Council meeting, 9 December 2010

An exploration of quality assurance programmes in professional regulators in Ontario, Canada

Executive summary and recommendations

Introduction

The attached report is one a series of reports as part of the HPC's programme of work exploring revalidation.

In July 2010, a fact-finding trip was undertaken by Anna van der Gaag (Chair) and Megan Scott (Policy Manager) to a number of regulatory colleges in Ontario, Canada. The purpose was to gain an in-depth understanding of the 'quality assurance programmes' in place in each of these Colleges, including the design of those programmes, the Colleges' experience of administering their programmes, the costs involved, and any evaluations of the benefits of the programmes. The quality assurance programmes are similar in many respects to the models suggested in the ongoing debate about revalidation and are of particular interest as they are focused on supporting registrants to improve the quality of their practice rather than on detecting poorly performing practitioners.

The attached report describes the information gathered during the four-day visit and considers the potential implications for the HPC. As this is one report in a much larger programme of work, the report does not make any firm recommendations and the Council is not invited to draw any specific conclusions at this stage. However, the Council is invited to discuss the attached report, in particular section 7 which discusses the potential implications for the HPC.

Decision

The Council is invited:

a) to discuss the attached report and the analysis contained within and suggest any amendments or additions to its content; and

b) to agree the text of the document (subject to minor editing amendments and any changes agreed at the meeting) for publication on the HPC website.

Background information

This report forms part of 9 projects looking at revalidation. The Council last received an update on these projects at its meeting on 20 May 2010.
http://www.hpc-uk.org/aboutus/council/councilmeetings_archive/index.asp?id=499

Appendix 1 includes a list of all the projects being undertaken with currently expected timescales. These will be subject to ongoing review (and some projects may be consolidated or changed in scope) and it is planned that an update will be provided to the Council at its February 2011 meeting. It is currently anticipated that a final report encompassing all the research strands will be submitted to the Council at its July 2011 meeting.

Resource implications

There are no resource implications from the Council's decision on this report.

Financial implications

There are no financial implications from the Council's decision on this report.

Appendices

- List of revalidation projects and expected timescales.

Date of paper

26 November 2010

Appendix 1 – List of projects and expected timescales

The following lists all the projects being conducted as part of the work on revalidation together with currently expected timescales. Please note that these timescales may be subject to change. An update will be provided to the Council at a future meeting.

*denotes a project involving externally commissioned research

Project 1 – Pre-registration education and training*
Duration: 12 months (March 2010 – March 2011)
Being completed by: University of Durham
Final report due: March 2011
Presented to Council: 12 May 2011

Project 2 – Professionalism tool*
Duration: 5 years (March 2010 – March 2015)
Being completed by: University of Durham
Final report due: March 2015 (annual interim reports every March)
Presented to Council: 12 May 2011 (first interim report)

Project 3 – FtP analysis*
Duration: Analysis is underway
Being completed by: Lesley Smith, Principal Lecturer, Oxford Brookes University
Final report due: March 2011 (TBC)
Presented to Council: 12 May 2011 (TBC)

Project 4 – CPD audit analysis*
Duration: In development phase; shortly due to be commenced
Being completed by: Lesley Smith, Principal Lecturer, Oxford Brookes University
Final report due: March 2011 (TBC)
Presented to Council: 12 May 2011 (TBC)

Project 5 - Literature review of the fitness to practise of the professions regulated by the HPC
Duration: Initial scoping work undertaken
Final report due: March 2011
Presented to Council: 31 March 2011

Project 6: Literature review of fitness to practise trends regarding professions other than those regulated by the HPC
Duration: Initial scoping work undertaken
Final report due: March 2011
Presented to Council: 31 March 2011

N.B: Initial scoping work has been undertaken for projects 5 and 6 and these projects may be consolidated together

Project 7: Review of existing revalidation processes that have been implemented by international regulators
Duration: Complete; subject to Council consideration
Final report due: November 2010
Presented to Council: 9 December 2010

Project 8: Review of existing revalidation processes that have been implemented or are being developed by other UK regulators
Duration: Meetings have taken place and continue to take place with other UK regulators
Final report due: March 2011
Presented to Council: 31 March 2011

Project 9: Exploration of patient feedback tools currently being developed by other health regulators
Duration: This project has not been initiated
Being completed by: Megan
Final report due: March 2011
Presented to Council: 31 March 2011

N.B: The scope of project 9 has yet to be determined; consideration will be given as to whether this project might also utilise externally commissioned research.

Final report – consolidation of all projects and recommendations
Duration: This project has not been initiated
Final report due: June 2011
Presented to Council: 7 July 2011

hpc health professions council

An exploration of quality assurance programmes in professional regulators in Ontario, Canada

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1. Executive Summary

1.1 This report is one of a series of reports on the work that the Health Professions Council (HPC) has undertaken on revalidation. Its purpose is to describe a selection of quality assurance programmes that have been implemented by regulatory 'colleges' in the Canadian province of Ontario.

1.2 The Ontario colleges have well established quality assurance programmes that are underpinned by legislative requirements. These programmes are focused on enhancing the post registration practice of health professionals beyond the threshold standards for safe practice.

1.3 The models used in Ontario differ to the HPC's current systems, as they are focused primarily on quality improvement. Programmes are not specifically designed with the aim of identifying poorly practising professionals, although they may sometimes do so. The HPC's primary role is to protect the public and our current systems are focused on quality control, however our systems also act as a driver for quality improvement.

1.4 If the HPC were to introduce a quality assurance model we would be moving to another level of regulatory activity, beyond safeguarding the public by setting the threshold level of safe practice. Based on the experience of Ontario regulators, we might expect the majority of registrants to report improvements in their practice as a result of participation in the programmes and, by implication, we might conclude that this benefits service users by increasing the quality of services. However, we know that there are clear difficulties in establishing a 'causal' rather than 'implied' link between any revalidation, quality assurance or continuing professional development (CPD) system and increased public protection. There are also relatively high costs associated with some aspects of the quality assurance models studied in this paper.

1.5 This report does not try to draw definitive conclusions about revalidation. It is intended to feed into the wider discussion about whether revalidation is necessary and, if so, what systems would be appropriate. However, there are some key messages that can be drawn from this study.

1.6 In making a decision about whether to proceed with a new regulatory system, the HPC must decide whether the primary purpose of revalidation is to identify practitioners who do not meet our standards (quality control), or to raise the practising standards of all registrants (quality improvement). If we want to raise the standards of our registrants, the models of quality assurance used across Ontario could provide us with some interesting options as we move forward.

However, if we are looking to introduce a system that identifies those individuals who do not meet our threshold standards, but whom are not already identified through existing regulatory systems, the outcomes of quality assurance programmes may be unlikely to meet our requirements.

1.7 Regardless of whether the HPC does decide to introduce revalidation, there are many ways that the HPC could learn from the processes and systems used across Ontario, including the way the colleges engage with their registrants and the sampling techniques in their quality assurance processes.

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2. Introduction

2.1   This report is one of a series of reports on the work which the Health
       Professions Council (HPC) has undertaken on revalidation. Its purpose
       is to describe a selection of quality assurance programmes that have
       been implemented by regulatory 'colleges' in the Canadian province of
       Ontario.

2.2   The regulatory bodies in Ontario were chosen after investigation into a
       number of professional regulators worldwide. Legislation mandates that
       all Ontario health regulatory colleges have quality assurance
       programmes in place. Although all colleges are working under the
       same legislation, they have taken different approaches in developing
       and implementing programmes that are appropriate for their
       professions and registrants.

2.3   The aims of this study were to gain an in-depth understanding of
       quality assurance programmes in place across Ontario, in particular:

   •   the different components that form quality assurance programmes and
       how they work together;
   •   the development and ongoing costs of different approaches to quality
       assurance;
   •   numbers of registrants who have fallen below the quality assurance
       standards;
   •   results of evaluations about how successful these systems have been
       in increasing public protection;
   •   feedback from registrants who have participated in the process;
   •   similarities to the HPC's continuing professional development
       programme; and
   •   the implications of this model for the HPC.

Approach to study

2.4   Following the initial scoping work, a visit to the colleges was
       undertaken over a four day period between 13 and 16 July 2010. The
       Chair of the HPC and Policy Manager held one-to-one meetings with
       representatives from the following regulatory colleges:

   •   College of Dietitians of Ontario[1]
   •   College of Medical Technologists of Ontario[2]
   •   College of Occupational Therapists of Ontario[3]
   •   Ontario College of Pharmacists[4]

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[1] College of Dietitians of Ontario: www.cdo.on.ca/en/
[2] College of Medical Technologists of Ontario: www.cmlto.com
[3] College of Occupational Therapists of Ontario: www.coto.org/

- College of Physiotherapists of Ontario[5]

2.5 At each meeting, we discussed:

- the content of the quality assurance programme;
- how the programme was developed and implemented;
- what evaluations and reviews have been conducted to date; and
- the development and on-going costs of the programme.

2.6 A summary of the quality assurance programmes for the above colleges can be found in Appendix A.

2.7 A group meeting was also held with representatives from the following colleges:

- College of Physicians and Surgeons of Ontario[6]
- College of Nurses of Ontario[7]
- Ontario College of Social Workers and Social Service Workers[8]
- Royal College of Dental Surgeons of Ontario[9]

(N.B: Unless specified, 'colleges' refers to the five colleges we met with on a one-to-one basis.)

Background to the HPC's revalidation research programme

2.8 This study forms part of a series of research projects focussing on whether additional measures are needed to ensure the continuing fitness to practise of our registrants.

2.9 The 2007 the White Paper – Trust, Assurance and Safety - the Regulation of Healthcare Professionals in the 21st Century stated that:

'…revalidation is necessary for all health professionals, but its intensity and frequency needs to be proportionate to the risks inherent to the work in which each practitioner is involved…the regulatory body for each non-medical profession should be in charge of approving standards which registrants will need to meet to maintain their registration on a regular basis.'[10]

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[4] Ontario College of Pharmacists: www.ocpinfo.com/
[5] College of Physiotherapists of Ontario: www.collegept.org/
[6] College of Physicians and Surgeons of Ontario: www.cpso.on.ca
[7] College of Nurses of Ontario: www.cno.org/
[8] Ontario College of Social Workers and Social Service Workers: www.ocswssw.org
[9] Royal College of Dental Surgeons of Ontario: www.rcdso.org
[10] Department of Health (2007), *Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century*, paragraphs 2.29 and 2.30.

2.10   The current government has recommended that medical revalidation be subject to further feasibility assessments before any decision is made about how systems might be introduced across the health sector. In June 2010, the Secretary of State for Health stated that 'we need strong evidence on what works for both patients and the profession'.[11] This evidence-based approach aligns with the HPC's approach to revalidation. We advocate that any new regulatory layer of inspection must be underpinned by a strong evidence base to ensure that it is robust and fit for purpose.

2.11   The HPC already has a number of systems in place to ensure the continuing fitness to practise of our registrants. These include our registration renewals process, continuing professional development standards and fitness to practise processes. In the first phase of revalidation work, we are undertaking a series of projects to increase our understanding about whether additional measures are needed to ensure the continuing fitness to practise of our registrants.

2.12   We are also exploring the different systems that are already in use across the UK to learn from the successes of others and assess the feasibility of different models.

Differences between quality assurance and revalidation

2.13   In the 2008 Continuing Fitness to Practise Report, we explored the potential dichotomy which exists between the different aims of 'quality improvement' and 'quality control'.[12] Quality improvement is aimed at improving the quality of the service delivered by practitioners at every level; whereas quality control is focussed on the minority of practitioners who fail to meet the threshold standards.

2.14   The primary driver behind the UK government's decision to introduce revalidation was a small number of high profile cases where patient safety was severely compromised. The government has directed regulators to introduce revalidation as means of ensuring that all health professionals demonstrate their continuing fitness to practise.[13] The definitions used for revalidation by government and other health regulators suggest that revalidation is widely perceived to be a quality control mechanism:

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[11] Letter from the Rt Hon Andrew Lansley, Secretary of State for Health to the Chair of the General Medical Council (June 2010).
[12] Health Professions Council (2008), *Continuing Fitness to Practise: towards an evidence-based approach to revalidation*, p.7.
[13] Department of Health (2007), *Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century*.

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"Revalidation is the process by which a regulated professional periodically has to demonstrate that he or she remains fit to practise." (Department of Health)[14]

"Revalidation is a mechanism which allows health professionals to demonstrate, at regular intervals, that they remain both up-to-date with regulator's standards, and are fit to practise." (General Optical Council)[15]

"Revalidation is a new process which will require osteopaths to show, at regular intervals, that they remain up to date and fit to practise." (General Osteopathic Council)[16]

2.15   The quality assurance programmes examined in this study are similar in some respects to the models of revalidation discussed and suggested in the UK – for example, they include CPD, peer assessment of competence and remediation.

2.16   However, in contrast to how the purpose of revalidation has often been perceived in the UK, these programmes are focused on quality improvement ('raising the bar' of all registrants' practice) rather than quality control. The College of Occupational Therapists states that their quality assurance programme 'is aimed at promoting reflective practice and providing tools and resources for therapists to continue to enhance their knowledge and skills'. The aim of the College of Physiotherapists quality management programme is to 'foster an environment that supports physiotherapists in reflective practice and setting goals toward life-long learning while providing the opportunity to demonstrate competence and meet the College mandate'.[17]

2.17   In the 2008 Continuing Fitness to Practise report we concluded that the HPC's existing processes achieve quality control whilst also acting as a driver for quality improvement.[18] The work we are now undertaking on revalidation is primarily focussed on quality control; however, we are also exploring existing quality improvement models to learn more about the operational requirements and benefits to health professionals and members of the public.

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[14] Department of Health (2006), *The Regulation of the Non-Medical Healthcare Professions*, p.48.
[15] General Optical Council: http://www.optical.org/en/about_us/revalidation/index.cfm
[16] General Osteopathic Council: http://www.osteopathy.org.uk/practice/standards-of-practice/revalidation/
[17] College of Physiotherapists of Ontario: http://www.collegept.org/Physiotherapists/Quality%20Management/QualityManagement
[18] Health Professions Council (2008), *Continuing Fitness to Practise – Towards an evidence-based approach to revalidation*, p.11.

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3. Regulated Health Professions Act 1991 of Ontario

3.1   The Regulated Health Professions Act, 1991 (RHPA) came into force in Ontario on 31 December 1993. The Act provides a common legislative framework under which all 24 health regulatory colleges in Ontario must function.[19]

3.2   These colleges regulate most of the health professions that are also regulated in the UK. A small number of additional health professions, including massage therapists, also come under statutory regulation in Ontario. There are also three transitional Councils in place for professions that are in the process of being regulated for the first time.

3.3   Ontario medical laboratory technologists are included in this study. These professionals are regulated as biomedical scientists in the UK.

Quality assurance legislation

3.4   Clauses 80 – 83 of the RHPA mandate that all colleges must have a quality assurance programme in place. As a minimum, all quality assurance programmes must include the following components:

- continuing education or professional development;
- self, peer and practice assessments; and
- a mechanism for the college to monitor members' participation in, and compliance with, the quality assurance programme.

3.5   The RHPA also requires colleges to establish quality assurance committees. The committees are the decision making bodies who decide whether a registrant has met the quality assurance standards. If a registrant is found to fall below the required standard for any part of the quality assurance programme, committees can take the following action:

- direct the registrant to participate in specified continuing education or remediation programmes;
- direct the Registrar to impose terms, conditions or limitations for a specified period to be determined by the Committee on the certificate of registration of a member; or
- report the registrant to a disciplinary committee if they feel that the registrant may have committed an act of professional misconduct, or may be incompetent or incapacitated.

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[19] Ontario (1991) *Regulated Health Professions Act 1991*, *Chapter 18*: www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_91r18_e.htm

Amendments to the legislation

3.6 The original wording of the legislation enacted in 1993 was less prescriptive than the current legislation in terms of mandating what quality assurance programmes should include. For example, the original wording did not prescribe the components that programmes must include.

3.7 In June 2007 a revised RHPA was enacted, which had significant amendments to the quality assurance clauses. The amendments made the legislation much more specific about what the programmes should include. This was partly in response to a lack of progress being made by some regulatory colleges in developing and implementing quality assurance programmes.

3.8 The revisions to the legislation also followed the high profile Wai-Ping case.[20] Dr Wai Ping was a gynaecologist who had numerous complaints made against him between 1994 and 2001, but had no restrictions placed on his practice by the Ontario College of Physicians and Surgeons until 2004. This was due, at least in part, to the quality assurance process in place at the College. Disciplinary committees referred these complaints to the College's Quality Assurance Committee. As Quality Assurance Committee decisions are confidential, each time a complaint was received this was considered in isolation without taking into account previous decisions. Furthermore the role of quality assurance committees was to provide remediation and practice enhancement, not to stop a professional from practising or to impose restrictions on their practice. The changes have made the legislation much more prescriptive about how quality assurance programmes must operate, which means that disciplinary committees are no longer allowed to refer competence complaints to quality assurance committees.

3.9 In December 2009, a new requirement was added to the quality assurance component which stated that programmes must promote inter-professional collaboration. This was partly in response to public concerns about the lack of communication between health professionals and the feeling that stronger inter-professional collaboration across health professions could safeguard against similar cases of misconduct arising in the future.

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[20] CBN News (2009), *The Fifth Estate - First, Do No Harm*: www.cbc.ca/fifth/donoharm.html

4. The components of quality assurance programmes

4.1   Ontario health regulatory colleges operate under shared legislation which mandates the minimum requirements of quality assurance programmes. Despite this, colleges have chosen to develop their quality assurance programmes in different ways. The result is a range of quality assurance programmes that share the same legislation, but differ in the way they operate.

4.2   This section looks at the different components that form quality assurance programmes and provides examples of the different approaches used by regulatory colleges. It is intended to provide an overview of the programmes and comparison of approaches. More details about how each programme works can be found in Appendix A.

4.3   There are three components to the quality assurance programmes which are discussed in turn:

- professional development
- practice assessment
- practice enhancement

Shared principles and philosophies across Ontario colleges

4.4   A consistent theme running across all quality assurance programmes in Ontario is the focus on enhancing and improving the practice of all registrants. Quality assurance programmes were not designed with the aim of identifying and removing poorly performing individuals. The philosophy underpinning all quality assurance programmes is to support registrants to reflect on their current level of practice and to strive continually to achieve a higher standard.

Professional development

4.5   For all colleges included in this study, registrants are required to maintain a 'professional development portfolio'. As a minimum, portfolios include a self-assessment tool and learning or professional development plan. These plans are used by registrants to identify their strengths, weaknesses, future learning needs and goals.

4.6   Some colleges also have additional components included in the portfolio. For example, the College of Occupational Therapists portfolios include self-directed learning modules that help registrants improve their understanding about a topical issue. An example of a recent module is 'understanding professional boundaries'. The modules change yearly and are developed based on feedback from registrants, the committees and the public.

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Self-assessment

4.7   It is a legislative requirement in Ontario that all registered health professionals complete regular self-assessments. Most regulatory colleges require their registrants to complete an annual self-assessment either online or using a paper based format. In these assessments, registrants are asked to assess themselves against the standards of practice for their profession. For example, the College of Occupational Therapists has published the 'Essential Competencies of Practice for Occupational Therapists in Canada' which registrants self assess against. Most colleges also include a testing element where registrants are required to complete a clinical knowledge or behavioural test.

4.8   All colleges, except the College of Pharmacists, require registrants to complete the self-assessment on an annual basis. Pharmacists are required to complete an online self-assessment once every five years, although the College does encourage more regular participation.

Jurisprudence tests

4.9   Jurisprudence tests are another example of how some colleges encourage registrants to focus on enhancing their understanding of a particular element of practice.

4.10   The College of Dietitians' quality assurance programme includes a 'jurisprudence knowledge and assessment tool' which is aimed at improving the knowledge and application of laws, standards, guidelines and ethics relevant to dietitians.

4.11   All registrants are required to complete the assessment every five years. It is an online tool which focuses on knowledge acquisition and registrants are given access to the information they need to complete the test.

4.12   The College of Physiotherapists also require registrants to complete a jurisprudence test every five years. This is a requirement for registration renewal and is not a part of the quality assurance programme itself.

Online systems

4.13   Amongst the models studied in this review, there is a clear trend towards developing online self-assessment and learning portfolio tools, rather than continuing to use paper-based systems. Colleges who use online systems reported significant advantages, particularly in terms of ongoing costs associated with running the programme. Online systems

also require fewer staffing resources within colleges to monitor and ensure compliance.

4.14   The added advantage of online tools is that they allow the colleges to give the registrants instantaneous feedback on their results and how they compare to other registrants. For example, the College of Physiotherapists online tool allows registrants to compare their self-assessment results with those of other registrants. Their results are shown against an aggregated result from all registrants, so registrants can gain an understanding of the level they are practising at compared to their peers. As part of the self-assessment, registrants also complete a short clinical test. Registrants are given their results and directed to further reading for questions they have answered incorrectly.

4.15   The College of Dietitians monitors registrants' online portfolios to collect information about which areas of practice most registrants identify as an area for further development. The college then targets learning modules and guidance documents towards these areas of practice.

Measuring compliance

4.16   Compliance for this component of quality assurance is measured in different ways by the colleges. The College of Medical Laboratory Technologists, who use a paper-based portfolio and self-assessment, audit a random sample of registrants (most recently 220 registrants / 2.85% of the register). These registrants are required to send a hard copy of their portfolio. While the registrant cannot 'pass' or 'fail' the assessment, they are given a report on their submission.

4.17   Other colleges, including the College of Occupational Therapists and the College of Pharmacists, only ask for the portfolios of individuals who are randomly selected to participate in a practice assessment, which is the next stage of the quality assurance process. They do not ask for proof of completion for the remaining registrants, although registrants are required to self-declare that they meet the quality assurance standards when they renew their registration.

4.18   Registered pharmacists are required to complete a self-assessment once every five years. When selected, registrants have eight weeks to complete their assessment. The online tool alerts the College when each registrant completes the assessment. The College only monitors compliance, it does not review the results of the assessments.

4.19   Several colleges discussed the risks involved with staff monitoring and reviewing self-assessments and professional portfolios. Some argued that if a college can request a review of self-assessments, either as

part of a random audit or practice assessment, registrants are less likely to complete a candid self-assessment.

Limitations of self-assessment

4.20   Many of the colleges have taken account of the research into the relative merits and demerits of quality assurance methodologies when developing their programmes. Most of this research concludes that self-assessment alone is not sufficiently robust to assure continuing competence, although it is an important element in it. For example, Austin and Gregory, in their study of pharmacy students, found that self-assessment skills were a critical element of competence.[21] Handfield-Junes describes the successful self-regulating professional as 'one who regularly self-identifies areas of professional weakness for the purposes of guiding continuing education activities that will overcome these gaps in practice'.[22]

4.21   However there are limitations to self-assessments. Researchers such as Eva and Regehr have argued that humans are predisposed to being poor at self-assessment and suggest a variety of reasons.[23] These include cognitive reasons (e.g. information neglect), socio-biological reasons (e.g. learning to maintain a positive outlook) and social reasons (e.g. not receiving adequate external feedback from peers or supervisors).

4.22   This argument is supported by a recent study of pharmacy students which found significant misalignment between self-assessment and assessment done by others.[8] Generally, students who received the poorest assessment results overestimated their abilities in their self-assessment, while those who performed the strongest underestimated their performance. The researchers conducting this study concluded that that 'accurate and appropriate self-assessment is neither a naturally occurring nor easily demonstrated skill or propensity'. This is supported by the work of others who have stated that personal, unguided reflections on practice do not provide the information sufficient to guide practice.[10]

4.23   Several researchers have suggested that peer assessment may be more accurate than self-assessment, as learning about ones own performance comes from using the responses of others to our own

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[21] Austin, Z. and Gregory, P.A.M. (2007), Evaluating the accuracy of pharmacy students self-assessment skills. In: *American Journal of Pharmaceutical Education,* 71(5).
[22] Handfield-Jones R.M. (2002), Self-regulation, professionalism, and continuing professional development. In: *Canadian Family Physician*, 48, p.856–858. Quoted in: Eva, K.W. and Regehr, G. (2008) "I'll never play professional football" and other fallacies of self-assessment. In: *Journal of Continuing Education in the Health Professions*, 28(1), p.14-19.
[23] Eva, K.W.and Regehr, G. (2008) "I'll never play professional football" and other fallacies of self-assessment. In: *Journal of Continuing Education in the Health Professions*, 28(1), p.14-19.

behaviour.[24,25] This supports the view of some quality assurance experts within colleges who have observed that registrants who rate themselves above their level will continue to do so unless they receive external feedback that tells them differently.

4.24   In a study looking at self-assessment amongst physicians, Sargeant et. al. found that physicians struggled to reconcile negative feedback that was inconsistent with their own self perceptions. They found that multisource feedback was more easily reconciled than feedback from individual colleagues. They also found that reflection on both external feedback and their own self-perceptions was instrumental in physicians being able to reconcile the negative feedback and take action to address their shortfalls. They proposed a model for self-assessment, which is described below.
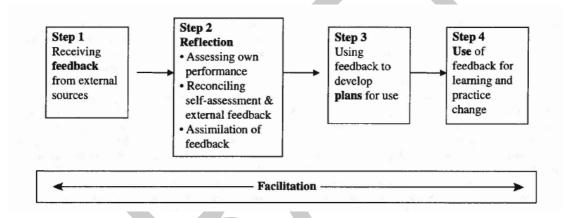
Figure 1. 'Model for 'directed' self-assessment within a social context'[26]

4.25   One of the strengths of multisource feedback is that it is difficult for an individual to disregard negative feedback if it comes from a variety of colleagues and service users. The success that the College of Occupational Therapy has had with multisource feedback is discussed in sections 4.35 – 4.42.

4.26   There are ways of harnessing the benefits of both self-assessment and peer assessment. The colleges included in this study are aware of the limitations of self-assessment as an accurate indicator of performance. This is why their quality assurance programmes do not rely solely on self-assessment as a way of ensuring the continued competency of their registrants. Several colleges spoke of the importance of promoting

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[24] Eva, K.W. and Regehr, G. (2005) Self-assessment in the health professions: A reformulation and research agenda. In: *Academic Medicine,* 80(suppl 10), S46-S54.
[25] Sargeant, J., Mann, K., van der Vleuten, C. and Metsemakers, J. (2008) "Directed" self-assessment: practice and feedback within a social context. In: *Journal of Continuing Education in the Health Professions,* 28(1), p.47-54.
[26] Reproduced from Sargeant, J., Mann, K., van der Vleuten, C. and Metsemakers, J. (2008) "Directed" self-assessment: practice and feedback within a social context. In: *Journal of Continuing Education in the Health Professions,* 28(1), p.47-54.

reflective learning through their self-assessment tools and their desire to embed self reflection into continuous practice. This approach is supported by a substantial body of research which supports the value of reflective practice. Once such study, for example, recommends that health professionals should spend time reflecting on the daily problems they encounter in the workplace as this can lead to 'informed and intentional' changes in a professional's practice.[27]

Practice assessments

4.27   The RHPA requires quality assurance programmes to include a peer and practice review. Of the five quality assurance programmes reviewed in this study, we found three different approaches to practice assessments.

Physiotherapists, pharmacists and dietitians

4.28   The colleges for pharmacists, physiotherapists and dietitians have adopted similar approaches to the practice assessment component of quality assurance.

4.29   Each year a random sample of registrants are selected to take part in a practice assessment. The sample sizes vary depending on the size of the register, but generally between two to five per cent of registrants are selected.

4.30   The College of Pharmacists has two parts to the register and only those who are engaging in direct patient care are eligible for selection. For dietitians and physiotherapists all registrants are eligible.

4.31   The way the assessments are conducted varies slightly across the three colleges. For pharmacists, selected registrants are required to attend a six hour assessment, which is held at the College premises. This includes a multiple choice clinical knowledge test, standardised patient interviews and learning portfolio sharing. Pharmacists are assessed on their clinical knowledge, ability to gather information, patient management skills and communication.

4.32   Dietitians and physiotherapists are assessed at their workplace through semi-structured interviews which test them against competencies.

4.33   All colleges use 'peer assessors' to complete the assessments. These are registrants who have previously been through a practice assessment and have undergone assessor training.

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[27] Reghr, G. and Mylopoulos, M. (2008) Maintaining competence in the field: learning about practice, through practice, in practice. In: *Journal of continuing education in the health professions,* 28(S1), S1-S5.

4.34 After the assessment has taken place, the assessor writes a report which is considered by their Quality Assurance Committee. The Committee makes the final decision about whether registrants meet the standards and if any further action needs to be taken.

Occupational Therapists

4.35 The College of Occupational Therapists practice assessment process has two stages.

4.36 Each year, a random sample of registrants is selected to participate in a multisource feedback and submit their learning portfolio to the College. The portfolio is checked for completeness, but not assessed.

4.37 For those selected, feedback must be obtained from a minimum of nine clients and 16 co-workers. The feedback tool is based on the essential competencies for occupational therapists and focuses on key competencies such as communication skills and professional behaviour.

4.38 The assessment results from all registrants are collated and placed into a bell curve. Registrants who appear in the bottom tenth percentile (and therefore received the poorest results) are then required to move to the next stage of the practice review, which is a peer assessment. The peer assessment is similar to that of the colleges above.

4.39 The College have undertaken validity testing which confirmed that the bottom tenth percentile from multisource feedback are mostly likely to perform poorly on practice assessments and require further support.

4.40 We considered this risk-based approach to the selecting registrants for peer assessments to be particularly interesting. Only those who have concerns identified through multisource feedback are required to undergo a peer assessment. The multisource feedback is a way of targeting the professionals who pose the highest risk to the public, and therefore reducing the costs associated with high numbers of registrants undergoing a peer assessment.

4.41 For example, the College of Physiotherapists (who have 7,200 registrants) selects 5% for practice assessment, which equates to 360 registrants. There are 4,700 registered pharmacists and the College of Pharmacists selects 600 each year to participate in the practice review (around 12.5% of total registrants). For the most recent year, out of the 600 who completed a multisource feedback, 24 were in the bottom tenth percentile and underwent a peer assessment. Therefore the College of Occupational Therapists reached a higher number of registrants but had far lower costs associated with peer assessments.

The cost of multisource feedback is £32 per registrant, which is significantly less than practice assessments which range from £300-1040 per assessment.

4.42 The College has published an evaluation of their multisource feedback pilot which concluded that their current instruments and procedures have high reliability, validity, and feasibility and are feasible for health professions in general.[28]

Medical Laboratory Technologists

4.43 The College of Medical Laboratory Technologists does not yet have a practice assessment component of quality assurance in place. It will soon be launching a pilot study to test its proposed approach.

4.44 The College's approach differs to the models previously discussed as it does not include a peer assessment component. The practice review will be an online assessment. A sample of registrants (100 individuals in the pilot year with future years to be reviewed) will be required to complete the assessment within 30 days of selection. The assessment will consist of 25 questions based on five different learning modules related to the standards of practice.

4.45 The focus of the practice assessment will not be clinical skills. The College feels that quality assurance already occurs in the workplace and testing clinical or technical skills through the College's quality assurance practice would be duplication. Furthermore the environment in which a laboratory technologist works is quality assured by the Ontario Medical Association Quality Assurance Programme. This is similar to the role of Clinical Pathology Accreditation UK which accredits clinical pathology services.[29]

4.46 The College have instead targeted the practice assessment at ethical decision making and will develop modules to help registrants understand how to assess a situation and make an appropriate decision.

4.47 There are benefits and limitations to the online system being developed by the College. The system is relatively inexpensive compared to the peer assessments used by other colleges. The development costs for the software was £12,000 and the practice review has an annual budget of £18,000.

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[28] Violato, C., Worsfold, L. and Polgar, J.M. (2009) Multisource Feedback Systems for Quality Improvement in the Health Professions: Assessing Occupational Therapists in Practice. In: *Journal of Continuing Education in the Health Professions*, 29(2), p.111–118.
[29] Clinical Pathology Accreditation UK: www.cpa-uk.co.uk/

4.48   The College does not plan to undertake validity testing on the assessments, which means that it will be difficult to draw conclusions about whether the assessment results are an accurate indication of a registrant's skills and knowledge. Furthermore, the tests will not be undertaken in secure environments and there will be no measures in place to ensure that registrants do not seek outside assistance. However, the College do not view this as a problem as they operate on a principle of self-regulation and believe that registrants are responsible for following the process set by the College.

Sampling methods

4.49   Colleges have different approaches as to how often registrants can be selected for practice review. Some colleges operate on a strictly random basis where registrants can get selected year after year, which is similar to the HPC's CPD audits.

4.50   The College of Occupational Therapists exempts registrants for five years after they have completed a practice assessment. They are considering changing their system so that those who have been assessed are exempt from selection until all registrants have been assessed. The College wants all registrants to complete an assessment as they believe it has real benefits to an individual's practice.

4.51   Some colleges exclude registrants for their first five years of professional registration. This is because new registrants are required to take exams to join the register and colleges feel that it is not necessary to subject new registrants to the practice reviews. However, this approach is not supported by the results from the College of Occupational Therapists practice assessments. The College of Occupational Therapists do not have a period of exemption for new registrants and they have found that registrants who have been on the register for two years are one of the groups who are performing the most poorly in the practice review. The College were not able to explain why this trend was occurring. We might hypothesise that this may be because newly qualified registrant are less fit to practise, or it could be because some new registrants struggle to understand what is required of them during the practice review.

Practice enhancement

4.52   Practice enhancement is used with registrants who do not meet the quality assurance standards through practice assessments. All colleges emphasised that registrants cannot 'fail' the practice assessment. The purpose of quality assurance is to support registrants to meet the standards.

Role of Quality Assurance Committees

4.53   As previously mentioned, quality assurance committees make the final decision about whether registrants meet the quality assurance standards.

4.54   Most committees operate using similar processes and can make one of the following decisions for each registrant:

- standards are met, no further action;
- areas for further development required – registrant is provided with written instructions with suggestions of how they could further develop (not monitored); or
- registrants are required to undergo 'practice enhancement' which can be a period of supervision or directed learning.

4.55   Committees base their decisions on the reports submitted by peer assessors. Most colleges allow registrants to view the assessors report before it is considered by the committee. The registrant is also invited to submit a personal statement that is considered by the committee. Some colleges reported that after reading the assessment report some registrants take self-directed action before the committee considers their assessor's report. In some cases where the quality assurance standards were not met, committees accepted that the registrant had remediated themselves and no further action was required. Since the purpose of the process is to bring people up to the standards, colleges believe that it does not matter whether the registrant reaches the standards by self-directing or by order of the committee.

How practice enhancement works

4.56   The way practice enhancement works varies across colleges, but all approaches are designed to support registrants who have not met the standards. Registrants are usually required to undertake additional training in their areas of weakness.

4.57   The College of Physiotherapists sometimes uses a practice enhancement coach to mentor and support the registrant towards meeting competency standards. When cases are serious, the College of Pharmacists will ask registrants to develop an action plan for how they will remediate. They are also offered the opportunity to meet with a peer support group if they would like further support. Some registrants may be required to undergo the second peer assessment after completing practice enhancement.

Number of registrants referred to practice enhancement

4.58   All colleges reported low numbers of registrants referred for practice enhancement. These are summarised in the table below. The way the figures are presented varies as some colleges sample registrants using a percentage and others set a number. Some figures are an average over the years and others are from the most recent year.

Table 1 – Numbers of registrants selected for peer assessment referred to practice enhancement

Profession	Number of registrants selected for peer assessment	Number of registrants referred to practice enhancement
Occupational Therapists	24 registrants (approx 0.5 of the Register)	20 registrants (approx 83% of registrants selected for peer assessment)
Pharmacists	240 registrants (approx 2% of the Register)	12% of registrants selected for peer assessment (approx 28 registrants)
Physiotherapists	5% of Register (approx 360 registrants)	1-4% of registrants selected for peer assessment (between 3-14 registrants)
Dietitians	40 registrants (approx 1.26% of the Register)	1 registrant (0.4% of registrants selected for peer assessment)

4.59   The table shows that the College of Occupational Therapists have a much higher percentage of registrants who are referred to practice enhancement than other colleges. This is because the first stage of the practice assessment is multisource feedback, whereby registrants in the bottom tenth percentile from this stage are required to undertake peer assessment. As 600 registrants are selected for the multisource feedback, 3% of the total number of registrants selected for 'practice assessment' (as opposed to 'peer assessment') are referred to practice enhancement. These figures show how effective the system is in targeting the most at risk professionals to undertake the peer assessment as only four individuals in the bottom tenth percentile of the multisource feedback were not referred to practice enhancement over the previous year.

4.60   The College of Pharmacists has been running their practice review component for 13 years. They have undertaken two reviews of their data to identify trends as to which pharmacists are mostly likely to struggle with the peer assessment. They found a trend that the more time a registrant has spent in practice, the more difficult they find the

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practice review and the less likely they are to meet the standards. They also found that internationally educated registrants are more likely to fail to meet the standards. 28.9% of international registrants were unsuccessful compared to 7.5% for Canadian and USA educated registrants.[30] This is in direct contrast to what we have found through our fitness to practise processes. No one group of registrants are more likely to come before our fitness to practise procedures, including internationally qualified registrants.[31]

Relationship between quality assurance and disciplinary committees

4.61   As discussed in Section 3, the relationship between quality assurance and disciplinary committees in Ontario has been a cause for concern in the past. There has been some public criticism about the lack of transparency surrounding quality assurance and the focus on remediation over public safety, particularly surrounding the Wai-Ping case. Colleges now have measures in place to ensure that serious public safety concerns are dealt with appropriately through the disciplinary committees. As the programmes are mandatory, registrants who refuse to participate are referred to disciplinary committees for misconduct.

4.62   When serious misconduct or a lack of competence is identified, quality assurance committees have the power to refer the registrant to the Registrar or a disciplinary committee, depending on the College's process. This provides a safeguard for public as serious public safety concerns can be addressed appropriately. We did, however, hear of very few registrants being referred this way. The principles behind quality assurance are about support and remediation, rather than disciplining and removing practitioners from the Register.

4.63   Quality assurance committee decisions are confidential and cannot be accessed by disciplinary committees. If a disciplinary committee receives a complaint about a registrant, they have no way of finding out how the registrant has performed in quality assurance or whether they have needed practice enhancement. Quality assurance and disciplinary procedures are intentionally kept separate. This is important because quality assurance is largely focussed on self - reflection and assessment. A registrant is unlikely to identify their weaknesses if they can be used by a disciplinary committee to assess their fitness to practise. Registrants participate in quality assurance in good faith after being assured that their assessment results will only be used for quality assurance. If this information is then passed on to a

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[30] Austin, Z., Marini, A., Croteau, D. and Violato., C. (2004) Assessment of Pharmacists' Patient Care Competencies: Validity Evidence from Ontario (Canada)'s Quality Assurance and Peer Review Process. In: *Pharmacy Education,* 4(1), 23.32.
[31] Health Professions Council (2009), *Fitness to Practise Annual Report 2009*, p.13.

disciplinary committee, it is likely that registrants would lose confidence in the quality assurance processes and regulatory systems.

5. Approaches to establishing and reviewing quality assurance programmes

5.1   When speaking to colleges about the way quality assurance programmes were developed, we were particularly keen to find out about how colleges developed their evidence base and sought the input of their registrants and stakeholders. We were also interested in how colleges evaluate and review their programmes. Below is a description of how two colleges developed their programmes followed by an overview of some of the common elements used by all colleges, such as focus groups, registrant feedback surveys and evaluations.

College of Medical Laboratory Technologists

5.2   The College of Medical Laboratory Technologists are still in the process of developing some components of their quality assurance programme. This meant that our visit was a timely opportunity to meet with the College to discuss what approaches they were using to engage their members to develop a quality assurance programme that would be appropriate for their profession.

5.3   The College began working on their quality assurance programme in 1995, shortly after the RHPA came into force. Their initial approach was to undertake research as to what an appropriate quality assurance framework should look like, which included feedback from a questionnaire distributed to members. The College reported that they have continuously sought feedback from registrants, both formally and informally throughout the whole process of developing the programme.

5.4   More recently, the College invited their members to input into the development of the practice review component. 57 members volunteered to help develop the practice review and draft the assessment questions for the pilot study. This high number of volunteers is most likely due to the incentives used by the College. Volunteers are exempt from the practice review for the first few years of the programme.

College of Physiotherapists

5.5   The College of Physiotherapists quality assurance programme has undergone several revisions over the years. When it was first developed in the late 1990s there was no remediation component to the practice review. In the early 2000s, the College became aware of a high level of dissatisfaction amongst registrants who felt there was no framework for the programme. Many felt that the programme was not effectively quality assuring registrants and that it had become more of a data collection exercise where findings were not being fed back to registrants to help improve practice.

5.6   In 2002 the College closed the programme for two years while an evaluation was conducted. The College re-launched the quality assurance programme in 2004 and the components have remained the same to this date.

5.7   Although the framework has remained the same, the College has made some recent changes to the focus of the programme, and in particular how the peer assessor process is managed.

5.8   In the years immediately following the re-launch, the College became aware of new concerns present amongst their registrants, in particular about the peer assessors. Feedback showed that registrants felt that peer assessors were not always objective in their assessment, and assessors were thought to be actively looking for performance issues. This was creating a culture of mistrust in the College and the quality assurance programme. The College also noticed that assessors were beginning to assess other registrants against their own personal standards of performance rather than the written quality assurance standards.

5.9   In 2007, the College changed the programme's branding and the messages being communicated to registrants. They shifted to a 'partnership focus' and promoted a transparent approach to the peer assessment. Registrants were able to access the interview questions on the website ahead of the assessment and they were given their assessor's report before it is considered by the Committee. They also changed the contracts for peer assessors from two years to one year with an option to renew. This allows the College to remove assessors who are not performing well. Although the structure of the programme did not change, registrants responded much more positively after the programme was rebranded.

Focus Groups

5.10   Regulatory colleges in Ontario have effective ways of allowing registrants to input into new policy developments, in particular by using focus groups. Colleges with small registrant numbers ask for volunteers through their newsletter when they require registrant views on a particular topic. Larger colleges use a pool of volunteers who have registered their interest. Colleges then select registrants from the pool when they need to run a focus group. This is an effective way of ensuring that the focus groups are representative of all registrants, as they can select a group of registrants who represent different ages, practice levels, and backgrounds. Some colleges also use online forums to ask for registrant feedback on a new policy development.

5.11 All colleges reported that holding focus groups in addition to formal written consultations is an effective way to gain the support of their members.

Feedback surveys

5.12 Colleges also effectively use feedback surveys as a way of measuring the success of their programmes. For example, all physiotherapists who complete a practice assessment are given the opportunity to complete a feedback survey. The College has a high response rate of around 70%. The feedback shows that most registrants have been apprehensive when selected for peer assessment but are generally positive about the overall process. Most colleges have similar systems in place and use the feedback when reviewing their programmes.

Evaluations

5.13 All colleges spoke of the importance of regularly evaluating their programmes. Below are some examples of findings from the evaluations.

5.14 The College of Physiotherapists has published an evaluation report on their professional portfolio system.[32] Most registrants gave positive feedback about the process of creating the portfolio and said that they identified strengths, set goals and developed learning plans as a result of portfolio development. A small percentage also indicated that they used reflective thinking skills, with around 60% saying they made changes in their practice as a result of creating a portfolio. Interestingly, they found that physiotherapists who had not been selected for practice assessment did not rate the process of developing a portfolio to be as valuable as those who had.

5.15 The College of Pharmacists published an evaluation in 2004 in which they concluded that 'the Quality Assurance Programme in general and the practice review in particular are having a positive impact'.[33] The evaluation found that most registrants reported improvements in the way they practice, in particular in how they communicated with patients. Almost 92% of pharmacists agreed that quality assurance as a whole is positive for the profession. However, 11% did report that the peer assessment decreased their self-confidence as a pharmacist. This figure is similar to the percentage of pharmacists who are referred to practice enhancement after completing the peer assessment.

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[32] Nayer, M. (2005) *Report on usage of the professional portfolio guide, A report for the Ontario College of Physiotherapists.*
[33] Cummings, H. (2004) *An evaluation of the impact of the practice review, A report for the Ontario College of Pharmacists.*

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5.16   Evaluations undertaken to date have focussed on how registrants feel
       their practice has improved and their experience of participating in
       quality assurance programmes. Colleges have to date not explored
       whether patients and clients observe a difference in their practitioner as
       a result of quality assurance. They have also not tried to measure
       whether public protection has increased.

5.17   This is likely to be because of the philosophy underpinning the quality
       assurance programmes in Ontario. The programmes have not been
       designed with the primary aim of identifying and removing unsafe
       practitioners, but rather as a way of improving the practice of all
       professionals. Therefore, colleges have focussed their evaluations on
       how registrants feel they have benefited through the programme, rather
       than how public protection has increased.

5.18   The lack of evidence about whether public protection has been
       enhanced may also be due to the difficulties associated with measuring
       public protection, which is discussed further in Section 7. All colleges
       spoke of low numbers of complaints about their registrants, but were
       not able to provide information about whether there are links between
       quality assurance and disciplinary procedures. They do not measure
       whether their quality assurance programmes have reduced the
       numbers of complaints about their registrants. However, the difficulty
       of identifying a clear causal link, between a quality assurance
       programme or other regulatory initiative and trends in complaints has to
       be acknowledged here. Colleges did speak of the low numbers of
       registrants who are required to undergo practice enhancement more
       than once. Almost all registrants who undergo a second practice
       assessment following remediation pass. This might suggest that quality
       assurance programmes are raising the standards of practice or at the
       very least increasing engagement between the regulator and the
       registrant population.

6. Costs

6.1   The cost of developing, reviewing and maintaining quality assurance programmes varies across the colleges. This is due to differences in the types of quality assurance programmes, sizes of the colleges, nature of the health professions and operating budgets.

6.2   Not all colleges were able to provide information about the break down of costs for their quality assurance programmes. The table below provides an overview of costs across the colleges, followed by a more detailed discussion.

Table 2 – Overview of the costs of quality assurance programmes*

Regulatory college**	Approx registrant numbers	Registrant fee (per annum)	College income from fees (per annum)	QA Development costs (total)	QA running costs (per annum)	Cost per peer assessment
Pharmacists	11,000	£370	£4m	£730k	£360k	£1040
Physiotherapists	7,200	£370	£2.6m	£1.2m	£180–250k	£300
Dietitians	3,156	£300	£1m	Unknown	Unknown	£610
OTs	4,700	£750	£2.1m	£100k	£90 – 120k	£490
Physicians & Surgeons	28,000	£860	£26m	Unknown	£3m	£1040

*Figures are based on exchange rate of CAD 1 = GBP 0.613123 (current at 05/08/2010)

**The College of Medical Laboratory Technologists have not been included in this table as we did not receive a breakdown of their costs

Peer assessment

6.3   Table 2 shows that there are significant differences in the cost of peer assessments. The costs of assessing physiotherapists and occupational therapists are less than for pharmacists and physicians. These differences are because of the different ways the assessments are conducted.

6.4   For the College of Physiotherapists, the assessment is a four hour interview conducted at the registrant's workplace. The assessor is paid £230 per assessment and the total cost of the assessment is £300.

6.5   The College of Occupational Therapists uses a similar process to the physiotherapists. They reported that they have recently been able to reduce their costs from £3000 to £490 per assessment by reducing the length of the assessment and moving to an online assessment system.

6.6   Assessors for the College of Physicians and Surgeons are paid £83 an hour. The total cost for each assessment is relatively high because assessors are paid by the hour for one hour of preparation, three hours to conduct the assessment, three hours to write the report and time spent travelling.

6.7   The College of Pharmacists has high costs due to the way they run their peer assessments. As discussed previously, the College runs group assessments over weekends at their premises. There are additional costs associated with this approach above, such as assessors' fees, catering, travel costs for registrants and the salaries of college staff who facilitate the days.

6.8   If the HPC were to sample 5% of its 205,000 registrants for practice assessment, we estimate base on the available information that it would cost approximately £10,680,500 to use a process similar to the College of Pharmacists and approximately £3,136,500 for the process used by College of Dietitians.

6.9   All colleges reported that they try to reduce their costs by assigning assessors to registrants who live reasonably close, which reduces travel costs. However, Ontario is a relatively large province and there will always be times when a registrant or assessor must travel long distances.

Self-assessment

6.10   The College of Pharmacists were the only college who were able to provide a break down of the costs of running their self-assessment component. The development of the online system and learning modules cost between £20-30,000. The yearly budget for running the self-assessment component is £16,000 plus £3,000 a year for software upgrades.

Development costs

6.11   The development costs in the table are estimates only as most colleges found it difficult to provide exact figures for expenditure. This was because colleges developed their programmes over a period of many years and funds were allocated from different departments within the colleges.

6.12   The College of Occupational Therapists were able to provide a detailed breakdown of development costs. The development of the multisource feedback tool was approximately £43,000. The practice assessment tool cost £30,000 to develop, of which £21,000 was spent on developing the online system. They are also in the process of developing an online e-portfolio tool with an integrated learning management system which has a budget of £25,000.

Running costs

6.13   The table shows that the College of Physicians and Surgeons has the highest yearly quality assurance budget, however they also have the highest fees and number of registrants. Most colleges allocate around 10% of their revenue to the ongoing costs of running the quality assurance programme. The biggest expenditure reported by colleges was the practice assessment component.

6.14   The College of Physicians and Surgeons was able to provide a breakdown of their yearly costs, which include £1.8 million for assessments, almost £1 million for departmental costs (salaries and administrative costs) and £180,000 for the Quality Assurance Committee.

Indirect costs

6.15   Aside from the costs outlined above there are also likely to be indirect costs associated with quality assurance programmes as with any other kind of regulatory activity. We did not receive feedback on assessments of potential 'indirect costs' and the following points are based principally on our interpretation of some of these costs and their relevance to the HPC in its analysis of the merits of additional quality assurance processes

6.16   In the quality assurance models studied here there is likely to be some impact on service delivery, as most practice assessments require registrants to spend a day out of clinical practice. There will also be time associated with registrants preparing for the assessment and completing the self-assessment and professional portfolio requirements.

6.17   Quality assurance may have an indirect impact on recruitment and retention rates. Anecdotal evidence from colleges suggested that some professionals approaching retirement age will retire from the profession rather than going through a practice assessment. The HPC has noted similar trends, in some professions, during its CPD audits.[34]

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[34] Health Professions Council (2008), *Continuing Professional Development Annual Report 2008-09.*

7. Discussion

7.1   This report has provided an account of the quality assurance
        programmes used by health regulators in Ontario.

7.2   This section provides a discussion of the implications of this model for
        the work of HPC across three broad areas:

- Our 'philosophical' or 'in principle' approach to revalidation – in
  particular, what we see as the purpose of revalidation and our role as a
  regulator in light of the information we have collected.

- The financial and stakeholder implications affecting our decisions in
  this area.

- What we can learn from the broader regulatory approaches, processes
  and systems in place in Ontario, even if we were not to adopt a similar
  quality assurance methodology.

7.3   Please note that this report is not intended to be used in isolation to
        make decisions about whether a system of revalidation should be
        introduced or what such a system should look like. This report is one
        part of nine workstreams in the first phase of the HPC's programme of
        revalidation work, and only once we have gathered all the necessary
        evidence will we be in a position to draw firm conclusions.

The purpose of revalidation?

7.4   In this report we have discussed the differences between quality
        control and quality improvement. The HPC has yet to make a definitive
        decision over whether the purpose of revalidation is to identify poorly
        performing registrants who are not being identified through our fitness
        to practise process, to improve the standard of practice for all our
        registrants, or a combination of both.

7.5   In the Continuing Fitness to Practise Report, we concluded that quality
        improvement and quality control are not necessarily mutually exclusive
        and can be achieved simultaneously. We suggested that the HPC's
        existing processes achieve quality control whilst also acting as a driver
        for quality improvement.

7.6   However, our primary role as a regulator is to safeguard the public and
        any new system would need to have clear benefits in this regard. The
        White Paper states that revalidation should be introduced as means of
        ensuring that all health professionals demonstrate their continuing
        fitness to practise.

7.7   The evaluations completed by Ontario regulatory colleges have shown that registrants believe they have improved their practice as a result of participating in quality assurance programmes. Furthermore, registrants support the programmes and see them as beneficial to the professions as a whole. However, we do not have direct evidence that quality assurance programmes increase public protection or that patients report improvements in their practitioners as the quality assurance programmes in Ontario are primarily designed to improve the quality of practice rather than to identify poor performance.

7.8   The evaluation of whether a regulatory system increases public protection might arguably sometimes rely upon reasoned assumption rather than direct, unequivocal quantitative evidence. For example, we might reasonably hypothesise that by increasing the quality of registrants' practice across the board the quality assurance programmes in place in Ontario improve the quality of services to the public and therefore the programmes are entirely consistent with safeguarding the public and the public interest. We might suggest some discrete indicators for measuring whether a regulatory initiative meets its public protection purpose, for example, by measuring whether there are fewer complaints or whether there are increases in measures of patient experience, but we have already discussed the limitations of such approaches to evidence. We need to acknowledge, however, that these limitations are not peculiar to revalidation - for example, how does the HPC demonstrate a direct, causal link between its CPD requirements and public protection?

7.9   It will arguably be difficult for us to predict how successful any revalidation system would be without first piloting and collecting the necessary data that allows us to compare the difference between results for pre and post-implementation. This would need to cover the outcomes of any process as well as the experience of those going through it.

7.10   If the HPC decides that revalidation is to be focused on identifying practitioners who are not fit to practise (as per the 2007 White Paper) the quality assurance models in this report may not be the most appropriate approach. We would instead need a system that had some means of identifying registrants who did not meet our threshold standards. As discussed in this report, quality assurance is not designed to identify registrants who are not fit to practise.

7.11   However, if we decide that revalidation should focus (at least in part) on improving the standards of all registrants, there are elements of the quality assurance programmes that may suit our needs and should be considered as the discussion around revalidation progresses.

Our existing approach and revalidation

7.12   Our legislation does not currently give us the power to introduce a revalidation process. Our role is to set threshold standards for safe and effective practice. We protect the public by ensuring that health professionals who use our protected titles meet these standards.

7.13   Our role is also to ensure that our registrants remain fit to practise throughout their professional career. We do this by asking registrants to declare that they continue to meet our standards each time they renew their registration. Registrants are also required to undertake continuing professional development. Finally, our fitness to practise process helps us to identify when someone is not practising safely and to take appropriate action.

7.14   Introducing an enhanced post registration quality assurance programme as described in this report would be a departure from how we have conceived our public protection remit to date. We would be moving to another level of regulatory activity, beyond safeguarding the public by ensuring that our registrants meet the threshold level of safe practice, to one focused on increasing the quality of registrants practice and arguably, therefore, increasing the service user experience and public protection by a different route. The current arrangements for CPD provide a useful existing parallel as they are based on the widely accepted principle that registrants continue to learn and develop in order not only to maintain their skills and knowledge but to develop (beyond the threshold entry point to a Register) as they progress through their careers.

Threshold and risk

7.15   The purpose of the quality assurance programmes in Ontario is to raise the standards of all registrants. There is no 'threshold' standard to quality assurance, but rather registrants are required to continually reflect on their practice and further develop their skills. Participation in Quality assurance is not specifically targeted to those who are performing poorly or posing the greatest risk to the public (as participation is an ongoing or periodic expectation of all registrants), although the approaches used ensure that those for whom potential concern has been identified are subject to increasing levels of scrutiny as they pass through the process.

7.16   The 2007 White Paper stated that revalidation should be 'proportionate to the risks inherent to the work in which each practitioner is involved'.[35] At a very basic level, registrants who pose the most risk to

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[35] Department of Health (2007) *Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century*, paragraph 2.29.

patients are those who do not meet our threshold standards for safe and effective practice. To be effective in increasing public protection, revalidation would need some mechanism to capture the registrants who do not meet our standards but who are not being picked-up by existing processes. We have previously noted that there is a paucity of evidence to suggest that there are significant numbers of registrants who fall below the threshold and who are not picked-up through existing processes.

7.17   If quality assurance raises the practising standards of all our registrants, we may capture some registrants who are currently not fit to practise and bring them to the threshold level. However, there is a risk that those who are currently practising unsafely may not engage in quality assurance as effectively as those who are competent and fit to practice. This is supported by the literature discussed in section 4 which demonstrates the limitations of self-assessment in ensuring continuing competence.

7.18   If the purpose of revalidation is to capture those who do not meet our standards, a quality assurance model would not be a cost effective approach as we would be investing significant funding into raising the standards of those who pose a limited risk to the public.

7.19   The majority of complaints we receive about our registrants are about misconduct.[36] To increase public protection, revalidation would need to have an element which focuses on conduct. The work we have commissioned from the University of Durham on exploring what constitutes professional behaviour will be particularly important as we move forward with understanding more about the relatively higher levels of misconduct and measures to address this.

Justifying the costs

7.20   Ontario colleges allocate on average around 10% of their operating budget to quality assurance. If we were to introduce a quality assurance model similar to those in this study, it would be likely to cost somewhere in the region of £500-£800,000 in development costs and anywhere upward of £500,000 a year depending on the programme we adopted. If we were to introduce practice based assessments, the costs would be significantly higher.

7.21   We would need to consider the impact that allocating a significant portion of our budget to revalidation would have on our capacity to focus on other priorities. In particular, we would need to decide whether it is more important to increase the regulation of our current professions or focus on bringing new professions under regulation.

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[36] Health Professions Council (2009), *Fitness to Practise Annual Report 2009.*

7.22   The cost of revalidation must be justified by the benefits. In this study
        we have seen evidence of the benefits quality assurance programmes
        bring to registrants, but not directly to public protection. If we decided to
        introduce a new 'quality improvement' model, we would need to feel
        confident that the benefits to registrants justified the costs. This is
        especially important as we are funded by registrants' fees and must be
        able to account for our spending.

Achieving stakeholder 'buy-in'

7.23   Our role as a regulator is to set the standards for safe and effective
        practice and maintain a register of those who meet our standards. If we
        were to introduce quality assurance and support post registration
        development, this would be a major change in our role.

7.24   If we adopt a quality assurance model we would need to work in close
        partnership with professional bodies. The precise roles of professional
        bodies vary, but all exist to protect the interests of their members and
        to promote and advance their profession. Rather than duplicating effort
        by establishing a new quality assurance programme, working in
        partnership with professional bodies is likely to be a more effective
        approach.

7.25   We would need to consult widely with our registrants to determine
        whether registrants would support the HPC taking on an enhanced
        quality assurance role. The success of the Ontario quality assurance
        programmes has relied upon the willingness of registrants to engage in
        the process. The contents of self-assessments and learning portfolios
        are not reviewed by colleges. Colleges trust their registrants to
        participate in quality assurance in good faith. If we introduced a quality
        improvement process without the support of our registrants, it is
        unlikely that it would be effective or sustainable.

Areas for further consideration

7.26   Regardless of whether the HPC implements a new quality assurance
        system, there are many ways that the HPC could learn from the
        processes and systems used across Ontario.

7.27   The following sections identify some of the key processes used across
        Ontario that the Council could consider as we continue to evaluate and
        improve our systems and processes. These are not recommendations,
        but rather are intended to stimulate discussion about the feasibility and
        appropriateness of the HPC adopting some of the approaches seen in
        Ontario. We have not included estimates of the costs and resource
        implications, and more work would be required if the Council decided to
        take any of these learning points forward. These areas for
        consideration should be viewed alongside existing work being done on
        future priorities for the HPC.

Modify our sampling techniques

7.28 Ontario regulatory colleges have different approaches to sampling for practice assessments, including excluding practitioners for the first years of their professional practice and exempting them for a period after they have been selected.

7.29 We currently audit a random sample of 2.5% of each profession against our CPD standards. New registrants are exempt until they have been on the register for two years. We do not target specific groups of practitioners or exclude registrants who have successfully passed the audit process. This is because our CPD audit process is principally about checking whether registrants are keeping up-to-date, not about assessing directly an individual's 'competence'. A stratified sampling approach is therefore not appropriate. There is an ongoing debate about whether the CPD audit process is primarily about ensuring the compliance of all registrants or about identifying non-compliance, on the assumption that those who do not comply present a risk, and our conclusion to this debate will govern any future changes in the current sampling approach.

7.30 If we decided to focus the audits on identifying non-compliance, on the basis of clear evidence that linked CPD, discrete identifiable groups and risks of unfitness to practise, we could then justify a stratified approach to sampling. This would mean a change in the philosophy underpinning our CPD standards and audit process.

7.31 In this study we again heard evidence from some colleges that practitioners who have been in practice for a longer period of time represent a higher risk group. However, this was contradicted by the College of Occupational Therapists who found that new practitioners who have been on the Register for less than two years also pose a higher risk. If we did decide to adopt a stratified sampling approach we should carefully consider how we would identify our target groups. The analysis of the first round of CPD audit results being undertaken by an external researcher will be able to provide more information about options for stratified sampling approaches.

7.32 The Ontario College of Occupational Therapists excludes practitioners for five years after they have successfully completed a practice assessment. They are considering extending this period until all registrants have been selected to participate in the assessment. Anecdotal feedback from our CPD audit process suggests that registrants who have been audited found the process helped them to reflect on what they have learned in the workplace and through CPD. Adopting an exclusion period similar to the College of Occupational Therapists would increase the number of registrants who participate in

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the audit process and may therefore increase the numbers of registrants who engage in reflective learning.

7.33   However, there are some risks associated with this approach. We ask registrants to engage in continuous CPD, but we audit based on CPD undertaken over a two year registration cycle. If we introduced a period of exemption, there is a risk that some registrants may not engage in CPD while they are exempt from selection.

Use registrants who have been through the CPD audits

7.34   Ontario colleges work in partnership with their registrants in a number of innovative ways, including using registrants who have previously been through a practice assessment to provide 'peer support' to those who have had difficultly passing the assessment.

7.35   Anecdotal evidence shows that registrants who have been through our CPD process were apprehensive at first, but once they completed the audit found the overall experience to be positive. One way we could ease some of the apprehension could be through using registrants who have been through the process. For example, we could publish written testimonials in the HPC newsletter or on our website. We could also encourage registrants to speak to their colleagues or at work events to allay fears of the process and advocate the benefits of being audited.

7.36   A small number of registrants do not pass the audit the first time they submit their CPD profile. This is usually because they have not satisfactorily explained how their CPD has benefited their practice, or provided evidence to support their statements. We could consider providing further support to these registrants through using registrants who have successfully completed the audit process. One approach the Council may wish to consider in the future could be introducing a voluntary mentoring scheme.

Enhance registrant engagement

7.37   Ontario colleges have strong registrant engagement strategies and ways of engaging their registrants in the early stages of policy development. Colleges reported that engaging their registrants at an early point in the process of developing a new policy leads to a stronger sense of ownership of the regulatory processes across registrants. The College of Physiotherapists spoke of the higher levels of satisfaction amongst registrants after they moved to a partnership approach between the College and registrants.

7.38   We consult when we develop or change policies, standards and guidance documents. However, the majority of responses normally come from organisations rather than individuals.

7.39   Increasing registrant engagement input into policy developments at an early stage could improve the perception about regulation and the role of the HPC. Anecdotal evidence suggests that some registrants see regulation as another layer of bureaucracy which has little benefit to them. Working in partnership with our registrants could lead to a stronger sense of ownership of our policies and processes. The HPC has already had success in doing this. For example, the development of the CPD standards and audit process was informed by more than 50 public meetings held to seek registrants' views.

7.40   There are many ways we could improve our registrant engagement. We could strengthen the engagement sessions at listening events, possibly by introducing topic related focus groups. Registrant input could be particularly useful when developing guidance documents, as registrants could provide practical examples and case studies for inclusion.

7.41   The larger Ontario colleges had interesting ways of managing registrant engagement through databases of volunteers. Due to our high registrant numbers it may be appropriate to consider maintaining a register of volunteers who we select from when we wish to assemble a focus group. Using an online portal may also be another effective way to reach high numbers of registrants. Some colleges use online systems to post new developments and ideas at an early stage for registrant feedback.

7.42   Introducing voluntary feedback surveys for the CPD audit process could be an effective way of increasing our understanding about how registrants feel about the process and whether they feel their practice has improved as a result of CPD.

Move towards online systems

7.43   This study has highlighted some of the benefits of moving away from paper- based systems to online systems. The HPC recently launched the online renewals system and have already seen evidence of the benefits to registrants and the cost savings for the organisation.

7.44   Most of the Ontario colleges have online systems that allow registrants to update their professional portfolios, complete learning modules and store self-assessment results. The RHPA mandates that it's compulsory for Ontario health professionals to participate in these programmes.

7.45   The HPC could consider introducing similar online systems with voluntary participation. Online tools could be used to raise registrant awareness about HPC standards and what it means to be a registered health professional. We could explore the possibility of introducing self-assessments tools, professional portfolios, knowledge acquisition tools and guidance documents that would increase registrants' understanding of their strengths, weaknesses and learning needs. We could focus on topics that are applicable to all our professions, and the issues that commonly arise in fitness to practice complaints, for example ethical decision making.

7.46   In exploring this idea further we may find that the existing range of tools used by professional bodies is sufficient and developing our own guidance tools would not be a cost-effective investment. It may also be cost prohibitive for us to develop meaningful clinical competency assessment tools or profession specific guidance. It may be more appropriate for the HPC to act as a portal to signpost registrants to the range of existing tools, while developing our own tools that pick up on some of the key topics that apply to all registrants.

Introduce compulsory CPD subjects

7.47   Some Ontario regulators decide which areas of practice registrants should focus on for each year. Colleges identify the most common areas where registrants require more support and develop learning modules to help registrants improve their standard.

7.48   HPC registrants are responsible for managing their own CPD and deciding what activities they undertake. Our standards require registrants to undertake CPD that is relevant to their current or future practice, but we do not prescribe areas that they should focus on. Our approach to CPD is focused on empowering registrants to make their own decisions about their CPD based on their learning needs.

7.49   We could consider changing our CPD approach to introduce compulsory CPD components that target the areas in which our registrants commonly have difficulties. For example, record keeping is an area that our registrants often contact us with questions and we also receive a relatively high number of complaints about registrants (at least in some professions) who fail to keep appropriate records.[37]

7.50   Some other UK regulators are considering introducing mandatory CPD projects as part of revalidation. For example the General Optical Council are considering setting minimum requirements for their Continuing Education and Training scheme which include units focussing on communication and professional conduct.[38] The General

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[37] Health Professions Council (2009), *Fitness to Practise Annual Report 2009.*

Chiropractic Council and the General Osteopathic Council both require their registrants to undertake at least 15 hours of learning with colleagues or other professionals.

7.51   This idea would need further exploration as the relatively low numbers of fitness to practise complaints means that we have insufficient evidence to justify selecting CPD subjects that all our registrants must undertake. We would also need to consider the impact of changing the philosophy behind CPD to a more prescriptive approach.

7.52   The Council may wish to revisit this idea after the completion of the analysis of the first round of CPD audits. This analysis will increase our understanding about the types of CPD our registrants are undertaking and the numbers of registrants who are not meeting our standards for CPD.

Explore the use of multisource feedback tools

7.53   This study has shown how useful and cost effective multisource and peer feedback can be at helping registrants to understand their strengths and weaknesses. We will be undertaking further work in this area through one of the revalidation projects which is looking at the types of patient and multisource feedback tools available and their applicability to the HPC.

Continue to gather the evidence from the Ontario regulators

7.54   We should continue to gather evidence and learn from the work being done in Ontario. In particular we should stay aware of the programme evaluations and the publication of literature competence evaluation and competence frameworks. The list of references in this study is just a small sample of the copious amounts of interesting and relevant research being undertaken across Ontario.

Conclusion

7.55   This report is not intended to be used to draw definitive conclusions about revalidation. It is intended to feed into the wider discussion about whether revalidation is necessary and, if so, what models might be appropriate.

7.56   This study has highlighted many benefits which can arise from using a quality assurance approach to regulation. Evaluations of the Ontario programmes have shown that registrants believe they have improved

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[38] General Optical Council, Council papers and minutes - June 2010: http://www.optical.org/en/about_us/how_we_work/Council_meetings_and_papers/index.cfm.

their practice as a result of participating in the quality assurance programmes. And importantly, registrants support the programmes and see them as beneficial to the professions as a whole. However, this study has also shown the lack of evidence that exists about whether quality assurance leads to increased public protection. We have also seen evidence of the limitations to self-assessment, and the costs that are associated with introducing rigorous practice assessments.

7.57   In making a decision abut whether to proceed with a new regulatory system, the HPC must decide whether the purpose of revalidation is to identify practitioners who do not meet our standards (quality control), or raise the practising standards of all registrants (quality assurance). If we want to raise the standards of all our registrants, the model of quality assurance used across Ontario could provide us with some interesting options as we move forward. However, if we are looking to introduce a system that identifies those individuals who do not meet our threshold standards, quality assurance is unlikely to meet our requirements.

7.58   Regardless of whether the HPC does decide to introduce revalidation, there are many ways that the HPC can learn from the Ontario colleges as we continue to review and strengthen our regulatory processes and systems.

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Appendix A - Summary of quality assurance programmes

Ontario College of Physiotherapists

The Ontario College of Physiotherapists' quality assurance programme consists of three components:

1. Practice Reflection
2. Practice Assessment
3. Practice Enhancement

1. Practice Reflection

All registrants who hold an Independent or Academic Practice Certificate of Registration (i.e. those who are practising and/or teaching physiotherapy) must participate in the practice reflection component on an annual basis.

There are two mandatory parts to the practice reflection:

- creating and maintaining a portfolio
- completing a self-assessment

This component is not externally assessed or viewed by members of the College.

2. Practice Assessment

Each year the Council determines a percentage of registrants who will randomly be selected to undertake a practice assessment.

The assessment is undertaken by a peer assessor who meets with the registrant at their workplace. The assessment is a comprehensive review of the registrant's practice and takes approximately four hours.

The assessor submits a report to the Quality Management Committee who makes the final decision about each registrant.

If the Committee decides that the registrant demonstrates sufficient knowledge, skills and judgement no further action is required. If the Committee identifies concerns, the registrant will be required to comply with the Committee's recommendations within a specified timeframe.

3. Practice Enhancement

This component of the Quality Manager Programme is designed to assist those registrants who have had concerns identified through the Practice Assessment. The Committee may determine that some registrants may

benefit from a Practice Enhancement Coach who will mentor and support the registrant towards meeting competency standards.

Results from the Practice Assessment are used to develop a learning plan for this component of the programme.

College of Dietitians of Ontario

All members of the College are required to participate in the Quality Assurance Programme.

The programme consists of four components:

1. Self-assessment
2. Professional development
3. Practice assessment
4. Practice enhancement

1.   Self-assessment

All registrants must complete an annual self directed learning tool (SDL Tool). The tool has four parts:

- Self-assessment
- Identifying the challenges and barriers faced in the workplace
- An evaluation of the previous years learning goals
- A minimum of two professional improvement plans which describe learning goals for the year

The College uses the information to create an aggregate profile of dietetic practice, to identify common learning goals among members and to detect trends or changes in the profile of the profession. Information from individual member's SDL Tools is not used for any other purpose.

2.   Professional Development

As well as voluntary professional development, all registrants must complete mandatory professional development components including the SDL Tool (above) and the Jurisprudence Knowledge and Assessment Tool (JKAT).

The JKAT is an online knowledge acquisition and assessment tool designed to improve the knowledge and application of laws, standards, guidelines and ethics relevant to the profession of dietetics in Ontario.

All registered dietitians in Ontario are required to complete the JKAT and achieve a score of 80% once every five years.

3.   Practice Assessment

A number of registrants each year are selected to participate in the peer and practice assessment component. This includes a random sample of between 2 - 5% annually and others who have been referred to the Quality Assurance Committee as they have not complied with other quality assurance measures such as the SDL Tool or the JKAT.

The assessment takes place at the registrant's workplace. An assessor uses behavioural-based questions to assess the registrant's practice performance. All interviews include general questions that assess competencies common to all registrants and questions that assess competencies specific to a registrant's area of practice.

The assessor submits a report to the Quality Assurance Committee who makes the final decision about each registrant.

4.   Practice enhancement

Registrants who do not successfully complete the assessments are required to participate in practice enhancement.

Ontario College of Pharmacists

All pharmacists in Part A of the Register (practitioners who are engaging in direct patient care) are subject to random selection for the College's Practice Review process. The Quality Assurance (QA) Practice Review consists of two phases:

Phase I

Every year, 20% of members in Part A of the Register are selected to take part in Phase I of the practice review process. Every pharmacist in Part A will be selected to participate in Phase I once every five years.

Candidates who are selected for Phase I are required to complete the Self-Assessment Tool and notify the College of completion within eight weeks.

Phase II

Approximately 240 pharmacists per year are selected for Phase II of the Practice Review, which is the Peer Review, a clinical knowledge and practice-based assessment lasting approximately six hours. Peer Reviews are held quarterly at the Ontario College of Pharmacists.

The Peer Review consists of:

- Orientation session (30 minutes)

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- Learning Portfolio sharing session (60 minutes)
- Clinical Knowledge Assessment (CKA) consisting of 20 cases each followed by three multiple choice questions (135 minutes)
- Standardised Patient Interviews (SPI) during which interactions with trained standardised patients in 5 case scenarios will be assessed by peer assessors (75 minutes)
- A general feedback session at the end of the review process

The assessor submits a report to the Quality Assurance Committee who makes the final decision about each registrant. Remediation candidates must be reassessed after the completion of their action plan. They are also offered the opportunity to meet with a Peer Support Group.

Ontario College of Occupational Therapists

The Ontario College of Occupational Therapists Quality Assurance Programme consists of three main components:

1. Competency Enhancement: All occupational therapists participate annually.

2. Competency Review and Evaluation: Randomly selected occupational therapists participate.

3. Competency Improvement: Only those occupational therapists who need assistance to develop and demonstrate the Essential Competencies participate.

1. Competency Enhancement

All registrants must maintain a professional portfolio. The following are mandatory components of the portfolio. Registrants may choose to include additional information that is meaningful to their continued learning.

- Prescribed Regulatory Education Programme (PREP) Modules - self-directed learning modules that help occupational therapists ensure they are up-to-date on the key issues and practices of the profession.

- Self-assessment Tool - a process to promote self-reflection on competence relative to the Essential Competencies of practice. The Self-assessment tool is completed every two years, or when a change in practice setting occurs.

- Professional Development Plan - a plan for the Occupational therapists to document their own learning goals, activities and results of the learning. This tool is completed annually.

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2. Competency Review and Evaluation

This process monitors compliance with the Quality Assurance Programme's mandatory requirements and assesses the knowledge, skill and judgment of selected occupational therapists.

Each year a number of occupational therapists are randomly selected to participate in Competency Review and Evaluation.

Step 1:
- Portfolio Review
- Multi-Source Feedback Surveys

Step 2 - Practice Assessment

If Step 1 of the competency review shows up concerns in a registrant's practice, the individual will be required to participate in a more detailed evaluation in the form of a practice assessment.

A peer assessor uses four different assessment tools used during this step: pre-questionnaire, case-based questions, situation-based questions and chart review. The assessor then submits a report to the Quality Assurance Committee describing the therapist's practice and identified learning needs.

The Committee determines whether the occupational therapist's practice demonstrates continued competence and meets acceptable standards. If practice concerns and/or learning needs are identified the Quality Assurance Committee may recommend continuing competency activities or require the occupational therapist to engage in Competency Improvement.

3. Competency Improvement

For those registrants whose level of competence is identified through Competency Evaluation as falling below acceptable standards for the profession, there will be opportunities to improve competency through remediation programmes. Such programmes, resources and learning activities will be individually tailored to the occupational therapist's learning needs.

College of Medical Laboratory Technologists of Ontario

The Quality Assurance process for the Medical Laboratory Technologists of Ontario is based on self-regulation. It is still being developed but once finished will consist of three components:

1. Professional portfolio
2. Practice Review
3. Technical Competence Evaluation

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1. Professional portfolio

Each registrant has access to a portfolio template to complete over the course of the calendar year. It consists of a professional profile and self-assessment to identify strengths and weaknesses.

Registrants are asked to develop two goals for the year with at least one of them being an area or competency that they decided requires further development.

These goals are then supported by 'activity hours'. Each registrant is expected to complete 30 activity hours in the course of the year in at least 3 different areas of practice which are above and beyond their routine work.

The College conducts a random sample of the portfolios (440 registrants for the 2009 portfolios). Selected registrants are given 30 days to submit their portfolio to the College. Portfolios are reviewed and registrants are given an audit summary.

2. Practice Review

The practice review is not yet running but will be formally launched soon. It will be a dedicated online assessment which registrants will log in to and have 30 days to complete. The practice review is designed to assess registrants' competency based on the standards of practice. It consists of 25 questions based on 5 different learning modules related to the standards of practice.

3. Competence Component

The competence component is being developed by the Quality Assurance Committee this year and will be a form of remediation should there be issues with the portfolio or practice review.

Date	Ver.	Dept/Cmte	Doc Type	Title	Status	Int. Aud.
2010-08-17	i	POL	DCB	Report of international revalidation study	Draft DD: None	Public RD: None

Appendix B - List of Ontario Colleges we met with

We are enormously grateful to all the Ontario colleges we met with for their input into this project.

- Royal College of Dental Surgeons of Ontario (www.rcdso.org)

- College of Dietitians of Ontario (www.cdo.on.ca/en/)

- College of Medical Technologists of Ontario (www.cmlto.com/)

- College of Nurses of Ontario (www.cno.org/)

- College of Occupational Therapists of Ontario (www.coto.org/)

- Ontario College of Pharmacists (www.ocpinfo.com/)

- College of Physicians and Surgeons of Ontario (www.cpso.on.ca/)

- College of Physiotherapists of Ontario (www.collegept.org/)

- Ontario College of Social Workers and Social Service Workers (www.ocswssw.org)

Appendix C - List of health professions under statutory regulation in Ontario, Canada

Audiologists and Speech-Language Pathologists
Chiropodists/Podiatrists
Chiropractors
Dental Hygienists
Dental Technologists
Dentists
Denturists
Dietitians
Massage Therapists
Medical Laboratory Technologists
Medical Radiation Technologists
Midwives
Nurses
Occupational Therapists
Opticians
Optometrists
Pharmacists
Physicians and Surgeons
Physiotherapists
Psychologists & Psychological Associates
Respiratory Therapists

Transitional Council of the College of Homeopaths of Ontario

Transitional Council of the College of Traditional Chinese Medicine
Practitioners and Acupuncturists of Ontario

Transitional Council of the College of Registered Psychotherapists and
Registered Mental Health Therapists of Ontario