis to support revalidation and has dedicated resource and budget for this work.

**Current systems – PREP and midwifery supervision**

Table 2.8 below summarises the NMC’s current systems for assuring the fitness to practise of its registrants – PREP linked to renewal of registration and midwifery supervision. Further information on these systems is provided in Appendix 7.

| **Table 2.8: Summary of current measures to assure continuing fitness to practice used by the NMC – PREP and midwifery supervision** |
|---|---|
| **Approach** | 1. Post-Registration Education and Practice (PREP)
Currently nurses and midwives are required to meet the NMC’s PREP standards to remain on the NMC register. Renewal of registration takes place on a three year cycle and individuals sign a notification of practice form declaring they have met the PREP requirements and their health and character are sufficiently good to enable them to practise safely and effectively.

2. Midwifery supervision
A system of supervision for midwives, which is separate from management structures, and aims to support and guide midwives as well as offer protection to women and babies. Midwifery supervisors are experienced midwives who receive additional training and education for their role. Midwives meet at least annually with their midwifery supervisor to evaluate practice and identify areas for development. |
| **Standards** | The NMC’s Code: Standards of conduct, performance and ethics (NMC, 2008) applies to all registrants and contains statements relating to maintaining and developing competence and performance, and keeping up to date knowledge and skills.

There are broadly two Prep standards – practice standard where individuals must have worked for at least 450 hours in the previous three years as a result of their nursing or midwifery qualification; and a CPD standard where individuals must have undertaken and recorded at least 35 hours of CPD over the three years prior to their renewal of registration.

There are separate Rules for midwifery supervision as well as guides for midwives. |
| **Accreditation** | The NMC does not approve CPD (Prep) learning activities. |
| **Assessment** | The NMC states that it aims to audit compliance but this appears not to have been done systematically.

In relation to midwifery supervision, each Local Supervising Authority both audits services in its own area and reports to the NMC. The NMC compiles the reports from across the UK and produces an annual report. Each midwife is assessed on an ongoing basis and measures can be taken to improve practice as a result (eg structured reflection, further training, and if necessary supervised practice). |
| **Incentives & penalties** | Incentives beyond professional honesty and integrity are minimal in the current Prep system due to the lack of auditing or checking. Fitness to practise proceedings may be implemented against any registrant who is found to have submitted fraudulent information.

The NMC’s annual report 2011-2012 on midwifery supervision states that 109 midwives (0.27% of the midwifery workforce) undertook a period of supervised practice in that year. |
2011 – 2012 and 25 midwives (0.07% of the midwifery workforce) were referred for consideration under fitness to practise mechanisms. A slight increase on the previous year.

| Funding | There is an annual registration fee of £100. The majority of the NMC’s income comes from the registration fees. Registrants will often have to pay for their own CPD costs unless CPD activities are provided by their employer. The costs of midwifery supervision are borne by Local Supervising Authorities and employers, with the NMC participating in the quality assurance of this system. |

**Summary**

The NMC has two systems for assuring continuing fitness to practise:

- Post-Registration Education and Practice (PREP) standards apply to all registrants with registration taking place on a three year cycle and requiring nurses and midwives to meet two standards related to a minimum amount of practice (or the completion of an approved return to practice course) and CPD, plus a declaration regarding sufficient health and character.

- Midwifery supervision applies to midwives with the aim of supporting and guiding every midwife as well as offering protection to women and babies through the active promotion of a safe standard of midwifery practice.

The Francis Report (2013) recommended that the NMC should introduce a system of revalidation similar to that of the GMC. In September 2013, the NMC made a commitment to introduce revalidation by the end of 2015 based on a system of nurses and midwives gathering and reflecting on evidence against the code and standards and gaining third party confirmation that they are fit to practise and are complying with the code and standards. To put this in place the code, standards and CPD requirements will need to be reviewed and developed, and further development work on revalidation undertaken. In January 2014, the NMC launched the first part of a two part, six month consultation focused on revising its current Code (NMC, 2008) and implementing revalidation.
COMMENTARY

This final section of this chapter summarises the current systems of CPD that all the UK healthcare profession regulators have in place prior to considering more recent developments to assure continuing fitness to practise.

Current systems of CPD

As can be seen from the information presented on each of the UK healthcare profession regulators, each has a mandatory system of CPD which together with periodic registration forms the minimum ways of assuring the continuing fitness to practise of professionals. Only the GOC uses a model of accredited continuing education. All other regulators emphasise that practitioners are best placed to decide their own learning needs and decide on the learning activities that are best suited to them. A recent GDC communication to its CPD providers and registrants emphasises the need for quality in CPD which suggests it is an imperfect market. However, the GDC does not appear to be planning to change its approach to one of accreditation / approval.

The use of an adult learning cycle tends to be the favoured approach although the extent to which it is used in monitoring CPD varies. For example, the GPhC has the completion of records related to learning cycles as one of its requirements as to a lesser extent does the GCC, whereas the GoSC advises on the use of learning cycles but does not appear to require evidence of their use. The activities that can be recognised as counting as CPD also varies with the HCPC appearing to accept any activity as long as the practitioner can reflect on it and identify the learning that has taken place. Other regulators, such as the GoSC and the GCC, have requirements about the need to learn with others (which it seems is to counter the possible isolation that their practitioners might experience), whilst the GDC requires a certain percentage of activities that are verifiable in the sense of having clear aims and objectives at their start.

The measures that regulators use to assess that the required CPD has taken place vary with some using a mix of outcome and input measures, such as hours and learning cycles including evaluation and reflection (eg the GCC) or the number of CPD entries that relate to learning cycles (eg the GPhC). The HCPC is the only regulator to focus solely on registrants undertaking sufficient CPD to remain up to date and fit to practise although this is an aspect of the GMC’s CPD system albeit coupled to annual appraisal leading into a five year revalidation cycle. The outcomes of specific CPD activities in terms of the learning that has been achieved are not formally assessed with regulators seeking evidence of it having been undertaken through such mechanisms as attendance certificates, reflections on learning and lecture notes.

Most regulators have some form of checking at the point of registration renewal or the end of the CPD period that requirements have been met. This is usually done by scrutinising CPD returns, often as some form of summary of the CPD that has been undertaken, with the GPhC probably having the most detailed approach and requirements for such returns. The HCPC and NMC both require only a declaration from the registrant that CPD has been completed. All of the UK regulators state they audit a sample of returns although the proportion varies (HCPC state 2.5% whereas others such as the GOC state 10%). However it appears that audit has not always been implemented (eg NMC).

The NMC is distinctive in that its CPD system - PREP – also has a requirement related to hours of practice or in the case of some practitioners, a return to practice course. For midwives there is also a
process of statutory supervision that is independent of management structures and is intended to enhance practice and protect mothers and babies.

**Broader approaches to assuring continuing fitness to practise**

In chapter 1, the development of approaches to assuring the continuing fitness to practise of professionals was discussed from a government policy perspective with the initial focus being on the need to introduce systems of revalidation for all regulated healthcare professionals. The principles of non-medical revalidation (DH, 2008) emphasised the need for approaches to be risk-based and proportionate whereas the publication of the PSA’s guidance (2012) saw the language shift to the outcome of the system and the adoption of the term ‘assurance of continuing fitness to practise’.

The developments undertaken by the different regulators are set in this policy context but also influenced by the stage of their own development and the particular challenges and priorities they each face. The state of play for the UK regulators in relation to developing approaches to assuring the continuing fitness to practise of their registrants at the time at which this study took place is shown in table 2.9.
<table>
<thead>
<tr>
<th>Regulator</th>
<th>Explicit reference to assuring cont: FtP</th>
<th>Reported plans to amend / improve approaches to continuing fitness to practise</th>
<th>Current approach to assuring continuing fitness to practise</th>
<th>Validation of continuing competence</th>
<th>Auditing</th>
</tr>
</thead>
<tbody>
<tr>
<td>GCC</td>
<td>Yes</td>
<td>Had plans to pilot a scheme of revalidation in 2014 but in December 2013 announced that it wished to reconsider if this was the most appropriate way forward</td>
<td>Annual re-registration Mandatory CPD</td>
<td>Monitors CPD summary sheets for compliance. Return of CPD summary form prior to renewal of registration</td>
<td>Audit a sample each year</td>
</tr>
<tr>
<td>GDC</td>
<td>Yes</td>
<td>Seeking enhanced CPD once necessary legislation in place Revalidation - potentially for dentists</td>
<td>Mandatory CPD over 5 year cycle with some changes following recent research work Annual registration</td>
<td>CPD returns checked to ensure meet requirements</td>
<td>Audits are carried out on a sample</td>
</tr>
<tr>
<td>GMC</td>
<td>Yes</td>
<td>Already actioned</td>
<td>Revalidation system implemented from December 2012 after extensive development work (CPD one component part) Registration and licensing</td>
<td>Based on the standards in Good Medical Practice, principally implemented through regular appraisals between a doctor and their employer. Responsible officers report to GMC every five years</td>
<td>On receipt of a revalidation recommendation from a responsible officer, a series of checks made to ensure there are no other concerns, and revalidation follows if all okay</td>
</tr>
<tr>
<td>GOC</td>
<td>Yes</td>
<td>Already actioned</td>
<td>Enhanced CET (CPD) system implemented from January 2013 on a three year cycle</td>
<td>Review of registrants’ CET activity every year to confirm meeting annual requirements. Check made on every registrant at end of three year CET cycle</td>
<td>Audit of 10% of registrants’ reflection statements made each year by comparing the content to the learning objectives</td>
</tr>
<tr>
<td>GOsC</td>
<td>Yes</td>
<td>Yes having undertaken a revalidation pilot now taking forward proposals which can be viewed as enhanced CPD model</td>
<td>Mandatory CPD (for all except new graduates in first year of practice) Annual re-registration</td>
<td>Checks CPD annual summary forms to confirm requirements met - information used towards annual renewal of registration</td>
<td>Samples a number of CPD record folders every year to verify their contents against the statements made on the summary form</td>
</tr>
<tr>
<td>Regulator</td>
<td>Explicit reference to assuring cont: FtP</td>
<td>Reported plans to amend / improve approaches to continuing fitness to practise</td>
<td>Current approach to assuring continuing fitness to practise</td>
<td>Validation of continuing competence</td>
<td>Auditing</td>
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<tr>
<td>GPhC</td>
<td>Yes</td>
<td>Currently considering development of continuing fitness to practise framework (as distinct from revalidation)</td>
<td>Mandatory CPD Annual re-registration</td>
<td>Registrants’ CPD records monitored usually every five years but can be called for review at any time linked to risk – reviews by trained reviewer</td>
<td>(Registrants’ full records are assessed at least every five years)</td>
</tr>
<tr>
<td>HCPC</td>
<td>Yes</td>
<td>Stated in 2009 that current systems are sufficient</td>
<td>Mandatory CPD Two year cycle of registration</td>
<td>At renewal of registration individuals need to declare they have met the CPD standards</td>
<td>Audits 2.5% of registrants by profession every two years</td>
</tr>
<tr>
<td>NMC</td>
<td>Yes</td>
<td>Plan to implement revalidation in 2015</td>
<td>PREP – practice &amp; CPD requirements 3 year cycle. Midwifery supervision</td>
<td>PREP – returns linked to registration Midwifery supervision – minimum annual requirement</td>
<td>Aims to audit but not achieved to date</td>
</tr>
</tbody>
</table>
It is evident from table 2.9 that the term ‘assuring continuing fitness to practise’ is now widely used by UK healthcare profession regulators. For a number this appears to have replaced the earlier focus on the term ‘revalidation’ (e.g. GOC, GOsC, GPhC), whilst for the HCPC continuing fitness to practise was the term it used in its initial work in this area undertaken in 2008-2009. The GMC is the only UK healthcare profession regulator in the UK (and possibly in the world) to have implemented a system of revalidation. The NMC has announced plans to introduce revalidation in 2015 following the findings of the Francis Inquiry into failings at Mid-Staffordshire NHS Trust, although it has yet to publish detailed proposals. The GCC had stated that it planned to pilot revalidation in 2014, however more recently it has announced its intention to review its plans in the light of the emerging developments of other regulators.

This suggests that amongst the non-medical regulators there is a growing interest in enhancing CPD as a more proportionate and effective means of assuring continuing fitness to practise of their registrants. For the GOC this conclusion was reached following detailed work on the risks posed in optical practice and by identifying the most cost-effective means of addressing these risks. For the GOsC it is a result of the outcomes of an extensive pilot of stage one of a proposed revalidation scheme which led to questions being asked about its fundamental nature (i.e. whether registrants are able to reflect on practice and self-assess). For the GDC, which has also piloted a draft scheme of revalidation for dentists as well as undertaking a number of other research projects, the focus has shifted to reviewing and improving its CPD scheme which it now sees as a fundamental step on the path to a full revalidation system for dentists (although when this step will be taken is not currently evident). More recently, the GPhC has agreed to move to a system based round CPD and peer review - two aspects of which are common to the GOC and GOsC.

**Areas of development related to good practice**

In chapter 1 we identified the areas that the PSA have set out in relation to a right-touch approach to providing assurances about registrant continuing fitness to practise. These can be used as a basis to identify good practice and have been used below to summarise the work of the different UK regulators.

**Core standards of competence and behaviour (i.e. conduct and competence)**

All of the regulators have standards of conduct and competence although the extent to which they are integrated, how they are presented and how they have been used in developing approaches to the assurance of continuing fitness to practise varies. The GMC has produced a framework for appraisal and revalidation from its core standards of Good Medical Practice which focuses on 12 themes, three under each of the four areas of Good Medical Practice, designed to summarise the key elements of the standards and presumably to facilitate implementation in an appraisal. The GOsC and the GDC have both revised their standards whilst undertaking their developments and have adopted a four theme approach (like the GMC). However the GOsC is using one integrated document covering both conduct and competence, whilst the GDC’s four themes are contained within its document related to learning outcomes for the dental team and it retains a separate, recently revised, document relating to conduct. The latter is interesting in that the standards are clearly related to patient expectations.
The recent proposal from the GPhC states that it will use its standards of conduct, performance and ethics as the basis of assuring continuing fitness to practise and a proposed review of these standards will take this into account. The NMC is similarly reviewing its standards as it develops its revalidation process, as is the GCC, although statements about how these developments will affect each other do not appear to have been made. The GOC is alone in not appearing to have developed its code of conduct or sets of competencies during the development and implementation of its enhanced CET scheme despite the latter being significantly more detailed than the approaches used by other regulators.

A clear understanding of what professionals (registrants) do and the context in which they do it

It has been difficult to assess how a clear understanding of what their registrants do has influenced the development of approaches to assuring continuing fitness to practise because regulators have not made this explicit in reporting developments in this area. For example, the predecessor body to the GPhC (the RPSGB) undertook workforce censuses, which would contain such information and the GMC’s annual publications on the state of medical education and practice would be examples of such information. Some regulators are able to state the proportion of their register that works in different employment settings, such as the NHS or private practice. The GOsC appears to be the one regulator to have recognised the need to understand how its practitioners practise as part of its development work in this area, commissioning the How do osteopaths practise? report (KPMG, 2011).

Severity and prevalence of risks relating to continuing fitness to practise guiding decision-making and the approaches used

The development of a risk-based approach is one of the fundamental principles of regulation that has emerged over the last few years in the UK. A number of the healthcare profession regulators have undertaken detailed risk assessments (beyond an analysis of their fitness to practise case data, which shows only those instances on which complaints have been made to a regulator, rather than all risks), although these appear to differ in approach and coverage.

Three of the regulators - the GOsC, the GCC and the GDC - have also commissioned research into patient and public expectations of their practitioners, perhaps reflecting that osteopathy and chiropractic receive little or no public funding so expectations are less well established.

Table 2.10 summarises the studies that have been undertaken on risk using the broad areas of risk within the PSA report. It also draws a distinction between actual risks that are capable of quantification (albeit not always easily) and perceived risks perhaps best illustrated through the work around patient and public expectations.

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54 Reported in the GPhC third work stream report, Boak et al (2011)
Table 2.10: Studies of risk in different areas of healthcare undertaken by UK healthcare profession regulators

<table>
<thead>
<tr>
<th>Risks</th>
<th>Activity</th>
<th>Context</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actual</td>
<td>GCC – Europe Economics 2010</td>
<td>GOC, Europe Economics 2010</td>
</tr>
<tr>
<td></td>
<td>GOC, Europe Economics 2010</td>
<td>GOSC, Adverse events</td>
</tr>
<tr>
<td></td>
<td>GOSC, Adverse events</td>
<td></td>
</tr>
<tr>
<td></td>
<td>GPhC, Phipps et al, Risk assessment in pharmacy practice 2010</td>
<td></td>
</tr>
<tr>
<td>Perceived</td>
<td>GDC, Ipsos Mori Public expectations 2009</td>
<td>GOSC, Leach et al, Patient Expectations 2011</td>
</tr>
<tr>
<td></td>
<td>GCC, Firefly – Patient Expectations 2012</td>
<td></td>
</tr>
</tbody>
</table>

As table 2.10 shows, not all of the regulators have undertaken (or perhaps published) studies on risk (eg GMC and NMC) even though they have taken forward approaches to assuring continuing fitness to practise or plan to do so. Where work on risk has been undertaken some studies have focused on the risks in the activity of the professions concerned (eg the GCC), whereas others have focused on risks in both the activity and the context (eg GOC). The GoS C has apparently deliberately targeted different studies to explore different areas of risk and also perceptions of risk and expectations. All three of these bodies indicate how their work on risks and expectations has influenced their direction of travel in assuring continuing fitness to practise with this being most strongly evident in the work of the GOC. Work was undertaken on risk for (initially the predecessor body of) the GPhC although it is not clear how it is being used in the current proposals.

The GDC has commissioned a study which is due to report at the end of 2013. The HCPC used information from its fitness to practise cases in 2009 and does not appear to have undertaken further analysis of risk, although the professional groups it registers have changed over time.

The work undertaken by the GOC is clearest in showing where an analysis of risks, benefits and costs has directly influenced the decisions made and the final approach used. To a large extent the context for doing this was favourable as the GOC already had a very structured form of CPD on which to build and cost components. It could also use the costs of an assessment system for awarding NHS optometry contracts in Scotland to calculate the costs of an alternative more extended assessment approach.

The GoS C also commissioned a cost-benefit analysis of its then proposed approach to revalidation. This was not carried out in full for two broad reasons related to its revalidation pilot: firstly, only the first of the proposed four stages was piloted and therefore gave limited information on costs, and secondly the outcomes of the pilot questioned the basis of that stage. As the consultants KPMG commented, risk-benefit analysis needs to relate to the specific proposals that are to be taken forward. A cost-benefit analysis of medical revalidation was carried out by the Department of Health in England (DH, 2012). As this was published in November 2012 and medical revalidation started in December 2012, it seems reasonable to question the extent to which this had any impact on decision making about the model to be used for medical revalidation or whether it should be implemented.

Use of existing mechanisms
There are various examples of the UK regulators using existing mechanisms to assure continuing fitness to practise. These mechanisms might be ones a regulator already has in place, such as CET in the GOC which led to it being enhanced, or through the use of devolved systems such as building revalidation onto the annual appraisals of doctors that were already specified in medical contracts (although at that time these were not always taking place). However in relation to the latter the main costs of the assurance system are covered by the state through NHS funding. The GPhC has as one of its three components the use of external performance measures although there is insufficient detail at present on the nature of these. There is also evidence of regulators exploring whether they could use devolved systems as the basis of revalidation but then finding issues with them, such as the research that GOC commissioned on appraisal systems (Moore, 2010).

More recent developments within the GDC, GOsC and the GPhC (if agreed) suggest that non-medical regulators are increasingly seeing the enhancement of CPD, or what might be termed ‘CPD-Plus’, as the most cost-effective way to proceed for areas of practice where the risks are low.

**Assessments made are sufficiently valid and reliable for the risks identified**

The validity and reliability of assessments can only be identified through evaluative studies designed for that purpose. However forms of assessment that have face validity and the potential to be reliable have formed the focus of developments, as has the engagement of practitioners in the process. The predominant themes that emerge in relation to assessment are:

- concern about self-assessment being the basis for the assurance process (best evidenced in the outcomes of the GOsC pilot)
- the benefits of peer review that is structured to provide some form of objectivity - as illustrated in:
  - the use of appraisals in medical revalidation
  - the peer review requirements in GOC’s enhanced CET
  - the GOsC proposals of having peer discussion and analysis (including of patient notes) as one of its four defined activities at the start of a cycle
  - the GPhC proposals related to professional peer review
- the use of feedback from patients and service users, illustrated in this being one of the sources of evidence in medical revalidation, one of the four defined activities at the start of a cycle in the GOsC proposals and research into service user feedback undertaken for the HCPC.

The other key theme that emerges from the work of a number of regulators is the active engagement of practitioners as a central and fundamental basis of measures to assure continuing fitness to practise. Non-engagement is the basis of referral to the GMC in medical revalidation (as opposed to incompetence or poor conduct which should be addressed immediately through performance management structures and, if necessary, escalation to the GMC’s fitness to practise processes). The NMC proposes that a process in which nurses and midwives actively gather evidence and reflect on it against the standards, coupled with third party confirmation of meeting the standards, be at the heart of its system. The GOsC has identified non-engagement as a critical issue. Where current systems span more than a year there is evidence of a move (the GOC) - or a planned move (the GDC) - to seek annual confirmation of CPD engagement. Active engagement in such
professional behaviour can be seen as lying at the heart of the research that the HCPC has been taking forward on professionalism.

Fairness in any assessments undertaken is also a necessary feature. An equality analysis of medical revalidation was undertaken by the Department of Health (2012) and has been noted by the GPhC as something that will need to be undertaken in its development programme. However this does not appear to be a feature highlighted by other regulators.

**Transparency and accountability - the reasons for these forms of assurance being used and the levels of assurance that the approaches provide are made explicit and public**

The evidence cited in this report illustrates how transparent each regulator is in accounting for policy developments to assure continuing fitness to practise. The GDC is explicit about the process that it has taken and the range of research that has been commissioned to inform decisions and this is easily accessible. Similarly the GOC provides the background to the reasons for adopting the enhanced CET process although interestingly the information on costs and benefits affecting the final decision is not available in the same section and can only be found by searching Council papers. The GOsC also has extensive information on the work that it has undertaken. Similarly the GMC has a wealth of information on its website, and a search function which reveals numerous papers. The genesis and development of medical revalidation is more difficult to track however due to the numerous partners involved and the direct policy interventions of the UK government. As mentioned previously, there is no published risk analysis of medical practice or any analysis of whether the current system of medical revalidation is the most appropriate to address those risks. In relation to other regulators, we are aware of work that has been undertaken but which no longer appears on websites (e.g. GCC) and might surmise from the information that is available that it is not fully indicative of all the work that has been carried out to date (e.g. NMC, GPhC).

In relation to the public interest, there is little information from any regulator as to how patient and public involvement has directly influenced the direction of travel beyond evidence of them being a stakeholder consulted or through lay Council members forming part of project management groups.

It will not be possible to provide public information on the levels of assurance that finalised approaches to assuring continuing fitness to practise provide until implementation has taken place. There will also be issues as to how best to do this, for example, whether reductions in the number and type of fitness to practise cases would be a suitable measure.

In addition to identifying best practice which, in the context of the difficulties of comparing different regulators with different professional groups and different challenges, we have interpreted as good practice, this study was asked to report on business cases and time frames. These are considered below.

**Business cases**

As referred to above, little public information is available on the business case for adopting different forms of assuring continuing fitness to practice. The Department of Health produced a cost-benefit analysis related to the implementation of medical revalidation (DH, 2012). The focus of this work was essentially on whether the model should be rolled out over a three or five year timescale as the
decision to proceed with medical revalidation based on devolved annual appraisals had already been taken.

KPMG undertook an impact assessment of the GOsC’s revalidation pilot scheme using the Impact Assessment Toolkit published by the Department for Business Innovation and Skills (KPMG, 2013b). Using this toolkit, the researchers identified a number of benefits and costs to the scheme including direct costs and indirect / unintended costs (e.g., reduction in time spent on CPD by registrants) as well as monetising different aspects of running the pilot giving an estimated overall cost for the pilot as £1,558,989. They also detailed the different aspects that would need to be taken into account to develop costs and benefits for rolling out the scheme and the different ways in which this might be done but did not proceed to do this due to the outcomes of the pilot, possible changes to the scheme itself, and the focus of the pilot being solely on stage one of the then four-stage proposed scheme.

A cost benefit analysis undertaken for the GOC is perhaps the best example of a business case that exists in the work to date. Building on earlier work undertaken in relation to risks, this included costing both an enhanced form of CET as well as the introduction of a direct assessment of a practitioner’s clinical skills in two areas of practice every six years (Europe Economics, 2012). The outcomes of this work showed that for the enhanced CET scheme with an enhanced element of peer review the total additional cost could be estimated at approximately £3.97 million of which the additional cost per registrant was estimated at £176 (£3,341,862 in total for registrants), for providers £584,731 and for the GOC £39,439. This contrasted with the introduction of a clinical skills assessment where the additional costs were estimated at approximately £4.67 million for England alone. Using a tipping point analysis for both risks that would be addressed by this assessment and the benefits that would accrue coupled with the outcomes that would need to be achieved to make it worthwhile expending the additional cost, the researchers concluded that enhancements to the current scheme would give better value for money. This research did not consider the impact of the decision on the resourcing of the regulator itself and the feasibility of implementation within the organisation, perhaps because the case for moving to an enhanced form of CET with fairly minor cost increase for the GOC was so strong.

In conclusion, there is little information in the public domain on the business cases for approaches to assuring continuing fitness to practise, either because these are seen as internal documents or potentially because they have not been undertaken.

**Time frames**

The time frames for implementation of developed forms of assuring continuing fitness to practise vary with some regulators such as the GMC and GOC already having started implementation (in December 2012 and January 2013 respectively), whilst the GPhC are looking to 2018 (subject to its Council’s agreement). Within this there is a spectrum of dates with the GDC seeking legislation to enhance its current CPD scheme to start in 2014 subject to legislation, and the NMC stating 2015, although its revalidation proposals are not fully formed. Others do not yet appear to have committed to a firm date, such as the GOsC, the GCC and the GDC in relation to the possible revalidation of dentists. The HCPC appears to retain its position, first set out in 2009, that it has not established a need for any enhanced mechanisms beyond those it already has in place. All regulators will have to address the outcomes of the Law Commission review of healthcare profession
regulation and the impact it has on their freedom to change their approaches. This coupled with the general political context and often driven by concerns over patient safety and the quality of care in the NHS, may speed up the timescales sought or put pressures on individual regulators to move to one approach rather than another.
CHAPTER 3: APPROACHES TO ASSURING THE CONTINUING FITNESS TO PRACTICE OF PHARMACISTS IN OTHER COUNTRIES

INTRODUCTION
This chapter reviews the approaches adopted by pharmacy regulators in other countries to assure continuing fitness to practise. Most regulatory jurisdictions outside the United Kingdom do not use the concept of ‘continuing fitness to practise’ as an organising principle. However in many the concept is implicit and can be inferred from the widespread adoption of regulated continuing education and professional development tied to periodic re-registration.

This chapter focuses only on arrangements in respect of pharmacists. We acknowledge that most pharmacy regulators are also responsible for other members of the pharmacy team. To avoid the distraction of numerous references to differential arrangements, and for reasons of brevity, we have omitted analysis of other regulated pharmacy professions. In practice it seems that most regulators have or are introducing measures to assure continuing fitness to practise – such as CPD – incrementally, starting with pharmacists and then applying similar standards and requirements to others.

The following geographical jurisdictions were examined in the PSI report in relation to pharmacy and have been revisited, revised and updated in this chapter:

- Australia
- Canada (Ontario and British Columbia)
- Finland
- Ireland
- Netherlands
- New Zealand
- USA.

The PSI report (PSI, 2010) included a review of CPD in Portugal. We have been unable to replicate and update that work because of a lack of primary sources available in English. We believe much of the information in the PSI report may have been gleaned from a conference paper by the President of the Portuguese Pharmaceutical Society 55 which is no longer available. The competent authority in Portugal is the Order of Pharmacists (Ordem dos Farmaceuticos), but as a professional membership organisation its website provides limited public access to policies and regulations relevant to this review. We have therefore substituted another country as an additional comparator: South Africa.

Great Britain is included alongside the other health professions reviewed in the chapter addressing regulators in the United Kingdom.

The chapter concludes with a commentary on the findings.

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55 The paper cited in the PSI report is: 6th International Conference on Life Long Learning in Pharmacy “Continuing Professional Development – The Portuguese Experience”, Fernando Ramos, Vice-President; José Aranda da Silva, President; Tania Saraiva, Professional Secretary of the National Board; Ivana Silva, Professional Secretary of the National Board; Portuguese Pharmaceutical Society Lisbon, Portugal.
AUSTRALIA

Since publication of the PSI report in June 2010 changes have occurred to the regulatory framework for pharmacists in Australia. The principal elements of the new arrangements are described in the section immediately below.

Regulatory structure

All states and territories enacted the Health Practitioner Regulation National Law during 2009 or 2010. Ten health professions were brought into the National Registration and Accreditation Scheme in 2010, and a further four professions were included in the new arrangements during 2012.

The Australian Health Practitioner Regulation Agency (AHPRA) is responsible for implementing the national scheme. It does so by working with National Health Practitioner Boards – one for each of the 14 professions regulated – which set the standards that practitioners have to meet in order to register. Once registered, practitioners must continue to meet the standards and renew their registration yearly with the National Board.

The Pharmacy Board of Australia (PBA) is the National Board responsible for setting registration standards for pharmacists. It has over 26,70456 individuals on its register.

The PBA:

- registers pharmacists and students
- develops standards, codes and guidelines for the pharmacy profession
- handles notifications, complaints, investigations and disciplinary hearings
- assesses overseas trained practitioners who wish to register in Australia
- approves accreditation standards and accredited courses of study.

In respect of this last function, under the Health Practitioner Regulation National Law, National Boards are empowered to decide whether accreditation is to be exercised by a committee of the Board or an external accreditation entity. Where the accreditation authority is an external entity that organisation is required to work with the Board to deliver specified accreditation functions under a formal agreement with AHPRA.

The Pharmacy Board of Australia decided to delegate responsibility for accreditation to the Australian Pharmacy Council (APC) (until July 2018). Among other things it conducts written examinations on the PBA’s behalf and assesses the qualifications and skills of overseas trained pharmacists; it also accredits pharmacy schools and programmes, intern training programmes and agencies that accredit continuing professional development activities.

In summary, the overarching regulator is the AHPRA. It unifies and supports the work of 14 National Boards to ensure a consistent approach to regulation across 14 health professions. The PBA determines standards, including for CPD, which must be met by all pharmacists upon annual renewal

56 Of these over 1600 are provisional, nearly 900 are non-practising and 17 have limited registration (Data Tables September 2012).
of their registration. Responsibility for accrediting CPD activities has been delegated by the PBA to the APC. It accredits other organisations that meet its standards for CPD delivery.

**Approach to assuring continuing fitness to practise**

The PBA does not refer explicitly to ‘assuring continuing fitness to practise’ but it can be inferred as an objective from measures such as annual re-registration, mandatory CPD, and its policies and procedures to deal with complaints about registrants. Similarly, the PBA makes no reference to the concept of revalidation, which to date appears to have been addressed only by its parent body, the AHPRA, and only in respect of medicine.

In terms of public protection concerns about a pharmacist’s professional conduct may be raised at any time. Guidance about submitting a complaint concerning a pharmacist’s health, conduct or performance is described as ‘voluntary notification’ (AHPRA, undated[a]). In contrast, in addition to being able to make a ‘voluntary notification’, health professionals regulated under National Law (ie other AHPRA registrants), employers of practitioners, and education providers all have a duty in law to make a ‘mandatory notification’ in certain instances of specified ‘notifiable conduct’ (AHPRA, undated[b]).

Standards for registration are specified by the Pharmacy Board of Australia and include, among others, the Pharmacy Continuing Professional Development Registration Standard (PBA, undated), which came into effect in July 2010. The CPD standard specifies an incremental approach to introduction, requiring registrants to undertake 20 CPD credits for the period ending 30 September 2011, 30 CPD credits for the period ending 30 September 2012, and 40 CPD credits for the period ending 30 September 2013. The PBA states that it will review the standard at least every three years (but at the time of writing there is no evidence on its website of publications indicating that additional or new requirements have been agreed for the period beyond September 2013).

The standard defines CPD as “…the means by which members of the profession continue to maintain, improve and broaden their knowledge, expertise and competence, and develop the personal and professional qualities required throughout their professional lives” (PBA, undated).

A range of educational activities are cited as suitable on condition that they have significant intellectual or practical content, deal primarily with matters related directly to pharmacy and – with the exception of self-directed learning – are conducted by appropriately qualified people. In supplementary guidance (PBA, 2010a) three types of weighted CPD activity are delineated as follows:

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57 These include practising while intoxicated with alcohol or drugs, engaging in sexual misconduct in connection with professional practice, placing the public at harm because the practitioner has an impairment, or because of a significant departure from accepted professional standards.

58 Other registration standards concern criminal history, indemnity insurance, recency of practice, supervised practice arrangements, examination for general registration, and English language skills.

59 The standard was approved by the Australian Health Workforce Ministerial Council in March 2010 pursuant to the Health Practitioner Regulation National Law (2009) (the National Law) with approval taking effect from 1 July 2010.

60 The CPD period is 1st October to 30th September each year. Annual renewal of registration occurs by 30th November each year.
Group 1: information accessed without assessment (e.g., didactic presentations and activities with little or no attendee interaction), which is rated as one PBA CPD credit point per hour of activity.

Group 2: knowledge and skills improved with assessment (e.g., activities that provide for the measurement of a participant’s achievement of the learning objectives and individual feedback on performance in assessments), which is rated as two PBA CPD credits points per hour of activity.

Group 3: quality or practice improvement facilitated (e.g., activities where an assessment of existing practice (as an individual or within a pharmacy practice) and the needs and barriers to change is undertaken prior to development of a particular activity that addresses identified learning needs and includes post-activity reflection to evaluate the resulting outcomes, which may extend over a number of weeks or months), which is rated as three PBA CPD credits per hour of activity.

Group 1 activities may constitute no more than 50% of CPD credits (no limits are currently applied to group 2 and 3 activities). The PBA requires activities to be:

- relevant to the scope of the pharmacist’s role (for example, it is not necessary for pharmacists with non-patient facing roles to undertake CPD related to direct patient care)
- planned with reference to national competency standards (which are maintained by the Pharmacy Society of Australia61 (PSA, 2010), and the Board’s Code of Conduct for Pharmacists, in particular a registered pharmacist’s obligation to maintain professional competence (PBA, 2010b).

**Accreditation of CPD**

CPD can be accredited or non-accredited. The PBA states that it decided not to determine what proportion of CPD activities should be accredited because “pharmacists may not have access to accredited CPD activities across the various activity groups or that cover the entire scope of the practice of pharmacy” (PBA, 2010, p1), but it does not rule out doing so following a review of the guidelines. However, accreditation is described as providing “an assurance to pharmacists that an activity has been reviewed for its educational quality and for its relevance to a pharmacist’s practice” (PBA, 2010 a p1).

The PBA has authorised the Australian Pharmacy Council (APC) to accredit CPD providers. It accredits organisations it assesses as having met its criteria to accredit CPD on its behalf (as set out in its Accreditation Standards for Continuing Professional Development Activities (APC Ltd, 2013)). An organisation can apply to become CPD accredited for a period of up to three years, during which time the APC will conduct at least two audits of the organisation. Currently, there are four organisations listed as being accredited to accredit CPD:

- Australian College of Pharmacy
- Pharmacy Guild of Australia

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61 PSA is a national organisation representing Australia’s 25,000 pharmacists working in all sectors. Its core business is practice improvement by providing continuing professional development and practice support. It provides an extensive programme of education and professional development activities across Australia, including a National Intern Training Program.
Recording CPD
The PBA’s supplementary guidance emphasises that adequate records must be maintained for all CPD activities, either by participants or by CPD providers on their behalf (PBA, 2010). Pharmacists must maintain a portfolio of evidence that includes at least the information required by the PBA (i.e., date of activity; source or provider details; type of activity; topics covered during activity; accreditation status; and PBA credits). The PBA may however seek additional information – for example to provide evidence of attendance or, in the case of self-directed learning, details of the learning plan (development of which can attract up to 2 CPD credits).

CPD records and supporting information must be kept by registrants for three years but pharmacists are not required to submit records unless they are called to do so as part of the audit process.

Assessing and auditing CPD
Pharmacists are permitted to self-assess their CPD needs, determine a learning plan (which is not mandatory) and self-assess outcomes (unless – as for Group 2 activities – there is a formal assessment of learning outcomes).

When applying for renewal of registration applicants are required to complete a declaration of compliance with the standard. Penalties for non-compliance may include a condition being placed on a pharmacist’s registration, or renewal of registration being denied.

The CPD standard specifies that the PBA will audit compliance annually using methods it determines. The AHPRA and the National Boards are currently developing a nationally consistent approach to auditing compliance with mandatory registration standards. A pilot study has been conducted to determine the frequency, size and type of audits required to help develop the ongoing audit methodology.

Pilot audits have been used to check the declarations made by a statistically valid and reliable random sample of practitioners and to request supporting documentation. In 2012 the first phase of the pilot audit was conducted with the pharmacy profession (AHPRA, 2012), and a subsequent pilot was undertaken with the pharmacy, optometry and chiropractic professions (AHPRA, 2013). Phase one showed that 90% of practitioners complied with the Board’s registration standards (rising to 92.2% in the second phase reported in 2013). In phase one 5% of practitioners had not met one or more of the registration standards and were referred to the Board; 1% did not renew registration and 2% changed their registration status to non-practising.

The AHPRA states that the pilots have provided valuable information about the process. It is now working with the National Boards to establish a permanent audit team to introduce the auditing as a ‘business as usual’ function, is investing in software systems to support the audit function and ensure integration with registration, notification and compliance software, and is refining information, documentation and systems to ensure requirements are clearly articulated, fair and transparent for practitioners.
There is no evidence of published information about any risk assessments, cost-benefit analyses or business cases that may have been prepared to inform the policy decisions that underpin the approach described above.

Table 3.1: Summary of measures to assure continuing fitness to practice in Australia

| Approach | The concept of assuring continuing fitness to practise is not referred to explicitly but can be inferred as the goal of annual re-registration, mandatory CPD, and policies and procedures to deal with complaints. All pharmacists are required to declare at the point they apply for annual renewal of registration that they have met the CPD standard in the preceding year. This is currently 40 CPD points derived from three groups of CPD activity with differential values (eg group 1 includes didactic presentations and attracts 1 CPD point per hour, whereas group 3, which focuses on practice improvement, attracts 3 points per hour). Pharmacists are required to maintain adequate records and, if requested to do so, to submit a portfolio of evidence to substantiate their self-declaration of compliance with the CPD standard. Pilot activity has taken place to refine an audit methodology. A statistically valid sample of pharmacists will be selected for audit when the system is rolled out. |
| Standards | Standards are set by the registering body, the Pharmacy Board of Australia (PBA), one of 14 national boards functioning under the auspices of the Australian Health Practitioner Regulation Agency, which promotes national consistency as regards standards, policies and procedures across the fourteen health professions regulated. |
| Accreditation | Currently not mandatory – pharmacists are responsible for determining their own needs which may be satisfied through both accredited and non-accredited learning activities. In respect of accredited CPD, the accreditation function is delegated by the PBA to the Australian Pharmacy Council, which in turn accredits other organisations that meet its standards to provide CPD activities. |
| Assessment | Pharmacists undertake self-assessment of need and determine learning appropriate to their role. Group 2 activities include formal assessment of achievement of learning objectives. |
| Incentives & penalties | The scheme is mandatory and reflects the professional obligation to maintain professional competence expressed in the Code of Conduct. Failure to meet the standard can result in conditional registration or a decision to refuse renewal. |
| Funding | Standard setting and auditing are funded by the AHPRA from registration fee income. Pharmacists are responsible for their own CPD but some employers, sponsors and professional organisations may provide support and / or CPD as a member benefit. |
CANADA
This section explores the arrangements to assure the continuing fitness to practise of pharmacists in two Canadian jurisdictions, Ontario and British Columbia, provinces identified as being of particular interest in the PSI report (PSI, 2010). Arrangements in other provinces and territories have not been examined in detail but some are cited to provide confirmatory or alternative perspectives.

**Regulatory structure**
In Canada pharmacists are regulated by statutory bodies in each province or territory, each with a mandate to protect the public through the regulation of pharmacists, pharmacy practice and the operation of pharmacies. All the provincial and territorial regulatory authorities are voluntary members of an umbrella organisation, the National Association of Pharmacy Regulatory Authorities (NAPRA), a not-for-profit body that aims to provide national leadership in pharmacy regulation to enhance patient care and public protection. Among other things it develops national model standards, guidelines and frameworks to harmonise regulatory practices across Canada (see for example NAPRA, 2007; 2009), develops and maintains reciprocity frameworks to enable pharmacists to move freely between provinces and territories, and acts as a national voice for Canadian pharmacy regulators.

Two other pan-Canadian organisations are of significance. The Pharmacy Examining Board of Canada (PEBC) is a not-for-profit organisation that assesses qualifications for pharmacists on behalf of participating provincial regulatory authorities. It evaluates qualifications and competence, develops and administers examinations – including a national Qualifying Examination – and issues Certificates of Qualification to enable candidates to seek a license from provincial regulatory authorities.  

The Canadian Council on Continuing Education in Pharmacy (CCCEP) is a national organisation that accredits continuing pharmacy education programmes to be delivered in more than one province or nationally. CCCEP accreditation is recognised by all the provincial and territorial regulatory authorities. It accredits both education programmes and education providers to accredit their own programmes against published standards and criteria.

**British Columbia**
The regulatory body in British Columbia is the College of Pharmacists (CPBC). It is responsible for registering pharmacists and pharmacy technicians and for licensing pharmacies. Its mandate is to “protect the public by ensuring pharmacists provide safe and effective care to help people achieve better health”. It currently has a register of 5207 full pharmacists (CPBC, 2013a).

In addition to ensuring that new entrants to practice meet its registration requirements, it aims to ensure the continuing competence of its registrants through its professional development and continuing education requirements tied to annual renewal of registration. It also provides retrospective assurance through its professional disciplinary procedures.

**Approach to assuring continuing fitness to practise**
The CPBC does not refer explicitly to ‘assuring continuing fitness to practise’, nor to the concept of revalidation, but it does describe development and administration of its mandatory continuing

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62 A requirement in all provinces with the exception of Quebec.
education programme as one of the ways in which it responds to its mandate to ensure its registrants provide safe and effective pharmacy care (CPBC, 2012b, p17). The scheme is backed by statutory regulations which refer to these continuing professional development requirements as a ‘Quality Assurance Program’ (Health Professions Act Bylaws 2012, Part V).

The current scheme – the Professional Development and Assessment Program (PDAP) – was approved in 2010 following an extensive review of its predecessor during the period 2004-08. The new scheme became fully operational during 2011/12. It comprises both a mandatory continuing education component and a mandatory assessment component.

The continuing education component of PDAP requires pharmacists to complete a minimum of 15 hours of learning and to document it in a minimum of 6 learning records in its ‘CE-Plus’ tool, an online tool designed to assist registrants to identify their learning needs, to tailor their professional development to their practice, and to record learning using an online template (CPBC, 2013b). Ultimately, it is the learning records that have to be submitted to the College as part of the annual registration renewal process. The CPBC provides guidance about accessing and using the online ‘CE-Plus’ tool (CPBC, undated [a]) and a learning record rating scale to help pharmacists assess the effectiveness of their learning activities (CPBC, 2013c).

The PDAP continuing education component provides scope for pharmacists to self-assess their learning needs and to determine the most appropriate form of professional development. The CPBC states that it:

“...appreciates that registrants practice in various settings and that people learn in different ways which is why CE-Plus has been designed to recognise all types of learning. Whether a registrant chooses to participate in a traditional course or seminar that has been accredited, or engages in learning through a focused dialogue with a colleague, it is all valid as long as it is appropriately documented on the required Learning Record.”

The assessment component of the PDAP is undertaken by registrants once every 10 years, with 10% of registrants being randomly selected each year (during 2012, its first year of operation, registrants were selected on a voluntary basis to test delivery of the knowledge assessment examination). If selected, the examination must be undertaken during the current (12 month) PDAP cycle in addition to the continuing education component.

The knowledge assessment is a criterion-referenced, open book, computer based, three hour examination comprising 70 multiple choice questions. It is completed under invigilation at an examination centre. Its stated purpose is to enable pharmacists to demonstrate that they have continued to keep their knowledge, skills and abilities current in accordance with the standards of practice, and to show that they can apply the knowledge and skills needed to solve drug therapy problems (CPBC, 2012b).

A guidance booklet provides information about the assessment specification blueprint in addition to the practical arrangements associated with sitting a formal invigilated examination (CPBC, 2012b).

To help pharmacists to familiarise themselves with the knowledge assessment format, the CPBC provides a system tutorial quiz and a sample examination.

**Accreditation of CPD**

The PDAP is permissive of both accredited and non-accredited learning. However in guidance the CPBC observes that learning activities accredited by bodies such as the CCCEP “have been reviewed using stringent criteria to ensure they are of high quality, unbiased, and clearly identify learning objectives for participants,” and that they “indicate the number of accredited hours assigned to the activity by the accrediting body” (CPBC, undated [a]). The CPBC also refers in particular to the University of British Columbia which “receives a substantial annual financial grant ... to support ongoing learning opportunities for pharmacists” (CPBC, 2013a p25). The product of this investment is detailed in the CPBC’s annual report which provides details of the types of programmes provided, the contact hours delivered, and the number of pharmacists that participated in the CPD programmes and events (CPBC, 2013a, p27).

**Recording of CPD**

The requirement to maintain learning records in the CE-Plus online database – and their submission as part of the annual renewal of registration process – is described above. In guidance the CPBC suggest that learning activity records should be supported by evidence: for formal accredited learning this may be a certificate, a letter of completion, or record of CE credits granted; and for informal non-accredited learning a photocopy of the cover of reading material reviewed, the flyer advertising an event attended, or an email verifying a meeting or conversation should be used.

**Assessing and auditing CPD**

The continuing education component of the PDAP scheme is built around pharmacist self-assessment of both professional development needs and the effectiveness of subsequent learning activity. In contrast, decadal assessment of knowledge is by computer-based multiple choice examination.

In terms of audit, learning records are submitted annually as part of the registration renewal process. There is no accessible published information indicating whether, and if so how, learning records are sampled, but a random audit of 10% of submissions is planned.

In respect of penalties for failing to meet PDAP requirements, the CPBC states that registration cannot be renewed if a pharmacist fails to complete all requirements by the renewal date (CPBC, undated [b]). In the case of the knowledge assessment, byelaws set out a process to be followed by the Quality Assurance Committee: failure at the first attempt is to be followed by a further attempt, and failure at a second attempt is to be followed by an “individualised remediation plan and assessment of professional performance” (Health Professions Act Bylaws 2012, Part V). The CPBC PDAP web page provides an orphan link to what is described as a Practice Audit, but in the absence of published policies or other links it is not clear when this is to be applied. It is described as follows:

“... an on-site process during which you are observed at your place of work by a trained peer auditor who records your actual performance. The process usually takes several hours over one day. Practising pharmacists trained as auditors conduct the audit using the Framework

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65 Personal communication from the CPBC Director of Practice Reviews and Competency, October 2013.
of Professional Practice (FPP) as a guide. By carefully observing interactions between you and your clients, auditors can determine both the nature of the outcomes and how well you meet your client’s needs.66

There is no publicly accessible information available about any cost-benefit or risk analyses that may have been undertaken as a prelude to the current arrangement, but some background information is available in the Handbook concerning the previous PDAP cycle (CPBC, 2006b).

Table 3.2 Summary of measures to assure continuing fitness to practice in British Columbia

| **Approach** | The CPBC does not refer explicitly to assuring continuing fitness to practise, nor to revalidation, but it cites its mandatory continuing education programme as one way in which it responds to its mandate to ensure pharmacists provide safe and effective care.
| | The CPBC’s Professional Development and Assessment Program (PDAP) became operational in 2011/12 and is mandatory for all pharmacists.
| | It has two elements: a requirement to undertake 15 hours of continuing education annually, and to record this on an online database for scrutiny as part of the annual renewal of registration process; and a decadal knowledge assessment in the form of a computer-based, invigilated multiple choice examination. The continuing education element is supported by an online tool, CE-Plus, to help pharmacists with the CPD cycle of plan, act and reflect. CE-Plus must be used by all pharmacists to record their learning.
| **Standards** | There is limited reference to standards in information about the PDAP scheme but the Framework of Professional Practice serves to provide a blueprint for good pharmacy practice.
| **Accreditation** | The PDAP scheme is permissive of both accredited and non-accredited learning. Pharmacists determine how best to satisfy their professional development needs and what proportion of formal and informal learning is appropriate.
| **Assessment** | The continuing education element of the PDAP scheme is based on self-assessment of needs and self-assessment of the effectiveness of learning activities. The knowledge assessment is an invigilated multiple choice examination.
| **Incentives & penalties** | The scheme is mandatory. Registration cannot be renewed if a pharmacist fails to meet the PDAP requirements. An additional attempt at the decadal knowledge assessment is permitted before an ‘individualised remediation plan and assessment of professional performance’ is instituted.
| **Funding** | Pharmacists are responsible for funding their own CPD but some accredited providers – such as the University of British Columbia – are substantially subsidised to provide continuing professional education, and employers and other sponsors may also provide support.

Ontario

The Ontario College of Pharmacists (OCP) regulates pharmacists and pharmacy practice in the province of Ontario. It derives its statutory authority from the Pharmacy Act, one of a number of profession-specific Acts established under the Regulated Health Professions Act 1991. It is charged with serving and protecting the public interest and has a register of over 13,400 pharmacists (just over 800 of whom are on the ‘no patient care’ part of the register (OCP, 2012). Its regulatory responsibilities include, among other things, duties to:

- “develop, establish and maintain standards of qualification for persons to be issued certificates of registration
- develop, establish and maintain programs and standards of practice to assure the quality of the practice of profession
- develop, establish and maintain standards of knowledge and skill and programs to promote continuing evaluation, competence and improvement among the members.”

In this context the OCP asserts that to provide optimal patient care throughout their careers, pharmacists must maintain their competency through ongoing professional development. To this end it requires registrants (who it refers to as members) to undertake continuing professional development (CPD). It provides a number of tools to help them do so.

Assuring continuing fitness to practise

The OCP does not use the term ‘assuring continuing fitness to practice’, nor does it refer to the concept of revalidation, but its continuing professional development provisions are corralled under the heading of ‘continuing competence’ on its website. However the main elements of the scheme are constituted as its Quality Assurance Program (OCP, undated), a requirement specified in some detail in statute.

The Regulated Health Professions Act 1991 requires establishment of a Quality Assurance Committee, and regulations prescribing a quality assurance programme comprising continuing education or professional development designed to promote continuing competence and continuing quality improvement among the members. This is elaborated in Part VIII of Regulations made under the Pharmacy Act, which state that the Committee will administer a quality assurance programme which will include: maintenance of a portfolio of continuous learning; maintenance of a two-part register for pharmacist members; and practice review and remediation, elsewhere specified as a requirement that “each year the College shall select at random the names of pharmacists required to undergo a practice review”. The OCP’s approach is therefore enshrined in regulations which serve to underpin a mandatory approach to continuing professional development and continuing competence.

The Quality Assurance Program has several elements. Some of its requirements distinguish between two parts of the register, either of which pharmacists can elect to enter at the time of their annual
renewal of registration. Pharmacists on Part A, those engaged in ‘patient care’, are subject to all elements of the quality assurance programme, whereas those on Part B, ‘no patient care’ are subject only to the requirement to maintain a learning portfolio (the other two elements of the scheme involve practice review: phase 1 – self-assessment and phase 2 – peer review). The nature and requirements for inclusion in either parts A or B of the register, and the consequent restrictions on practice associated with Part B, are detailed in current guidance; as are the circumstances in which the Quality Assurance Committee is empowered to move a pharmacist from Part A to Part B (OCP, undated).

The learning portfolio is described as a “tool that assists members in planning and documenting their learning activities” (OCP, undated, p7). The OCP has made the tool available online as part of a suite of facilities accessible only to members (registrants) to support CPD. It comprises an education action plan; a continuing education log; a frequently asked question log; and a professional profile. All registered pharmacists “are expected to engage in continuing professional development and to maintain a record of their learning” using the online learning portfolio (OCP, undated, p7). However they may use any method to file and record learning activities provided it is kept up-to-date and retained with supporting documentation for a minimum of five years.

The second element of the Quality Assurance Program is Phase 1 of the Practice Review – a self-assessment. The OCP provides a tool to help registrants identify their learning needs in order to maintain their competence, to advance professionally, and to create a learning plan. It too is available online only to members via the CPD portal. Only those pharmacists on Part A of the register are required to complete the Phase 1 Practice Review, which they are encouraged to complete annually. However they are required to complete it if selected for audit. The OCP randomly selects 20% of pharmacists from Part A of the register each year to complete the Self-Assessment (which means that every pharmacist will be selected once in every five years). Those selected are afforded 8 weeks to complete the assessment. It is not clear how, and if so how many of these assessments are audited or reviewed, or by whom.

The third element of the Quality Assurance Program is the Phase 2 Practice Review – the peer review. This was first piloted in 2010. Currently around 2% or registrants are selected each year to undertake the assessment. Pharmacists who undertake the assessment are excluded from the selection process for the next 10 years, and the number of candidates randomly selected for a second time in the subsequent 5 years is limited to no more than 5% of the total number selected for Peer Review (OCP, undated, p15).

Pharmacists have to travel to the provincial capital, Toronto, to undertake the assessment, which is held four times a year and lasts for approximately 6 hours. Expenses incurred by those selected are reimbursed by the OCP.

The assessment is based on current standards of practice (NAPRA, 2007; 2009) and comprises:

- an orientation session
- a learning portfolio sharing session
- a computer-based clinical knowledge assessment (area 1) consisting of 18 cases, each followed by three multiple choice questions for each study
standardised patient interviews during which interactions with trained standardised patients in 5 case scenarios are assessed by peer assessors, focusing on information gathering skills (area 2), patient management and follow-up (area 3), and communication skills (area 4)

- a general feedback session at the end of the process (OCP, undated, p9).

Results are considered by the Quality Assurance Committee by candidate number only. Outcomes are notified to candidates who have met or exceed the standards in all four areas, and those who may have fallen below the standard in one or more of the four areas assessed but where it is judged no further action is required, 6-8 weeks after the peer review. Candidates who the Committee determine require remediation or reassessment are notified separately. They are offered an opportunity to meet with a peer support group comprising “two education minded pharmacists and a staff resource” (OCP, undated, p20). The purpose is to help the candidate develop an education action plan, set target dates for reassessment and discuss remedial activities.

The OCP reports that over the last five years, 90 per cent of pharmacists have been successful, requiring only self-directed professional development after their first assessment (OCP, 2012, p42). Of the 253 candidates randomly selected for peer-review during 2012, 20 (8%) were required to enter peer-guided learning. The data does not report how serious the deficiencies were or what magnitude of remedial action and peer support was required by the 8% (of the 2% assessed) judged to have fallen below the required standards (OCP, 2012, p43).

There is no obvious publicly accessible information about the costs of this scheme, nor of any cost-benefit analysis that might have been undertaken prior to its adoption.

Accreditation
Published information available on the OCP website does not specify whether pharmacists are permitted to undertake only accredited continuing education. However the OCP states that it applies the Canadian Council on Continuing Education in Pharmacy (CCCEP) guidelines to evaluate continuing education programs within Ontario, and that programmes advertised or provided to pharmacists outside of Ontario must be approved by CCCEP.

Recording
All pharmacists are required to maintain a record of their learning and may use the online learning portfolio for this purpose. However, use of other methods is also permitted provided the record of learning activities is kept up-to-date and retained for a minimum of five years.

Assessing and audit
The Quality Assurance Program relies on self-assessment except for the minority of pharmacists selected each year for a formal knowledge assessment and peer review. While the OCP is clear about the proportion of its registrant population whose portfolios and phase 1 self-assessments are audited annually, there is no publicly accessible information about how the 20% of self-assessments undertaken each year are reviewed, or what action is taken if any are judged inadequate. In contrast the outcomes of the phase 2 review of the 2% of registrants selected each year for the peer review process are stated explicitly, with the Quality Assurance Committee reviewing results, instituting reassessment and remedial action, and having the power ultimately to change a member’s registration status.
There is no evidence of published information about any risk assessments, cost-benefit analyses or business cases that may have been prepared to inform the policy decisions that underpin the approach described above.

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Other provinces and territories

The Alberta College of Pharmacists (ACP) has 4431 practising pharmacists on its register (ACP, 2013). It has a policy of mandatory CPD linked to annual renewal of registration. The scheme has two elements: a continuing education component and a competence assessment.

The ACP requires each registrant to maintain and enhance their professional knowledge and skills through continuing education activities. They must achieve a minimum of 15 continuing education units (CEUs) per registration year from accredited or non-accredited learning activities, which must be relevant to the registrant’s practice (there is no minimum requirement for accredited CEUs).

Practice-related learning must be documented in a learning portfolio and be summarised in the ACP’s CPD Log for submission at the time of each annual registration renewal. The ACP has moved away from accrediting provincial continuing education programmes itself, arguing that it was duplicating a national accreditation process (undertaken by CCCEP) and because accreditation was unnecessary because pharmacists have been able to claim non-accredited learning since 2001.

Statute requires that all health professions in Alberta establish a ‘continuing competence programme’. Each year the ACP randomly selects a percentage of clinical pharmacists to undergo competence assessment (252 pharmacists were selected in 2012) until eventually “all clinical pharmacists will have been assessed and the cycle will repeat” (ACP, 2011). To meet this demand the ACP established the RxCEL Competence Program to ensure fair mechanisms to assess pharmacists’ competence and performance. The scheme aims to assist pharmacists to assess their own levels of competence and the quality of their practice, and through this to identify their strengths and focus on areas where they may wish to enhance their skills or knowledge. In recognition that individuals have different learning styles and pharmacists work in a variety of practice settings, pharmacists are permitted to choose between one of two forms of assessment:

- a knowledge assessment – an open-book, computer-based, three hour assessment, of up to 75 multiple choice questions, or a

- professional portfolio assessment – which is “a different ‘philosophy’ than Knowledge Assessment for competence assessment [and] ... does not ask you to demonstrate your competence as such, but rather to demonstrate how you maintain and enhance your competence in your own practice” (ACP, 2011).

Full details of the programme are set out in its Competence Assessment Handbook (ACP, 2011).

The ACP audits compliance with its requirements and notes that “the majority of audits are random; however, reviews of registrants who have been non-compliant in the past may be directed” (ACP, 2013, p19). In 2012 it conducted 459 learning portfolio audits resulting in 4 referrals to the Competence Committee, 1 referral to the Complaints Director, and 10 letters of non-compliance (ACP, 2013, p22). The ACP can therefore report 99% successful compliance with learning portfolio requirements. It also reports a 92% success rate on first attempt at the competence assessment.

In Manitoba all pharmacists are expected to maintain their competency through continuous development of knowledge, skills and attitudes. The Manitoba Pharmaceutical Association requires
all licensed pharmacists to submit a copy of their professional development log each year at the time of license renewal, along with a signed declaration. 20% of pharmacists are then selected on an annual, random basis to submit supporting documents for review.

The focus in New Brunswick is on continuing education. Every Licensed Pharmacist “shall in each CE year be required to obtain a minimum of fifteen (15) Units, from two (2) or more sources, to qualify for licensing in the following licensing year” (NBPS, 2006). Each year 10% of registrants are randomly selected for audit. Records are evaluated to establish completeness, the number of hours documented, the kinds and source of the recorded activities and any committee member comments or notations. Pharmacists submitting records deemed non-compliant are notified of the discrepancies and invited to respond. If the response is not acceptable, the registrant is referred to the Complaints Committee for possible disciplinary action.

FINLAND

The report below sets out the position today as far as can be determined from web searching and email correspondence. As with other sections of the PSI report (PSI, 2010) the absence of information about the methods used and the sources consulted to inform the sub-section on Finland precludes methodological replication. It appears that the information presented there may have been drawn largely, and sometimes directly, from a secondary source; that is from the only reference cited in that section (footnote 34, p60, PSI, 2012).

Regulatory structure

The PSI report refers to the National Agency for Medicines to highlight its role in giving consideration to the CPD undertaken by applicants for licenses to operate a community pharmacy (PSI, 2010, 59). Today licensing of pharmacies is undertaken by the Permits and Inspections Unit of the Finnish Medicines Agency (Fimea), a central administrative agency of the Ministry of Social Affairs and Health. Fimea is the competent authority for the regulation of medicines and pharmaceutical products (not pharmacists).

The Medicines Act 295/1987 sets out the broad parameters for the award of licenses but is no more specific about CPD than a reference to consideration of the ‘studies’ undertaken by the applicant where more than one is competing for the same license. However since the application process requires submission of a curriculum vitae it seems reasonable to assume that continuing professional development in the form of postgraduate and continuing ‘studies’ will be taken into account in assessing suitability.

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71 Section 43 (1112/2010) (3) of the Medicines Act 295/1987 states that: “If there is more than one applicant, a pharmacy license is granted to the applicant who can be considered to have the overall best potential for operating a pharmacy business. In assessing the potential, the applicant’s work in pharmacies and other pharmaceutical services, including the date on which any previous pharmacy license entered into force, as well as studies, managerial skills and other activities pertinent to operating a pharmacy business must be taken into account” (English translation accessed via the Fimea web site at: http://www.fimea.fi/frontpage).
The competent authority for the registration and regulation of pharmacists in Finland is Valvira – the National Supervisory Authority for Welfare and Health. Its statutory purpose is to supervise and provide guidance to healthcare and social services providers and to manage related licensing activities. In this regard it has responsibility for ‘professional practice rights’ in respect of 17 regulated health professions.

Upon application Valvira assess and determines applications for licensure (including direct notifications from Finnish universities about pharmacy graduates) and, subject to applicants meeting its requirements, issues a license to practice and enters the applicant on the publicly accessible Central Register of Health Care Professionals (the Terhikki). Under Finnish law the practice of pharmacy is restricted to licensed pharmacists (and practising without a license will result in a fine or imprisonment).

**Approach to assuring continuing fitness to practise**

As a consequence of the limited information available publicly, the sub-sections used to describe the position in other countries reviewed in this report have been condensed into a general account describing the position in Finland.

There is no obvious evidence of a system to assure the continuing fitness to practise of pharmacists or of any reference to the concept of revalidation. Registration is indefinite – there is no system of periodic re-registration for pharmacists. However pharmacists in Finland are expected to undertake CPD.

The PSI report observed in 2010 that “CPD for pharmacists is not mandatory” (PSI, 2010, p59), and there is certainly no evidence on its website that Valvira sets standards or requirements for continuing professional development for pharmacists. Indeed in a profile of pharmacy in Finland prepared with the World Health Organisation, the Ministry of Social Affairs and Health states that “mandatory continuing education that includes rational use of medicines is not required for pharmacists” (MSAH, 2011, p29) and “a professional association code of conduct which governs the professional behaviour of pharmacists does not exist” (MSAH, 2011 p29). Yet in an earlier publication, citing an article by Ovakainen et al (2004), the Ministry of Social Affairs and Health says that the “law requires all pharmacists to update their professional knowledge”, noting however that “there is no formalised system to count credits for continuing education or attendance at events” (Mossialos and Srivastava, 2008, p45). In fact the Health Care Professions Act 1994 makes it clear that health professionals must:

“...maintain and improve their professional knowledge and skills required to carry on their professional activity and familiarise themselves with the provisions and regulations concerning them. Employers of health care professionals shall create opportunities for participation of the latter in necessary further training for the profession”.

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72 Personal communication, Senior Officer, National Supervisory Authority for Welfare and Health, 10th October 2013.

In summary, while it is not obvious that a system is in place to monitor and enforce compliance, updating professional knowledge and skills is mandatory insofar as it is a legal requirement for pharmacists and other regulated health professionals.

The Ovakainen article, although rather dated, asserts among other things that “Finland has developed a well-organised pharmaceutical continuing education system”, that it consists of “long-term professional development training, other long-term training modules and short ad hoc courses”, and that keeping updated is considered “a shared responsibility of the employer and the individual” (Ovakainen et al 2004, p100). There seems to be no reason to doubt that this analysis applies equally to pharmacy in contemporary Finland. Among the principal continuing education providers today are the Pharmacy Learning Centre, the Pharmaceutical Information Centre, and the universities.

The Pharmacy Learning Centre (Farmasian Oppimiskeskus) based in Helsinki is a not-for-profit organisation that aims to provide high quality education and training to pharmacists and the pharmaceutical industry. It seeks to encourage lifelong learning and provides extensive calendar of training events in the form of study days, evening lectures, courses and online learning. It encourages and supports personal professional development planning and the use of portfolios to record learning and development.

The Pharmaceutical Information Centre Ltd is a drug information and skills development company. It provides online information services and training, with nearly 2,000 industry professionals taking part in its training events each year.

A search of the three universities providing pharmaceutical education revealed limited information about continuing education, with the exception of a significant volume of material about award-bearing postgraduate education in the form of Masters and Doctoral programmes. This is not to say that these universities do not provide other pharmacy continuing professional development, but rather that it is not well signposted. However the University of Eastern Finland’s ‘Aducate’ Centre for Training and Development claims to be the third largest university-level adult education unit in Finland. It employs a staff of 140 experts and provides adult and continuing education and training across a wide range of subjects, but no pharmacy-specific activities are listed currently. Similarly, a search of the website of the Palmenia Centre at the University of Helsinki – also a provider of continuing education cited in the PSI report – did not reveal any current programmes of particular relevance to pharmacists.

In addition to the provision described above the professional associations (including the Association of Finnish Pharmacies, the Finnish Association of Pharmacists and the Finnish Pharmacists Society) also provide varying levels of training and support for continuing professional education. For example the Finnish Association of Pharmacists is about to launch what it claims is the first mentoring programme designed for pharmacists, aimed at developing participants’ leadership and networking skills and of helping them advance their careers (the Promentor-mentoring program, FAP, 2013).

74 The University of Helsinki, the University of Eastern Finland and Åbo Akademi University.
75 See http://www.proviisoriyhdistys.net/node/450
### Table 3.4: Summary of measures to assure continuing fitness to practice in Finland

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<th>Approach</th>
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<tr>
<td><strong>Licensure</strong></td>
<td>(registration) is undertaken by the National Supervisory Authority for Welfare and Health (Valvira – the competent authority and regulator). There is no obvious reference to the concepts of revalidation or assuring continuing fitness to practise, but CPD is mandatory insofar as it is a legal obligation that applies to all registered health professionals that fall within the Health Care Professions Act 1994. However there is no evidence of a system to monitor compliance. Pharmacists are therefore expected to determine their own CPD needs and to access appropriate education, training and development to satisfy them.</td>
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| Standards | There is no obvious evidence of national standards or requirements for CPD. |
| Accreditation | There is no evidence of a national accreditation policy. In addition to the three universities in Finland that offer pharmacy education there are a number of organisations that provide continuing professional development, education and training to pharmacy professionals. Each appears to accredit its own provision. |
| Assessment | Assessment of learning may be a feature of some CPD provision offered by the main providers, but the onus is on pharmacists to assess their own learning. |
| Incentives & penalties | Pharmacists must by law ‘maintain and improve their professional knowledge and skills required to carry on their professional activity’ but it is not clear what sanction(s) may be imposed if they do not. |
| Funding | Pharmacists are responsible for funding their own CPD but it appears that employer and industry bodies provide subsidies and financial support. |

### IRELAND

In the Republic of Ireland pharmacists and pharmacy services are regulated by The Pharmaceutical Society of Ireland (PSI). The PSI is an independent statutory body established by the Pharmacy Act 2007. It works to protect the health and safety of the public by regulating the pharmacy profession and pharmacies. Currently it has approximately 5,000 pharmacists and 1,800 pharmacies on its registers.

**Assuring continuing fitness to practice**

Among its responsibilities the PSI is required to set standards of professional competence and ethical conduct (see PSI, 2013 and PSI, undated), to review and promote the competence and conduct of pharmacists, and to recognise, accredit, and set programmes of education and training to ensure the ongoing competence of pharmacists. These and other obligations underpin the PSI’s approach to assuring continuing fitness to practise, which is based on a scheme of continuing professional development.

The Pharmacy Act 2007 – which came fully into force in August 2009 – introduced mandatory CPD. The PSI requires all pharmacists who wish to practise in Ireland to renew their registration annually. In doing so they are required to declare that they will:
“...maintain appropriate experience in the practice of pharmacy, keep abreast of continuing education and professional developments in the profession of pharmacy and undertake appropriate continuing professional development relevant to the practice of pharmacy”.

The manner in which this is to be achieved has been under review. In 2009 the PSI commissioned a review of international CPD models to inform its development of CPD policy (PSI, 2010). The review recommended a system of mandatory CPD with the following features:

- “It maintains the focus of improving patient safety at its core by assuring competency across the profession, as well as providing opportunities for both personal development and for the development of the profession.
- The recognition of CPD activities envisaged in the model will offer a flexibility that should meet the needs of all pharmacists, irrespective of their practice setting or stage in their career, as well as meeting the needs of the wider health services and supporting engagement with other healthcare professionals.
- It is a reflective model that allows for all learning activities to be acknowledged and that provides a system for standards, accreditation and assessment.
- The establishment of an institute-type structure to oversee the management and delivery of CPD, with the PSI controlling the regulatory processes and defining the competency standards against which the CPD system would be framed.
- Funding support for the model should be based on a structure including funding from the PSI, the existing funding base of the HSE for pharmacy educational activities, third parties (such as the pharmaceutical industry) and from pharmacists and the profession itself”.

Following consideration of the report a new system of CPD is currently in development. In 2011 the PSI established the Irish Institute of Pharmacy to oversee the CPD system on its behalf. The Institute became operational in August 2013.

The PSI claims the new model of CPD will encourage pharmacists to reflect on their practice and to identify their own learning and development needs, based on an assessment of the skills and competencies they need for professional pharmacy practice in their current role. The system will eschew the accumulation of contact hours or points in favour of a more flexible approach enabling pharmacists to demonstrate their professional development in a style that best suits their requirements. It will be permissive of a wide range of activities in which pharmacists engage to progress their professional development, including both formal and informal learning. The aspiration is to devise a system to accommodate both the learning activities necessary for pharmacists to develop their careers and those addressing local and national health priorities.

The aim will be to ensure that pharmacists engage in a range of learning activities to meet their individual learning needs undertaken over a period of time, possibly as long as five years. The new approach is to include a portfolio to serve as a template. The portfolio is intended to help pharmacists to assess their learning needs, to plan, record, track and evaluate their learning in an outcomes-based form, and to serve as a record demonstrating they have met the CPD requirements for continued registration.

The PSI plans to commission the Institute to provide certain formal learning activities and these will require accreditation against the PSI’s accreditation standards (PSI, 2011). Not all learning activities will require accreditation in the PSI’s CPD model. In referring to three universities providing CPD it indicates that their education programmes may be of interest to pharmacists and might be considered suitable for CPD, but that these are provided only as examples of what is available. Consistent with the philosophy outlined above, pharmacists will be at liberty to determine the learning activities that best satisfy their needs whether formal or informal, accredited or non-accredited with the overall intention that a pharmacist’s learning and development should encompass a balanced range of activities across the learning spectrum over a period of five years. There is no indication yet about how the new CPD system is to be audited or what remedies and sanctions might apply.

In terms of assuring continuing fitness to practise, while the PSI does not refer to it in these terms, it does say that the purpose of the new scheme will be to ensure that pharmacists “retain their capacity to practise safely, effectively and legally within their evolving career and scope of practice”. Furthermore, the PSI has indicated that the Irish Institute of Pharmacy will implement a peer led and developed competency based quality assurance process, based on the scheme operating in Ontario, which it is anticipated will be piloted in 2016 and rolled out in 2017.

Aside from the report prepared by PA Consulting for the PSI (PSI, 2010) there is no evidence of published information about any risk assessments, cost-benefit analyses or business cases that the PSI may have undertaken to inform the policy decisions that underpin the approach described above.

**NETHERLANDS**

The analysis in this section is limited because there are few primary sources available in English. The overview provided below is derived from the following: the Dutch Ministry of Health, Welfare and Sport BIG register; the KNMP; a KNMP White Paper (Bouvy et al, 2011); Driesen et al (2007); and Schäfer et al (2010), some of which are secondary sources.

**Regulatory structure**

The Royal Dutch Association for the Advancement of Pharmacy (KNMP) is both a professional and a trade association for pharmacists in the Netherlands. It regulates pharmacists under the Individual Health Care Professions Act (BIG Act). Registration is separate from KNMP professional membership.

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78 Private communication with the PSI.

Healthcare professions are classified into two groups (defined in sections 3 and 34 of the Healthcare Professionals Act). Only Section 3 professions – which includes pharmacists – are listed in the BIG register and are subject to disciplinary rules, including sanctions, restrictions of practice and removal from the register.

**Assuring continuing fitness to practise**

Pharmacists are subject to periodic re-registration and must re-apply for renewal of registration every five years. This is linked to an hours-based system of professional education. To qualify to re-register community pharmacists must have worked at least 16 hours a week in a community pharmacy (averaged over the preceding five years) and have undertaken 200 hours of accredited training during the five year period.

Only training accredited by a ‘Committee of Experts’ (the Committee of Experts on Public Pharmacists) counts for re-registration. It is recommended that at least half this training must be ‘professional’, or about pharmacotherapy and pharmaceutical care. No more than half the number of hours may be in the form of accredited on-line learning.

A database of accredited education programmes is provided and can be accessed from the KNMP website. An online system (‘PE-Online’) is provided for course organisers and pharmacists to record training activity undertaken and continuing professional development.

**Accreditation**

Training that is to count towards the re-registration requirements is reviewed and accredited by a Committee of Experts. When considering applications for accreditation the committee:

- considers whether the topic is relevant to the community pharmacist
- considers whether the training courses or individual training is associated with some form of review
- considers whether the curriculum relates to contemporary issues in the field of community pharmacy
- considers whether the curriculum is at a level commensurate with the professional practice of a community pharmacist
- ensures the curriculum is not directly related to a single product
- ensures the organiser observes the applicable advertising code
- agrees the time spent in the activity, for example the full length of the training day included in effective full hours (completion of less than 30 minutes is not counted but more than 30 minutes is rounded up to a full hour)
- assesses each course separately – there is no programme accreditation or accreditation of institutions or education providers.

Similar provisions apply to hospital pharmacists (and more recently specialist pharmacists). Hospital pharmacists must have been continuously engaged in the practice of hospital pharmacy during the preceding five years for at least an average of 16 hours a week over the five year period, and fulfilled the requirements for participation in professional development of 40 hours of training a year, that is 200 hours for the five years period, of learning activities accredited by the Commission of Experts of the NVZA (the Dutch Association of Hospital Pharmacists).
There is no published information about whether, and if so how, the scheme is audited, but because the expert committees review individual courses and events for accreditation (the function is not delegated to institutions or providers), it might be inferred that all such training is both current and of an appropriate quality.

NEW ZEALAND

Since the arrangements for continuing professional development (CPD) were reported in the PSI publication in June 2010, two significant developments have occurred. The Pharmacy Council of New Zealand (PCNZ) refined, consulted upon, approved and published a modified Recertification Framework (PCNZ, 2012) and it approved two organisations to provide accredited CPD programmes for recertification. Subsequently one provider – the Pharmacy Guild of New Zealand83 – withdrew, leaving the original provider – the Pharmaceutical Society of New Zealand84 (PSNZ) – as the only organisation offering the CPD recertification programme. As a consequence the PCNZ has stated that from April 2013 all practising pharmacists must be enrolled with the PSNZ’s ‘ENHANCE 2.0’ online programme, which is to be made available to members and to non-members (the latter at a cost). The programme has been approved until March 2016 (subject to the PSNZ addressing key points raised by the PCNZ by March 2014).

Regulatory structure

The Pharmacy Council of New Zealand (PCNZ) was established under the Health Practitioners Competence Assurance Act 2003 (HPCCA). The PCNZ has a duty to protect the public and promote good pharmaceutical practice. It exercises its responsibilities through a range of regulatory functions including, among others:

- determining the scope of practice for pharmacists
- prescribing the qualifications required and accrediting and monitoring educational institutions and courses85
- recognising, accrediting, and setting programmes to ensure the ongoing competence of pharmacists.

At June 2013 the PCNZ had 4557 registrants, 978 of whom were non-practising and 223 of whom were restricted to an intern scope of practice (PCNZ, 2013a).

Approach to assuring continuing fitness to practise

The PCNZ does not refer explicitly to assuring continuing fitness to practise, nor does it make reference to the concept of revalidation, but it does exercise its responsibility to ensure that pharmacists are ‘fit for practise’ (HPCCA, 2003) through its recertification policy and a process described as ‘competence review’. Applicants seeking registration or renewal of registration must

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83 A professional membership association providing support and services to community pharmacy owners.
84 The Pharmaceutical Society of New Zealand is a professional association representing over 3,000 pharmacists from all sectors of practice. It provides professional support and representation, training for continuing professional development, and support to pharmacists to help them maintain high standards of pharmaceutical practice.
85 Accreditation of degree courses leading to qualification as a pharmacist is undertaken by the Australian Pharmacy Council in both Australia and New Zealand.
meet the PCNZ’s ‘fitness to register’ requirements by disclosing any information about their health, convictions or professional conduct that might affect their fitness to practise.

In respect of ongoing competence the PCNZ issues an Annual Practising Certificate (APC) to those who meet its requirements. The recertification mechanism is used to ensure that pharmacists maintain their competence through continuing professional development. When applying for an APC a pharmacist must complete a declaration confirming their participation in CPD. All pharmacists must be enrolled on an accredited CPD-based recertification programme (currently offered by just one provider) and achieve a specified number of CPD points.

Standards and requirements for both pharmacists and recertification programme providers are detailed in the publication *Recertification Framework and Guidelines* (PCNZ, 2012). The guidance sets out the philosophy and principles upon which the scheme is based and justifies the requirements by reference to professional obligations set out in the *Code of Ethics for pharmacists* (PCNZ, 2011).  

The CPD process is described as cyclical, comprising four stages: reflection, planning, action (learning activities) and outcomes. Pharmacists are required to review their practice against the Council’s competence standards for pharmacists (PCNZ, undated) – and any supplementary guidance that applies to their area of practice – at the beginning of each three year cycle.

The process is supported by a ‘learning peer’ (who is usually a pharmacist but could be another health professional where specialist expertise is appropriate) whose role is to affirm, encourage and where appropriate to advise and challenge. Importantly the PCNZ acknowledges that the ‘learning peer’ is not accountable for what the pharmacist does or does not do by way of professional development. A ‘learning peer’ may not be required where an ‘accredited learning facilitator’ is provided (see the Accreditation and the Assessment sections below).

The scheme is mandatory. Not only must all pharmacists satisfy outcome requirements (a specified number of CPD points each year), they must also be enrolled with an approved recertification programme. Thus, all practising pharmacists must be actively engaged in professional development on a continuous and ongoing basis as a condition of their registration.

The PCNZ operates a weighted points-based CPD scheme, with greater value attributed to activities resulting in assessed learning outcomes and demonstrable practice improvement. Pharmacists are required to complete a minimum of 20 points annually and 70 points in three years, which includes a minimum of 10 points from completing two ‘significant learning goals’ (PCNZ, 2012). Self-assessment against competence standards is required once every three years, although the PCNZ acknowledges that it is for the pharmacist to determine whether a full or abridged review is required.

Specified professional development options comprise:

- Group 1 activities – such as presentations with limited or no attendee interaction – which attract 1 point per hour of activity.

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86 The relevant clauses are ‘undertake continuing education and professional development relevant to your field of practice’ and in competency requirements the commitment to ‘continuing professional development and lifelong learning’.
• Group 2 activities – where knowledge attainment is demonstrated through successful completion of an assessment (for example associated with a continuing education event or reading of a journal article and subsequent assessment of learning) – which attract 2 points per hour of activity.

• Group 3 activities – which involve achievement of a ‘significant learning goal’ by demonstrating practice improvement through identification of a learning need, planning activities to meet the need, and recording evidence of outcomes that demonstrate the need has been met – which attracts 5 points per learning goal.

Group 1 activities may not exceed a maximum of 50% of points (that is 35 points over three years).

**Accreditation of CPD**

Part 2 of the publication *Recertification Framework and Guidelines* (PCNZ, 2012) sets out the role of the provider of recertification programmes, together with requirements and options for delivery. For group 1 and 2 activities the PCNZ states that it endorses the Australian Pharmacy Council’s accreditation standards (APC, 2013) as “the standards to which providers should aspire” (PCNZ, 2012, p13), and that where there is no approval process for group 2 activities, recertification programme providers have a role in ensuring that knowledge acquisition is demonstrated through assessment.

As drafted the Part 2 guidance implies the prospect of multiple providers but in practice the PCNZ is has delivered a monopoly provider. In 2012 three organisations expressed an interest, two were approved but one subsequently withdrew (later endorsing the remaining provider as having met the needs of its members (PCNZ, 2013), leaving a single recertification programme provider – the Pharmaceutical Society of New Zealand – as the original and only provider. As a result every pharmacist in New Zealand, whether a member of this professional association or not, is required to enrol in its ‘ENHANCE 2.0’ recertification programme – a web-based programme described by the PSNZ as follows:

*ENHANCE provides the official framework and professional development guidelines to ensure you acquire or update key skills to get your Annual Practising Certificate. The package includes a two hour training session on how to best use the ENHANCE framework, a comprehensive folder that enables you to plan and monitor your continuing education plus provision for personal feedback and advice from ENHANCE providers at the Society.*

*This website contains:*

• *Practice Review (online with information and support for most activities)*

• *Recommended and quality Learning Resources (both General and targeted for Competence Standard 1)*

• *InPHARMation Learning Resources (targeted for each month’s topic)*

• *Clinical Knowledge Self Assessments (with targeted recommended Learning Resources)*
• Any Practice Reviews and/or CPD records you may have completed in the ENHANCE 1.0 system (prior to 01 April 2013).87

Part 2 of the Recertification Framework and Guidelines states that a recertification programme provider (ie the PSNZ) may make an ‘accredited learning facilitator’ available to “monitor the participation of programme members”, an option providing “assurance to the Pharmacy Council of the quality of participation” (PCNZ, 2012, p14). Accredited learning facilitators are “pharmacists who have been trained to assist other pharmacists with their professional development” (PCNZ, 2012, p15). The PCNZ cites competence standards developed in the UK as an example of a suitable basis for facilitator training (LPET, 2010).

The PCNZ places the onus on the recertification programme provider to “identify and deal with non-participation” (PCNZ, 2012, p14) and to have procedures in place to refer to the Pharmacy Council any pharmacist who does not satisfy the requirements of the recertification programme.

Recording CPD
Pharmacists must record learning activities in a learning log. Detailed guidance is provided about minimum requirements and about the value of having a personal development plan and maintaining a learning portfolio to record all professional development activity. Guidance is also provided about what is to be included in the Annual Declaration of CPD activities (PCNZ, 2012). Template CPD record sheets are available as is guidance about the process of assigning credit to CPD learning goal outcomes.

Assessment and audit of CPD
Pharmacists are expected to self-assess learning needs, and to self-assess achievement of learning objectives where the activity has not been formally assessed. In practice the recertification programme provider and, where provided, the ‘accredited learning facilitator,’ support and advise pharmacists in this process.

The PCNZ has a policy of conducting recertification audits. Up to 20% of the practising register may be audited in any year. The PCNZ defines audit as “an official assessment of CPD records against set criteria” (PCNZ, 2006). The 2013 audit is a retrospective review of CPD records for the period April 2010 to March 2013 of a random sample of registrants. Timescales, information about the documentation required and the consequences of failure to satisfy the requirements have been set out in a leaflet for pharmacists (PCNZ, 2013b).

The Recertification Framework and Guidelines (PCNZ, 2012) indicate that, because of the anticipated quality assurance role of the ‘accredited learning facilitator, pharmacists with access to a facilitator “would be exempt from Pharmacy Council recertification audits” (PCNZ, 2012, p14).

The process is undertaken by independent auditors appointed by the PCNZ to conduct assessments against predetermined criteria. Auditors provide feedback to registrants, for example about how to optimise their professional development by documenting it more effectively.

The recertification audit policy (PCNZ, 2006) makes it clear that failure to satisfy the requirements is not in itself grounds for removal from the register. A failure to comply will result in conditions being placed on the pharmacist’s scope of practice, requiring them to work under the oversight of a professional peer, and barring them from certain activities such as acting as a preceptor. Following a right of appeal, the condition of oversight is applied to the Annual Practising Certificate (APC) for the forthcoming year and is noted on the public register. When the recertification requirements are met the condition of oversight is lifted. If they are not met the Council may decline to issue an APC for the following year.

**Competence review**

When a pharmacist’s competence is called into question (as opposed to their health or conduct) the PCNZ is empowered by the HPCCA to initiate a competence review.\(^{88}\) The process is described as educative and enabling, as distinct from a disciplinary process.\(^{89}\) A review is only initiated if the PCNZ believes a pharmacist may pose a risk of harm to the public as a consequence of practising below acceptable standards of competence. It involves a Competence Review Team (CRT) undertaking assessments – including on-site observation – to determine what "gaps" there may be in a pharmacist's practice. The CRT then recommends further education, assessment, counselling or mentoring as required.

There is no evidence of any publicly accessible information about any risk assessments, cost-benefit analyses or business cases that may have informed the policy decisions that underpin the approach described above.

| Table 3.5: Summary of measures to assure continuing fitness to practice in New Zealand |
| Approach | Mandatory. Each year all pharmacists must declare to the Pharmacy Council that they have met CPD requirements in order to receive an Annual Practising Certificate, necessary to work as a pharmacist in New Zealand. To attain sufficient CPD credit points, pharmacists must be enrolled on an accredited recertification programme. There is just one, so all pharmacists are enrolled with the on-line programme (‘**ENHANCE 2.0**’) provided by the Pharmacy Society of New Zealand (PSNZ), irrespective of whether they are members of this professional association.

A weighted, points based CPD scheme (valuing assessed learning and practice improvement more highly than attendance at didactic sessions) requires pharmacists to undertake a three-year cycle of development activities based on a learning plan derived from a process of reflection, planning, action and review of outcomes, and from these activities to accrue a minimum 20 credit points a year and 70 points over three years. The process is supported by ‘learning peers’ or ‘accredited learning facilitators’.

Pharmacists are required to maintain a learning log and portfolio of evidence which may be required to substantiate self-declaratory claims of compliance if the registrant is selected for audit. Audits of CPD records, learning logs and portfolios of up to 20% of registrants each year are undertaken by PCNZ independent auditors. |

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\(^{88}\) The latest available information indicates that there were 5 such referrals in 2011/12 (Pharmacy Council of New Zealand Annual Report 2012).

\(^{89}\) In New Zealand the Health Practitioners Disciplinary Tribunal undertakes disciplinary proceedings, hearing and determining sanctions against health practitioners, including pharmacists.
| **Standards** | Standards for CPD and recertification are determined by the regulator, the Pharmacy Council of New Zealand (PCNZ), and are set in the context of its Code of Ethics for pharmacists, its competencies for pharmacists, and where relevant, supplementary standards and guidance for pharmacists. |
| **Accreditation** | The PCNZ accredits recertification programme providers (currently just one) to provide support, resources and learning activities to pharmacists. It also endorses the accreditation standards and recognition process offered by the Australian Pharmacy Council for other providers of continuing education. |
| **Assessment** | Self-assessment of learning needs is undertaken in the context of the Code of Ethics and against the competence standards for pharmacists, and any supplementary guidance that applies to the pharmacist’s area of practice, supported by a ‘learning peer’, ‘accredited learning facilitator’ and the recertification programme provider. In the case of non-accredited and non-assessed continuing professional development activities, self-assessment of outcomes and attribution of an appropriate points score are required, also supported by the recertification programme provider. |
| **Incentives & penalties** | The PCNZ cites professional obligations specified in the Code of Ethics and competencies for pharmacists as the principal motivations for undertaking CPD. The sanctions for non-compliance – that is a failure to satisfy the CPD requirements if audited – comprise imposition of a conditional Annual Practising Certificate, placing restrictions on scope of practice, fulfilment of certain roles, and oversight by a designated pharmacist. Non-compliance does not, in itself, result in removal from the register. A conditional APC and period of oversight is designed to enable the pharmacist to take remedial action to satisfy the requirements, and then to have the conditions lifted. However failure to do so may result in a decision not to renew the subsequent APC. |
| **Funding** | The costs of standard setting and auditing is borne by the PCNZ and is funded from running costs generated from fee income. Pharmacists are responsible for funding their own CPD but benefit from membership of professional associations such as the PSNZ, which provides free access to the ENHANCE recertification programme. Non-members pay a fee to access the online system. Some employers and industry bodies may provide sponsorship. |

**SOUTH AFRICA**

**Regulatory structure**

The South African Pharmacy Council (SAPC) is the statutory body responsible for regulating the pharmacy professions. It aims to ensure the provision of high quality pharmaceutical services in South Africa, drawing its powers from the Pharmacy Act, 1974 (as amended). Its work is funded from registrant fees, enabling it to administer a system of registration of both individuals and organisations (ie pharmacies and bodies providing pharmacy education and training), and to maintain standards of education and training and standards of professional practice.90

The Council has over 13,500 pharmacist, community service pharmacist and specialist pharmacist registrants.

**Approach to assuring continuing fitness to practise**

The SAPC does not refer to ‘assuring continuing fitness to practise’ in its policies and guidance, nor does it make any reference to the concept of revalidation. Its interest in the continuing competence of its registrants is cast in the context of its public protection mandate.

Deriving its powers and responsibilities from the Pharmacy Act (Act 53 of 1974), the SAPC states that:

“... the Council must ensure that registered persons undertake CPD to maintain their competence. CPD will assist Council to identify pharmacy personnel who have been unable to maintain their competence to practise”.

The SAPC’s guidance emphasises the “individual’s personal commitment to continuing professional development” and construes it as a “professional obligation ... to remain informed about the profession in scientific, political and legal terms and to maintain a level of competence sufficient to provide pharmaceutical services, including care, effectively and efficiently” (SAPC, undated[a], p3).

The Council also observes that continuing professional development (CPD) needs to address emerging health needs and to be relevant to the health needs of the country.

It is in this context that the SAPC has developed and is introducing a system of mandatory CPD for pharmacists in five phases, which commenced in 2009 and will reach full implementation by January 2015 (following which it will be extended to other registrant categories). The final phase will culminate in mandatory recording of CPD with an assessment of CPD records (SAPC, undated[a]). The scheme has been given legal force in regulations (Government Gazette, 2011).

Pharmacists are required to make an annual declaration to the SAPC as to whether they are practising or non-practising (the public register is annotated accordingly). If practising they are required to pay an annual fee and to declare that they will comply with the requirements relating to CPD.

CPD is elaborated as a cycle comprising four steps: reflection; planning; implementation; and evaluation or reflection on learning. The SAPC has published guidance about what is involved in each step (SAPC, undated[a]) and has developed an online facility to record completion of each stage of the cycle, all of which are obligatory and form part of the permanent record of CPD activity that may be subject to inspection to assess compliance.

Competence standards – based on the seven minimum competencies required for entry into the profession, and three further competencies (developing personnel, practising pharmacy professionally and ethically, and managing a pharmacy service) – are annexed to guidance to be used as a basis for reviewing practice and assessing learning needs. Personal development plan and learning plan templates are also provided (SAPC, undated[a]).

Pharmacists are required to record at least 12 learning activities or events in each 12 month period (which should be spread evenly throughout the year). The activities should be relevant to their practice or concerned with career development.

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92 Paper based submissions may be agreed in exceptional circumstances where there is no internet access.
A range of learning activities are cited as suitable, including:

“... self-study, attendance of journal clubs, lectures, symposia, attendance of courses, workshops as well as formal education programmes. Instances where the person delivers a presentation or provides input at a course/symposium/workshop etc may also be included if it contributes to the personal and professional growth/learning of the person” (SAPC, undated[a], p8).

An appendix to CPD guidance (SAPC, undated[a]) provides examples of acceptable learning activities in three categories:

- non measurable learning activities (ie learning activities undertaken or presented on a once-off, non-continuous basis that do not necessarily have a clearly measurable outcome)
- measurable/structured learning programmes (ie learning activities presented by an accredited provider or training institution that are undertaken in a period covering not more than six months)
- structured learning/formal programmes (ie including learning activities that are planned, recorded and/or presented by an accredited training institution, or evaluated by an accredited assessor, with a measurable outcome, and undertaken over a period exceeding seven months).

However, currently these categories are provided as guidance only and are not differentially weighted. Similarly, the CPD scheme is not points based – rather, emphasis is placed on the rigour applied in each stage of the CPD cycle and the flexibility inherent in the system in permitting pharmacists to meet identified needs.

Accreditation of CPD

Pharmacists are not obliged to undertake only accredited education to fulfil their continuing professional development obligations, but the SAPC does accredit education providers wishing to offer such learning activities to pharmacists.

Recording of CPD

Registrants are required to record the learning activities and events they undertake online, no later than one month after completion. They are also expected to maintain hard copy and associated evidence of having completed the requisite CPD in a personal portfolio.

Assessing and auditing CPD

Self-assessment of “competence to practise” (SAPC, undated[a], p9), of learning needs and of the outcomes of subsequent learning activities, is a pivotal part of the scheme. Considerable emphasis is placed on rigorous completion of each step of the CPD cycle as the quid pro quo for a flexible and needs-based system which does not dictate the type(s) of CPD to be undertaken nor, for example, the weight or points to be attributed to any particular type of activity.

In terms of audit, contrary to the assertion that “CPD will assist Council to identify pharmacy personnel who have been unable to maintain their competence to practise”, at this stage it is not envisaged that competence will be assessed directly (SAPC, undated[a], p2). Rather, compliance with

CPD requirements is assessed by inspecting online CPD records. Where necessary a pharmacist may also be required to submit their portfolio of evidence in support of the information online.

It is not clear what proportion of the registrant population will be sampled each year but it is to include those flagged as a result of failing to record activities and those registrants who have changed their status from non-practising to practising (SAPC, undated[a], pp9-10). A flow chart available on the SAPC website implies that registrants will have their records reviewed annually and assessed at least every five years.94

Assessors are appointed and trained by the SAPC (and paid a fee) to review CPD records. Published guidance includes an assessment matrix derived from quality criteria developed by the Royal Pharmaceutical Society of Great Britain (SAPC, undated[a] p81). The assessment process is to be subject to “moderation and verification” (SAPC, undated[a], p10).

Pharmacists found to have failed to comply with the CPD requirements may request a further assessment, may be granted a deferment for a specified period, or may be required to follow a support or remedial programme or another method of assessment. In the event that a pharmacist fails to comply with the decision of the Continuing Professional Development Committee, the Committee may direct the Registrar to change the status of the registrant from practising to non-practising or take disciplinary action by arranging a professional conduct investigation (Government Gazette, 2011).

There is no evidence of published information about any risk assessments, cost-benefit analyses or business cases that may have been prepared to inform the policy decisions that underpin the approach described above.

| Approach | The SAPC does not use the term ‘assuring continuing fitness to practise’, nor does it refer to the concept of revalidation. Its responsibility to ensure that registrants maintain their competence is exercised through a system of mandatory CPD which, while backed by statutory regulations, is presented as an important professional obligation incumbent on all pharmacists. The scheme will be fully operational, including a system of audit, by January 2015. The scheme is linked to an annual declaration and fee payment which requires that registrants indicate their intention to practise and commitment to comply with the SAPC’s CPD requirements. The scheme revolves around the full and active participation in all stages of a CPD cycle, recorded in templates online and in a hard copy personal professional portfolio. The scheme is not points based or prescriptive beyond the requirement that the CPD cycle is undertaken rigorously, that learning activities are related to the pharmacists’ practice and career development, and that at least 12 learning activities are undertaken each year. |
| Standards | The CPD requirements are enshrined in statutory regulations. Standards of competence (entry level plus three additional competencies) are provided only as a basis against |

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which to self-assess continuing competence and learning needs.

**Accreditation**
Pharmacists may undertake a wide range of learning activities. There is no requirement that any be accredited. However, the SAPC is able to accredit continuing education providers and training institutions that offer continuing professional development activities.

**Assessment**
The system is rooted strongly in self-assessment — of continuing competence, learning needs and the outcomes and effectiveness of learning activities. CPD records, but not competence, are subject to audit. Assessors review online records and may call for additional evidence from professional portfolios.

**Incentives & penalties**
The obligation to undertake CPD, while mandatory, is presented as a core professional obligation. Penalties for not complying with the requirements to undertake and record CPD as required range from deferment, prescription of a remedial programme, imposition of a change of registration status to non-practising, and ultimately disciplinary action.

**Funding**
Pharmacists are responsible for funding their own CPD. Some employers and industry bodies may provide sponsorship.

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**UNITED STATES OF AMERICA**

There are at least 54 statutory bodies regulating pharmacists in the USA. It was not feasible to undertake a full review of each in the time and resources available for this study. After surveying a sample of nine State Pharmacy Boards, we concluded that sufficient similarities in approach were evident to obviate the need to explore others. We are confident that the report below is representative but in the absence of an analysis of all 54 regulators, we cannot rule out the possibility that one or more of those that we have not reviewed pursues a different approach to the model described below.

**Regulatory structures**
Pharmacists are regulated at State level in the USA, each State licensing individuals to practise within its own jurisdiction. However, it is evident that there is a considerable degree of commonality in statutes, policies and procedures, perhaps not least because of the work of the National Association of Pharmacy Boards (NAPB), an independent national membership body comprising all 50 state boards of pharmacy, plus those in four additional jurisdictions.\(^{95}\)

**Assuring continuing fitness to practise**
The NAPB works to create uniform policies and practices to facilitate pharmacist transfer between States and to promote common standards in pharmacy practice to help protect the public health. The NAPB’s *Model State Pharmacy Act and Model Rules* (NAPB, 2013a) is one example of its efforts to encourage and support a uniform approach to standards and regulation. Since the statutes and regulations examined in the small survey of State Boards conducted for this review appear to have very similar provisions, the model Act provides a helpful proxy for what would otherwise be repetitive references to State legislation.

\(^{95}\) The District of Columbia, Guam, Puerto Rico, and the Virgin Islands.
The model Act includes the following:

“Section 304. Renewal of Licenses and Registrations: (a) Each Pharmacist ... shall apply for renewal of his or her license annually [or at such interval determined by the Board, (and) ... file with the Board an application in such form and containing such data as the Board may require for renewal of the license.

Section 305. Continuing Pharmacy Education: The Board shall, by rule, establish requirements for continuing education in Pharmacy, including the determination of acceptable program content and fees. The Board shall adopt rules necessary to carry out the stated objectives and purposes, to enforce the provisions of this Section, and to ensure continued competence” (NAPB, 2013a).

The review of a sample of State Pharmacy Boards revealed that these sections of the model Act reflect the prevailing norm: that pharmacists are required to undertake continuing education and to declare at the time of renewing their license to practise (usually annually) that, among other things, they have completed the required number of continuing education hours. Indeed a recent NAPB survey reported that 53 boards of pharmacy require pharmacists to participate in continuing pharmacy education (CPE) activities as a prerequisite for license renewal (NAPB, 2013b).

According to the 2013 Survey of Pharmacy Law, 53 boards of pharmacy require pharmacists to participate in continuing pharmacy education (CPE) activities as a prerequisite for license renewal.

The concept of continuing professional development rarely appears in the regulatory policies and procedures of Pharmacy Boards and is mentioned only once in the model Act. Similarly, no references to the concept of ‘assuring continuing fitness to practise’ (nor indeed to revalidation) were identified in either State Board literature or the model Act. Rather, the apparently universal approach to assuring continuing fitness to practise rests on the inference that a pharmacist who has completed the required continuing education remains fit to practise.

The apparently low profile afforded CPD is reflected in a White Paper on credentialing in pharmacy (CCP, 2010). On one hand it provides a comprehensive account of credentialing – the process by which “health care practitioners are educated, trained, licensed, and otherwise recognised for their competence and achievements” (CCP, 2010, p1) – yet on the other mentions CPD only once, in the glossary. A substantial ‘resource document’ about CPD signposted on the Council on Credentialing in Pharmacy website – an apparently authoritative national body – is dated 2004. The paper concluded then that:

“...implementation would certainly create challenges as well as opportunities ...The full implications of widespread adoption of a CPD model needs further discussion. What is clear, however, is that a different approach would be required by both CE providers and practitioners” (CCP, 2004, p27).

State Boards require registered pharmacists to complete either a minimum number of hours or set number of continuing education units (CEUs) as a condition of license renewal. Most commonly this amounts to 15 hours each year, as for example in Kentucky and Washington, but can be structured

96 In respect of preceptors for pharmacist interns.
and expressed in different ways. For example Alabama requires that 3 of the 15 hours is ‘live’, that is achieved through course attendance, plus 12 non-live hours approved by an ACPE approved provider (see accreditation below). In California pharmacists are required to complete 30 hours every two years. In Pennsylvania the requirement is specified as 30 ‘contact hours’ of continuing education approved by the ACPE. In New Hampshire pharmacists are required to earn 1.5 CEUs (equivalent to 15 hours) in the 12 months preceding license renewal. New York specifies a minimum of 45 contact hours, of which 23 must be ‘live’, and 3 credits worth of home study or ‘live’ education must be formal continuing education on strategies and techniques to reduce medication and prescription errors.

**Accreditation**

In most (possibly all) cases, CE hours or CEUs must be earned through participation in learning activities from a provider accredited by the State Board or its nominee (for example in California it is the Pharmacy Foundation of California), or by the Accreditation Council for Pharmacy Education (ACPE), a national autonomous independent agency that accredits pharmacy degrees and providers of continuing pharmacy education. The ACPE’s accreditation standards (ACPE, 2007) specify 12 standards to be met by providers of continuing education in order to achieve recognition. The ACPE publishes a directory of accredited providers of continuing pharmacy education (CPE).

Pharmacists can obtain ‘hours’ or CEUs by attending a range of accredited learning activities including educational events, seminars and meetings, or by reading journal articles or completing computer-based educational activities. Evidence of a “satisfactory score on an assessment that is created by and submitted to the CE provider is generally required as documentation that a CE activity has been completed” (CCP, 2010, p4). The NABP has developed a CPE tracking service – CPE Monitor – which records and stores completed CPE units offered by ACPE accredited providers, enabling State Boards, CPE providers and pharmacists to save time and costs by streamlining the process of verifying that licensees and registrants meet CPE requirements.

**Audit**

The small sample of State Boards of Pharmacy examined for this study suggests that most require very limited documentation to confirm that the CE requirement has been satisfied. Some make reference to periodic audits of a random sample of registrants’ renewal documentation, but none of those reviewed provide detailed information about how this is done, or by whom. Nor is it clear from published policies and procedures what sanctions are applied for non-compliance, aside from the non-renewal of a pharmacist’s license to practise.

“Article V – Discipline – Section 402. Grounds, Penalties, and Reinstatement: The Board of Pharmacy may refuse to issue or renew, or may Revoke, Summarily Suspend, Suspend, place on Probation, Censure, Reprimand, issue a Warning against, or issue a Cease and Desist order against, the licenses or the registration of, or assess a Fine/Civil Penalty or

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97 Its Board of Directors is appointed by the American Association of Colleges of Pharmacy (AACP), the American Pharmacists Association (APhA), the National Association of Boards of Pharmacy (NABP), and the American Council on Education.
Among 17 specified grounds for disciplinary action there is one broad provision that may well be cited in respect of non-compliance with requirements to undertake and produce evidence of successful completion of continuing education: “...(15) being found by the Board to be in violation of any of the provisions of this Act or rules adopted pursuant to this Act” (NAPB, 2013a).

It is worthy of note that the NAPB has developed a **Pharmacist Assessment for Remediation Evaluation (PARE)**. It is described as a multi-dimensional assessment for State Boards to use as a tool when making decisions about a pharmacist’s practice deficiencies due to ‘non-compliance with pharmacy practice standards, laws or regulations’ that may compromise patient safety; but it is not at all clear – although feasible – that referral would necessarily arise from non-compliance with CE requirements. The PARE is a computer-based assessment comprising over 200 multiple choice questions concerning medication safety and the practice of pharmacy, professional ethics and pharmacist judgment, and clinical pharmacy practice.

### Table 3.7: Summary of measures to assure continuing fitness to practice in the USA

<table>
<thead>
<tr>
<th><strong>Approach</strong></th>
<th>Pharmacists are regulated by each State but there is considerable uniformity of approach. The details that follow are representative but may not necessarily apply in every State. Neither the concept of ‘assuring continuing fitness to practise’ nor that of revalidation has currency among the State Boards, nor does continuing professional development feature significantly as a regulatory measure. Insofar as it may be considered, continuing competence is apparently inferred from successful completion of continuing education. Continuing Education (CE) is mandatory. A specified number of hours or accredited units are required for (usually annual) renewal of registration.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Standards</strong></td>
<td>State Boards of Pharmacy tend to cite legislation and regulations as authority for the standards they require for re-licensure; detailed policy statements and guidance do not appear to be commonplace.</td>
</tr>
<tr>
<td><strong>Accreditation</strong></td>
<td>Accreditation is carried out by State Boards or their nominees, for many this is providers accredited by the national organisation, the Accreditation Council for Pharmacy Education.</td>
</tr>
<tr>
<td><strong>Assessment</strong></td>
<td>Accredited providers undertake assessments. A satisfactory score on an assessment that is created by and submitted to the CE provider is generally required as documentary evidence that a CE activity has been successfully completed. Some Boards refer to random sample audits of CE documentation.</td>
</tr>
<tr>
<td><strong>Incentives &amp; penalties</strong></td>
<td>CE is mandatory and is tied to re-licensure. Sanctions for a failure to comply with licensing requirements are not obviously publicised beyond the often implicit implication that the consequence is refusal to renew registration.</td>
</tr>
<tr>
<td><strong>Funding</strong></td>
<td>Pharmacists are responsible for funding their own CE but there is evidence of sponsorship.</td>
</tr>
</tbody>
</table>
COMMENTARY

It is evident from the countries reviewed that the term ‘assuring continuing fitness to practise’ is not widely used elsewhere in the world. In those instances where the term ‘fitness to practise’ is used – on websites, in regulations and in policy documents – it tends to be confined to matters associated with professional conduct and discipline. Similarly, the term ‘revalidation’ (from which it might be argued the term ‘assuring continuing fitness to practise’ has emerged) has yet to achieve currency in pharmacy regulation in the countries reviewed. However the concept can be inferred from the widespread adoption of regulatory measures to promote continuing competence through continuing education and professional development, affirmed through processes of periodic re-registration.

Periodic re-registration (ranging from once a year to once every five years) is the principal means through which pharmacists are obliged to declare and/or to demonstrate that they continue to meet expectations as regards competence and conduct. Pharmacists in Australia, British Columbia, Ontario, the Republic of Ireland, the Netherlands, New Zealand, South Africa and the USA98 are required to renew their registration periodically and to make a declaration that they continue to meet registration standards (and usually also to confirm or provide evidence of having undertaken continuing education or professional development). Of the countries reviewed, Finland is alone in awarding indefinite registration.

Maintaining competence and keeping up-to-date with professional and health care developments is a professional obligation promulgated by all the regulators reviewed. The obligation appears in statutes, regulations, rules, codes of conduct and policies. In some jurisdictions it is cast primarily as an ethical duty and in others it is emphasised as a legal requirement. A mandatory requirement to complete a specified number of hours, credits or units of learning or to follow a continuing professional development cycle during the registration period has been adopted widely as the means of regulating what would otherwise be a matter of registrant discretion based on a personal appreciation of professional obligations.

A distinction can be drawn between the more permissive schemes (that allow pharmacists to determine how best to satisfy their continuing education and professional development needs and to produce evidence of having done so) and the more tightly specified schemes (that require completion of accredited continuing education and/or the acquisition of a specified number of accredited hours or units of learning). The distinction appears to reflect differences of underlying philosophy about purpose and methods.

It is evident from the policy documents and guidance reviewed that there is less justification offered for the continuing education hours-based systems than there is for the more permissive continuing professional development schemes. This might be because hours and points-based schemes have been in operation for some time and explanatory guidance and justificatory policy statements have been withdrawn from websites to make way for more recent developments, or because the purpose and benefits are now considered to be self-evident. In contrast the more permissive schemes appear to place greater emphasis on explaining why they are structured as they are, emphasising among other things that pharmacists learn in different ways, work in different settings, have different needs.

98 We can only make this claim for the States reviewed but we believe the requirement applies across the USA.
at different points in their careers, are likely to benefit most from access to the widest range of learning opportunities and activities, and that greater flexibility in what is to count as CPD and to attract recognition is more likely to result in practice and service improvements. If it is the case that explanation of underpinning philosophy and approach is more evident among the more permissive schemes and during the early stages of implementation (when promoting understanding and achieving ‘buy-in’ are important goals), then the Republic of Ireland provides a contemporary case example. In describing its new scheme its website eschews reference to detailed regulations and requirements in favour of a broader explanation of its approach.\(^{99}\)

Where regulators stipulate that a proportion of learning activities must or may be accredited, the accreditation function may be undertaken by the regulator (as in South Africa where the Council can directly accredit continuing education providers), delegated to agents (as in Australia where responsibility is delegated to the Australian Pharmacy Council), or conducted by independent bodies recognised by the regulator (as in the US where many States afford recognition to the Accreditation Council for Pharmacy Education).

It is not uncommon for continuing education to be formally assessed, enabling participants to claim credits without equivocation; but of the countries reviewed only Canadian jurisdictions (British Columbia, Ontario and Alberta\(^{100}\)) select a sample of registrants to undertake a formal, invigilated, computer-based, multiple-choice knowledge assessment. These regulators report exceptionally high pass rates; on the one hand providing reassurance to the public about practising pharmacists’ knowledge, yet on the other begging the question: are the assessments sufficiently demanding? The regulators point out that the assessments are designed and validated to test only what every pharmacist should know, and thus to identify those who fall below minimum registration standards.

We found no published evidence about the costs of developing, validating and maintaining a sufficiently large bank of multiple-choice questions, nor of running the centralised examination centre days or providing remedial support to those who fall below the required standard. However it is important to stress that the absence of publicly available information about this or any of the other schemes described is not to imply that data about costs, evaluations or other potentially helpful material does not exist, but rather that access may require a direct request, regulator-to-regulator.

Ontario is alone among the regulators reviewed in subjecting a small minority of randomly selected registrants to what is described as a peer review assessment (although Ireland has indicated its intention to adopt a similar approach). In Ontario, peer review is one element of a day long process that includes among other things a computer-based multiple-choice knowledge assessment (in which the peer reviewer plays no part). The role of the peer reviewer is to observe and to rate several dimensions of performance during a candidate interview with a (role played) patient in a standardised scenario. Peers are also involved subsequently in supporting and advising pharmacists who fall below the required standard and who are required to undergo a process of remediation.


\(^{100}\) Alberta provides those selected for ‘competence assessment’ with an option to elect to sit the knowledge assessment or to submit a portfolio for scrutiny.
The extent and nature of the evidence required at registration renewal to demonstrate that continuing education (CE) or continuing professional development (CPD) requirements have been met varies among the regulators reviewed. All require pharmacists to keep adequate records and to make a self-declaration of compliance, and most offer an online facility to log CE, CPD and learning activities, in many cases in real time as they occur throughout the registration period. A wide range of guidance, development cycle templates, portfolio pro-forma and other forms of support are also provided online by regulators and professional associations. The policy to audit a sample of registrant declarations and associated evidence is commonplace but not all regulators provide details of how this is done, by whom, or against what standards. However there is also published evidence – as in Australia – of rigorous pilot auditing to establish the validity and reliability of audit processes.

There is an apparent absence of information about the costs of operating the various schemes described. The financial information provided in regulator annual reports tends to be at too high a level of generality to isolate the costs of the measures described above. We found no direct evidence of Government funding for measures to assure the continuing fitness to practise of pharmacists (although this may have occurred as initial pump priming) and have inferred from annual reports that most schemes are accounted for in general operating expenditure, funded from registrant fees and other established income streams. The direct costs to registrants of undertaking CE and CPD and of meeting any other re-registration requirements are usually borne by pharmacists themselves, although in some cases with the benefit of employer or sponsor support.

There is a paucity of published information reporting any risk-assessments, cost-benefit analyses or business cases that may have been undertaken or developed to inform policy decisions leading to the adoption of the models described. It seems reasonable to assume that if analyses of this sort had been undertaken they would probably have been considered by Committees *in camera*. It also seems likely that policies and practices have evolved incrementally, reducing the likelihood of calls for detailed analyses and policy appraisal that might be expected of a ‘big bang’ approach. One informant referred to what might be described as an ‘arms race’ mentality, attributing the absence of detailed costing and policy appraisal to a sense of urgency about the need to catch-up with other regulators.

Key elements of the approaches adopted by regulators in other countries are summarised in Table 3.8. The table serves to highlight the finding that the concept of revalidation and the imperative to assure continuing fitness to practise do not feature as such in the policies of regulators outside the UK (at least not in the countries reviewed). The table also serves to emphasise that – to the extent that other regulators are concerned about assuring continuing fitness to practise – the principal regulatory measures adopted comprise continuing professional development linked to self-declaration of compliance at renewal of registration. There are therefore no regulatory blueprints to assure continuing fitness to practise or to validate continuing competence suitable for evaluation as a potential model for consideration by the PSNI. However elements of several of the schemes reported provide helpful pointers regarding specific measures that might be adopted.
Table 3.8: Summary of key elements of approaches to assuring continuing fitness to practise adopted by regulators of pharmacists in other countries

<table>
<thead>
<tr>
<th>Regulator</th>
<th>Policy references to ‘assuring continuing fitness to practice’</th>
<th>Policy references to ‘revalidation’</th>
<th>Core elements of the approach to assuring continuing fitness to practise</th>
<th>Risk assessments, cost-benefit analyses or business cases</th>
</tr>
</thead>
</table>
| Pharmacy Board of Australia (of the Australian Health Practitioner Regulation Agency) | No                                                               | No                                 | • Annual renewal of registration  
• Mandatory CPD  
• Self-declaration of compliance with CPD standard  
• Pilot auditing of declarations and learning portfolios started recently | No published information identified |
| College of Pharmacists of British Columbia (Canada)                      | No                                                               | No                                 | • Annual renewal of registration  
• Mandatory CPD  
• Each year 10% undertake computer based knowledge assessment (MCQ)  
• Self-declaration & submission of learning records at registration renewal  
• Audit: random sample of 10% of learning records is planned | No published information identified |
| Ontario College of Pharmacists (Canada)                                 | No                                                               | No                                 | • Annual renewal of registration  
• Mandatory CPD  
• 20% randomly selected to submit annual self-assessed practice review, learning plan & CPD record  
• 2% randomly selected for ‘peer review’ (computer based knowledge assessment and ‘peer’ observed patient interview)  
• Quality Assurance Committee reviews results | No published information identified |
| Alberta College of Pharmacists (Canada)                                 | No                                                               | No                                 | • Annual renewal of registration  
• Mandatory Continuing Education  
• Random sample of registrants undergo ‘competence assessment’ (option of computer based knowledge assessment by MCQ, or professional portfolio assessment) | No published information identified |
Table 3.8: Summary of key elements of approaches to assuring continuing fitness to practise adopted by regulators of pharmacists in other countries

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</tr>
</thead>
</table>
| Valvira – the National Supervisory Authority for Welfare and Health (Finland) | No | No | - None – registration is indefinite  
- Law requires pharmacists to update their professional knowledge but there is no formalised system to count credits for continuing education; however there is evidence of significant CPD activity | No published information identified |
| The Pharmaceutical Society of Ireland (Republic of Ireland)  
Approximately 5000 registrants | No | No | - Mandatory CPD  
- Self-declaration when renewing registration annually that undertake CPD.  
- Scheme in development but will be flexible and permissive of a wide range of activities to ensure pharmacists “retain their capacity to practise safely, effectively and legally within their evolving career and scope of practice”  
- No indication as yet about auditing or sanctions  
- Proposed peer led and developed competency based quality assurance process, based on the scheme operating in Ontario, under auspices of Institute of Pharmacy. | Policy comparison and review: Pharmaceutical Society of Ireland, (2010), Review of International CPD Models, Dublin, PSI. |
| Royal Dutch Association for the Advancement of Pharmacy: regulates under the Health Care Professions Act (Netherlands) | No | No | - Quinquennial re-registration  
- Hours-based accredited continuing education requirement  
- Self-declaration at registration renewal  
- No evidence of audit | No published information identified |
| Pharmacy Council of New Zealand  
Approximately 4500 registrants | No | Ensures pharmacists are ‘fit to practise’ through its ‘recertification policy’ and, | No | - Recertification: annual practising certificate issued on self-declaration of compliance with CPD  
- Mandatory CPD  
- Weighted points based scheme – registrants must be enrolled on accredited recertification programme | No published information identified |
## Table 3.8: Summary of key elements of approaches to assuring continuing fitness to practise adopted by regulators of pharmacists in other countries

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<th>Policy references to ‘assuring continuing fitness to practice’</th>
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<tbody>
<tr>
<td></td>
<td>independently, ‘competence review’ when continuing competence called into question</td>
<td>• Random sample of up to 20% of CPD records audited annually &lt;br&gt; • Sanctions – including period of oversight by professional peer and/or restricted scope of practice – imposed if fail to comply with recertification requirements &lt;br&gt; • ‘Competence review’ is independent of recertification, CPD and professional disciplinary action, and is initiated when a pharmacist’s continuing competence is called into question (5 referrals in 2011/12)</td>
<td></td>
<td>No published information identified</td>
</tr>
<tr>
<td>South African Pharmacy Council &lt;br&gt; <em>In excess of 13,500 registrants</em></td>
<td>No</td>
<td>No</td>
<td>• Annual renewal of registration &lt;br&gt; • Mandatory CPD &lt;br&gt; • Self-assessment and self-declaration of compliance &lt;br&gt; • CPD records subject to audit – reviewed online but assessors may call for additional documentary evidence &lt;br&gt; • Non-compliance triggers a professional conduct investigation</td>
<td>No published information identified</td>
</tr>
<tr>
<td>United States of America, where 54 statutory bodies regulate pharmacists – 9 of which were sampled for this study</td>
<td>No</td>
<td>No</td>
<td>• Re-licensure (usually annually) &lt;br&gt; • Mandatory continuing education (hours-based) &lt;br&gt; • Strong orientation towards accredited and assessed continuing education &lt;br&gt; • Self-declaration of compliance and evidence from CE providers at re-licensure &lt;br&gt; • Periodic audits of CE records but limited information about how this is conducted</td>
<td>No published information identified</td>
</tr>
</tbody>
</table>
CHAPTER 4: ASSURING CONTINUING FITNESS TO PRACTISE IN OTHER PROFESSIONS

INTRODUCTION
This chapter examines contemporary approaches to assuring continuing fitness to practise in other professions. The review focuses mainly on the position in the UK but some references are made to other countries to help contextualise the findings. We look again at the non-health professions examined in the PSI report (PSI, 2010):

- Accountancy
- Aviation
- Teaching.

ACCOUNTANCY
The occupation of ‘accountant’ is not a protected title in UK law and there is no statutory requirement for individuals to be registered or licensed to practise as an accountant. However, accountants who undertake certain regulated financial functions (such as audit) must be qualified to do so through full membership of a designated professional body.

A sample of professional accountancy bodies is examined below but only insofar as this helps to elucidate any arrangements they may have that approximate to assuring the continuing fitness to practise of their members. In many cases these are large and complex bodies that offer a range of professional qualifications and various levels of membership, but it is important to recognise any public protection function they may have is largely self-imposed not mandated by statute.

Association of Chartered Certified Accountants (ACCA)
The ACCA is a global professional body for accountants with over 162,000 members. It has over 428,000 registered students in 173 countries following courses leading to accountancy qualifications. It works through a network of 89 offices and more than 8,500 approved employers worldwide to provide high standards of employee learning and development. Its core training leads to qualification as a chartered certified accountant. The ACCA qualification is recognised worldwide. To qualify as an ACCA member, individuals must have completed a minimum of five of 14 specified exams, provided evidence of three years’ experience in a relevant role, and undertaken the Professional Ethics module.

The ACCA works to ensure that its members adopt the highest standards of practice and ethical conduct by publishing standards and ethical guidance (ACCA, 2011), by licensing practitioners, by regulating and monitoring statutorily reserved areas of practice, by quality assuring firms and by investigating complaints regarding professional standards of discipline.

The ACCA provides continuing professional development (CPD) to its members, all of whom are required to maintain and develop their knowledge and skills. Payment of fees and making an annual CPD declaration are requirements for ongoing ACCA membership, but members are not required to
submit evidence of CPD. However they must retain such evidence for at least three years. The ACCA conducts reviews of CPD evidence, selecting a proportion of members annually, following which it says it will:

“...provide feedback to you on your CPD activities and, where necessary, will give you guidance and support to enable you to meet the requirement. In cases where members do not cooperate with the review process (for example, by failing to respond to communications or submit CPD evidence), they may be removed from the register of members” (ACCA, undated).

In the UK, ACCA is a Recognised Supervisory Body and a Recognised Qualifying Body under the Companies Act 2006, which enables it to award the UK statutory audit qualification and to register and regulate auditors. As a consequence much of its continuing quality assurance monitoring concerns compliance with standards concerning regulated activities such as these (ACCA, 2013), rather than assuring the continuing fitness to practise of every member.

**Association of International Accountants (AIA)**

AIA is an internationally recognised membership body for professional accountants with members in over 85 countries. It offers a range of qualifications recognised in over 30 countries around the world. The AIA provides a representative voice for its members and aims to ensure they meet the necessary CPD, ethical and professional standards. It has adopted the International Federation of Accountants ethical code (IFAC, 2010), which all AIA members are bound to observe by its Constitution.

AIA members are required to ensure that they have the knowledge and skills to fulfil their role and responsibilities and are required to complete at least 120 units of relevant CPD activity during each three-year period, of which 60 units should be verifiable. AIA provides detailed guidance (AIA, 2012), a comprehensive suite of online continuing provisional development activities and a facility to record CPD online. Records must be completed and submitted annually as part of the required ‘CPD Declaration’. Members are required to maintain evidence supporting the online CPD Record for each rolling three-year period.

As part of the AIA’s monitoring process, each year a sample of returns are selected and members are asked for evidence demonstrating that the CPD units they have recorded have been completed and were relevant to their development needs.

**Chartered Institute of Management Accountants (CIMA)**

CIMA is the world’s largest professional body for management accountants. Membership is open to accounts who have completed the CIMA professional qualification and demonstrated three years relevant practical experience. It was established by Royal Charter and claims to be committed to upholding the highest ethical and professional standards and to maintaining public confidence in the profession (CIMA, undated). It offers a number of specialist qualifications which build to full CIMA membership, and a range of continuing professional development events and learning activities.

Membership imposes ethical obligations detailed in a Code of Ethics (CIMA, 2010) and certain standards of professionalism, including commitments to undertake continuing professional development, to maintain professional indemnity insurance, and in respect of other aspects of good
practice such as making provisions to deal properly with complaints. Members are required to confirm that they meet these requirements on renewal of registration. Failure to do so can result in withdrawal of membership, as can misconduct resulting from a conviction or failure to comply with the Institute’s Byelaws.

Each year the CIMA undertakes quality assurance checks of a random sample of members to ensure they have continued to comply with all the mandatory requirements of membership. This appears to be based on a scrutiny of relevant documentation.

**Chartered Institute of Public Finance and Accountancy (CIPFA)**

Established under Royal Charter (CIPFA, 2012), CIPFA is the only professional accountancy body in the world exclusively dedicated to public finance. Its 14,000 members work throughout the public services, in national audit agencies, in major accountancy firms, and in other bodies where public money needs to be effectively and efficiently managed. It provides the benchmark professional qualification for public sector accountants (the Chartered Public Finance Accountant), continuing professional development and postgraduate qualifications.

CIPFA regulations and guidance help its members provide the highest standards of professional practice in public financial management and governance. Its code of ethics adopts the International Federation of Accountants Code in full (IFAC, 2010) which, together with a CIPFA’s foreword (CIPFA, 2011), constitutes its *Standard of Professional Practice* (CIPFA, 2002). It has policies and procedures to deal with complaints (CIPFA, 2012a) based on regulations for managing conduct and discipline (CIPFA, 2012b).

CIPFA’s *Standard of Professional Practice* includes a mandatory requirement to participate in CPD (CIPFA, 2011). Two levels of CPD are specified: level 1 is the minimum requirement (a learning and development record and portfolio of evidence), while level 2 is considered to be best practice (a learning development plan, record and portfolio). Members are expected to complete 120 hours over a 3-year period, with a minimum of 20 hours in any one year, and are expected to be able to provide independent verification that structured activities listed on the learning and development record have been completed.

CIPFA members are required to confirm participation in the CPD scheme by completing and returning an annual declaration, and if selected, to submit their learning and development records and provide evidence of CPD activities (or equivalent if participating in an accredited CPD route). Participation in a CIPFA accredited employer scheme means members can submit paperwork from an employer scheme as evidence of their CPD activities allowing more time to be spent on development.

**Institute of Chartered Accountants of England and Wales (ICAEW)**

The ICAEW is a professional membership organisation that promotes, develops and supports over 140,000 chartered accountants worldwide. It provides qualifications and professional development, shares knowledge, insights and technical expertise among its members, and aims to protect the quality and integrity of the accountancy and finance professions.

The ICAEW offers a range of accountancy qualifications including the chartered accountancy qualification, the ACA, which it claims is one of the most advanced learning and professional
development programmes available. It asserts that the ‘chartered’ title is “an internationally recognised professional designation indicating the highest standards of ethical and professional conduct, up-to-date technical expertise and the capabilities of a qualified professional”.  

Members are expected to undertake relevant CPD and to make a declaration to that effect when renewing membership annually, described as a ‘reflect, act, impact and declare approach’. The ICAEW does not dictate how much CPD members must do, nor does it specify a set number of hours or points to be attained. Rather, members must complete as much development activity as they consider necessary to remain competent. (ICAEW, 2010). An online facility is provided for members to record their CPD.

No evidence is required at the time of declaration but the ICAEW may require members to:

“...supply any information requested under Principal Bye-law 56 (whether in the Annual Members Profile or otherwise) promptly and in accordance with the terms specified. Information includes any evidence requested to demonstrate compliance with Continuing Professional Development. Such evidence may include records, documents and other information whether in hard copy or electronic form”.  

Members providing services to the public must hold a Practising Certificate – which also has to be renewed annually – professional indemnity insurance, and be part of ICAEW’s practice assurance scheme. Member firms are required to comply with these standards and are monitored through an annual return and reviews by the ICAEW’s Quality Assurance Department.

The ICAEW can also investigate misconduct and has processes and regulations to deal with the investigation of complaints, disciplinary action and appeals.

**International Federation of Accountants (IFAC)**

The IFAC comprises more than 170 professional accountancy bodies in 129 countries (recognised by law or general consensus within their countries as substantial national organisations) representing 2.5 million accountants in public practice, education, government service, industry, and commerce. It works in the public interest by contributing to the development and implementation of high-quality standards and guidance; by helping to develop strong professional accountancy organisations and accounting firms, and high-quality practice by professional accountants.

Section 130, ‘Professional Competence and Due Care’, of its *Handbook of the Code of Ethics for Professional Accountants* (IFAC, 2010) sets out expectations regarding the attainment and maintenance of professional competence through, among other things, continuing professional development, with which member bodies must comply as a condition of continued membership. The requirement includes the assertion that continuing professional development “enables a professional accountant to develop and maintain the capabilities to perform...” (IFAC, 2010, p17, 130.3).

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The CPD requirement has been reinforced more recently in a revised education standard developed by the IFAC’s International Accounting Education Standards Board (2012a). It states that IFAC member bodies shall:

“… facilitate access to CPD opportunities and resources to assist professional accountants in meeting their personal responsibility for CPD and maintenance of professional competence.

… require all professional accountants to undertake CPD to contribute to the development and maintenance of professional competence that is appropriate to their work and professional responsibilities.

… establish their preferred approach to measuring professional accountants’ CPD activity from the three models: output-based, input-based, or combination approaches

… establish a systematic process to (a) monitor whether professional accountants meet the IFAC member body’s CPD requirements, and (b) provide appropriate sanctions for failure to meet those requirements” (IAESB, 2012a).

The rationale for the revisions to these requirements is explained in IAESB (2012b). Since member organisations are bound by the IFAC’s standards, it seems reasonable to assume that professional bodies will be working to develop more robust systems of monitoring and enforcement, and that in due course such arrangements could warrant scrutiny to assess their applicability to other professions, including pharmacy.

Summary
The occupation of ‘accountant’ does not have protection of function or title in UK law and there is no statutory regulatory body with rights to reserve application of the title only to those who meet its standards. However there are financial functions that are regulated and that can only be undertaken by qualified accountants – that is individuals whose qualifications, experience and standing are recognised by a professional body designated for the purpose. In the absence of a single regulatory body, there are no universal registration or membership standards against which continuing fitness to practise could be assessed and assured.

There are a number of professional accountancy associations (only some which have been reviewed above). In the UK, those bodies established by Royal Charter have a legal basis for rules, regulations in byelaws. They are able to set standards of education, professional practice and ethics but only have authority over their (voluntary) members. The incentives to comply with membership standards and requirements derive from the benefits that accrue from belonging to an organisation of standing within the professional community and among employers, and whose qualifications are respected. Membership is usually qualification, experience and fee dependent.

The absence of exclusive rights to regulate an occupational function or title means that professional accountancy bodies have only limited scope to make demands on their members in terms of assuring continuing fitness to practise (in contrast to medicine or pharmacy for example). The predominant approach is to specify expectations in respect of continuing professional development

103 The exception to this is that full membership is a condition to be able to undertake certain regulated financial functions such as audit.
and to demand a declaration of compliance upon (usually annual) renewal of membership. Byelaws permit these bodies to discipline, decline or refuse to renew membership to individuals who do not comply with the CPD standard but, in the absence of occupational exclusivity, exclusion from the association does not equate to a prohibition on working as an accountant.

AVIATION

Around the world aviators, air traffic controllers, aero-engineers and other safety-critical personnel are licensed in the interests of public safety. The overarching regulatory body is the International Civil Aviation Organisation (ICAO), a specialised agency of the United Nations that was created to promote the safe and orderly development of international civil aviation throughout the world. It “sets standards and regulations necessary for aviation safety, security, efficiency and regularity, as well as for aviation environmental protection.”

In Europe regulation is undertaken by the European Aviation Safety Authority (EASA) which was established to “promote the highest common standards of safety and environmental protection in civil aviation in Europe through a common regulatory framework,” which has to be adopted by member States.

In the UK the competent authority is the Civil Aviation Authority (CAA), a public corporation established by statute as an independent specialist aviation regulator and provider of air traffic services. It is funded entirely from charges to the bodies and individuals it regulates. Based on EU directives and regulations, the CAA regulates professional and private pilots, licensed aircraft engineers, air traffic controllers, commercial air operators, licensed aerodromes, organisations involved in the design, production and maintenance of aircraft, and aircraft registered in the UK.

The CAA licenses pilots in a number of different categories for commercial and private flying. It does so based on the training, knowledge, skills and experience of the pilot and the type of flights they wish to undertake. License holders are restricted to the ‘privileges’ associated with each type of license, but can have additional ‘ratings’ endorsed. For some categories of license a process of transition is currently underway to move from CAA to EASA regulations and a European-wide license (to be completed by 2017). The same levels of license will continue to apply and most procedures will remain unchanged (such as those outlined below).

Mandatory requirements regarding training, flight instruction, flight experience, theoretical knowledge, skills testing and competence assessment, together with a required level of health (as determined by a medical examination) are specified for each type of license (see for example CAA, 2013). For example an Airline Transport Pilots License (ATPL) entitles the holder to act as ‘Pilot in Command’ of multi pilot aircraft and single pilot aircraft, provided they meet the medical, knowledge and skill requirements for doing so. To achieve the license they must, among other things, have 1500 hours flight time in aeroplanes, including 500 hours in multi-pilot operations.

The CAA draws a distinction between renewal of a license (which it defines as the administrative action taken after a license has lapsed for the purpose of renewing the privileges of the license for a

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107 Or a rating or certificate, ie the endorsements that elaborate or extend the LICENSE.
Further specified period, consequent upon fulfilment of specified requirements) and the revalidation of a license (which it defines as the administrative action taken within the period of validity of a license which allows the holder to continue to exercise the privileges for a further specified period, consequent upon the fulfilment of specified requirements) (CAA, 2013, s1, ptB, p9).

Revalidation requirements are defined for each type of license but usually involve a proficiency check—defined as the “demonstration of skill to revalidate or renew ratings, and including such oral examination as may be required” (CAA, 2013, s1 ptB, p9)—which must be completed within a set period prior to expiry of the license rating’s validity. A license may be awarded for life but elements of it (ratings) are valid only for a short period, in many cases just one year, and must be revalidated by means of a proficiency check and such other assessments as are specified. Examiners are required to sign revalidation certificates confirming revalidation of particular ratings. Other standards to be met for revalidation include currency or recency requirements (i.e., having undertaken a number of hours of flying during a specified period prior to revalidation) and health checks (medical certification), which are also mandatory but vary according to the type of license and ratings endorsements.

Crucially, the same standards apply to initial licensure, renewal and revalidation. As an example, the regulations concerning the validity, renewal and revalidation of the EASA Instrument Rating for Aeroplanes (IR(A)) indicates that it is valid for 1 year, and that it has to be revalidated within the 3 months immediately preceding the expiry date of the rating. Applicants who fail to pass the relevant section of an IR(A) proficiency check before the expiry date are not permitted to exercise the IR(A) privileges until they have satisfied the proficiency check. In the case of renewal of an IR(A) that has expired, to renew their privileges pilots have to go through refresher training to reach the level of proficiency needed to pass the instrument element of the skill test in accordance with the specified standards, and then complete a proficiency check in accordance with the standards. If the IR(A) has not been revalidated or renewed within the preceding 7 years, the holder is required to pass again the IR theoretical knowledge examination and skill test (CAA, 2013, s4, ptG, p3).

The many and various requirements for the different types of license are specified in the 864 pages of the Flight Crew Licensing: Mandatory Requirements, Policy and Guidance (CAA, 2013). Arrangements for other safety-critical aviation occupations are also specified in regulations. For example, air traffic controllers (ATCs) are also required to meet certain health requirements (if under 40 years of age they need a medical certificate every two years) and to undertake a competence assessment to maintain their license.

ATC competence units are endorsed for a period of 12 months and may be renewed by an assessment of continuing competence to provide the air traffic services detailed in the unit endorsement. Competence examinations are conducted either by an accredited examiner or CAA Inspector. ATCs are not permitted to continue to provide air traffic control services associated with any unit endorsement in which they are assessed as not competent, unless supervised by a suitably qualified on-the-job training instructor (OJTI). The ATC must demonstrate competence before the unit endorsement is renewed; if this is not achieved before the current unit endorsement expires, the ATC is required to undergo a unit endorsement examination. Failure to meet the required standard following retraining results in license variation or removal.
**Summary**

Standards of safety in civil aviation are regulated by national bodies, in the case of European Union members in a manner consistent with European Union Directives and the European Aviation Safety Authority. The regulation of pilots and other safety-critical aviation personnel is by license, not registration. In the UK the Civil Aviation Authority is responsible for licensing pilots (and other aviation personnel). It specifies the mandatory standards to be met to attain and retain a license.

The concept of assuring fitness to practise, while not expressed in that way, is exercised through a process of revalidation involving periodic proficiency checks (which may be of knowledge, skills or general competence). Currency or recency requirements and health checks (requiring medical certification) are also mandatory and vary according to the type of license and ratings endorsements.

Detailed regulations spell out the schedule of requirements for revalidation for each type of license. For any particular type this might involve an annual proficiency check for some elements (ratings) and less frequent revalidation of others. Crucially, the checks use the same standards as apply for initial licensure. Failure to demonstrate competency to the satisfaction of an examiner in a proficiency check results in withdrawal of the privilege and can mean retraining and demonstration of competence through the knowledge and skills assessments that are used to determine competence for initial licensure.

**TEACHING**

Teaching is a regulated profession in most jurisdictions across the developed world. There are a number of core regulatory measures which appear to be common to most teacher regulatory authorities. Measures such as criminal records and police checks on first and subsequent registrations are not referred to in the analysis below because of their ubiquity. Rather, the emphasis is on other measures that can be construed as contributing to an assurance of continuing fitness to practise, or more accurately and as some regulators in this field express it, ‘fitness to teach’.

**England**

In England the regulation of teachers involved in the education of children and young people up to the age of 18 years has undergone considerable change over the last two years. The General Teaching Council was established by the Teaching and Higher Education Act 1998 to help improve standards of teaching and the quality of learning, and to maintain and improve standards of professional conduct among teachers. From April 2012 it was replaced by the Teaching Agency, a body which then ceased to operate just a year later when it merged with the National College for School Leadership to form the National College for Teaching and Leadership (NCTL).

The NCTL is a government agency created to enable and support the development of a ‘self-improving, school-led system’. With the abolition of the GTC, annual renewal of registration for teachers ceased. Considerable responsibility for managing teacher performance and conduct has been delegated to schools, although responsibility for dealing with the most serious misconduct is a power reserved to the Secretary of State.
Anyone who wants to teach in a state-maintained school in England needs to gain qualified teacher status (QTS) (although Academies can employ teachers without QTS if they believe they are suitably qualified). QTS can be achieved on completion of a period of initial teacher training designed to enable individuals to meet specified professional standards. New standards were introduced in 2012 (DfE 2013a) setting a baseline of expectations for professional practice and conduct of teachers from the point of qualification. These standards must be used to induct new teachers to ensure the quality of new entrants to the professions (DfE, 2013b). They are also used to assess the performance of all teachers who are subject to appraisal (The Education (School Teachers’ Appraisal) (England) Regulations, 2012), and may also be used by individual teachers to review their practice and to inform their plans for continuing professional development (DfE, 2013b).

The standards require teachers to “keep their knowledge and skills as teachers up-to-date” and to “take responsibility for improving teaching through appropriate professional development, responding to advice and feedback from colleagues” (DfE, 2013a).

Teacher appraisal is a mandatory requirement (The Education (School Teachers’ Appraisal) (England) Regulations, 2012) and is normally applied over a twelve month period (DfE, 2012). It involves classroom based teaching observations, rating and feedback throughout the year, and is used as the basis for annual objective setting and performance monitoring. Where the appraiser judges that performance has fallen below the standards expected, the teacher is notified in writing that the appraisal system will no longer apply and that their performance will be managed under the capability procedure. This is a formal procedure during which a continued failure to improve and to meet minimum standards could result in dismissal.

The Education Act 2011 gives responsibility to the Secretary of State to regulate teachers’ conduct and to hold a list of teachers who have been prohibited from teaching. A prohibition order is a lifetime ban imposed by the Secretary of State and means that the person concerned is not permitted to undertake teaching work unsupervised in schools or similar settings. It is likely to be imposed when a teacher’s behaviour has been incompatible with being a teacher and is used to protect pupils and maintain public confidence in the profession (DfE, 2013c).

**Wales**

In Wales a national regulatory body responsible for the statutory registration of teachers has been retained. The mission of the General Teaching Council for Wales (GTCW) is to protect the public by ensuring that teachers are appropriately qualified and maintain high standards of conduct and practice. Each registrant is required to pay an annual retention fee to remain on the register, but it does not appear that this is related to any formal demonstration or declaration of continuing fitness to teach.

Under the Education Act 2002 registration is mandatory for every qualified teacher who carries out specified work in a maintained school. Regulations setting out conditions of entry to and retention on the register are specified in statutory Rules (GTCW, 2013), and expectations regarding standards of practice and conduct are detailed in a Code of Professional Conduct and Practice (GTCW, undated).

The Code of Conduct requires teachers to “keep their professional knowledge and skills up to date throughout their teaching career” and “maintain an up-to-date knowledge of relevant guidelines and
educational developments in their phase of teaching/particular role, and teaching in general” (GTCW, undated). The GTCW makes the point that failure to comply with the Code “may call a teacher’s registration into question” and that it has legal powers to “investigate and hear cases of alleged unacceptable professional conduct, serious professional incompetence and criminal offences involving registered teachers” (GTCW, undated).

In Wales arrangements for appraisal (The School Teacher Appraisal (Wales) Regulations 2011) and performance management (WAG, 2012), including the use of teaching standards (WAG, 2011) and teaching observations, are not dissimilar to those described above for England. Procedures to address under-performance are the subject of separate regulations. The annual appraisal outcome statement does not form any part of formal disciplinary, competency or capability procedures. As teaching unions are keen to stress: “there is no direct link between appraisal and capability procedures. If a teacher’s performance is causing serious concern and evidence has been provided to demonstrate this then the informal stage of the agreed capability procedure should be used” (NUT/NASUWT, undated).

**Northern Ireland**

The General Teaching Council for Northern Ireland (GTCNI) has a statutory duty to determine who should be a member of the teaching profession in Northern Ireland. Registration is required by all teachers working in grant-aided schools; employing authorities are required to ensure that they only employ teachers who are registered with the GTCNI. Teachers are required to pay an annual retention fee to remain on the register but this does not appear to be associated with any declaration or assessment of continuing competence.

Despite claims to the contrary on its website, the GTCNI does not currently have the necessary powers to regulate the conduct or competence of the teachers it registers. It currently registers teachers based on their teaching qualifications and a number of ‘suitability checks’. However it is anticipated that the Council will get the necessary regulatory powers once a proposed GTCNI Bill passes through the NI Assembly and becomes law.

In Northern Ireland performance management takes place under the performance review and staff development scheme (PRSD). Each school has a legal responsibility to establish a PRSD policy, and it is the duty of the board of governors to ensure that training and development needs that are identified through PRSD are reflected in the school development plan, and that teaching staff are given adequate opportunities for professional development (ATL, undated). The process includes teaching observations as in the similar schemes in England and Wales.

**Scotland**

The General Teaching Council for Scotland (GTCS) is responsible for regulating the teaching profession in Scotland. The GTCS has a responsibility to ensure that teachers are ‘fit to teach’ by achieving and maintaining professional standards of competence (GTCS, 2012a) and conduct (GTCS, 2012b). By maintaining a register it seeks to provide assurances to employers, parents and children that teachers meet a national standard of teaching. GTCS registration is required to teach in any State school in Scotland. Teachers pay an annual registration fee to remain on the register (GTCS, 2012c).

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108 Personal communication from a GTCNI official, 16th October 2013.
Under its ‘Fitness to Teach’ rules (GTCS, 2012d) the GTCS investigates and considers complaints made by the public or employers concerning alleged misconduct or alleged incompetence, or upon notification by the police of a conviction for a criminal offence or in the course of applicant disclosure checks and vetting. In serious cases of misconduct, for example where there is a child protection issue, a teacher can be removed from the register. Separate procedures are set out in the *Framework on Teacher Competence* (GTC, 2012e) to deal with short-lived and long-running under-performance.

In addition to these measures the GTCS is currently developing a scheme of ‘reaccreditation’ at the request of the Scottish Government, a process it has decided to call ‘Professional Update’. The scheme is intended to “maintain and improve the quality of our teachers as outlined in the relevant Professional Standards and to enhance the impact that they have on pupils' learning”, and also to “support, maintain and enhance teachers' continued professionalism and the reputation of the teaching profession in Scotland”. The GTCS says the scheme is intended to focus on “continuous improvement rather than on determining whether or not a teacher is, or has remained, competent”; competence cases will continue to be handled by employers using the *Framework on Teacher Competence* procedures, with cases of alleged serious professional incompetence referred to the GTCS. The GTCS says that cases which lead to a formal review of competence “may be assisted by the improvements in professional review and development arising from the introduction of Professional Update”.

A recent presentation about the emerging shape of ‘Professional Update’ suggests that it will ensure that teachers are aware of their responsibility to consider their own development needs, provide an entitlement to a system of supportive performance review and development, and confirm that they are maintaining the high standards required of a teacher in Scotland (GTCS, 2013). Reaccreditation will be about “improving not proving” and will culminate in an annual update being submitted to the GTCS, including registrant and manager confirmation that the individual “has engaged in ongoing professional development in line with the GTCS Professional Standards, maintained a CPD record and portfolio of evidence, and has discussed the impact of this as part of the professional review and development process” (GTCS, 2013).

Following a period of development, consultation and refinement, the ‘Professional Update’ reaccreditation scheme is currently being piloted. National roll-out is planned to take place from August 2014.

**Other countries**

In New Zealand teachers are required to renew their ‘practising certificates’ every three years to retain full registration with the New Zealand Teachers Council. They may be asked to provide a copy of recent appraisals against the Registered Teacher Criteria (NZTC, 2009). A project is underway to help professional leaders to strengthen their systems to ensure their teachers and students benefit from appraisal as a professional learning and development process. In addition to personal declarations the application for renewal must be endorsed by a ‘professional leader’ confirming that the teacher is of good character and ‘fit to be a teacher’, has had satisfactory recent teaching

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experience, that the teacher’s performance has been assessed as satisfactory against each of the registered teacher criteria, and that the teacher has completed satisfactory professional development (NZTC, 2013).

In the Australian State of Victoria teachers are required to renew their registration with the Victorian Institute of Teaching annually (although it had been quinquennially until 2011). Registration renewal requires teachers to make a legally binding declaration that they meet an annual professional practice requirement (of 20 days teaching, equivalent practice or educational leadership in the previous twelve months, and 20 hours of ‘standards referenced’ professional development activities that update knowledge about pedagogy or practice). They must also satisfy the requirements for continued suitability to be a teacher to be able to renew their registration. The standards referred to are the national Australian Professional Standards for Teachers, which have been given Ministerial approval for implementation by the Institute during 2013 (VIT, 2013a), and are soon to be used by all Australian teacher registration and accreditation authorities.

To verify that the professional development activity relates to the professional standards the VIT advises teachers to keep documented reflections on the contribution of professional development activities to their professional knowledge and practice, and how it supports student learning, plus another form of documented reflection that addresses the professional standards in relation to the professional development activity (VIT, 2013b). This can be recorded online on the ‘MyPD’ site, available to all registrants. To audit the process a random sample of teachers are selected to verify their declarations about maintenance of professional practice.

Similar arrangements apply in other Australian States varying only in the level of prescription about continuing professional development and standards of competence and conduct. For example the Teachers Registration Board of Western Australia requires that all applicants seeking renewal of registration confirm that they have undertaken professional learning in respect of each of three professional standard domains (TRBNWA, 2013); but it recognises that activities across the three domains will vary according to the teacher’s situation and are likely to comprise both formal and informal learning and development (TRBNWA, 2012).

In New South Wales the Institute of Teachers (NSWIT) refers to teacher accreditation (rather than registration), describing accreditation as the structure through which teachers are recognised as meeting the national standards for teaching. The NSWIT says that continuing professional development – which is mandatory in New South Wales – should be aligned with a teacher’s career development (NSWIT, 2012). The Institute is currently working with others to determine the evidence and develop the procedures necessary to monitor the ongoing maintenance of teacher accreditation (NSWIT, 2013), in other words to assure continuing competence.

In Ireland the Teaching Council regulates the profession in the public interest and promotes professional teaching standards. It publishes a Code of Conduct for teachers setting out the standards of professional practice and conduct expected of them (TTC, 2012). It investigates complaints made against registered teachers and applies sanctions where appropriate, ranging from imposition of conditions on a teacher’s registration to suspension or removal from the Register.

Registrants are required to renew their registration annually on payment of a fee (TTC, 2013). The TTC’s Code of Conduct states that teachers have a personal responsibility for sustaining and improving the quality of their professional practice by “actively maintaining their professional knowledge and understanding to ensure it is current, reflecting on and critically evaluating their professional practice in light of their professional knowledge base, [and] availing of opportunities for career-long professional development” (TTC, 2012). The Council reviews and accredits relevant programmes but it makes no specific demands on registrants to affirm their continuing competence or to demonstrate that they have undertaken professional development when renewing their registration (TTC, 2013).

In March 2013 the Chief Inspector at the Department of Education in Ireland is reported to have said that formal teacher appraisal “is the least developed in Ireland”, observing that the Teaching Council would soon acquire the legal powers which would enable it to conduct inquiries into the “fitness to teach of any registered teacher” and to “remove teachers from the register and hence from eligibility for employment as a teacher in Ireland” (The Journal, 2013). His comments were prompted by a recent study which found that “at least four countries surveyed ...which are in the top 25 of the OECD’s Programme for International Student Assessment, do not have jurisdiction wide formal schemes (for example: Denmark, Finland, Iceland and Norway)” (Figazzolo, 2013).

Figazzolo observes that despite the fact that:

… *teacher evaluation takes place on a regular basis in many countries, and appears to be increasingly common, teachers (and unions) frequently indicate that principals and other senior staff often lack the time, tools or training to perform these evaluations satisfactorily.* (Figazzolo, 2013, p40).

She notes also differences in philosophy and approach, ranging from

… *a more formal, objective approach (eg as part of a formal performance management system, involving set procedures and criteria) to a more informal, subjective one (eg informal discussions with the teacher, interviews and definition of individual professional development plans)* … *Criteria typically include the subject and pedagogical knowledge of the teacher, some assessment of teaching methods, levels of in-service training and, increasingly, measures of student performance through standardised tests.* (Figazzolo, 2013, p39).

**Summary**

Many regulatory bodies for teachers have policies for periodic re-registration but few are associated with formal requirements to demonstrate continuing competence or fitness to teach. Where renewal of registration is linked to a requirement to undertake continuing education and professional development this is usually expressed as a professional obligation in a Code of Conduct and is affirmed through self-declaration. In some cases ‘professional leaders’ are required to endorse registrant declarations and to confirm their own assessments of the registrant’s continuing ‘fitness to teach’.

Other measures to assure teachers’ continuing fitness to teach include Government directed (mandatory) employer-led appraisal, including direct observation of teaching practice, other forms of staff development and performance review, and emergent schemes of reaccreditation. Teacher
appraisal – whether an employer (Government led) or professional (regulator inspired) initiative – is increasingly used in many countries.

Procedures to deal with poor performance are usually independent of employer appraisal schemes. Those jurisdictions that have professional-self regulation tend also to have established systems of professional conduct and discipline, providing a retrospective measure of assurance of continuing fitness to teach by responding to complaints and notifications of misconduct or incompetence.

Peer appraisal (even if the peers are selected by managers or professional leaders) that includes direct observation of practice provides a model that might warrant further scrutiny to assess its potential for application in other professions, including pharmacy. However as Figazzolo has observed, the evidence is that:

... for appraisal schemes to have value and to contribute to the quality of education, teachers need to be able to trust them and to consider them fair. Teachers value appraisal if they see that it can yield positive outcomes such as high quality professional development and relevant professional and career advice. (Figazzolo, 2013, p48).

CONCLUSION
In this chapter three non-health professions have been examined to review how each assures the continuing fitness to practise of the practitioners for whom it is responsible. A number of points can be made by way of conclusion.

Neither the accountancy profession nor the aviation profession enjoy the benefits of statutory regulation or the protection of title afforded most health professions. However certain of their activities are regulated by statute and there can be little argument that their occupational activities warrant oversight in the public interest. In contrast teachers do have regulatory bodies in most jurisdictions, which fulfil broadly similar roles to the health professions regulators. The move away from this model in England – where greater emphasis is being placed on the role of employers to regulate teachers – will provide a potentially valuable case study of an alternative approach that could have implications for other (currently) regulated professions.

Neither the accountancy profession nor the aviation profession refer to assuring the continuing fitness to practise of their members, but the concept of ‘fitness to teach’ is recognised within that profession. It is clear that all three professions subscribe to a model of competence maintenance, improvement and updating, an imperative expressed in codes of conduct, rules and regulations.

Many of the professional membership associations and bodies for accountants are established in the image of a regulated profession, with restricted entry, explicit standards of competence and ethical conduct, and disciplinary rules and procedures – and with continuing professional development a condition of continued membership. However, as voluntary membership organisations, these bodies are somewhat hamstrung when specifying and implementing assurance measures.

Periodic re-registration linked to fee-payment and evidence of continuing professional development is commonplace in those jurisdictions where there is an established teacher regulatory body. Self-declaration predominates but confirmatory endorsement by a professional leader of ‘fitness to teach’ is also required in some cases. There is evidence of an increasing use of regular teacher
appraisal and direct observation of practice as a means of assuring continuing fitness to teach; and also of a strengthening of development and performance review to underpin ‘reaccreditation’.

A different approach is applied in the aviation professions where international, European and national standards and regulations reflect a universal concern for public safety. In contrast to the registration approach typically adopted by the health professions, aviation authorities use licensing as the means to assess initial competence and to admit individuals to regulated and tightly defined occupational roles, and then through periodic but regular checks to revalidate an individual’s competence and fitness to operate (quite literally in the case of regular medical examinations). These regular tests of proficiency appear to be rigorous reassessments of continuing competence and specific job capabilities and inspire confidence that substandard performance will be detected. Arguably, this ‘live’ approach to licensure provides a greater level of assurance about continuing fitness to practise than is achieved in most other professions.
CHAPTER 5: CONCLUSIONS AND RECOMMENDATIONS

In this report we have drawn together information on how UK healthcare profession regulators, pharmacy regulators in different areas of the world and regulators for three other professions approach assuring the continuing fitness to practise of the practitioners they regulate. This section draws conclusions from our findings, which are historically bound by the time at which the work was undertaken and the information that is publicly available and relatively easily accessible. We then set out the options that appear to be available to the PSNI in taking forward its own developments in this area before making recommendations on the way forward.

CONCLUSIONS

Use of the term continuing fitness to practise

This review of approaches to assuring the continuing fitness to practise of professionals in the UK, and for pharmacy professionals in selected jurisdictions elsewhere in the world, has shown that:

- the term ‘assuring continuing fitness to practise’ is a relatively recent addition to discussions about regulation in the UK and is concentrated in healthcare. The concept implies a proactive approach to assuring that practitioners continue to meet standards of conduct, behaviour and competence, in contrast to the more reactive systems that are in place to deal retrospectively with conduct, behaviour or competence when something has gone wrong, also referred to under the rubric of ‘fitness to practise’
- the term ‘assuring continuing fitness to practise’ is not widely used by pharmacy regulators elsewhere in the world where the focus tends to be on renewal of registration linked to continuing professional development
- statutory regulation and/or protection of title which are commonplace among the health professions are not privileges extended to every profession; some other professions have to rely on the regulation of certain of their activities as the basis of standard setting and policing
- in the aviation professions where international, European and national standards and regulations reflect a universal concern for public safety, licensing is used as the means to assess initial competence and to admit individuals to regulated and tightly defined occupational roles, and then to periodically reassess continuing competence and specific job capabilities with the aim of detecting substandard performance
- the teaching profession is regulated in many jurisdictions by statutory bodies that have similar functions to health professions regulators in the UK, although it is noteworthy that in England statutory self-regulation has been repealed in favour of employers assuming greater responsibility for assuring fitness to teach
- evidence of risk-based approaches to regulation is very limited in the pharmacy jurisdictions that were surveyed and in the other professions, as well as being limited in UK healthcare professions regulation. This is often coupled with a paucity of information from regulators about how or why they have selected their policies to assure continuing fitness to practise.

CPD systems
Periodic renewal of registration (or licensing) and an associated requirement to undertake continuing professional development are the most commonly adopted regulatory measures to assure continuing fitness to practise among the professions studied. In the UK the approach tends to be at the more permissive end of the spectrum inasmuch as it is usually based on an adult learning cycle in which practitioners are viewed as best placed to identify their learning and development needs, to select and undertake appropriate continuing education and professional development, and to produce evidence of having done so. However a number of the UK schemes also operate some form of input requirement (such as hours or number of record entries) to provide clarity for practitioners and a form of evidence for the regulator to confirm that requirements have been met.

Most of the pharmacy regulators in other countries reviewed for this study, and the GOC in the UK, operate more tightly specified schemes which require completion of accredited continuing education, and which can also have some form of assessment linked to them.

The rigour regulators apply to confirmation of compliance can also be seen on a spectrum, ranging from those who ask for a declaration from the registrant at the point of renewal of registration / the end of CPD period (eg the HCPC and NMC) to those, such as the GPhC, where CPD returns are assessed to confirm that they meet the CPD standards and where feedback is given to registrants to help them improve in the future. All regulators refer to auditing a sample of registrant declarations and associated evidence but not all regulators provide details of sample size and frequency, how this is done, by whom, or against what standards. However there is published evidence in Australia of rigorous pilot auditing to establish the validity and reliability of audit processes.

**Broader approaches to assuring continuing fitness to practise**

The term ‘assuring continuing fitness to practise’ is now widely used by UK healthcare profession regulators. For a number this appears to have replaced the earlier focus they had on the term ‘revalidation’ (eg GOC, GOsC, GPhC) whilst for the HCPC this is the term it has used throughout. The GMC is the only healthcare profession regulator in the UK (and possibly in the world) to have implemented a revalidation system. The NMC has announced plans to introduce revalidation in 2015 whilst the GCC had plans to pilot revalidation in 2014 but these are now on hold whilst further consideration is given to the possible enhancement of CPD. Neither the NMC nor the GCC provide detailed information on the form that the systems will take.

There is a growing interest amongst the non-medical regulators in enhancing CPD as a more proportionate and effective means of assuring continuing fitness to practise or in introducing what might be termed ‘CPD Plus’. For the GOC this conclusion was reached after detailed work on the risks posed in optical practice and identifying cost-effective means of addressing these risks. For the GOsC it is a result of the outcomes of an extensive pilot of one stage of a proposed revalidation system. For the GDC the need to improve its CPD scheme is seen as a fundamental step on the path to a full revalidation system if such a policy is agreed. The GPhC appears to be moving in a similar direction.

**Good practice**

It is unrealistic in a study of this sort to make judgements about best practice because each regulator has to develop measures that are most appropriate and proportionate to the risks posed by their
registrants. We believe direct comparisons are problematic and not especially helpful. We have therefore used the areas that the PSA identify as characteristics of a right-touch approach to assuring continuing fitness to practise as a basis to identify good practice. These are summarised below.

**Core standards of competence and behaviour (ie conduct and competence)**

All of the regulators have standards of conduct and competence although the extent to which they are integrated, how they are presented and how they have been used in developing approaches to the assurance of continuing fitness to practise varies. The approach taken by the GMC to summarise the key elements of Good Medical Practice into 12 themes as the basis of a framework for appraisal and revalidation appears to show how the standards required of a practitioner in all areas of their practice can be condensed and explained simply. The extent to which a regulator would need to do this depends on the complexity and sophistication of the standards they use. There is evidence that some regulators have reviewed and developed their standards with the assurance of continuing fitness to practise in mind (eg GOsC, GDC) and the GPhC has indicated its plans to do so. The GCC is in the process of reviewing its standards and has stated that these will form the basis of assuring continuing fitness to practise.

**A clear understanding of what professionals (registrants) do and the context in which they do it**

We have found it difficult to establish how clear an understanding each regulator has of what their registrants do within the time and resources available for this project. However there are examples of such understandings (eg the workforce censuses undertaken by the predecessor body to the GPhC - the RPSGB – and the GMC’s now annual publications on the state of medical education and practice). The GOsC commissioned a project to understand better how its registrants practise which has fed into its understanding of risk, particularly as related to the context of practice.

**Severity and prevalence of risks relating to continuing fitness to practise guiding decision-making and the approaches used**

The development of a risk-based approach is one of the fundamental principles of regulation that has emerged over the last few years in the UK. A number of the healthcare profession regulators have undertaken detailed risk assessments (beyond an analysis of their fitness to practise case data) although these differ in approach and coverage. Some focus on the risks in the activity of the professions concerned (eg the GCC), others consider both the activity and the context (eg GOC) and some the context alone (eg the GPhC). The GOsC has undertaken a number of studies to explore different areas and perceptions of risk. Not all UK healthcare profession regulators have undertaken / published studies on risk (eg GMC and NMC) although this does not appear to have prevented them from developing or announcing systems for assuring continuing fitness to practise. The HCPC drew on information from its fitness to practise cases in 2009 as the foundation for its assessment of risk and then further developed the analyses through a more detailed statistical study. The GDC has a study in progress due to report at the end of 2013. Three of the regulators (GOsC,
GDC and GCC) have commissioned research into patient and public expectations of their practitioners.

Information on risks and the benefits and costs associated with addressing those risks is clearest in the work undertaken by the GOC, where it is possible to track a path through from risk assessment to potential ways of addressing those risks and then a costing of the different approaches. The GOsC also commissioned a cost-benefit analysis of its then proposed approach to revalidation although this was not carried through to completion following piloting. A cost-benefit analysis of medical revalidation was published in November 2012 immediately prior to the start of medical revalidation the following month (DH, 2012).

Use of existing mechanisms

There are various examples of the UK regulators using existing mechanisms to assure continuing fitness to practise, either those already in place within the regulator (eg the GOC’s use of CET) or in healthcare organisations (such as the use of annual appraisals in medical revalidation). Where devolved systems are used, the main costs of the assurance system appear to be covered by the state through NHS funding. Regulators have also explored the use of existing systems and found them insufficient as a basis for assuring continuing fitness to practise (eg GOC research into appraisal). Recent developments by the non-medical regulators (GDC, GOsC and the GPhC) suggest that increasingly they are following the path taken by the GOC, viewing CPD enhancement as the most cost-effective way to proceed for areas of practice where there is low risk.

Assessments made are sufficiently valid and reliable for the risks identified

The predominant themes that emerge in relation to assessment are:

- concerns about relying solely on self-assessment as the basis of the assurance process (eg GOsC) and for driving practitioner improvement
- the benefits of peer review that is structured to provide a measure of objectivity (eg GMC, GOC, GPhC and GOsC)
- the use of feedback from patients and service users (eg GMC, GOsC and HCPC).

Another key theme to emerge from the work of a number of regulators is the active engagement of practitioners in processes to assure continuing fitness to practise. For example, the GOsC considers active engagement to be a critical issue and in medical revalidation non-engagement is a reason for referral to the GMC. The GOC and GDC have plans to seek evidence to confirm CPD engagement every year and practitioner engagement might also be seen to lie at the heart of the research that the HCPC has taken forward on professionalism.

There appears to be no appetite generally for one-off assessments of practice of healthcare professionals (as with licensing in the aviation industry) to determine whether an individual is competent to remain on the register. In the context of other governance mechanisms, on patient safety and risk grounds, on economic grounds given the cost of educating and employing healthcare professionals, and on human rights grounds this appears to be a proportionate approach to take.
Transparency and accountability - the reasons for these forms of assurance being used and the levels of assurance that the approaches provide are made explicit and public

This report illustrates the level of availability and accessibility of information on some regulators’ websites. The GDC is explicit about the process that it has taken and the range of research that it has commissioned, as are the GOC and the GOsC. There is also a wealth of information on the GMC’s website although the genesis and development of medical revalidation is more difficult to track due to the numerous partners involved and the direct involvement of the UK government. There is however no published risk analysis of medical practice or any assessment of whether the current system of medical revalidation is the most appropriate response to the risks that exist. In relation to the other regulators, we are aware of work having been undertaken but that is no longer accessible via regulator websites (eg GCC), or where it might be assumed that what is available is not fully indicative of the work that has been undertaken (eg NMC, GPhC). There is little information from any regulator about how patients and the public have influenced the decisions that they have made.

Clearly, regulators will not be in a position to provide publicly accessible information about the level of assurance delivered by the approaches to assuring continuing fitness to practise they have proposed until after implementation.

This project also sought information on business cases and time frames.

Business cases

Little public information is available on business cases in support of particular approaches for assuring continuing fitness to practise although costs and benefits are presented for medical revalidation (DH, 2012), for the initial revalidation scheme proposed by the GOsC (KPMG, 2013b), and for enhanced CET by the GOC (Europe Economics, 2012).

The benefits of taking forward approaches to assuring continuing fitness to practise beyond what might be termed a standard approach to CPD include:

- improved patient safety and quality of care
- increased public trust and confidence
- earlier identification of issues in practice for the minority of practitioners whose practice is not up to standard
- removal of the minority of practitioners who are not fit to practise
- potential reductions in costs relating to legal fees, malpractice and litigation costs
- improvements in the quality of information about practice
- facilitating a positive cultural change.

However the difficulty of quantifying such benefits in monetary terms is considered to be challenging.

The costs include:
- direct costs - to registrants, to their employing organisations, to providers of CPD as well as to the regulator
- indirect / unintended costs (eg reduction in time spent on CPD by registrants due to the time spent completing information required for assessment / revalidation).

As well as costs each regulator has to consider its capacity to deliver such systems in terms of human and capital resources (such as the size of premises that might be needed to accommodate additional staff, IT capacity). Generally speaking larger regulators are likely to have greater flexibility than smaller ones.

**Time frames**

The time frames for implementation of measures to assure continuing fitness to practise vary. Some regulators (the GMC and GOC) have started implementation, others have plans to implement their approaches within the next two years (NMC and GDC) subject to legislation, while the GPhC is looking to 2018. Other regulators (eg GOsC, GCC and GDC for the possible revalidation of dentists) do not appear to have committed to a firm date. The HCPC appears to retain its original position that it has not established a need for any new or enhanced mechanisms. For all regulators the outcomes of the Law Commission review may affect decisions on timing and approach.

**OPTIONS**

The approaches to assuring continuing fitness to practise surveyed in the preceding chapters provide the context for the options discussed below. We suggest consideration be given to all four options. However, for the reasons outlined below, we recommend the fourth option as potentially the most productive way forward.

Options for developing a revalidation scheme for registered pharmacists in Northern Ireland fall into four broad categories:

1. Do nothing
2. Develop a revalidation model from first principles
3. Import and adopt (wholesale or adapted) an established revalidation model from another regulator (ie the regulator of another health profession, a pharmacy regulator in another country, GPhC or the regulator of another profession)
4. Strengthen existing PSNI regulatory policies and procedures to improve the assurance of continuing fitness to practise of pharmacists in Northern Ireland.

We have drawn out the advantages and disadvantages of these options in table 5.1.
<table>
<thead>
<tr>
<th>Option</th>
<th>Advantages</th>
<th>Disadvantages</th>
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</table>
| 1. Do nothing | a. Potentially defensible in the short-term if the purpose is to avoid unnecessary pre-emptive action and expenditure pending other developments | a. The Government & the PSA expects all health professions regulators to assure the continuing fitness to practise of their registrants based on risks  
b. The PSNI’s draft position paper on revalidation (PSNI, October 2012) sets out clearly the case for revalidation  
c. Awareness has been raised and the public and profession now expect that the PSNI will develop measures to assure the continuing fitness to practise of its registrants  
d. May create the impression that the PSNI is abrogating its responsibility to exercise leadership in assuring the public that its registrants remain fit to practise throughout their careers  
e. The GPhC announced at the end of 2013 that it would undertake development of a framework for assuring the continuing fitness to practise of pharmacists and pharmacy technicians in GB involving peer review, enhancing the review of CPD and external performance indicators. |
| 2. Develop a revalidation model from first principles | a. Will enable the PSNI to establish the underlying purpose, philosophy and objectives of revalidation  
b. Will enable a model best suited to pharmacy in NI to be devised and tailored to the characteristics of the NI registrant base and the professional and organisational structures within which registrants practise  
c. Potentially achieve a high measure of ‘buy-in’ through consultation & collaborative development facilitating subsequent implementation  
d. The PSNI might be seen to demonstrate leadership in public protection. | a. No obvious regulatory blueprints for revalidation (although elements of several of the pharmacy schemes reported provide helpful pointers to specific measures that might be adopted)  
b. Out of alignment with the proposals coming from the GPhC on assuring continuing fitness to practise and with the developments being undertaken in Ireland by the PSI – leading to questions as to why pharmacists in NI require a tougher regulatory approach.  
c. Inconsistent with the approaches coming from most other UK non-medical and non-pharmacy regulators  
d. No guarantee that the outcome would be any more robust than models arising from options 3 or 4  
e. Mandatory CPD only recently introduced by PSNI leading to |
Table 5.1: Options for the way forward for the PSNI

<table>
<thead>
<tr>
<th>Option</th>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
</table>
| 3. Import and adopt (wholesale or adapted) an established revalidation model from another regulator | a. PSNI has a robust mandatory CPD scheme comparable to the most comprehensive models in operation in other countries on which revalidation could potentially be built.  
b. Some elements of established schemes should be transferable (eg pharmacy regulators in British Columbia, Ontario and Alberta have experience of devising MCQ banks and administering invigilated computer based knowledge assessments; the Ontario College of Pharmacists has experience of devising and administering assessment centres and of training and using peer reviewers)  
c. The PSNI might be seen to demonstrate leadership in public protection.  
d. Although none of the professions reviewed in ch 4 use revalidation, the increasing emphasis on direct observation of practice and of peer appraisal in teaching, and the principle of regularly testing competence against initial licensure standards in aviation could be used as high revalidation thresholds against which to benchmark a proposal for pharmacists. | a. Regulatory contexts are different for each profession and tend to reflect varying professional, educational and regulatory histories, and in some cases markedly different registrant characteristics  
b. The standards of conduct and practice are unique to the profession concerned  
c. Principles of revalidation / processes for assuring continuing fitness to practise are that it should be risk-based and proportionate  
d. No other non-medical regulator has yet developed a revalidation system to import nor have pharmacy regulators in other countries  
e. The GPhC is not favouring the use of revalidation and is recommending different approaches to assure continuing fitness to practise – leading to inconsistency across the UK  
f. The PSI has not developed or announced the use of revalidation in Ireland using a model of CPD – leading to inconsistency across Ireland  
g. The GMC model is unlikely to be appropriate or feasible for use in pharmacy not least because of reliance on NHS structures which may not be available to a substantial section of the PSNI registrant population  
h. Mandatory CPD only recently introduced by PSNI leading to possible questions as to need for change so soon |
Table 5.1 sets out the broad options that the PSNI might pursue in taking forward its work on assuring the continuing fitness to practise of pharmacists in Northern Ireland.

Option 1 - doing nothing - whilst potentially defensible in the short-term in avoiding unnecessary pre-emptive action and expenditure, has a number of disadvantages including: not taking forward Government and PSA policy imperatives; a lack of consistency with the developments announced by
the GPhC for pharmacists and pharmacy technicians in the rest of the UK; and appearing to reverse the policy direction that the PSNI had already started to explore.

Option 2 - developing a revalidation model from first principles - has the potential advantages of demonstrating that the PSNI is demonstrating leadership in public protection by developing a revalidation model for NI pharmacists devised and tailored to their characteristics and the professional and organisational structures within which they practise. However there are a number of disadvantages. Politically the PSNI would find itself having to justify why the model for assuring the continuing fitness to practise of pharmacists in NI needs to be much stronger than the ones proposed in the rest of the UK by the GPhC and / or across Ireland. Such an action would need to be supported by clear evidence that the risks posed by pharmacists in NI are much higher than in the rest of the UK or Ireland. Practically the PSNI currently does not have a model of revalidation to take forward and is in the early stages of implementing mandatory CPD. This option is also likely to have the highest resource costs - financial, human and capital.

Option 3 - importing and adopting (wholesale or adapted) an established revalidation model from another regulator - appears to have some potential advantages in that there are elements of some established schemes (eg the MCQ banks, invigilated computer based knowledge assessments, assessment centres, the use of peer reviewers) that might be of relevance to an NI scheme. However, these elements would need to be combined with other measures to constitute a comprehensive model of revalidation for pharmacists in Northern Ireland. A major disadvantage of importing and adopting an established revalidation model is that the only regulator to have implemented a system of revalidation for its registrants is the GMC. Its model is unlikely to be appropriate or feasible for use in pharmacy not least because of its reliance on NHS structures. No other UK non-medical regulator has yet developed a revalidation model suitable for adoption by the PSNI and there is no evidence of a comprehensive model of revalidation among pharmacy regulators in other countries suitable for importation. As in the case of option 2, implementing revalidation for pharmacists in NI when it is not being taken forward in the rest of the UK is likely to raise some difficult questions for which there may be no satisfactory evidence based response.

Option 4 - strengthening existing PSNI regulatory policies and procedures to improve the assurance of continuing fitness to practise of pharmacists in Northern Ireland - has a number of advantages. These include: building on the work that the PSNI has already undertaken, not least the recently introduced, comprehensive scheme of mandatory CPD; enabling evaluation of the GPhC’s recent proposals and their applicability to pharmacy practice in NI, facilitating a UK-wide approach to assuring continuing fitness to practise; representing a feasible way forward in terms of resources whilst also potentially securing development funding from the NI Government. The disadvantages are that the mandatory CPD scheme has only recently been introduced to NI pharmacists and there might be development fatigue. There are also some resource implications. However, given that there was a relatively long run-up period to CPD being made mandatory, with support provided by the PSNI, it could be argued that developing this scheme further would be a natural consequence and development of its introduction, particularly if this is done over a reasonable timescale.

Weighing the advantages and disadvantages of each option highlights the relative merits of option 4 which provides a potentially appropriate and feasible way forward.
RECOMMENDATIONS

We offer a number of recommendations based on our review of current approaches to assuring the continuing fitness to practise of registrants by other regulators, and by reference to the PSA’s expectations for right-touch regulation.

We recommend that:

1. the PSNI does not develop a revalidation scheme for pharmacists in NI, either from first principles or through adapting another existing scheme, because:
   a. there is no evidence that the risks posed by pharmacists in NI are different to or greater than those posed by pharmacists practising elsewhere in Great Britain
   b. the pharmacy regulator for Great Britain is seeking to assure the continuing fitness to practise of their registrants through what might be construed as an enhanced system of CPD
   c. no other UK non-medical health professions regulator has yet developed a revalidation scheme for its registrants (although the NMC has signalled its intention to do so)
   d. the medical revalidation scheme being implemented by the GMC is unlikely to be appropriate or feasible for use in pharmacy, not least because of its reliance on NHS structures
   e. it would be difficult to justify that such a scheme is needed for NI pharmacists on the basis of the evidence currently available.

2. the PSNI seeks to strengthen its existing regulatory policies and procedures to improve the assurance of continuing fitness to practise of pharmacists in NI, building on the work undertaken to implement a comprehensive scheme of mandatory CPD.

3. in seeking to strengthen its existing regulatory policies and procedures, the PSNI evaluates the GPhC’s recent proposals and their applicability to pharmacy practice in NI so that a UK-wide approach is facilitated. This should specifically include evaluating the potential of three key components:
   a. incorporating a peer review process
   b. how reviews of individual registrant’s CPD might be improved
   c. using external performance indicators related to the registrant’s scope of practice and learning from the developments being undertaken by the GPhC as they proceed.

4. in this work, and in addition to the components of the GPhC model, the PSNI also:
   a. specifies standards against which continuing competence and performance can be assessed (which might be the current registration performance standards or competencies developed for the purpose)\(^\text{112}\)
   b. identifies ways in which practitioners can be actively engaged in understanding standards of conduct and practice and enabled to see the value of assuring continuing fitness to practise
   c. evaluates whether some forms of CPD are required to facilitate improvements in practice

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\(^\text{112}\) See for example the Core Competency Framework developed by the Pharmaceutical Society of Ireland (PSI, 2013).
d. evaluates whether current proposals for remediation in response to non-compliance with CPD standards are sufficient to deal with a failure to meet continuing fitness to practise standards, and if not, what system of support would be fair and appropriate whilst also protecting patients

e. develops a business case for enhancing its regulatory policies linked to the risks of pharmacy practice in Northern Ireland that such enhancements seek to address.

5. in the context that research and development funding has been afforded to other healthcare profession regulators in the UK through the Department of Health, the PSNI seeks development funding from the NI Government for taking forward policies to assure the continuing fitness to practise of pharmacists in Northern Ireland.
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ACRONYMS

AACP - American Association of Colleges of Pharmacy
ACCA – Association of Chartered Certified Accountants
ACP – Alberta College of Pharmacists
ACPE - Accreditation Council for Pharmacy Education (in USA)
AHPRA - Australian Health Practitioner Regulation Agency
AIA - Association of International Accountants
APC – Australian Pharmacy Council
APhA - American Pharmacists Association
ATCs - Air Traffic Controllers
ATPL - Airline Transport Pilots License
BRE - Better Regulation Executive
CAA - Civil Aviation Authority (in the UK)
CCCEP - Canadian Council on Continuing Education in Pharmacy
CE - Continuing Education
CET – Continuing Education and Training (used by the GOC)
CEU - Continuing education unit
CHRE - Council for Healthcare Regulatory Excellence (now PSA)
CIMA - Chartered Institute of Management Accountants
CIPFA - Chartered Institute of Public Finance and Accountancy
CPBC - College of Pharmacists of British Columbia
CPD – Continuing Professional Development
CPE - Continuing Pharmacy Education (in USA)
CRT - Competence Review Team (in New Zealand)
DH - Department of Health
EASA - European Aviation Safety Authority
FAP – Finnish Association of Pharmacists
Fimea - Finnish Medicines Agency
GCC – General Chiropractic Council
GDC – General Dental Council
GMC – General Medical Council
GOC – General Optical Council
GOsC – General Osteopathic Council
GPhC – General Pharmaceutical Council
GTCNI - General Teaching Council for Northern Ireland
GTCS - General Teaching Council for Scotland
GTCW - General Teaching Council for Wales
HCPC – Health and Care Professions Council (previously the HPC Health Professions Council)
HPCCA - Health Practitioners Competence Assurance Act 2003 (in New Zealand)
ICAEW - Institute of Chartered Accountants of England and Wales
ICAO - International Civil Aviation Organisation
IFAC - International Federation of Accountants
IR(A) - Instrument Rating for Aeroplanes
KNMP - Royal Dutch Association for the Advancement of Pharmacy
LPET – London Pharmacy Education and Training
MSAH - Ministry of Social Affairs and Health (in Finland)
NAPB - National Association of Pharmacy Boards (in USA)
NAPRA - National Association of Pharmacy Regulatory Authorities (in Canada)
NBPS – New Brunswick Pharmaceutical Society
NCAS – National Clinical Assessment Service
NCTL - National College for Teaching and Leadership
NHS - National Health Service
NI – Northern Ireland
NMC – Nursing and Midwifery Council
NSWIT - New South Wales the Institute of Teachers
NVZA - Dutch Association of Hospital Pharmacists
NZTC - New Zealand Teachers Council
OCP - Ontario College of Pharmacists
OJTI - on-the-job training instructor (in the aviation industry)
PARE - Pharmacist Assessment for Remediation Evaluation (run by the NAPB in the USA)
PBA - Pharmacy Board of Australia
PCNZ - Pharmacy Council of New Zealand
PDAP - Professional Development and Assessment Program (used in British Columbia)
PDP - Personal Development Plan
PEBC - Pharmacy Examining Board of Canada
PREP - Post-Registration Education and Practice (term used by the NMC)
PRSD - Performance Review and Staff Development Scheme (in teaching in Northern Ireland)
PSA - Professional Standards Authority (previously the CHRE)
PSI – Pharmaceutical Society of Ireland
PSNI – Pharmaceutical Society of Northern Ireland
QTS - Qualified Teacher Status
RWG - Revalidation Working Group
SAPC - South African Pharmacy Council
TRBNWA - Teachers Registration Board of Western Australia
Valvira - National Supervisory Authority for Welfare and Health (in Finland)
WAG – Welsh Assembly Government
Appendix 1: General Chiropractic Council CPD scheme

Standards and approach

The standards for Continuing Professional Development (CPD) are set out in the GCC’s Mandatory Requirements (GCC, 2003). This states that:

“Professional education and training is a continuum, embracing undergraduate, postgraduate and regular refresher training. CPD will enrich chiropractors’ lives through offering challenges and interest as they continue to work, and provide opportunities to take forward practice with others.” (GCC, 2003)

CPD is defined by the GCC as: “the process whereby chiropractors take responsibility for their own learning and development and apply it to improve their practice in the interests of patients and the development of the profession”.

The requirements are based on a learning cycle with the approach being that it is for chiropractors themselves to: know how the needs of their patients are changing, identify their own learning needs and interests, know their preferred ways of learning and identify the progress of their learning. To fulfil the CPD requirements chiropractors have to complete a CPD summary sheet annually consisting of:

- a report of one complete learning cycle – the learning needs and interests they identified, the learning activities they planned at the start of the CPD year, the learning activities they undertook to meet those learning needs and interests, and their evaluation of those learning activities
- a summary of the other learning activities undertaken in the year – as there is a requirement to complete at least 30 hours of learning activities each year of which at least 15 hours is learning with others (as chiropractors work in relative isolation from other members of the profession)
- an overall summary of all of the learning undertaken in the year showing both learning cycle activities and other CPD activities
- the registrant’s signature constituting a declaration that the content of the summary sheet is a valid reflection of their CPD and that they have met the requirements (GCC, 2012).

Whilst there are no specific requirements on the content and focus of the CPD, it is stated that registrants “need to link this learning to maintaining their competence against the Standard of Proficiency and the Code of Practice”. To show this, registrants are asked to state whether their learning is related to improved patient care, and/or the development of the profession. There is no indication within the Mandatory Requirements as to how these two categories cross-refer to the Code of Practice and Standard of Proficiency. The CPD guidance states that these two links were introduced to help chiropractors think about the areas and then goes onto explain the sort of learning that might relate to each (GCC, 2012 pages 6-7).
Accreditation

The GCC does not distinguish between accredited and non-accredited CPD activities and does not itself evaluate the quality of CPD. It is for registrants themselves to evaluate the learning that is likely to be most beneficial to them.

Records

Chiropractors are required to keep an up-to-date record of their CPD learning cycles and learning activities – the CPD summary sheet is intended to draw from this more detailed information. It is the summary sheet that is submitted annually to the GCC.

Registrants are required to keep their CPD records for seven years.

Assessment and audit

The GCC monitors registrants’ summary sheets for confirmation that they have met the CPD requirements (see above). The timing of the CPD year precedes that of the registration year to ensure that CPD requirements have been met prior to the renewal of registration. The GCC does not tell “individuals they have undertaken the wrong sort of learning, should have learnt something else or should have learnt in a different way. Nor will registrants have to seek GCC approval of their identified learning needs at any stage in the process.” (GCC, 2012, page 9)

The GCC seeks more detailed information (their full CPD records) from a sample of registrants each year to confirm that the summaries are a direct match with the fuller records. This includes seeking verification of payment receipts, attendance details, and informal notes and formal records of learning activities (such as lecture notes and handouts). Analysis of the information contained in the audited records is used to identify any further CPD guidance that is needed and trends in learning and development.

Developments

Whilst the GCC’s Mandatory Requirements for CPD (referred to above) do not specifically mention the link to continuing fitness to practise, the more recent CPD guidance states: “CPD helps chiropractors to stay up to date and fit to practise, with the aim of maintaining and improving the standards of practice for the benefit of patients and the public” (GCC, 2012, page 4).

In November 2011, the GCC announced in its 2012 – 2014 strategic plan a review of its CPD scheme (GCC, 2011b). This was described as including: a questionnaire to registrants, an opportunity for stakeholders to provide input and a review of research undertaken on CPD by other healthcare regulators, following which the next steps in the review would be decided. The CPD review was also to be informed by a system of revalidation under development. It is noted that changes to the CPD scheme before the end of 2013 are unlikely.\(^\text{113}\) The quantitative results of the questionnaire to registrants (465 responses – 16.9% of the registrant base) reveal that:

- just over half of respondents (53.9%) reported being clear as to what was meant by recording a learning cycle

• just under 60% (59.6%) reported that the distinction between identifying the learning they needed to do and planning how to undertake the learning was clear
• the vast majority saw the value of learning with others - 35.8% also felt that some forms of learning with others were valuable whilst others are not
• just over half (54.9%) stated that having some form of hours input measure was of value
• just over half (51.6%) saw value in recording all of their learning (ie the learning they do on their own as well as the learning they do with others)
• there were mixed views of evaluating and recording the learning undertaken with 43.8% stating that it was straightforward to describe how learning had been applied to practice.

As there is no qualitative analysis of the responses, it is not possible to unpick the meaning behind some of the statements made. There appears to be no further information on developments in the CPD scheme on the GCC’s website and it is not referred to as a separate activity in an update on delivering key activities in the Council’s strategic plan considered by the Council in August 2013\textsuperscript{114}.

Appendix 2: General Dental Council CPD scheme

Standards and approach

The Standards for the Dental Team, which came into effect on 30 September 2013, set out the standards of conduct, performance and ethics that govern all dental professionals (GDC, undated). These standards include nine core ethical principles of practice attached to which are:

- patient expectations – what patients can expect from the dental team
- standards – what dental professionals must do to meet patients’ expectations
- guidance – to help dental professionals meet the standards using their own professional judgment and by applying insight.

Principle 7 of the standards is: “maintain, develop and work within your professional knowledge and skills”. This includes providing “good quality care based on current evidence and authoritative guidance” and “update(ing) and develop(ing) your professional knowledge and skills throughout your working life” with the latter specifically referencing CPD requirements in the guidance.

Supplementary guidance on the principles is also available on the GDC website (eg for using social media)\(^{115}\). The Standards are also supported by learning materials, case studies and scenarios to assist registrants apply the standards in their work – collectively called Focus on Standards\(^{116}\).

The current edition of Standards for the Dental Team introduces the requirement that those who manage a team must display clearly in a public area the fact that dental professionals are regulated by the GDC and the nine core principles. Downloadable posters are available on the GDC website for this purpose\(^{117}\).

The GDC has also issued revised guidance on CPD that is consistent with the revised standards (GDC, 2013a). A report from the GDC’s Revalidation Working Group (RWG) (GDC, 2013b) to the new Council\(^{118}\) notes that the revised guidance consolidates the previous guidance on CPD but does not change it significantly. This is due to the need to change the CPD Rules before any substantial changes on CPD can be bought in. There is ongoing work with the Department of Health to seek to make these rule changes.

Mandatory CPD was introduced for dentists in 2002 and for dental care professionals in 2008 meaning that this broad group have just come to the end of their first full CPD five-year cycle. CPD is defined by the GDC as:

> lectures, seminars, courses, individual study and other activities, that can be included in (your) CPD record if it can be reasonably expected to advance your professional development

\(^{115}\) A full list of the supplementary guidance is available at: [http://www.gdc-uk.org/Dentalprofessionals/Standards/Pages/standards.aspx](http://www.gdc-uk.org/Dentalprofessionals/Standards/Pages/standards.aspx)

\(^{116}\) See [http://www.gdc-uk.org/Dentalprofessionals/Standards/cases/Pages/default.aspx](http://www.gdc-uk.org/Dentalprofessionals/Standards/cases/Pages/default.aspx)

\(^{117}\) See [http://www.gdc-uk.org/Dentalprofessionals/Standards/Pages/standards.aspx](http://www.gdc-uk.org/Dentalprofessionals/Standards/Pages/standards.aspx)

\(^{118}\) The GDC’s Council reduced in size and contained a number of new members for the start of the autumn 2013.
as a dentist or dental care professional and is relevant to your practice or intended practice”.
(GDC, 2013a)

Dentists are required to undertake a minimum of 250 hours of CPD over five years of which 75 hours must be verifiable. Dental Care Professionals need to undertake a minimum of 150 hours of CPD over five years of which 50 hours must be verifiable. Verifiable CPD is learning activity that meets the definition of CPD (see above) for which it possible to obtain documentary evidence of the activity and which has concise educational aims and objectives, clear anticipated outcomes and quality controls. If registrants are unable to obtain documentary evidence of learning they believe to be verifiable, they can use the learning as part of their total CPD hours but not for the verifiable requirement. Registrants have to use their own judgment as to whether a CPD activity is verifiable or not with advice from the provider concerned.

A CPD cycle is five years in length for all registrants and is determined by the date at which an individual first enters the GDC register with the CPD cycle starting on 1 January of the year after which the register is joined. The CPD five-year cycles keep running even if the individual is not on the register for a period of time; it is necessary for the individual to meet CPD requirements to be restored to the register.

The GDC expects that registrants will choose CPD activities that help them practise consistently with the Standards for the Dental Team. Registrants are encouraged to use a Personal Development Plan (PDP) to inform the decisions they make about CPD although this is not a requirement.

The GDC recommends certain topics related to patient safety that registrants might wish to consider for their verifiable CPD. These include: medical emergencies, disinfection and decontamination, and radiography and radiation protection. However these are recommendations not requirements although there is strong advice that registrants must keep up-to-date in these areas. Registrants are also recommended to undertake CPD on a regular basis (ie spread learning across the five year cycle) and learn with other members of the dental team, particularly when they are practising as a sole practitioner.

Registrants are encouraged as consumers of learning activity to be careful in evaluating the relevance, quality and cost-effectiveness of the CPD they undertake. CPD providers are encouraged to provide written feedback to users of the CPD and respond rapidly when complaints are made. The GDC notes that it will take seriously any mis-selling of CPD by its registrants.

Accreditation

The GDC does not accredit or approve CPD providers or learning activities. It is for registrants to decide the CPD activities that are relevant to them and to obtain documentary evidence of the learning when it is being used for verifiable CPD.

Records

Individual registrants are required to record: a description of each CPD item completed and whether or not it is verifiable CPD, the number of CPD hours for each item (excluding breaks and travel time) and documentary evidence of verifiable CPD.
Registrants are also asked to let the GDC know how much CPD they have done in any one year through reporting this through the e-GDC online system. This can be done on an ongoing basis or periodically on request from the GDC. At the end of the five year CPD cycle, the GDC will seek confirmation from each registrant that their CPD records for that CPD cycle are correct.

**Assessment and audit**

Registrants are required to retain their CPD records for five years after the end of a CPD cycle to allow the records to be audited if necessary. The audit consists of a check that the CPD return is capable of being supported by documentary evidence, specifically for the verifiable component. If the audit reveals that some of the verifiable activity does not meet the GDC’s requirements, then the GDC will not accept it meaning that an individual may no longer meet the CPD requirements.

If individuals do not meet the CPD requirements they can be removed from the register. If removed from the register then individuals have a right of appeal. Individuals need to fulfil the CPD requirements before being restored to the register.
Appendix 3: General Medical Council CPD scheme

Standards and approach

The GMC publishes separate guidance on continuing professional development (GMC, 2012d). CPD is described as:

“any learning outside of undergraduate education or postgraduate training that helps you maintain and improve your performance. It covers the development of your knowledge, skills, attitudes and behaviours across all areas of your professional practice. It includes both formal and informal learning activities.” (GMC, 2012d, page 7)

Its purpose is “to help improve the safety and quality of care provided for patients and the public” (page a2).

CPD is seen as an integral aspect of revalidation and doctors are required to take along a summary of their CPD activities to their annual appraisal to contribute to meeting the requirements of revalidation.

Doctors are responsible for identifying their own CPD (learning) needs, planning how they will address these, and undertaking activities to support their own professional development that are relevant to their practice and related to Good Medical Practice. It is noted that such consideration needs to cover all of a doctor’s professional practice, both clinical and non-clinical, as well as any management, teaching/training and research responsibilities that the individual has. Learning can take place informally as well as formally. It does not always need to be planned as such learning opportunities are seen as, if not more, valuable than more formal forms of learning. From time to time, the GMC identifies and publicises issues that it believes to be relevant to the CPD of all or some specific groups of doctors.

Doctors are required to reflect on their own practice and identify their own learning needs in relation to supporting patients and teams as well as use feedback from participation in clinical governance processes, audit and other forms of assessment. Consequently doctors are expected to maintain and manage their CPD on an ongoing basis and ensure its relevance to their practice. The GMC does not promote one way of undertaking CPD but recommends a variety of activities will facilitate different forms of learning. No minimum amount of CPD is required rather all doctors are given the responsibility for doing enough appropriate CPD to remain up-to-date and fit to practise. A number of the medical royal colleges have their own CPD schemes and guidance some of which include requirements to obtain a specific number of CPD credits over five years (GMC, 2012c).

Accreditation

The GMC does not accredit particular CPD activities, hold lists of CPD providers or award points or credits for learning activities. Other organisations, such as medical royal colleges, specialist associations and deaneries may accredit or approve CPD but responsibility for making sure that the learning that is undertaken is relevant and of good value rests with individual doctors.

Records
For CPD, doctors are required to record their reflections, learning needs, learning activities (both formal and informal) and learning outcomes – these records feed into appraisal discussions as part of revalidation.

The GMC does not normally ask to see the records of CPD activities but it is noted that the standards of practice require honesty and integrity and hence CPD activities must be recorded fully and accurately.

**CPD research**

Prior to issuing its revised CPD guidance in 2012, the GMC undertook a review of CPD following a recommendation in the Patel report on education and training (PMETB & GMC, 2010). This noted that as revalidation was intended to provide a new focus for doctors’ CPD helping to ensure that it was both effective and appropriate, there would be a need for the GMC to relook at its role in this area and, at the least, issue clear guidance on the role of CPD in revalidation and how it related to doctors keeping up-to-date (section 15). The same report emphasised the individual nature of CPD and hence the need to avoid rigid requirements which might only serve to undermine its most valuable aspects.

In the same year, the GMC published the outcomes of a study it had commissioned on the effectiveness of doctors’ CPD (Schostak et al, 2010). Using a mixed methods research design (including literature review, interviews and questionnaires), Schostak et al explored how consultants, from new to senior, understand their own learning or the learning of other doctors and how this learning relates to conceptions of CPD and its provision and uptake. The findings included:

- CPD is seen as learning about ‘doing the job’ and essential to effective practice and development within the profession
- CPD is linked to personal learning needs and related to appraisals and a means of addressing issues
- CPD having two broad forms: learning something new, and verifying that what you are doing is the same or similar to others’ practice
- CPD is used to systematise learning through, for example, the use of different approaches
- however as medicine varies widely there is a need for CPD providers to develop learning to support this range of practice
- learning opportunities tend to favour specific geographical areas (eg London and the south east)
- informal CPD is recognised as important and often significant but raises issues of rigorous assessment
- “effective CPD involves both ‘learning’ and being ‘fit to practise’, knowing both the ‘why’ and the ‘how’ and putting learning into practice”.

The GMC also commissioned a study to outline the medical CPD systems around the world and report more fully on any that were of particular relevance to the GMC’s work on revalidation (Murgatroyd, 2011). This noted that a number of countries were moving to mandatory CPD and away from previous voluntary CPD systems and with this there tended to be specific CPD standards and guidance developed. At the least regulatory bodies set a minimum number of hours or credits of CPD that doctors need to achieve each year, although there were examples of some going much
further requiring the formation of collegial relationships, specific CPD activities and participation in peer review (New Zealand). In both Canada and New Zealand, doctors were required to participate in specific CPD programmes. The consequences of not complying with CPD were reported as varying from country to country with the most severe sanction being withdrawal of registration (although as Murgatroyd points out it is difficult to establish whether and how often this occurs).

He reports that auditing is the most common method by which regulators both help to ensure that there is (a degree of) compliance and by which they check whether CPD is being undertaken as required. He reported a range of audit percentages from 15% in Ireland to 2.5% in Slovenia. Auditing most generally includes submitting a portfolio of CPD activities and evidence of the more formal aspects of CPD (eg conference and lecture attendance). Many countries have a retention of records policy for doctors’ personal CPD records (eg Canada six years) while some also require CPD providers to retain attendance registers.

Many medical regulators were reported as accrediting CPD activities and providers whilst some run their own CPD schemes or delegate the running to other organisations (such as medical societies, specialist colleges). Murgatroyd reports that a number of countries make participation in CPD a prerequisite for recertification (eg the Netherlands) whilst others link their schemes to re-registration. He notes that the Medical Council of Singapore planned to move to a system of revalidation and the federation of state medical boards in the USA were planning to legally mandate doctors to participate in a more robust form of CPD related to their area of practice and assessed using objective data sources (ie similar to a revalidation system).

Between 2010-2012 the GMC reviewed its regulatory role in CPD (GMC, 2011a) and consulted on its proposals for the way forward (GMC, 2011b). The consultation focused on three main areas: introduction of new revised CPD guidance, incorporation of the guidance into local processes of appraisal and personal development plans, and the GMC identifying and disseminating information about key trends and developments in medical practice. The consultation document emphasised the GMC’s view that:

- CPD should be driven by individual doctor’s needs, the needs of the people they work with and the organisations and teams they work in
- it is the GMC’s role to provide a framework for approaching their professional development and not prescribe specific activities
- doctors have personal responsibility for identifying and addressing their own development needs in the context of employers and contractors having a responsibility for ensuring their workforce is competent
- the GMC should not be a provider of CPD but does have a role in analysing the wealth of information it collects and sharing this more widely with individual doctors and learning providers encouraging them to offer more inclusive provision.

It is possible to see the principles on which the GMC set out its consultation carried through into the guidance it issued on CPD in 2012.

In 2012, the GMC commissioned the University of Sheffield and Capita Health to research the impact of CPD on doctors’ performance and patient / service outcomes (Mathers et al, 2013). The study
used semi-structured telephone interviews and in-depth interviews (60 in total), in both primary and secondary care settings, to address five research questions:

- How does doctors’ participation in CPD affect their practice and performance?
- How does participation in CPD contribute to improvements in patient or service outcomes?
- Can you identify examples of good or innovative practice in CPD?
- Can you identify examples where CPD may have contributed to changes to an individual’s practice and/or changes to the way care is provided either by a team or individual?
- Can you identify examples of barriers encountered by individuals or organisations when implementing aspects of or learning from CPD and how these barriers were overcome?

The evidence of the benefits of CPD ranged from anecdotal to hard outcomes that were capable of measurement. However Mathers et al reported a general belief that CPD will have benefits through implementation in practice although the timing of this is variable. In the case studies undertaken they reported that for some it was too soon to identify hard outcomes whilst, in other cases, the CPD was focused on rare events that were very unlikely to take place but for which it was necessary to receive training (eg anaesthetic resuscitation).

Barriers to CPD related to both undertaking it initially and then implementing the learning. The main barriers to undertaking CPD were reported as: time / workload, funding issues, protected time in consultant contracts, the location of CPD, and the ability to remove staff from delivering clinical services so that they can learn as a team. The barriers to implementing CPD learning in practice were found to be: time, tick-box mentality (eg in relation to obtaining credits or points), idiosyncratic approach to CPD, and lack of opportunity to implement learning. A wide range of things were seen to facilitate implementing CPD in practice including: CPD being part of a larger process such as appraisal and PDPs, revalidation, CPD being driven by strategic objectives, reflection (although many doctors struggled to know how to do this effectively), case-based / audit, benchmarking and financial incentives to implement learning.

Mathers et al (2013) reported seven broad themes to overcoming barriers to CPD as follows: acknowledging the time and effort required to implement their learning; the need for ongoing support over and above training; using routinely collected data to measure outcomes; simplicity; learning with peers; targeting of CPD; and winning hearts and minds. The researchers reported great variation in the attitude of senior management to CPD, including: ranging from being directive to laissez faire approaches, some seeing it as maintaining the status quo, perceptions of the lack of evidence for the impact of CPD, and the hope that was being placed in revalidation to link CPD to appraisal. The research also reported cultural differences between how CPD is organised in primary and secondary care, such as it being better integrated with appraisal in primary care.
Appendix 4: General Osteopathic Council CPD scheme

Standards and approach

There is a mandatory scheme of CPD for osteopaths registered with the GOsC whether they are practising full or part-time, in the UK or overseas or are not practising (GOsC, undated). New osteopathic graduates do not have to meet the CPD requirements for the first 10 months of registration providing that they apply for registration within three months of qualifying. This is due to them having completed an intensive course of training, likely to have limited financial resources and the GOsC not wishing to overburden them in the initial period of their career. Whilst mandatory CPD requirements only apply to registrants, individuals who leave the register and have the intention to return at a later date are advised to continue to undertake CPD so they can provide evidence of having done so when they reapply for registration.

CPD is described as ‘activities undertaken to maintain, enhance and develop existing knowledge and skills following the completion of a professional qualification’ (page 7) and it is viewed as of particular importance for healthcare professionals as their actions may have direct consequences for their patients. The GOsC’s CPD guidance sets out the benefits for patients, osteopaths and the profession of CPD including: improvements in the osteopathic care provided, reassurance that the osteopath is up to date, evidence of continuing competence, and showing the public that osteopaths take quality and safety seriously.

CPD activities can be any learning undertaken by an osteopath that may reasonably be expected to contribute to their own professional development or the development of osteopathy. As individual registrants come from different backgrounds and have different experiences and needs, they are seen as being best placed to identify their own learning needs and set their own learning objectives. Individuals are encouraged to identify their own aims and objectives for their CPD and to choose CPD that is most relevant to their needs. This should take account of: its level, the requirements of the mandatory scheme regarding hours and achieving a balance across the range of osteopathy practice (e.g. including osteopathic treatment as well as running a business). Osteopaths are advised to use a structured approach to managing their CPD through reviewing and reflecting on their learning needs, planning their CPD, undertaking it and evaluating their progress.

The CPD requirements for osteopaths are that they undertake at least 30 hours of CPD each year of which 15 hours must be learning with others. This is to address the potential isolation of osteopaths as many work on their own enabling them to learn and exchange ideas with others. Learning with others is ‘any relevant learning activity that involves interaction with osteopaths, healthcare practitioners or other professionals’ (GOsC, undated, page 11). Individuals can undertake all of their CPD learning with others if they wish to do so as there is no minimum requirement for learning on their own.

The timing of an individual registrant’s CPD year is two months prior to that of their registration year. At the end of the CPD year registrants are provided with a further month in which to complete and submit a CPD annual summary form. Any delay in submitting this form and showing they have

119 And further defined in the GOsC CPD Rules.
met the CPD requirements may delay or jeopardise the renewal of registration and license to practise.

There is no period of grace and the requirements should be met in the set period. Individuals who are concerned that they not meet the requirements within the CPD year are advised to proactively alert the GOsC in writing.

Accreditation

The GOsC does not accredit CPD activities and does not itself evaluate the quality of CPD, because it sees this as complex and resource intensive with the potential of limiting availability and raising costs. It encourages registrants to evaluate the CPD activities that might be useful for them and provides some ideas that they might wish to consider.

Records

Osteopaths are asked to make an annual declaration of having completed their CPD via a CPD annual summary form submitted online or on paper. This is designed to summarise the information contained in the individual’s CPD Record Folder that they are also required to maintain. This electronic or paper folder should contain items such as notes taken during research, evaluation of an article or reference material as well as notes/records from learning with others. It should be in chronological order. When recording the CPD activities they have undertaken, registrants are expected to link the records to specific activities or articles not, for example, just state they read a monthly journal. Registrants are also advised to keep in their CPD folder a copy of their summary form and any information on review, planning, justification for activities and evaluation of learning. Unplanned or opportunistic learning can be included as CPD activity as long as it is recorded appropriately.

The CPD summary form asks individuals to detail the CPD activities undertaken in the year (for example, containing references, purpose of practice meetings), a brief summary of how the activities are relevant to their work as an osteopath and the number of hours spent on each indicating whether it is learning with others or learning by oneself. Whilst it is recognised that many osteopaths will complete more than 30 hours of learning each year, the summary declaration form only needs to include the minimum hours requirement.

Osteopaths are required to retain their CPD records for a minimum of five years.

Assessment and audit

The GOsC checks the CPD annual summary forms to confirm that the CPD requirements have been met and this information is then used towards the annual renewal of registration. Failure to meet the requirements may result in removal from the register not unless there is evidence of mitigating circumstances. Outstanding CPD requirements need to be met prior to any restoration of registration.

The GOsC retains the right to challenge the choice of CPD activities of an individual registrant but this is only likely to happen when there is no obvious relationship with the purpose of CPD being to maintain and enhance their professional work as an osteopath.
Every year the GOsC samples a number of CPD record folders to verify their contents against the statements made by the individual on their CPD annual summary form.
Appendix 5: General Pharmaceutical Council CPD scheme

Standards and approach - CPD

The GPhC’s Standards for Conduct, Ethics and Performance set out the standards of conduct, ethics and performance that all pharmacy professionals must follow (i.e., pharmacists and technicians) (GPhC, 2012a). The standards are organised under seven broad principles that the pharmacy professional must undertake and as follows:

1. “Make patients your first concern
2. Use your professional judgement in the interests of patients and the public
3. Show respect for others
4. Encourage patients and the public to participate in decisions about their care
5. Develop your professional knowledge and competence
6. Be honest and trustworthy
7. Take responsibility for your working practices”. (GPhC, 2012a, page 6)\(^{120}\)

Principle 5 includes statements requiring pharmacy professionals to “maintain and improve the quality of your practice by keeping their knowledge and skills up to date and relevant to your role and responsibilities”, “learning from assessments, appraisals and reviews of your professional performance and undertake further education and training if necessary” and “undertake and keep up-to-date evidence of your continuing professional development” (GPhC, 2012a). The GPhC notes that it has not yet developed its standards of proficiency following the outcome of an initial consultation – the date for doing this is still to be determined\(^{121}\).

The GPhC also sets standards for the initial education and training of pharmacists (GPhC, 2011a) and of pharmacy technicians (GPhC, 2010a). The GPhC’s standards are supported by guidance in a number of areas to help pharmacy professionals to meet the standards\(^ {122}\).

The GPhC’s standards for Continuing Professional Development “ensure that pharmacy professionals maintain their knowledge and skills and remain up to date with practice. The CPD requirements apply equally to all pharmacy professionals and are not changed by factors such as part-time employment”. It is noted that patients, the public and the government all expect “every pharmacy professional to maintain their capability throughout the professional career”. (GPhC, 2010b)

The CPD standards for pharmacy professionals are brief and contained in five statements as follows:

1. “Keep a record of your CPD that is legible, either electronically online at the website www.uptodate.org.uk, on another computer, or as hard copy on paper and in a format published or approved by us and carrying the CPD approved logo.

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\(^{120}\) These are the same principles that are used by the GCC to structure its Code of Practice and were originally developed by an inter-regulator working group looking at the principles they had in common.


\(^{122}\) The different guidance notes are available at: http://www.pharmacyregulation.org/standards/guidance
2. **Make a minimum of nine CPD entries per year which reflect the context and scope of your practice as a pharmacist or pharmacy technician.**

3. **Keep a record of your CPD that complies with the good practice criteria for CPD recording published in Plan and Record by us** ([www.uptodate.co.uk](http://www.uptodate.co.uk)).

4. **Record how your CPD has contributed to the quality or development of your practice using our CPD framework.**

5. **Submit your CPD record to us on request.**” (GPhC, 2010b, page 7)

The CPD framework came into force on 2 July 2011 (GPhC, 2011b) and sets out in detail what pharmacy professionals must do in order to meet the CPD standards. The framework notes that given that the standards for conduct, ethics and performance require all pharmacy professionals to maintain and improve the quality of their practice (see principle 5 referred to above) registrants will need to undertake sufficient CPD for them to be able to do this.

The entries within the CPD record, and hence the learning that pharmacy professionals undertake and claim as CPD, has to be within the scope of pharmacy practice of the individual, address their learning needs within that scope of practice (including specialisations and environmental factors) and be structured against a learning cycle - reflect, plan, do and record.

*Plan and Record* - separate guidance produced by the GPhC - defines CPD as “a continual process of lifelong learning. It follows a cycle of four stages; reflection, planning, action and evaluation. It includes everything that you learn that makes you better able to do your job as a pharmacy professional” (GPhC, 2011c, page 4). CPD is described as a range of activities that helps individuals improve as a pharmacy professional including: conferences, courses, practise-based learning including feedback from patients and audits, critical incident analysis and review, self-directed learning, learning with others. CPD must be relevant to the individual’s area of practice, should include a mixture of different types of learning over a five year period and registrants are advised to focus on those activities that will have the biggest impact on their services, colleagues or organisation.

Registrants are required to structure their CPD records against the CPD cycle although it is recognised that not every learning experience includes every stage. It is a requirement of the CPD framework that a minimum of three of the required nine entries per year start at reflection and include the other three stages of the learning cycle as well. Evaluation is described as the most important stage of the cycle as it relates to reflecting on learning both in terms of the success of the learning activities and secondly how the learning has benefited or will benefit the individual’s practice. Every CPD entry must include an evaluation of what the individual has learnt and its benefits for development and practice.

To meet the CPD requirements:

- CPD record entries must cover the full review period (and if not, registrants must provide evidence for the period concerned such as illness or maternity leave)
- at least three of the entries must start at the reflection stage and cover the whole learning cycle
- across all of the entries at least half of the assessable criteria for good recording practice must have been applied.
The GPhC also offers guidance on good CPD practice including: keeping a learning portfolio and personal development plan, keeping CPD records up to date, and taking part in different types of learning (GPhC, 2011c).

Failure to comply with the CPD standards can put an individual’s registration at risk. When a pharmacy professional annually renews their registration they are required to declare that they will comply with the CPD framework. A CPD review mechanism is used to monitor that registrants have complied with the declarations they have made. The GPhC also notes that consideration of the CPD standards will also be taken into account if a concern is raised about a registrant.

Registrants can be required to undertake and record additional CPD activities if: the outcome of the CPD review shows they have not met the CPD requirements, following restoration to the register or as an outcome of Fitness to Practise cases.

**Accreditation**

There is no mention of accredited or approved CPD activities or providers in the GPhC documentation.

**Records**

The GPhC’s five standards for CPD focus on what pharmacy professionals have to record, that is in brief, keep a legible CPD record that complies with good practice criteria and record how your CPD has contributed to the quality or development of your practice. The record structure that pharmacy professionals have to use is set and is based on: reflection on practice, planning learning activities, action (ie what action the individual took to meet their plan) and evaluation. A briefer recording structure is available for recording unplanned learning.

**Assessment and audit**

The GPhC monitors registrants’ CPD records usually every five years but can call for them at any time for review. More frequent monitoring may also take place when, for example, registrants have been asked to undertake remedial CPD measures or have a poor history of regulatory compliance. The review covers the five year period prior to the date of review (or the period between the review date and the point of initial registration). Individuals who fail to submit their records in the allotted time may have their registration cancelled.

The GPhC records the outcomes of every review and retains the information on the Council’s registration database. The GPhC retains the records for five years.

The reviews are undertaken by a trained CPD reviewer appointed by the GPhC. Reviewers consist of both pharmacy professionals and people who are not from the profession. Appointment is on the basis of ‘ability to review information objectively against the review criteria’. The review criteria are:

1. “A CPD record has been submitted to the GPhC in the time specified by the Registrar.
2. The CPD record is legible and has been structured as specified in appendix 1 in a format published or approved by the GPhC.
3. The CPD record contains entries covering the full period of the review, or, where there are gaps in the record, an adequate explanation has been provided.

4. There are nine entries completed for each full year of the review period which are relevant to the safe and effective practice of pharmacy within the individual’s scope of practice, including any specialisations and the environment in which the individual practices. At least three of the entries completed for each full year start at reflection.

5. Entries within the CPD record comply with the GPhC’s criteria for good recording practice (outlined in appendix 3). Collectively, the entries demonstrate that at least half of the assessable good practice criteria have been applied”. (GPhC, 2011b, page 17)

There are 19 criteria for good recording practice split into two sections: the first and the largest relates to recording learning starting at reflection; the second to recording learning starting at action (unplanned learning).

The quality of each reviewers’ work is assessed. During the review process, registrants can be asked to provide supplementary information for verification purposes. Following the review, registrants are informed of the outcome of the review and feedback is given on their performance against the review criteria. They can also access a more detailed feedback report showing their strengths and weaknesses on the CPD cycle.

The GPhC’s CPD Rules set out a number of ways in which registrants may have failed to comply with the CPD requirements (eg they do not submit the record by the deadline, the record is not set out in the correct manner, there are insufficient entries) and hence not complied with the CPD framework (Statutory instrument 2011 No.1367). The Rules also state the procedures that the GPhC will follow. Mostly registrants would be asked to remedy the issue within a set timescale, however if they fail to do this or there are significant deficiencies then registration can be cancelled or annotations to the register indicating an area of speciality can be removed. Any instances of potential fraud or dishonesty in CPD will be dealt with through the GPhC’s fitness to practise procedures.
Appendix 6: Health And Care Professions Council CPD scheme

Standards and approach

The HCPC sets Standards of Conduct, Performance and Ethics which are applicable to all registrants and set the ethical framework within which they must work (HCPC, 2012a). 14 standards are detailed and each standard is further explained by guidance. The document states that: ‘the standards are written in broad terms and designed to apply to all registrants as far as possible. However, we recognise that some of the standards may not apply to all the professions that we regulate or to the practice of some registrants. The standards that might not directly apply to all registrants include standard eleven, which says that ‘You must deal fairly and safely with the risks of infection’. (HCPC, 2012a) Standard 5 is ‘you must keep your professional knowledge and skills up to date’ and the guidance makes reference to the fact that the standards for CPD link learning and development to continued registration.

There are also Standards of Proficiency for each profession based on a generic model and set at a level that the HCPC believes is necessary to protect members of the public.

The Standards for Continuing Professional Development define CPD as ‘a range of learning activities through which health and care professionals maintain and develop throughout their career to ensure that they retain their capacity to be able to practise safely, effectively and legally, within their evolving scope of practice’ (HCPC, 2012b). The standards are in the form of five broad statements stating that registrants must:

1. maintain a continuous, up-to-date and accurate record of their CPD activities
2. demonstrate that their CPD activities are a mixture of learning activities relevant to current or future practice
3. seek to ensure that their CPD has contributed to the quality of their practice and service delivery
4. seek to ensure that their CPD benefits the service user; and
5. 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.

The HCPC explain what this means for registrants which is:

- they must keep a record of their CPD – they can decide for themselves how to do this
- they must undertake different forms of learning relevant to their work, either their current role or a planned future role
- CPD should have the aim of improving the quality of their work
- CPD should have the aim of benefiting service users
- if selected for audit, registrants must send to the HCPC their CPD profile to show how they have met the standards. The HCPC will send registrants a CPD profile to complete and registrants must do this as well as send supporting evidence.

Within the HCPC CPD scheme registrants decide for themselves the CPD activity that is relevant to them, they can make use of schemes run by professional bodies or employers, can structure their
activities around their own personal development plan, and plan their own CPD in the way that suits them best. CPD activities include: work-based learning (e.g., learning by doing, case studies, reflective practice), professional activity (e.g., involvement in a professional body, lecturing or teaching, mentoring), formal / educational (e.g., courses, attending conferences), self-directed learning (e.g., reading journals / articles) and other (e.g., voluntary work, public service).

The HCPC has no specific input requirements in terms of hours of CPD as different people will have different amounts of time they can spend on CPD and also because the time spent does not reflect the learning gained.

When individuals renew their registration, they must declare they have met the CPD standards.

Accreditation

The HCPC does not approve CPD activities as it is thought that it is registrants who are best placed to decide the CPD activities that are most suitable for them.

Records

The HCPC has no specific requirements on the records that registrants have to keep of their CPD activities.

Assessment and audit

The HCPC audits a random sample of registrants who have been registered for more than two years and are renewing their registration to make sure the standards are being met. New registrants are given two years in which to build up their CPD evidence. The audit is run on the basis of professional groups and the HCPC publishes the dates of its forthcoming audits and the professional groups that will be involved. The first audits used a sample of 5% of the professional group but as the results were seen to be positive, this was reduced to 2.5% although this may change over time depending on the results found.

Individual registrants are contacted by the HCPC and sent a CPD profile to complete to show how the CPD the registrant has undertaken over the previous two years meets the CPD standards. The profile asks registrants to explain how they planned their CPD, decided on the activities they would undertake and how the CPD meets the standards. The most recent audit report states that assessor feedback indicates that registrants only need to report in detail on three to five activities over the last two years although they should list everything to show they have been undertaking continuous CPD (HCPC, 2012e).

Specific guidance is available for registrants who have been selected for a CPD audit although it is noted that other registrants who want to find out more about CPD might also find it useful (HCPC, 2012c). This states that ‘there is no automatic link between your CPD and your competence. This is because it would be possible (although unlikely) for a competent professional not to undertake any CPD and yet still meet our standards for their skills and knowledge’ (HCPC, 2012c, page 4). Further guidance is available for registrants on completing the CPD profile (HCPC, 2012d).

Registrants are able to contact the HCPC and seek deferral of the audit due to circumstances beyond their control, such as illness or maternity leave, and provide evidence of these circumstances. If the
HCPC accepts the reason, the individual will automatically be included in the next audit two years later.

The CPD profile includes:

- a summary of the individual’s practice history over the previous two years (maximum of 500 words) to help show how the CPD activities link to their work
- a statement of how they have met the CPD standards (maximum of 1500 words) explaining how the registrant believes they have met the standards and referring to all their CPD activities and the evidence submitted
- evidence to support the statement.

CPD assessors assess the CPD profiles received against assessment criteria linked to the CPD standards and based on a spectrum from ‘not met, partly met and met’. The assessors then inform the HCPC of whether the registrant has met the standards. CPD assessors are selected and trained and their performance reviewed. CPD assessors are senior members of the professions regulated by the HCPC and contracted as partners (HPC, 2010). Each profession’s CPD audit is assessed by two HCPC partners, at least one of which (though usually both) will be from the relevant profession.

There are three possible outcomes from the assessment of the CPD profile:

- the profile meets the standards – the individual is informed and remains on the register
- a request for further information
- the profile does not meet the standards and the assessors recommend either a three month time period to enable the registrant to meet the standards or recommend registration is ended. A three month time period is offered to those who appear to have completed their CPD profile honestly, met some of the standards and are likely to be able to meet the CPD standards within the time allocated.

Registrants can be removed from the register if they do not meet the CPD standards (with a right of appeal) and if a CPD profile is found to be fraudulent then the registrant would be referred to fitness to practise processes.

The most recent CPD audit report states that in 2009-10, 4,377 registrants were selected for CPD audit and 80.2% had their profiles accepted without further information being sought (HCPC, 2012e). There was variation across the professions ranging from 74.8% for chiropodists / podiatrists to 83.9% for clinical scientists. The HCPC interprets these figures as showing that the majority of registrants engaged in the CPD audit successfully with the guidance provided. Voluntary deregistering or lapsing as a result of being selected for CPD audit was at an average of 4.9% across the professions (and for prosthetists / orthotists stood at 9.1%). 16 of the 4377 registrants selected for the CPD audit were removed from the register either because they failed to submit a CPD profile or were assessed as not meeting the CPD standards. The HCPC plan to commission and publish a statistical report of the CPD audit to better understand the relationship between different variables (such as age, gender and route to registration) and to inform CPD audit reporting.
Appendix 7: Nursing And Midwifery Council current systems – CPD and midwifery supervision

Standards and approach

The NMC’s Code: Standards of conduct, performance and ethics applies to all registrants (NMC, 2008). The five broad statements are broken down into more detailed sub-statements. The fourth statement “provide a high standard of practice and care at all times” includes two statements relating to learning and maintaining knowledge and skills. They are: “you must keep your knowledge and skills up to date throughout your working life” and “you must take part in appropriate learning and practice activities that maintain and develop your competence and performance” (NMC, 2008, page 6).

The NMC also has standards of education and / or proficiency relating to nurses, midwives and specialist community public health nurses as well as for nurse and midwife prescribers (NMC, 2004, 2006, 2009a and 2010). The standards relate to the educational programmes that prepare individuals for the different areas of practice and are set at a level of entry to the register (or, in the case of prescribing, to prepare nurses and midwives to prescribe). There are also rules and standards for midwives as well as other standards relating to: the preparation and practice of supervisors of midwives, to support learning and assessment in practice (outcomes for mentors, practice teachers and teachers) and for medicines management. The NMC also produces guidance notes on: record keeping, raising concerns, the care of older people and professional conduct for students.

Post-Registration Education and Practice (PREP)

At present, nurses and midwives are required to meet the NMC’s Post-Registration Education and Practice (PREP) standards to remain on the NMC register. Renewal of registration takes place on a three year cycle and includes a requirement for individuals to sign a notification of practice form declaring they have met the PREP requirements and their health and character are sufficiently good to enable them to practise safely and effectively. The two PREP requirements that nurses and midwives have to meet to retain their registration are:

- the Prep (practice) standard – individuals must have worked for at least 450 hours in the previous three years as a result of their nursing or midwifery qualification (or completed an approved return to practice course)
- the Prep (CPD) standard – individuals must have undertaken and recorded 35 hours of CPD over the three years prior to their renewal of registration (NMC, 2011).

The aim of the practice standard is to “safeguard the health and wellbeing of the public by ensuring that anyone renewing their registration has undertaken a minimum amount of practice” (NMC, 2011, page 5). For midwives there is also the requirement to submit an annual intention to practise notification to their named supervisor of midwives (see later). The Prep practice standard can be met through paid or voluntary work. If individuals are not able to meet the required hours of practice within the three year period then they need to successfully complete an approved return to practice course to remain on or rejoin the register.
To meet the Prep (CPD) standard, nurses and midwives have to undertake a minimum of 35 hours of learning relevant to their practice during the three years and record it, maintain a personal professional profile of their learning and comply with any request from the NMC for their records to be audited.

**Accreditation**

The NMC does not approve CPD (Prep) learning activities.

**Records**

There are no specific requirements related to the recording of the CPD activities undertaken beyond it being documented within a personal professional profile. The NMC suggests that individuals might find it helpful to collect any routinely available information on learning (such as from appraisals or certificates of events) and advises that the record includes:

- a list and description of the individual’s workplace / organisation and their role within it
- the nature of the learning activities they undertake – dates and amount of time
- a description of the learning activities – what it consisted of, why it was selected / occurred, where it was, what it was and the learning objectives the individual hoped to achieve
- outcomes of the learning activities – the effect of the learning on the individual’s current or future work and any future learning that is planned as a result.

**Assessment and audit**

The NMC audits compliance with the Prep standard by asking registrants to complete Prep (CPD) summary forms on which they briefly describe their learning activities and the relevance of these to their work. Registrants may also be asked for evidence of their CPD activities (eg appraisal documentation, attendance and completion certificates). The NMC may commence fitness to practise proceedings against any registrant who is shown to have submitted fraudulent information. An initial sample of compliance with the Prep standards, from an audit of a random stratified sample of 100 registrants, showed that “the Prep standards are not fit for purpose in that they do not provide adequate assurance of registrants’ continuing fitness to practise”\(^{123}\)

The CHRE strategic review noted that stakeholders responding to its strategic review reported that the NMC had done little to check Prep standards (CHRE, 2012).

**Midwifery supervision**

Midwifery supervision is a statutory responsibility that aims to both support and guide every midwife practising in the UK, as well as offer protection to women and babies through the active promotion of a safe standard of midwifery practice (NMC, 2009b). The structure is as follows:

- the NMC - sets the statutory midwives rules and standards, provides advice and guidance to the Local Supervising Authorities (LSAs) and supervisors of midwives, and ensures that the rules and standards are met

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\(^{123}\) Quote from the revalidation web page - available at: [http://www.nmc-uk.org/Nurses-and-midwives/Revalidation/](http://www.nmc-uk.org/Nurses-and-midwives/Revalidation/) There does not appear to be any further information on the Prep audit process.
• LSA midwifery officers - carry out the functions of the LSA, develop and audit standards of supervision within the LSA and report to the NMC
• supervisors of midwives – are accountable to the LSA midwifery officer. They support and advise midwives and ensure their practice is consistent with the regulatory framework
• midwives – meet the needs and expectations of mothers and babies, act as an advocate for them, report any issues or critical incidents to their midwifery supervisor, and contribute to risk management and clinical governance.

Midwives need to meet at least annually with their midwifery supervisor. These regular supervisory review sessions are intended to evaluate practice and identify areas for development. Midwives must also inform the LSA of their intention to practise annually via their supervisor. Midwifery supervisors and LSA midwifery officers are separate from NHS provider or commissioning structure (ie they are not part of the management structure within which a midwife works). The relationship between a midwife and their supervisor is seen as being central to them being able to access the support they need, including gaining advice on ethical issues such as when there are tensions between professional and contractual accountabilities. Midwifery supervisors are experienced midwives who receive additional training and education for their role.

Midwifery supervisors are seen to promote safety by activities such as: providing leadership, supporting best practice and evidence-based care, and mentoring. They have a number of responsibilities described as:

• administrative – receiving intention to practise forms, ensuring midwives have access to requisite guidance and rules, reporting serious cases of misconduct to the LSA, and contributing to activities such as confidential enquiries
• interactive – such as: monitoring standards of midwifery practice through auditing records and assessing clinical outcomes, monitoring local maternity services, investigating critical incidents and identifying action and promoting learning
• developmental – supporting midwives learning and development, enabling midwives to evaluate their practice, and ensuring that there are systems in place for every midwife.

The organisations that act as LSAs are part of the NHS structure (eg health boards) although they differ across the UK. The role of the LSA midwifery officer is to act as a focus for any issues that are affecting midwifery practice within an area as well as contributing to the public health agenda. LSAs must report annually to the NMC and every LSA is subject to periodic review on a three year timescale.

The NMC has also produced guidance for mothers as to how supervisors of midwives can support them and their child(ren) (NMC, 2012). This explains that the midwifery supervisor is there to monitor the ability and behaviour of the midwife as well as advise parents on care options and listen to any concerns about their care. It explains their rights to contact the supervisor of midwives and how to do this as well, as how to make a complaint if they wish to do so.

The NMC publishes annual reports on the quality assurance of the LSAs. The most recent report covering 2011 – 2012 contains key findings relating to: birth rates, staffing challenges and the complexity of births; governance and risk management processes; investigations and outcomes; LSA annual audits; and the recruitment of midwifery supervisors. Key findings of note include:
• difficulty in recruiting a sufficient number of individuals of the right calibre to act as supervisors of midwives and provide the recommended ratio of 1:15 midwives

• the auditing of maternity services varied across the UK with some using a combination of formal and informal audit processes while others used themed audits. There is also evidence of involving service users / lay people in the local audits.

• through the supervisory framework, midwifery supervisors are able to identify concerns with the practice of midwives and highlight and address any issues through, for example, the use of structured reflection, further training, and if necessary supervised practice

• there has been an increase in complaints to LSAs from service users indicating that the role of midwifery supervision is being communicated more effectively

• 109 midwives (0.27% of the midwifery workforce) undertook a period of supervised practice for the year 2011 – 2012 and 25 midwives (0.07% of the midwifery workforce) were referred for consideration under fitness to practise mechanisms, a slight increase on the preceding year.