Principles for Revalidation

Report of the Working Group for non-Medical Revalidation

Professional Regulation and Patient Safety Programme
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Revalidation Principles

This report from the non-medical revalidation working group outlines the principles that regulatory bodies will consider when preparing proposals for the revalidation of their professional groups.

Gavin Larner, Chair of the Working group on Non-Medical Revalidation
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Executive Summary

Revalidation is a mechanism that allows health professionals to demonstrate that they remain up-to-date and can demonstrate that they continue to meet the requirements of their professional regulator. Revalidation confirms that the registrant is practising in accordance their regulators professional standards and will identify for further investigation, and remediation, poor practice where local systems are not robust enough to do this or do not exist.

The White Paper *Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century* (February 2007), set out our proposals to ensure that all the statutorily regulated health professions have arrangements in place for the revalidation of their professional registration through which they can periodically demonstrate their continued fitness to practise. We continue to support the principle of revalidation and will develop a timetable for ensuring the process will encompass all health professionals over the next five years.

The White Paper endorsed the recommendations of the review led by Andrew Foster on ‘The regulation of the non-medical healthcare professions’. We agree that the regulatory body for each non-medical profession should develop the professional standards that the registrant will need to meet and demonstrate by provision of evidence to maintain their registration. It will be important that those standards and arrangements for assessment are proportionate to the risk that each profession may pose to the public.

The non-medical revalidation in developing this key principles paper, took account of the five principles\(^2\) for good regulation as identified in the Better Regulation Task Force report *Regulation – Less is More: Reducing Burdens, Improving Outcomes*. The key principles for the development of non-medical revalidation proposals are summarised in table one on page 6.

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The Better Regulation Executive (BRE) is part of the Department for Business, Enterprise and Regulatory Reform (BERR) and leads this regulatory reform agenda across government.
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1. Introduction

1.1 The UK Government White Paper *Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century*\(^2\) endorsed the findings of the Foster Review *The Regulation of the Non-Medical Healthcare Professions*\(^3\) that revalidation is necessary for all health professionals (see Annex A for the relevant extract from the White Paper). The White Paper set out the key principles that will underpin the regulation of health professionals over the next decade. It also acknowledged that professional regulation should be as much about sustaining, improving and assuring the professional standards of the overwhelming majority of health professionals as it is about identifying and addressing poor practice or inappropriate behaviour.

1.2 The primary purpose of revalidation is to enhance public protection by ensuring that health professionals in clinical practice are up to date and demonstrate that they continue to meet the requirements of their professional regulator. Revalidation confirms that the registrant is practising in accordance their regulators standards and will identify for further investigation, and remediation, poor practice where local systems are not robust enough to do this or do not exist.

1.3 The Government agrees that the regulatory body for each non-medical profession should approve the standards that registrants will need to meet to maintain and renew their registration on a regular basis. Where appropriate, common standards and systems should be developed across professional groups where this would benefit patient safety.

1.4 Revalidation is necessary for all health professionals in clinical practice, but its intensity and frequency needs to be proportionate to the risks inherent in the work in which each practitioner is involved. Working closely with the Devolved Administrations, the Department of Health will discuss with each regulator the most appropriate arrangements that are proportionate to the risk that each profession may pose to patients.

1.5 In order to support delivery against the actions identified above, this paper sets out the high-level principles that will guide the development of models of revalidation for the non-medical professions by the following healthcare professional regulatory bodies:

- General Chiropractic Council;
- General Dental Council;
- General Optical Council;
- General Osteopathic Council;
- Health Professions Council;
- Nursing and Midwifery Council;
- Pharmaceutical Society of Northern Ireland and
- Royal Pharmaceutical Society of Great Britain.


\(^3\) *The Regulation of the Non-Medical Healthcare Professions*(2006) COI DH
1.6 The Non-Medical Revalidation Working Group was one of seven working groups established to take forward the recommendations in the 2007 White Paper, *Trust, Assurance and Safety - The Regulation of Health Professionals in the 21st Century*. The working group was chaired by Professor Jim Smith in 2007 and latterly by Gavin Larner, Director Professional Regulation, Department of Health. This paper draws upon discussions held within the working group. The Council for Healthcare Regulatory Excellence convened and provided secretariat services to the group’s meetings. The report from the medical revalidation working group was published on the 23rd July 2008 and charted the way forward for medicine.

1.7 The group’s primary objective was to set out the way forward to implement the White Paper’s intention to introduce a new model of revalidation for non-medical health professions. The group’s members had been invited both as the leaders of key organisations and for their personal practical experience of the issues. The group met between July 2007 and July 2008. The meetings were used to discuss and refine the key components of revalidation and to examine and resolve concerns and potential problems, in order to identify practical steps that would support the development of an implementation strategy by the key stakeholders.

2. Background

2.1 In preparing this paper, the Group took account of the five principles for good regulation as identified in the Better Regulation Task Force report *Regulation – Less is More Reducing Burdens, Improving outcomes*. The Legislative and Regulatory Reform Act (2006) came into force in January of 2007 to underpin the principles. These principles were put in place to ensure regulatory activities are carried out in such a way that they are:

- Transparent;
- Accountable;
- Proportionate;
- Consistent; and
- Targeted where action is needed.

2.3 It was acknowledged by the group that these principles will help the regulatory bodies for non-medical healthcare professionals develop proposals for revalidation including the systems and processes and to provide advice on the piloting required. The UK Government, working in partnership with the Devolved Administrations, agreed in the White Paper that each

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5 Legislative & Regulatory Reform Act (2006) LRRA - This Act included powers to remove or reduce regulatory burdens (the definition of burden includes financial, administrative, an obstacle to efficiency, productivity or profitability or a sanction which affects the carrying out of an lawful activity) and a power to promote regulatory principles where a Minister of the Crown may, by Order, make any provision that would ensure that regulatory functions are exercised so as to comply with the principles listed above. NB parts of this Act vary in Scotland, Ireland and Wales.
statutory professional regulator would be responsible for approving the standards that registrants would need to reach and maintain to secure their initial and continuing registration (full text at Annex A).

The twelve principles agreed on by the group have been cross-referenced to the five principles from the Better Regulation Executive.

2.4 Definition of terms used in this document:

- **Patient**: a person who receives care or treatment from a healthcare professional
- **Service User**: a person who receives care or treatment from a healthcare professional, clinical support staff or support from administration and reception staff.
- **Carers**: Carers provide care by looking after an ill, frail or disabled family member, friend or partner.
- **Employers**: persons or organisations who directly employ health professionals and other staff who come into contact with the patient and in some circumstances organise and commission services.

3. **Definition Statement**

3.1 The purpose of revalidation is to ensure that health professionals remain up to date and continue to demonstrate that they continue to meet the requirements of their professional regulator. The professional standard against which each is judged is the contemporary standard required to be on the register, and not the standard at the point at which the individual may have first registered.

4. **Revalidation Principles**

4.1 Following the deliberations of the UK Non-Medical Revalidation Working Group, it was agreed that the principles of revalidation should be made explicit so that the regulatory bodies could use them to guide the development of models of revalidation. These twelve key principles reflect further discussions held with the regulatory bodies and are set out below. The principles are consistent with the Legislative and Regulatory Reform Act. Under each principle are further points for consideration when exploring how the principle is to be enacted.

**Transparency**

**Principle 1 (Consistency)** Models should be consistent with the Better Regulation Executive’s five principles of good regulation.

**Principle 2 (Professional Standards)** The regulatory body for each profession should at all times set out the contemporary professional standards or competence, which registrants will have to meet in order to maintain registration. The standards or competence will determine the

Contemporary standard – The standard that demonstrates that a practitioner is up to date in their specialty in order to be fit to practise within a contemporary healthcare setting. This is the fundamental standard necessary for public protection.
evidence that the regulator requires in order to decide whether a registrant meets it. Individual registrants will be responsible for submitting this evidence in order that a revalidation decision can be made. The regulatory body will determine the frequency of revalidation.

Issues for consideration:

- The need to ensure sufficient flexibility in standard setting to facilitate working across the diversity of employment environments within the UK;
- The need to develop guidance and clarity on the role of both the contracting body, employer and the individual in revalidation;
- In order to ensure equity for all registrants, the needs of those practitioners who do not practise within recognised employment frameworks such as the self-employed, need to be fully considered so they are still able to be revalidated;
- The need to decide how members of the profession not in active clinical practice should be revalidated (e.g. educationalists, policy advisors);
- The need to decide on what evidence registrants will be expected to provide in order to demonstrate that they meet the contemporary standard plus any relevant to their current scope of practise e.g. higher level practise where this is clearly defined;
- Whether issues such as declaration of cautions and convictions and vetting checks are a matter for on going registration rather than revalidation but also may be linked.

Principle 3 (Remediation) Where revalidation processes highlight performance concerns there should be scope for remediation of the professional but measures to secure public safety must remain paramount. Proposals should also reflect a common sense approach to supporting practitioners who return to practice after prolonged periods of sick leave, maternity leave, sabbaticals or who change sector of practice.

Issues for consideration:

- Proposals should define clearly what would happen if a registrant failed to meet the required standards in the revalidation cycle (because of prolonged absence or lack of competence) with the next steps for individuals and employers clearly stated. Clarity around when it would be appropriate for the regulator to intervene should be encompassed within this;
- Standards and guidance for employers will be required. It will be essential to have the employer’s support for remediation where this is appropriate;
- Support related to the self-employed in accessing remediation;
- The need for a transparent assessment tool that will determine the nature of remediation and ensure that the practitioner understands clearly the areas in which they are deficient, the evidence that led to these decisions and the action required to address the deficiencies;
- If remediation fails, regulators need to be clear on next steps in relation to formal fitness to practise procedures;
- Models for revalidation need to take account of existing best practice for remediation and to accommodate this.
Principle 4 (Patient and Public Involvement) A successful revalidation process must have the confidence of the public that it is appropriate, relevant and fit for purpose. The public and service users must be involved in and seen to be involved in the design and delivery of revalidation processes.

Patients and the public want to be treated by competent, skilled, up to date professionals. The involvement of patients and the public will greatly enhance the quality of the process of revalidation and help promote public confidence in healthcare professions. Patients and members of the general public need to be able to easily access the standards set by the regulators so that they know what to expect of the healthcare professionals looking after them. Patient feedback on practitioner performance is recommended where possible as it enables reflective care, and should be integral to good practice and revalidation as a part of a range of sources of evidence.

Patients and carers have a vital role to play in helping to define what counts as good healthcare, in identifying good professional practice and in drawing attention to unacceptable standards of care.

Issues for Consideration

- Lay input should develop patient and public confidence in the quality assurance of revalidation processes and the quality of information on which the process is based;

- The standards set must be understandable to the public, and as patients increasingly have care delivered by multiprofessional teams, consistency of standards will enhance confidence in the process. Example of standards applying across professional groups are:
  
  i. communication skills (listening, informing and explaining);
  
  ii. involving patients in treatment decisions and patient consent;
  
  iii. treating patients with dignity and respect.

Revalidation should routinely include feedback from patients and information from complaints systems.

Principle 5 (Continuing Professional Development) (CPD) This is the process by which individual registrants keep themselves up to date with healthcare developments in order to maintain the highest standards of professional practice. It should be seen as an integral part of revalidation and may provide supporting evidence that a practitioner submits to the regulatory

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body for consideration at the time of revalidation judgement. CPD needs to be relevant to the practitioner’s scope of practice, where such scope has been defined.

Issues for consideration:

- The role of CPD should be made clear in terms of its contribution to a regulatory body’s decision on whether or not the practitioner meets the contemporary standard for continued registration;
- The CPD system should not be based on a process (points collection, number of hours etc.) but on outcome measurement together with some audit of the adequacy/relevancy of the individual’s programme.

Principle 6 (Quality Assurance) Quality assurance mechanisms must be built into revalidation processes.

Issues for consideration:

- Patient and public involvement and lay input should be incorporated into all aspects of quality assurance; it must be clear to the public how their input will be evaluated. Wherever possible, existing lay input mechanisms should be incorporated into this process;
- The ability to demonstrate on an ongoing basis that revalidation processes are valid, reliable and fit for purpose;
- Whether the role of employers in the system should be quality assured and accredited and if so at what level;
- When an employer is found not to have a satisfactory internal process to support revalidation requirements then alternative approaches must be introduced and an appeals mechanism identified;
- Consider agreed principles for quality assurance across all regulators.

Consistent

Principle 7 (Equality) Equality and diversity considerations must be evident in the development of all systems and processes.

Issues for consideration

- While equality and diversity considerations will inform the work and policy development of regulators generally, specific consideration will need to be given to how they will be brought to bear in development of revalidation processes. Impact Assessments (IA) should include specific consideration of equality and diversity (see Principle 12);
The Disability Discrimination Act 2005,\(^8\) reflects the need to acknowledge that some individuals may need to be treated/supported differently so that the desired outcome is achieved. Demonstration of equality of opportunity will be key. Revalidation processes may highlight a poor response to the legislative requirements to ‘make reasonable adjustments’ within practice.

**Principle 8 (Integration)** The implementation of clinical governance frameworks yields information on professionals’ performance and practice. Where appropriate, effective connections need to be made between them and the system of revalidation. Appraisal processes, Knowledge and Skills Framework (KSF) development reviews - where these are available – and other evaluation systems should be seen as a parallel process to revalidation, carried out for different purposes. Information from these parallel processes may provide evidence that contributes to the regulatory body’s decision on revalidation, but may also highlight a practitioner who is not practising at the required level and therefore allow early intervention before it becomes a fitness to practise issue.

**Issues for consideration:**

- KSF development reviews are only available to staff employed in the NHS and are linked to the current role and scope of practice of the practitioner. The group has therefore commissioned a feasibility study on the potential use of a model such as the KSF in revalidation both within and outside of the NHS;

- The potential use of the KSF development review model is currently being explored in the independent sector. However, consideration needs to be given to the alternatives to formal development reviews for those not employed in the NHS e.g. in the corporate healthcare sector or other managed environments or for the self-employed or those who move around frequently, i.e. temporary staff;

- Whether such alternatives should have common frameworks across the regulators;

- The need to acknowledge that not all appraisal systems are aligned with revalidation for example where they are concerned with achievement of commercial targets;

- Whether appraisal should be considered a cornerstone of good employment practice;

- The need for revalidation models must work across all employment situations.

**Principle 9 (UK-wide)** Revalidation arrangements should be consistent in outcome across the United Kingdom and required by all who work in the UK thus providing a basic standard of assurance for the public anywhere in the UK.

**Issues for consideration:**

- Under European legislation on recognition of professional qualifications (Directive 2005/36/EC), a qualification listed in one of the annexes to the Directive should be automatically recognised by other member states who have listed an equivalent qualification.

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qualification. The requirement for CPD or revalidation cannot be made a condition for recognising the qualification. Once the person is registered as a UK registrant they can however be expected to meet the same conditions as other registrants for staying on the register, so can be obliged to do whatever their UK peers have to do to stay on the register. The development of revalidation schemes in the UK needs to be communicated to competent authorities in other jurisdictions in order to facilitate increasing mutual recognition of qualifications for a more mobile professional population serving a correspondingly mobile patient base.

Proportionate and Targeted

Principle 10 (Demonstrating Benefits – effective in confirming fitness to practise) The structures and processes surrounding revalidation should knit together in a coherent, unbureaucratic and proportionate manner to ensure that resources invested yield valid and reliable outcomes together with the anticipated benefits to service users and health professionals.

Issues for consideration:

- Models for piloting recommendations should be developed by the regulator(s) and should include proposals for evaluation of the pilot at relevant stages of the process if required;
- Whether analysis of data on the benefits to service users could be used or whether the numbers of successful/unsuccessful practitioners through revalidation would be a more practical measure;
- Whether the analysis and evaluation should be based on the risk from the specific profession or be on an agreed quality assurance framework across regulators.

Principle 11 (Information) The nature of the information required by each regulatory body will be based on their risk profiling of their registrant groups and should be undertaken systematically. The frequency and breadth/depth of evidence each regulator requires information on and the evaluation/assessment methods used will be based on the assessed potential risk posed by practitioners to patients and the public. Regulators should work towards valid and robust risk profiling of their registrant groups to inform this process. The nature of the information required will depend on the value the information adds when making an assessment against standards and in reaching revalidation decisions that are just and defensible.

Issues for consideration:

- Consideration should be given to those groups who undertake elements of advanced practice as to whether they have additional revalidation requirements placed on them. Advanced practice is discussed in more detail at paragraph 5.3;
• How should intensity be defined? Is it meant to indicate that some professions, or indeed subsections of professions, may require a full performance assessment in order to revalidate and others will rely on a knowledge test or self-certification and others will rely solely on appraisal?

• Clarity on the accountability and responsibility of employers and contracting organisations is required;

• Clarity on the accountability and responsibilities of professionals is required.

**Principle 12 (Introduction)** The introduction of revalidation should be incremental. This will enable proper piloting and effective preparation and will avoid overburdening regulatory bodies, professionals and employers with the process of implementation. The timetable for comprehensive implementation should be known at the outset.

**Issues for consideration**

• Piloting should be with a representative sample of registrants and not focus solely on areas/sectors where revalidation would be easiest;

• An impact assessment will be required from the regulatory bodies

5. **General themes for consideration.**

5.1 **Harmonisation**

• Where appropriate, common standards and systems should be developed across professional groups. In particular, this should encompass common and shared competences relating to specific aspects of direct care delivery e.g. prescribing, as well as common systems and standards for regulators such as those described on page 10, communication skills, involving patient in treatment decisions and treating patient with respect and dignity.

• The extent to which attempts are made to harmonise high-level principles should be determined by the principles of regulation. To ensure public protection, there will be areas/occasions where harmonisation is not appropriate;

• Whether CPD requirements should be standardised across regulators.

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5.2 Impact of multidisciplinary teams

- Care is increasingly being delivered in multiprofessional teams and team members will be contributing to each other’s revalidation processes through the use of team performance data. This will not be prevalent in professions like osteopathy for example where practitioners are mainly engaged with patients on an individual basis in private practice.

- There is increasing patient awareness that treatment is delivered by teams and of the benefits of this rather than sole professionals. There is a need to ensure that regulation allows the standards of teams to be set and understood by patients.

5.3 Advanced practice

- There is currently no agreed definition of advanced practice that applies across professions. This was recognised by the recent report A High Quality Workforce – NHS Next Stage Review, which proposed work with CHRE and the professional regulators “to ensure a consistent definition of advanced practice across the health professions”\(^{10}\). It is recommended that the observations in the following bullet points are taken into account in that work;

- If a level of “advanced practice” is recognised by a regulatory body, this must be on the grounds of public protection alone and not for professional recognition/enhancement;

- Systems surrounding the sign-off process (i.e. who signs off, how is the process structured, how are uni-professional considerations resolved if harmonisation of processes, as well as principles is the aim) need to be agreed;

- How will revalidation link to the recognition of advanced practitioners by employers who are not recognised as advanced by the regulator (e.g. practitioners with special interests or those carrying out expanded scopes of practice)?

- Where a practitioner for example practises against a set of standards that are normally associated with the primary practice of another professional group e.g. a nurse who practises endoscopy or a podiatrist who practises foot surgery, then the distributed model of regulation could apply if implemented. What implications would this have for revalidation? Would the nurse or podiatrist be required to meet the standards and revalidation requirements set by the lead regulatory body for the original profession? Would regulatory bodies accept the standards of others?

5.4 General point

- Regulators should identify any legislative constraints related to the introduction of revalidation for their registrants and discuss with UK-wide Health Departments at the earliest opportunity.

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\(^{10}\) A High Quality Workforce – NHS Next Stage Review, Department of Health, June 2008, para 54.
6. Challenges to implementation

6.1 There are six main areas that could challenge implementation as referenced in the medical revalidation report:

**Logistic:** large numbers of healthcare professionals need to be covered by the revalidation schemes, which need to encompass a great diversity of groups, roles and practice settings. The numbers involved in non-medical revalidation will be greater than one million and the scope of practice varies significantly even within discrete professional groups.

**Methodological:** valid, reliable, proportionate and fair systems still need to be designed in all areas to set standards and to assess practice against them. Proportionality is essential and a one-size fits all approach should be avoided.

**Connections:** many systems and organisations examine the quality of healthcare in the NHS and throw light on professionals’ performance and practice. Where appropriate, effective connections need to be made between them and the system of revalidation.

**Information:** high quality data is vital to effective assessment of practice and although these may have been lacking in the past in some areas they must be developed. This might be outcome data or other measures could be used.

**Cultural:** revalidation should be seen primarily as supportive, focussed on raising standards, not a disciplinary mechanism to deal with the small proportion of health professionals who may cause concern. The involvement of patients and the public at all stages will greatly enhance the quality of the process of revalidation and help promote public confidence in the profession itself. Careful consideration needs to be given to how patients and the public can be involved meaningfully.

**Resources:** revalidation will require considerable investment to develop, including potentially advanced expertise in assessment. There may be an adverse reaction from both professional groups and employers if packages of revalidation are resource intensive. Implications for registration fees would need to be handled carefully in such circumstances. To what extent will employers be able to provide additional resources for non-medical revalidation and in particular remediation? In the case of contractor professions, what funding will be needed by the primary care groups to ensure revalidation can be taken up?

7. Next Steps

7.1 The council’s of the regulatory bodies will consider the report now that the non-medical working group has completed the work on the high level principles that will guide the

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work. The regulatory bodies will develop models of revalidation that both meet the needs of the profession and the public and will report in January 2009. This work will be influenced by the two pieces of commissioned research outlined below.

7.2 The commissioned research on the use of a model such as the KSF will be completed and the outcomes circulated to the regulators and those working in non-NHS settings for consideration.

7.3 The commissioned research on decision-making based on risk and proportionality will be circulated to the regulatory bodies for their consideration.

7.4 The regulatory bodies will come back with proposed models for piloting including recommendations and early discussion of evaluation in order to get robust baseline data prior to piloting any new systems. Proposals will need to work for health professionals in non-NHS sectors, research, teaching and private sector health provides.

7.5 These high-level principles will now be shared with the Working Group for Medical Revalidation with a view to cross-professional endorsement.

7.6 As proposed by *A High Quality Workforce – NHS Next Stage Review*, The Council for Healthcare Regulatory Excellence will be asked to work with the Department of Health, the Regulatory Bodies, the Devolved Administrations and other key stakeholders to agree on the definition and criteria for recognition of advanced practice.
Revalidation for the non-medical healthcare professions

2.29 ‘The regulation of the non-medical healthcare professions’ review endorsed the principle of revalidation for these professional groups as well. The Government endorses the recommendations in this review. Revalidation is necessary for all health professionals, but its intensity and frequency needs to be proportionate to the risks inherent in the work in which each practitioner is involved. Working closely with the Devolved Administrations, the Department will discuss with each regulator the most appropriate arrangements that are proportionate to the risk that each profession may pose to patients.

2.30 The Government agrees that the regulatory body for each non-medical profession should be in charge of approving the standards which registrants will need to meet to maintain their registration on a regular basis. Where appropriate, common standards and systems should be developed across professional groups where this would benefit patient safety. The Department will ask the Council for Healthcare Regulatory Excellence (CHRE) to work with regulators, the professions and those working on European and international standards to support this work. This will encompass the development of standards for higher levels of practice, particularly for advanced practice in nursing, AHPs and healthcare scientists. The Department will discuss with the Nursing and Midwifery Council the outcome of their consultation on advanced nursing practice to agree next steps.

2.31 There are some non-medical professional staff, such as clinical scientists, who undertake higher specialist training and practise for most of their careers at a specialist autonomous level. The Department will work with the Devolved Administrations to establish a short-term working party to consider how regulation and revalidation should reflect this.

2.32 Professionals will fall broadly into one of three groups for revalidation in England:

- for employees of an approved body, for example, nurses, dietitians or paramedics working in an NHS organisation or a licensed private or independent sector provider, evidence to support revalidation will be provided as part of the normal staff management and clinical governance systems, with employers providing recommendations to the professional regulators;

- for those, including self-employed contractors, performing services commissioned by NHS primary care organisations (such as dentists or optometrists), the revalidation processes will be carried out under the supervision of either the NHS commissioning organisation or, particularly where it is necessary to take an overview of both NHS and private work, the regulatory
body, but in either case with appropriate collaboration between the two bodies; and

- for all others, for example, osteopaths, their regulatory bodies will develop direct revalidation arrangements.

2.33 The responsibility for revalidation arrangements for professionals directly employed by primary care contractors, for example practice nurses or dental hygienists, will be discussed with the relevant professions and regulators.

2.34 The Government agrees that the appraisal process within the NHS, which will be a central component of revalidation, should be both formative and summative, to ensure objectively that required standards are met. Information gathered under the Knowledge and Skills Framework should be used as far as possible as the basis of revalidation, with any additional requirements justified by risk analysis. As these measures will require the introduction of summative elements to assessment, the Department will discuss these proposals with the Devolved Administrations, the relevant regulators, NHS employers, trades unions and others with an interest to ensure this is proportionate, fair and appropriate. As far as possible, the agreement of such arrangements should be professionally led, provided that they secure adequate objective assurance to patients and the public that they give appropriate safeguards to the maintenance of high professional and clinical standards. Scotland, Wales and Northern Ireland will consider how they wish to take this forward within their particular contexts.

Ensuring effective systems for revalidation

2.35 For all health professionals, including doctors, it will be important to ensure that the organisations, whether providers or commissioners, responsible for their revalidation are doing so in a sufficiently rigorous and fair manner to ensure patient safety and fair treatment of health professionals. In England, the Department will include the capacity of organisations to carry out this role as a core component of the standards against which organisations are judged when they are granted their licence to operate by the new national system regulator (Care Quality Commission). As with the current arrangements, this is likely to be based on evidence-based self-assessment, validated through risk-based audit and investigation where concerns are identified. The Devolved Administrations will consider how to address this within their particular contexts.

Introducing revalidation

2.36 The Secretary of State commissioned CHRE to provide advice on the issues that needed to be considered in implementing revalidation arrangements for health professionals. Their main findings are that:

- there is general support for the concept of revalidation, and the most important issue is how to implement it;

- the Department needs to consider carefully the additional responsibilities placed on local organisations, to avoid overloading them; and
• the implementation of revalidation should be sufficiently flexible to take account of the diversity of employment environments across the UK.

2.37 The Department welcomes this advice. The introduction of a new appraisal and revalidation system covering all health professionals in the UK needs to be piloted thoroughly, managed carefully and phased in over time to ensure that it works well, that it works fairly and that it enables employers and commissioners to put in place the capacity and capability needed to make it work well. The setting of standards by the professions themselves will take time, thought, piloting and consultation. The Government is resolved that these changes should be introduced, but is equally determined that they should be introduced in a way that does not place unmanageable burdens on employers, staff or resources.

2.38 The Government will discuss with the Devolved Administrations and with public, private and voluntary sector employers the development of an affordable and manageable timetable for the effective implementation of revalidation. This will reflect the state of readiness of each profession to deliver robust revalidation processes; the impact revalidation would have on diverting frontline staff from direct patient care; the capacity of regulators and employers for each professional group; the level of public concern about professional standards within each professional group; the risks inherent in the care provided by each professional group; the numbers of professionals working in each professional group, including the proportion of self-employed; the ability of practitioners taking career breaks, maternity leave and other absences from practice to engage with these processes; and the particular circumstances in Scotland, Wales and Northern Ireland.

Conclusion

2.39 The measures set out in this chapter will provide the objective assurance that the public now expect to underpin their trust in health professionals. The measures are framed in a way that is proportionate to the risk inherent in each professional group and designed to assure patient safety in relation to that risk. The Department believes that revalidation should be professionally led and proportionate and will work with the regulators for each profession to ensure that this is the case. It will be a complex undertaking to create workable and appropriate detailed arrangements for each profession involved and it will be important to develop and adapt these proposals to ensure effective implementation. Therefore, a United Kingdom Revalidation Steering Group will be established to develop and co-ordinate this work.
## Annex B - Group Membership

### NON-MEDICAL REVALIDATION UK WORKING GROUP MEMBERS

<table>
<thead>
<tr>
<th>Organisation represented</th>
<th>Name</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>University of Sunderland</td>
<td>Professor Jim Smith</td>
<td>Chair (2007); Professor of Pharmacy Practice and Policy, University of Sunderland Chair (2008); Director of Professional Regulation, DH</td>
</tr>
<tr>
<td>Department of Health</td>
<td>Gavin Larner</td>
<td></td>
</tr>
<tr>
<td>General Chiropractic Council</td>
<td>Margaret Coats</td>
<td>Chief Executive and Registrar</td>
</tr>
<tr>
<td>General Dental Council</td>
<td>Carol Varlaam</td>
<td>Lay Member; Chair, Revalidation Working Group</td>
</tr>
<tr>
<td>General Medical Council</td>
<td>Una Lane</td>
<td>Assistant Director, Revalidation</td>
</tr>
<tr>
<td>General Optical Council</td>
<td>Jon Levett</td>
<td>Director of Standards</td>
</tr>
<tr>
<td>General Osteopathic Council</td>
<td>Vince Cullen, Evlynne Gilvarry</td>
<td>Head of Development Chief Executive and Registrar</td>
</tr>
<tr>
<td>Health Professions Council</td>
<td>Anna van der Gaag</td>
<td>President</td>
</tr>
<tr>
<td>Nursing and Midwifery Council</td>
<td>Kathy George, David Hutton</td>
<td>Director of Standards and Registration Professional Adviser, Revalidation</td>
</tr>
<tr>
<td>Royal Pharmaceutical Society of Great Britain</td>
<td>Dr Peter Wilson, Andreas Hasman</td>
<td>Head of Post Registration Division Policy Coordinator</td>
</tr>
<tr>
<td>Pharmaceutical Society of Northern Ireland</td>
<td>Brendan Kerr, Dr Deirdre McAree</td>
<td>Registrar and Head of Professional Services Post Registration Facilitator (2008) PSNI lead for Revalidation</td>
</tr>
<tr>
<td>Dept. Health (England)</td>
<td>Sue Hill</td>
<td>Chief Scientific Officer</td>
</tr>
<tr>
<td>NHS Employers</td>
<td>Alastair Henderson</td>
<td>Deputy Director</td>
</tr>
<tr>
<td>NHS Staff Council, KSF Group</td>
<td>Gary Theobald</td>
<td>Employer Side Chair, KSF Group of the NHS Staff Council</td>
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<tr>
<td>Prime R&amp;D Ltd</td>
<td>Lindsay Mitchell</td>
<td>Consultant</td>
</tr>
<tr>
<td>Council of Deans for Nursing and AHPS</td>
<td>Paul Turner</td>
<td>Chief Executive</td>
</tr>
<tr>
<td>SHA Workforce Lead</td>
<td>Peter Blythin</td>
<td>Director of Nursing and Workforce</td>
</tr>
<tr>
<td>Independent Healthcare Advisory Services</td>
<td>Sally Taber</td>
<td>Chief Executive</td>
</tr>
<tr>
<td>Public/patients representation</td>
<td>Kate Webb</td>
<td>Senior Policy Analyst, CHRE (Principal Policy Adviser, Which?, to June 2008)</td>
</tr>
<tr>
<td>Public/patients representation</td>
<td>Judy Wilson</td>
<td>Independent Consultant</td>
</tr>
<tr>
<td>Scottish CNO</td>
<td>Paul Martin</td>
<td>Scottish CNO</td>
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<tr>
<td>Scotland</td>
<td>Audrey Cowie</td>
<td>Professional Adviser</td>
</tr>
<tr>
<td>Organisation represented</td>
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<tr>
<td>23 Wales</td>
<td>• Barbara Bale</td>
<td>Head of Workforce Policy Development and Commissioning</td>
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<td></td>
<td>• Mary Gilbert</td>
<td>Regulation and Education Project Lead</td>
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<tr>
<td>24 Northern Ireland</td>
<td>Joyce Cairns</td>
<td>Deputy Director HR</td>
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<tr>
<td>25 MOD</td>
<td>Jerry Tuck</td>
<td>Defence Medical Services</td>
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<tr>
<td>26 BDA</td>
<td>Graham Brown</td>
<td>Chair, Education Committee</td>
</tr>
<tr>
<td>27 RCM</td>
<td>Louise Silverton</td>
<td>Deputy Secretary General</td>
</tr>
<tr>
<td>28 Federation of Ophthalmic and Dispensing Opticians</td>
<td>Paul Carroll</td>
<td>Director of Professional Services</td>
</tr>
<tr>
<td>29 Allied Health Professionals Federation</td>
<td>Ralph Graham</td>
<td>Chair, Allied Health Professionals Federation</td>
</tr>
<tr>
<td>30 CHRE</td>
<td>Douglas Bilton</td>
<td>Project Manager</td>
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</tbody>
</table>
Annex C – Terms of Reference

To consider the recommendations in *Trust, Assurance and Safety* on non-medical revalidation and to develop proposals for the timely, effective and affordable introduction of a revalidation system for these groups. Working closely with the medical revalidation and education-working group, Chaired by the Chief Medical officer, the group will, in particular, consider and make recommendations on:

- A clear definition of revalidation across medical and non-medical working groups to ensure commonality of understanding and language
- The scope, structure and processes for revalidation for all statutorily regulated non-medical health professionals, paying particular attention to how these interact with existing clinical governance/risk systems
- What revalidation will mean in terms of post-registration (advanced or higher level practice)
- A process for establishing common standards across the regulators and clarifying where this is not appropriate
- The use of information systems to collect data that might be used for appraisal and revalidation, and how to overcome problems around confidentiality and data protection issues
- Effective appraisal processes (both formative and summative) and clarifying the role of the Knowledge and Skills Framework in revalidation
- Revalidation and appraisal processes for health professionals working in non-NHS sectors, e.g., research, teaching and private sector health providers
- Models for Continuing Professional Development and demonstrating how they fit in with formative and summative processes for appraisal
- Models for piloting recommendations made by the group and early discussion of evaluation in order to get robust baseline data prior to piloting any new systems
- The consequences of failed revalidation in terms of systems and support and how this would work with fitness to practise procedures
- The timetable for the introduction of new processes within the 5 year window

The group will liaise with other working groups and establish its own sub-groups where appropriate to examine matters in more detail.