Council, 19 May 2016

Continuing fitness to practise

Executive summary and recommendations

Introduction

Continuing fitness to practise is an umbrella term used to describe the different approaches of the health and care professional regulators to assuring the fitness to practise of registrants beyond the point of initial registration. The HCPC's existing continuing fitness to practise model is based on the CPD standards and audits.

The attached paper summarises the background and context to this policy area; our existing model; our previous and ongoing research work in this area; and the approaches of the other regulators.

The paper highlights that the policy context has changed since 'revalidation' was first suggested for the so-called 'non-medical' professions in 2007; that there has been a move amongst the other regulators towards an enhanced approach to CPD requirements; and discusses the Executive's assessment that the research activities concluded to date do not seem to immediately indicate the need for any significant changes to our existing model.

Decision

The Council is invited to discuss the attached paper – in particular, the questions at paragraph 6.4.

The Council is invited to agree for the Executive to:

- progress amendments to the CPD guidance; and
- commission analysis to inform a review of our approach to auditing of CPD.

Background information

See paper and appendices

Resource implications

None as a result of this paper

Financial implications

None as a result of this paper

Appendices

- Appendix 1: HCPC's programme of work.
- Appendix 2: Summary of models developed or being developed by UK professional regulators.

Date of paper

9 May 2016

Continuing fitness to practise

Introduction

1.1 In 2007, the White Paper 'Trust, Assurance and Safety – The regulation of health professionals in the 21st Century' proposed that all regulated health professionals should be subject to some kind of periodic assessment to ensure that they continued to be fit to practise beyond the point of initial registration ('revalidation'; DH 2007).

1.2 In response to this report, we set up the Continuing Fitness to Practise Professional Liaison Group (PLG) to explore and make recommendations in this area. The PLG concluded that existing arrangements were appropriate and sufficient when considered in the context of the wider environment in which they operate and the risk of harm posed by the regulated professions. The PLG report, however, identified some areas for further research (HCPC 2009).

1.3 In 2009, the Department of Health awarded us a grant to undertake further research to explore the evidence base which would inform any new systems and to explore the feasibility of those systems (HCPC 2013). In 2015, the Department commissioned Newcastle University to look at the costs and benefits of the HCPC's existing approach (HCPC 2014).

1.4 The HCPC's existing continuing fitness to practise model is based on its CPD standards and audits.

1.5 This paper (and appendices) includes a summary and discussion of:

- the background and context to this policy area;
- our existing model;
- our previous (and ongoing) research work in this area; and
- the approaches of the other regulators.

2. Background and context

Definitions

2.1 There has generally been a lack of clarity about the definition of terms used in this area and considerable debate about the purpose and desired outcomes of the UK regulators' approaches.

2.2 The concept of 'revalidation' has its origins in the medical profession. The idea that doctors should be subject to some kind of periodic assessment of their fitness to practise came to prominence as a result of the Public Inquiry into the murder of patients by Dr Harold Shipman. However, proposals for the revalidation of doctors predated the Inquiry. It can be observed that the strongest political imperatives for revalidation have largely concerned the medical profession (with some attention focused on the nursing profession in more recent years).

2.3 In 2007, Trust, Assurance and Safety (DH 2007) defined revalidation as a 'mechanism that allows professionals to demonstrate that they remain up to date and fit to practise' (paragraph 2.2). The PSA has used a similar definition (PSA 2012).

2.4 In recent years, the term 'continuing fitness to practise' has started to be more commonly used as an umbrella term to describe activities including 'revalidation' but also other regulatory activities such as requirements for mandatory Continuing Professional Development (CPD). The PLG defined continuing fitness to practise as a holistic term describing 'all those steps taken by regulators, employers, health professionals and others which support the maintenance of fitness to practise beyond the point of initial registration' (HCPC 2009, page 7). The PSA has also adopted this term, suggesting that there is a continuing fitness to practise continuum, with auditing of 'self-reported CPD' at one end and 'formal revalidation' at the other (PSA 2012, paragraph 2.4).

2.5 Over time, references to revalidation have generally (though not exclusively) become specific to those arrangements put in place by the General Medical Council (GMC) for doctors. 'Medical revalidation', as it is frequently known, was introduced in late 2012.[1]

[1] The Nursing and Midwifery Council (NMC) have described their new process as 'nursing revalidation'. However, there are many features which are similar to those in place or being developed by the other 'non-medical' regulators. In this paper the NMC's model has been included amongst those considered in section five and in appendix 2.

Continuing fitness to practise, risk and cost-effectiveness

2.6 Risk and its management has been a continued theme in the policy informing the regulators' work in this area. In more recent years, there has also been an expectation that the so-called 'non-medical' regulators will have an evidence base for any new activities in this area which add to regulatory burden and, further, that they should develop and deliver activities within their existing legislative powers. 'Enabling excellence' (DH 2011) says that the Government will only agree 'additional central regulatory effort on revalidation' where there is 'evidence to suggest significant added value in terms of increased safety or quality of care for users of healthcare services' (paragraph 5.3).

2.7 In 2012, the PSA published its advice in this area. This said that the assurance of continuing fitness to practise 'can be and, in most cases, should be achieved by means other than formal revalidation' (PSA 2012, paragraph 3.4). They also identified a range of risk factors which might inform decisions about proportionate approaches in this area. They include factors related to context (e.g. level of practitioner isolation) and activity (e.g. complexity of task). The 'severity and prevalence' of any risks would inform decisions about the regulatory force required, with the level of assurance needed lower at lower levels of risk.

3. HCPC's existing model

3.1 Our existing continuing fitness to practise model is based around our CPD standards and audits. (The powers for which exist in the Health and Social Work Professions Order 2001 and a supporting set of statutory rules.) Some key points follow.

- The CPD standards were introduced in 2006 following an extensive consultation process. In summary, registrants have to keep a continuous record of their CPD; undertake a mixture of different types of learning which are relevant to their current or future scope of practice; and reflect on the benefits of their learning for their practice and for service users. The focus on the standards is on the outcome of learning – there are no input based requirements (e.g. points and hours).

- Audits began in 2008. The purpose of the audits is to check compliance with the standards but primarily to promote compliance amongst all registrants. Every two years at the point of renewal, 2.5% of each profession is sampled at random. Registrants are required to submit a profile which includes a statement describing how they have met the standards and attaching supporting evidence. Profiles are assessed by two CPD assessors (at least one of whom must be from the relevant profession).

- The audit process is designed to give registrants ample support and opportunity to meet the standards. Only a very small minority of registrants in each audit who have participated are removed from the Register as a result of non-compliance (normally 0-2 registrants in each audit). In every

audit there will also be approximately 5-10% of the sample who do not participate in the audit or renew as required and who are therefore removed from the Register. There will also be approximately 5-10% who request and are accepted for a deferral due to extenuating circumstances. They are automatically selected for audit next time around.

- The PLG considered the CPD standard and audits in the context of the other parts of our regulatory model including self-declaration against standards every two years and returning to practice requirements. (Some of the other regulators have included such arrangements under the umbrella of 'revalidation' or 'continuing fitness to practise' – see appendix 2.)

4. HCPC's programme of work

4.1 Appendix 1 provides a summary of the previous research / information gathering work that the HCPC has carried out in this area.

4.2 One of the activities was gathering information about other UK regulators' approaches – a more up-to-date summary and discussion is provided in Appendix 2 and in section five of this paper.

4.3 A separate paper is on the agenda at this Council meeting about the conclusion of the research undertaken by Durham University which looked at developing and piloting a professionalism tool.

4.4 Perhaps the most useful recent research has been the CPD perceptions and experiences study undertaken by QA research (HCPC 2015). This found (amongst the registrants, professional bodies and registrants that participated) that the CPD standards were generally well understood and that generally most did not consider that the standards or process needed to change. The research team also found that some registrants reported that the audit process had encouraged them to think about how they record their CPD and how they select which CPD opportunities to take.

4.5 The research suggested making changes to guidance and standard correspondence. The research findings have previously been considered by the Education and Training Committee. The changes to the guidance have yet to be progressed, pending the Council's discussion of this paper and the subsequent outcomes of the Newcastle University study (on the basis that it would not be prudent to progress changes to guidance should changes to the CPD standards or process be required first). The Newcastle study is due to report to the Department of Health in May 2016.

5. Continuing fitness to practise models amongst the non-medical professional regulators

5.1 Appendix 2 provides a summary of the models currently in place or being developed by the other regulators overseen by the PSA. The regulators are at various stages of developing and implementing approaches. The regulators as a whole have had different starting points.

5.2 Medical revalidation has involved the investment of considerable time and resources across the healthcare sector and harnesses the existing professional infrastructure in the medical profession, including the roles of the medical royal colleges. This is supported by legislation. It is clear that the UK Government would not contemplate extending this system to (or creating something similar in) the 'non-medical' professions, with all its attendant resource and financial implications (even if this was considered desirable). This section, therefore, discusses the approaches of the 'non-medical' regulators.

Enhanced CPD

5.3 Over time, there has generally been a move away from developing new systems or processes based on similar approaches to the medical revalidation model, toward those which are based on enhancements to the regulators' approaches to CPD. This is sometimes referred to as an 'enhanced CPD' or 'CPD plus' model.

5.4 This has been influenced by two factors. First, the change in Government policy towards proportionality to risk and cost-effectiveness. The likelihood that changes to legislation will not be made has meant that the regulators have had to focus on what can be achieved within their existing powers. Second, for some regulators, this approach has been influenced by the outcomes of consultations and/or pilots on previously proposed revalidation schemes. They have reconsidered their proposals because of concerns about proportionality and feasibility.

Risk and infrastructure

5.5 A number of the regulators have undertaken research and/or have sought to analyse the characteristics of fitness to practise cases to gain an increased understanding of the risk profile of the professions they regulate. There is evidence that this understanding has directly influenced the models developed or being developed by at least some of the regulators – for example, by requiring CPD activities on consent and communication (GOsC) or requiring peer review to combat professional isolation (GOC).

5.6 The models in place at different regulators also vary as a result of the profile and professional infrastructure for the regulated professions – for example, whether the profession typically practises in independent practice and the existence and reach of professional bodies, royal colleges, deaneries and the like.

Common features

5.7 There are a number of features common to some or all of the models developed or being developed by the other seven 'non-medical' regulators.

- A focus on reflection – such as via completion of reflective statements on CPD activities or third party feedback. (For most regulators, in addition to a points or hours based CPD requirement.)

- A requirement for a proportion of CPD to involve learning with others.

- A requirement to collect 'objective' evidence or to participate in 'objective activities' for which such evidence is possible.

- A requirement for some kind of 'peer-discussion' activity which involves discussing practice or reflecting on CPD activities with a peer or group of peers.

- Requirements to ensure that CPD is undertaken throughout the registration or CPD cycle – such as via a prescribed minimum of hours or points within a certain period.

- A greater link to competency and/or conduct standards – such as a requirement for CPD in each competency area.

6. Discussion

6.1 The Executive would make the following observations about this area of work.

- Since 'revalidation' for the 'non-medical' professions was first suggested, and the HCPC's programme of research began, the policy of Government has changed. The indications are that in any future legislation that might be brought forward, a flexible approach is likely to be adopted which provides regulators the ability to determine the arrangements they consider most appropriate and feasible for assuring continuing fitness to practise.

- Since our programme of work began, the HCPC Register has grown in size and we have taken on the regulation of three new professions. The programme of work has also evolved, with additional projects added around the perceptions and experiences of the CPD standards and Department of Health commissioned research into costs and benefits.

- Medical revalidation has to a great extent developed separately with stronger policy imperatives than for the other so-called 'non-medical' regulators. Medical revalidation has involved considerable effort across the system. Its evaluation is ongoing, with a large study being carried out by the University of Plymouth. The early outputs and outcomes of medical

revalidation, however, are not dissimilar to those that we have reported from our CPD model – the vast majority of doctors have been successfully revalidated, with doctors generally having their licence to practice removed as a result of non-engagement rather than non-compliance. The early benefits reported have included raising awareness of the benefits of reflection and encouraging CPD activity (Nath *et al* 2014).

- The movement towards 'enhanced CPD' amongst the 'non-medical' regulators has been influenced by an increased focus on evidence, cost and impact on the wider system. The models in place or being developed vary in complexity (in part based on professional group and professional infrastructure). However, there is a large degree of commonality, particularly in terms of a focus on reflection. The limited research evidence on the impact of CPD (much of which is focused on medical education) indicates that activities involving interactivity and approaches which promote self-reflection are most effective.

- The outcomes of learning and reflection are central to our existing CPD model. Perhaps of note compared to other developing schemes is that we do not include components which mandate features such as service user / multi-source feedback or peer discussion. However, if considered potentially of value, the feasibility of such approaches would need very careful examination. The most recent market research on stakeholder perceptions and experiences indicated that most stakeholders are content with our existing approach and there was no great clamour for greater prescription (with the caveat that this study did not engage with service users and the public).

- The research activities undertaken under this umbrella since 2009 have been useful, particularly our work on professionalism which has been very well received by stakeholders. However, the external policy context has changed during the lifetime of this work. The Executive has concluded that the outcomes of these activities, whilst useful, do not immediately seem to suggest the need for any significant changes to our existing approach in this area – in terms of changes to the CPD standards or the creation of new processes.

6.2 At a future meeting (once signed off by the Department of Health, timescale TBD), the Council will receive a paper which discusses the outcomes of the Newcastle University research and appends the final report. The outcomes of this work might potentially influence decisions in this area. The Executive has recently seen and commented on an early draft of the final report.

6.3 In addition, in any event, should our legislation change in the future as a result of any regulatory reform bill which is brought forward, the Council would need to keep this area under review to ensure that it continued to discharge its statutory responsibilities.

6.4 The Council is invited to discuss this paper and in particular to consider the following questions.

- Do you agree with the assessment that no significant changes to the HCPC's model appear necessary at this time?

- Do you think any further research is necessary and, if so, in which areas?

6.5 The Council is invited to agree the following proposal from the Executive.

- **Progress amendments to the CPD guidance**. Amendments to the CPD guidance taking into account the findings of the perceptions and experiences study should be progressed. These amendments might usefully draw registrants' attention to the value of third party feedback and interactive activities such as peer review as both CPD activities and activities which can help identify learning needs.

- If the above was agreed, a plan for completion of this work would be taken to the Education and Training Committee's June 2016 meeting. The Executive has tentatively planned that following a consultation revised guidance might be published in the spring of 2017, with activities to highlight it to all registrants, including a launch event to be held in Scotland.

- **Commission analysis to inform a review of our approach to auditing of CPD**. It might be valuable to review our existing approach to auditing of CPD which has been based on a random sample of 2.5% since 2009. The Executive proposes to commission some analysis / advice from statisticians to inform a decision by the Council about our approach in the future. (Such analysis previously informed the Council's decision making about auditing.)

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Appendix 1: HCPC's programme of work

Project	Description	Findings / key points
Review of existing revalidation processes that have been implemented by international regulators (2010) http://www.hcpc-uk.org/assets/documents/10003214201012090Council_11_revalidation_in_Ontario.pdf	Visit in 2010 to Ontario, Canada, to find out more about the quality assurance programmes put in place by five regulatory colleges.	• Approaches in Canada are focused primarily on improvement. • Evaluations had found registrant support for the programmes, but less definitive links to benefit to patients and the public. • The costs associated with these approaches could be significant – the Colleges reported that these programmes accounted for around 10% of operating costs. • Some interesting arrangements included approaches to sampling for CPD audit; and multi-source feedback tools as a way for registrants to identify their learning needs.

Appendix 1: HCPC's programme of work

Review of existing revalidation processes that have been implemented or are being developed by other UK regulators (2011) http://www.hcpc-uk.org/assets/documents/100036D0Enclosure06-Currentapproachestorevalidation.pdf	Report on the existing revalidation processes that were being developed by other UK regulators.	• The regulators had conceptualised risk differently – including risks associated with individuals (e.g. relative inexperience) and situations (e.g. lone working). • A variety of different approaches had been adopted in research examining risk including economic modelling; literature reviews; surveys of registrants; and analysis of complaints data. • Where firm proposals had been made, for most regulators the anticipated approach to revalidation was to be based on the threshold standards required for entry to the Register. • Most of the regulators were proposing a phased revalidation process by which the level of scrutiny of registrants increased at each stage. • All of the regulators were considering the role that CPD plays in revalidation.

Appendix 1: HCPC's programme of work

Professionalism in healthcare professions - qualitative study undertaken by Durham University (2011) http://www.hcpc-uk.org/publications/research/index.asp?id=511	Literature review and focus groups with students and educators in four different education providers and two professions: paramedics and occupational therapists. The research sought to explore what is perceived as professionalism by both students and educators and why and how professionalism and lack of professionalism may be identified.	• 'Professionalism' did not have a fixed definition but was a holistic, multi-dimensional concept covering aspects such as professional identity, professional attitudes and professional behaviour. This covered things such as communication and appearance. • Regulation was seen as providing basic guidance, providing a baseline for behaviour rather than a specification. • Professionalism had a basis in individual characteristics and values, but was defined by context including factors such as the following. o Organisational support. o The workplace. o Expectations of others (including role modelling). o Specifics of each service user / patient encounter. • Rather than a set of discrete skills, professionalism was instead a 'meta skill', knowing about what is most appropriate in a specific situation, drawing on appropriate technical and practical skills. • The research was well received and has been used by the HCPC in presentations and events as part of a growing focus for the regulators on how they promote professionalism.

Appendix 1: HCPC's programme of work

Service user feedback tools - literature review and Delphi consultation exercise undertaken by the Picker Institute Europe (2011) http://www.hcpc-uk.org/publications/research/index.asp?id=669	This study involved a literature review to explore 'standardised instruments' developed to gather service user feedback for the professional groups regulated by the HCPC. A Delphi consultation was also undertaken to identify areas of consensus on the use of service user feedback between individuals from professional bodies representing the professions regulated by the HCPC.	• There were relatively few instruments found relating to HCPC professions. They looked at areas of practice such as communication and respect for privacy. • Further evidence of the validity and reliability of standardised instruments is needed. In medicine, there were challenges in applying such tools in the summative assessment of doctors' performance. • Any approach to obtaining feedback for HCPC professions must be tailored to the professional group and, where appropriate, sub-sets of the professional group, and be designed according to judgements about the capacity and willingness of a particular service user group to respond to a particular form of assessment. • There was limited evidence of a clear link between the standardised instruments identified in the research and improved professional practice. • The overall conclusion was that although the case for measuring service user feedback is 'strong, the systems to do so are as yet imperfect and must continue to be developed in ways that accommodate the wide variety of contexts and service user groups encountered by HCPC registrants' (page 4).

Appendix 1: HCPC's programme of work

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Fitness to practise multi-variant analysis – data analysis undertaken by a researcher at Oxford Brookes University (2012) http://www.hcpc-uk.org/assets/documents/10003DCFenc06-RevalidationFitnesstopractisedataanalysis.pdf	This study looked at data from registrants who have reached a final fitness to practise hearing and where a sanction had been applied. It looked at the characteristics of registrants reaching final hearings and whether there were relationships with variables such as age, gender and route to registration. The study was a case control study. It compared two data sets – the first derived from registrants who had a well-founded fitness to practise case with a sanction applied; the second of a sample of registrants without any fitness to practise cases.	• Age, male gender, grandparenting application route and registration year within the last 10 years were found to be predictors of a well-founded fitness to practise case. • The research also looked at the independent effects of variables and found that age was not a significant independent predictor. • Male gender and grandparenting application route (based on a very small data set) were found to be significant independent predictors with the strongest relationships to well-founded fitness to practise cases.

Appendix 1: HCPC's programme of work

CPD perceptions and experiences – QA research (2015) http://www.hcpc-uk.org/assets/documents/10004CECEnc03-PerceptionsandexperiencesoftheHCPCsapproachtocontinuingprofessionaldevelopmentstandardsandaudits.pdf	Survey, interviews and focus groups with registrants and stakeholders. The purpose of this study was to understand registrants' and stakeholders' perceptions and experiences of the CPD standards and audit process.	• The CPD standards are well understood. • There was general agreement amongst the majority that no changes to the CPD standards were required. • There was general satisfaction with the audit process, but with some suggestions for improvements to feedback, guidance and standard letters. • There were mixed reports about the impact of the audit process. There was some evidence that the CPD standards / audits had influenced how registrants recorded their CPD and selected which activities to take.

Appendix 1: HCPC's programme of work

Professionalism tool - quantitative study undertaken by Durham University (2015)	See separate paper at this Council meeting.	See separate paper at this Council meeting.

Appendix 2: Summary of models developed or being developed by UK professional regulators

General Chiropractic Council (GCC)

Summary of arrangements	• The GCC has stated that it will ensure the fitness to practise of its registrants through an 'enhanced' version of its CPD scheme. • The scheme is being developed but will include: - A requirement for 30 hours of learning each year, of which at least 15 hours is learning with others. - The use of learning cycles as the basis for planning, undertaking and reflecting on learning. - In a three year period undertaking an activity which is objective, such as those involving case based discussion or patient feedback; a mandatory activity prescribed by the GCC from time-to-time (such as CPD on a topic identified as persistent in GCC complaints); and a peer discussion. - Annual sampling and audit of compliance. • The overall focus of the enhanced CPD scheme is formative, informing changes in behaviour for the benefit of patients.

General Dental Council (GDC)

Summary of arrangements	• The GDC has agreed an enhanced CPD scheme which it plans to introduce following piloting in 2017. • Dentists would be required to undertake 100 hours of CPD every five years and other registrants between 50 to 75 dependent upon their profession (a reduction in existing hours requirements). • New components of the enhanced scheme include: - A greater link to the GDC's standards through the introduction of learning outcomes to be achieved in CPD. - CPD will in future all need to be verifiable (e.g. capable of third party verification), on the basis that otherwise the GDC would not be confident that an activity has taken place or be confident of its quality. - Registrants required to undertake at least 10 hours of CPD every two consecutive years. - Annual declarations to the GDC about CPD recording and number of hours achieved. The GDC says that this will help provide 'continuing assurance for patients and the public that those on our registers continue to be up to date and fit to practise'. This could be the first phase to develop 'a fuller scheme of continuing assurance'.

General Medical Council (GMC)

Summary of arrangements	• Medical revalidation was introduced from late 2012. Doctors who hold a licence to practice are required to revalidate every five years. In summary, the process involves the following. - Doctors must undergo an annual workplace appraisal. The appraisal covers their whole medical practice and is based upon the GMC's core guidance – Good medical practice. - Doctors must be connected to a 'designated body' which carries out the appraisal and supports them in meeting the revalidation requirements. This is normally their employer (or an employer if they have more than one), but alternative arrangements exist for doctors for whom this is problematic. - Doctors must demonstrate in their appraisal that they have collected and reflected upon: CPD activities; quality improvement activity; significant events; feedback from colleagues; feedback from patients; and a review of complaints and compliments. - Every five years, a Responsible Officer (RO) at the designated body will make a recommendation to the GMC about the revalidation of each doctor. The RO is normally the medical director of that body. - The RO can recommend that the doctor is revalidated because they consider they are up-to-date and fit to practise; recommend a deferral because they need more time or more information to make their decision; or make a recommendation of non-engagement. - The GMC is able to withdraw a licence to practice from a doctor who fails to complete successfully their revalidation.

General Optical Council (GOC)

Summary of arrangements	• In 2013, the GOC introduced an enhanced version of its Continuing Education and Training (CET) programme. Key features include the following. - Registrants are required to log their CPD on an ongoing basis. - 36 points are required in a three year cycle, with at least 6 points being gained per year. - The GOC approves all CPD activities, weighting activities which involve interaction and which support reflection – so, for example, peer discussion will accrue more points than attending a lecture. - Half of the total number of points must be interactive learning activities. - Registrants must undertake activities across all of the competency units for their professional group, with extra requirements for those with additional entitlements (e.g. therapeutic prescribing). - At least one point must be from a peer review activity – such as a registrant-led discussion group or peer review activity. - Registrants are required to complete reflective statements for the activities they undertake.

General Osteopathic Council (GOsC)

Summary of arrangements	• The GOsC's revised CPD scheme will include the following. - 90 hours of CPD in a three year cycle, 30 hours each year. - At least 45 hours must be activities which involve learning with others. - Registrants will need to undertake activities in each of the four areas of the osteopathy practice standards. - At least one activity must be objective: patient feedback; peer review or observation; clinical audit; or case-based discussion. The osteopath will have to demonstrate their reflection and what they have learnt. - Every three years, an activity on consent or communication will be required (on the basis that these are the areas that generate most complaints). - At the end of the three years, the osteopath will be required to discuss their compliance with the standards as evidenced in their CPD folder with a peer ('peer discussion review'). This will be documented. • The GOsC will undertake audits of osteopaths' CPD folders to check compliance. • The revised scheme will be phased in from late 2016.

General Pharmaceutical Council (GPhC)

Summary of arrangements	• The GPhC is developing its continuing fitness to practise scheme through an ongoing programme of research, engagement, testing and piloting. The component parts of its model will be: - Annual renewal and the associated declarations (existing activity). - Continuing professional development (CPD) activities and the recording of them (considering changes to existing arrangements). - A peer discussion (new activity). - A case study on a change to practice for the benefit of patients or service users (new activity). • The GPhC are piloting their new model from April 2016. • The GPhC's existing CPD process is based on a five year cycle which involves keeping a record of CPD (in line with GPhC guidelines which focus on reflection); making at least nine entries a year in the record that reflect the registrant's scope of practice; and recording how the CPD has improved or developed practice. The GPhC reviews every registrant's CPD record over a five year period.

Nursing and Midwifery Council (NMC)

Summary of arrangements	• The NMC has introduced a 'revalidation' model, effective at renewal from 1 April 2016. • The NMC's revalidation model involves the following: - 450 practice hours over three years. - 40 hours of CPD every three years, at least half of which must be participatory learning (i.e. learning with others). - 5 pieces of practice related feedback has to be collected every three years (i.e. feedback from students, service users, colleagues, patients). - 5 written reflective statements on CPD or feedback collected. - Discussion of those reflective statements with another NMC registrant. - Health and character and professional indemnity declarations - Sign-off from a confirmer who would normally be the registrant's line manager. The confirmer is expected to have a face-to-face meeting with the registrant to assure themselves that the nurse has met the revalidation requirements. • An application for revalidation is made by the registrant at their three yearly renewal. The NMC will then audit a sample of registrants to ensure compliance, by asking them to upload further information – for example, evidence of their third party confirmation.

Pharmaceutical Society of Northern Ireland (PSNI)

Summary of arrangements	• The PSNI says that it expects that its system of continuing fitness to practise will be based on its CPD standards. However, no other information is available from its website about what form this model might take. • The PSNI's CPD model is similar to that in place at the GPhC. Pharmacists have to keep a record of CPD; undertake 30 hours of CPD each year; and complete at least four CPD records for each cycle. The requirements also focus on the pharmacist undertaking planned activity which is relevant to the safe and effective practice of the profession and the individual's scope of practice.

Source: Information readily available from regulatory bodies websites. Accurate as at March 2016.