Continuing Professional Development

key decisions

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foreword

I am pleased to present this report on our proposals for continuing professional development (CPD). Here, we summarise the responses we received during the consultation we ran from September to December 2004, and outline the key decisions that we have made since.

Our consultation attracted a high level of interest and we received a large number of responses, from organisations and individuals. We received almost 1500 written responses, and around 6500 people attended the 46 consultation events we held throughout the United Kingdom. So we have received a wealth of information which we have used to shape our decisions.

To make sure this report accurately and fairly reflects your views on continuing professional development, we have highlighted both positive responses and concerns that you brought to our attention. Comments we received focused on:

- whether our proposals can be applied in the same way to all registrants;
- how our proposals relate to existing continuing professional development and appraisal schemes;
- whether we needed to give more guidance or set minimum standards to make health professionals feel confident that they have achieved a satisfactory level of CPD;
- how employers can be encouraged to support health professionals' CPD activities; and
- how our proposals relate to health professionals on, or returning from extended leave and to those employed in various work contexts

We will continue to take your views into account over the coming weeks and months, in order to develop appropriate and workable procedures, exemplar documentation and supplementary information, to help you in meeting our CPD requirements.

In response to your feedback, the Council has been able to make the following key decisions about the CPD process. Some of these decisions involve maintaining our original proposals but others are changes made in direct response to your feedback. These are set out below and explained throughout this paper. Thanks to your feedback, it is also clear that we need to give further consideration to a number of processes. Where this applies, we have said so in this report. We will be able to provide more details on those issues and will publish a document containing comprehensive information and exemplars in April 2006.

Our key decisions are as follows.

Decisions in response to feedback

- The first audit of the CPD process will now take place between 31 July 2008 and 30 December 2008 with a focus on the activities undertaken in the two years preceding this. The professions for audit in the first round will be ODPs and chiropodists/podiatrists.
- In April 2006, we will start a communications campaign to make sure employers and health professionals know about the changes being made.
- The proposed title of the 500-word summary part of the profile will be changed to 'Summary of recent work/practice'.

- The originally proposed 14 day grace period for those who send an incomplete profile will be changed to 28 days.

Standards

- The proposed CPD standards are considered to be sufficient to meet the needs of the wide range of work contexts and professions we regulate. These standards will be introduced as part of the CPD process.
- The overall CPD process will run as in our original consultation document.

CPD activities

- The HPC will be looking for a range of CPD activity that includes those activities found in appendix 1 of the consultation paper.
- The CPD process will be based on continuous learning and development with a focus on individual learning achievements and how these enhance service delivery.
- The HPC will not organise, certify or manage CPD activities.
- The range of CPD activities originally proposed is sufficient to meet the needs of HPC registrants.
- We confirm that it is not appropriate to set a prescriptive CPD process for the range of professions and contexts experienced by HPC registrants. We will keep a flexible approach to CPD.

Supporting information:

- We will draw up and publish details of the processes and comprehensive supporting information including exemplar documentation This will be completed by April 2006;

Audit

- The HPC will undertake biennial audits after the registration renewal process for each profession, to assess the CPD being undertaken and to confirm self-declaration.
- All registrants will be required to undertake CPD and, if selected for audit, will be required to show evidence of their learning and outcomes.
- The expected content of the profile will not change from that explained in the consultation document.
- We confirm that we will not change the random nature of the audit sampling process, or the number of samples assessed.

You can learn more by visiting our website at www.hpc-uk.org, where you will find all of the information we have published about our consultation.

Thank you for your continued interest in our work.

Professor Norma Brook
President, Health Professions Council

introduction

We are the Health Professions Council. We were created by the Health Professions Order 2001 to regulate Health Professionals. Our role is to protect the health and wellbeing of anyone using or needing the services of the health professions we regulate. We currently register members of 13 professions. Each person we register must meet the standards we set for their professional skills, behaviour and health in order to practise.

On 13 September 2004 we launched a three-month consultation on our proposals for continuing professional development (CPD). When we made our proposals we expected health professionals to have to start keeping a record of their CPD activity from the summer of 2005, with an audit of this activity starting in 2007.

However, due to a number of issues that have arisen during the consultation process, we have decided that the first audit will not take place until 31 July 2008.

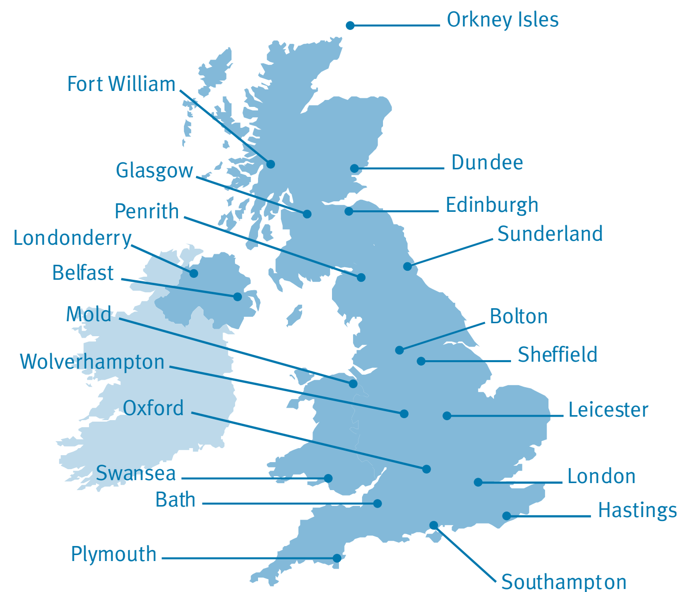
About the consultation

We tried to communicate with as many of the people and organisations who will be affected by our proposals as possible. We did this in two ways. Firstly, we published a consultation document (Continuing Professional Development – Consultation paper). Secondly, we held a series of public meetings that were open to everyone.

In the consultation document we set out our proposals for CPD, which included our proposed standards and proposed supporting information for these standards. The document asked for your answers to a series of questions about our proposals.

We sent copies of the consultation document to many people and organisations, including professional bodies and associations, health regulators, policy makers and commissioners, and royal colleges. In total, we sent copies to around 350 organisations and 157,000 registrants, and published the document on our website (www.hpc-uk.org). We asked you to send written responses to the consultation document by 6 December 2004.

During the consultation period, we held 46 consultation meetings in 22 different locations around England, Northern Ireland, Scotland and Wales. All these meetings, which were publicised in the consultation document and on our website, were open to the public. The map below shows where the meetings were held, and a detailed list of locations is given in appendix 1 at the back of this document.



At each meeting, members of our Education and Training Committee gave a short presentation on our proposals, after which people asked questions and made comments. We recorded these questions and comments and then analysed them along with all the comments received through other channels.

Analysing your responses

Now that the consultation has ended, we have analysed all of the responses we received. We cannot include all of the responses in the document, but we do give a summary of them. Although we could acknowledge the individual written responses we received to our consultation document, unfortunately we could not normally reply to individual questions due to the volume of interest we received.

To make sure that our analysis of your comments, however we received them, was fair, we used a simple four-step process for working.

- Step 1

  The first step was to make a record of each written response to the consultation (whether the response was a letter, an e-mail or a form downloaded from our website).

When we recorded each response, we also recorded the date it was received, what organisation (if any) and profession the person making the response told us they belonged to, and whether the response was given on behalf of an organisation or by the relevant person.

- Step 2

  Next, we summarised each response, linking the comments made to the themes of our consultation, to provide a clear structure.

- Step 3:

  We gathered responses at consultation meetings by taking notes. We then treated the comments in the same way as the written responses we received on the consultation document (that is, made a record of the comments and then summarised them).

- Step 4:

  Finally, once we put all of the information into the same clear structure, we analysed it. When deciding what information to include in this report, we looked at the frequency and type of responses received on each theme in our consultation document, assessed the strength of feeling of the responses, and took account of the details of each response.

Making our decisions

We based our decisions about our standards for CPD on your comments, suggestions and questions. Our decisions are set out in this document. We show any changes we have made to the proposals as a result of your feedback and, when appropriate, explain our reasons for not adopting some suggestions, particularly when they fell outside our role of making sure health professionals provide safe and effective practice.

how this document works

This document:

- summarises your comments and questions about our CPD proposals;
- sets out our main decisions in response to your feedback ;
- provides comments on your feedback; and
- explains why we made the decisions we did.

We have split the summary of your responses and our key decisions into 15 major sections. The first 12 sections focus on one or more of the questions asked in the consultation document, while the last three sections summarise additional issues that were raised during the consultation.

The sections are as follows.

Section 1	Proposed rules
Section 2	CPD activities
Section 3	Approach
Section 4	Proposed standards
Section 5	Standards process
Section 6	Audit process
Section 7	Profile
Section 8	Audit size
Section 9	Summary of recent work/practice
Section 10	Additional CPD activities
Section 11	Evidence
Section 12	Profile guidelines
Section 13	Existing CPD schemes
Section 14	Resources
Section 15	How the standards apply

Sections 1 to 12 are split into four parts under the subheadings 'our proposals', 'your responses', 'key decisions' and 'our comments'.

- In the text under the subheading 'our proposals', we explain the parts of our proposals that the section applies to. In these sections, any reference to him/his is legislative terminology and refers to both male and female registrants.

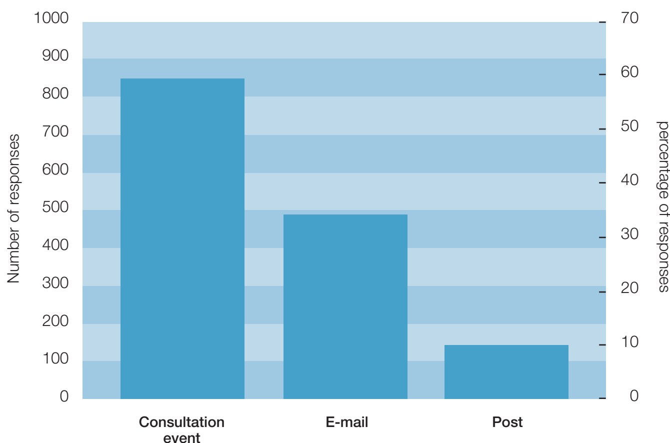
- Under the subheading 'your responses', we discuss the responses we received in relation to the relevant parts of our proposals and any important issues that were raised.

- Under the subheading 'key decisions', we set out the main decisions that we have made in light of the responses gathered during the consultation.

- Under the subheading 'our comments', we explain why we have taken particular decisions.

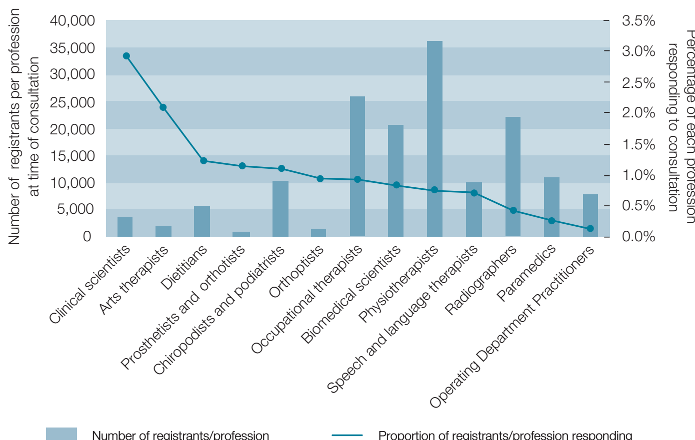
analysis of those who responded

We received 1459 responses to our consultation. As the graph below shows, most responses (59%) arose from our consultation meetings. In total, 6500 people attended our meetings. The people who attended included representatives from professional bodies and associations, government departments and health service organisations, plus individual health professionals and other people with an interest in CPD.



We received written responses to the consultation document between September and December 2004. Of those responses, 130 (9%) were made on behalf of organisations and 1329 (91%) were from individual professionals. In 265 responses (18%), we could not identify the profession the person belonged to, but we have treated these responses in the same way as other responses and analysed them according to whether they were from an individual or an organisation.

Of all the professions, physiotherapists provided the largest percentage of responses (18%), followed by occupational therapists (16%) and biomedical scientists (12%).



The preceeding graph shows the actual numbers of people of each profession who responded as well as the percentage of each profession. At the end of this document (appendix 2) there is a list of all of the organisations that responded.

Section 1 - Proposed rules

Our proposals

'Our proposed Rules are set out below. Please note that these are in draft form as the final text has to be approved by the Privy Council:

3.1 A registrant must –
undertake continuing professional development in accordance with the Standards specified by the Council under article 19(4) of the Order and which apply to him; and maintain a written record (including any supporting documents or other evidence) of the continuing professional development he has undertaken.

3.2 The Committee may at any time require a registrant to – submit his continuing professional development record for inspection; and provide the Committee with such other evidence as it may reasonably require; for the purpose of determining whether the registrant has met the requirements of paragraph (1).

3.3 If a registrant fails to meet a requirement imposed by paragraph (1)(a) or (b) or one imposed by the Committee under paragraph (2) the Committee may refuse to renew the registrant's registration or direct the Registrar to remove the registrant's name from the register.

3.4 Before taking any action under paragraph (3) the Committee shall provide the registrant with an opportunity to make written representations to the Committee.

Question 1: What are your views of the HPC's proposed Rules?'

Your responses

Many people agreed with our proposed rules, viewing them as an effective way of regulating health professions and promoting good practice. As one person said, "I think it's an excellent,

common-sense approach to establishing CPD." Several people also thought that the proposed rules would protect both professionals and the public.

The most common questions related to:

- how the rules can be fairly and consistently applied across the broad range of professions and employment contexts;
- how a professional's fitness to practise relates to CPD, specifically whether a lack of CPD can lead to removal from the register; and
- how the appeals process will work.

Some of these issues also arose in response to other proposals in our consultation, and are dealt with later in this report.

Several people asked how the introduction of the NHS' 'Agenda for Change' and the 'Knowledge and Skills Framework' relates to and affects our proposed rules. Agenda for Change is the new pay system that applies to almost all staff employed by the NHS in all four countries in the UK. It started being introduced on 1 December 2004 and is expected to be fully introduced by October 2005. The Knowledge and Skills Framework is an important element of the Agenda for Change package. It defines and describes the knowledge and skills that NHS staff need to deliver high-quality services. It will come into force no later than October 2006 and after that all staff must review their progress each year. Please note that while the rollout date for the Agenda for Change has been set at October 2005, this may have changed since we printed this document.

The need to clarify the difference between CPD and CPC (continued professional competence) was raised by a number of people. They asked for the difference between CPD and CPC to be made clear. One described a lack of clarity about this as "the scheme's Achilles heel".

A few people questioned our legal authority to link CPD with registration, particularly in relation to the threat of removal from the register. The Society of Chiropodists and Podiatrists picked up on this point saying, "If our interpretation is correct, the HPC cannot lay down rules that determine criteria with regard to registrants' continued professional competence, i.e. continuing to meet the Standards of Proficiency to remain on the Register, but is restricted to determining rules related to CPD, which is very different."

Other general comments included requests for clarity surrounding, "such other evidence as it [the Education and Training Committee] may reasonably require" (paragraph 3.2, page 6 of the consultation paper) and for the final Rules to use universal, non-gender-specific language.

Key decisions

Decision 1.

We will introduce a CPD process in line with the Health Professions Order, 2001, in July 2006. All registrants must undertake CPD and will be expected to show evidence of their learning and the outcomes of this.

Decision 2.

We will undertake an audit of the relevant profession/s after the registration renewal process for that profession/s has been run.

Our comments

- We cannot tailor our CPD rules and standards to one particular employer's processes and systems as we are a UK-wide organisation concerned with the protection of patients across all professions and within all types of contexts. Agenda for Change and the Knowledge and Skills Framework are systems introduced by just one employer of health professionals, even if it is the largest. However, our CPD rules and standards can be used alongside such individual processes and systems. 'Lifelong learning' is an important part of the Knowledge and Skills Framework, which has clear similarities with CPD. Many other employers and professional bodies also have professional development initiatives. Because of this, included in the example of types of evidence of CPD that will be acceptable (appendix 2, on page 17 of the consultation document) is "Documentation from compliance with local or national CPD schemes".
- Judging from responses to our consultation, the links and differences between CPD, competence, our Standards of Proficiency and fitness to practise need to be made clear in respect of the Health Professions Order 2001. The relevant sections of the Health Professions Order 2001 and the links to it are outlined below:

We are entitled to:

> "…establish the standards of education and training necessary to achieve the standards of proficiency it has established under article 5.2)" (Order 2001, Section 15.1(a));
>
> "…make rules requiring registrants to undertake such CPD as it shall specify in standards" (Order 2001, Section 19.1), in which case we will "…establish the standards to be met in relation to (a) CPD; or the education or training mentioned in paragraph (3)…" (Order 2001, Section 19.4); and,
>
> "…grant the application for renewal if the applicant satisfies the Education and Training Committee that he has met any prescribed requirements for CPD within the prescribed time" (Order 2001, Section 10.2(b)).

This means the following.

- When you renew your registration, you declare that you have undertaken CPD and so meet our standards. If we find that you have not met the necessary standards, we will give you the opportunity to put the situation right, within a set time as long as when you made the declaration, you had made a genuine attempt to meet those standards. If you then fail to meet the standards within the set time, we may remove you from the register (although you have the right to appeal).
- Although in the Health Professions Order 2001, there is no automatic link between CPD and fitness to practise (Part V of the Order), if your actions in relation to CPD amount to misconduct (for example, making a false declaration or falsifying CPD records), this will lead to your fitness to practise being questioned and the procedure set out above will not apply. If, as a result, you are struck off the register, you cannot apply to be registered again for at least five years.

At this point, it is worth noting that the main difference between being 'removed' from the register and being 'struck off' the register is that being removed from the register can be voluntary but if we remove you from the register, you have the right to appeal. Being "struck off" the register is part of the fitness to practise process and means that you cannot apply to go back on the register for at least five years.

Section 2 - CPD activities

Our proposals

'The range of CPD learning activity is extensive and includes:

i) work-based learning, for example, reflective practice, clinical audit, significant event analysis, user feedback, membership of a committee, journal club;

ii) professional activity, for example, member of specialist interest group, mentoring, teaching, expert witness, presentation at conferences;

iii) formal/educational, for example, courses, undertaking research, distance learning, planning or running a course;

iv) self-directed learning, for example, reading journals/articles, reviewing books/articles, updating knowledge via www/TV/press;

v) other activities, for example, public service.

A more extensive list of examples can be found in Appendix 1 [of the consultation document].

Question 2: Are there any additional activities which you believe should be included in Appendix 1 [of the consultation document]?'

Your responses

Most people agreed with the activities listed in appendix 1 of the consultation paper, viewing the list as both helpful and comprehensive. This is shown by Burnley, Pendle & Rossendale Primary Care Trust, which noted that "We are pleased to see a wide range of CPD activities acknowledged".

Several people asked for appendix 1 of the consultation document to be acknowledged as a flexible and developing list rather than one set in stone. This would mean that, if necessary, it could be expanded at a later date and underline the fact that an activity not listed in appendix 1 would not be dismissed by CPD assessors.

Some people suggested that some of the proposed activities are not good examples of CPD. They referred to:

- 'learning by doing', making the point that this is only valuable if registrants are learning to 'do' correctly;
- 'reflective practice', in terms of the difficulties of defining and including this in a formal CPD programme;
- 'peer review', which professionals have different opinions on; and
- 'public service', in terms of its suitability as a CPD activity.

A handful of people noted that some activities listed in appendix 1 are largely passive, such as membership of a specialist interest group, whereas others are much more active and demanding. They felt that this could cause problems when assessing a registrant's CPD performance. Some proposed that a rating system for CPD activities could address the inequality, or that we should regulate and monitor the quality of courses and activities.

The concerns were also mentioned by a larger number of people, who commented that activities listed in the consultation paper varied greatly, and that this should be taken into account when assessing CPD performance. Some also identified what they felt was a bias towards practitioners, as opposed to managers or educators, in terms of access to the activities listed.

Key decisions

Decision 3.

As per the original proposals, we confirm that we will be looking for a range of CPD activity that is extensive and includes those activities found in appendix 1 of the Continuing Professional Development – consultation paper.

Our comments

- Each person's CPD needs and activities depend on their work context. Registrants will take part in a mix of CPD activities that is appropriate to their particular work and scope of practice. Some of these activities may be more passive or wide-ranging but this does not mean they would be of little benefit to a registrant or their contribution to patient care. The variation of CPD activities reflects differences between the professions and the work of individual registrants. Introducing a rating system would wipe out this important benefit and need CPD standards to be set for each profession, and for individual circumstances within each profession.
- Peer review is tackled under the section 'Audit Process'.
- Appendix 1 of the consultation document (examples of CPD activities), lists examples of CPD activities and is not a complete list of all CPD activities. Registrants may choose from these and other activities, and must make sure their CPD has contributed to the quality of their work and has benefited the service user. Registrants must make sure that CPD activities are appropriate to their current or future scope of practice.

Section 3 - Approach

Our proposals

'In determining the Standards for CPD, the Council recognises that registrants are already engaged in a diverse range of CPD activities as an integral part of their professional life. Some CPD activities are opportunistic and are taken on as an evolving component of working life. Following the response to the 2002 Consultation, the Council decided that the proposed scheme for CPD should not be based simply on the number of hours undertaken each year. The scheme should be based upon on-going learning and development, with a focus on individuals' learning achievements and how these enhance service delivery, either directly or indirectly.

Question 3: Do you agree with this approach for CPD? Please give us your views.'ox1

Your responses

Most people broadly agreed with our approach to CPD. Many praised our principle that registrants should demonstrate the affect of their learning on their work rather than specify the amount of CPD undertaken purely in terms of hours, points and courses. As one person said, "I am delighted that [the

CPD programme] is all about quality rather than quantity." A further response also expressed support for our approach: "We welcome the emphasis on the outcome of CPD and not just the process" (The Department of Health, Social Services and Public Safety (Belfast)).

Where concerns were raised, you generally questioned the lack of assessing the quality of CPD activities and highlighted difficulties in a universal approach towards CPD. The most common concerns surrounded:

- whether CPD can be measured fairly and clearly without minimum requirements or a points system;
- whether our approach accounts for the varied nature of the professions, and professionals who are being assessed; and
- how our approach relates to and takes account of existing CPD schemes.

The issue of whether our approach should measure quantities was of particular concern. Some people praised the focus on outcomes, but others expressed the need for a system based on points or number of hours. At the very least, they asked for guidance on a minimum level and mix of CPD activities that would reassure registrants and make the audit process clearer.

It was suggested by The Department of Health (England) that we had not effectively dealt with higher levels of practice, which will need specialist or higher specialist training. It gave the example of clinical scientists and podiatric surgeons who undertake high-risk clinical activity: "It is this area that raises some fundamental concerns from the perspective of some groups of health professionals and in relation to public safety."

Finally, a few people asked whether our approach would be tested, or piloted before it is fully introduced and whether we will consult professional bodies to get their support.

Key decisions

Decision 4.

We confirm that the CPD process will be based on ongoing learning and development, with a focus on an individual's learning achievements and how these improve service delivery, either directly or indirectly.

Our comments

In our proposals, CPD is defined as how "…professionals maintain and develop throughout their career to ensure that they retain their capacity to practice safely, effectively and legally within their evolving scope of practice". This recognises that higher levels of practice are different from original practice and that the CPD of registrants involved in higher levels of practice should reflect this. As the Department of Health notes in its response, it would be inappropriate to rate podiatric surgeons with six years' training against basic Standards of Proficiency, but our proposals do not set out to do this. The Standards of Proficiency are a level which all new graduates are expected to meet, while the CPD proposals relate to current levels of a registrant's practice.

- Our proposals provide for 5% of registrants from those professions renewing their registration in, or after, August 2008 to be audited. This is effectively the pilot study. A review of these audits will confirm the processes and percentage of registrants assessed in the future, with this expected to reduce to 2.5%.
- We sent the consultation paper to around 350 organisations, including professional bodies and associations, and asked them to respond.
- Concerning the link to the Knowledge and Skills Framework and existing CPD schemes, we dealt with this issue earlier in this paper in section 1.
- The range of CPD activities and different scope of practice of registrants means that we cannot adopt an approach based on hours or points. It is the quality, rather than the quantity, of CPD learning that is of concern and this is why our proposals focus on the outcomes of CPD. Given this, our reference to a minimum standard of CPD (in figure 2 of the consultation document) is misleading and will be removed. We will create exemplars and other supporting information and publish them on our website to give some indication of our expectations of CPD activities.

Section 4 - Proposed standards

Our proposals

'2.1 The proposed Standards

All registrants will be required to undertake Continuing Professional Development (CPD) as a condition of their registration…

A registrant 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;
5. present a written portfolio containing evidence of their CPD upon request.

Question 4: What are your views of the HPC's proposed Standards for CPD?

Question 5: Are there any other Standards for CPD that should be included?'

Your responses

Most people agreed with our proposed standards for CPD, describing them as appropriate and comprehensive. Many respondents also commented on the need for self-directed learning to continue throughout their careers. For example, one wrote that "The document describes a welcome approach to CPD that places responsibility on the individual to assemble his/her own programme rather than prescribing what or how much should be in it".

Most people felt that no other standards should be included, although a few extra ones were proposed, such as:

- there being a minimum time set for registrants to complete their CPD; and
- a standard for employers to make sure they give registrants enough time and resources to undertake CPD activities.

When concerns were raised, these surrounded what some people felt to be the large amount of work involved in meeting the standards and the precise nature of their obligations. The points most frequently made were that:

- our standards may be too onerous and take too much time;
- not all CPD activities contribute to the quality of a registrant's work or benefits the service users.

It was suggested by The Department of Health (England) that we had missed an opportunity to cross-reference with work being undertaken nationally, raising the following issue: "The proposed standards do not appear to be competency based or align with national occupational standards which either have been or will be developed for many of the health professions, including healthcare scientists."

Several people asked us to make the language used in our proposals more understandable. For example, 'continuous', 'up-to-date' and 'seek to ensure' (box 2, page 8 of the consultation document) may be too vague and not user-friendly. The intended distinction between 'profile' and 'portfolio' within the consultation document also caused confusion. Finally, a handful of people suggested that third and fourth standards overlap and so should be combined.

Key decisions

Decision 5

We confirm that our proposed standards, as set out in the consultation paper meet the needs of the wide range of professions regulated by us and will become part of the CPD process in July 2006.

Decision 6

In line with the Health Professions Order 2001, the HPC will not organise, approve or manage CPD activities.

Decision 7

We will draw up and publish details of the processes, and provide comprehensive supporting information by April 2006.

Our Comments

- We deal with the issue of Employers' commitment to CPD later in this paper under the heading 'Resources'.
- As well as the response earlier in this paper in the 'Proposed rules' section, under the Knowledge and Skills Framework, NHS staff must keep a record of their learning activities, just like the requirement for keeping a record of CPD activities. The Knowledge and Skills Framework both creates and increases opportunities for NHS employees to take part in CPD, with their managers' support. By not referring to specific schemes of individual employers, we make sure that registrants who do not work for the NHS are not disadvantaged.
- As, in theory, registrants could have their CPD audited every two years, the term 'up to date' will generally refer to the most recent two year period. However, some activities (for example completion of a PhD in a relevant field of study), may continue to have direct benefit for a longer period of time. Again, it is up to the registrant to demonstrate, to the assessors satisfaction, that the activity is relevant to, and has improved their work and has benefited the service user.
- We will provide a glossary to define terms such as 'profile' and 'portfolio'.
- We have designed our CPD process with the needs of all registrants in mind. Registrants come from a range of professions and types of employment so we have designed a process that does not take up too much time. Most registrants already undertake a range of CPD activities, even if they don't recognise it. We simply need you to keep a record of your activities and, if assessed, show that you have met the standards.
- Our proposed standards are based on the understanding that most CPD activities are of benefit. If the activity you undertake prompts you to examine, alter or review your work, then this has been beneficial. Even deciding not to implement something you have learned can be considered to be of benefit. However, each registrant must demonstrate how their CPD activity has improved their work.

Section 5 - Standards process

Our proposals

'2.2 The CPD Standards process

The overall CPD Standards process will operate by:

i) each registrant making a self-declaration at each registration renewal that they continue to meet the Council's Standards for CPD;

ii) sample audits of registrants taken at random from each section of the register;

iii) submission of a profile of evidence by registrants selected for sample audit;

iv) assessment of profile against the Standards of CPD using appropriate and experienced partners.

Question 6: What are your views of the HPC's proposed CPD Standards process?'

Your responses

Most people agreed with our proposed process for assessing registrants' performance against CPD standards, and there was a general feeling that the process is appropriate, sensible and fair. As one person said, "…a pragmatic approach, which formalises what all responsible registrants should undertake with respect to their practice."

When you expressed concerns, you typically asked questions about the consequences of not submitting a CPD profile, and our ability to monitor and govern the process. For example, you asked:

- will the process be too onerous and time-consuming;
- is a system of making a self-declaration at renewal, adequate and appropriate, and what form will the declaration take;
- how long will it take us to review and decide on evidence provided; and
- how exactly will the appeals process work?

The focus of The Department of Health (England) was our proposed system of registrants making self-declarations. It highlighted the case of registrants whose work is similar to that of medical practitioners and observed that "For these groups

of professionals, the process of self-declaration would not be robust enough to demonstrate and ensure safe practice. Registration at any level should be evidence-based".

Those who felt that the proposed appeals process was too vague often asked for further information about the time allowed for making appeals and how the process will actually work. A particular point raised was whether a different assessor will review an appeal (rather than the assessor who had initially failed the registrant), and whether registrants will be allowed to appear in person at their appeals.

People also asked for further information about the definition, identity and choice of 'appropriate and experienced HPC partners' who will assess registrants' profiles against our CPD standards. For example, the Department of Health, Social Services and Public Safety (Belfast) noted that, "The document does not specify who will undertake the role of assessor. It is assumed that they will be drawn from the professions being regulated and currently engaged themselves in some branch of professional activities…It should be specified that the assessor should work in the same field as the registrant being assessed."

Key decisions

Decision 8

We confirm that the overall CPD Standards process will be as we originally proposed in the consultation document.

Our comments

- The evidence based registration issue raised by the Department of Health relates to the Shipman Inquiry, which is obvious from the reference made to registrants whose work is similar to that of medical practitioners. The process for doctors, demonstrating that they are fit to practise, as proposed by Dame Janet Smith is thorough, and needs evidence to be signed by an appropriate professional. If a registrant undertakes CPD for an employer or professional body for which evidence must be signed by an appropriate professional, this may be included in the supporting evidence.
- Any registrant found to have provided false evidence would be guilty of misconduct and removed from the Register.
- The appeals process will work along similar lines as our registration appeals process. In particular, registrants and their advisors will be able to be involved in their appeal hearings, but CPD assessors will not be involved in the CPD appeals process.
- We deal with the issue of choosing appropriate and experienced partners in the 'Audit Process' section of this report.
- We do not intend to introduce onerous processes and we have designed our CPD process with the needs of all registrants in mind. Registrants come from a range of professions and work contexts and so we have designed a process that does not take up too much time. Most registrants already undertake a range of CPD activities, even if they don't realise it. We simply require registrants to keep a record of their activities and, if audited, prove that they have met our standards.

Section 6 - Audit process

Our proposals

'3.1 What registrants will be required to do

The HPC will require all our registrants to keep ongoing and regularly updated records of their CPD. We will audit a sample of registrants' CPD in each profession. We will require the registrants we select for the audit to submit a profile within 28 days (and we will send a reminder at the end of the time if we have not had a profile back, providing a grace period of 28 days). The profile must set out the Continuing Professional Development (CPD) they have undertaken. This should not be an onerous task if the registrant is following CPD Standard 1 (i.e. to maintain a continuous, up-to date and accurate record of their CPD activities). We will appoint two CPD assessors to evaluate the profile. At least one of these CPD assessors will be from the same section of the Register as the registrant being assessed. The assessors will advise us whether the registrant has met our Standards of CPD.

Registrants can appeal against a decision and their appeal will be submitted to the Registration Appeals Panel of the Council.

Only registrants who have been on the register for more than two years will be liable to audit.

Question 7: Have you any views on the proposed audit process as set out?'

Your responses

Many people agreed with this proposed audit process, noting that it is accessible and straightforward. When concerns were raised, they focused on apparent inconsistencies in the process, the role of CPD assessors and our ability to monitor and govern the process. For example, some people expressed concerns about:

- the identity, qualifications, knowledge and competence of CPD assessors, how they are chosen and the training they will receive;
- how the appeals process will work, including whether we will provide feedback to registrants whose evidence of CPD do not pass the audit process;
- the security of CPD profiles, in terms of relying on the postal service and the potential for delays or losses; and
- the lack of a timescale for examining CPD evidence.

Several people asked whether 28 days is a reasonable length of time in which to expect registrants to provide evidence of their CPD. A handful of people also pointed out that although we will allow a 28 day 'grace period' for registrants who fail to provide evidence on time, we only propose to offer a 14 day grace period for registrants who provide incomplete evidence.

More general comments focused on the need for a registrant's CPD profile to be anonymous to protect against discrimination, bias or the release of sensitive information, as well as the need for us to maintain a consistent audit process. As one person wrote, "There should be published guidelines as to the criteria the assessors use to complete the audit so members have a clearer understanding of exactly what is required."

> ## Key decisions
>
> ### Decision 9
>
> In response to feedback, as well as allowing a 28 day grace period for registrants who fail to provide a CPD profile on time, we will also offer a 28 day grace period for registrants who provide an incomplete CPD profile.

Our comments

- We will publish further information on how to assess CPD profiles, which will be part of the assessors' training package. The first assessment will take place in July 2008 and we will be able to provide further information about the training of assessors at that time.
- Our proposals state that, "At least one of the two assessors will be from the same section of the register as the registrant being assessed".
- We currently have in place a formal process for recruiting and choosing partners. The process includes advertising, a formal application procedure and interviews. We will use the same process to recruit CPD assessors.
- The issue of evidence being anonymous is complicated and we will investigate it further, particularly with reference to patient confidentiality and confidentiality between registrants and assessors.
- All documents and information registrants provide as part of the CPD audit will be kept confidential, in line with the Data Protection Act.

Section 7 - Profile

Our proposals

> **'3.2 The profile for submission for audit**
>
> The contents of each profile will consist of:
>
> i) front cover (pro-forma provided);
>
> ii) contents page;
>
> iii) summary of practice history for the last two years (maximum 500 words);
>
> iv) statement of how Standards of CPD have been met (maximum 1500 words) on the pro-forma provided;
>
> v) documentary evidence to support statement.
>
> **Question 8: Is any further information required for the profile?'**

Your response

Most people felt that no further information should need to be included in a profile. A few suggested that a registrant's direct manager should provide an extra report or summary, and others suggested that the limit of 1500 words is too short to allow a registrant to adequately describe how they have met the standards.

The most common concerns relating to the proposals for CPD profiles were that:

- the content and requirements of the profile may be excessive;
- the profile relies on registrants being able to write well;
- pro-formas and exemplars should be published on the style and content of profiles and on how long registrants should spend putting them together.

To reduce the workload involved in preparing a profile, several people suggested that job descriptions and personal development plans should be sufficient to introduce a registrant's written evidence. This would remove the need for a summary of work over the past two years and a statement of how CPD standards have been met. As one person commented "the profile statement is likely to measure an employee's expressive flair and familiarity with jargon as much as the adequacy of their CPD activity".

Finally, concerning the security of CPD profiles, people who responded asked how we will handle confidential and sensitive information. Some asked whether we would accept photocopies of evidence to protect against the loss of original documents and, similarly, whether profiles can be sent by e-mail. One person summed up the feeling of many: "Sending all that hard-won information through the post feels an alarming thought."

Key decisions

Decision 10

We confirm that our proposals for the content of profiles will not change.

Our comments

- Producing a profile should not place an undue burden on registrants as they will draw on information and materials they already have as part of their up-to-date records kept in line with our CPD proposals.
- In our generic Standards of Proficiency (section 1.b.4 of the Health Professions Order), we specify that all registrants need to "be able to communicate in English to the standard equivalent to level 7 of the International English Language Testing System (IELTS), with no element below 6.5". We assure registrants that writing skills above level 6.5 of the IELTS are not needed for any part of the profile.
- We will draw up and publish (by April 2006) additional information about the evidence that will need to be provided in a profile.
- We will be flexible and are investigating the various formats in which profiles, pro-formas and portfolio evidence can be submitted.

Section 8 - Audit size

Our proposals

'3.3 Sampling of CPD

The HPC proposes to audit a sample of registrants' CPD each year, rather than checking each and every registrant. We believe that this is safe to do because we trust that, as professionals, registrants will take responsibility for, and keep to, the Standards of CPD. By auditing a sample of registrants, rather than all registrants, we will keep the costs of assessment down and achieve better value for registrants' money.

We have had advice from the Statistical Service Unit of the University of Reading on how to conduct an effective audit of compliance with our CPD requirements. The advice was:

i) to choose separate random samples of registrants for each of the 12 professions we regulate. This is because each profession is effectively unique and therefore needs testing by itself; and

ii) to audit 5% for the first professions, thereafter we will then audit 2.5% of each profession, subject to a review of the initial audits. Samples of this size will allow us to be confident that we have a good picture of whether registrants are generally complying with our requirements or not, while keeping costs down to manageable levels. Statistical theory says that the larger the population we are checking, the smaller the proportion we need to sample to be confident that we have got an accurate picture of compliance. The levels of 5% and 2.5% are based on providing us with confidence about compliance for the numbers of health professionals on our register (about 150,000 in total). Of course, we will use different-sized samples if we find that the proportions we currently propose using are not working adequately in some way.

Question 9: What do you think of the proposed size of the audit sample?'

Your responses

Most people agreed with our proposed sample size. A handful felt that the sample was either too large or too small because of:

- our ability to deal with a large sample size;
- a small sample might be only a 'token gesture'; and
- the possible increased costs to registrants as a direct result of our assessments.

Several people suggested ways in which the sample size could be rated or split into levels. For example, Play Therapy UK proposed a sliding scale for the sample, with a higher number of new registrants being audited compared to more experienced registrants. The organisation observed that "the audit sample should be randomly drawn from all registrants using a stratified frame that takes into account the number of years of registration [and places] a greater emphasis on the newer practitioners".

Along similar lines, the Department of Health (England) suggested that the relative size of each of the professions should be a factor in determining the sample size, while others proposed that a higher proportion of self-employed registrants should be audited. The Royal College of General Practitioners commented that "The Council should consider weighting the sample towards those who are likely to be professionally isolated, e.g. the self-employed, and those who are in direct contact with patients and for whom patient safety is a key issue". Finally, other people suggested that registrants who take part in the CPD schemes of professional bodies should be audited less frequently than those who do not.

Some people asked how we would choose the first professions to be assessed, and for further explanation of why the audit sample size will drop from 5% to 2.5% when all professions are assessed.

Key decisions

Decision 11

We confirm that we received professional advice on this issue when drawing up the proposals, and we will not change the random nature of the sampling process or the audit sample size.

Our comments

- By sampling the same percentage of registrants from each profession, the number of those sampled will be greater for larger professions and lower for smaller ones. In setting the sample size, we consulted the University of Reading who advised that a randomly chosen 5% in the first year and 2.5% in future years was an accurate way of measuring how effective CPD is.
- We have a commitment to monitoring the CPD process and changing it where appropriate. If, after the first audit, the sample size of 5% proves to be inaccurate, we will make appropriate changes.
- In response to requests for registrants who take part in the CPD schemes of professional bodies to be assessed less often; all registrants will be treated equally. The length of time that a professional has been on the register or their involvement in other CPD schemes will not affect the CPD standards they must meet.
- We deal with the issue of possible increased costs to registrants later in this report in the 'Resources' section.

Section 9 - Summary of recent work/practice

Our proposals

'Summary of practice (work) history

…This is the descriptive element of the profile. It should provide a concise account of your work context. The summary should include the key responsibilities relating to your role, identify the specialist areas in which you work and identify the key people with whom you communicate and collaborate.

Question 10: Do you believe that the summary of practice (work) history should contain anything else and, if so, what?'

Your responses

Most people were content that the summary of recent work/practice did not need to contain any further information. As the Association of Operating Department Practitioners wrote, "The summary of practice history seems sufficient as a brief outline of a registrant's role."

However, many questioned the summary's proposed format and suggested that:

- submitting a job description and Curriculum Vitae (CV) might be a more appropriate alternative;
- the summary, if it is to be included at all, should be a structured questionnaire; and
- it relies too heavily on a registrant being able to write well.

Several people asked for details of the preferred style of the summary, including providing exemplars. Others suggested that use of the word 'history' does not accurately describe what the summary is intended to represent because it also covers current practice.

Key decisions

Decision 12

In recognition of feedback received, the title of the 500 word summary element of the profile will be changed to 'Summary of recent work/practice'

Our comments

- We will not accept job descriptions instead of summaries of work/practice, although summaries may be based on them.
- A CV is not an appropriate summary of work/practice - it is a self-marketing tool intended for a very different purpose. However, it may be included as supporting evidence.
- We will draw up and publish (by April 2006) additional information about the evidence that will need to be provided in profiles.
- In recognition of feedback received, the title of the 500 word summary element of the profile will be changed to 'Summary of recent work/practice'.
- The summary, as proposed, must be provided in writing. We will provide exemplars and further details about writing the summary.

Section 10 - Additional CPD activities

Our proposals

'The evidence to support your statement

You are asked to support your statement with appropriate evidence. The evidence should relate directly to what has been written in your statement and therefore support fulfilment of the Standards. Evidence must relate directly to and be cross-referenced with the CPD Standards…

A range of evidence can be used, for example: letters from users, personal development plans, course assignments, business plans, learning contacts or guidance material, peer assessment forms, learning packages, workshop attendance and reflections, learning and reflections on dissemination of research/publications. Appendix 2 [of the consultation document] provides further examples of evidence that might be used.

Question 11: Are there any additional activities which you believe should be included in Appendix 2 [of the consultation document]?'

Your responses

Most people were content with the different types of evidence listed in appendix 2 of the consultation paper, viewing them as both useful and wide-ranging. As Sheffield Hallam University noted in its response, "This is very comprehensive and should give registrants a fantastic range of options to explore."

Some people suggested extra activities that should be listed, most notably reflective logs, although several expressed the desire for appendix 2 to be clearly acknowledged as a flexible and ever-changing list (as with appendix 1). Others questioned the appropriateness of some of the activities listed, arguing that they do not illustrate CPD. For example, 'testimonies' and 'letters from users, carers, students or colleagues' could not be considered objective evidence. As one hospital remarked, "The use of patient letters and testimonials as supporting evidence is open to abuse." It also highlighted the potential for "confidentiality breaches" when providing certain types of evidence.

Key decisions

Decision 13

We confirm that the extensive, but not exhaustive, range of CPD activities we have proposed is suitable to meet the needs of our registrants. We will not be altering the range of proposed activities.

Our comments

- We dealt with the issue of security and confidentiality previously in 'Summary of recent work/practice' section.
- Appendix 2 in the consultation document clearly states "Examples of types of evidence for CPD". This is not intended to be a complete list and it is expected that registrants will have a range of other activities that they will be able to include.

Section 11 - Evidence

Our proposals

'Question 12: Do you believe that requirements should be set for the number of pieces of evidence to be submitted?

Question 13: How can the assessors satisfy themselves that all documentary evidence is verifiable as either an original piece of work or, where claimed, that the registrant has actually contributed to the work?'

Your responses

The issue of whether we should set requirements for the number of pieces of evidence resulted in equal numbers of people supporting and disagreeing with our proposals. Respondents in favour of requirements being set suggested the following:

- Without a minimum requirement, registrants cannot know whether they have provided enough documentary evidence. As one person commented, "…there needs to be some measure of what is required."
- We should set minimum and maximum numbers. This would guide the shape and structure of a registrant's CPD profile and control the amount of information we would have to handle. Some people were confused by the reference to a 'minimum standard of CPD' in Figure 2 of the consultation paper because this is not mentioned elsewhere in our proposals.
- We should give guidance on what sufficient CPD is. Reflecting this, the British Association for Counselling and Psychotherapy wrote, "There certainly needs to be greater clarity on this, otherwise how will registrants know what is expected and how can parity be achieved across the different assessors?"

Other people focused on the quality, rather than the quantity of CPD evidence. For example, the British and Irish Orthoptic Society noted that, "It is the quality rather than the quantity of evidence that counts; however, some additional information about the minimum number of pieces of evidence might be helpful, particularly as achieving a mix of learning activities is one of the CPD requirements."

The College of Occupational Therapists agreed with this point of view when it proposed that, "…a minimum number or a range (minimum to maximum) of evidence pieces should be set to guide the registrant in compiling his/her CPD profile. This would help to ensure that the assessors maintain standardisation in their assessment."

Those who disagreed with setting the number of pieces of evidence generally shared the following concerns:

- Our proposals reflect the different professions and professionals we regulate.
- The evidence provided should cover the range of standards, which is not the same as specifying the volume of evidence to be provided.

Many people felt that although it would not be possible for assessors to be completely satisfied about how authentic evidence was, a certain level of trust must be given to registrants. As the College of Occupational Therapists observed, "It is important to regard the registrant as a professional who is required to abide by the HPC's Standards of Conduct, Performance and Ethics as well as the Code of Ethics of his/her professional body."

However, we received several suggestions for how assessors could check how authentic evidence was, including the following.

- A registrant's CPD profile could be verified by a line manager before it is sent in for assessment.
- An assessor could arrange a personal interview with a registrant if they have questions about the evidence that has been provided.
- Character references and signatures of independent witnesses could be provided as evidence.

Canterbury and Coastal Primary Care Trust summarised its opinion about the need for verification as "A manager, supervisor, team leader, acknowledged mentor or peer should validate each registrant's submission with a short piece of written documentation in a standard format, stating their relationship to the registrant, how long they have known this registrant and verifying their written portfolio as a true reflection of that individual".

The British Association of Prosthetists and Orthotists would prefer an interview process in cases where doubt exists. This was supported by the Association of Clinical Biochemists, which suggested that an assessor could get answers to any questions they have about evidence by "…seeking confirmation from another registrant who works closely with the registrant undergoing review. This is where an interview would be helpful, but is not part of the proposed process".

Key decisions

Decision 14

We confirm that in order to meet the needs of an expanding range of professions and contexts, it is not appropriate to introduce a fixed CPD process. We will keep the flexible process we originally proposed.

Our comments

- The issue of setting minimum and maximum levels for the number of pieces of evidence that must be provided was discussed earlier in this report in the 'Approach' section. Given the range of CPD activities and varying scope of practice and work contexts, we cannot set a minimum or maximum number of pieces of CPD evidence. It is the quality rather than quantity of CPD learning that we are concerned with. Given this, our reference to a minimum standard of CPD (in figure 2 of the consultation paper) is misleading and we will explain or remove it. We will draw up and publish additional information (by April 2006), on the range of evidence that will need to be provided.
- We do not intend to introduce an interview process. This would mean we would have to increase registration fees. If assessors are not satisfied with the evidence a registrant has provided, we will tell registrants that they have not met the necessary CPD standard and will have three months in which to improve their portfolios and meet any conditions set by the assessors. If the registrant does not do this, they may be removed from the register. A registrant would be given the opportunity to give written explanations to the Education and Training Committee before we decide whether or not to remove them from the register. If a registrant does not agree with our decision, they can appeal to us and, ultimately, the courts.

Section 12 - Profile guidelines

Our proposals

'Question 14: Do you believe that the information contained in the Guidelines for Preparing a Profile and the 'prompt' questions detailed in Appendix 3 [of the consultation document] are adequate to allow registrants to take a critical and evaluative approach to their learning and how it has impacted on their work, and to demonstrate that they have met the CPD Standards? If not, please suggest more appropriate questions.'

Your responses

Most people felt that the information in appendix 3 of the consultation paper was adequate, with many praising the helpful examples of how a profile may be structured and prepared. As Enfield Primary Care Trust wrote, "We all found this very comprehensive, extremely useful and thought provoking, and congratulate the HPC on producing this section."

Where concerns were raised, people questioned the amount of information and the level of detail provided. The most common comments were about:

- how relevant the prompt question, 'Who approved your CPD plan?' in the consultation paper is;
- the questions being confusing and ambiguous;
- there being too many questions, which in turn lead to unnecessary paperwork;
- example profiles and pro-formas would be a more user-friendly and appropriate alternative;
- mentoring, individual guidance or a helpline being of benefit.

Key decisions

This section relates only to the consultation paper itself and we did not need to make any decisions.

Our comments

- By April 2006, we will draw up and publish further information on the evidence registrants will need to provide in a profile. This information will clearly reflect the questions in appendix 3 of the consultation paper.
- We do not currently have the resources to staff a helpline, but we may in the future. In the meantime, we intend to publish exemplar profiles and comprehensive information on our website to help registrants produce profiles.
- The prompt questions in appendix 3 were provided as suggestions in order to promote discussion and get feedback. Many of the questions were useful in encouraging people to provide feedback while others were not quite as useful. Overall, the feedback we received was well thought out and helped us to critically analyse our proposals.

Section 13 - Existing CPD schemes

Your responses

We did not specifically ask any questions about existing CPD schemes. However, many people commented on their involvement in these schemes and felt that this should be taken into account when we assess CPD.

People also asked whether we have consulted the professional bodies running these schemes. They suggested that we should invite them to share their knowledge and expertise, and be involved in introducing our CPD process. This reflects a strong desire to avoid repeating work already carried out and to build on existing CPD schemes. As one person remarked, "Please do not underestimate what some organisations already provide for their staff. There is no need to reinvent the wheel." The Chartered Society of Physiotherapy also expressed enthusiasm for such a collaborative approach, writing: "The Society strongly recommends that the HPC develop, pilot, evaluate and refine the CPD scheme… This is an area [in which] the Society and other professional bodies could collaboratively assist the HPC."

It was also suggested that we could assess the suitability of existing CPD schemes, then recognise and approve those schemes that reflect the principles, approach and intended outcomes of our proposals.

Some registrants also felt that their CPD was already well managed by their employers. Twenty-two registrants from a single foundation trust commented that: "We feel that as professionals we are regularly appraised within the physiotherapy department of a leading and renowned teaching hospital. By requiring further documentation you are demeaning our current and important appraisal system for upholding standards and promoting professional growth." The group also added that: "The current appraisal system is trust regulated and in accordance with new national Knowledge and Skills Framework guidelines. This will surely prove our competency as physiotherapists and save on additional costs and unnecessary work for the Council and its members."

Our comments

- We sent our consultation paper to around 350 organisations, including professional bodies and associations, and we asked everyone to respond.
- We will not organise, approve or manage formal CPD activities.
- We realise that a number of employers and professional bodies already run appraisal and CPD schemes. As a result, any activity and associated documents undertaken under another scheme will be an acceptable activity for us. However, if a registrant is audited, they must be able to show that the activity they undertook meets our Standards of Continuing Professional Development.

- With reference to the foundation trust's comments, all foundation trusts must keep to the KSF in full so their staff should be able to use materials associated with that to meet our CPD requirements.

Section 14 - Resource issues

Your responses

We did not ask specific questions about the potential time and costs to registrants of taking part in our CPD process. However, several people expressed concerns about the resources needed to introduce our process. Specific issues included:

- the need for support from employers, in terms of setting aside both time and funding;
- when during the working day, should registrants be expected to undertake CPD (for example, whether we expect all, or most of, CPD to be carried out during working hours, as this may affect self-employed registrants' earnings;
- whether registrants will receive any help from us, in terms of access to CPD activities, funding and campaigning; and
- the negative effect CPD could have on patient care, due to the amount of time needed to undertake CPD activities.

The issue of employer support raised particularly strong comments. Some people suggested that we should tell employers about their responsibilities in relation to their staff's CPD requirements, perhaps by issuing additional information to employers. For example, the National Association of Occupational Therapists working with People with Learning Disabilities asked how CPD will be promoted to employers, to make sure they work with registrants and provide time and funding for CPD. Other people went further and asked that employers be told they must set aside time for CPD. As one person observed, "As the onus lies with the individual, the HPC will need to put a lot of work into getting employers and health professional bodies on side with regard to resources."

A handful of people were concerned that our CPD process would have a negative effect on recruiting and keeping staff within the professions we regulate. Some, like the Chartered Society of Physiotherapy, also questioned whether the CPD process will increase costs for registrants.

Key decisions

Decision 15.

We will undertake a communications campaign to make sure that employers know about our CPD process and are encouraged to support it. We believe that this will have a positive effect on patient care.

Our comments

- We have no powers to provide funding for CPD or to insist that employers fund CPD.
- Our main aim is to protect the public. Over protecting doctors' interests rather than public safety resulted in the GMC being criticised in the Shipman Inquiry. The same could apply to us and our registrants if we do not keep our focus on protecting the public.
- We set no expectations for when registrants undertake CPD, so it does not need to effect self-employed registrants' incomes. Some types of CPD listed in appendix 2 of the consultation paper can be done 'on the job' (for example, learning by doing, gaining and learning from experience, job rotation) so would not involve longer working hours or result in a loss of income.
- We do not agree that CPD will have a negative effect on patient care. In fact, it should positively improve it. The NHS Knowledge and Skills Framework also links learning to improved services.

Section 15 – How the standards apply

Your responses

Many people asked how general CPD proposals applied to all registrants. Some suggested that our CPD process should take account of the individual circumstances of registrants. These comments centred on the ability of specific groups of registrants to meet our requirements, notably those who are:

- physically disabled;
- not currently practising;
- working part-time;
- self-employed;
- based outside the UK;

- peripatetic (working in various places for relatively short periods);
- located in rural areas;
- locums; or
- registered with more than one statutory regulator.

Many people asked for allowances to be made for some or all of these groups, due to the inequalities they experience in terms of time and funding for, access to, and the availability of CPD. The Department of Health, Social Services and Public Safety (Belfast), commented that the majority of professionals work within a “governance structured framework” and that we should also consider international registrants and those working in the private or voluntary sectors.

Questions were also raised about whether we would make allowances for those on leave at the time we ask for profiles or during assessment, and whether registrants who are on leave will be able to keep to the CPD standards or meet our deadlines for providing evidence. In particular, questions were asked about:

- maternity and paternity leave;
- sick leave;
- other types of extended leave.

Our comments

- As stated in the consultation paper, our proposed CPD process is ‘context-driven’ and intends to reflect an individual registrant’s scope of practice. If a registrant’s particular circumstances influence their scope of practice, this will be reflected in their CPD activities and the assessors’ expectations. This applies to all of the groups of registrants listed in this section, apart from registrants who are not practising.
- If a registrant chosen for audit is on maternity, paternity or extended sick leave, or on leave to care for young or elderly relatives, they can put off the assessment for two years, when they will automatically be chosen for assessment again. It is worth noting that when a registrant is on leave, this does not necessarily mean that no CPD is being undertaken. This is one of the reasons we ask registrants to put their practice and learning into context in the summary section of the profile. If you are in this situation and want to provide a CPD profile, you may still be able to do so.
- Registrants who have not worked for several years and cannot meet the necessary Standards of Proficiency should consider whether they should still be on the Register. If a registrant fails to meet our CPD standards we would remove them from the register. If the registrant wanted to renew their registration at a later date and met our CPD and other necessary standards, they would be able to apply to go back on the register.
- If a registrant takes up a post outside the UK, it provides the opportunity for widening experience. We recognise that a post outside the UK means a new environment and a range of different methods of work, which can benefit an individual’s learning. Gaining experience in a new and different environment may contribute to CPD.

appendix 1- consultation events

We held 46 public consultation events in 22 different venues around the United Kingdom. These venues are listed in table 1 below.

Table 1: Locations and dates of public consultation events

Town or city	Venue	Date
London	School of Oriental and African Studies	13 September 2004
Orkney Islands	Phoenix Theatre	16 September 2004
Mold	Beaufort Park Hotel	21 September 2004
Bolton	The Pack Horse Hotel	22 September 2004
Leicester	Leicester Tigers RFC	28 September 2004
Sheffield	Sheffield United FC	29 September 2004
Wolverhampton	Britannia Hotel	30 September 2004
Fort William	Moorings Hotel	4 October 2004
Glasgow	Hampden Park	5 October 2004
Hastings	The Cinque Ports Hotel	12 October 2004
Oxford	The Oxford Centre	20 October 2004
Ipswich	Ipswich Town FC	21 October 2004
Swansea	Holiday Inn	27 October 2004
Bath	Hilton Bath City	28 October 2004
Belfast	Wellington Park Hotel	2 November 2004
Londonderry	Tower Hotel	4 November 2004
Plymouth	New Continental Hotel	9 November 2004
Southampton	Southampton FC	11 November 2004
` Dundee	Hilton Dundee	17 November 2004
Edinburgh	Apex International Hotel	18 November 2004
Sunderland	Sunderland FC	24 November 2004
Penrith	Exhibition Hall	25 November 2004
London	Regent's College Conference Centre	29 November 2004

appendix 2 – organisations that responded

Organisations that responded to our consultation document are listed below.

- All Wales NHS Physiotherapy Managers Committee
- Allied Health Professions
- Amicus Trade Union
- Association of Chartered Physiotherapists in Management
- Association of Clinical Biochemists
- Association of Clinical Cytogeneticists
- Association of Clinical Scientists
- Association of Operating Department Practitioners
- Barnet, Enfield and Haringey Mental Health NHS Trust
- Bedfordshire Education Authority
- Birmingham Heartlands and Solihull NHS Trust
- Board of Welsh Community Health Councils
- British Psychological Society Division of Health Psychology
- British Academy of Audiology
- British Association of Arts Therapists
- British Association for Counselling and Psychotherapy
- British Association of Play Therapists
- British Association of Prosthetists and Orthotists
- British Blood Transfusion Society
- British and Irish Orthoptic Society
- British Psychological Society
- Burnley, Pendle and Rossendale Primary Care Trust
- Canterbury and Coastal Primary Care Trust
- Canterbury Christ Church University College
- Cardiff and Vale NHS Trust
- Care Council for Wales
- Castle Point and Rochford PCT
- City University London
- Colindale Hospital
- College of Occupational Therapists
- Department of Health (Quarry House, Leeds)
- Department of Health, Social Services and Public Safety (Belfast)
- Derby City Council
- Dudley Social Services
- Eastern Birmingham Primary Care Trust
- Elekta Ltd
- Enfield Primary Care Trust
- Federation of Clinical Scientists
- Ferndown Local Office
- Fife Acute Hospitals
- General Chiropractic Council
- General Medical Council
- General Optical Council
- Glasgow Caledonian University
- Guy's and St Thomas' NHS Foundation Trust
- Health Professions Wales
- Healthcare Commission
- Homerton School of Health Studies
- Institute of Biomedical Science
- Institute of Physics and Engineering in Medicine
- Isle of Man Government
- Joint Royal Colleges Ambulance Liaison Committee
- Kneesworth House Hospital
- Macmillan National Institute of Education
- National Association of Primary Care Educators
- National Blood Service
- Newbury Physiotherapy Service
- NHS Education for Scotland
- North Bristol NHS Trust
- North Devon Primary Care Trust
- North East London Strategic Health Authority

- North Hampshire Hospitals NHS Trust
- North Hertfordshire and Stevenage Primary Care Trust
- North Kirklees Allied Health Professional Forum
- North Surrey Primary Care Trust
- North West London Occupational Therapist Liaison Committee
- Northern Ireland Council of the Society and College of Radiographers
- Nottingham City Primary Care Trust and Social Services
- Nuffield Orthopaedic Centre
- Operating Department Practitioners of Northern Ireland
- Oxford Brookes University
- Papworth Hospital NHS Trust
- Pharmaceutical Society of Northern Ireland
- Play Therapy UK
- Queens Medical Centre
- Raigmore Hospital
- Registration Council for Clinical Physiology
- Rotherham General Hospital NHS Trust
- Royal College of General Practitioners
- Royal College of Midwives
- Royal College of Speech & Language Therapists
- Royal Free Hospital
- Royal Pharmaceutical Society of Great Britain
- Royal Shrewsbury Hospital
- Royal Surrey County Hospital
- Rushcliffe Primary Care Trust
- Scarborough, Whitby and Ryedale Primary Care Trust
- Sheffield Hallam University
- Society and College of Radiographers
- Society of Chiropodists & Podiatrists
- Society of Homeopaths
- Society of Sports Therapists
- South Birmingham Primary Care Trust
- South Manchester Primary Care Trust
- St Mary's Hospital
- St George's Healthcare NHS Trust
- Swindon Primary Care Trust
- Thames Valley Strategic Health Authority
- The Alliance of Private Sector Chiropody and Podiatry Practitioners
- The British Dietetic Association
- The Chartered Society of Physiotherapy
- The Health Service Ombudsman
- The Institute of Chiropodists and Podiatrists - Wolverhampton Branch
- Tonbridge and Malling Borough Council
- UNISON Health Group
- University College London
- Victoria Hospital and Queen Margaret Hospital
- Welsh Therapies Advisory Committee
- Wessex Primary Care Research Network
- Western Infirmary (Glasgow)
- West Lincolnshire Primary Care Trust
- West Sussex Health and Social Care NHS Trust
- West Yorkshire Strategic Health Authority
- Wrightington, Wigan and Leigh NHS Trust

where to get more information

If you need more information or further copies of this report, please contact:

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