

**TYPE OF DOCUMENT**Trust Policy for approval by **Trust Policy Committee**  
orPatient based standard, guideline or policy for approval by  
**Standards and Guidelines Committee**

<b>Statutory and Mandatory Training Policy</b>	
<b>Summary</b>	This policy sets out the definition for statutory and mandatory training and the arrangements in place to meet our obligations.
<b>Operational date</b>	October 2011
<b>Review date</b>	October 2013 or as required in line with implementation of replacement of Human Resources Management System
<b>Version Number</b>	V1
<b>Director Responsible</b>	Marie Mallon
<b>Lead Author</b>	Elaine Kehelly
<b>Lead Author, Position</b>	Senior Learning and Development Manager
<b>Department / Service Group</b>	Human Resources
<b>Contact details</b>	██ ██████████
<b>Additional Author(s)</b>	Moira Mannion Co Director Nursing ██ Jonathan McAleer ██

<b>Reference Number</b>	TP071/11
<b>Supersedes</b>	Any legacy policies relating to this area.

Trust Policy - Statutory and Mandatory Training Policy – V1 – Dec 2011

**Version Record**

Date	Version	Author	Comments
10.12.10	0.1	E Kehelly	Initial Draft
03.02.11	0.2	E.Kehelly	Minor changes
11.04.11	0.3	E. Kehelly	Update further to consultation
06.06.11	0.4	E. Kehelly	Final amendment
21.10.11	0.5	E. Kehelly	Minor updates further to policy committee

**Policy Record**

		Date	Version
Author (s)	Approval		
Director Responsible	Approval		

**Approval Process – Trust Policies**

Policy Committee	Approval	17.10.11	
Executive Team	Authorise	19.10.11	
Chief Executive	Sign Off	19.10.11	

**Approval Process – Clinical Standards and Guidelines**

Standards and Guidelines Committee	Approval		
Policy Committee	Ratify		
Executive Team	Authorise		
Appropriate Director	Sign Off		

**Local Approval Process**

	Approval		
--	----------	--	--

**Dissemination**

Areas :	

**Full Description**

<b><u>Statutory and Mandatory Training</u></b>	
	<p><b>Purpose:</b></p> <p>The Belfast Health and Social Care Trust (BHSCT) recognises that statutory and mandatory training is of vital importance in the provision of high quality services to our patients and clients and is essential for effective risk management and the maintenance of required standards.</p> <p>We recognise our duty to deliver appropriate and sufficient training and to ensure that employees have reasonable access to complete such training.</p> <p>This policy sets out the definition for statutory and mandatory training and the arrangements in place to meet our obligations.</p> <p>For the purposes of this policy, statutory and mandatory training will be referred to under the collective title of mandatory training.</p>
	<p><b>The Scope:</b></p> <p>All employees, regardless of contract type, including those engaged in a regular volunteer capacity, are required to attend, within the specified time frames, all mandatory training as defined within the Trust's corporate training matrix (Appendix 1) or as identified specifically for their post.</p> <p>The corporate training matrix defines the types of training that are considered to be mandatory for all staff or across broad groups of staff. There are four imperatives that govern whether or not training is included in the corporate training matrix:</p> <ol style="list-style-type: none"> <li>1. A statutory obligation – where the law defines that training must be undertaken.</li> <li>2. A Health and Social Care mandate – where a formal, official directive has been handed down within the Health and Social Care sector.</li> <li>3. A corporate mandate – where the Trust has identified training as being essential to organisational priorities.</li> <li>4. Training which is regarded as being a requirement of individual professions for their members to maintain core occupational competences, is not included in the corporate training matrix. Professions and service managers will determine and record separately what training is mandatory to cover core role skills.</li> </ol> <p>The requirement to undertake such training is normally also defined within a Trust Policy for the particular topic.</p> <p>The content of the corporate training matrix is not exhaustive as requirements are subject to change and therefore will be regularly reviewed by the Trust's Inter Professional Learning and Development Group.</p> <p>Due regard is to be given to the RQIA's guidance on mandatory training for providers of care in regulated services.</p>

	<p>Reference should be made to other BHSCCT policies which set out specific training requirements.</p>
	<p><b>Objectives:</b></p> <ul style="list-style-type: none"> <li>• To comply with the law</li> <li>• To support staff in carrying out their duties safely and efficiently</li> <li>• To reduce risks to our service users, staff, visitors and the public</li> <li>• To maintain competence to the required standards</li> <li>• To provide a systematic approach to the provision and monitoring of mandatory training for all staff</li> <li>• To ensure that a systematic approach is in place to review recommendations for proposed mandatory training</li> <li>• To ensure acceptable governance arrangements are in place regarding the provision of and attendance/completion of training</li> <li>• To outline responsibilities for managers and staff members to comply with the requirements of this policy</li> </ul>
	<p><b>Roles and Responsibilities:</b></p> <p><b>Directors</b>          It is the responsibility of Directors to:</p> <p>Implement the policy on Mandatory Training within their Directorate, ensuring that Managers are aware of their responsibilities for staff to attend/complete the relevant training.</p> <p>Ensure that, where necessary, insurmountable issues with compliance are identified on the risk register.</p> <p>For those Directors who also carry responsibility for the provision of mandatory training, to ensure that arrangements are in place to meet the objectives of this policy.</p> <p><b>Managers</b>          It is the responsibility of Managers to:</p> <p>Facilitate staff to attend mandatory training.</p> <p>Cascade information relating to attendance/completion of training to Line Managers, agreeing an action plan if the Department/area is not achieving the targeted uptake of relevant mandatory training.</p> <p>Implement and monitor this policy ensuring that all employees within their areas of responsibility have addressed issues of non compliance for training completion/attendance.</p> <p>Contact training providers, if required, to request the provision of targeted training sessions in their service group.</p> <p>Ensure that additional role specific mandatory training for posts within their span of control is identified and the necessary arrangements implemented to meet identified need. Heads of Profession will have a responsibility to ensure that mandatory training needs across the particular profession are identified and provided.</p>



Ensure that all their staff have a current Personal Development Plan. During the process to agree this, a review of the training completed during the previous year will be undertaken and the mandatory training requirements for the forthcoming year will be identified and included in the employee's personal development plan. The line manager and the employee must agree an appropriate timetable and to ensure attendance at mandatory training events.

For new employees and those new to post, the line manager will identify what mandatory training is necessary and agree an action plan as part of induction arrangements.

Follow up and investigate non attendance/completion of training and rearrange for training as soon as possible.

Bring to their Co Director's attention, should significant issues arise in securing compliance with this policy.

Maintain their own records of training for staff members and ensure Trust training administration systems are appropriately utilised and updated.

### **Employees**

It is the responsibility of Employees to:

Be aware of their personal mandatory training requirements as outlined in the corporate training matrix and in their own personal development plans.

Exercise personal accountability to ensure that mandatory training requirements are kept up to date and report to their line manager any difficulties preventing them from undertaking the required training.

Attend/complete mandatory training as agreed with their line manager. Ensure that when completing/attending training the attendance/completion register is signed so that their training record can be maintained. Failure to do this will result in the individual appearing to be non-compliant with this policy.

Complete and return as necessary, training evaluation forms and report to their manager any areas of concern they may have following the training.

Transfer the learning received into practice on return to work.

### **In house Mandatory Training Providers**

It is the responsibility of in house mandatory training providers to:

Provide sufficient training to meet the identified need in line with specified timeframes and to identify to their Manager any issues that may prevent this.

Arrange for the provision of training, in an appropriate format and mode, to meet organisational need.

Clearly communicate the details for the provision of training to managers and staff in a timely way.

Regularly review training content to ensure its currency and relevance and consider mode of delivery, to take into account, the possibility of modernised modes eg

	<p>electronic learning, where appropriate.</p> <p>Ensure that all training has specific learning objectives stated as well as a detailed programme of content.</p> <p>Maintain an attendance/completion record on the agreed Trust IT system. This may be through TAS or a local database until arrangements are in place for the utilisation of the replacement of the Human Resources Management System.</p> <p>Provide reports of attendance/completion to service managers on request and bring non compliance issues to the attention of Directorate senior management.</p> <p>Provide information and reports as requested by the Inter professional Learning and Development Group.</p> <p>Provide to the Inter professional Learning and Development Group, any proposals for revisions to the corporate training matrix.</p> <p>Have a procedure in place to follow up, through their line manager, staff who fail to attend mandatory training.</p> <p>Carry out appropriate evaluation of training.</p>
	<p><b>The definition and background of the policy:</b></p> <p>The need for this policy has been identified in order to strengthen good governance arrangements around the provision and recording of attendance/completion of mandatory training. This will support the Trust in ensuring compliance with the law as well as promoting quality standards and minimising risk to staff, service users, visitors and the public.</p> <p>It will clarify the minimum requirements across all Trust staff and set out the expectations of managers and training providers to ensure robust systems are in place to meet our Trust obligations.</p>
	<p><b>Policy statements:</b></p>
	<p>Mandatory training is compulsory for all staff regardless of staff group or professional status. However the mandatory training programme comprises of different requirements depending on the staff group and individual role. This policy sets out the corporate mandatory requirements for all staff or broad categories of staff across the Trust.</p> <p>Training which is regarded to be a requirement by service managers and individual professions for their members to maintain core occupational competences is not defined on the corporate training matrix. Service managers along with Professions will determine and record separately what training is mandatory to cover core role skills.</p> <p>In making a distinction between mandatory training and Continuing Professional Development (CPD), it is acknowledged that some staff are required to undertake specific training and updates in order to fulfil professional registration requirements. It is the responsibility of the individual with their line manager to identify and agree any CPD required through their personal development plan. It is emphasised that these requirements must be undertaken in addition to the Trust’s mandatory training programme.</p>

All staff are expected to comply with the training set out within the corporate training matrix and for their own role within the stated time limits.

Completion of such training will take priority over non mandatory training.

Mandatory training should be completed as far as possible, within the first 6 months of taking up post and no later than 12 months. The manager, at all times, must ensure that any delay in completion of mandatory training does not create a risk for the employee or service user.

In line with the Assistance to Study policy, mandatory training will be fully funded for any associated course fees with paid time off to attend. Please refer to policy for detail regarding completion of training outside of normal working hours. Separate payment arrangements are set out for bank staff within the Bank Staff policy.

Mandatory training requirements specific to the Trust for Agency staff must be met by their employer as well as the Trust, as appropriate. Such staff must be able to demonstrate evidence of competency in such requirements. Reference should be made to the specific conditions of the contract for agency staff. In relation to health and safety training, the cost of any training which the Trust is required to provide will be met by the employer of the agency staff.

It will be a requirement that Agencies providing staff to the Trust will have ensured that all staff have up to date training to undertake the duties of their post. This will be reflected in the contract arrangements with Agencies. Where staff are recruited from Agencies off contract, it will be the responsibility of the approaching Trust Officer to ensure such training is in place.

Honorary contract holders must have their mandatory training needs considered by their placement supervisor in the Trust and arrangements made for training completion/attendance if deemed necessary.

Attendance/completion of training will be monitored by the Training Provider on a regular basis and reported to various Trust committees which have responsibility for such matters. Such committees will determine what action may be required to address non compliance and communicate this to managers.

Although all managers and staff are expected to comply with mandatory training requirements, it is acknowledged that service priorities, sickness and leave may impact on the achievement of full compliance from time to time. However it is expected that the highest levels of compliance are achieved. Directorates will be required to report on this as part of performance management and accountability arrangements.

Non-compliance with the required mandatory training may result in an investigation from which possible disciplinary action may be taken in accordance with the Trust's Disciplinary policy.

Mandatory training is currently delivered through a variety of methods including classroom delivery and E learning. The Trust will explore and develop methods of learning to assist with flexibility of access and as appropriate to the subject matter.

Audit mechanisms will support managers to ensure that competency levels for staff have been achieved.

	<p>The Trust is cooperating regionally in the development of a mandatory training passport which will support the transferability of an individual’s training record from one Trust to another. Such arrangements, when completed and operational, will be communicated to managers.</p> <p>All corporate mandatory training will be advertised and administered using the Trust’s Training Administration System (TAS) or agreed alternatives eg Beeches website for Nursing/Midwifery. Training Providers who wish to seek an exemption from this must secure the agreement of the Inter professional Learning and Development Group.</p> <p>Mandatory training requirements must be reviewed by line managers for staff new to the Trust, as well as those new to post and action taken as necessary to support compliance for the individual’s role.</p> <p>All proposed new areas of mandatory training will be considered by the Inter Professional Learning and Development Group and the corporate training matrix updated as required.</p> <p>For Agenda for Change staff, the non achievement of mandatory training may result in the employee’s failure to comply with the Knowledge and Skills Framework core dimension Health, Safety and Security and may adversely affect progression through gateways. Line Managers are required to ensure that they have facilitated the completion/attendance at training to avoid this situation occurring.</p>
	<p><b>Implementation / Resource requirements:</b></p> <p>This policy is required to be implemented by all Directorates and by all providers of mandatory training. All staff are required to comply with this policy.</p>
	<p><b>Source(s) / Evidence Base:</b></p> <p>This policy is based on best practice and in light of statutory training requirements.</p>
	<p><b>References, including relevant external guidelines:</b></p> <p>BHSCT Policies : -          Assistance to Study Policy          Induction Policy          Medical Appraisal          Personal Contribution Framework Guidance Notes          Knowledge &amp; Skills Framework Guidelines          General Health and Safety Policy          Manual Handling          Risk Management Strategy          Data Protection and Protection of Personal Information          Fire Safety Policy          Equal Opportunities Policy          Bank Policy          Zero Tolerance Policy          Our responsibilities for safeguarding children – an information and training framework          RQIA Guidance on mandatory training for providers of care in regulated services.</p>
	<p><b>Consultation Process:</b></p>

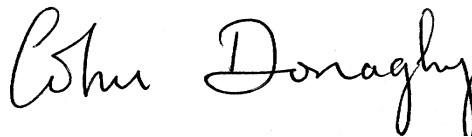
	<p>This policy has been subject to consultation with Directors, Co Directors, Senior Managers, Members of Inter professional Learning and Development Group and Senior HR Managers. Staff side have been consulted through the Learning and Development Sub Committee and Policy Sub Committee.</p>	
	<p><b>Equality and Human Rights screening carried out:</b>                  In line with duties under the equality legislation (Section 75 of the Northern Ireland Act 1998), Targeting Social Need Initiative, Disability discrimination and the Human Rights Act 1998, the Belfast Trust has carried out an initial screening exercise to ascertain if this policy should be subject to a full impact assessment.</p>	
	<p><input checked="" type="checkbox"/> <input type="checkbox"/> Screening completed                  No action required.</p>	<p><input type="checkbox"/> Full impact assessment to be carried out.</p>



**Author**  
 Printed Name Elaine Kehelly  
 Date: 21 October 2011



**Director of Human Resources**  
 Date 19 October 2011



**Chief Executive**  
 Date 19 October 2011

## Statutory and Mandatory Training Matrix Appendix 1

Training Programmes	Required Frequency	Delivery Method f=face to face, e=e-learning	Staff required to complete statutory/mandatory training
<b>STATUTORY/MANDATORY FOR ALL STAFF</b>			
Corporate Welcome includes: -Opening by Chief Executive  -Human Resources (inc. Learning and Development, Employee Relations, Improving Working Lives, Occupational Health)  -Inequalities and Partnership  -Records Management  -Finance  -Child Protection/Protection of vulnerable adults  -Governance and Risk  -Infection prevention & control	Once	f	All newly appointed staff to the Trust must attend within 4 months of appointment.  Excludes doctors in training who have separate arrangements. Automatic invite will be issued from Human Resources.
Local Induction	Once	f	All staff who are new to a department/role must have a local induction
Fire & Environmental Awareness	Annually	f	All staff (biannual for residential care staff)
Health & Safety Awareness	3 yearly	e	All staff
Adverse Incident reporting	Once	f	All staff
Complaints Management	Once	f	All staff
<b>STATUTORY OR MANDATORY FOR SOME STAFF GROUPS</b>			
Induction for Doctors in Training	Once	f	All doctors in training on rotation
Preceptorship	Once	f	All newly registered nurses and midwives
Nursing and Midwifery Induction Programme	Once	f	All nurses and midwives new to the Trust
Band 2 Induction & Development Programme	Once	f	All newly employed Band 2 Nursing/Midwifery support staff
Band 3 Induction & Development Programme	Once	f	All newly employed Band 3 Nursing/Midwifery support staff
Recruitment and Selection	Once	f	All staff who will be sitting on a recruitment panel with no previous Trust R&S training or it has been more than 3 years since last active on a recruitment panel
Recruitment and Selection Refresher	3 yearly	f/e	All staff who have been on the R&S Training within the last 3 years and will be sitting on a recruitment panel within this period
Management of Attendance	3 yearly	f	All staff who have staff management/supervisory responsibilities
Equal Opportunities	Once	f/e	All staff who <b>do not</b> have staff management/supervisory responsibilities
Managing Diversity	Once	f	All staff who have staff management/supervisory responsibilities
PCF/KSF Development Review	Once	f	All reviewers
Medical Appraiser Training	Once	f	All medical staff who are appraisers in the Appraisal Process for Medical Practitioners
Medical Appraiser Training Refresher	3 yearly	f	All medical staff who are appraisers in the Appraisal Process for Medical Practitioners and who have been on Medical Appraiser Training within the last 3 years
Safeguarding Vulnerable adults	Variable	f	Requirement and frequency is particular to your care environment needs - refer to local arrangements
Protection of Children	Variable	f	Requirement and frequency is particular to your care environment needs - refer to local arrangements
Life Support (various levels)	Annually	f	Requirement and frequency is particular to your care environment needs - refer to local arrangements and Life Support Policy
First Aid at Work	3 yearly	f	Designated staff in each workplace
Personal Safety and disengagement	2 yearly	f	All staff whose job has been risk assessed as requiring Personal Safety and Disengagement training

<b>Training Programmes</b>	Required Frequency	Delivery Method f=face to face, e=e-learning	Staff required to complete statutory/mandatory training
----------------------------	--------------------	--	---

Page 2

Basic Personal Safety Training	2 yearly	f	Clinical staff working in theatres, specialist services, rheumatology, and student social workers on placement
Back Care for Office Workers	2 yearly	f	All staff who use display screen equipment
Display Screen Equipment Facilitators Course	Once	f	Designated staff in each workplace
Introduction to Patient Handling for Hospital Staff	Once	f	All hospital staff who undertake patient handling duties
Update in Patient Handling for Hospital Staff	2 Yearly	f	All hospital staff who undertake patient handling duties and who have completed the Introduction to Patient Handling for Hospital Staff or Update in Patient Handling for Hospital Staff within the last 2years
Introduction to Client Handling for Community Staff	Once	f	All community staff who undertake client handling duties
Update in Client Handling for Community Staff	Every 18mths	f	All community staff who undertake client handling duties and who have completed the Introduction to Client Handling for Community Staff or Update in Client Handling for Community Staff within the last 18 months
Load Handling	2 yearly	f	All staff who undertake load handling but have no patient/client contact
Patient/Client Handling Facilitators Course	Once	f	Designated Trust staff who are identified as having a formal link to the Ergonomics Team
Update Patient Handling Facilitators Course	Annually	f	Designated Musgrave Park Hospital staff who facilitate patient/client handling courses and who have completed the Patient/Client Handling Facilitators Course within the last year
COSHH Awareness	3 yearly	e	All staff who may be exposed to hazardous substances in the course of their work activity and where a risk assessment deems it necessary. Please also refer to the RQIA Training Matrix
COSHH Risk Assessors Course	3 yearly	f	Designated COSHH risk assessors
Deputy Nominated Officer (Fire)/Fire Warden	3 yearly	f	Designated staff in each workplace
Infection Prevention & Control	2 Yearly	f	All clinical/community staff with direct patient/client contact.
General Health & Safety Risk Assessment Workshop	3 yearly	f	Designated general risk assessors
CIEH Level 2 Award in Food Safety(Basic Food Hygiene)	Once	f	All PCSS staff who handle food. Care staff within domiciliary, residential and daycare settings
CIEH Level 2 Award in Food Safety(Refresher)	3 yearly	f	All PCSS staff who handle food and care staff within domiciliary, residential and daycare settings who have been on Basic Food Hygiene training within the past three years
CIEH Level 3 Award in Supervising Food Safety in Catering (Intermediate Food Hygiene)	Once	f	All staff who work in food preparation areas at supervisory level or above
CIEH Level 4 Award in Food Safety (Advanced Food Hygiene)	Once	f	All trainers and managers working within the Catering Department
CIEH Level 3 Awards in TSP -Training Skills & Practice (Professional Trainer Certificate)	Once	f	All trainers who deliver CIEH qualifications in food safety
DHPSS Colour Coding - Environmental Cleanliness /Infection control	Once	f	All PCSS staff
CIEH Level 3 Award HACCP in Catering	Once	f	All catering line managers and supervisors
Waste	3 yearly	f	All PCSS staff and as designated in Waste Policy.
Medical Devices Awareness	3 yearly	f	All staff who use and manage medical devices
Basic Medical Gas Safety	Once	f	All staff responsible for using, moving, handling, storing, and transporting medical gases, including cylinders and piped supplies (this is not intended for those staff who repair or maintain medical gas pipeline systems)
Management of Actual and Potential Aggression (MAPA)(5 day)	Once	f	As identified through risk assessment. Refer to Zero Tolerance policy
Management of Actual and Potential Aggression (MAPA) update	Variable	f	Requirement and frequency as identified through risk assessment. Refer to Zero Tolerance policy
Management of Actual and Potential Aggression (MAPA) for Security Staff (5 day)	Once	f	All security officers on BCH, RVH, Musgrave and Mater sites
Management of Actual and Potential Aggression (MAPA) for Security Staff Update	Annually	f	*All security officers on BCH, RVH, Musgrave and Mater sites who have attended the 5 day programme in the past 12 to 15 months. *Refer to service group risk assessment
SCIP - Strategies in Crisis Intervention and Prevention (3 day)	Once	f	All social care, community nursing, social services, allied health professional and medical staff who work in learning disability services in residential and day care facilities
SCIP - Strategies in Crisis Intervention and Prevention Refresher (1 day)	Annually	f	All social care, community nursing, social services, allied health professional and medical staff who work in learning disability services in residential and day care facilities and who have completed the 3 day programme within the last 12 months

Trust Policy - Statutory and Mandatory Training Policy – V1 – Dec 2011

<b>Training Programmes</b>	Required Frequency	Delivery Method f=face to face, e=e-learning	Staff required to complete statutory/mandatory training
----------------------------	--------------------	--	---

## Page 3

Safe Transfusion practice	Once	f/e	All medical and nursing staff involved in any of the processes of transfusion
Safe Transfusion practice update	Annually	f/e	All medical and nursing staff involved in any of the processes of transfusion
HIV Awareness	Once	f	All nursing, midwifery, medical, AHP and social care staff with direct patient/client contact
Right Patient Right Blood competency assessment	3 yearly	f	Any member of staff taking blood for pre-transfusion sampling, collecting blood from a blood fridge or administering blood
Blood collection and good manufacturing process training	Annually	f	Any member of staff collecting blood from the transfusion laboratory
Pre-transfusion sampling	Once	f	Phlebotomists taking blood for pre-transfusion sampling
Pre-transfusion sampling update	Annually	f	Phlebotomists taking blood for pre-transfusion sampling
Hyponatremia	Once	e	All staff involved in administering intravenous fluids to children
Therapeutic Crisis Intervention Systems [TCI] (5 days)	Once	f	All residential child care workers
Therapeutic Crisis Intervention Systems Update (1 day)	Every 6months	f	All residential child care workers who have completed the 5 day training within the last 6 months
Medicines Update	3 yearly	f	Nurses/Midwives who administer medications
Administration of Intavenous Medications	Once	f	Nurses/Midwives who administer intravenous medications
UNOCINI Training Modules 1 - 3	Once	f	Requirement and frequency is particular to your care environment needs - refer to local arrangements and Child Protection Nurse Adviser
Mentorship Training	Every 5 years	f	Mentors supporting nursing & midwifery students on non NMC registerable/recordable programmes
Mentorship Training	Annually	f	Mentors supporting nursing & midwifery students on NMC registerable/recordable programmes



<b>Title:</b>	<b>Statutory and Mandatory Training Policy</b>		
<b>Author(s)</b>	<b>Elaine Kehelly</b> : Senior Learning and Development Manager <b>Moira Mannion</b> : Co-Director Nursing <b>Jonathan McAleer</b> : Senior Learning and Development Facilitator		
<b>Ownership:</b>	Director of Human Resources and Organisational Development Director of Nursing and User Experience Director of Social Work / Children's Community Services Medical Director Director of Unscheduled and Acute Care Director of Specialist Hospitals, Women and Child Health Director of Adult Social and Primary Care Director of Surgery and Specialist Services Director of Finance and Estates Director of Performance, Planning and Informatics		
<b>Approval by:</b>	Policy Committee Executive Team	<b>Approval date:</b>	1 April 2015 15 April 2015
<b>Operational Date:</b>	Apr 2015	<b>Next Review:</b>	Apr 2018
<b>Version No.</b>	V2	<b>Supersedes</b>	V1 – October 2011 - 2013
<b>Key words:</b>	The Belfast Health and Social Care Trust (BHSCT) recognises that statutory and mandatory training is of vital importance in the provision of high quality services to our patients and clients and is essential for effective risk management and the maintenance of required standards.		
<b>Links to other policies</b>			

<b>Date</b>	<b>Version</b>	<b>Author</b>	<b>Comments</b>
10/12/10	0.1	E Kehelly	Initial draft
03/02/11	0.2	E Kehelly	Minor changes
11/04/11	0.3	E Kehelly	Update further to consultation
06/06/11	0.4	E Kehelly	Final amendment
21/10/11	0.5	E Kehelly	Minor updates further to Policy Committee
01/12/12	06	E Kehelly	Review of Policy for consultation
22/05/14	1.1	E Kehelly	Review of Policy for consultation
06/01/15	1.2	E Kehelly	Final minor amendments to policy following audit
22/05/2015	V2	E Kehelly	Sent for Hub

## 1.0 **INTRODUCTION / PURPOSE OF POLICY**

### 1.1 **Background**

The need for this policy has been identified in order to strengthen good governance arrangements around the provision and recording of attendance/completion of mandatory training. This will support the Trust in ensuring compliance with the law as well as promoting quality standards and minimising risk to staff, service users, visitors and the public.

It will clarify the minimum requirements across all Trust staff and set out the expectations of managers and training providers to ensure robust systems are in place to meet our Trust obligations.

### 1.2 **Purpose**

The Belfast Health and Social Care Trust (BHSCT) recognises that statutory and mandatory training is of vital importance in the provision of high quality services to our patients and clients and is essential for effective risk management and the maintenance of required standards.

We recognise our duty to deliver appropriate and sufficient training and to ensure that employees have reasonable access to complete such training.

This policy sets out the definition for statutory and mandatory training and the arrangements in place to meet our obligations.

For the purposes of this policy, statutory and mandatory training will be referred to under the collective title of mandatory training.

### 1.3 **Objectives**

- To reduce risks to our service users, staff, visitors and the public;
- To comply with the law;
- To support staff in carrying out their duties safely and efficiently;
- To maintain competence to the required standards;
- To provide a systematic approach to the provision and monitoring of mandatory training for all staff;
- To ensure that a systematic approach is in place to review recommendations for proposed mandatory training;
- To ensure acceptable governance arrangements are in place regarding the provision of and attendance/completion of training;
- To outline responsibilities for managers and staff members to comply with the requirements of this policy;

## 2.0 **SCOPE OF THE POLICY**

All employees, regardless of contract type, including those engaged in a regular volunteer capacity, are required to attend, within the specified time frames, all mandatory training as defined within the Trust's corporate training matrix (Appendix 1) or as identified specifically for their post.

The corporate training matrix defines the types of training that are considered to be mandatory for all staff or across broad groups of staff. There are four imperatives that govern whether or not training is included in the corporate training matrix:

1. A statutory obligation – where the law defines that training must be undertaken.
2. A Health and Social Care mandate – where a formal, official directive has been handed down within the Health and Social Care sector.
3. A corporate mandate – where the Trust has identified training as being essential to organisational priorities.
4. Training which is regarded as being a requirement of individual professions for their members to maintain core occupational competences, is not included in the corporate training matrix. Professions and service managers will determine and record separately what training is mandatory to cover core role skills and communicate this to their staff.

The requirement to undertake such training is normally also defined within a Trust Policy for the particular topic.

The content of the corporate training matrix is not exhaustive as requirements are subject to change and therefore will be regularly reviewed by the Trust's Learning, Development and Education Committee.

Due regard is to be given to the RQIA's guidance on mandatory training for providers of care in regulated services.

Under Quality 2020 there is a separate regional agreement under development in relation to Statutory and Mandatory Training for Medical Consultants and Specialty Doctors. However this Trust policy applies until such times as it may be superseded by a new regional agreement.

Reference should be made to other BHSCT policies which set out specific training requirements.

### **3.0 ROLES / RESPONSIBILITIES**

**Directors** : It is the responsibility of Directors to :-

Provide assurance with compliance with this Policy.

Implement the policy on Mandatory Training within their Directorate, ensuring that Managers are aware of their responsibilities for staff to attend/complete the relevant training.

Ensure that, where necessary, insurmountable issues with compliance are identified on the risk register.

For those Directors who also carry responsibility for the provision of mandatory training, to ensure that arrangements are in place to meet the objectives of this policy.

**Managers** : It is the responsibility of Managers to :-

Communicate to their staff the mandatory training required for their post and facilitate their attendance/completion.

Inform training providers if a staff member cannot attend a booked training session to avoid waste thereby reducing DNA rates.

Cascade information relating to attendance/completion of training to Line Managers, agreeing an action plan if the Department/area is not achieving the targeted uptake of relevant mandatory training.

Implement and monitor this policy ensuring that all employees within their areas of responsibility have addressed issues of non-compliance for training completion / attendance.

Contact training providers, if required, to request the provision of targeted training sessions in their Directorate.

Ensure that additional role specific mandatory training for posts within their span of control is identified, communicated to post holders and the necessary arrangements implemented to meet identified need. Heads of Profession will have a responsibility to ensure that mandatory training needs across the particular profession are identified and provided.

Ensure that all their staff have a current Personal Development Plan. During the process to agree this, a review of the training completed during the previous year will be undertaken and the mandatory training requirements for the forthcoming year will be identified and included in the employee's personal development plan. The line manager and the employee must agree an appropriate timetable and to ensure attendance at mandatory training events.

For new employees and those new to post, the line manager will identify what mandatory training is necessary and agree an action plan as part of induction arrangements.

For staff who are planning to go on an extended period of leave to encourage them to update their training requirements before the leave commences. To ensure that any training that requires an update is completed within a maximum period of 12 months on their return.

Follow up and investigate non-attendance/completion of training and rearrange for training as soon as possible.

Bring to their Co Director's attention, should significant issues arise in securing compliance with this policy.

Maintain their own records of training for staff members for training completed prior to implementation of HRPTS in November 2013 and up to full deployment and access to HRPTS.

**Employees** : It is the responsibility of Employees to :-

Be aware of their personal mandatory training requirements as outlined in the corporate training matrix and in their own personal development plans.

Use the Employee Self Service function on HRPTS, once fully deployed, to check their own training records and to raise with their Manager if there are inaccuracies or to flag up if training needs to be arranged. In the interim, to check other sources of available training records, eg. TAS, local databases, as necessary

Exercise personal accountability to ensure that mandatory training requirements are kept up to date and report to their line manager any difficulties preventing them from undertaking the required training.

Attend / complete mandatory training as agreed with their line manager. Ensure that when completing/attending training the attendance/completion register is signed so that their training record can be maintained. Failure to do this will result in the individual appearing to be non-compliant with this policy.

Complete and return as necessary, training evaluation forms and report to their manager any areas of concern they may have following the training.

Transfer the learning received into practice on return to work.

**In-House Mandatory Training Providers** : It is the responsibility of in- house mandatory training providers to :-

Plan for and provide sufficient training to meet the identified need in line with specified timeframes and to identify to their Manager any issues that may prevent this.

Arrange for the provision of training, in an appropriate format and mode, being flexible in approach if necessary, to meet organisational need.

Monitor DNA rates on training programmes and communicate these to managers as necessary and agree any appropriate actions in order to reduce waste and maximise availability of training places.

Clearly communicate the details for the provision of training to managers and staff in a timely way.

Regularly review training content to ensure its currency and relevance and consider mode of delivery, to take into account, the possibility of modernised modes eg electronic learning, where appropriate.

Ensure that any electronic systems for training or associated processes are capable of identifying the individual member of staff who has completed the training

Ensure that all training has specific learning objectives stated as well as a detailed programme of content.

Carry out administration and maintain an accurate attendance / completion record on the agreed Trust IT system. From November 2014 Training Providers will use HRPTS to maintain training records. In the circumstances where Training Providers have not been provided with administrator access to HRPTS during the deployment phase, they must continue to use their existing system to maintain attendance / completion records until such times that HRPTS access is provided.

Provide reports of attendance/completion to service managers on request.

Provide information and reports as requested by the Learning, Development and Education Committee.

Provide to the Learning, Development and Education Committee, any proposals for revisions to the corporate training matrix using the agreed process.

Ensure cancellations of training only happen in extreme circumstances, participants notified and arrangements made to reschedule as early as possible.

Carry out and record appropriate evaluation of training.

#### **4.0 KEY POLICY PRINCIPLES**

Mandatory training is compulsory for all staff regardless of staff group or professional status. However the mandatory training programme comprises of different requirements depending on the staff group and individual role. This policy sets out the corporate mandatory requirements for all staff or broad categories of staff across the Trust.

Training which is regarded to be a requirement by service managers and individual professions, for their members to maintain core occupational competences, is not defined on the corporate training matrix. Service managers, along with Professions will determine and record separately what training is mandatory to cover core role skills. Managers will also communicate training requirements to their staff.

In making a distinction between mandatory training and Continuing Professional Development (CPD), it is acknowledged that some staff are required to undertake specific training and updates in order to fulfil professional registration requirements. It is the responsibility of the individual with their line manager to identify and agree any CPD required through their personal development plan. It is emphasised that these requirements must be undertaken in addition to the Trust's mandatory training programme.

All staff are expected to comply with the training set out within the corporate training matrix and for their own role within the stated time limits.

Completion of such training will take priority over non mandatory training.

Mandatory training should be completed as far as possible, within the first six months of taking up post and no later than 12 months in normal circumstances. The Manager, at all times, must ensure that any delay in completion of mandatory training does not create a risk for the employee or service user.

In line with the Assistance to Study policy, mandatory training will be fully funded for any associated course fees with paid time off to attend. Please refer to policy for detail regarding completion of training outside of normal working hours. Separate payment arrangements are set out for bank staff within the Bank Staff policy.

Mandatory training requirements specific to the Trust for Agency staff must be met by their employer as well as the Trust, as appropriate. Such staff must be able to demonstrate evidence of competency in such requirements. Reference should be

made to the specific conditions of the contract for agency staff. In relation to health and safety training, the cost of any training which the Trust is required to provide will be met by the employer of the agency staff.

It will be a requirement that Agencies providing staff to the Trust will have ensured that all staff have up to date training to undertake the duties of their post. This will be reflected in the contract arrangements with Agencies. Where staff are recruited from Agencies off contract, it will be the responsibility of the approaching Trust Officer to ensure such training is in place and to follow the appropriate Trust checklist.

Individuals undertaking a placement in the Trust must have their mandatory training needs considered by their placement supervisor in the Trust and arrangements made for training completion/attendance if deemed necessary. A record of this should be kept by the Placement Supervisor. Reference should be made to the Trust's Placement Policy.

Attendance / completion of training will be monitored by the Training Provider on a regular basis and reported to various Trust committees which have responsibility for such matters. Such committees will determine what action may be required to address non-compliance and communicate this to managers.

Although all managers and staff are expected to comply with mandatory training requirements, it is acknowledged that service priorities, sickness and leave may impact on the achievement of full compliance from time to time. However it is expected that the highest levels of compliance are achieved. Directorates will be required to report on this as part of performance management and accountability arrangements.

Non-compliance with the required mandatory training may result in an investigation from which possible disciplinary action may be taken in accordance with the Trust's Disciplinary policy.

Mandatory training is currently delivered through a variety of methods including classroom delivery and E learning. The Trust will explore and develop methods of learning to assist with flexibility of access, as appropriate, to the subject matter.

Until full deployment of HRPTS for Employee Self Service, Training Providers will operate dual processes for application to training courses, however it is expected that records will be maintained on HRPTS.

Statutory and Mandatory Training will be advertised, administered and recorded using HRPTS. Training Providers who wish to seek an exemption from this must secure the agreement of the Learning, Development and Education Committee. This is also subject to Training Providers having been given administrator access to the system during the deployment phase.

Mandatory training requirements must be reviewed by line managers for staff new to the Trust, as well as those new to post and action taken as necessary to support compliance for the individual's role.

All proposed new areas of mandatory training will be considered by the Learning, Development and Education Committee in line with the agreed Protocol and endorsement by the Executive Team. (Appendix 2)

For Agenda for Change staff, the non-achievement of mandatory training may result in the employee's failure to comply with the Knowledge and Skills Framework core dimension Health, Safety and Security and may adversely affect progression through gateways. Line Managers are required to ensure that they have facilitated the completion / attendance at training to avoid this situation occurring.

## **5.0 IMPLEMENTATION OF POLICY**

### **5.1 Dissemination**

This Policy should be disseminated throughout the Trust as it applies to all Belfast Trust staff.

### **5.2 Resources**

A range of training provision is widely available through both in-house and external Training Providers. Further details of training can be accessed by contacting the named contact person on the Training Matrix (Appendix 1).

### **5.3 Exceptions**

Policies are open to all staff within the Belfast Trust who meet the eligibility criteria.

## **6.0 MONITORING**

The Learning, Development and Education Committee will be responsible for monitoring the overall use of the Policy. Directors will monitor compliance within their own Service areas.

## **7.0 EVIDENCE BASE / REFERENCES**

Belfast HSC Trust Policies :-

Assistance to Study Policy

Induction Policy

Medical Appraisal

Personal Contribution Framework Guidance Notes

Knowledge & Skills Framework Guidelines

General Health and Safety Policy

Manual Handling

Risk Management Strategy

Data Protection and Protection of Personal Information

Fire Safety Policy

Equal Opportunities Policy

Bank Policy

Zero Tolerance Policy

Our responsibilities for safeguarding children – an information and training framework

RQIA Guidance on mandatory training for providers of care in regulated services

Data Protection Policy

Placement Policy

Resuscitation Policy

Infection Control Policy

Volunteers Policy



**8.0 CONSULTATION PROCESS**

This policy has been subject to consultation with Directors, Co Directors, Senior Managers, Members of Learning, Development and Education Committee and Mandatory Training Providers. Trade Unions have been consulted through the Learning and Development Sub Committee and Policy Sub Committee.

**9.0 APPENDICES / ATTACHMENTS**

Appendix 1 : Training Matrix

Appendix 2: Process for Amendment to Training Matrix

**10.0 EQUALITY STATEMENT**

In line with duties under the equality legislation (Section 75 of the Northern Ireland Act 1998), Targeting Social Need Initiative, Disability discrimination and the Human Rights Act 1998, the Belfast Trust has carried out an initial screening exercise to ascertain if this policy should be subject to a full impact assessment. The outcome of the Equality screening for this policy is:

- Major impact
- Minor impact
- No impact

**SIGNATORIES**

(Policy – Guidance should be signed off by the author of the policy and the identified responsible director).



15 April 2015

Date: \_\_\_\_\_

\_\_\_\_\_  
**Damian McAlister**  
 Director of Human Resources/  
 Organisational Development



15 April 2015

Date: \_\_\_\_\_

\_\_\_\_\_  
**Dr Michael McBride**  
 Chief Executive

	Training Programmes	Frequency	f=face to face e=e-learning	Staff required to complete statutory/mandatory training	Lead Contact	Senior Responsible Officer*	Director
<b>CORE (ALL STAFF)</b>	Corporate Welcome/Induction for Doctors in Training	Once	f	All newly appointed staff to the Trust must attend within 4 months of appointment. Doctors in training have separate induction arrangements.	Elaine Kehelly/Una Carabine	Joan Peden/Una Carabine	Director of HR & Organisational Development/ Medical Director
	Local Induction	Once	f	All staff who are new to a department/role must have a local induction.	All managers	All Directors	All Directors
	Fire & Environmental Awareness	Annually	f	All staff (biannual for residential care staff).	George McCracken	Eamon Malone	Director of Finance & Estates
	Health & Safety Awareness	Once	f/e	All staff (further consideration being given to enhanced frequency for other staff eg Estates)	Karen Cunnigham	Rachel Maxwell	Medical Director
	Adverse Incident Reporting	Once	f/e*	All staff (*e-learning available from Nov 2014)	Kevin Sira	Claire Cairns	Medical Director
	Data Protection	3 yearly	f/e	All staff	Gillian Acheson	Noel Williams	Director of Planning, Performance & Informatics
	Equality for Staff/Managers	5yrlly	f/e*	All staff (Staff with management/supervisory responsibilities must complete Equality Training for Managers course). (*e-learning available for Staff in April 15)	Alison Kerr/Louise Beckett	Joan Peden	Director of HR & Organisational Development
	Manual Handling Theory	2 yearly	f/e	All staff	Hilary Preston (Community), Maria Rush (Mater & RVH), Angela Clarke (MPH & BCH)	Caroline Parkes (Community, Mater, RVH), Gloria Mills (MPH & BCH)	Medical Director

	Training Programmes	Frequency	f=face to face e=e-learning	Staff required to complete statutory/mandatory training	Lead Contact	Senior Responsible Officer*	Director
<b>JOB SPECIFIC</b>	Management of Attendance	Once	f	All staff who have staff management/supervisory responsibilities.	Alison Kerr/Louise Beckett	Jacqui Kennedy	Director of HR & Organisational Development
	KSF/PCF Development Review	Once	f	All reviewers	Catherine Shannon	Joan Peden	Director of HR & Organisational Development
	Complaints Management	Once	f	All staff who have direct patient/client contact	Adrienne McKimm	Caroline Parkes	Medical Director
	Safeguarding Vulnerable adults	Variable	f	Requirement and frequency is particular to your care environment needs - refer to local arrangements.	Sandra Gray (Social Work/Care)	John Growcott (Social Work/Care)	Executive Directors/All Trust Directors
	Safeguarding Children	Variable	f	Requirement and frequency is particular to your care environment needs - refer to local arrangements.	Caroline Brogan (Social Work Social Care), Nuala Toner (Nursing)	John Growcott (Social Work/Care), Moira Mannion (Nursing)	Executive Directors/All Trust Directors
	Life Support (appropriate to care setting*)	2 Yearly	f	All nursing, midwifery, medical and AHP staff with direct patient contact.( *refer to life support training matrix 15/16)	Joanna McCormick	Janet Johnston	Director of Unscheduled Care & Acute
	Infection Prevention & Control for staff with direct patient care	2 yearly	f	All staff in primary or secondary healthcare settings with direct patient care responsibilities including those with responsibility for invasive devices i.e. all Medical, Nursing, Midwifery & AHP staff.	Irene Thompson	David Robinson	Director of Nursing & User Experience
	Infection Prevention & Control for staff with indirect patient care	2 yearly	f	All staff working in primary or secondary healthcare settings who have indirect patient care responsibilities i.e. PCSS or other support staff who visit clinical areas.	Irene Thompson	David Robinson	Director of Nursing & User Experience

	Training Programmes	Frequency	f=face to face e=e-learning	Staff required to complete statutory/mandatory training	Lead Contact	Senior Responsible Officer*	Director
<b>JOB SPECIFIC</b>	Infection Prevention & Control for staff in Community and Social Care Settings	1 yearly	DVD	All non-registered support staff working in community or social care settings e.g. Home care, Day care, Residential care	Irene Thompson	David Robinson	Director of Nursing & User Experience
	HIV Awareness	Once	f	All nursing, midwifery, medical, AHP and social care staff with direct patient/client contact.	Sandra Gray	John Growcott	Director of Social Work & Children's Community Services
	Safe Transfusion practice	18 mthly	f/e	All medical and nursing staff involved in any of the processes of transfusion.	Haemovigilance Coordinator	Patricia McKinney	Director of Surgery & Specialist Services
	Right Patient Right Blood competency assessment	3 yearly	f	Any member of staff taking blood for pre-transfusion sampling, collecting blood from a blood fridge or administering blood.	Haemovigilance Coordinator	Patricia McKinney	Director of Surgery & Specialist Services
	Blood collection and good manufacturing process awareness	Annually	f	Any member of staff collecting blood from the transfusion laboratory.	Alison Geddis/ Haemovigilance Coordinator	Patricia McKinney	Director of Surgery & Specialist Services
	Hyponatraemia	3 yearly	e	All staff involved in administering intravenous fluids to children	Christine Murphy / Peter Watson	Prof. Ian Young	Medical Director
	Medical Devices Awareness	3 yearly	f/e	All staff who use and manage medical devices.	Eugene Doherty	Claire Cairns	Medical Director
	Basic Medical Gas Safety	Once	f	All staff responsible for using, moving, handling, storing, and transporting medical gases, including cylinders and piped supplies (this is not intended for those staff who repair or maintain medical gas pipeline systems).	TBC	TBC	Medical Director

	Training Programmes	Frequency	f=face to face e=e-learning	Staff required to complete statutory/mandatory training	Lead Contact	Senior Responsible Officer*	Director
<b>JOB SPECIFIC</b>	Display Screen Equipment (DSE)	Once	e	All staff who use display screen equipment.	Hilary Preston (Community), Maria Rush (Mater & RVH), Angela Clarke (MPH & BCH)	Caroline Parkes (Community, Mater, RVH), Gloria Mills (MPH & BCH)	Medical Director
	Moving & Handling Hospital (Practical)	2 yearly	f	All hospital staff who have patient handling duties.	Maria Rush (Mater & RVH), Angela Clarke (MPH & BCH)	Caroline Parkes (Mater, RVH), Gloria Mills (MPH & BCH)	Medical Director
	Moving & Handling Community (Practical)	Every 18mths	f	All community staff who have client handling duties. Homecare Staff must also complete.	Hilary Preston	Caroline Parkes	Medical Director
	Personal Safety and Disengagement	Annually	f	All staff whose job has been risk assessed as requiring Personal Safety and Disengagement training.	Tara Patterson	Caroline Parkes	Medical Director
	Basic Personal Safety Training	2 yearly	f/e	All staff whose job has been risk assessed as requiring Basic Personal Safety training.	Tara Patterson	Caroline Parkes	Medical Director
	Management of Actual or Potential Aggression (MAPA)	Annually	f	As identified through risk assessment. Refer to Zero Tolerance policy.	Tara Patterson (All)/Michael McBride (MAH and Iveagh)	Caroline Parkes (All), Esther Rafferty (MAH & Iveagh)	Medical Director (All), Director of Adult Social & Primary Care (MAH & Iveagh)
	COSHH Awareness	3 yearly	f/e	All staff who may be exposed to hazardous substances in the course of their work activity and where a risk assessment deems it necessary. Please also refer to the RQIA Training Matrix.	Karen Cunnigham	Rachel Maxwell	Medical Director

	Training Programmes	Frequency	f=face to face e=elearning	Staff required to complete statutory/mandatory training	Lead Contact	Senior Responsible Officer*	Director
<b>INDIVIDUAL ROLE SPECIFIC</b>	Recruitment and Selection	3 yearly	f/e*	All staff who will be sitting on a recruitment panel. *Refresher training	Gladys McKibbin	Jacqui Kennedy	Director of HR & Organisational Development
	Medical Appraiser Training	3 yearly	f	All medical and dental staff who are appraisers for medical and dental practitioners. Full training before take up role, and 3 yearly thereafter	Cathy McCook	Deputy Medical Director	Medical Director
	First Aid at Work	3 yearly	f	Designated staff in each workplace (see First Aid at Work Policy).	Karen Cunningham/Philip Boyle	Rachel Maxwell	Medical Director
	Display Screen Equipment Facilitators Course	Once	f	Designated staff in each workplace.	Hilary Preston (Community), Maria Rush (Mater & RVH), Angela Clarke (MPH & BCH)	Caroline Parkes (Community, Mater, RVH), Gloria Mills (MPH & BCH)	Medical Director
	Patient/Client Handling Facilitators Course	Annually	f	Designated Trust staff who are indentified as having a formal link to the Ergonomics Team.	Hilary Preston (Community), Maria Rush (Mater & RVH), Angela Clarke (MPH & BCH)	Caroline Parkes (Community, Mater, RVH), Gloria Mills (MPH & BCH)	Medical Director
	Load Handling Facilitators Course	Annually	f	Designated Trust staff who are indentified as having a formal link to the Ergonomics Team.	Hilary Preston (Community), Maria Rush (Mater & RVH), Angela Clarke (MPH & BCH)	Caroline Parkes (Community, Mater, RVH), Gloria Mills (MPH & BCH)	Medical Director
	Fire Warden	3 yearly	f	Designated staff in each workplace.	George McCracken	Eamon Malone	Director of Finance & Estates
	COSHH Risk Assessors Course	3 yearly	f	Designated COSHH risk assessors.	Karen Cunnigham	Rachel Maxwell	Medical Director
	General Health & Safety Risk Assessment Workshop	3 yearly	f	Designated general risk assessors.	Karen Cunnigham	Rachel Maxwell	Medical Director

\* Senior Responsible Officer has delegated responsibility from the director for the provision of training in line with the Policy requirements

## Request for Amendment to Trust’s Statutory/Mandatory Training Matrix within the Trust’s Statutory/Mandatory Training Policy

***This form must be fully completed for training to be added or amended on Statutory Mandatory Training Matrix***

**1. With reference to the Statutory/Mandatory Training Policy, which of the following is the reason for the training to be included on the Matrix?**

*A statutory obligation – where the law defines that training must be undertaken.*

*A Health and Social Care mandate – where a formal, official directive has been handed down within the Health and Social Care sector.*

*A corporate mandate – where the Trust has identified training as being essential to organisational priorities.*

**2. Please provide details of the reason selected in 2:**

**3. Title of training course:**

**4. Please detail who is the lead responsible officer for the provision of this training in the Trust:**

**5. Staff group required to complete training (please give specific details):**

**6. What is the method(s) of delivery:** *(Please tick one or both boxes as appropriate)*

*Face to face*

*e-learning*

**7. Frequency of training:** *e.g. to be completed once, annually, three yearly. If there is a refresher/update version of this course the frequency of the course above will be “Once”.*

8. Is there a separate update/refresher version of this course? (Please tick appropriate box)

<input type="checkbox"/>	Yes
<input type="checkbox"/>	No

**\*NOTE: Only complete questions 9, 10, and 11 if you have ticked "Yes" in question 8 above.**

9. \*What is the title of the update/refresher course

10. \*What is the method(s) of delivery of update/refresher training: (Please tick one or both boxes as appropriate)

<input type="checkbox"/>	Face to face
<input type="checkbox"/>	e-learning

11. \*Frequency of update/refresher training: e.g. to be completed annually, three yearly etc.

12. The Trust's Statutory Mandatory Training Policy identifies the roles and responsibilities of Trust training providers in relation to such training. Please provide assurance that there are arrangements in place to meet the following requirements of the policy for this training:

*Please tick the appropriate box for each question*

	Yes	No
a) Will sufficient training be provided to meet the identified need within required timeframes?	<input type="checkbox"/>	<input type="checkbox"/>
b) Will the details regarding the provision of this training be clearly communicated to Managers and Staff in a timely way?	<input type="checkbox"/>	<input type="checkbox"/>
c) Has the training content and delivery method been prepared to ensure its currency?	<input type="checkbox"/>	<input type="checkbox"/>
d) Does this training programme have stated objectives and programme of content?	<input type="checkbox"/>	<input type="checkbox"/>
e) Will there be a procedure in place to notify Line Managers when staff do not attend/complete this training?	<input type="checkbox"/>	<input type="checkbox"/>
f) Will this training programme be evaluated?	<input type="checkbox"/>	<input type="checkbox"/>
g) Will an attendance record be maintained for this training?	<input type="checkbox"/>	<input type="checkbox"/>



*h) What system will be used to record attendances for this training? (Please note the implementation of HRPTS will require all providers to use this system to record their training activity):*

**If you have indicated NO on any of the above questions, please provide further details:**

--

**Sign Off:**

**Requested by:**

<i>Name &amp; Grade:</i>	<i>Signed:</i>	<i>Date:</i>

**Approved by  
Responsible Lead  
Officer for  
Provision of this  
Training:**

<i>Name &amp; Grade:</i>	<i>Signed:</i>	<i>Date:</i>

Please forward completed form to:

**Jonathan McAleer ( [REDACTED] )  
Learning & Development  
3<sup>rd</sup> Floor McKinney House  
Musgrave Park Hospital  
Stockman's Lane  
Belfast**

**Final Sign Off:**

**Approved by  
Learning  
Development &  
Education  
Committee:**

<i>Name &amp; Grade:</i>	<i>Signed:</i>	<i>Date:</i>

**Added to Matrix:**

<i>Name &amp; Grade:</i>	<i>Signed:</i>	<i>Date:</i>

## Process for Training to be included on Trust's Statutory/Mandatory Training Matrix

A need for new (or a change to) statutory/mandatory training arises as a result of a statutory obligation, a Health & Social Care mandate or a corporate mandate.

A training programme is designed or identified to meet the requirements identified above. The programme will include clear objectives and a programme of content. This will be the responsibility of the Lead Responsible Officer.

The training requirements and provision should be endorsed by the relevant professional committees and appropriate sponsorship secured with Executive Team.

The Lead Responsible Officer for the provision of the training in the Trust will formulate a plan to communicate, deliver and evaluate the training within the necessary timescales.

The Lead Responsible Officer will complete the request form for amendment to the Trust's Statutory/Mandatory Matrix and submit it to Jonathan McAleer, Learning Development, email: [REDACTED]

The Request Form will be tabled for endorsement at the next available Learning, Development & Education Committee.

The Training will be added to the Trust's Statutory Mandatory Training Matrix by the Learning & Development Department in Human Resources. The updated Matrix will be issued to Directors & Co-Directors for implementation in their Directorate. A copy will be uploaded to the intranet. The training will also be added to the course catalogue in HRPTS by the relevant training provider.

Human Resources will assign relevant training to positions in HRPTS to indicate any training gaps in training requirements for staff. (Nb. this functionality is currently under development regionally as at January 2015.)

<b>Title:</b>	<b>Core Statutory and Mandatory Training Policy</b>		
<b>Policy Author(s)</b>	Yvonne Connolly, Senior People and Organisational Development Manager Tel: 028 950 46401 [REDACTED] Elaine Kehelly, Senior People and Organisational Development Manager Tel: 028 950 48505 [REDACTED] Bernie Owens, Director of Neurosciences, Radiology, MAH Tel: 028 950 40109 [REDACTED] Charlene Stoops: Director, Performance Planning and Informatics Tel: 028 950 40107 [REDACTED]		
<b>Responsible Director:</b>	Jacqui Kennedy, Director of Human Resources and Organisational Development		
<b>Policy Type:</b> (tick as appropriate)	*Directorate Specific <input type="checkbox"/>	Clinical Trust Wide <input type="checkbox"/>	Non Clinical Trust Wide <input checked="" type="checkbox"/>
If policy type is confirmed as <b>*Directorate Specific</b> please list the name and date of the local Committee/Group that policy was <b>approved</b>			
<b>Date:</b>			
<b>Approval process:</b>	Trust Policy Committee Executive Team Meeting	<b>Approval date:</b>	08/10/2020 13/10/2020
<b>Operational Date:</b>	October 2020	<b>Review Date:</b>	October 2025
<b>Version No.</b>	3	<b>Supersedes</b>	V2 – April 2015 – April 2018
<b>Key Words:</b>	The Belfast Health and Social Care Trust (BHSCT) recognises that statutory and mandatory training is of vital importance in the provision of high quality services to our patients and clients and is essential for effective risk management and the maintenance of required standards.		
<b>Links to other policies</b>			

Date	Version	Policy Author	Comments
10/12/2010	0.1	E Kehelly	Initial draft
03/02/2011	0.2	E Kehelly	Minor changes
11/04/2011	0.3	E Kehelly	Update further to consultation
06/06/2011	0.4	E Kehelly	Final amendment
21/10/2011	0.5	E Kehelly	Minor updates further to Policy Committee
01/12/2012	0.6	E Kehelly	Review of Policy for consultation
22/05/2014	1.1	E Kehelly	Review of Policy for consultation
06/01/2015	1.2	E Kehelly	Final minor amendments to policy following audit
22/05/2015	2	E Kehelly	Sent for Hub
22/05/2019	3.1	Y Connolly	Revision and update of Policy
13/11/2019	3.2	Y Connolly	Update further to consultation

19/02/2020	3.3	Y Connolly	Update further to changes requested by Exec Team
14/07/2020	3.4	Y Connolly	Update further due to Welcome Event being stood down
06/08/2020	3.5	E Kehelly	Update further to Equality Manager and Trust Committee Feedback

## 1.0 **INTRODUCTION / SUMMARY OF POLICY**

This policy addresses only Core Statutory and Mandatory training requirements, that is, Statutory and Mandatory training which all Trust staff are required to attend/complete regardless of role and/or profession. **The policy does not cover individual/role specific training which is applicable across broad groups of staff and/or training regarded as being a requirement of individual professions for their members to maintain core occupational competences.**

### 1.1 **Background**

Belfast Health and Social Care Trust (BHSCT) is committed to providing safe and high quality care to all patients, clients and service users.

Statutory and mandatory training is of vital importance in the provision of high quality services and is essential for effective risk management and maintenance of required standards.

We recognise our duty to deliver appropriate training and ensure employees have reasonable access to complete such training. This policy identifies the minimum core mandatory training requirements across all Trust staff and clarifies the monitoring and reporting arrangements in place for this training.

For the purposes of this policy, core statutory and mandatory training will be referred to under the collective title of mandatory training.

### 1.2 **Purpose**

This policy identifies core statutory and mandatory training for all Trust staff and arrangements in place to meet our obligations as an employer.

The purpose of this policy is to ensure all staff complete their core statutory and mandatory training within the required timescale and frequencies in order to contribute to the delivery of high quality services and care. This will support the Trust in ensuring compliance with the law as well as promoting quality standards and minimising risk to staff, service users, visitors and the public.

This policy will outline governance and assurance mechanisms for the management, provision and recording of core statutory and mandatory training. This will be by ensuring there is a process whereby all such training is consistently delivered, attendance recorded, compliance monitored and action taken where non-attendance occurs.

### 1.3 **Objectives**

- To reduce risks to our service users, staff, visitors and the public;
- To comply with the law;
- To support staff in carrying out their duties safely and efficiently;

- To provide a systematic approach to the provision, recording and monitoring of core statutory and mandatory training for all staff;
- To ensure robust governance arrangements and assurance mechanisms are in place and maintained regarding the provision, attendance/completion and recording of core statutory and mandatory training;
- To outline responsibilities for managers and all staff members to comply with the requirements of this policy;

## 2.0 **SCOPE OF THE POLICY**

This policy applies to all staff (including bank staff) and volunteers at the Belfast Trust regardless of role, contract type, staff group or professional status.

Temporary staff, employed through agencies and/or by contractors, are required to have had their core mandatory training needs met by their employer before starting work in the Trust.

The policy applies to all Core Statutory and Mandatory training set out in the Core Mandatory Training Matrix (Appendix 1). All staff are required to attend/complete, within the specified timeframes, all training identified within this matrix. Please note the training identified is applicable to all staff, some groups of staff will be also be required to attend additional training known as Role Specific/Individual.

**Individual / Role Specific Mandatory Training, which is applicable across broad groups of staff, and training regarded as being a requirement of individual professions for their members to maintain core occupational competences, is not covered by this policy or included in the Core Mandatory Training Matrix. Clarification on such training requirements will be provided to staff members by their line managers and/or professional heads.**

Reference should be made to other Trust policies which set out additional mandatory training requirements for broad groups of staff and/or individual professions.

## 3.0 **ROLES AND RESPONSIBILITIES**

**Directors:** It is the responsibility of Directors to:

- Provide assurance of compliance with this Policy.
- Implement the policy on Core Mandatory Training within their Directorate, ensuring Managers are aware of their responsibilities for staff to attend/complete the relevant training.
- Ensure that, where necessary, insurmountable issues with compliance are identified and appropriately recorded and assessed with monitoring of progress on the appropriate risk register.
- Directors who carry responsibility for provision of core statutory and mandatory training should ensure arrangements are in place to meet objectives of this policy.

**Managers:** It is the responsibility of Managers to:

- Ensure all new to Trust staff complete the Welcome Event Programme on their first working day or if this is not possible within their first week of employment (*the majority of staff including Medical staff are required to complete this programme. Separate arrangements are in place for Trainee Doctors*).
- Communicate to their staff the core mandatory training required and facilitate their attendance/completion.
- Inform training providers if a staff member cannot attend a booked training session to reducing Do Not Attend rates and minimise waste.
- Cascade information relating to attendance/completion of training to Line Managers, agreeing an action plan were the Department/area is not achieving the targeted uptake of relevant mandatory training.
- Implement and monitor this policy ensuring that all employees within their areas of responsibility have addressed issues of non-compliance for training attendance /completion.
- Contact Trust Mandatory training providers, if required, to request the provision of targeted training sessions in their Directorate.
- Ensure that all staff within their remit have a current Personal Development Plan (PDP). During the process to agree this, a review of the training completed during the previous year will be undertaken and the mandatory training requirements for the forthcoming year will be identified and included in the employee's personal development plan. The line manager and the employee must agree an appropriate timetable and to ensure attendance at mandatory training events.
- Encourage staff planning to go on an extended period of leave to update their training requirements before the leave commences.
- To ensure that any training that requires an update is completed promptly on their return.
- Follow up and investigate non-attendance/completion of training and rearrange for training as soon as possible.
- Notify Co-Directors should significant issues arise in securing compliance with this policy.
- Pay due care and attention to the training records of their staff.

**Employees:** It is the responsibility of Employees to:

- Be aware of their personal core mandatory training requirements and required refresher frequencies as outlined in the core mandatory training matrix and in their own personal development plans.
- Complete the Welcome Event Programme on their first working day or if this is not possible within their first week of employment.
- Use the Employee Self Service function on HRPTS to check their own training records and to raise with their Manager if there are inaccuracies or to flag up if training needs to be arranged.
- Exercise personal accountability to ensure that core mandatory training requirements are kept up to date and report to their line manager any difficulties preventing them from undertaking the required training.
- Attend / complete core mandatory training as agreed with their line manager. Ensure that when attending/completing training the attendance/completion register is signed to ensure their training record is updated. Failure to do this will result in the individual appearing to be non-compliant with this policy.
- Complete and return as necessary, training evaluation forms and report to their manager any areas of concern they may have following the training.
- Exercise personal accountability to ensure they inform the training provider of any reasonable adjustment and or accessible alternative formats they may require

**In-House Core Mandatory Training Providers:** It is the responsibility of in- house training providers to:

- Plan for and provide sufficient training to meet the identified staff need in line with specified timeframes and to identify to the Senior Responsible Officer (SRO) for the training any issues that may prevent this.
- Arrange for the provision of training, in an appropriate format and mode, being flexible in approach if necessary, to meet organisational need and also accommodating any reasonable adjustments/alternative format\* requests. This includes, if required, being available to deliver their core mandatory training as part of the Trust's Welcome Event Programme.

\* *Accessible/ Alternative formats should be made available upon requests eg. larger font print. For advice on making information accessible and inclusive for staff with a disability, click [Making Communication Accessible guidance](#).*

- Monitor DNA rates on training programmes and take appropriate actions as necessary in order to reduce waste and maximise availability of training places.

- Clearly communicate details for the provision of training (other than training provided as part of the Corporate Induction programme ) to managers and staff in a timely way.
- Regularly review training to ensure its currency and relevance with both content and modern workplace learning technologies.
- Ensure any electronic systems for training or associated processes are capable of identifying the individual member of staff who has completed the training.
- Ensure that all training has specific learning objectives stated as well as an appropriate programme of content.
- Carry out administration and maintain an accurate attendance / completion record on the HRPTS for all training delivered.
- Provide reports of attendance/completion to service managers on request.
- Provide information and reports as requested by the Statutory and Mandatory Training Policy Working Group.
- Provide to the Statutory and Mandatory Training Policy Working Group, any proposals for revisions to the core training matrix using the agreed process.
- Ensure cancellations of training only happen in extreme circumstances, participants notified and arrangements made to reschedule as early as possible.
- Carry out and record appropriate evaluation of training.

**HR, People and Organisational Development Team:** It is the responsibility of the HR, People and Organisational Development Team to:-

- Manage and oversee the Trust Welcome Event Programme.
- Ensure an invite to complete the Trust Welcome Event Programme is issued to all new to Trust staff within the agreed timeframe.
- Record attendance and update staff training records on HRPTS for all Core Mandatory Training completed as part of the Trust's Welcome Event Programme.
- Advise managers of non-completion in respect of new to Trust staff and completion of the Trust's Welcome Event Programme.
- Produce and send monthly Core Mandatory Training matrix dashboard reports to Directors, Divisional Leads etc. for their information and action.
- Regularly review and make updates/changes to the Trust's Welcome Event Programme.
- Obtain feedback and evaluate the Trust's Welcome Event Programme.



- Should a member of the HR, People and Organisational Development team become aware that there is a requirement for a reasonable adjustment and/or alternative accessible format this should be communicated to the In-House Core Mandatory Training Provider

#### 4.0 **CONSULTATION**

This policy has been subject to consultation with Directors, Co-Directors, Senior Managers, Members of Statutory and Mandatory Training Policy Working Group and Statutory and Mandatory Training Providers. Trade Unions have been consulted through the Learning and Development Sub Committee.

#### 5.0 **POLICY STATEMENT/IMPLEMENTATION**

##### 5.1 **Policy Principles**

Mandatory training is compulsory for all staff regardless of staff group or professional status. However the mandatory training requirements differ depending on staff group, profession and individual role. **This policy pertains to and sets out only the core mandatory training common to all staff in the Belfast Trust.** Please note Core Mandatory Training is suitable for all staff. Some groups of staff will also require additional training in some of these subject areas. For example many staff will require additional training in Manual Handling, Safeguarding Children and Safeguarding Adults to ensure they have the necessary knowledge and competence for their job role.

There are currently four imperatives that govern whether or not training is considered as core mandatory training and therefore falls under this policy:

1. The training is applicable to all Trust staff regardless of their role and/or profession;  
and;
2. Is a statutory obligation: where the law defines that training must be undertaken;  
or
3. A Health and Social Care mandate: where a formal, official directive has been handed down within the Health and Social Care sector;  
or
4. A corporate mandate – where the Trust has identified training as being essential to organisational priorities;

**Training which is regarded to be a requirement by service managers and or by individual professions so their members maintain core occupational competences, is not covered in this policy or identified within the corresponding core mandatory training matrix. Service managers, along with professions will determine and record separately what training is mandatory to cover specific role skills.**

In making a distinction between core mandatory training and Continuing Professional Development (CPD), it is acknowledged that some staff are required to undertake specific training and updates in order to fulfil professional registration requirements. It is the responsibility of the individual, with their line manager, to identify and agree

any CPD required through their personal development plan. It is emphasised that these requirements must be undertaken in addition to the Trust's core mandatory training programme.

All staff are expected to comply with the training set out within the core mandatory training matrix within the stated time frame. Completion of such training will take priority over non-mandatory training.

All Trust staff must ensure they undertake core mandatory training at the required frequencies to ensure they remain compliant (eg. Manual Handling Theory every two years).

New to Trust staff (with the exception of Doctors in Training for whom separate arrangements are in place) should have completed Core Mandatory training on their first working day or within their first week of employment if this is not possible. Core mandatory training is currently provided for new to Trust staff (with the exception of Doctors in Training for whom separate arrangements are in place) via the Trust's Welcome Event Programme. Prior to commencing employment with the Trust, new to Trust staff are invited to complete this programme. In circumstances where staff are unable to complete this training prior to or on their first day of employment, they should do so within their first week of employment. The manager, at all times, must ensure that any delay in completion of core mandatory training does not create a risk for the employee or service user.

Where there is agreement from managers and training is undertaken or completed before an individual commences employment or outside of normal working hours, the individual can be paid for these hours or avail of time off in lieu (TOIL) to be taken at a mutually convenient time.

In line with the Assistance to Study policy, mandatory training will be fully funded for any associated course fees with paid time off to attend. Please refer to the Assistance to Study policy for detail regarding completion of training outside of normal working hours. Separate payment arrangements are set out for bank staff within the Bank Staff policy.

Core mandatory training requirements specific to the Trust for Agency staff must be met by their employer as well as the Trust, as appropriate. Such staff must be able to demonstrate evidence of competency in such requirements. Reference should be made to the specific conditions of the contract for agency staff. For health and safety training, the cost of any training which the Trust is required to provide will be met by the employer of the agency staff.

It will be a requirement that Agencies providing staff to the Trust will have ensured that all staff have up to date training to undertake the duties of their post. This is reflected in the contract arrangements with Agencies. Where staff are recruited from off-contract Agencies, it is the responsibility of the approaching Trust Officer to ensure such training is in place and to follow the appropriate Trust checklist.

Individuals undertaking a placement in the Trust must have their core mandatory training needs considered by their placement supervisor in the Trust and arrangements made for training attendance/completion if deemed necessary. A

record of the training should be kept by the Placement Supervisor. Reference should be made to the Trust's Placement Policy.

Attendance / completion of core mandatory training will be monitored by the Training Provider on a regular basis and reported to various Trust committees which have responsibility for such matters. Such committees will determine what action may be required to address non-compliance and communicate this to managers. Core Mandatory training provided to new to Trust staff as part of the Trust's Welcome Event Programme will be recorded and reported to Directors by the HR, People and Organisational Development Team. All managers and staff are expected to comply with core mandatory training requirements. It is acknowledged however that service priorities, sickness and leave may occasionally impact on the achievement of compliance from time to time. However it is expected that the highest levels of compliance are achieved. Directorates will be required to report on this as part of performance management and accountability arrangements.

Non-compliance with the required core mandatory training may result in an investigation from which possible disciplinary action may be taken in accordance with the Trust's Disciplinary policy.

Core mandatory training is currently delivered for new to Trust staff (with the exception of Doctors in Training for whom separate arrangements are in place) via the Trust's Welcome Event Programme. The Trust will explore and develop methods of learning to assist with flexibility of access, as appropriate, to the subject matter.

The Trust strives to ensure that our welcome programme is accessible and inclusive and will provide reasonable adjustment upon request.

Core Mandatory Training **must** be advertised, administered and recorded using HRPTS. Training Providers who wish to seek an exemption from this must secure the agreement of the Statutory and Mandatory Training Policy Working Group. Local training databases may also be held, if required, but these should supplement rather than be an alternative to the recording of SM training on HRPTS.

All proposed new areas of core mandatory training will be considered by the Statutory and Mandatory Training Policy Working Group. in line with the agreed Protocol and endorsement by the Executive Team. (Appendix 2)

For Agenda for Change staff, the non-achievement of core mandatory training may result in the employee's failure to comply with the Knowledge and Skills Framework core dimension Health, Safety and Security and may adversely affect progression through gateways. Line Managers are required to ensure that they have facilitated the completion / attendance at training to avoid this situation occurring.

## 5.2 Dissemination

This Policy should be disseminated throughout the Trust as it applies to all Belfast Trust staff.

If support or alternative formats and reasonable adjustments are required in terms of communication / delivery in relation to the Policy, this will be provided.

**5.3 Resources**

A range of training provision is widely available through both in-house and external Training Providers. Further details of training can be accessed by contacting the named contact person on the Training Matrix (Appendix 1).

**5.4 Exceptions**

Policies are open to all staff within the Belfast Trust who meet the eligibility criteria.

**6.0 MONITORING AND REVIEW**

The Statutory and Mandatory Training Policy Working Group will be responsible for monitoring the overall compliance with the Policy. Regular reports will be provided to Directors to enable them to monitor compliance within their own service areas and take appropriate action.

**7.0 EVIDENCE BASE/REFERENCES**

Belfast HSC Trust Policies:

- Assistance to Study Policy
- Induction Policy
- Medical Appraisal
- Staff Development Review Guidance Notes
- Knowledge & Skills Framework Guidelines
- General Health and Safety Policy
- Manual Handling
- Risk Management Strategy
- Data Protection and Protection of Personal Information
- Fire Safety Policy
- Equal Opportunities Policy
- Bank Policy
- Zero Tolerance Policy
- Our responsibilities for safeguarding children – an information and training framework
- RQIA Guidance on mandatory training for providers of care in regulated services
- Data Protection Policy
- Placement Policy
- Volunteers Policy

**8.0 APPENDICES**

Appendix 1: Training Matrix

Appendix 2: Process for Amendment to Training Matrix

**9.0 NURSING AND MIDWIFERY STUDENTS**

Nursing and/or Midwifery students on pre-registration education programmes, approved under relevant 2018/2019 NMC education standards, must be given the

opportunity to have experience of and become proficient in **(insert name of policy related practice/skill)**, where required by the student's programme. This experience must be under the appropriate supervision of a registered nurse, registered midwife or registered health and social care professional who is adequately experienced in this skill and who will be accountable for determining the required level of direct or indirect supervision and responsible for signing/countersigning documentation.

Direct and indirect supervision

- Direct supervision means that the supervising registered nurse, registered midwife or registered health and social care professional is actually present and works alongside the student when they are undertaking a delegated role or activity.
- Indirect supervision occurs when the registered nurse, registered midwife or registered health and social care professional does not directly observe the student undertaking a delegated role or activity. (NIPEC, 2020)

This policy has been developed in accordance with the above statement.

Wording within this section must not be removed.

## 10.0 **EQUALITY IMPACT ASSESSMENT**

The Trust has legal responsibilities in terms of equality (Section 75 of the Northern Ireland Act 1998), disability discrimination and human rights to undertake a screening exercise to ascertain if the policy has potential impact and if it must be subject to a full impact assessment. The process is the responsibility of the Policy Author. The template to be complete by the Policy Author and guidance are available on the Trust Intranet or via this [link](#).

All policies (apart from those regionally adopted) must complete the template and submit with a copy of the policy to the Equality & Planning Team via the generic email address [equalityscreenings@belfasttrust.hscni.net](mailto:equalityscreenings@belfasttrust.hscni.net)

**The outcome of the equality screening for the policy is:**

- Major impact   
 Minor impact   
 No impact

Wording within this section must not be removed

## 11.0 **DATA PROTECTION IMPACT ASSESSMENT**

New activities involving collecting and using personal data can result in privacy risks. In line with requirements of the General Data Protection Regulation and the Data Protection Act 2018 the Trust considers the impact on the privacy of individuals and ways to mitigate against any risks. A screening exercise must be carried out by the Policy Author to ascertain if the policy must be subject to a full assessment. Guidance is available on the Trust Intranet or via this [link](#).

If a full impact assessment is required, the Policy Author must carry out the process. They can contact colleagues in the Information Governance Department for advice on Tel: 028 950 46576

[Completed Data Protection Impact Assessment forms must be returned to the Equality & Planning Team via the generic email address equalityscreenings@belfasttrust.hscni.net](mailto:equalityscreenings@belfasttrust.hscni.net)

**The outcome of the Data Protection Impact Assessment screening for the policy is:**

- Not necessary – no personal data involved**
- A full data protection impact assessment is required**
- A full data protection impact assessment is not required**

Wording within this section must not be removed.

## **12.0 RURAL NEEDS IMPACT ASSESSMENT**

The Trust has a legal responsibility to have due regard to rural needs when developing, adopting, implementing or revising policies, and when designing and delivering public services. A screening exercise should be carried out by the Policy Author to ascertain if the policy must be subject to a full assessment. Guidance is available on the Trust Intranet or via this [link](#).

If a full assessment is required the Policy Author must complete the shortened rural needs assessment template on the Trust Intranet. Each Directorate has a Rural Needs Champion who can provide support/assistance.

[Completed Rural Impact Assessment forms must be returned to the Equality & Planning Team via the generic email address equalityscreenings@belfasttrust.hscni.net](mailto:equalityscreenings@belfasttrust.hscni.net)

Wording within this section must not be removed.

## **13.0 REASONABLE ADJUSTMENT ASSESSMENT**

Under the Disability Discrimination Act 1995 (as amended) (DDA), all staff/ service providers have a duty to make Reasonable Adjustments to any barrier a person with a disability faces when accessing or using goods, facilities and services, in order to remove or reduce such barriers. E.g. physical access, communicating with people who have a disability, producing information such as leaflets or letters in accessible alternative formats. E.g. easy read, braille, or audio or being flexible regarding appointments. This is a non-delegable duty.

The policy has been developed in accordance with the Trust's legal duty to consider the need to make reasonable adjustments under the DDA.

Wording within this section must not be removed.

**SIGNATORIES**

(Policy – Guidance should be signed off by the author of the policy and the identified responsible director).

*James Kennedy*

13/10/2020

**Date:** \_\_\_\_\_

\_\_\_\_\_  
**Policy Author**

*Cathy Jack*

13/10/2020

**Date:** \_\_\_\_\_

\_\_\_\_\_  
**Director**

**Appendix 1**

<b>Core Training Programmes</b>	<b>Frequency</b>	<b>Lead Contact *</b>	<b>Senior Responsible Officer **</b>	<b>Directorate</b>	<b>Operational Contact *** (if different from Lead Contact)</b>
Trust Welcome Programme <b>1</b>	Once	Kevin Kennedy	Jacqui Kennedy	HR & Organisational Development	Kevin Kennedy
Fire Safety Awareness Training <b>2</b>	Annually <b>3</b>	Joanna Dougherty	Maureen Edwards	Finance & Estates	Mairead McCartan
Health & Safety Awareness Training	Once	Anne Mageean	Claire Cairns	Medical Directorate	
Adverse Incident Reporting (incorporates Being Open)	Once	Gillian Moore	Claire Cairns	Medical Directorate	Heather Whiteman
Data Protection	3 yearly	Gillian Acheson	Charlene Stoops	Planning, Performance & Informatics Directorate	Cathy Cole & Deborah Crozier
Equality for Staff/Managers	5yrly	Samantha Whann	Jacqui Kennedy	HR & Organisational Development	Martin McGrath
Manual Handling Theory	2 yearly	Caroline Parkes / Elaine McConnell	Jacqui Kennedy / Bernie Owens	HR & Organisational Development / Unscheduled & Acute Care	Maria Rush (Mater & RVH) Angela Clarke (MPH & BCH) Claire Campbell (Community)
Quality 2020: Level 1 Awareness	Once	Kevin Kennedy	Jacqui Kennedy	HR & Organisational Development	Eamon Doherty
Safeguarding Adults and Children Awareness <b>4</b>	Once	Caroline Brogan (Social Work, Social Care) Jennifer Donnelly (only for induction awareness training)	Carol Diffin	Children's Community Services	
Infection Prevention Control Awareness <b>5</b>	Once	Lead Nurse IPC	Brenda Creaney	Nursing and User Experience	



- <sup>1</sup> The majority of staff including Medical staff are required to complete the Welcome Event Programme. Separate arrangements are in place for Trainee Doctors.
- <sup>2</sup> The E-learning training module is designed solely for staff who **DO NOT** have any involvement/responsibility for patient/client evacuation in the event of a fire
- <sup>3</sup> Residential care staff are required to attend Fire Safety Training every six months.
- <sup>4</sup> This is awareness raising only. More detailed training will need to be completed by identified groups of staff e.g. Allied Health Professionals, Dentists, Medical Practitioners, Nursing, Psychology, Social Work and Social Care Staff. If in doubt, please check with your line manager.
- <sup>5</sup> This is awareness raising only. More detailed training will need to be completed by identified groups of staff e.g. Clinicians. If in doubt please check with your line manager

**Please Note:**

- \* Lead Contact is responsible for managing the provision of the specific training indicated and not necessarily other levels beyond awareness.
- \*\* Senior Responsible Officer has responsibility or delegated responsibility from the Director for the provision of training in line with the Policy.
- \*\*\* Operational Contact supports the delivery of training on a day to day basis.

Appendix 2

**Request for Amendment to Trust’s Core Statutory / Mandatory Training Matrix within the Trust’s Core Statutory / Mandatory Training Policy**

***This form must be fully completed for training to be added or amended on Core Statutory Mandatory Training Matrix***

1. **With reference to the Core Statutory / Mandatory Training Policy, which of the following is the reason for the training to be included on the Matrix?**

<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>

*A statutory obligation: where the law defines that training must be undertaken*

*A Health and Social Care mandate: where a formal, official directive has been handed down within the Health and Social care sector*

*A Corporate mandate: where the Trust has identified training as being essential to organisational priorities*

2. **Please provide details of the reason selected in 2:**

3. **Title of training course:**

4. **Please detail who is the lead responsible officer for the provision of this training in the Trust:**

5. **Please confirm that the training is applicable to all Trust staff:**

6. **What is the method(s) of delivery:** *(please tick one or both boxes as appropriate)*

<input type="checkbox"/>
<input type="checkbox"/>

Face to Face

e-learning

7. **Frequency of training:** *eg. to be completed once, annually, three yearly. If there is a refresher / update version of this course the frequency of the course above will be "Once"*

8. **Is there a separate update / refresher version of this course?:** *(please tick appropriate box)*

	YES
	NO

**NOTE: Only complete questions 9, 10, 11 if you have ticked "YES" in question 8 above**

9. **What is the title of the update / refresher course?**

10. **What is the method(s) of delivery?:** *(please tick one or both boxes as appropriate)*

	Face to Face
	e-learning

11. **Frequency of update / refresher:** *eg. to be completed annually, three yearly*

12. **The Trust's Core Statutory Mandatory Training Policy identifies the roles and responsibilities of Trust training providers in relation to such training. Please provide assurance that there are arrangements in place to meet the following requirements of the Policy for this training:**

***Please tick the appropriate box for each question***

	Yes	No
a) Will sufficient training be provided to meet the identified need within required timeframes?		
b) Will the details regarding the provision of this training be clearly communicated to Managers and Staff in a timely way?		
c) Has the training content and delivery method been prepared to ensure its currency?		
d) Does this training programme have stated objectives and programme of content?		

e) Will there be a procedure in place to notify Line Managers when staff do not attend/complete this training?		
f) Will this training programme be evaluated?		
g) Will an attendance record be maintained for this training?		
h) Will HRPTS be used to record attendances for this training? <i>(Please note all providers are required to use HRPTS for the recording of their training activity):</i>		

**If you have indicated NO on any of the above questions, please provide further details:**

---

**Sign Off:**

**Requested by:**

<i>Name &amp; Grade:</i>	<i>Signed:</i>	<i>Date:</i>
--------------------------	----------------	--------------

**Approved by Responsible Lead Officer for**

<i>Name &amp; Grade:</i>	<i>Signed:</i>	<i>Date:</i>
--------------------------	----------------	--------------

**Provision of this Training:**

Please forward completed form to:

**Eimear Moore** [Redacted] **People and Organisational Development Team, 3<sup>rd</sup> Floor McKinney House Musgrave Park Hospital Stockman's Lane Belfast**

**Final Sign Off:**

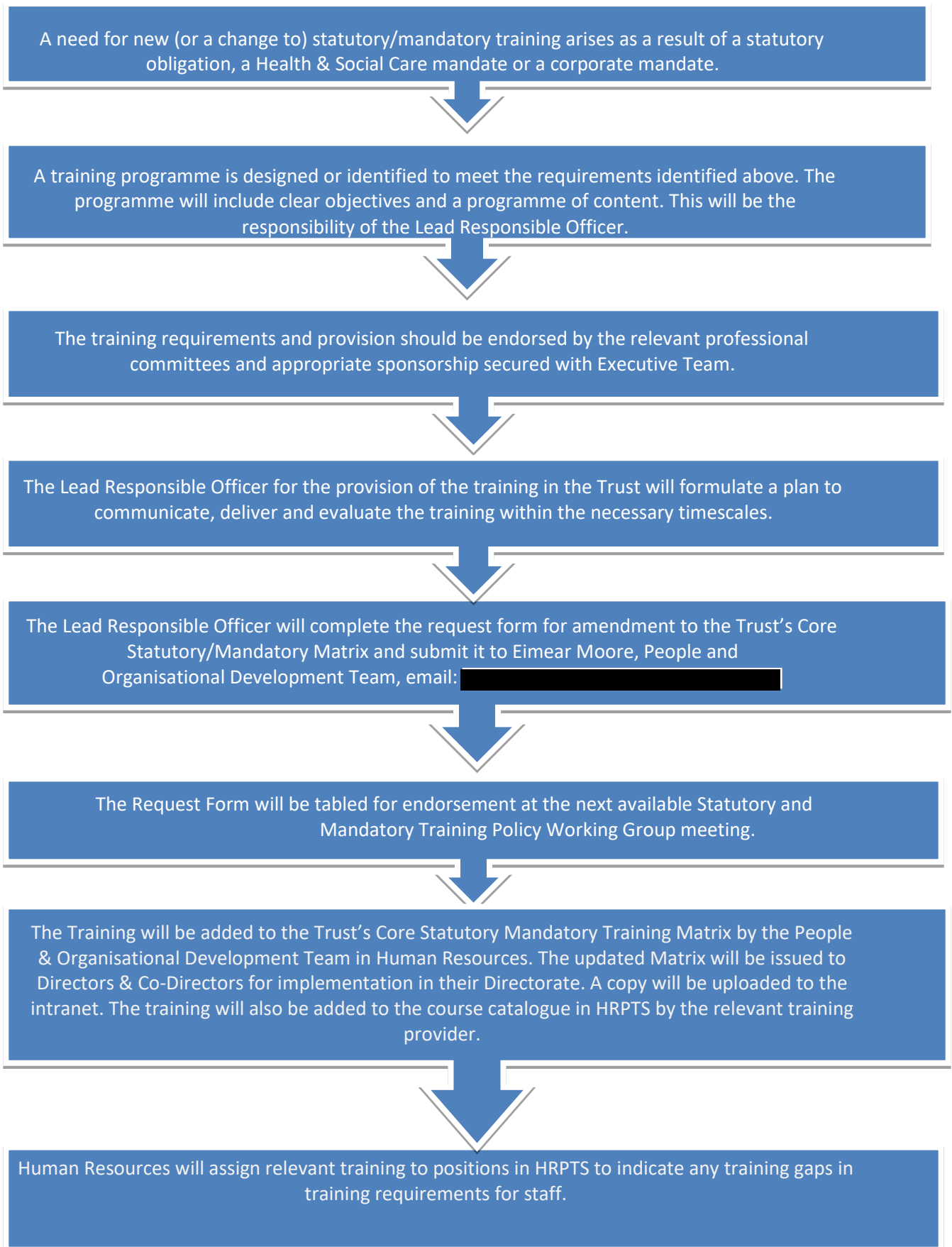
**Approved by Statutory and Mandatory Training Policy Working Group:**

<i>Name &amp; Grade:</i>	<i>Signed:</i>	<i>Date:</i>
--------------------------	----------------	--------------

**Added to Matrix:**

<i>Name &amp; Grade:</i>	<i>Signed:</i>	<i>Date:</i>
--------------------------	----------------	--------------

## Process for Training to be included on Trust's Core Statutory/Mandatory Training Matrix



# The Prep handbook

We are the nursing and midwifery regulator for England, Wales, Scotland, Northern Ireland and the Islands.

- We exist to safeguard the health and wellbeing of the public.
- We set the standards of education, training and conduct that nurses and midwives need to deliver high quality healthcare consistently throughout their careers.
- We ensure that nurses and midwives keep their skills and knowledge up to date and uphold the standards of their professional code.
- We ensure that midwives are safe to practise by setting rules for their practice and supervision.
- We have fair processes to investigate allegations made against nurses and midwives who may not have followed the code.

## Contents

Introduction	2
You, Prep and the NMC	4
The Prep (practice) standard	7
Returning to practice	9
The Prep (continuing professional development) standard	11
Prep (CPD) – guidance for recording your learning	13
Examples of Prep (CPD) learning	16
How will the NMC know that you have met the standards?	38
Further information	40
Contact us	42



## Introduction

Post-registration education and practice (Prep) is a set of Nursing and Midwifery Council (NMC) standards and guidance which is designed to help you provide a high standard of practice and care. Prep helps you to keep up to date with new developments in practice and encourages you to think and reflect for yourself. It also enables you to demonstrate to the people in your care, your colleagues and yourself that you are keeping up to date and developing your practice. Prep provides an excellent framework for your continuing professional development (CPD), which, although not a guarantee of competence, is a key component of clinical governance.

Most nurses and midwives are already familiar with Prep. This may be through the various publications produced by the UKCC and the NMC since 1995. It might also be from reading about it in professional journals or from discussing it with your colleagues. This booklet is designed to consolidate everything you need to know about the Prep standards and guidance.

The best thing about Prep is that it is entirely up to you to decide how to meet the standards. The NMC believes that you are the best person to decide what learning activity you need to undertake. You should choose whether it is free or if you wish to pay for it. You are the best person to decide the extent to which you are practising as a registered nurse, midwife or specialist community public health nurse.

We hope that you will find this handbook useful. If you have any further queries about how to meet the Prep standards, you can contact us in confidence. Our contact details are on the back cover.

The NMC is reviewing and updating the standards for the maintenance and renewal of registration. This is being informed by the outcomes of the reviews of revalidation and regulation.

**Prep helps you to:**

- keep up to date with new developments in practice
- think and reflect for yourself
- demonstrate that you are keeping up to date and developing your practice
- provide a high standard of practice and care.

# You, Prep and the NMC

## The role of the NMC

The NMC is the regulatory body for nurses and midwives. Our purpose is to establish and improve standards of care in order to safeguard the health and wellbeing of the public. The key tasks of the NMC are to:

- maintain a register of nurses and midwives
- set standards and guidelines for education, conduct, performance and ethics
- provide advice on professional standards
- consider allegations of lack of fitness to practise due to misconduct, lack of competence or ill health.

## The NMC register

Registration with the NMC is essential for you to be able to work in the United Kingdom (UK) as a nurse or midwife. We maintain a register of all the people who have fulfilled the NMC's registration requirements and who are, therefore, entitled to practise in the UK. The register is at the heart of the NMC's role in safeguarding the health and wellbeing of the public.

## Requirements for renewal of registration with the NMC

In order to renew your registration every three years, you will need to provide a signed Notification of practice (NoP) form and pay your renewal of registration fee. The NoP asks you to declare that you have met the Prep requirements (see below) and are of good health and good character. Your registration will not be renewed until the NMC has received and processed your completed and signed form, together with your fee payment.

Please note that now the NMC has moved to the annual payment of fees, you will be required to pay a retention of registration fee at the end of the first and second years of registration period.

Additionally, in order to practise, midwives need to give notice of their intention to practise, in accordance with rule 3 of the *Midwives rules and standards*. This is done by submitting a completed annual Intention to practise (ItP) form every year to their named supervisor of midwives.

**If you are not registered with the NMC, you cannot be employed to practise as a nurse or midwife in the UK.**

## The NMC's Prep requirements

The Prep requirements are professional standards set by the NMC. They are legal requirements, which you must meet in order for your registration to be renewed.

There are two separate Prep standards which affect your registration:

- **The Prep (practice) standard**  
You must have worked in some capacity by virtue of your nursing or midwifery qualification during the previous three years for a minimum of 450 hours, or have successfully undertaken an approved return to practice course within the last three years.
- **The Prep (continuing professional development) standard**  
You must have undertaken and recorded your continuing professional development (CPD) over the three years prior to the renewal of your registration. All nurses and midwives have been required to comply with this standard since April 1995. Since April 2000, you must have declared on your NOP form that you have met this requirement when you renew your registration.

## The Prep (practice) standard

- 1 The aim of this standard is to safeguard the health and wellbeing of the public by ensuring that anyone renewing their registration has undertaken a minimum amount of practice. This standard requires you to have practised in some capacity by virtue of your nursing or midwifery qualification for a minimum of 450 hours during the three years prior to the renewal of your registration. If you do not meet this requirement, you will need to undertake an approved return to practice course before you can renew your registration.

### Meeting the Prep (practice) standard

- 2 In order to meet the practice standard you must have undertaken the 450 hours in your capacity as a nurse or midwife. For example, you can only meet the practice standard for midwifery by practising midwifery, and similarly for nursing. Any practice that was undertaken when you were not registered cannot be counted towards meeting the practice standard.
- 3 As a midwife, you will need to continue to submit your Intention to practise notification annually to your named supervisor of midwives in accordance with rule 3 of the *Midwives rules and standards*, if you wish to practise midwifery.
- 4 The following table is designed to help you to know how many hours you need to complete in order to meet the practice standard and so renew your registration(s).

Renewing your registration for	Hours required
Nursing	450
Midwifery	450
Nursing and midwifery	900
Nursing and specialist community public health nursing	450
Midwifery and specialist community public health nursing	900
Nursing, midwifery and specialist community public health nursing	900

5 You can meet the Prep (practice) standard whether you are:

**in paid work**

5.1 for example, when you are employed by an organisation such as an NHS trust, a care home, an independent healthcare provider, a nursing agency, a health authority or health board, educational institution, another type of company or organisation, or if you work in independent practice

**in unpaid work**

5.2 for example, when you are working on a voluntary basis, such as for a charity

**not working**

5.3 for example, when you are taking a career break within the three-year re-registration period, you may still be able to meet the practice standard. If you do not meet the Prep (practice) standard, you will need to successfully complete an approved return to practice course before you can renew your registration.

8 The Prep handbook

## Returning to practice

- 6 If you are unable to comply with the practice standard, you will have to successfully complete an approved return to practice programme. These programmes are designed to allow you to renew your registration and return to practice when your registration has lapsed after a break in practice of three years or more. Courses whose outcomes have been validated by the NMC must include:
  - 6.1 an understanding of the influence of health and social policy relevant to the practice of nursing and midwifery
  - 6.2 an understanding of the requirements of legislation, guidelines, codes of practice and policies relevant to the practice of nursing and midwifery
  - 6.3 an understanding of the current structure and organisation of care, nationally and locally
  - 6.4 an understanding of current issues in nursing and midwifery education and practice
  - 6.5 the use of relevant literature and research to inform the practice of nursing and midwifery
  - 6.6 the ability to identify and assess need, design and implement interventions and evaluate outcomes in all relevant areas of practice, including the effective delivery of appropriate emergency care
  - 6.7 the ability to use appropriate communications, teaching and learning skills
  - 6.8 the ability to function effectively in a team and participate in a multi-professional approach to people's care



- 6.9 the ability to identify strengths and weaknesses, acknowledge limitations of competence, and recognise the importance of maintaining and developing professional competence.
- 7 An approved return to practice programme will be not less than five days in length. The length and nature of the programme will be determined by the education provider and the particular individual. This will take into account your registration history, previous levels of knowledge and experience, and any relevant experience undertaken while you have been out of professional practice.
- 8 If you would like further information about return to practice courses, please contact your local strategic health authority if you live in England. If you live in Northern Ireland, Scotland or Wales, details of how to find out about return to practice courses are available on our website or from our Advice Centre.

## The Prep (continuing professional development) standard

- 9 The Prep requirements include a commitment to undertake continuing professional development (CPD). This element of Prep is referred to as Prep (CPD). The Prep (CPD) standard is to:
  - 9.1 undertake at least 35 hours of learning activity relevant to your practice during the three years prior to your renewal of registration
  - 9.2 maintain a personal professional profile of your learning activity
  - 9.3 comply with any request from the NMC to audit how you have met these requirements.

### 10 You must comply with the Prep (CPD) standard in order to maintain your NMC registration.

#### Meeting the Prep (CPD) standard

- 11 The learning activity which you undertake to meet this standard must be relevant to your practice. There is no such thing as approved Prep (CPD) learning activity.
- 12 You must document, in your profile, your relevant learning activity and the way in which it has informed and influenced your practice. Although there is no approved format for the profile, we have developed a template which you might like to consider when organising your profile. This is reproduced, along with the accompanying guidance, on pages 13–15.

**13 You can meet the Prep (CPD) standard in many different ways. The important things to remember are that:**

- 13.1 it doesn't have to cost you any money
- 13.2 there is no such thing as approved Prep (CPD) learning activity
- 13.3 you don't need to collect points or certificates of attendance
- 13.4 there is no approved format for the personal professional profile
- 13.5 it must be relevant to the work you are doing or plan to do in the near future
- 13.6 it must help you to provide the highest possible standards of practice and care.

## Prep (CPD) – guidance for recording your learning

- 14 The following headings have been designed to help you think about how you might like to record what you do, what you learn and how you apply it to your professional practice. This structure enables you to document your learning activities and how these relate to your practice over the three years prior to your renewal of registration. You may find it helpful to keep this information in your personal professional profile as a record of your learning. You should document each learning activity you have undertaken in the three years prior to renewing your registration. You may choose to group together a number of similar activities, such as a series of one-day workshops.

### The three-year registration period this form covers

- 15 You must complete your Prep (CPD) requirements in the three years leading up to each renewal of your registration.

#### Work place

- 16 You can record your work place and your work or role that relate to the learning activity you describe. If you have worked in various places, but in essentially the same role (for example, if you are a bank nurse or an agency nurse), you may want to group this type of work together and summarise it in this section.

#### Name of organisation

- 17 Record the name of the organisation for which you were working at the time – for example, St Elsewhere NHS Trust, ABC General Practice, XYZ Limited. If you were not working, we suggest you put 'not working' in this column.

### **Brief description of your work or role**

- 18 Examples of this could include:
- 18.1 **if you are working with people in your care:** staff nurse in intensive care; midwife working in a community setting; district nurse working mainly with elderly patients; palliative care in a care home; or bank nurse mainly on surgical wards
  - 18.2 **if you are working in healthcare education:** senior lecturer in health and social science faculty; or part-time tutor specialising in sexual health
  - 18.3 **if you are working in healthcare research:** research nurse in respiratory medicine; or researching different shift patterns
  - 18.4 **if you are working in management or administration in healthcare:** nurse manager in medical directorate; or administrator for nursing agency
  - 18.5 **if you are working in areas not directly related to healthcare:** clinical research assistant in respiratory team; or management consultant in health group
  - 18.6 **if you are not working:** maternity leave; retired or long-term ill health; paid or unpaid caring.

### **Nature of the learning activity – what did you do?**

- 19 Record the learning activity related to the work you identified in the previous section. This learning activity should be undertaken during the three-year registration period which you identified at the top of the form.

#### **Date**

- 20 State the date or period when this learning activity took place.

### **Briefly describe the learning activity**

- 21 For example: I read an article in a professional journal on wound healing; I attended a course on policy developments in primary care groups; I discussed with my colleagues the importance of patient dignity when in hospital.

### **How many hours did this take?**

- 22 Please state how many hours the learning activity took.

### **Description of the learning activity – what did it consist of?**

- 23 Provide a fuller explanation of the learning activity.  
For example: why you decided to do the learning or how the opportunity came about; where, when and how you did the learning; the type of learning activity; what you expected to gain from it.

- 24 Please see the case studies for examples of how this section could be completed on pages 20–39.**

### **Outcome of the learning activity – how did the learning relate to your work?**

- 25 This section will show what you gained from your learning (not the learning activity itself). You should record how the learning related to your work; the effect it has had on the way in which you work or intend to work in the future; any follow-up learning which you may be planning in the future. This will be a personal view (reflection) of the way in which the learning has informed and influenced your work. Begin by completing the sentence 'The ways in which this learning has influenced my work are: ...'.

## Examples of Prep (CPD) learning

You may find reading some of the following case studies helpful in enabling you to think about how this section could be completed.

### Acute care

#### Example 1:

Direct patient care using unstructured or informal learning 18

#### Example 2:

Direct patient care using structured or formal learning 19

### Midwifery

#### Example 3:

Direct client care using structured or formal learning 21

#### Example 4:

Direct client care using unstructured or informal learning 22

### Community care

#### Example 5:

Direct client care using unstructured or informal learning 23

#### Example 6:

Direct patient care using structured or formal learning 25

#### Example 7:

Direct client care using structured or formal learning 26

#### Example 8:

Not working using unstructured or informal learning 27

### Education and research

#### Example 9:

Working in education using unstructured or informal learning 29

Example 10:	
Working in education using structured or formal learning	30
Example 11:	
Working in research using unstructured or informal learning	31
Example 12:	
Working in research using structured or formal learning	32

## Management

Example 13:	
Working in a management or administrative role using unstructured or informal learning	33
Example 14:	
Working in a management or administrative role using structured or formal learning	34

## Practising in other areas

Example 15:	
Not working using structured or formal learning	35
Example 16:	
Working but not in professional practice using unstructured or informal learning	36
Example 17:	
Working but not in healthcare using structured or formal learning	37

**The following examples help you relate your learning to your work. They use the format outlined on pages 15–17. They have been divided into categories so that you can refer to the one most relevant to your situation. There are examples of both unstructured or informal learning and structured or formal learning.**



## Acute care

### Example 1:

#### Direct patient care using unstructured or informal learning

##### Description of the learning activity

I work on a general medical ward and observed the siting of a chest drain. The staff nurse explained to me the importance of asepsis when cleaning the chest drain site. We also discussed the comfort of the patient in relation to the procedure.

##### Outcome of the learning activity – how did the learning relate to your work?

The way in which this learning has influenced my work is that I have been reminded of the principles of asepsis and the importance of this in the care of all wounds. I now not only concentrate on the preparation of the dressing trolley but also on the wider environment to create the most hygienic environment possible.

The chest drain site requires cleaning and redressing each day. The staff nurse observed me on the first two occasions and I then did the dressing on my own. The chest drain was removed after a period of one week and there was no evidence of infection (this was confirmed by the results of a swab being sent to pathology when the drain was taken out).

I was also able to apply my learning to other patients. One lady with leg ulcers used to get distressed every time her dressing was changed. I assumed this was because the procedure was painful. In fact it was because the wounds smelt and she felt very embarrassed by this. We therefore made certain the wounds were dressed away from other patients and not by her bed, and that air fresheners were used. I am also speaking to pharmacy about other preparations that may be available to help with this particular problem.

**Example 2:**

**Direct patient care using structured or formal learning**

**Description of the learning activity**

I see my own patients in A&E without reference to a doctor. I attended a two-hour lecture by a professor of anatomy at a major teaching hospital. We examined some arms and legs – anatomical parts which I am used to examining in my daily work.

I was transfixed as he pointed out all the structures. The bones and muscles were obvious but I was really interested in the tendons and ligaments, blood vessels and nerves. We were able to handle the specimens and I could really see how the different parts work together and make limbs move. I thought I knew my anatomy from the textbooks but this really brought it all to life.

**Outcome of the learning – how did the learning relate to your work?**

The way in which this learning has influenced my work is apparent in a number of ways:

I am now much clearer about the underlying structures when I examine patients' injuries and can actually visualise the parts I am trying to feel.

The session has prompted me to learn more anatomical terminology so that I can name all the structures which I am trying to describe. This means that my notes are much more accurate and clear – an important factor since other people may need to read them and I may have to defend them in court one day. I no longer write just 'ligament strain' but name the ligament.

I am more clear than ever about why I need to explore wounds to ensure that I can see the base of them and be certain that all the underlying structures are intact. I will not miss a partial cut in a tendon now because I know what I am looking for and where it is likely to be.

My confidence has been boosted as a result of my increased knowledge and I feel even more competent to see patients with minor injuries because I can assess them knowledgeably.

I will never again wonder why people donate their bodies to medical science. It is so people like me can be inspired – and I am grateful that they continue to do so. I will try to attend the service held at the end of the academic year when the body parts are cremated.

## Midwifery

### Example 3:

#### Direct client care using structured or formal learning

##### Description of the learning activity

I am a team midwife employed by a community trust. I completed a course on teaching and assessing to enable me to act as a mentor or supervisor for student nurses and midwives.

##### Outcome of the learning – how did the learning relate to your work?

The way in which this learning has influenced my work is that I am much more confident when acting as a role model for student midwives and nurses. I now feel more able to teach student midwives and support their learning experiences in the clinical setting. Overall, thinking about the learning needs of students has helped to focus my attention on my own learning needs.

**Example 4:**

**Direct client care using unstructured or informal learning**

**Description of the learning activity**

I am a practising midwife. I have recently started working in an area with very high levels of social disadvantage. I went to the library and looked at various databases to see how our local caesarean rate compared with the national average.

**Outcome of the learning activity – how did the learning relate to your work?**

The way in which this learning has influenced my work is that, at the next team meeting, I was able to ask relevant questions, using the information I had gathered, about the criteria used to identify women who need a caesarean section. This made me better able to answer the women's questions during their antenatal phase.

## Community care

### Example 5:

#### Direct client care using unstructured or informal learning

##### Description of the learning activity

I work in a community mental health resource centre as a community psychiatric nurse (CPN), specialising in assertive outreach for people with complex needs who are difficult to engage through mainstream services. As a newly appointed CPN, I spent a day shadowing an experienced colleague who demonstrated the role and functioning of the team, planning a work schedule and discussing strategies to engage two people whom we visited that day.

##### Outcome of the learning activity – how did the learning relate to your work?

The way in which this learning has influenced my work is that I am now able to clarify the difference between assertive outreach work and holding a general caseload. I appreciate the need to plan my day carefully, taking into account the clients' patterns of living, their interests and hobbies, and ensuring that these match opportunities to meet. I was able to think about different venues that could be used and was reminded how important it is to get behind the signs and symptoms and understand the person.

I was also reminded that, as a specialist team covering an area with three mental health centres, there was a need to develop effective communication systems. I discussed a number of options and was able to draw upon my mentor's experience to agree a weekly forum meeting backed up by monthly caseload reports to the team.

I had the opportunity to discuss how my colleague had dealt with an aggressive client who initially refused to see us. I was reminded of the need to remain calm and be conscious of my body language to ensure I did not portray myself as being annoyed. I was able to see how my colleague used his knowledge of the client and specifically his interest in fishing to engage him in conversation, and agreed to meet at the local lake later that week.

**Example 6:**

**Direct patient care using structured or formal learning**

**Description of the learning activity**

I work in the community and looked after a patient who was dying at home from cancer. I attended a course on pain control because the patient was having large doses of intravenous drugs and I wanted to learn more about aspects of pain control at home. The course was run by the local hospice.

**Outcome of the learning activity – how did the learning relate to your work?**

The way in which this learning has influenced my work is that I am much more confident in the care of people who are having intravenous pain control at home. I am able to change the syringe drivers as required and help the patients manage their pain both through titrating the drugs against the level of pain and through other means, such as change of posture and the application of heat. I also now understand more about the pharmacology of the pain-relieving drugs, which is useful when answering questions from patients and relatives about the different drugs and why they are being used. I am also more informed about the potential side effects of such drugs and am able to observe my patients in a more focused way.

The course also drew attention to the mental suffering which people experience when faced with intractable pain. I am now much more aware of this and make time to spend with them so that there is the opportunity to talk and for them to express other worries and concerns to me.



**Example 7:**

**Direct client care using structured or formal learning**

**Description of the learning activity**

I work as a staff nurse in a community day care project for people with learning disabilities who have been discharged after long term hospital care. Most have functional problems and significant life skills deficits, as well as periodic psychotic symptoms. I went to a seminar given by a service user entitled 'Living with voices'. He had heard voices for over 20 years, and had been an inpatient, but now he was an advocate and had written a self-help booklet with exercises and strategies to cope with these problems.

**Outcome of the learning activity – how did the learning relate to your work?**

The way in which this learning has influenced my work is that I have changed the way I think about auditory hallucinations. I have adapted some of the ideas from the booklet into a discussion topic for one of my groups. This has allowed people to talk about their voices in a way they haven't before, as they are less afraid that I will think they are relapsing or not coping. This has really made a difference to our relationships. I don't see the voices as just a clinical symptom but as an aspect of the way clients are feeling and as a way of them communicating their feelings to me.

I have also developed a workbook for the use of one of my more disabled clients. He and his mother are making use of it to help him understand his voices and use some of the calming methods. The seminar made me much more positive about this kind of problem and gave me practical advice on how to give effective support to people who will probably always have to live with it. It also stimulated me to do a literature review of current research into hallucinations and deliver a short tutorial to student nurses on their community placement. All in all, it was a really useful learning experience.

**Example 8:**

**Not working using unstructured or informal learning**

**Description of the learning activity**

I am currently on maternity leave and will soon be returning to specialist community public health nursing in my role as a health visitor. I took my son to the Sure Start centre just after he was born as a way to meet other parents. Prior to his birth I had worked full time and so it was important for me to meet other parents and to allow my child to socialise with others. While attending the Sure Start centre, I participated in a programme to help other parents communicate with their children as they had difficulty with literacy.

**Outcome of the learning activity – how did the learning relate to your work?**

The way in which this learning has influenced my work is that I was able to see how working in partnership with not only the statutory agencies but also the voluntary agencies helped to address health inequalities that I was not even aware of within my own community. This learning was not only useful in developing a social support system for myself and being able to arrange child care arrangements for my son, but will also be valuable information for me when I return to work and am required to consider innovative ways of identifying and addressing health inequalities.

Taking my son to a Sure Start centre also gave me first-hand experience of how parents can feel in these situations. I was worried about the stigma, who I might meet there and worried about my reaction. In the event, I found the experience fulfilling and realised the potential of working from the 'bottom up', and how the patient experience can have better outcomes for those it aims to support.

I was able to ask all the questions I wanted at the Sure Start centre without feeling rushed and without feeling stupid. I was also confident in being able to share my experiences with some of the other families, knowing that we all shared the sleepless nights and the feelings of both frustration and joy that children can bring.

I learnt that the professionalism and calmness of the staff there, together with their kindness and support, helped me to relax and therefore cope with a new situation. I will try to mirror this on my return to work. I also think that my understanding of how the parents may be feeling will be useful in helping them to cope with new and possibly difficult situations.

**Postscript:** I have been back at work for six months now and have found this experience extremely valuable. I now have an insight into how parents can feel about attending resources that are available to them, which can feel very threatening when they are offered as a resource to your own family. I feel I am now more caring and responsive, helping to make the experience easier for the families I come into contact with. I have used the knowledge in identifying health inequalities and, by working in partnership with the community, I really feel I am undertaking public health nursing that addresses the determinants of health.

## Education and research

### Example 9:

#### Working in education using unstructured or informal learning

##### Description of the learning activity

I run a course on health and social policy at the local university. I need to keep up to date about developments in the NHS and related health and social care organisations. I regularly read the relevant journals and NHS documents. In this instance, I read the white paper *A first class service: Quality in the new NHS*, issued by the Department of Health in July 1998.

##### Outcome of the learning activity – how did the learning relate to your work?

The way in which this learning has influenced my work is that I am now able to incorporate two sessions on clinical governance, its impact on the health services and on the role of the professional into the quality module of my course. I am also carrying out a literature search on clinical governance and I am consulting with colleagues and others from the professions allied to medicine. I will also talk to the chief executives of my local NHS trusts and ask them about their new responsibilities, so that my students gain an insight into how changes in policy at government level affect organisations within the health services.

**Example 10:**

**Working in education using structured or formal learning**

**Description of the learning activity**

I recently attended an interdisciplinary study day on utilising learning sets as a method of personal and professional development.

**Outcome of the learning activity – how did the learning relate to your work?**

The way in which this learning has influenced my work is that I have used the icebreaking activity we did on that day with a group of enrolled nurses I teach on the conversion course. I have also extended my reading and knowledge of learning styles analysis, which I will incorporate into my teaching of study skills at a later date.

**Example 11:**

**Working in research using unstructured or informal learning**

**Description of the learning activity**

I recently met a researcher at a conference. After her session, we talked about her work over lunch. She mentioned how she used the internet to keep in touch with the latest developments, but also stressed the importance of discriminating sound material on the internet from the rubbish which is also available. We exchanged email addresses so that we could keep in touch.

**Outcome of the learning activity – how did the learning relate to your work?**

The way in which this learning has influenced my work is that I have learned the importance of networking. Since this conference, I have been in contact with the researcher. I visited her unit and met two of the research assistants working on the pain management programme. I prepared a one-hour teaching session (including a handout) for colleagues to let them know what I had learned from the pain management symposium. I also discussed the possibility of my unit becoming involved in the research programme. This would enable us to experience some research at first hand, which should help to bring it alive.

I have also taught myself, with the assistance of an 'Internet for Beginners' guide, to access the internet and have been given some guidance concerning the best sites to visit. I have become involved in two discussion groups but I am very careful to evaluate what I gather, just as I would if I were reading a research paper.

**Example 12:**

**Working in research using structured or formal learning**

**Description of the learning activity**

I am a ward sister who qualified in the mid-1980s. Since then, I have attended numerous study days and, as a result, I have become quite interested in learning more about research. Since all the nursing students are now qualifying with a diploma and mention research a lot, I decided to enrol on a 20-point Level 2 research awareness module at my local university.

**Outcome of the learning activity – how did the learning relate to your work?**

The way in which this learning has influenced my work is that I have been able to learn a lot about different ways of doing research, how to carry out a literature search and about the importance of critically evaluating any research that I read. Just because something is published does not mean that it is sound. I now critically evaluate everything I read and only consider changing practice when I know that there have been a number of research studies which have reported similar findings. I also now understand the importance of randomised controlled trials to evaluate the effectiveness of specific treatments or interventions, and always start by looking for a systematic review which summarises the evidence relating to a particular clinical issue.

To encourage colleagues to get involved, I have recently set up a journal club on the ward, which meets every three weeks to discuss research on a topic that is important to our work. Through this club I am trying to introduce an evidence-based culture on the ward, so that it becomes the norm to discuss the reasons why we do what we do, and thereby question any ritual or traditional practices.

## Management

### Example 13:

#### Working in a management or administrative role using unstructured or informal learning

##### Description of the learning activity

My mother died recently and I needed information quickly on probate and the role of executors of wills. I went to the public library and, with the help of both the librarian and the microfiche, I found a range of helpful leaflets and books on what to do when someone dies, which included a number of checklists.

##### Outcome of the learning activity – how did the learning relate to your work?

The way in which this learning has influenced my work is apparent in a number of ways. On a personal level, it helped me to get through a very difficult time without the problems associated with wills that you sometimes hear about. Since returning to work, I have spoken to staff in the legal department of our organisation. We are revising our guidelines for staff in nursing homes, since they often get asked about what to do when someone has died.



**Example 14:**

**Working in a management or administrative role using structured or formal learning**

**Description of the learning activity**

I am the matron or manager of a nursing home and attended a course on dealing with complaints.

**Outcome of the learning activity – how did the learning relate to your work?**

The way in which this learning has influenced my work is that I have become more aware of legal requirements when a complaint is made. As a result of this, I am now in the process of developing protocols for my own organisation to assist staff in such circumstances.

I also became aware of the position of other stakeholders, including, for example, the complainant and the person against whom the complaint is made. Role play was used to help us to understand the different emotions involved and the effects of these emotions on people's behaviour. This was particularly important for me because it highlighted the ways in which emotions can become heightened in times of stress. I was surprised at how vulnerable and alone I felt when role playing the person against whom the complaint had been made, and how it was very easy to take everything personally.

This learning is useful to me in a number of ways. All members of staff, including myself, will be more competent in dealing with complaints and will be able to follow the correct procedures once the protocols are completed. I will be more aware of the need to try and understand how the different parties are feeling and the type of support which they require in such stressful situations.

## Practising in other areas

### Example 15:

#### Not working using structured or formal learning

#### Description of the learning activity

I have recently retired from the NHS on health grounds. However, I am interested in alternative forms of healthcare and am looking into beginning a new career in this area. I have attended an evening course on aromatherapy which was run by my local higher education institution. The course was a 10-week course and studied the basics of aromatherapy and massage techniques.

#### Outcome of the learning activity – how did the learning relate to your work?

The way in which this learning has influenced my work is that I have investigated the possibilities of local work through the course leader. I found the course very interesting, particularly with my previous experience of nursing. I have already used my knowledge to prepare a blend of essential oils for my sister after childbirth, and a relaxing compound for my brother who is suffering from stress. Although the course has ended, the group is keeping in touch and I am also looking into completing a diploma in aromatherapy next year.

**Example 16:**

**Working but not in professional practice using unstructured or informal learning**

**Description of the learning activity**

I work for a pharmaceutical company in the healthcare division and am working on a particular brand of respiratory drug. I am a member of a local special interest group in respiratory medicine and met other members for an informal get-together. Inevitably, we talked about work and I found out more about the ways in which patients with chronic obstructive airways disease are now cared for in the local hospital.

**Outcome of the learning activity – how did the learning relate to your work?**

The way in which this learning has influenced my work is that, although the information I was given about how patients with this disease are now cared for will not help me in my work at present, the knowledge will be useful in determining the sites for the clinical trials and the types of patients whom we need to recruit.

**Postscript:** We have now begun the clinical trials and the knowledge I gained from that informal get-together was very useful in helping to determine our criteria for recruiting patients to the study. I have realised that information picked up in an informal setting can be just as useful as that obtained from a specific course.

**Example 17:**

**Working but not in healthcare using structured or formal learning**

**Description of the learning activity**

I often make presentations in my work as a management consultant. Although I am confident in doing this, I know that it is always useful to update key skills and to practise new techniques and methodologies. I therefore attended a presentation skills workshop.

**Outcome of the learning activity – how did the learning relate to your work?**

The way in which this learning has influenced my work is that I now have some new skills. However, the most useful element was the ability to practise risky techniques in a safe environment. On my return to work, I gave three presentations in quick succession and used some of the new ideas with success. One of the key things I learnt was to use the flip chart for greater emphasis and effect, and to minimise the use of overheads, although these decisions have to be taken in the context of the audience and their expectations.

Feedback from those three presentations was encouraging, with comments ranging from 'very clear and informative' to 'would have liked a bit more time to absorb the information on the visual aids'. I would like to attend the advanced presentation skills course, once I have had the opportunity to practise and refine my new skills over the next nine months or so.

## How will the NMC know that you have met the standards?

### Testing compliance

In order to be able to demonstrate to patients and the public the rigour of the Prep standards, the NMC has a number of ways in which it can ensure that nurses and midwives are complying with them.

### Notification of practice form

Everyone on our register must declare that they have complied with the Prep (CPD) standard and the Prep (practice) standard on their Notification of practice (NoP) form which they complete when they renew their registration every three years.

### The Prep (CPD) audit

The NMC audits compliance with the Prep (CPD) standard. Nurses and midwives may be asked to provide the NMC with a brief description of their learning activity and the relevance of this learning to their work. If you are asked to take part in the audit, your evidence will need to be provided using Prep (CPD) summary forms which the NMC will send to you.

### The Prep (CPD) summary form

The Prep (CPD) summary form is only issued to those involved in the audit. Please note that the completed contents of the form are used by the NMC only for the purpose of monitoring Prep (CPD). Please therefore do not enclose any other correspondence or certificates with the form. If there is a question with regard to your Prep (CPD) summary form, the NMC will write to advise you.

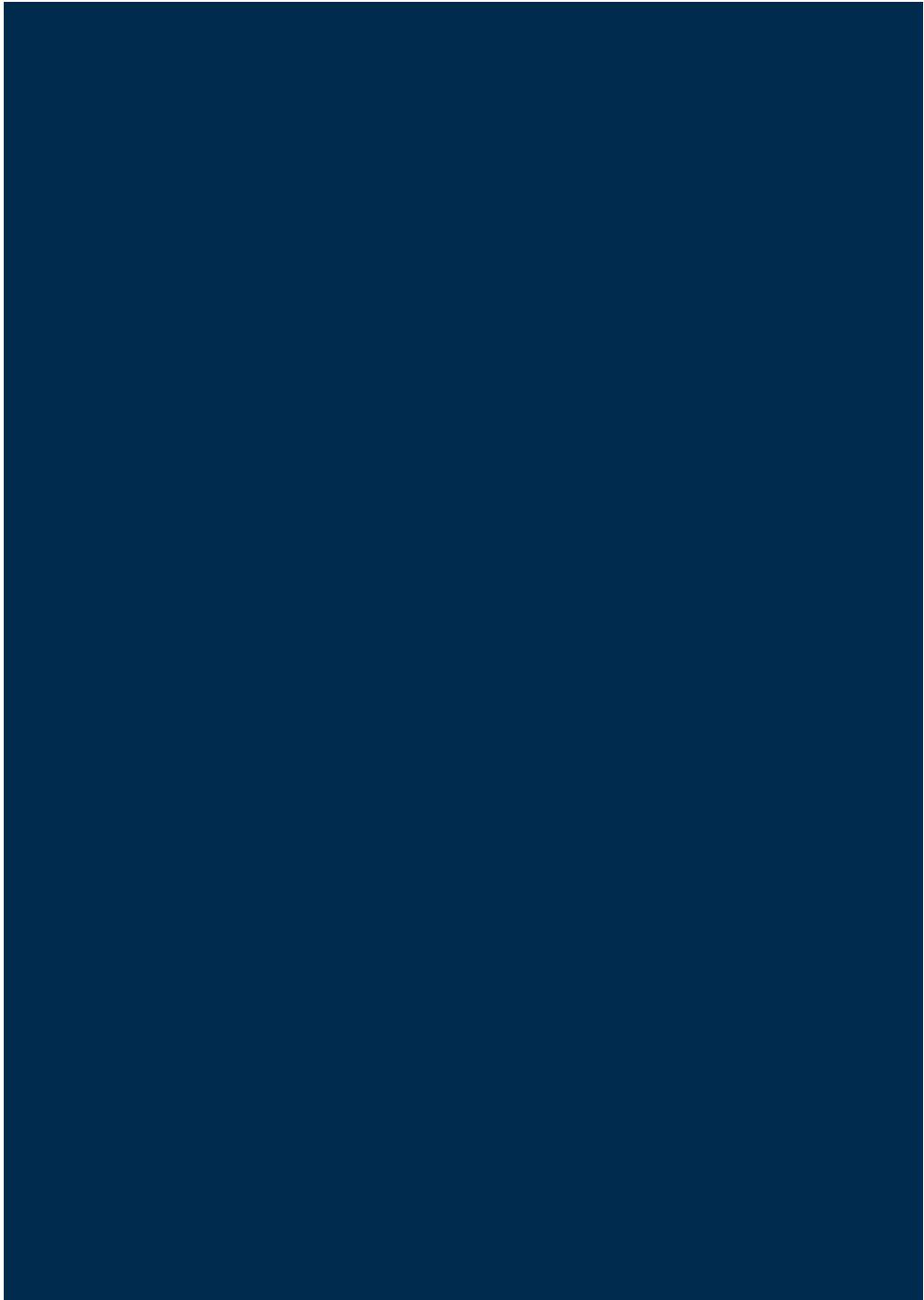


*The Prep handbook* was first published by the former United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) in January 2001. It was revised in April 2002 following the establishment of the NMC, and again in August 2004 to bring it into line with changes brought about by the Nursing and Midwifery Order 2001. Further changes were made in relation to intention to practise notifications in accordance with rule 3 of the *Midwives rules and standards*. This was altered in November 2004 and a new version of *The Prep handbook* was published in April 2005.

The rules to establish the new register in August 2004 also required that the time frames for meeting the practice and continuing professional development standards should both be three years. The date for implementation of this rule was August 2006. Further changes have been made in relation to the standards required for re-registering as a specialist community public health nurse.

This booklet was reissued in a new format in April 2008, with updated practice hours requirements for people on the specialist community public health nursing part of the register.

This current design was introduced in April 2010 with the addition of paragraph numbers for the Prep standards, however the content has not changed.





**Contact us**

Nursing and Midwifery Council  
23 Portland Place  
London W1B 1PZ  
020 7333 9333  
advice@nmc-uk.org  
[www.nmc-uk.org](http://www.nmc-uk.org)

PB-PREP-A5-0410

## The Prep handbook

We are the nursing and midwifery regulator for England, Wales, Scotland, Northern Ireland and the Islands.

- We exist to safeguard the health and wellbeing of the public.
- We set standards of education, training, conduct and performance so that nurses and midwives can deliver high quality healthcare consistently throughout their careers.
- We ensure that nurses and midwives keep their skills and knowledge up to date and uphold our professional standards.
- We have clear and transparent processes to investigate nurses and midwives who fall short of our standards.

## Contents

Introduction .....	2
You, Prep and the NMC .....	3
The Prep (practice) standard .....	5
Returning to practice .....	7
The Prep (continuing professional development) standard .....	8
Prep (CPD) – guidance for recording your learning .....	9
How will the NMC know that you have met the standards? .....	10
Important reminders .....	11
Further information .....	12
Contact us .....	12

## Introduction

Post-registration education and practice (Prep) is a set of Nursing and Midwifery Council (NMC) standards and guidance which is designed to help you provide a high standard of practice and care.

This handbook consolidates everything you need to know about the Prep standards and guidance. You should read it in conjunction with *The code: Standards of conduct, performance and ethics for nurses and midwives* (the code).

If you have any further queries about how to meet the Prep standards, you can contact us in confidence. Our contact details are on the back cover.

Like many professional regulators in healthcare, the NMC is reviewing and updating the standards for the maintenance and renewal of registration. This will form the basis of our approach to revalidation which will be launched in 2014.

### Prep helps you to:

- provide a high standard of practice and care
- keep up to date with new developments in practice
- think and reflect for yourself
- demonstrate that you are keeping up to date and developing your practice.

# You, Prep and the NMC

## The role of the NMC

We are the nursing and midwifery regulator for England, Wales, Scotland, Northern Ireland and the Islands.

- We exist to safeguard the health and wellbeing of the public.
- We set standards of education, training, conduct and performance so that nurses and midwives can deliver high quality healthcare consistently throughout their careers.
- We ensure that nurses and midwives keep their skills and knowledge up to date and uphold our professional standards.
- We have clear and transparent processes to investigate nurses and midwives who fall short of our standards.

## The NMC register

Registration with the NMC is essential for you to be able to work in the United Kingdom (UK) and the Islands as a nurse or midwife. We maintain a register of all the people who have fulfilled the NMC's registration requirements and who are, therefore, entitled to practise in the UK and the Islands. The register is at the heart of the NMC's role in safeguarding the health and wellbeing of the public.

## Requirements for renewal of registration with the NMC

To renew your registration every three years, you will need to provide a signed notification of practice (NoP) form and pay your renewal of registration fee. The NoP asks you to declare that you have met the Prep requirements (see page 4) and are of good health and good character. Your registration will not be renewed until the NMC has received and processed your completed and signed form, together with your fee payment.

Please note that now the NMC has moved to the annual payment of fees, you will be required to pay a retention of registration fee at the end of the first and second years of the registration period.

Additionally, in order to practise, midwives need to give notice of their intention to practise, in accordance with rule 3 of the *Midwives rules and standards*. This is done by submitting a completed annual intention to practise (ItP) form every year to their named supervisor of midwives.

**If you are not registered with the NMC you cannot be employed to practise as a nurse or midwife in the UK.**

## The NMC's Prep requirements

The Prep requirements are professional standards set by the NMC. They are legal requirements, which you must meet in order for your registration to be renewed.

There are two separate Prep standards which affect your registration.

- **The Prep (practice) standard**

You must have worked in some capacity by virtue of your nursing or midwifery qualification during the previous three years for a minimum of 450 hours, or have successfully undertaken an approved return to practice course within the last three years.

- **The Prep (continuing professional development) standard**

You must have undertaken and recorded your continuing professional development (CPD) over the three years prior to the renewal of your registration. All nurses and midwives have been required to comply with this standard since April 1995. Since April 2000, you must have declared on your NoP form that you have met this requirement when you renew your registration.

## The Prep (practice) standard

- 1 The aim of this standard is to safeguard the health and wellbeing of the public by ensuring that anyone renewing their registration has undertaken a minimum amount of practice. This standard requires you to have practised in some capacity by virtue of your nursing or midwifery qualification for a minimum of 450 hours during the three years prior to the renewal of your registration. If you do not meet this requirement, you will need to undertake an approved return to practice course before you can renew your registration.

## Meeting the Prep (practice) standard

- 2 In order to meet the practice standard you must have undertaken the 450 hours in your capacity as a nurse or midwife. For example, you can only meet the practice standard for midwifery by practising midwifery and similarly for nursing. Any practice that was undertaken when you were not registered cannot be counted towards meeting the practice standard.
- 3 As a midwife, you will need to continue to submit your intention to practise notification annually to your named supervisor of midwives in accordance with rule 3 of the *Midwives rules and standards*, if you wish to practise midwifery.
- 4 The following table is designed to help you to know how many hours you need to complete in order to meet the practice standard and so renew your registration(s).

Renewing your registration for	Hours required
Nursing	450
Midwifery	450
Nursing and midwifery	900
Nursing and specialist community public health nursing	450
Midwifery and specialist community public health nursing	900
Nursing, midwifery and specialist community public health nursing	900

- 5 You can meet the Prep (practice) standard whether you are:
  - 5.1 **in paid work:** for example, when you are employed by an organisation such as an NHS trust, a care home, an independent healthcare provider, a nursing agency, a health authority or health board, educational institution, another type of company or organisation, or if you work in independent practice
  - 5.2 **in unpaid work:** for example, when you are working on a voluntary basis in a role requiring registration, such as for an established healthcare charity

- 5.3 **not working:** for example, when you are taking a career break within the three year re-registration period, you may still be able to meet the practice standard if you have completed the required hours in practice as a registered nurse at some point during those three years. If you do not meet the Prep (practice) standard, you will need to successfully complete an approved return to practice course before you can renew your registration.

## Returning to practice

- 6 If you are unable to comply with the practice standard, you will have to successfully complete a return to practice programme approved by the NMC. These programmes are designed to allow you to renew your registration and return to practice when your registration has lapsed after a break in practice of three years or more. Courses whose outcomes have been validated by the NMC must include:
  - 6.1 an understanding of the influence of health and social policy relevant to the practice of nursing and midwifery
  - 6.2 an understanding of the requirements of legislation, guidelines, codes of practice and policies relevant to the practice of nursing and midwifery
  - 6.3 an understanding of the current structure and organisation of care, nationally and locally
  - 6.4 an understanding of current issues in nursing and midwifery education and practice
  - 6.5 the use of relevant literature and research to inform the practice of nursing and midwifery
  - 6.6 the ability to identify and assess need, design and implement interventions and evaluate outcomes in all relevant areas of practice, including the effective delivery of appropriate emergency care
  - 6.7 the ability to use appropriate communications, teaching and learning skills
  - 6.8 the ability to function effectively in a team and participate in a multiprofessional approach to people's care
  - 6.9 the ability to identify strengths and weaknesses, acknowledge limitations of competence, and recognise the importance of maintaining and developing professional competence.
- 7 An approved return to practice programme will be not less than five days in length. The length and nature of the programme will be determined by the education provider and the particular individual. This will take into account your registration history, previous levels of knowledge and experience, and any relevant experience undertaken while you have been out of professional practice.
- 8 For further information about return to practice programmes, visit **[www.nmc-uk.org/approved-programmes](http://www.nmc-uk.org/approved-programmes)** where you can search for universities that provide approved return to practice programmes in the UK.



## The Prep (continuing professional development) standard

- 9 The Prep requirements include a commitment to undertake continuing professional development (CPD). This element of Prep is referred to as Prep (CPD). The Prep (CPD) standard is to:
  - 9.1 undertake at least 35 hours of learning activity relevant to your practice during the three years prior to your renewal of registration
  - 9.2 maintain a personal professional profile of your learning activity
  - 9.3 comply with any request from the NMC to audit how you have met these requirements.

**10 You must comply with the prep (CPD) standard in order to maintain your NMC registration.**

### Meeting the Prep (CPD) standard

- 11 The learning activity which you undertake to meet this standard must be relevant to your practice. However, there is no such thing as approved Prep (CPD) learning activity.
- 12 You must document, in your profile, your relevant learning activity and the way in which it has informed and influenced your practice. Although there is no approved format for the profile and you can meet the Prep (CPD) standard in many different ways, we have developed a template which you might like to consider when organising your profile. This is outlined in paragraphs 13-14.4 on page 9.

## Prep (CPD) – guidance for recording your learning

- 13 You should document each learning activity you have undertaken in the three years prior to renewing your registration. You should think about how you might like to record what you do, what you learn and how you apply it to your professional practice.
- 14 We suggest your record covers:
  - 14.1 **A list and a description of your work place or organisation and role for the last three years.** You should record your work place(s) and your work or role(s) that relate to the learning activity you describe. If you have worked in various places, but in essentially the same role (for example, if you are a bank nurse or an agency nurse), you may want to group this type of work together and summarise it in this section. If you were not working, we suggest you put 'not working'.
  - 14.2 **The nature of the learning activity – what did you do?** You should record the learning activity related to the work you identified for the last three years. You should state the date or period when this learning activity took place and state how many hours the learning activity took.
  - 14.3 **Description of the learning activity – what did it consist of?** Provide a detailed description of what the learning activity consisted of, why you decided to do the learning or how the opportunity came about, where when and how you did the learning and what you expected to gain from it.
  - 14.4 **Outcome of the learning activity – how did the learning relate to your work?** You should record the effect it has had on the way in which you work or intend to work in the future and any follow-up learning which you maybe planning in the future. You may begin by completing the sentence 'The ways in which this learning has influenced my work are: ...'.

You may find it helpful to routinely collect documentation from any learning activity you undertake such as appraisals, attendance or completion certificates.

## **How will the NMC know that you have met the standards?**

### **Testing compliance**

To demonstrate the rigour of the Prep standards to patients and the public, the NMC has a number of ways in which it can ensure that nurses and midwives are complying with them.

### **Notification of practice form**

Everyone on our register must declare that they have complied with the Prep (CPD) standard and the Prep (practice) standard on their notification of practice (NoP) form which they complete when they renew their registration every three years.

### **The Prep (CPD) audit**

The NMC audits compliance with the Prep (CPD) standard. Nurses and midwives may be asked to provide the NMC with a brief description of their learning activity and the relevance of this learning to their work. If you are asked to take part in the audit, your evidence will need to be provided using Prep (CPD) summary forms which the NMC will send to you. We may also ask for evidence such as appraisals, attendance or completion certificates from your learning activity, so you may find it helpful to routinely collect these items.

### **The Prep (CPD) summary form**

The Prep (CPD) summary form is only issued to those involved in the audit. Please note that the completed contents of the form are used by the NMC only for the purpose of monitoring Prep (CPD) and we will advise you if we require any other correspondence or certificates to be sent with the form. If there is a question with regard to your Prep (CPD) summary form, the NMC will write to advise you.

## Important reminders

- If you submit fraudulent information to the NMC, we may commence fitness to practise proceedings against you.
- In accordance with the code, you must always declare any cautions and convictions to the NMC immediately.
- Please ensure your registered address and contact details are always up to date. The most common reason for lapsed registration, which leads to practising illegally, is addresses that haven't been updated resulting in registration documents being sent to the wrong address.

## Further information

The Prep handbook was first published by the former United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) in January 2001. It was revised in April 2002 following the establishment of the NMC, and again in August 2004 to bring it into line with changes brought about by the Nursing and Midwifery Order 2001. Further changes were made in relation to intention to practise notifications in accordance with rule 3 of the *Midwives rules and standards*. This was altered in November 2004 and a new version of *The Prep handbook* was published in April 2005.

The rules to establish the new register in August 2004 also required that the time frames for meeting the practice and continuing professional development standards should both be three years. The date for implementation of this rule was August 2006.

Further changes have been made in relation to the standards required for re-registering as a specialist community public health nurse.

This booklet was reissued in a new format in April 2008, with updated practice hours requirements for people on the specialist community public health nursing part of the register.

A new design was introduced in April 2010 with the addition of paragraph numbers for the Prep standards, however the content has not changed.

This current version of *The Prep handbook* was issued in October 2011, which includes some minor revisions for clarity, such as the removal of some examples.

## Contact us

Nursing and Midwifery Council  
23 Portland Place  
London W1B 1PZ  
**020 7333 9333**

**[www.nmc-uk.org](http://www.nmc-uk.org)**

This document is also available in  
large print, audio or Braille on request

PB-PREP-A5-1011

# REVALIDATION

**NMC** Nursing &  
Midwifery  
Council



## How to revalidate with the NMC

Requirements for renewing your registration



# CONTENTS

WHAT DOES THIS DOCUMENT DO? .....	3
WHAT IS REVALIDATION? .....	5
CHECKLIST OF REQUIREMENTS AND SUPPORTING EVIDENCE .....	7
THE REVALIDATION PROCESS .....	9
HOW TO APPROACH REVALIDATION .....	10
PRACTICE HOURS .....	12
CONTINUING PROFESSIONAL DEVELOPMENT .....	16
PRACTICE-RELATED FEEDBACK .....	18
WRITTEN REFLECTIVE ACCOUNTS .....	20
REFLECTIVE DISCUSSION .....	22
HEALTH AND CHARACTER.....	24
PROFESSIONAL INDEMNITY ARRANGEMENT.....	26
CONFIRMATION .....	28
THE APPLICATION PROCESS.....	31
VERIFICATION OF YOUR APPLICATION .....	34
REVALIDATION AND NMC FITNESS TO PRACTISE PROCESSES .....	36
CANCELLING YOUR REGISTRATION.....	37
GUIDANCE SHEET 1: GUIDANCE ON NON-IDENTIFIABLE INFORMATION .....	39
GUIDANCE SHEET 2: PRACTICE HOURS REQUIREMENTS.....	42
GUIDANCE SHEET 3: EXAMPLES OF CPD ACTIVITIES.....	44
FORMS AND TEMPLATES .....	46

**This updated document was published December 2015**

# WHAT DOES THIS DOCUMENT DO?

**This document is for nurses and midwives who are registered with the NMC. It sets out how to renew your registration with the NMC through revalidation every three years.**

The requirements for revalidation are either prescribed in the Nursing and Midwifery Order 2001 (the Order)<sup>1</sup> and the Education, Registration and Registration Appeals Rules (the Rules)<sup>2</sup>, or are standards set by the NMC for revalidation and readmission.<sup>3</sup>

These requirements are effective from April 2016 and replace the requirements for renewal set out in the Prep (Post Registration Education and Practice Standards) handbook.<sup>4</sup>

## About the NMC

The Nursing and Midwifery Council exists to protect the public. We do this by making sure that only those who meet our requirements are allowed to practise as a registered nurse or midwife in the UK.

We take action if concerns are raised about whether a registered nurse or midwife is fit to practise.





## How to use this document

Please note that you must still pay your annual fee every year to retain your registration with the NMC. Revalidation replaces the current Prep renewal process and you will have to complete the revalidation process every three years in order to renew your registration.

This document gives an overview of the revalidation process and sets out our recommendations for how you approach the process and collect the required information.

It includes a checklist of the revalidation requirements and the supporting evidence for each requirement.

On pages 12 to 30 we set out details of each requirement. After each requirement we provide further information to help you understand and meet the requirement. This information will set out:

- the purpose of the requirement;
- how you can comply with the requirement;
- our recommended approach to collecting and recording the required information, and
- how to demonstrate to us that you have met the requirement in your online application.

You should read this document in conjunction with the Code<sup>5</sup> and other guidance on our website. We have also published a range of resources that you might find helpful in preparing for revalidation, including completed templates and case studies. We have also provided information for confirmers, which you should ensure that your confirmer has read, as well as information for employers, which we recommend you encourage your employer (if appropriate) to read.

## How the NMC will use your information

As part of the revalidation process you are required to submit information about yourself to the NMC. We will only process your personal data, as permitted by the Data Protection Act 1998 ('DPA').



Details of our data protection policy are included in our privacy notice at: [www.nmc.org.uk/privacy](http://www.nmc.org.uk/privacy)

We will use your personal data for the purposes of administering and assessing your revalidation application and any subsequent verification of that application. We may also use information obtained through the revalidation process for research and for the purpose of maintaining and improving our internal systems and processes.

If there are grounds for believing that you have made a false declaration as part of your revalidation application, information supplied by you may be used to investigate any alleged breach of the Code and for the purpose of any subsequent fitness to practise proceedings.

## How to contact the NMC

For more information please see the revalidation section of the NMC website at: [www.nmc.org.uk/standards/revalidation](http://www.nmc.org.uk/standards/revalidation). If you are unable to find the information you need and you still require further help you can email us at: [revalidation@nmc-uk.org](mailto:revalidation@nmc-uk.org).

If you wish to make a complaint about the standard of our service, please visit the 'Contact us' pages of our website at: [www.nmc.org.uk/contact-us/complaints-about-us](http://www.nmc.org.uk/contact-us/complaints-about-us).

# WHAT IS REVALIDATION?

## Revalidation

- is the process that allows you to maintain your registration with the NMC;
- builds on existing renewal requirements;
- demonstrates your continued ability to practise safely and effectively, and
- is a continuous process that you will engage with throughout your career.

**Revalidation is the responsibility of nurses and midwives themselves. You are the owner of your own revalidation process.**

## Revalidation is not

- an assessment of a nurse or midwife's fitness to practise;
- a new way to raise fitness to practise concerns (any concerns about a nurse or midwife's practice will continue to be raised through the existing fitness to practise process), or
- an assessment against the requirements of your current/former employment.

## Why we are introducing revalidation

- to raise awareness of the Code and professional standards expected of nurses and midwives;
- to provide you with the opportunity to reflect on the role of the Code in your practice as a nurse or midwife and demonstrate that you are 'living' these standards;
- to encourage you to stay up to date in your professional practice by developing new skills and understanding the changing needs of the public and fellow healthcare professionals;
- to encourage a culture of sharing, reflection and improvement;
- to encourage you to engage in professional networks and discussions about your practice, and
- to strengthen public confidence in the nursing and midwifery professions.

## Revalidation and the Code

One of the main strengths of revalidation is that it reinforces the Code by asking nurses and midwives to use it as the reference point for all the requirements, including their written reflective accounts and reflective discussion.

This should highlight the Code's central role in the nursing and midwifery professions and encourage nurses and midwives to consider how it applies in their everyday practice.

The Code (paragraph 22) requires you to fulfil all registration requirements.

To achieve this you must:

- meet any reasonable requests so we can oversee the registration process (22.1);
- keep to our prescribed hours of practice and carry out continuing professional development activities (22.2), and
- keep your knowledge and skills up to date, taking part in appropriate and regular learning and professional development activities that aim to maintain and develop your competence and improve your performance (22.3).

# Overall, revalidation should lead to improved practice and therefore public protection benefits.



# CHECKLIST OF REQUIREMENTS AND SUPPORTING EVIDENCE

These are all of the requirements that you must meet in order to complete your revalidation and renew your registration every three years with the NMC.

Requirements	Supporting evidence
450 practice hours or 900 hours if revalidating as both nurse and midwife	<p>Maintain a record of practice hours you have completed, including:</p> <ul style="list-style-type: none"> <li>• dates of practice;</li> <li>• the number of hours you undertook;</li> <li>• name, address and postcode of the organisation;</li> <li>• scope of practice (see tip box on page 8);</li> <li>• work setting (see tip box on page 8);</li> <li>• a description of the work you undertook, and</li> <li>• evidence of those practice hours (such as timesheets, role profiles or job specifications).</li> </ul>
35 hours of continuing professional development (of which 20 must be participatory)	<p>Maintain accurate and verifiable records of your CPD activities, including:</p> <ul style="list-style-type: none"> <li>• the CPD method (examples of 'CPD method' are self-learning, online learning, course);</li> <li>• a brief description of the topic and how it relates to your practice;</li> <li>• dates the CPD activity was undertaken;</li> <li>• the number of hours and participatory hours;</li> <li>• identification of the part of the Code most relevant to the CPD, and</li> <li>• evidence of the CPD activity (Guidance Sheet 3 provides examples of the kind of evidence you can record, see pages 44-45).</li> </ul>
Five pieces of practice-related feedback	<p>Notes of the content of the feedback and how you used it to improve your practice. This will be helpful for you to use when you are preparing your reflective accounts. Make sure your notes do not include any personal data (see Guidance Sheet 1 on pages 39-41).</p>

Requirements	Supporting evidence
Five written reflective accounts	Five written reflective accounts that explain what you learnt from your CPD activity and/or feedback and/or an event or experience in your practice, how you changed or improved your work as a result, and how this is relevant to the Code. You must use the NMC form on page 46 and make sure your accounts do not include any personal data (see Guidance sheet 1).
Reflective discussion	A reflective discussion form which includes the name and NMC Pin number of the NMC-registered nurse or midwife that you had the discussion with as well as the date you had the discussion. You must use the NMC form on page 47 and make sure the discussion summary section does not contain any personal data (see Guidance sheet 1).
Health and character	You will make these declarations as part of your online revalidation application.
Professional indemnity arrangement	Evidence to demonstrate that you have an appropriate indemnity arrangement in place.  Whether your indemnity arrangement is through your employer, membership of a professional body or through a private insurance arrangement.  If your indemnity arrangement is provided through membership of a professional body or a private insurance arrangement, you will need to record the name of the professional body or provider.
Confirmation	A confirmation form signed by your confirmer. You must use the NMC form on pages 48-50.



### Scope of practice

Direct clinical care or management: adult and general care nursing; children's and neo-natal nursing; mental health nursing; learning disabilities nursing; midwifery; health visiting; occupational health; school nursing; public health; other.

Commissioning, Education, Policy, Quality assurance or inspection, Research, Other.

### Work setting

Ambulance service, Care home sector, Community setting (including district nursing and community psychiatric nursing), Consultancy, Cosmetic or aesthetic sector, Governing body or other leadership, GP practice or other primary care, Hospital or other secondary care, Inspectorate or regulator, Insurance or legal, Maternity unit or birth centre, Military, Occupational health, Police, Policy organisation, Prison, Private domestic setting, Public health organisation, School, Specialist or other tertiary care including hospice, Telephone or e-health advice, Trade union or professional body, University or other research facility, Voluntary or charity sector, Other.

# THE REVALIDATION PROCESS

## Over three years since your last renewal/you joined the register

You need to meet a range of revalidation requirements designed to show that you are keeping up to date and maintaining safe and effective practice



See pages 12–30: details of the requirements

## In 12 months up to your renewal date

Once you have met the requirements, you will need to discuss your revalidation with a confirmer. As part of this confirmation discussion, you will demonstrate that you have complied with all of the revalidation requirements, except professional indemnity arrangement and health and character.



See pages 28–30: 'Confirmation'

## At least 60 days before your revalidation application date

Every three years you will be asked to apply for revalidation using NMC Online. We will notify you at least 60 days before your application is due, either by email if you have set up an NMC Online account, or by letter sent to your registered address.



See pages 31–33: 'The application process'

## In the 60 days before your revalidation application date

Once you receive your notification you will need to go online and complete the application form. As part of that application, you need to declare to the NMC that you have complied with the revalidation requirements.



See pages 31–33: 'The application process'

## Following submission of your revalidation application

Each year we will select a sample of nurses and midwives to provide us with further information to verify the declarations they made as part of their revalidation application. If you are selected your registration will not be renewed until this process is completed.



See pages 34–35: 'Verification of your application'

# HOW TO APPROACH REVALIDATION

## Understand key terms

1. **The registration process:** Every three years from when you join (or re-join) the register you will need to renew your registration by revalidating. Every year you will also need to retain your registration by paying an annual fee. If you don't complete these processes on time your registration will expire.
2. **Fee expiry date:** The deadline for paying your annual fee in order to retain your registration.
3. **Revalidation application date:** The deadline for submitting your revalidation application. It is the first day of the month in which your registration expires, so if your renewal date is 30 April, your revalidation application date will be 1 April.
4. **Renewal date:** The date on which your registration will be renewed if you have successfully completed your revalidation application. It is the last day of the month in which your registration expires.

## Keep a portfolio

5. We strongly recommend that you keep evidence that you have met the revalidation requirements in a portfolio. This does not necessarily need to be an e-portfolio; please see our guidance sheet on e-portfolios at [www.nmc.org.uk/revalidation/revalidation-guidance-and-resources/](http://www.nmc.org.uk/revalidation/revalidation-guidance-and-resources/) for further information.
6. We expect any evidence to be kept in English, and nurses and midwives must submit their revalidation application, and any subsequent verification information, in English.



The NMC recognises the culture and linguistic needs of the Welsh speaking public. We have published Welsh language versions of our guidance for nurses and midwives, confirmers and employers, as well as our templates and forms, on our website.

[www.nmc.org.uk/about-us/our-equality-and-diversity-commitments/welsh-language-scheme/](http://www.nmc.org.uk/about-us/our-equality-and-diversity-commitments/welsh-language-scheme/)

7. The portfolio will be helpful for the discussion you have with your confirmer (see pages 28-30). You will also need to have this information available in case we request to see it to verify the declarations you made as part of your application (see pages 34-35).
8. You may already keep a professional portfolio. If so, you do not need to maintain a separate portfolio.

9. You can use the checklist on page 7 to make sure that all of the information is in your portfolio before you have your confirmation discussion with your confirmer or submit your revalidation application.
10. We recommend that you keep your portfolio until after your next revalidation. For example, if you revalidate in 2016, we suggest that you should keep your portfolio until after you have revalidated again in 2019.
11. Your portfolio must not record any information that might identify an individual, whether that individual is alive or deceased. This means that all information must be recorded in a way that no patient, service user, colleague or other individual can be identified from the information. Guidance Sheet 1 on pages 39-41 provides guidance on how to make sure that your portfolio does not contain any information that might identify an individual.

## Conflicts of interest and perceptions of bias

12. You need to be mindful about any personal or commercial relationship between you, your confirmer and your reflective discussion partner. It would not be appropriate for a family member or person with whom you have a close personal relationship to undertake those roles. You will need to decide whether there is any conflict of interest or perception of bias to ensure that the confirmation process and reflective discussion retains credibility and remains objective. In some cases you might decide to use a different person as your confirmer and reflective discussion partner. The responsibility for this lies with you, your confirmer and reflective discussion partner.

## Appraisals

13. Many nurses and midwives have an employer. It is important for their employers to be aware of the Code and the standards expected of registered nurses and midwives in their professional practice.
14. Appraisals are a way for employers to assess the performance of their employees against the requirements of their role and identify areas for improvement and development.
15. The revalidation process is designed so that it can be undertaken as part of a regular appraisal. If you are an employee who does not have a regular appraisal you could consider asking your employer to arrange an appraisal for you in advance of your revalidation application date.
16. We strongly recommend that, where possible, your confirmation discussion forms part of an annual appraisal, if you have one.
17. If your line manager is an NMC-registered nurse or midwife, you might like to have both your reflective discussion and your confirmation discussion as part of an annual appraisal, if you have one.
18. You might find it helpful to have a discussion with your confirmer every year as part of an annual appraisal, so that you can keep them updated on your revalidation.
19. If you are not an employee, or if you are an employee who has been unable to arrange an appraisal in advance of your revalidation application date, you will still be able to renew your registration by meeting the revalidation requirements. You are not required to arrange for another person or organisation to conduct an appraisal for the purposes of revalidation, but you will still need to arrange your reflective and confirmation discussions.



# PRACTICE HOURS

## The requirements

20. You must have practised for a minimum number of hours over the three year period since your registration was last renewed or you joined the register.<sup>6</sup>

Registration	Minimum total practice hours required
Nurse	450 practice hours required
Midwife	450 practice hours required
Nurse and SCPHN (Nurse/SCPHN)	450 practice hours required
Midwife and SCPHN (Midwife/SCPHN)	450 practice hours required
Nurse and midwife (including Nurse/SCPHN and Midwife/SCPHN)	900 practice hours required (to include 450 hours for nursing, 450 hours for midwifery)



A specialist community public health nurse (SCPHN) means a registered nurse or midwife who is also registered in the Specialist Community Public Health Nurses' part of the register.

21. If you have practised for fewer than the required number of hours in the three year period since your registration was last renewed or you joined the register, then you must successfully complete an appropriate return to practice programme approved by the NMC before the date of your application for renewal of registration.<sup>7</sup>
22. If you are practising as a midwife in the UK, you must file an Intention to Practise (ItP) form annually with your Local Supervising Authority Midwifery Officer.<sup>8</sup>
23. If you are a registered midwife who is also registered on the specialist community public health nurse (SCPHN) part of the register and whose only practice is in a SCPHN role then you do not need to file an ItP form. Your register entry will record that you are not entitled to practise as a midwife in the UK.
24. If you are a registered midwife and have not filed an ItP form during the current three year renewal period, and you now wish to return to midwifery practice, you must successfully complete an appropriate return to midwifery practice programme approved by the NMC before you can serve an ItP form and return to practice as a practising midwife.<sup>9</sup>

25. Registered nurses or midwives who are admitted to another part of the register since their registration was last renewed or they joined the register only need to meet the practice hours requirement for their initial registration. They will need to meet the practice hours requirements for registration in both parts in subsequent three year renewal periods.<sup>10</sup>

## The purpose of these requirements

26. The practice hours requirements are designed to help nurses and midwives to maintain safe and effective practice, and keep their skills up to date.

## How to meet the requirements

27. You can only count practice hours that you undertook while you were registered. You cannot count unregistered practice towards the practice hours requirement.
28. You must meet your practice hours in a role where you rely on your skills, knowledge and experience of being a registered nurse or midwife.
- This includes practice as a nurse, midwife and SCPHN, in roles that are likely to require registration;
  - This also includes nurses and midwives who rely on their skills, knowledge and experience of being a registered nurse or midwife, but are in roles where their employment contract does not expressly require them to be registered with us. For example, this could include roles in public health or nursing or midwifery management, commissioning, policy and education;
  - This may include work done in voluntary roles, where a nurse or midwife is relying on their skills, knowledge and experience of being a registered nurse or midwife;
  - Hours undertaken in any healthcare, nursing or midwifery assistant or support worker roles cannot be counted towards practice hours as a registered nurse or midwife.
29. Practice hours should reflect your current scope of practice. Practice hours do not have to be related to your original field of practice when you first joined the register. Irrespective of your role, you must comply with *The Code: professional standards of practice and behaviour for nurses and midwives*. This includes the duty to recognise and work within the limits of your competence.
30. If you are a registered midwife who is also registered on the SCPHN part of the register and only practising in a SCPHN role, please refer to Guidance Sheet 2 on pages 42-43.



Further information on working outside the UK and returning to practice can be found on our website [www.nmc.org.uk/registrations](http://www.nmc.org.uk/registrations)

## How to meet the requirements continued

31. If you are working overseas (or have worked overseas for part of your three year renewal period) as a nurse or midwife you can meet the practice hours on the basis of your registration with the NMC. You should always register with the appropriate regulator in the country in which you are practising. Please refer to our guidance on working outside the UK.
32. If you have had a career break, you will still be able to meet the practice hours requirement if you have completed the required hours of practice as a registered nurse or midwife during your three year renewal period.
33. If you have not undertaken any type of work where you relied on your skills, knowledge or experience as a registered nurse or midwife, or if you are unable to meet the practice hours requirement, you have two options:
  - You can successfully complete an appropriate NMC approved return to practice programme before the date of your revalidation application. These programmes are designed to allow you to renew your registration and return to practice after a break in practice. Further information about return to practice programmes is available online, or
  - You can cancel your registration. You will continue to hold a nursing or midwifery qualification, but will not be a registered nurse or midwife. You can apply for readmission to the register in future if you wish to practise as a nurse or midwife. Information on cancelling registration and seeking readmission to the register is available online.
34. If you choose not to renew your registration and lapse from the register (which includes cancelling your registration), you cannot rely on any hours of work you undertook in a role after the date you ceased to be registered for the purpose of seeking readmission to the register. Unregistered practice does not count towards meeting the readmission requirements.

## How to record practice hours

35. We strongly recommend that you maintain a record of practice hours you have completed. This will form part of the discussion you have with your confirmer, and you will also need to have this information available in case we request to see it for verification of your application. We have provided a template to help you record your practice hours. Your records should include:
  - dates of practice;
  - the number of hours you undertook;
  - name, address and postcode of the organisations;
  - scope of practice (see tip box on page 8);
  - work setting (see tip box on page 8);
  - a description of the work you undertook, and
  - evidence of those practice hours, such as timesheets, job specifications and role profiles.

36. You do not necessarily need to record individual practice hours. You can describe your practice hours in terms of standard working days or weeks.

## What you need to tell us in your online application

37. When you apply for revalidation, you need to declare that you have met the practice hours requirement. You only need to tell us about the most recent hours you have undertaken to meet the minimum 450/900 hours requirement. If you are currently practising in more than one setting, please tell us first about the one that you consider to be your main setting.
38. You will also be asked to enter the following details:
- whether you are currently practising;
  - if you are currently in practice, where you undertake that practice, including details of your scope of practice and work setting, and
  - if you are not currently in practice, where you undertook your most recent practice, including details of your scope of practice and work setting.
39. If you have completed a return to practice course or been admitted to another part of the register your practice hours declaration will be as follows:
- If you have recently completed an approved return to practice course since you last renewed your registration or joined the register, you will be able to meet the practice hours requirement for that registration.
  - If you have been admitted to another part of the register since you last renewed your registration or joined the register (for example you are a nurse who has undertaken training as a midwife and gained a second registration as a midwife), you only need to meet the practice hours requirement for your initial registration.
  - For further information about what you will need to tell us for the practice hours part of your revalidation application in these circumstances please see our guidance sheet at [www.nmc.org.uk/revalidation/revalidation-guidance-and-resources](http://www.nmc.org.uk/revalidation/revalidation-guidance-and-resources).
40. Please note that next time you apply for revalidation, if you wish to renew your registration on both parts of the register and continue practising as both a nurse and a midwife, you will need to meet the practice hours requirements for both parts.

# CONTINUING PROFESSIONAL DEVELOPMENT

## The requirements

41. You must have undertaken 35 hours of continuing professional development (CPD) relevant to your scope of practice as a nurse or midwife, in the three year period since your registration was last renewed or you joined the register.<sup>11</sup>
42. Of those 35 hours of CPD, at least 20 must have included participatory learning.<sup>12</sup>
43. You must maintain accurate records of the CPD you have undertaken. These records must contain:
  - the CPD method;
  - a description of the topic and how it related to your practice;
  - the dates on which the activity was undertaken;
  - the number of hours (including the number of participatory hours);
  - the identification of the part of the Code most relevant to the activity, and
  - evidence that you undertook the CPD activity.<sup>13</sup>

## The purpose of these requirements

44. As a professional, you have a duty to keep your professional knowledge and skills up to date through a continuous process of learning and reflection.
45. The CPD requirements are designed to help nurses and midwives to maintain safe and effective practice, to improve practice or develop new skills where a gap has been identified and to respond to changes and advances in nursing and midwifery.
46. The participatory requirement also helps to challenge professional isolation by requiring learning through engagement and communication with others.

## How to meet the requirements

47. We do not prescribe any particular type of CPD. We think that you are better placed to decide what learning activity would be most suitable and beneficial to your individual scope of practice. Guidance Sheet 3 on pages 44-45 lists some individual and participatory CPD activities that you can undertake. It is not an exhaustive list and we have only provided it as an example.
48. Any learning activity you participate in should be relevant to your scope of practice as a nurse or a midwife. Therefore, you should not include mandatory training that is not directly related to your practice (for example, fire training or health and safety training) as part of your 35 hours of CPD. However, if you undertake any mandatory training that is necessary to your scope of practice and professional development (for example, mandatory training on equality legislation if you are in a policy role), you could include that.
49. Participatory learning includes any learning activity in which you personally interact with other people. It is an activity undertaken with one or more professionals or in a larger group setting. The group does not always need to be in a common physical environment, such as a study group or conference. It could be a group in a virtual environment (such as an online discussion group). The professionals that you engage with through participatory learning do not have to be healthcare professionals.

## How to record CPD

50. You must maintain accurate records of your CPD activities. This will form part of the discussion you have with your confirmer, and you will also need to have this information available in case we request to see it for verification of your application. We have provided a template to help you record your CPD activities. Your records should include:
  - the CPD method;
  - a brief description of the topic and how it relates to your practice;
  - dates the CPD activity was undertaken;
  - the number of hours and participatory hours;
  - identification of the part of the Code most relevant to the CPD, and
  - evidence of the CPD activity (Guidance Sheet 3 on pages 44-45 provides examples of the kind of evidence you can record).

## What you need to tell us in your online application

51. You need to declare that you have met the CPD requirement.

# PRACTICE-RELATED

# FEEDBACK

## The requirement

52. You must have obtained five pieces of practice-related feedback in the three year period since your registration was last renewed or you joined the register.<sup>14</sup>

## The purpose of this requirement

53. The practice-related feedback requirement is intended to encourage nurses and midwives to be more responsive to the needs of patients and service users and those who care for them. Nurses and midwives need to seek feedback from those they work with and care for and importantly they need to use the feedback that they receive to assess and make improvements to their practice.

## How to meet the requirement

54. We recommend that you try to obtain feedback from a variety of sources, for example:

- feedback from patients, service users, carers or students as part of your day to day practice;
- feedback from colleagues such as nurses, midwives and healthcare professionals;
- feedback from colleagues in management, on reception, in assistant positions, as well as fellow teachers, researchers, academics or policy colleagues;
- complaints;
- team performance reports;
- serious event reviews, and
- feedback received through your annual appraisal.

55. Types of feedback:

- feedback can be about your individual practice or about your team, ward, unit or organisation's practice (you should be clear about the impact the feedback had on your practice);
- formal or informal;
- written or verbal, and
- positive or constructive.



56. It's likely that you will already receive a range of feedback. In many organisations, feedback is already collected in a variety of ways. You must seek consent to access or use your employer's information. Any information must be extracted in a way that no information identifying an individual is obtained, used or recorded. For example, you must not forward work emails to your personal accounts, or download and take copies of employer records. See Guidance Sheet 1 on pages 39-41 for more information.
57. Should you choose to solicit feedback directly from colleagues, patients or service users, you must make clear in your request that no information identifying individuals should be included in any feedback provided. You should also inform them how you intend to use their feedback.

## How to record feedback

58. We recommend that you keep a note of the content of any feedback you obtain, including how you used it to improve your practice. This will be helpful for you to use when you are preparing your reflective accounts.
59. You may choose to collect more feedback but to meet the revalidation requirement you only need to note the details of five pieces of feedback.
60. In any note you keep, you must not record any information that might identify an individual, whether that individual is alive or deceased. Guidance Sheet 1 on pages 39-41 provides guidance on how to make sure that your notes do not contain any information that might identify an individual.

## What you need to tell us in your online application

61. You need to declare that you have met the feedback requirement.





# WRITTEN REFLECTIVE

## ACCOUNTS

### The requirement

62. You must have prepared five written reflective accounts in the three year period since your registration was last renewed or you joined the register. Each reflective account must be recorded on the approved form and must refer to:

- an instance of your CPD and/or
- a piece of practice-related feedback you have received and/or
- an event or experience in your own professional practice and how this relates to the Code.

### The purpose of this requirement

63. We want to encourage nurses and midwives to engage in reflective practice so that they identify any changes or improvements they can make to their practice based on what they have learnt.
64. This requirement should also raise awareness of the Code and encourage nurses and midwives to consider the role of the Code in their practice and professional development.

### How to meet the requirement

65. Each reflective account can be about an instance of CPD, feedback, an event or experience in your practice as a nurse or midwife, or a combination of these. For example, you could create a reflective account on a particular topic which may have arisen through some feedback your team received following an event, such as consent and confidentiality and identify how that relates to the Code.



## How to record your reflective accounts

66. We have provided a form that you must use to record your reflective accounts. You must explain what you learnt from the CPD activity, feedback, event or experience, how you changed or improved your practice as a result, and how this is relevant to the Code.
67. This form can be hand written, typed or, if necessary, dictated.
68. Your reflective accounts must not include any information that might identify an individual whether that individual is alive or deceased. Guidance Sheet 1 on pages 39-41 provides guidance on how to make sure that your reflective accounts do not contain any information that might identify an individual.
69. You are not required to submit a copy of the reflective accounts to the NMC. However, you should retain these as a record to inform your reflective discussion and to show your confirmer.

## What you need to tell us in your online application

70. You need to declare that you have met the requirement for written reflective accounts.

# REFLECTIVE DISCUSSION

## The requirement

71. You must have had a reflective discussion with another NMC registrant, covering your five written reflective accounts on your CPD and/or practice-related feedback and/or an event or experience in your practice and how this relates to the Code.<sup>16</sup>
72. You must ensure that the NMC registrant with whom you had your reflective discussion signs the approved form recording their name, NMC Pin and email, as well as the date you had the discussion.<sup>17</sup>

## The purpose of this requirement

73. This requirement will encourage a culture of sharing, reflection and improvement. It does this in two ways: by requiring nurses and midwives to discuss their professional development and improvement, and by ensuring that nurses and midwives do not practise in professional isolation.

## How to meet the requirement

74. You must discuss your written reflective accounts with an NMC-registered nurse or midwife as part of a reflective discussion. The nurse or midwife must have an effective registration with the NMC, by which we mean they cannot be subject to any kind of suspension, removal or striking-off order at the time of having the discussion.
75. They could be someone you frequently work with or someone from a professional network or learning group. You do not need to work with them on a daily basis and you do not need to undertake the same type of practice. You do not need to be on the same part of the register as them (so a nurse can have a reflective discussion with a midwife and vice versa). It is for you to decide the most appropriate person for you to have this conversation with, including whether they are senior or junior to you.
76. If your confirmer is a nurse or midwife, your reflective discussion can form part of the confirmation discussion. If your confirmer is not a nurse or midwife, you will need to have your reflective discussion with an NMC-registered nurse or midwife before your confirmation discussion with your confirmer.
77. If you practise in a setting with few or no nurses or midwives, you can reach out to NMC-registered peers from your wider professional or specialty network in order to have your reflective discussion.
78. If you are a midwife, you may use your annual review with your midwifery supervisor as an opportunity to have your reflective discussion.
79. We expect the discussion to be a face-to-face conversation in an appropriate environment. If for some reason you cannot have a face-to-face discussion, then you could arrange a video conference.

80. During your discussion you should not discuss patients, service users or colleagues in a way that could identify them unless they expressly agree. For further information on reflective discussions please see our guidance sheet at [www.nmc.org.uk/revalidation/revalidation-guidance-and-resources](http://www.nmc.org.uk/revalidation/revalidation-guidance-and-resources).

## How to record your reflective discussion

81. We have provided an NMC form that you must use to record your discussion. You must make sure that the nurse or midwife with whom you had your reflective discussion signs the form and records their name, NMC Pin, email, professional address including postcode, contact number and the date you had the discussion and a summary of the discussion<sup>18</sup>. You should keep the completed and signed form.
82. The discussion summary section of the form must not include any information that might identify an individual, whether that individual is alive or deceased. Guidance Sheet 1 on pages 39-41 provides guidance on how to make sure that your notes do not contain any information that might identify an individual.

## What you need to tell us in your online application

83. You need to declare that you have had a reflective discussion with another NMC-registered nurse or midwife.
84. You will also need to enter the name, NMC Pin, email, professional address including postcode and contact number of the nurse or midwife with whom you had the discussion, as well as the date you had the reflective discussion.





# HEALTH AND CHARACTER

## The requirements

85. You must provide a health and character declaration.<sup>19</sup>
86. You must declare if you have been convicted of any criminal offence or issued with a formal caution.<sup>20</sup>
87. You will be asked to declare if you have been subject to any adverse determination that your fitness to practise is impaired by a professional or regulatory body (including those responsible for regulating or licensing a health and social care profession).<sup>21</sup>

## The purpose of these requirements

88. These requirements will help to satisfy the Registrar that the nurse or midwife is capable of safe and effective practice.

## How to meet the requirements

89. You will need to complete these declarations as part of your revalidation application.
90. When making these declarations please refer to our health and character guidance for nurses and midwives at [www.nmc.org.uk/cautions-convictions](http://www.nmc.org.uk/cautions-convictions), where there is also information on declaring police charges, cautions and convictions.
91. Your character is important and is central to the Code because nurses and midwives must be honest and trustworthy. Your character is based on your conduct, behaviour and attitude. You must declare if you have been convicted of any criminal offence or issued with a formal caution.<sup>22</sup> In accordance with the Code, we expect you to declare any cautions and convictions to the NMC immediately, not just at the point of revalidation.
92. You will also be asked to declare if you have been charged with a criminal offence or if you have been subject to any determination by a professional or regulatory body (including those responsible for regulating or licensing a health or social care profession) to the effect your fitness to practise is impaired.<sup>23</sup>
93. A caution or conviction includes a caution or conviction you have received in the UK for a criminal offence, as well as a conviction received elsewhere for an offence which, if committed in England and Wales, would constitute a criminal offence.<sup>24</sup> Please do not notify the NMC of motoring offences where you received a fixed penalty (unless it led to a disqualification of driving) or offences that have previously been considered by the NMC. See our website for further information on protected cautions and convictions.
94. We expect you to be in a state of health that ensures you are capable of safe and effective practice without supervision, after any reasonable adjustments are made by your employer.
95. This does not mean there must be a total absence of any disability or health condition. Many people with disabilities or health conditions are able to practise effectively with or without adjustments to support their practice.

## How to record health and character declarations

96. If your health and character are sufficiently good to enable you to practise safely and effectively in accordance with the Code, and you do not have any charges, cautions, convictions or determinations to declare, you do not need to keep any information as part of this requirement. Your confirmer does not need to check that you have met this requirement.
97. If you do need to declare any charges, cautions, convictions or determinations you will need to keep evidence of these to provide us with further information. You do not need to inform your confirmer of any declaration because we will be assessing these declarations ourselves.



Paragraph 23.2 of the Code states that you must inform us and any employers you work for at the first reasonable opportunity of any caution or charge against you, or if you have received a conditional discharge in relation to, or have been found guilty of, a criminal offence (other than a protected caution or conviction).

## What you need to tell us in your online application

98. You need to declare that your health and character are sufficiently good to enable you to practise safely and effectively in accordance with the Code.
99. You will be asked to declare if you have received a police charge, caution or conviction, other than a protected caution or conviction, or an adverse determination by a professional or regulatory body.



# PROFESSIONAL INDEMNITY

## ARRANGEMENT

### The requirement

100. You must declare that you have, or will have when practising, appropriate cover under an indemnity arrangement.<sup>25</sup>

### The purpose of this requirement

101. By law, you must have in place an appropriate indemnity arrangement in order to practise and provide care. While the arrangement does not need to be individually held by you, it is your responsibility to ensure that appropriate cover is in force.

### How to meet the requirement

102. You will need to complete this declaration as part of your revalidation application.
103. Most employers provide appropriate indemnity cover for their employees, so please check with your employer.
104. Please refer to our information on professional indemnity arrangements for nurses and midwives when making this declaration ([www.nmc.org.uk/indemnity](http://www.nmc.org.uk/indemnity)). This document defines 'appropriate cover' and sets out information for those who are employed, self-employed or undertake work in both employed and self-employed roles. It also sets out information for those who work in education, undertake voluntary work, or are having a break in their practice.
105. If it is discovered that you are practising as a nurse or midwife without an appropriate indemnity arrangement in place, you will be removed from the NMC register and unable to practise as a nurse or midwife.

## How to record your professional indemnity arrangement

106. Your declaration will be made as part of your revalidation application.
107. We strongly recommend that you retain evidence that you have an appropriate arrangement in place.
108. If your arrangement is provided through membership of a professional body or a private insurance arrangement, your declaration should be based on having in place an indemnity arrangement which provides 'appropriate cover' in relation to your individual scope of practice, as explained in information on professional indemnity arrangements for nurses and midwives. Please note that you will need to justify decisions on cover you put in place or rely on, if we request you to do so.
109. Your confirmer does not need to check that you have met this requirement.

## What you need to tell us in your online application

110. You need to inform the NMC whether your indemnity arrangement is through your employer, membership of a professional body, or a private insurance arrangement. Alternatively, you will be able to inform us that you are not practising at this time but that you intend to have appropriate cover in place before you practise.
111. You are required to have appropriate cover in place for all of your current practice settings. If you are currently practising in more than one setting, please tell us first about your arrangement in relation to your main practice setting. Please then add other arrangements to cover all your current practice settings.
112. If your indemnity arrangement is provided through membership of a professional body or a private insurance arrangement, you will be asked to provide the name of the professional body or provider.<sup>26</sup>





# CONFIRMATION

## The process

113. We will ask you for information for the purpose of verifying the declarations you have made in your application.<sup>27</sup>
114. This will be a declaration that you have demonstrated to an appropriate confirmer that you have complied with the revalidation requirements. We have provided a form for you to use to obtain this confirmation.
115. We will ask you to provide the name, NMC Pin or other professional identification number (where relevant), email, professional address and postcode of the confirmer.

## The purpose of confirmation

116. Confirmation encompasses several benefits for nurses and midwives. It will provide assurance, increase support and engagement between nurses and midwives and their confirmers, and make nurses and midwives more accountable for their own practice and improvement. It should support nurses and midwives by increasing their access to appraisals.
117. The interactive nature of the confirmation process should reduce professional isolation and encourage a culture of sharing, reflection and improvement.
118. Ultimately, the confirmation process is designed to increase professionalism by making nurses and midwives more accountable for their practice and improvement. This requirement also gives us an additional layer of assurance that nurses and midwives are complying with the revalidation requirements.
119. Confirmation is not about judging whether a nurse or midwife is fit to practise.

## How to obtain confirmation

120. The confirmation process involves having a discussion about your revalidation with an appropriate confirmer. We recommend that you obtain confirmation through a face-to-face discussion or video conference.
121. As part of that discussion, you will demonstrate to that confirmer that you have complied with all of the revalidation requirements, except professional indemnity arrangement and health and character, as set out in this guidance.
122. We recommend that you obtain your confirmation during the final 12 months of the three year renewal period to ensure that it is recent. If your confirmation was obtained earlier, we may ask you to explain why.
123. If your confirmer is a nurse or midwife, your reflective discussion can form part of the confirmation discussion. If your confirmer is not a nurse or midwife, you will need to have your reflective discussion with an NMC-registered nurse or midwife before your confirmation discussion with your confirmer.
124. We have provided further information about the role of confirmers in guidance which you should ensure your confirmer has read.

## An appropriate confirmer

125. Your line manager is an appropriate confirmer, and we strongly recommend that you obtain confirmation from your line manager wherever possible. A line manager does not have to be an NMC-registered nurse or midwife.
126. If you do not have a line manager, you will need to decide who is best placed to provide your confirmation. Wherever possible we recommend that your confirmer is an NMC-registered nurse or midwife. It is helpful if they have worked with you or have a similar scope of practice, but this is not essential.
127. If that is not possible, you can seek confirmation from another healthcare professional that you work with and who is regulated in the UK. For example, you could ask a doctor, dentist or a pharmacist. You will need to record their professional Pin or registration number and the name of their professional regulator.
128. If you do not have a line manager, or access to an NMC-registered nurse or midwife or another healthcare professional, please check our online confirmation tool for further guidance as to who can act as a confirmer in this situation at [www.nmc.org.uk/confirmation](http://www.nmc.org.uk/confirmation).
129. If your confirmer is an NMC-registered nurse or midwife, they must have an effective registration with the NMC. We may not be able to verify your application if your confirmation was provided by a person who was subject to any kind of suspension, removal or striking-off order at the time of making the confirmation.

## Obtaining confirmation if you work wholly overseas

130. If you work wholly overseas, you can seek confirmation from your line manager where you undertake your work.
131. If you do not have a line manager, you will need to decide who is best placed to provide your confirmation. Wherever possible we recommend that your confirmer is a nurse or midwife regulated where you practise, or another regulated healthcare professional. Our online confirmation tool provides further guidance as to who can act as a confirmer in this situation.

## Obtaining confirmation if you have more than one line manager

132. If you have more than one employer or undertake more than one role, you only need to obtain one confirmation. You will need to decide which line manager is most appropriate to provide confirmation that you have met the revalidation requirements.
133. We recommend that you have your revalidation discussion and obtain confirmation through the line manager where you undertake the majority of your work. You may choose to have a revalidation discussion with each of your line managers, and bring the outputs of those discussions to the line manager you think is most appropriate to be your confirmer.

## Confirmation and appraisals

134. The revalidation process is designed so that it can form part of an appraisal process, and where possible we recommend that you use your annual appraisal to have your revalidation discussion and obtain confirmation.
135. If your line manager is an NMC-registered nurse or midwife, you might like to have your reflective discussion at the same time as your confirmation discussion as part of your annual appraisal.
136. However, it is not a requirement of revalidation that you obtain your confirmation as part of an appraisal.

## How to record confirmation

137. We have provided an NMC form you must use to record your confirmation. Your confirmer will need to complete and sign this form.
138. You should keep the completed and signed form.

## What you need to tell us in your online application

139. You will be asked to enter the name, NMC Pin or other professional identification number (where relevant), email, professional address including postcode and contact number of your confirmer.
140. We will also ask you whether you have a regular appraisal and whether you have a line manager who is an NMC-registered nurse or midwife so that we understand what level of support was available to you in completing your revalidation application.

# THE APPLICATION

## PROCESS

### Before you apply

- **Set up an NMC Online account.**

You will need to submit your application through NMC Online. You can also check your renewal date on NMC Online. We have published a step-by-step guide to registering for NMC Online at [www.nmc.org.uk/registration/nmc-online](http://www.nmc.org.uk/registration/nmc-online).



Once you have set up your online account, you will receive all subsequent notifications by email. Please add the NMC as a safe sender and check your email regularly during the revalidation process.

- **Keep your contact details up to date so that we can notify you when your revalidation application is due.**

The most common reason for lapsed registration (and illegal practice) is a failure to keep the NMC updated on your contact details.

- **Make sure you know when your revalidation application is due.**

You must submit your application by the date we specify. You may affect our ability to process your revalidation application if you do not submit your application by this date, and the renewal of your registration may be at risk as a result.

- **Make sure that you have all your supporting evidence to hand when you start your online application.**

Do not forget that if you are a registered midwife practising in the UK, you will need to file your Intention to Practise notification form. This should be submitted annually to your named supervisor of midwives.<sup>28</sup>

- Please contact the NMC well in advance of your revalidation application date if you require a reasonable adjustment for using NMC Online.

### The online application

141. Your online application opens 60 days before your revalidation application date.

142. During this 60 day period you will need to log into your application via NMC Online and address each of the requirements.

#### Contacting your employer or any other relevant third party

143. As part of your application process we may need to contact your employer or any other relevant third party who can verify the information that you have provided in your application<sup>29</sup>.

144. In your online application you will be asked to provide consent for this purpose.

## Equality and diversity information

145. As part of the online application process you will be asked to supply some equality and diversity information. We will use this information to monitor our services and make sure we are treating everyone in a fair and equal way. The questions have been designed to gather data about our service users in relation to the characteristics protected by the law under the Equality Act 2010.
146. We will keep the information from this questionnaire confidential and store it in line with the Data Protection Act 1998 and the NMC's Data Protection Policy. By submitting this sensitive personal information to us, you explicitly consent to the collection and processing of your sensitive personal information in accordance with the NMC's Data Protection Policy.



Details of our Data Protection Policy are included in our privacy notice at:  
[www.nmc.org.uk/privacy](http://www.nmc.org.uk/privacy)

147. Providing this information is optional and will not affect your revalidation application or registration renewal. If you would prefer not to disclose this information you can select the 'prefer not to say' option for any/all of the questions.

## Paying your fee

148. You will also need to pay your annual fee as part of your revalidation application. Your registration will not be renewed until we have received your payment.
149. Please refer to our guidance on paying your fees which sets out the different ways that you can pay, including direct debit, online or by telephone. This guidance is available on our website at [www.nmc.org.uk/registration/staying-on-the-register/paying-your-fee](http://www.nmc.org.uk/registration/staying-on-the-register/paying-your-fee).
150. As a registered UK tax payer you can also claim tax relief on the NMC registration fees. HM Revenue and Customs (HMRC) allows individuals to claim tax relief on professional subscriptions or fees which have to be paid in order to carry out a job. Registration fees paid to us are included in this category. Please refer to our guidance on how to claim tax relief on your fee.
151. Please note that you must still pay your annual fee every year to retain your registration with the NMC.

## After you have completed your application

152. After you have completed your online application you will be offered the option of printing a paper copy of your application for your records.
153. Once your application has been successfully processed and your payment has been received we will send you an email confirming that your registration has been renewed.
154. We advise you to search the register on our website: [www.nmc.org.uk/search-the-register](http://www.nmc.org.uk/search-the-register) to double check your status.

## Reasonable adjustments for using NMC Online

155. We will make reasonable adjustments for nurses and midwives who have a disability which means that they may find using NMC Online difficult. If you require a reasonable adjustment to be made, you must contact the NMC well in advance of your application date so that we can consider your request and make any necessary adjustments.

## Arrangements for exceptional circumstances

156. We have special arrangements in place for nurses and midwives who cannot meet the revalidation requirements as a result of exceptional circumstances.

By exceptional circumstances we mean that you:

- have not been in practice for sufficient time between October 2015 when the revalidation guidance was published and your revalidation application date (for example, if you have been on maternity leave or sick leave) to meet the additional requirements, or
- you cannot meet one or more of the requirements at any time because a protected characteristic under the Equality Act may apply.

157. If you are able to establish that exceptional circumstances apply in your case, you will still need to meet the Prep requirements for renewal. Please see our guidance sheet on exceptional circumstances for further information at [www.nmc.org.uk/standards/revalidation/revalidation-guidance-and-resources](http://www.nmc.org.uk/standards/revalidation/revalidation-guidance-and-resources).

## Requesting an extension to submit your application

158. We will not usually consider any requests for extensions to submit a revalidation application. You should have met the requirements during the three years prior to the renewal of your registration.

159. However, if you believe that you have a good reason why you cannot submit your revalidation application by the specified date, you must contact the NMC as far in advance of your revalidation application date as possible to discuss your situation.

160. You should contact us by email (see page 4), and note in the subject line that your email is regarding a request to extend your revalidation application.

161. We are only able to grant an extension prior to the date your registration is due to lapse.<sup>31</sup> Extensions will be granted for a period of up to six weeks.<sup>30</sup>

162. In granting an extension, we will take into account:

- whether you have contacted the NMC in advance of the date your revalidation application is due;
- the reason why you cannot submit your revalidation application by the specified date;
- whether you are capable of completing the outstanding revalidation requirements and submitting your application within the additional period of time;
- whether there are any concerns about your fitness to practise, and
- whether the annual fee has been or will be paid by the required date.

163. Any extension we agree in relation to your revalidation application would not include an extension to the date on which your annual fee is due to be paid.



# VERIFICATION OF YOUR APPLICATION

164. Each year we will select a sample of nurses and midwives to provide further information or evidence to verify their application.<sup>32</sup> Such a request does not necessarily mean that there are any concerns about your application and you can continue to practise while we review the information that you provide.
165. Where possible we will notify you immediately after you have submitted your application and made your payment if you have been selected to provide further information. If this is not possible we will contact you by email within 24 hours of you submitting your revalidation application and making your payment. Please check your email during this time.
166. If you are selected to provide further information, you will need to complete an online form where you will be asked to provide further information. We may also request further evidence. We will ask you to provide this information within a reasonable time. Please note that although your registration will not lapse during the verification process, your registration will not be renewed until the verification process is complete.
167. The table overleaf sets out the information that you will need to provide if you are selected to provide further information. You should already have this information so you should not need to seek any additional information.
168. We will contact your confirmer to request further information. Please ensure that your confirmer is aware that if they do not respond to our request for verification they may put your revalidation application at risk. We may also contact your employer and reflective discussion partner.
169. If we identify that you have not complied with the revalidation requirements, or you submit fraudulent information, your registration might be at risk.
170. The verification process will be completed within three months of your renewal date.



## Verification information

### Practice hours

You will need to provide the following information, starting with your most recent practice until you demonstrate the minimum number of practice hours required:

- dates of practice;
- the number of hours you undertook;
- name, address and postcode of the organisations;
- scope of practice and work setting (see tip box on page 8);
- a description of the work you undertook, and
- if practising overseas, whether you are registered with the appropriate regulating body.

We may contact your employer for further information, and you may also be asked to provide further evidence of practice hours.

If you are using a completed return to practice course for your practice hours requirement, or you have been admitted to another part of the register since you last renewed your registration or joined the register, please see our guidance sheet at [www.nmc.org.uk/revalidation/revalidation-guidance-and-resources](http://www.nmc.org.uk/revalidation/revalidation-guidance-and-resources) for further information.

### Continuing professional development

You will need to provide the following information:

- the CPD method (see pages 44-45 for further information);
- a brief description of the topic and how it relates to your practice;
- the dates the CPD activity was undertaken;
- the number of hours and participatory hours, and
- identification of the part of the Code most relevant to the CPD.

You may also be asked to provide evidence of the CPD activity.

### Reflective discussion

You will not need to upload a copy of the signed reflective discussion form. We may contact your reflective discussion partner regarding your discussion.

### Professional indemnity arrangement

You are required to have appropriate cover in place for all of your current practice settings. If your arrangement is provided through membership of a professional body or a private insurance arrangement you will be asked to confirm a) that you have read and understood our information on professional indemnity arrangements for nurses and midwives; b) that you have in place an indemnity arrangement which provides "appropriate cover", in relation to your individual scope of practice, as explained in information on professional indemnity arrangements for nurses and midwives; and c) that you understand that you will need to justify decisions on cover you put in place or rely on, if we request you to do so. If you are currently practising in more than one setting, please tell us first about your arrangement in relation to your main practice setting, followed by any other arrangements to cover all your current practice settings.

### Confirmation

You will not need to upload a copy of the signed confirmation form. We will contact your confirmer using the contact details you provided us in your initial application. Please ensure that your confirmer is aware that if they do not respond to our request for verification they may put your revalidation application at risk.



# REVALIDATION AND NMC FITNESS TO PRACTISE PROCESSES



171. If an employer, a nurse or midwife, or any other individual becomes aware of a serious concern about the fitness to practise of another nurse or midwife they should raise it promptly through our fitness to practise procedures. All nurses and midwives have a professional duty to raise a concern about the practice of another nurse or midwife either through their employer or directly with us. They should not wait until a nurse or midwife's renewal is due to raise such a fitness to practise concern.
172. Revalidation does not create a new way of raising such a fitness to practise concern about a nurse or a midwife, and the confirmation stage of revalidation does not involve making a judgment as to whether a nurse or midwife is fit to practise.
173. If you are subject to an NMC investigation, condition(s) of practice order or a caution, you will be able to apply to renew your registration as long as you fulfil all the requirements for renewal. However, you will remain subject to NMC fitness to practise processes and the outcome of those processes.
174. If you have been struck off the register, you are not able to revalidate because you are no longer on the register. You will need to apply for restoration to the register.



**For more information**

[www.nmc.org.uk/concerns-nurses-midwives/information-under-investigation/restoration/](http://www.nmc.org.uk/concerns-nurses-midwives/information-under-investigation/restoration/)

175. If you are suspended from the register, you are not able to revalidate during your suspension. Following cessation of your suspension, if your registration is effective you will need to comply with the revalidation requirements at the time that your registration is due to be renewed. If your registration is not effective following the cessation of your suspension, you will need to follow the readmission process.

# CANCELLING YOUR REGISTRATION

176. You may not want to retain one or all your registrations with us.

- For example you may wish to cancel all of your registrations with us if you have moved abroad, have retired from practice or changed career,
- Alternatively you may wish to cancel one of your registrations if you wish to continue practising in one but not the other. For example if you are registered as both a nurse and a midwife but only wish to continue practising as a midwife you may want to cancel your nursing registration.



Please note that if you are receiving pay as a nurse or midwife whilst on maternity, sick or annual leave you may need to maintain your registration with us throughout this period.

177. If you wish to cancel at the time of your revalidation application, you can do this online through the online revalidation application.

178. If you want to cancel your registration when you are not due for revalidation, you must submit an 'application to lapse your registration' form.

179. You will need to provide your NMC Pin, full name, contact address, the reason for cancelling and a declaration stating that you are not aware of any matter which could give rise or has given rise to a fitness to practise allegation being made against you.



### For more information

Information on cancelling your NMC registration is available on our website at [www.nmc.org.uk/registration/leaving-the-register/cancelling-registration/](http://www.nmc.org.uk/registration/leaving-the-register/cancelling-registration/)

180. You will not be able to practise or present yourself as a registered nurse or midwife in the UK if you cancel your registration with the NMC. It is a criminal offence to falsely represent yourself as being on the register, or on part of it, or to use a title to which you are not entitled.<sup>33</sup>

181. If you choose to cancel your registration, and later wish to resume practising as a nurse or midwife in the UK, please refer to our guidance on readmission to the register at [www.nmc.org.uk/registration/returning-to-the-register](http://www.nmc.org.uk/registration/returning-to-the-register). If you apply for readmission within six months of having lapsed from the register after failing to revalidate, you will have to meet the revalidation requirements in addition to the usual readmission requirements, unless you are able to demonstrate that exceptional circumstances apply.

## Failure to revalidate and appeals

182. If you fail to submit your revalidation application before the end of your three year renewal period, your registration will lapse (automatically expire). If you want to come back on to the register, you will need to apply for readmission.
183. If you submit an application for revalidation, but you fail to meet the revalidation requirements and your application to renew your registration is refused as a result, you may appeal this decision within 28 days of the date on your decision letter.<sup>34</sup>
184. A notice of appeal should be made in writing and include:
- your name, address and NMC Pin;
  - the date, nature and other relevant details of the decision against which the appeal is brought;
  - a concise statement of the grounds of the appeal;
  - the name and address of your representative (if any) and a statement as to whether the NMC should correspond with that representative concerning the appeal instead of you;
  - a statement that the notice is a notice of appeal;
  - a signature by or on behalf of you, and
  - a copy of any documents that you propose to rely on for the purposes of your appeal.<sup>35</sup>

A notice of appeal should be sent to **ragssupport@nmc-uk.org**.

185. However, if you failed to pay the registration fee or to submit an application form at all within the required timescale and your application to renew your registration is refused as a result, you do not have a right of appeal.<sup>36</sup>
186. If you do not renew your registration and lapse from the register, you are no longer a registered nurse or midwife. It is an offence to falsely represent yourself as being on the register, or on part of it, or to use a title to which you are not entitled.<sup>37</sup> If you lapse from the register you need to be careful not to mislead people into thinking you are on the register.



# GUIDANCE SHEET 1:

## NON-IDENTIFIABLE INFORMATION

You are likely to process personal data as part of your day to day role. If you are employed, you are likely to be covered by your employer's registration under data protection legislation. If you are practising as an independent or self-employed nurse or midwife you are already likely to be registered under data protection legislation in your capacity.

This guidance sets out your obligations in relation to confidentiality and data protection in relation to meeting the revalidation requirements. It does not cover your existing obligations in relation to data protection legislation.



Personal data means data which identifies an individual. Section 1(1) of the Data Protection Act 1998.

## Your obligations in relation to confidentiality under the Code

The Code sets out the professional standards that you must uphold in order to be registered to practise in the UK. Paragraph 5 of the Code states:

### Respect people's right to privacy and confidentiality

As a nurse or midwife, you owe a duty of confidentiality to all those who are receiving care. This includes making sure that they are informed about their care and that information about them is shared appropriately.

To achieve this, you must:

- respect a person's right to privacy in all aspects of their care (5.1)
- make sure that people are informed about how and why information is used and shared by those who will be providing care (5.2)
- respect that a person's right to privacy and confidentiality continues after they have died (5.3)
- share necessary information with other healthcare professionals and agencies only when the interests of patient safety and public protection override the need for confidentiality, and (5.4)
- share with people, their families and their carers, as far as the law allows, the information they want or need to know about their health, care and ongoing treatment sensitively and in a way they can understand. (5.5)

## Making sure that your evidence does not include any personal information

In meeting the revalidation requirements and keeping your evidence, you must not record any information that might identify an individual, whether that individual is alive or deceased. This means that all information recorded must be recorded in a way that no patient, service user, colleague or other individual can be identified from the information.

For example, any notes or reflections must not include:

- the name of any individual;
- the date of any incident or event referred to;
- the particular ward or place where the event occurred, or
- descriptions of unique circumstances where an individual could be identified from the circumstances.

Any information extracted from employer data (such as complaints logs) must be extracted in a way that no information identifying an individual is obtained, used or recorded. For example, you must not forward work emails to your personal account, or download and take copies of employer records.

## Example scenarios

You will already be aware of the importance of keeping personal information confidential, and not processing personal information outside of your employment or work settings. However, we have provided some simple examples below to demonstrate how an instance of feedback could be recorded in a way that no individual can be identified.

### Scenario 1

In January 2015 Mrs Jones was in ward 8 with a broken hip. She made a complaint about lack of hydration. You want to use this feedback in one of your reflections as an example of where you put in place a new process to make sure all patients were offered water on a regular basis.

In your reflective account you could say: *'A patient with a serious injury made a complaint about lack of hydration.'*

No dates, names or wards have been included in the record, and the type of injury has also been omitted, so Mrs Jones cannot be identified from this information. You can then explain what you did, what improvement you made and how this is related to the Code.



## Scenario 2

In reviewing the complaints log held by the maternity unit where you work, you noticed a complaint made by Mrs Smith in relation to a lack of continuity of care and handover between midwives at the end of a shift on 12 January 2015. You were one of the midwives involved, along with your colleague Sarah. You discussed this with your colleagues and have made improvements in the way you handover at the end of shifts. You want to use this feedback in one of your reflections.

Before writing your reflective account, you need to check with your employer that you can use information from the complaints log. In your reflective account you could say: *'A complaint was received from a mother about the lack of continuity of care and handover between myself and a colleague at the end of a shift.'*

No information identifying any individual, including both the mother and your colleague, has been included in this record. You can then explain what you did, what improvement you made and how this is related to the Code.

## Storing your reflective accounts form, reflective discussion form and confirmation form

You are not required to submit these forms to the NMC at any point in the revalidation application. There is no requirement to store them electronically or upload them into NMC Online as part of your application, or if you are selected to provide further information to verify your evidence.

Your reflective discussion form and confirmation form contain personal data about another person. This means that there are data protection implications for nurses and midwives completing these forms. However, the Information Commissioner's Office (ICO) recognises that it would be highly disproportionate to expect nurses and midwives to have to register with them as data controllers. The ICO has confirmed that it is not planning to take any action against any nurse or midwife for failing to register. You may choose to store your completed reflective discussion and confirmation forms in either paper or electronic format. You should still respect the fact that these forms contain personal data about your reflective discussion partner and confirmer.

## Further information

The Information Commissioner's Office has published a guide to data protection at [ico.org.uk/for-organisations/guide-to-data-protection/](https://ico.org.uk/for-organisations/guide-to-data-protection/)

They have also published guidance specifically on anonymisation at [ico.org.uk/for-organisations/guide-to-data-protection/anonymisation/](https://ico.org.uk/for-organisations/guide-to-data-protection/anonymisation/)

# GUIDANCE SHEET 2: PRACTICE HOURS REQUIREMENTS

## FOR REGISTERED MIDWIVES WHO ARE ALSO REGISTERED AS SPECIALIST COMMUNITY PUBLIC HEALTH NURSES

Every person registered with the NMC is a nurse or a midwife or both. Some registered nurses and midwives have also completed a post-registration qualification which has resulted in an additional entry in the part of the register for Specialist Community Public Health Nursing (SCPHN).

SCPHN programmes can only be undertaken by individuals who are already registered on the nurses or midwives part of the NMC register. SCPHNs must maintain their registration as a nurse or a midwife and cannot renew their registration only as a SCPHN.

In this document, where we say 'midwife/SCPHN', we mean a registered midwife who is also on the register as a SCPHN.

## Practice hours requirement for registered midwives who are SCPHNs

Midwife/SCPHNs will have to complete 450 practice hours every three years in order to remain registered with the NMC. Midwives who work wholly in a SCPHN role can use their practice in their SCPHN role to meet the practice hours requirement.

## Submitting an Intention to Practise form

Midwife/SCPHNs who undertake any work as a practising midwife need to submit a completed Intention to Practise (ItP) form every year to their named supervisor of midwives and are subject to statutory supervision in accordance with rule 3 of the Midwives rules and standards 2012 (see Example A overleaf).

Midwife/SCPHNs who work wholly in a SCPHN role and do not undertake any work as a practising midwife do not need to serve an ItP and do not need to be supervised by a supervisor of midwives. They can maintain their midwifery registration but they are not entitled to provide midwifery care in the UK to women and babies or work as a practising midwife. Their entry on the register shows this (see Example B overleaf).

If a registered midwife has not served an ItP since the last time they renewed their registration or joined the register, they will need to complete a return to midwifery practice programme before being entitled to serve a new ItP and become a practising midwife again (see Example C overleaf).

- Example A:** A registered midwife practises as a midwife, but also works some of their time as a SCPHN. They will need to undertake 450 practice hours from across their midwifery and SCPHN scope of practice. They will need to submit a completed ItP form every year to their named supervisor of midwives and be subject to statutory supervision.
- Example B:** A registered midwife practises wholly as a SCPHN and does not undertake any practice as a midwife. They need to undertake 450 hours of practice in their SCPHN role. They don't have to submit an ItP form and are not supervised by a supervisor of midwives. They retain their midwifery registration, but the register makes clear that they are not able to provide midwifery care in the UK.
- Example C:** A registered midwife has been working wholly as a SCPHN and so has not served an ItP since the last time they renewed their registration or joined the register. They now wish to return to midwifery practice. Before they can return to midwifery practice, they will need to complete a midwifery return to practice programme. They can then submit an ItP and begin to practise as a midwife.

## Midwife/SCPHNs who are also registered nurses

Nurses and midwives who are registered on both the midwifery and nursing parts of the register have to complete 900 practice hours every three years in order to remain on both parts of the register. Of these hours, 450 must be as a nurse, and 450 as a midwife.

This means that if a midwife/SCPHN is also a registered nurse, they will need to meet 900 practice hours. They will also need to submit a completed ItP form every year to their named supervisor of midwives and are subject to statutory supervision, unless they do not undertake any midwifery practice.

If such a nurse or midwife is working wholly in a SCPHN role and does not wish to undertake any work as a practising midwife, they can choose to only retain their registration as a nurse and SCPHN and lapse their midwifery registration. If they want to return to midwifery practice in the future they can complete a midwifery return to practice programme and seek readmission to the midwifery part of the register.

## Midwives who work in community or other public health roles (such as Family Nurse Partnerships, neonatal or sexual health) but are not on the register as a SCPHN

These midwives must undertake 450 practice hours in each three year renewal period and submit their ItP to their supervisor of midwives annually and be supervised by a statutory supervisor of midwives. These requirements will apply to any registered midwives who are not also registered on the SCPHN part of the register.



# GUIDANCE SHEET 3: EXAMPLES OF CPD ACTIVITIES

The table below sets out some examples of CPD activities you can undertake and examples of the types of evidence you could keep (for example in your portfolio). It is not an exhaustive list. It also indicates whether an activity is individual or participatory

You will need to decide whether an activity is participatory or not. Many activities can be participatory if you personally interacted with other people.

CPD activity	Suggested evidence to retain	Individual/Participatory
Structured learning (direct or distance learning style)	Certificate of completion, notes, learning outcomes	Individual/Participatory
Accredited higher education or training	Certificate of completion, notes, learning outcomes	Individual/Participatory
Mandatory training specifically relevant to role/scope of practice	Certification of completion, learning outcomes	Individual
Learning events such as workshops, conferences	Certificate of attendance	Participatory
Reading and reviewing publications	Copies of publications read, review notes including practice-related outcomes	Individual
Enquiry based research	Copies of publications or data reviewed, notes including practice-related outcomes	Individual
Peer review activities	Evidence of peer review including notes, observations and outcomes	Participatory
Coaching and mentoring (role in either delivery or being a recipient)	Evidence of coaching/ mentoring undertaken including letters, notes, observations and practice-related outcomes	Participatory

CPD activity	Suggested evidence to retain	Individual/Participatory
Structured professional clinical supervision	Evidence of supervision including signed letters, notes, observations and practice-related outcomes	Participatory
Undertaking short supervised practice for specific skills development	Evidence of participation including signed letters, notes, observations and outcomes	Individual/Participatory
Group or practice meetings	Evidence of participation and role including signed letters, notes, observations and outcomes	Participatory
Participation in clinical audits	Evidence of participation and role including signed letters, notes, observations and outcomes	Participatory
Practice visits to different environments relevant to scope of practice	Evidence of participation including signed letters, notes, observations and outcomes	Individual/Participatory
Training related to job rotation or secondment, shadowing	Evidence of participation including signed letters, notes, observations and outcomes	Individual/Participatory



# REFLECTIVE ACCOUNTS FORM

You **must** use this form to record five written reflective accounts on your CPD and/or practice-related feedback and/or an event or experience in your practice and how this relates to the Code. Please fill in a page for each of your reflective accounts, making sure you do not include any information that might identify a specific patient, service user or colleague. Please refer to our guidance on preserving anonymity in Guidance sheet 1 in *How to revalidate with the NMC*.

**Reflective account:**

**What was the nature of the CPD activity and/or practice-related feedback and/or event or experience in your practice?**

**What did you learn from the CPD activity and/or feedback and/or event or experience in your practice?**

**How did you change or improve your practice as a result?**

**How is this relevant to the Code?**

Select one or more themes: Prioritise people – Practise effectively – Preserve safety – Promote professionalism and trust

# REFLECTIVE DISCUSSION FORM

You **must** use this form to record your reflective discussion with another NMC-registered nurse or midwife about your five written reflective accounts. During your discussion you should not discuss patients, service users or colleagues in a way that could identify them unless they expressly agree, and in the discussion summary section below make sure you do not include any information that might identify a specific patient or service user. Please refer to Guidance sheet 1 in *How to revalidate with the NMC* for further information.

**To be completed by the nurse or midwife:**

<b>Name:</b>	
<b>NMC Pin:</b>	

**To be completed by the nurse or midwife with whom you had the discussion:**

<b>Name:</b>	
<b>NMC Pin:</b>	
<b>Email address:</b>	
<b>Professional address including postcode:</b>	
<b>Contact number:</b>	
<b>Date of discussion:</b>	
<b>Short summary of discussion:</b>	
<p>I have discussed five written reflective accounts with the named nurse or midwife as part of a reflective discussion.</p> <p>I agree to be contacted by the NMC to provide further information if necessary for verification purposes.</p>	<b>Signature:</b>
	<b>Date:</b>

# CONFIRMATION FORM

You **must** use this form to record your confirmation.

## To be completed by the nurse or midwife:

Name:	
NMC Pin:	
Date of last renewal of registration or joined the register:	

## I have received confirmation from (select applicable):

- A line manager who is also an NMC-registered nurse or midwife
- A line manager who is not an NMC-registered nurse or midwife
- Another NMC-registered nurse or midwife
- A regulated healthcare professional
- An overseas regulated healthcare professional
- Other professional in accordance with the NMC's online confirmation tool

## To be completed by the confirmer:

Name:	
Job title:	
Email address:	
Professional address including postcode:	
Contact number:	
Date of confirmation discussion:	

If you are an NMC-registered nurse or midwife please provide:

NMC Pin:

If you are a regulated healthcare professional please provide:

Profession:

Registration number for regulatory body:

If you are an overseas regulated healthcare professional please provide:

Country:

Profession:

Registration number for regulatory body:

If you are another professional please provide:

Profession:

Registration number for regulatory body (if relevant):

## Confirmation checklist of revalidation requirements

### Practice hours

You have seen written evidence that satisfies you that the nurse or midwife has practised the minimum number of hours required for their registration.

### Continuing professional development

You have seen written evidence that satisfies you that the nurse or midwife has undertaken 35 hours of CPD relevant to their practice as a nurse or midwife

You have seen evidence that at least 20 of the 35 hours include participatory learning relevant to their practice as a nurse or midwife.

You have seen accurate records of the CPD undertaken.

### Practice-related feedback

- You are satisfied that the nurse or midwife has obtained five pieces of practice-related feedback.

### Written reflective accounts

- You have seen five written reflective accounts on the nurse or midwife's CPD and/or practice-related feedback and/or an event or experience in their practice and how this relates to the Code, recorded on the NMC form.

### Reflective discussion

- You have seen a completed and signed form showing that the nurse or midwife has discussed their reflective accounts with another NMC-registered nurse or midwife (or you are an NMC-registered nurse or midwife who has discussed these with the nurse or midwife yourself).

I confirm that I have read *Information for confirmers*, and that the above named NMC-registered nurse or midwife has demonstrated to me that they have complied with all of the NMC revalidation requirements listed above over the three years since their registration was last renewed or they joined the register as set out in *Information for confirmers*.

I agree to be contacted by the NMC to provide further information if necessary for verification purposes. I am aware that if I do not respond to a request for verification information I may put the nurse or midwife's revalidation application at risk.

Signature:

Date:

# PRACTICE HOURS LOG TEMPLATE

## Guide to completing practice hours log

To record your hours of practice as a registered nurse and/or midwife, please fill in a page for each of your periods of practice. Please enter your most recent practice first and then any other practice until you reach 450 hours. You do not necessarily need to record individual practice hours. You can describe your practice hours in terms of standard working days or weeks. For example if you work full time, please just make one entry of hours. If you have worked in a range of settings please set these out individually. You may need to print additional pages to add more periods of practice. If you are both a nurse and midwife you will need to provide information to cover 450 hours of practice for each of these registrations.

### Work setting

- Ambulance service
- Care home sector
- Community setting (including district nursing and community psychiatric nursing)
- Consultancy
- Cosmetic or aesthetic sector
- Governing body or other leadership
- GP practice or other primary care
- Hospital or other secondary care
- Inspectorate or regulator
- Insurance or legal
- Maternity unit or birth centre
- Military
- Occupational health

### Police

- Policy organisation
- Prison
- Private domestic setting
- Public health organisation
- School
- Specialist or other tertiary care including hospice
- Telephone or e-health advice
- Trade union or professional body
- University or other research facility
- Voluntary or charity sector
- Other

### Scope of practice

- Commissioning
- Consultancy
- Education
- Management
- Policy
- Direct patient care
- Quality assurance or inspection

### Registration

- Nurse
- Midwife
- Nurse/SCPHN
- Midwife/SCPHN
- Nurse and Midwife (including Nurse/SCHPN and Midwife/SCPHN)

Dates	Name and address of organisation	Your work setting (choose from list above)	Your scope of practice (choose from list above)	Number of hours	Your registration (choose from list above)	Brief description of your work



# CONTINUING PROFESSIONAL DEVELOPMENT (CPD)

## LOG TEMPLATE

### Guide to completing CPD record log

#### Examples of learning method

- Online learning
- Course attendance
- Independent learning

#### What was the topic?

Please give a brief outline of the key points of the learning activity, how it is linked to your scope of practice, what you learnt, and how you have applied what you learnt to your practice.

#### Link to Code

Please identify the part or parts of the Code relevant to the CPD

- Prioritise people
- Practise effectively
- Preserve safety
- Promote professionalism and trust

Please provide the following information for each learning activity, until you reach 35 hours of CPD (of which 20 hours must be participatory). For examples of the types of CPD activities you could undertake, and the types of evidence you could retain, please refer to Guidance sheet 3 in How to revalidate with the NMC.

Dates	Method Please describe the methods you used for the activity.	Topic(s)	Link to Code	Number of hours	Number of participatory hours
	<b>Total</b>			<b>Total</b>	<b>Total</b>

## ENDNOTES

- <sup>1</sup> SI 2002/253 as amended.
- <sup>2</sup> SI 2004/1767 as amended.
- <sup>3</sup> The standards for revalidation are made under Article 19(1) of the NMC Order 2001.
- <sup>4</sup> NMC 2011.
- <sup>5</sup> The Code: Professional standards of practice and behaviour for nurses and midwives, NMC, 2015.
- <sup>6</sup> Article 10(2)(c) of the Order, Rule 13(1)(b)(ii) of the Rules.
- <sup>7</sup> Standards set under Article 19(3) of the Order.
- <sup>8</sup> Rule 3 of The Nursing and Midwifery Council (Midwives) Rules Order of Council 2012 (SI 2012/3025).
- <sup>9</sup> Standards set under Article 19(3) of the Order.
- <sup>10</sup> Standard set under Article 19(3) of the Order.
- <sup>11</sup> Standards set under Article 19(1) of the Order.
- <sup>12</sup> Standards set under Article 19(1) of the Order.
- <sup>24</sup> Standards set under Article 19(1) of the Order and under rule 13(1)(b)(i) of the Rules.
- <sup>14</sup> Standards set under Article 19(1) of the Order .
- <sup>15</sup> Standards set under Article 19(1) of the Order.
- <sup>16</sup> Standards set under Article 19(1) of the Order.
- <sup>17</sup> Standards set under Article 19(1) of the Order.
- <sup>18</sup> Rule 13(1)(b)(i).
- <sup>19</sup> Rule 13(1)(a) of the Rules.
- <sup>20</sup> Rule 13(1)(a) and paragraph 2 of Schedule 4 of the Rules.
- <sup>21</sup> Rule 13(1)(a) and Rules 6(6)(d) and 6(6)(e).
- <sup>22</sup> Rule 6(6)(c).
- <sup>23</sup> Rule 6(6)(d) and Rule 6(6)(e).
- <sup>24</sup> Rule 6(6)(c) of the Rules.
- <sup>25</sup> Article 10(2)(aa) of the Order and Rule 13(1)(aa) of the Rules.
- <sup>26</sup> Paragraph 1(h)(ii) of Schedule 4 of the Rules.
- <sup>27</sup> Rule 13(1)(d) of the Rules.
- <sup>28</sup> Rule 3 of The Nursing and Midwifery Council (Midwives) Rules Order of Council 2012 (SI 2012/3025).
- <sup>29</sup> Rule 13(1)(d) of the Rules.
- <sup>30</sup> Rule 14(5) of the Rules.
- <sup>31</sup> We cannot extend any application beyond three months. Rule 14(5) of the Rules.
- <sup>32</sup> Rule 13(1)(d).
- <sup>33</sup> Article 44 of the Nursing and Midwifery Order 2001.
- <sup>34</sup> Article 37(1)(a) of the Order.
- <sup>35</sup> Article 37(1)(a) of the NMC Order 2001 and the Rules 19, 20 and 21 of the Registration Rules.
- <sup>36</sup> Article 37(2) of the Order.
- <sup>37</sup> Article 44 of the Nursing and Midwifery Order 2001.







23 Portland Place, London W1B 1PZ

T +44 20 7333 9333

[www.nmc.org.uk](http://www.nmc.org.uk)

The nursing and midwifery regulator for England, Wales, Scotland and Northern Ireland

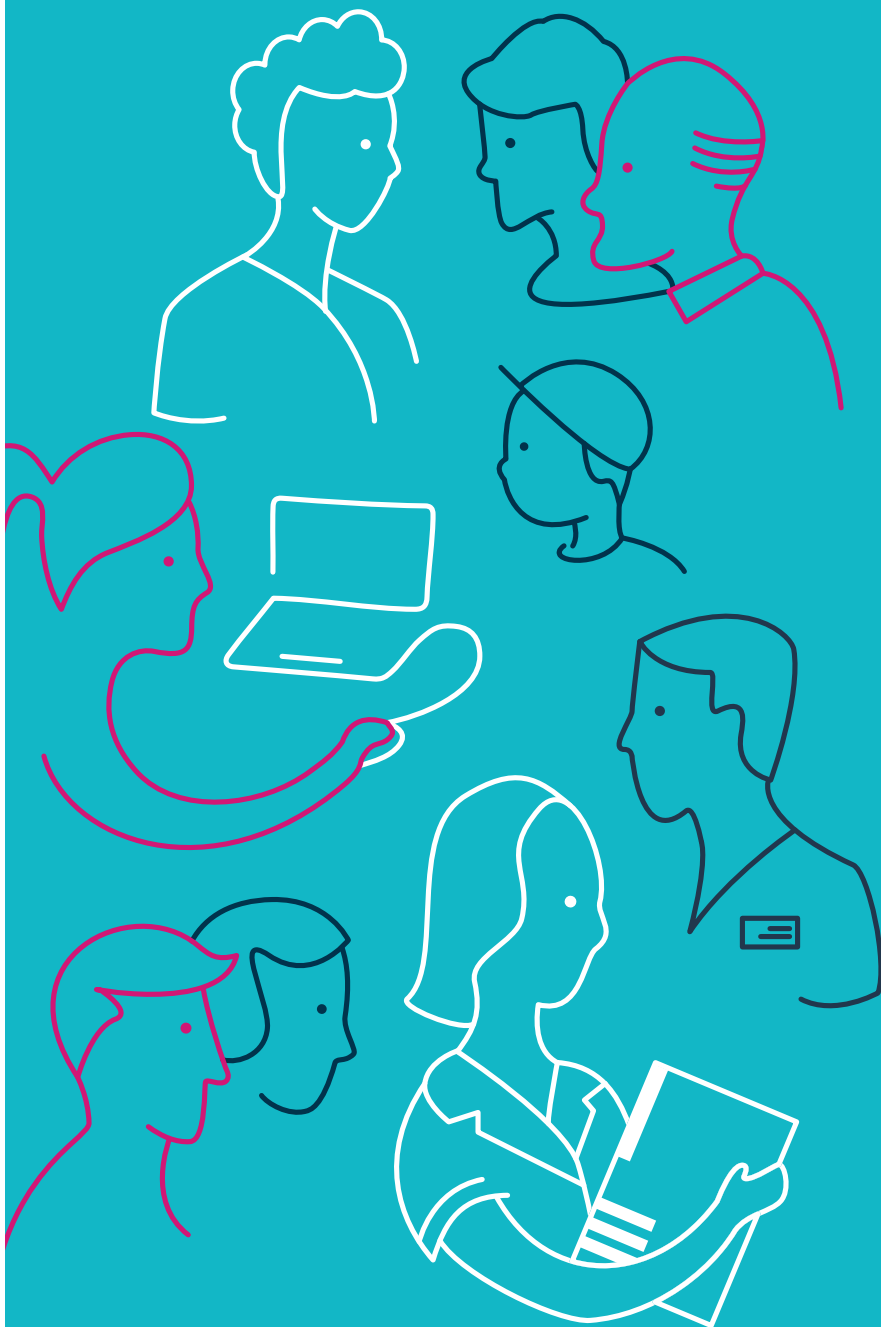
Registered charity in England and Wales (1091434) and in Scotland (SC038362)

**NMC** Nursing &  
Midwifery  
Council

# Future nurse: Standards of proficiency for registered nurses

---

Published 17 May 2018



# Contents

Introduction	3
The role of the nurse in the 21st century	3
How the proficiencies have been structured	6
<b>Platform 1</b> Being an accountable professional	7
<b>Platform 2</b> Promoting health and preventing ill health	10
<b>Platform 3</b> Assessing needs and planning care	13
<b>Platform 4</b> Providing and evaluating care	16
<b>Platform 5</b> Leading and managing nursing care and working in teams	19
<b>Platform 6</b> Improving safety and quality of care	21
<b>Platform 7</b> Coordinating care	24
<b>Annexe A: Communication and relationship management skills</b>	27
<b>Annexe B: Nursing procedures</b>	31
<b>Glossary</b>	38





# Future nurse: Standards of proficiency for registered nurses

## Introduction

The Nursing and Midwifery Council has a duty to review the standards of proficiency it sets for the professions it registers on a regular basis to ensure that standards remain contemporary and fit for purpose in order to protect the public. In reviewing the standards, we have taken into account the changes that are taking place in society and health care, and the implications these have for registered nurses of the future in terms of their role, knowledge and skill requirements.

The proficiencies in this document therefore specify the knowledge and skills that registered nurses must demonstrate when caring for [people](#) of all ages and across all care settings. They reflect what the public can expect nurses to know and be able to do in order to deliver safe, compassionate and effective nursing care. They also provide a benchmark for nurses from the European Economic Area (EEA), European Union (EU) and overseas wishing to join the UK register, as well as for those who plan to return to practice after a period of absence.

## The role of the nurse in the 21st century

Registered nurses play a vital role in providing, leading and coordinating care that is compassionate, evidence-based, and [person-centred](#). They are accountable for their own actions and must be able to work autonomously, or as an equal partner with a range of other professionals, and in interdisciplinary teams. In order to respond to the impact and demands of professional nursing practice, they must be emotionally intelligent and resilient individuals, who are able to manage their own personal health and wellbeing, and know when and how to access support.

Registered nurses make an important contribution to the promotion of health, health protection and the prevention of ill health. They do this by empowering people, communities and populations to exercise choice, take control of their own health decisions and behaviours, and by supporting people to manage their own care where possible.

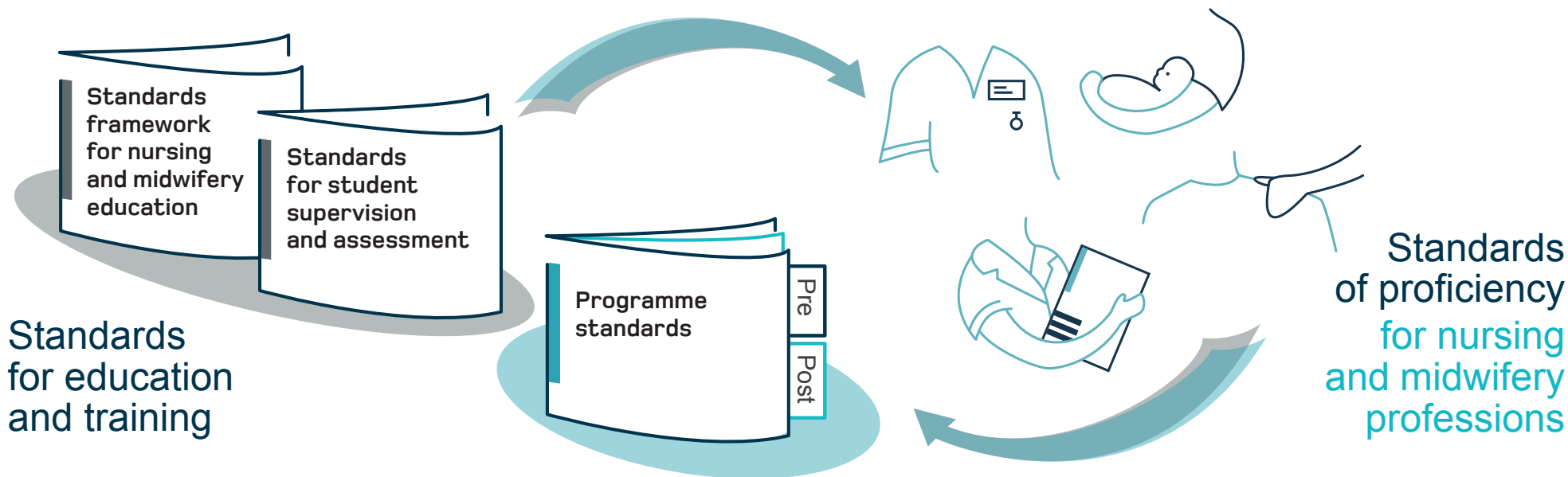
Registered nurses provide leadership in the delivery of care for people of all ages and from different backgrounds, cultures and beliefs. They provide nursing care for people who have complex mental, physical, [cognitive](#) and behavioural care needs, those living with dementia, the elderly, and for people at the end of their life. They must be able to care for people in their own home, in the community or hospital or in any health care settings where their needs are supported and managed. They work in the context of continual change, challenging environments, different models of care delivery, shifting demographics, innovation, and rapidly evolving technologies. Increasing integration of health and social care services will require registered nurses to negotiate boundaries and play a proactive role in interdisciplinary teams. The confidence and ability to think critically, apply knowledge and skills, and provide expert, evidence-based, direct nursing care therefore lies at the centre of all registered nursing practice.

## About these standards

These standards of proficiency apply to all NMC registered nurses. They should be read with *Realising professionalism: Standards for education and training* which set out our expectations regarding delivery of all pre-registration and post-registration NMC approved nursing and midwifery education programmes. These standards apply to all approved education providers and are set out in three parts: Part 1: *Standards framework for nursing and midwifery education*; Part 2: *Standards for student supervision and assessment*; and Part 3: *Programme standards*, which are the

standards specific for each pre-registration or post-registration programme. Education institutions must comply with our standards to be approved to run any NMC approved programmes.

Together these standards aim to provide approved education institutions (AEIs) and their practice learning partners with the flexibility to develop innovative approaches to education for nurses, midwives and nursing associates, while being accountable for the local delivery and management of approved programmes in line with our standards.





## Legislative framework

---

Article 15(1) of the Nursing and Midwifery Order 2001 ([‘the Order’](#)) requires the Council to establish standards for education and training which are necessary to achieve the standards of proficiency for admission to the register, as required by Article 5(2) of the Order. The standards for nursing and midwifery education providers are established under the provision of Article 15(1) of the Order.

Article 5(2) of the Nursing and Midwifery Order 2001 requires the NMC to establish standards of proficiency necessary to be admitted to each part of the register and for safe and effective practice under that part of the register. The standards of proficiency have been established under this provision.



# Future nurse: Standards of proficiency for registered nurses

## How the proficiencies have been structured

The proficiencies are grouped under seven platforms, followed by two annexes. Together, these reflect what we expect a newly registered nurse to know and be capable of doing safely and proficiently at the start of their career.

Key components of the roles, responsibilities and accountabilities of registered nurses are described under each of the seven platforms. We believe that this approach provides clarity to the public and the professions about the core knowledge and skills that they can expect every registered nurse to demonstrate.

These proficiencies will provide new graduates into the profession with the knowledge and skills they need at the point of registration which they will build upon as they gain experience in practice and fulfil their professional responsibility to continuously update their knowledge and skills. For example, after they register with us registered nurses will already be equipped to progress to the completion of a prescribing qualification.

## The platforms are:

1. [Being an accountable professional](#)
2. [Promoting health and preventing ill health](#)
3. [Assessing needs and planning care](#)
4. [Providing and evaluating care](#)
5. [Leading and managing nursing care and working in teams](#)
6. [Improving safety and quality of care](#)
7. [Coordinating care](#)

The outcome statements for each platform have been designed to apply across all four fields of nursing practice (adult, children, learning disabilities, mental health) and all care settings. This is because registered nurses must be able to meet the person-centred, holistic care needs of the people they encounter in their practice who may be at any stage of life and who may have a range of mental, physical, cognitive or behavioural health challenges. They must also be able to demonstrate a greater depth of knowledge and the additional more advanced skills required to meet the specific care needs of people in their chosen fields of nursing practice.

The annexes to these standards of proficiency are presented in two sections. The annexes provide a description of what registered nurses should be able to demonstrate they can do at the point of registration in order to provide safe nursing care. [Annexe A](#) specifies the communication and relationship management skills required, and [Annexe B](#) specifies the nursing procedures that registered nurses must demonstrate that they are able to perform safely. As with the knowledge proficiencies, the annexes also identify where more advanced skills are required by registered nurses, working in a particular field of nursing practice.

Being an  
accountable  
professional

Promoting  
health and preventing  
ill health

Assessing  
needs and  
planning care

Providing and  
evaluating care

Leading and managing  
nursing care  
and working in teams

Improving  
safety and  
quality of care

Coordinating  
care

Annexe A:  
Communication  
and relationship  
management skills

Annexe B:  
Nursing procedures

# Platform 1

## Being an accountable professional

Registered nurses act in the best interests of people, putting them first and providing nursing care that is person-centred, safe and compassionate. They act professionally at all times and use their knowledge and experience to make evidence-based decisions about care. They communicate effectively, are role models for others, and are accountable for their actions. Registered nurses continually reflect on their practice and keep abreast of new and emerging developments in nursing, health and care.



Being an accountable professional	Promoting health and preventing ill health	Assessing needs and planning care	Providing and evaluating care	Leading and managing nursing care and working in teams	Improving safety and quality of care	Coordinating care	Annexe A: Communication and relationship management skills	Annexe B: Nursing procedures
-----------------------------------	--	-----------------------------------	-------------------------------	--	--------------------------------------	-------------------	--	------------------------------

## 1. Outcomes:

The outcomes set out below reflect the proficiencies for accountable professional practice that must be applied across the standards of proficiency for registered nurses, as described in platforms 2-7, in all care settings and areas of practice.

### At the point of registration, the registered nurse will be able to:

- |   |   |
|---|---|
| <p>1.1 understand and act in accordance with <a href="#">the Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates</a>, and fulfil all registration requirements</p> <p>1.2 understand and apply relevant legal, regulatory and governance requirements, policies, and ethical frameworks, including any mandatory reporting duties, to all areas of practice, differentiating where appropriate between the devolved legislatures of the United Kingdom</p> <p>1.3 understand and apply the principles of courage, transparency and the professional <a href="#">duty of candour</a>, recognising and reporting any situations, behaviours or errors that could result in poor care outcomes</p> <p>1.4 demonstrate an understanding of, and the ability to challenge, discriminatory behaviour</p> | <p>1.5 understand the demands of professional practice and demonstrate how to recognise signs of vulnerability in themselves or their colleagues and the action required to minimise risks to health</p> <p>1.6 understand the professional responsibility to adopt a healthy lifestyle to maintain the level of personal fitness and wellbeing required to meet people's needs for mental and physical care</p> <p>1.7 demonstrate an understanding of research methods, ethics and governance in order to critically analyse, safely use, share and apply research findings to promote and inform best nursing practice</p> <p>1.8 demonstrate the knowledge, skills and ability to think critically when applying evidence and drawing on experience to make evidence informed decisions in all situations</p> <p>1.9 understand the need to base all decisions regarding care and <a href="#">interventions</a> on people's needs and preferences, recognising and addressing any personal and external factors that may unduly influence their decisions</p> |
|---|---|

Being an accountable professional	Promoting health and preventing ill health	Assessing needs and planning care	Providing and evaluating care	Leading and managing nursing care and working in teams	Improving safety and quality of care	Coordinating care	Annexe A: Communication and relationship management skills	Annexe B: Nursing procedures
-----------------------------------	--	-----------------------------------	-------------------------------	--	--------------------------------------	-------------------	--	------------------------------

- 1.10 demonstrate resilience and emotional intelligence and be capable of explaining the rationale that influences their judgments and decisions in routine, complex and challenging situations
- 1.11 communicate effectively using a range of skills and strategies with colleagues and people at all stages of life and with a range of mental, physical, cognitive and behavioural health challenges
- 1.12 demonstrate the skills and abilities required to support people at all stages of life who are emotionally or physically vulnerable
- 1.13 demonstrate the skills and abilities required to develop, manage and maintain appropriate relationships with people, their families, carers and colleagues
- 1.14 provide and promote non-discriminatory, person-centred and sensitive care at all times, reflecting on people's values and beliefs, diverse backgrounds, cultural characteristics, language requirements, needs and preferences, taking account of any need for adjustments
- 1.15 demonstrate the numeracy, literacy, digital and technological skills required to meet the needs of people in their care to ensure safe and effective nursing practice
- 1.16 demonstrate the ability to keep complete, clear, accurate and timely records
- 1.17 take responsibility for continuous [self-reflection](#), seeking and responding to support and feedback to develop their professional knowledge and skills
- 1.18 demonstrate the knowledge and confidence to contribute effectively and proactively in an interdisciplinary team
- 1.19 act as an ambassador, upholding the reputation of their profession and promoting public confidence in nursing, health and care services, and
- 1.20 safely demonstrate evidence-based practice in all skills and procedures stated in Annexes A and B.

Being an  
accountable  
professional

Promoting  
health and preventing  
ill health

Assessing  
needs and  
planning care

Providing and  
evaluating care

Leading and managing  
nursing care  
and working in teams

Improving  
safety and  
quality of care

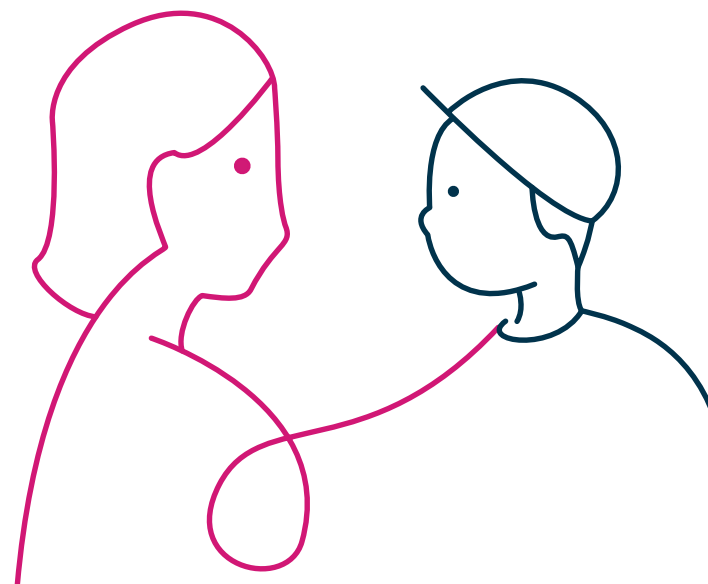
Coordinating  
care

Annexe A:  
Communication  
and relationship  
management skills

Annexe B:  
Nursing procedures

## Platform 2 Promoting health and preventing ill health

Registered nurses play a key role in improving and maintaining the mental, physical and behavioural health and well-being of people, families, communities and populations. They support and enable people at all stages of life and in all care settings to make informed choices about how to manage health challenges in order to maximise their quality of life and improve health outcomes. They are actively involved in the prevention of and protection against disease and ill health and engage in public health, community development and global health agendas, and in the reduction of health inequalities.



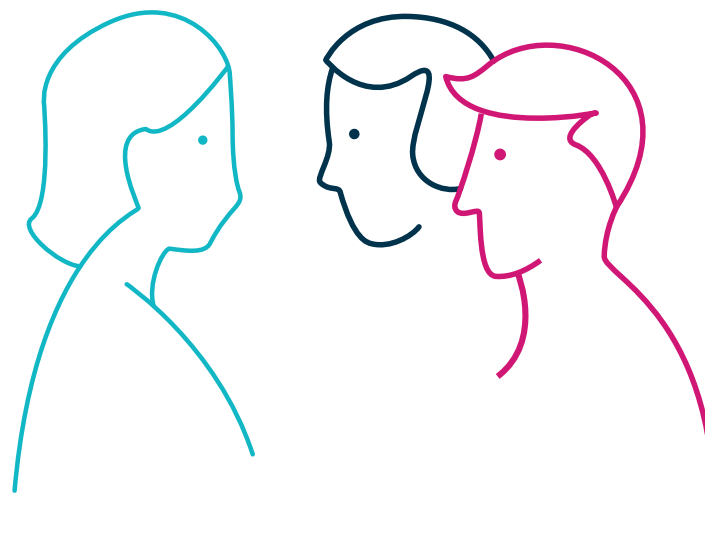
Being an accountable professional	Promoting health and preventing ill health	Assessing needs and planning care	Providing and evaluating care	Leading and managing nursing care and working in teams	Improving safety and quality of care	Coordinating care	Annexe A: Communication and relationship management skills	Annexe B: Nursing procedures
-----------------------------------	--	-----------------------------------	-------------------------------	--	--------------------------------------	-------------------	--	------------------------------

## 2. Outcomes:

The proficiencies identified below will equip the newly registered nurse with the underpinning knowledge and skills required for their role in health promotion and protection and prevention of ill health.

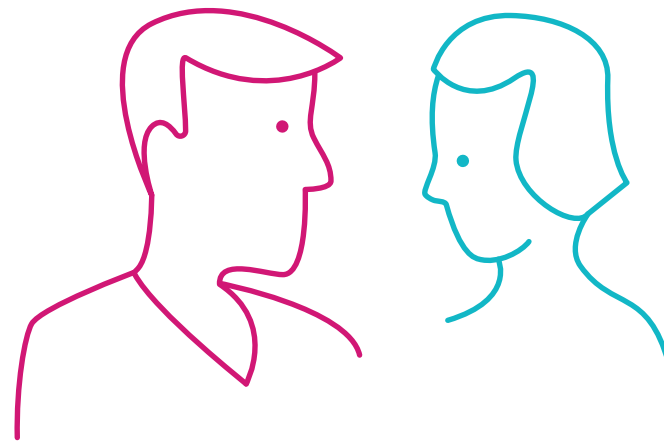
**At the point of registration, the registered nurse will be able to:**

- 2.1 understand and apply the aims and principles of health promotion, protection and improvement and the prevention of ill health when engaging with people
- 2.2 demonstrate knowledge of epidemiology, [demography](#), [genomics](#) and the wider determinants of health, illness and wellbeing and apply this to an understanding of global patterns of health and wellbeing outcomes
- 2.3 understand the factors that may lead to inequalities in health outcomes
- 2.4 identify and use all appropriate opportunities, making reasonable adjustments when required, to discuss the impact of smoking, substance and alcohol use, sexual behaviours, diet and exercise on mental, physical and behavioural health and wellbeing, in the context of people's individual circumstances



Being an accountable professional	Promoting health and preventing ill health	Assessing needs and planning care	Providing and evaluating care	Leading and managing nursing care and working in teams	Improving safety and quality of care	Coordinating care	Annexe A: Communication and relationship management skills	Annexe B: Nursing procedures
-----------------------------------	--	-----------------------------------	-------------------------------	--	--------------------------------------	-------------------	--	------------------------------

- 2.5 promote and improve mental, physical, behavioural and other health related outcomes by understanding and explaining the principles, practice and evidence-base for health screening programmes
- 2.6 understand the importance of early years and childhood experiences and the possible impact on life choices, mental, physical and behavioural health and wellbeing
- 2.7 understand and explain the contribution of social influences, [health literacy](#), individual circumstances, behaviours and lifestyle choices to mental, physical and behavioural health outcomes
- 2.8 explain and demonstrate the use of up to date approaches to behaviour change to enable people to use their strengths and expertise and make informed choices when managing their own health and making lifestyle adjustments
- 2.9 use appropriate communication skills and [strength based approaches](#) to support and enable people to make informed choices about their care to manage health challenges in order to have satisfying and fulfilling lives within the limitations caused by reduced capability, ill health and disability
- 2.10 provide information in accessible ways to help people understand and make decisions about their health, life choices, illness and care
- 2.11 promote health and prevent ill health by understanding and explaining to people the principles of pathogenesis, immunology and the evidence-base for immunisation, vaccination and herd immunity, and
- 2.12 protect health through understanding and applying the principles of infection prevention and control, including communicable disease surveillance and antimicrobial stewardship and resistance.





Being an  
accountable  
professional

Promoting  
health and preventing  
ill health

Assessing  
needs and  
planning care

Providing and  
evaluating care

Leading and managing  
nursing care  
and working in teams

Improving  
safety and  
quality of care

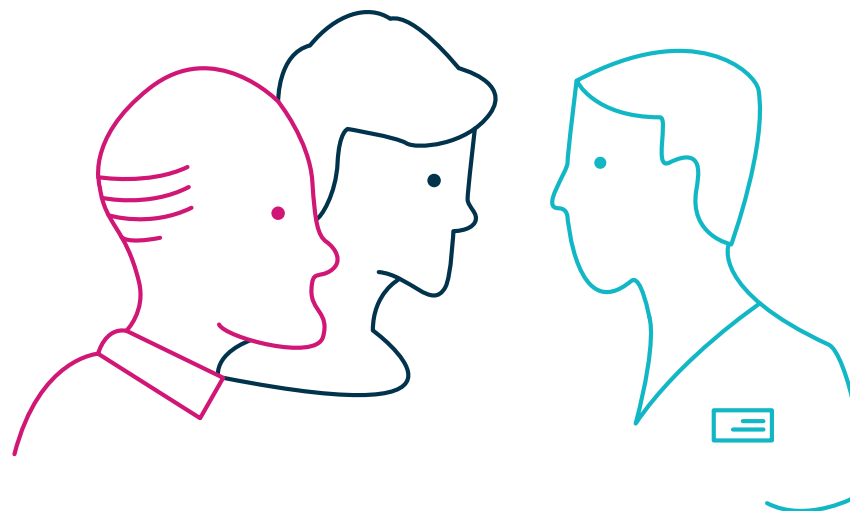
Coordinating  
care

Annexe A:  
Communication  
and relationship  
management skills

Annexe B:  
Nursing procedures

## Platform 3 Assessing needs and planning care

Registered nurses prioritise the needs of people when assessing and reviewing their mental, physical, cognitive, behavioural, social and spiritual needs. They use information obtained during assessments to identify the priorities and requirements for person-centred and evidence-based nursing interventions and support. They work in partnership with people to develop person-centred care plans that take into account their circumstances, characteristics and preferences.



Being an accountable professional	Promoting health and preventing ill health	Assessing needs and planning care	Providing and evaluating care	Leading and managing nursing care and working in teams	Improving safety and quality of care	Coordinating care	Annexe A: Communication and relationship management skills	Annexe B: Nursing procedures
-----------------------------------	--	-----------------------------------	-------------------------------	--	--------------------------------------	-------------------	--	------------------------------

### 3. Outcomes:

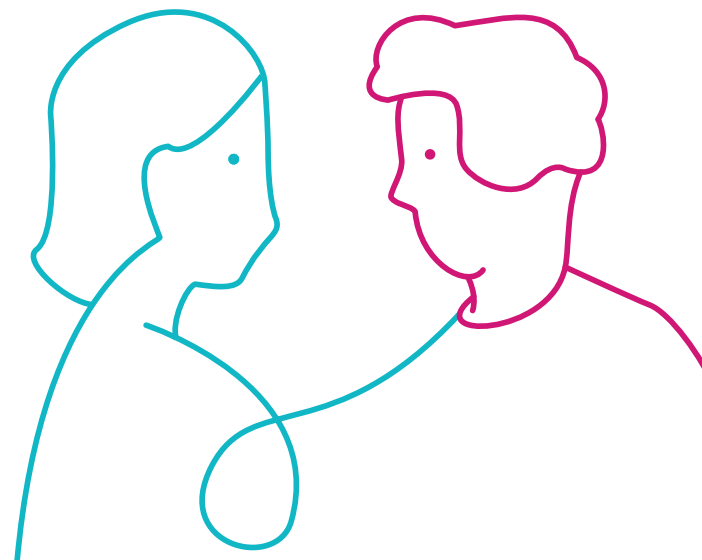
The proficiencies identified below will equip the newly registered nurse with the underpinning knowledge and skills required for their role in assessing and initiating person-centred plans of care.

**At the point of registration, the registered nurse will be able to:**

- 3.1 demonstrate and apply knowledge of human development from conception to death when undertaking full and accurate person-centred nursing assessments and developing appropriate care plans
- 3.2 demonstrate and apply knowledge of body systems and homeostasis, human anatomy and physiology, biology, genomics, pharmacology and social and behavioural sciences when undertaking full and accurate person-centred nursing assessments and developing appropriate care plans
- 3.3 demonstrate and apply knowledge of all commonly encountered mental, physical, behavioural and cognitive health conditions, medication usage and treatments when undertaking full and accurate assessments of nursing care needs and when developing, prioritising and reviewing person-centred care plans
- 3.4 understand and apply a person-centred approach to nursing care, demonstrating shared assessment, planning, decision making and goal setting when working with people, their families, communities and populations of all ages
- 3.5 demonstrate the ability to accurately process all information gathered during the assessment process to identify needs for individualised nursing care and develop person-centred evidence-based plans for nursing interventions with agreed goals
- 3.6 effectively assess a person's capacity to make decisions about their own care and to give or withhold consent
- 3.7 understand and apply the principles and processes for making reasonable adjustments
- 3.8 understand and apply the relevant laws about mental capacity for the country in which you are practising when making decisions in relation to people who do not have capacity

Being an accountable professional	Promoting health and preventing ill health	Assessing needs and planning care	Providing and evaluating care	Leading and managing nursing care and working in teams	Improving safety and quality of care	Coordinating care	Annexe A: Communication and relationship management skills	Annexe B: Nursing procedures
-----------------------------------	--	-----------------------------------	-------------------------------	--	--------------------------------------	-------------------	--	------------------------------

- 3.9 recognise and assess people at risk of harm and the situations that may put them at risk, ensuring prompt action is taken to safeguard those who are [vulnerable](#)
- 3.10 demonstrate the skills and abilities required to recognise and assess people who show signs of self-harm and/or suicidal ideation
- 3.11 undertake routine investigations, interpreting and sharing findings as appropriate
- 3.12 interpret results from routine investigations, taking prompt action when required by implementing appropriate interventions, requesting additional investigations or escalating to others
- 3.13 demonstrate an understanding of [co-morbidities](#) and the demands of meeting people's complex nursing and social care needs when prioritising care plans
- 3.14 identify and assess the needs of people and families for care at the end of life, including requirements for palliative care and decision making related to their treatment and care preferences
- 3.15 demonstrate the ability to work in partnership with people, families and carers to continuously monitor, evaluate and reassess the effectiveness of all agreed nursing care plans and care, sharing decision making and readjusting agreed goals, documenting progress and decisions made, and
- 3.16 demonstrate knowledge of when and how to refer people safely to other professionals or services for clinical intervention or support.



Being an  
accountable  
professional

Promoting  
health and preventing  
ill health

Assessing  
needs and  
planning care

Providing and  
evaluating care

Leading and managing  
nursing care  
and working in teams

Improving  
safety and  
quality of care

Coordinating  
care

Annexe A:  
Communication  
and relationship  
management skills

Annexe B:  
Nursing procedures

## Platform 4 Providing and evaluating care

Registered nurses take the lead in providing evidence-based, compassionate and safe nursing interventions. They ensure that care they provide and delegate is person-centred and of a consistently high standard. They support people of all ages in a range of care settings. They work in partnership with people, families and carers to evaluate whether care is effective and the goals of care have been met in line with their wishes, preferences and desired outcomes.



Being an accountable professional	Promoting health and preventing ill health	Assessing needs and planning care	Providing and evaluating care	Leading and managing nursing care and working in teams	Improving safety and quality of care	Coordinating care	Annexe A: Communication and relationship management skills	Annexe B: Nursing procedures
-----------------------------------	--	-----------------------------------	-------------------------------	--	--------------------------------------	-------------------	--	------------------------------

## 4. Outcomes:

The proficiencies identified below will equip the newly registered nurse with the underpinning knowledge and skills required for their role in providing and evaluating person-centred care.

### At the point of registration, the registered nurse will be able to:

- |  |   |
|--|---|
| <p>4.1 demonstrate and apply an understanding of what is important to people and how to use this knowledge to ensure their needs for safety, dignity, privacy, comfort and sleep can be met, acting as a role model for others in providing evidence based person-centred care</p> <p>4.2 work in partnership with people to encourage shared decision making in order to support individuals, their families and carers to manage their own care when appropriate</p> <p>4.3 demonstrate the knowledge, communication and relationship management skills required to provide people, families and carers with accurate information that meets their needs before, during and after a range of interventions</p> <p>4.4 demonstrate the knowledge and skills required to support people with commonly encountered mental health, behavioural, cognitive and learning challenges, and act as a role model for others in providing high quality nursing interventions to meet people's needs</p> | <p>4.5 demonstrate the knowledge and skills required to support people with commonly encountered physical health conditions, their medication usage and treatments, and act as a role model for others in providing high quality nursing interventions when meeting people's needs</p> <p>4.6 demonstrate the knowledge, skills and ability to act as a role model for others in providing <a href="#">evidence-based nursing care</a> to meet people's needs related to nutrition, hydration and bladder and bowel health</p> <p>4.7 demonstrate the knowledge, skills and ability to act as a role model for others in providing <a href="#">evidence-based, person-centred nursing care</a> to meet people's needs related to mobility, hygiene, oral care, wound care and skin integrity</p> <p>4.8 demonstrate the knowledge and skills required to identify and initiate appropriate interventions to support people with commonly encountered symptoms including anxiety, confusion, discomfort and pain</p> |
|--|---|

Being an accountable professional	Promoting health and preventing ill health	Assessing needs and planning care	Providing and evaluating care	Leading and managing nursing care and working in teams	Improving safety and quality of care	Coordinating care	Annexe A: Communication and relationship management skills	Annexe B: Nursing procedures
-----------------------------------	--	-----------------------------------	-------------------------------	--	--------------------------------------	-------------------	--	------------------------------

- 4.9 demonstrate the knowledge and skills required to prioritise what is important to people and their families when providing evidence-based person-centred nursing care at end of life including the care of people who are dying, families, the deceased and the bereaved
- 4.10 demonstrate the knowledge and ability to respond proactively and promptly to signs of deterioration or distress in mental, physical, cognitive and behavioural health and use this knowledge to make sound clinical decisions
- 4.11 demonstrate the knowledge and skills required to initiate and evaluate appropriate interventions to support people who show signs of self-harm and/or suicidal ideation
- 4.12 demonstrate the ability to manage commonly encountered devices and confidently carry out related nursing procedures to meet people's needs for evidence-based, person-centred care
- 4.13 demonstrate the knowledge, skills and confidence to provide first aid procedures and basic life support
- 4.14 understand the principles of safe and effective administration and optimisation of medicines in accordance with local and national policies and demonstrate proficiency and accuracy when calculating dosages of prescribed medicines
- 4.15 demonstrate knowledge of pharmacology and the ability to recognise the effects of medicines, allergies, drug sensitivities, side effects, contraindications, incompatibilities, adverse reactions, prescribing errors and the impact of polypharmacy and over the counter medication usage
- 4.16 demonstrate knowledge of how prescriptions can be generated, the role of generic, unlicensed, and off-label prescribing and an understanding of the potential risks associated with these approaches to prescribing
- 4.17 apply knowledge of pharmacology to the care of people, demonstrating the ability to progress to a prescribing qualification following registration, and
- 4.18 demonstrate the ability to co-ordinate and undertake the processes and procedures involved in routine planning and management of safe discharge home or transfer of people between care settings.

Being an  
accountable  
professional

Promoting  
health and preventing  
ill health

Assessing  
needs and  
planning care

Providing and  
evaluating care

Leading and managing  
nursing care  
and working in teams

Improving  
safety and  
quality of care

Coordinating  
care

Annexe A:  
Communication  
and relationship  
management skills

Annexe B:  
Nursing procedures

## Platform 5 Leading and managing nursing care and working in teams

Registered nurses provide leadership by acting as a role model for best practice in the delivery of nursing care. They are responsible for managing nursing care and are accountable for the appropriate delegation and supervision of care provided by others in the team including lay carers. They play an active and equal role in the interdisciplinary team, collaborating and communicating effectively with a range of colleagues.



Being an accountable professional	Promoting health and preventing ill health	Assessing needs and planning care	Providing and evaluating care	Leading and managing nursing care and working in teams	Improving safety and quality of care	Coordinating care	Annexe A: Communication and relationship management skills	Annexe B: Nursing procedures
-----------------------------------	--	-----------------------------------	-------------------------------	--	--------------------------------------	-------------------	--	------------------------------

## 5. Outcomes:

The proficiencies identified below will equip the newly registered nurse with the underpinning knowledge and skills required for their role in leading and managing nursing care and working effectively as part of an interdisciplinary team.

### At the point of registration, the registered nurse will be able to:

- 5.1 understand the principles of effective leadership, management, group and organisational dynamics and culture and apply these to team working and decision-making
- 5.2 understand and apply the principles of [human factors](#), environmental factors and strength-based approaches when working in teams
- 5.3 understand the principles and application of processes for performance management and how these apply to the nursing team
- 5.4 demonstrate an understanding of the roles, responsibilities and scope of practice of all members of the nursing and interdisciplinary team and how to make best use of the contributions of others involved in providing care
- 5.5 safely and effectively lead and manage the nursing care of a group of people, demonstrating appropriate prioritisation, delegation and assignment of care responsibilities to others involved in providing care
- 5.6 exhibit leadership potential by demonstrating an ability to guide, support and motivate individuals and interact confidently with other members of the care team
- 5.7 demonstrate the ability to monitor and evaluate the quality of care delivered by others in the team and lay carers
- 5.8 support and supervise students in the delivery of nursing care, promoting reflection and providing constructive feedback, and evaluating and documenting their performance
- 5.9 demonstrate the ability to challenge and provide constructive feedback about care delivered by others in the team, and support them to identify and agree individual learning needs
- 5.10 contribute to supervision and team reflection activities to promote improvements in practice and services
- 5.11 effectively and responsibly use a range of digital technologies to access, input, share and apply information and data within teams and between agencies, and
- 5.12 understand the mechanisms that can be used to influence organisational change and public policy, demonstrating the development of political awareness and skills.



Being an  
accountable  
professional

Promoting  
health and preventing  
ill health

Assessing  
needs and  
planning care

Providing and  
evaluating care

Leading and managing  
nursing care  
and working in teams

Improving  
safety and  
quality of care

Coordinating  
care

Annexe A:  
Communication  
and relationship  
management skills

Annexe B:  
Nursing procedures

## Platform 6 Improving safety and quality of care

Registered nurses make a key contribution to the continuous monitoring and quality improvement of care and treatment in order to enhance health outcomes and people's experience of nursing and related care. They assess risks to safety or experience and take appropriate action to manage those, putting the best interests, needs and preferences of people first.



Being an accountable professional	Promoting health and preventing ill health	Assessing needs and planning care	Providing and evaluating care	Leading and managing nursing care and working in teams	Improving safety and quality of care	Coordinating care	Annexe A: Communication and relationship management skills	Annexe B: Nursing procedures
-----------------------------------	--	-----------------------------------	-------------------------------	--	--------------------------------------	-------------------	--	------------------------------

## 6. Outcomes:

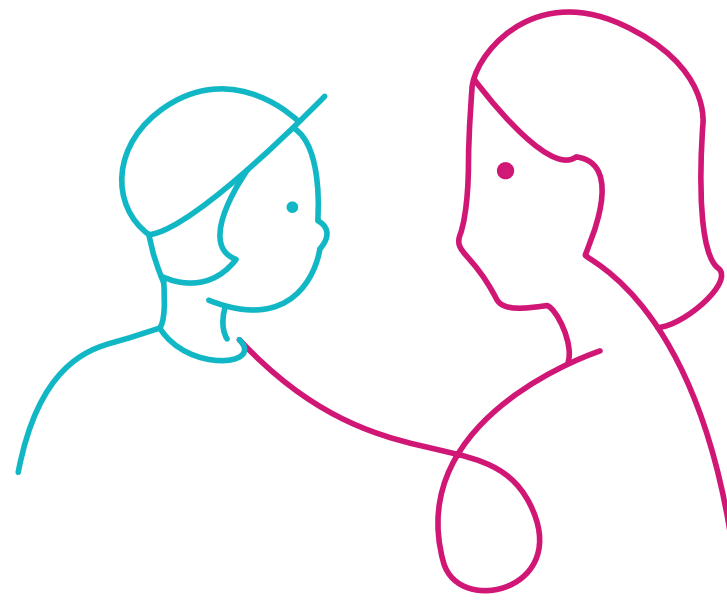
The proficiencies identified below will equip the newly registered nurse with the underpinning knowledge and skills required for their role in contributing to risk monitoring and quality of care improvement agendas.

### At the point of registration the registered nurse will be able to:

- 6.1 understand and apply the principles of health and safety legislation and regulations and maintain safe work and care environments
- 6.2 understand the relationship between safe staffing levels, appropriate skills mix, safety and quality of care, recognising risks to public protection and quality of care, escalating concerns appropriately
- 6.3 comply with local and national frameworks, legislation and regulations for assessing, managing and reporting risks, ensuring the appropriate action is taken
- 6.4 demonstrate an understanding of the principles of improvement methodologies, participate in all stages of audit activity and identify appropriate quality improvement strategies
- 6.5 demonstrate the ability to accurately undertake risk assessments in a range of care settings, using a range of contemporary assessment and improvement tools
- 6.6 identify the need to make improvements and proactively respond to potential hazards that may affect the safety of people
- 6.7 understand how the quality and effectiveness of nursing care can be evaluated in practice, and demonstrate how to use service delivery evaluation and audit findings to bring about continuous improvement
- 6.8 demonstrate an understanding of how to identify, report and critically reflect on near misses, critical incidents, major incidents and serious adverse events in order to learn from them and influence their future practice

Being an accountable professional	Promoting health and preventing ill health	Assessing needs and planning care	Providing and evaluating care	Leading and managing nursing care and working in teams	Improving safety and quality of care	Coordinating care	Annexe A: Communication and relationship management skills	Annexe B: Nursing procedures
-----------------------------------	--	-----------------------------------	-------------------------------	--	--------------------------------------	-------------------	--	------------------------------

- 6.9 work with people, their families, carers and colleagues to develop effective improvement strategies for quality and safety, sharing feedback and learning from positive outcomes and experiences, mistakes and adverse outcomes and experiences
- 6.10 apply an understanding of the differences between risk aversion and risk management and how to avoid compromising quality of care and health outcomes
- 6.11 acknowledge the need to accept and manage uncertainty, and demonstrate an understanding of strategies that develop resilience in self and others, and
- 6.12 understand the role of registered nurses and other health and care professionals at different levels of experience and seniority when managing and prioritising actions and care in the event of a major incident.



Being an  
accountable  
professional

Promoting  
health and preventing  
ill health

Assessing  
needs and  
planning care

Providing and  
evaluating care

Leading and managing  
nursing care  
and working in teams

Improving  
safety and  
quality of care

Coordinating  
care

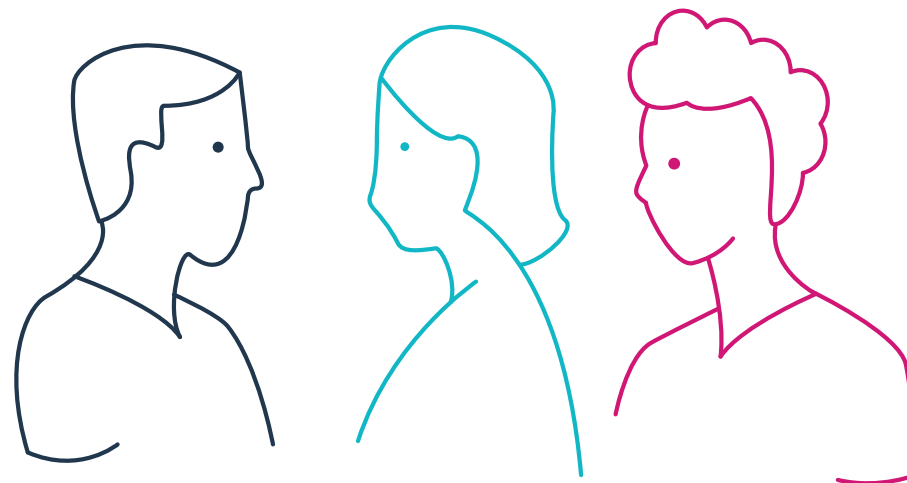
Annexe A:  
Communication  
and relationship  
management skills

Annexe B:  
Nursing procedures

# Platform 7

## Coordinating care

Registered nurses play a leadership role in coordinating and managing the complex nursing and integrated care needs of people at any stage of their lives, across a range of organisations and settings. They contribute to processes of organisational change through an awareness of local and national policies.



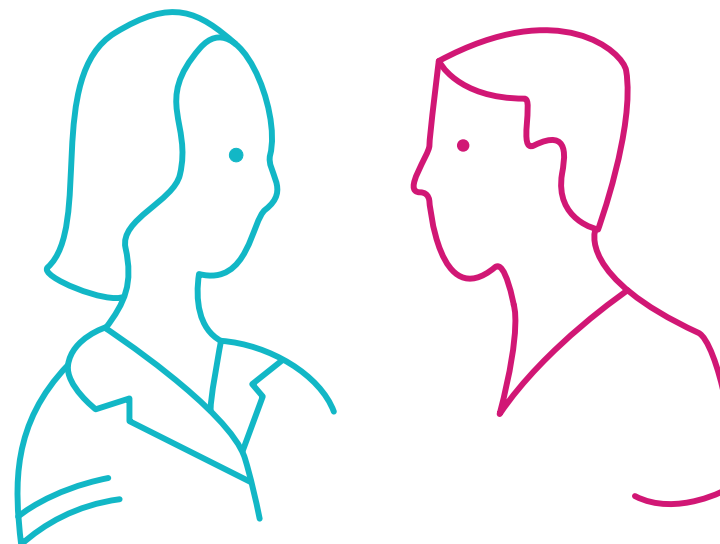
Being an accountable professional	Promoting health and preventing ill health	Assessing needs and planning care	Providing and evaluating care	Leading and managing nursing care and working in teams	Improving safety and quality of care	Coordinating care	Annexe A: Communication and relationship management skills	Annexe B: Nursing procedures
-----------------------------------	--	-----------------------------------	-------------------------------	--	--------------------------------------	-------------------	--	------------------------------

## 7. Outcomes:

The proficiencies identified below will equip the newly registered nurse with the underpinning knowledge and skills required for their role in coordinating and leading and managing the complex needs of people across organisations and settings.

### At the point of registration, the registered nurse will be able to:

- 7.1 understand and apply the principles of partnership, collaboration and interagency working across all relevant sectors
- 7.2 understand health legislation and current health and social care policies, and the mechanisms involved in influencing policy development and change, differentiating where appropriate between the devolved legislatures of the United Kingdom
- 7.3 understand the principles of [health economics](#) and their relevance to resource allocation in health and social care organisations and other agencies
- 7.4 identify the implications of current health policy and future policy changes for nursing and other professions and understand the impact of policy changes on the delivery and coordination of care



Being an accountable professional	Promoting health and preventing ill health	Assessing needs and planning care	Providing and evaluating care	Leading and managing nursing care and working in teams	Improving safety and quality of care	Coordinating care	Annexe A: Communication and relationship management skills	Annexe B: Nursing procedures
-----------------------------------	--	-----------------------------------	-------------------------------	--	--------------------------------------	-------------------	--	------------------------------

- 7.5 understand and recognise the need to respond to the challenges of providing safe, effective and person-centred nursing care for people who have co-morbidities and complex care needs
- 7.6 demonstrate an understanding of the complexities of providing mental, cognitive, behavioural and physical care services across a wide range of integrated care settings
- 7.7 understand how to monitor and evaluate the quality of people's experience of complex care
- 7.8 understand the principles and processes involved in supporting people and families with a range of care needs to maintain optimal independence and avoid unnecessary interventions and disruptions to their lives
- 7.9 facilitate equitable access to healthcare for people who are vulnerable or have a disability, demonstrate the ability to advocate on their behalf when required, and make necessary reasonable adjustments to the assessment, planning and delivery of their care

- 7.10 understand the principles and processes involved in planning and facilitating the safe discharge and transition of people between caseloads, settings and services
- 7.11 demonstrate the ability to identify and manage risks and take proactive measures to improve the quality of care and services when needed
- 7.12 demonstrate an understanding of the processes involved in developing a basic business case for additional care funding by applying knowledge of finance, resources and safe staffing levels, and
- 7.13 demonstrate an understanding of the importance of exercising political awareness throughout their career, to maximise the influence and effect of registered nursing on quality of care, patient safety and cost effectiveness.

Being an accountable professional

Promoting health and preventing ill health

Assessing needs and planning care

Providing and evaluating care

Leading and managing nursing care and working in teams

Improving safety and quality of care

Coordinating care

Annexe A:  
Communication and relationship management skillsAnnexe B:  
Nursing procedures

# Annexe A: Communication and relationship management skills

## Introduction

The communication and relationship management skills that a newly registered nurse must be able to demonstrate in order to meet the proficiency outcomes outlined in the main body of this document are set out in this annexe.

Effective communication is central to the provision of safe and compassionate person-centred care. Registered nurses in all fields of nursing practice must be able to demonstrate the ability to communicate and manage relationships with people of all ages with a range of mental, physical, cognitive and behavioural health challenges.

This is because a diverse range of communication and relationship management skills is required to ensure that individuals, their families and carers are actively involved in and understand care decisions. These skills are vital when making accurate, culturally aware assessments of care needs and ensuring that the needs, priorities, expertise and preferences of people are always valued and taken into account.

Where people have special communication needs or a disability, it is essential that reasonable adjustments are made in order to communicate, provide and share information in a manner that promotes optimum understanding and engagement and facilitates equal access to high quality care.

The communication and relationship management skills within this annexe are set out in four sections. For the reasons above, these requirements are relevant to all fields of nursing practice and apply to all care settings. It is expected that these skills would be assessed in a student's chosen field of practice.

Those skills outlined in **Annexe A, Section 3: Evidence-based, best practice communication skills and approaches for providing therapeutic interventions** also apply to all registered nurses, but the level of expertise and knowledge required will vary depending on the chosen field of practice. Registered nurses must be able to demonstrate these skills to an appropriate level for their intended field(s) of practice.

Being an accountable professional	Promoting health and preventing ill health	Assessing needs and planning care	Providing and evaluating care	Leading and managing nursing care and working in teams	Improving safety and quality of care	Coordinating care	<b>Annexe A: Communication and relationship management skills</b>	Annexe B: Nursing procedures
-----------------------------------	--	-----------------------------------	-------------------------------	--	--------------------------------------	-------------------	---	---------------------------------

At the point of registration, the registered nurse will be able to safely demonstrate the following skills:

**1. Underpinning communication skills for assessing, planning, providing and managing best practice, evidence-based nursing care**

- 1.1 actively listen, recognise and respond to verbal and non-verbal cues
- 1.2 use prompts and positive verbal and non-verbal reinforcement
- 1.3 use appropriate non-verbal communication including touch, eye contact and personal space
- 1.4 make appropriate use of open and closed questioning
- 1.5 use caring conversation techniques
- 1.6 check understanding and use clarification techniques
- 1.7 be aware of own unconscious bias in communication encounters
- 1.8 write accurate, clear, legible records and documentation
- 1.9 confidently and clearly present and share verbal and written reports with individuals and groups
- 1.10 analyse and clearly record and share digital information and data

- 1.11 provide clear verbal, digital or written information and instructions when delegating or handing over responsibility for care
- 1.12 recognise the need for, and facilitate access to, translator services and material.

**2. Evidence-based, best practice approaches to communication for supporting people of all ages, their families and carers in preventing ill health and in managing their care**

- 2.1 share information and check understanding about the causes, implications and treatment of a range of common health conditions including anxiety, depression, memory loss, diabetes, dementia, respiratory disease, cardiac disease, neurological disease, cancer, skin problems, immune deficiencies, psychosis, stroke and arthritis
- 2.2 use clear language and appropriate, written materials, making reasonable adjustments where appropriate in order to optimise people's understanding of what has caused their health condition and the implications of their care and treatment
- 2.3 recognise and accommodate sensory impairments during all communications
- 2.4 support and manage the use of personal communication aids



Being an accountable professional	Promoting health and preventing ill health	Assessing needs and planning care	Providing and evaluating care	Leading and managing nursing care and working in teams	Improving safety and quality of care	Coordinating care	Annexe A: Communication and relationship management skills	Annexe B: Nursing procedures
-----------------------------------	--	-----------------------------------	-------------------------------	--	--------------------------------------	-------------------	---	---------------------------------

- 2.5 identify the need for and manage a range of alternative communication techniques
- 2.6 use repetition and positive reinforcement strategies
- 2.7 assess motivation and capacity for behaviour change and clearly explain cause and effect relationships related to common health risk behaviours including smoking, obesity, sexual practice, alcohol and substance use
- 2.8 provide information and explanation to people, families and carers and respond to questions about their treatment and care and possible ways of preventing ill health to enhance understanding
- 2.9 engage in difficult conversations, including breaking bad news and support people who are feeling emotionally or physically vulnerable or in distress, conveying compassion and sensitivity.

### 3. Evidence-based, best practice communication skills and approaches for providing therapeutic interventions

- 3.1 motivational interview techniques
- 3.2 solution focused therapies
- 3.3 reminiscence therapies
- 3.4 talking therapies
- 3.5 de-escalation strategies and techniques
- 3.6 cognitive behavioural therapy techniques
- 3.7 play therapy
- 3.8 distraction and diversion strategies
- 3.9 positive behaviour support approaches

Being an accountable professional	Promoting health and preventing ill health	Assessing needs and planning care	Providing and evaluating care	Leading and managing nursing care and working in teams	Improving safety and quality of care	Coordinating care	Annexe A: Communication and relationship management skills	Annexe B: Nursing procedures
-----------------------------------	--	-----------------------------------	-------------------------------	--	--------------------------------------	-------------------	--	------------------------------

#### 4. Evidence-based, best practice communication skills and approaches for working with people in professional teams

- 4.1 Demonstrate effective supervision, teaching and performance appraisal through the use of:
  - 4.1.1 clear instructions and explanations when supervising, teaching or appraising others
  - 4.1.2 clear instructions and check understanding when delegating care responsibilities to others
  - 4.1.3 unambiguous, constructive feedback about strengths and weaknesses and potential for improvement
  - 4.1.4 encouragement to colleagues that helps them to reflect on their practice
  - 4.1.5 unambiguous records of performance
- 4.2 Demonstrate effective person and team management through the use of:
  - 4.2.1 strengths based approaches to developing teams and managing change
  - 4.2.2 active listening when dealing with team members' concerns and anxieties
  - 4.2.3 a calm presence when dealing with conflict

- 4.2.4 appropriate and effective confrontation strategies
- 4.2.5 de-escalation strategies and techniques when dealing with conflict
- 4.2.6 effective co-ordination and navigation skills through:
  - 4.2.6.1 appropriate negotiation strategies
  - 4.2.6.2 appropriate escalation procedures
  - 4.2.6.3 appropriate approaches to advocacy.

Being an accountable professional

Promoting health and preventing ill health

Assessing needs and planning care

Providing and evaluating care

Leading and managing nursing care and working in teams

Improving safety and quality of care

Coordinating care

Annexe A:  
Communication and relationship management skillsAnnexe B:  
Nursing procedures

# Annexe B: Nursing procedures

## Introduction

The nursing procedures that a newly registered nurse must be able to demonstrate in order to meet the proficiency outcomes, outlined in the main body of this document, are set out in this annexe.

The registered nurse must be able to undertake these procedures effectively in order to provide compassionate, evidence-based person-centred nursing care. A holistic approach to the care of people is essential and all nursing procedures should be carried out in a way which reflects cultural awareness and ensures that the needs, priorities, expertise and preferences of people are always valued and taken into account.

Registered nurses in all fields of practice must demonstrate the ability to provide nursing intervention and support for people of all ages who require nursing procedures during the processes of assessment, diagnosis, care and treatment for mental, physical, cognitive and behavioural health challenges. Where people are disabled or have specific cognitive needs it is essential that reasonable adjustments are made to ensure that all procedures are undertaken safely.

The nursing procedures within this annexe are set out in two sections. These requirements are relevant to all fields of nursing practice although it is recognised that different care settings may require different approaches to the provision of care. It is expected that these procedures would be assessed in a student's chosen field of practice where practicable.

Those procedures outlined in **Annexe B, Part I: Procedures for assessing needs for person-centred care, sections 1 and 2** also apply to all registered nurses, but the level of expertise and knowledge required will vary depending on the chosen field(s) of practice. Registered nurses must therefore be able to demonstrate the ability to undertake these procedures at an appropriate level for their intended field(s) of practice.

Being an accountable professional	Promoting health and preventing ill health	Assessing needs and planning care	Providing and evaluating care	Leading and managing nursing care and working in teams	Improving safety and quality of care	Coordinating care	Annexe A: Communication and relationship management skills	Annexe B: Nursing procedures
-----------------------------------	--	-----------------------------------	-------------------------------	--	--------------------------------------	-------------------	--	------------------------------

At the point of registration, the registered nurse will be able to safely demonstrate the following procedures:

### Part 1: Procedures for assessing people's needs for person-centred care

#### 1. Use evidence-based, best practice approaches to take a history, observe, recognise and accurately assess people of all ages:

- 1.1 mental health and wellbeing status
  - 1.1.1 signs of mental and emotional distress or vulnerability
  - 1.1.2 cognitive health status and wellbeing
  - 1.1.3 signs of cognitive distress and impairment
  - 1.1.4 behavioural distress based needs
  - 1.1.5 signs of mental and emotional distress including agitation, aggression and challenging behaviour
  - 1.1.6 signs of self-harm and/or suicidal ideation
- 1.2 physical health and wellbeing
  - 1.2.1 symptoms and signs of physical ill health
  - 1.2.2 symptoms and signs of physical distress
  - 1.2.3 symptoms and signs of deterioration and sepsis.

#### 2. Use evidence-based, best practice approaches to undertake the following procedures:

- 2.1 take, record and interpret vital signs manually and via technological devices
- 2.2 undertake venepuncture and cannulation and blood sampling, interpreting normal and common abnormal blood profiles and venous blood gases
- 2.3 set up and manage routine electrocardiogram (ECG) investigations and interpret normal and commonly encountered abnormal traces
- 2.4 manage and monitor blood component transfusions
- 2.5 manage and interpret cardiac monitors, infusion pumps, blood glucose monitors and other monitoring devices
- 2.6 accurately measure weight and height, calculate body mass index and recognise healthy ranges and clinically significant low/high readings
- 2.7 undertake a whole body systems assessment including respiratory, circulatory, neurological, musculoskeletal, cardiovascular and skin status
- 2.8 undertake chest auscultation and interpret findings
- 2.9 collect and observe sputum, urine, stool and vomit specimens, undertaking routine analysis and interpreting findings

Being an accountable professional	Promoting health and preventing ill health	Assessing needs and planning care	Providing and evaluating care	Leading and managing nursing care and working in teams	Improving safety and quality of care	Coordinating care	Annexe A: Communication and relationship management skills	Annexe B: Nursing procedures
-----------------------------------	--	-----------------------------------	-------------------------------	--	--------------------------------------	-------------------	--	------------------------------

- 2.10 measure and interpret blood glucose levels
- 2.11 recognise and respond to signs of all forms of [abuse](#)
- 2.12 undertake, respond to and interpret neurological observations and assessments
- 2.13 identify and respond to signs of deterioration and sepsis
- 2.14 administer basic mental health first aid
- 2.15 administer basic physical first aid
- 2.16 recognise and manage seizures, choking and anaphylaxis, providing appropriate basic life support
- 2.17 recognise and respond to challenging behaviour, providing appropriate safe holding and restraint.

## Part 2: Procedures for the planning, provision and management of person-centred nursing care

### 3. Use evidence-based, best practice approaches for meeting needs for care and support with rest, sleep, comfort and the maintenance of dignity, accurately assessing the person's capacity for independence and self-care and initiating appropriate interventions

- 3.1 observe and assess comfort and pain levels and rest and sleep patterns
- 3.2 use appropriate bed-making techniques including those required for people who are unconscious or who have limited mobility
- 3.3 use appropriate positioning and pressure-relieving techniques
- 3.4 take appropriate action to ensure privacy and dignity at all times
- 3.5 take appropriate action to reduce or minimise pain or discomfort
- 3.6 take appropriate action to reduce fatigue, minimise insomnia and support improved rest and sleep hygiene.

Being an accountable professional	Promoting health and preventing ill health	Assessing needs and planning care	Providing and evaluating care	Leading and managing nursing care and working in teams	Improving safety and quality of care	Coordinating care	Annexe A: Communication and relationship management skills	Annexe B: Nursing procedures
-----------------------------------	--	-----------------------------------	-------------------------------	--	--------------------------------------	-------------------	--	------------------------------

**4. Use evidence-based, best practice approaches for meeting the needs for care and support with hygiene and the maintenance of skin integrity, accurately assessing the person's capacity for independence and self-care and initiating appropriate interventions**

- 4.1 observe, assess and optimise skin and hygiene status and determine the need for support and intervention
- 4.2 use contemporary approaches to the assessment of skin integrity and use appropriate products to prevent or manage skin breakdown
- 4.3 assess needs for and provide appropriate assistance with washing, bathing, shaving and dressing
- 4.4 identify and manage skin irritations and rashes
- 4.5 assess needs for and provide appropriate oral, dental, eye and nail care and decide when an onward referral is needed
- 4.6 use aseptic techniques when undertaking wound care including dressings, pressure bandaging, suture removal, and vacuum closures
- 4.7 use aseptic techniques when managing wound and drainage processes
- 4.8 assess, respond and effectively manage pyrexia and hypothermia.

**5. Use evidence-based, best practice approaches for meeting the needs for care and support with nutrition and hydration, accurately assessing the person's capacity for independence and self-care and initiating appropriate interventions**

- 5.1 observe, assess and optimise nutrition and hydration status and determine the need for intervention and support
- 5.2 use contemporary nutritional assessment tools
- 5.3 assist with feeding and drinking and use appropriate feeding and drinking aids
- 5.4 record fluid intake and output and identify, respond to and manage dehydration or fluid retention
- 5.5 identify, respond to and manage nausea and vomiting
- 5.6 insert, manage and remove oral/nasal/gastric tubes
- 5.7 manage artificial nutrition and hydration using oral, enteral and parenteral routes
- 5.8 manage the administration of IV fluids
- 5.9 manage fluid and nutritional infusion pumps and devices.

Being an accountable professional	Promoting health and preventing ill health	Assessing needs and planning care	Providing and evaluating care	Leading and managing nursing care and working in teams	Improving safety and quality of care	Coordinating care	Annexe A: Communication and relationship management skills	Annexe B: Nursing procedures
-----------------------------------	--	-----------------------------------	-------------------------------	--	--------------------------------------	-------------------	--	------------------------------

**6. Use evidence-based, best practice approaches for meeting needs for care and support with bladder and bowel health, accurately assessing the person's capacity for independence and self-care and initiating appropriate interventions**

- 6.1 observe and assess level of urinary and bowel continence to determine the need for support and intervention assisting with toileting, maintaining dignity and privacy and managing the use of appropriate aids
- 6.2 select and use appropriate continence products; insert, manage and remove catheters for all genders; and assist with self-catheterisation when required
- 6.3 manage bladder drainage
- 6.4 assess bladder and bowel patterns to identify and respond to constipation, diarrhoea and urinary and faecal retention
- 6.5 administer enemas and suppositories and undertake rectal examination and manual evacuation when appropriate
- 6.6 undertake stoma care identifying and using appropriate products and approaches.

**7. Use evidence-based, best practice approaches for meeting needs for care and support with mobility and safety, accurately assessing the person's capacity for independence and self-care and initiating appropriate interventions**

- 7.1 observe and use evidence-based risk assessment tools to determine need for support and intervention to optimise mobility and safety, and to identify and manage risk of falls using best practice risk assessment approaches
- 7.2 use a range of contemporary moving and handling techniques and mobility aids
- 7.3 use appropriate moving and handling equipment to support people with impaired mobility
- 7.4 use appropriate safety techniques and devices.

**8. Use evidence-based, best practice approaches for meeting needs for respiratory care and support, accurately assessing the person's capacity for independence and self-care and initiating appropriate interventions**

- 8.1 observe and assess the need for intervention and respond to restlessness, agitation and breathlessness using appropriate interventions

Being an accountable professional	Promoting health and preventing ill health	Assessing needs and planning care	Providing and evaluating care	Leading and managing nursing care and working in teams	Improving safety and quality of care	Coordinating care	Annexe A: Communication and relationship management skills	Annexe B: Nursing procedures
-----------------------------------	--	-----------------------------------	-------------------------------	--	--------------------------------------	-------------------	--	------------------------------

8.2 manage the administration of oxygen using a range of routes and best practice approaches

8.3 take and interpret peak flow and oximetry measurements

8.4 use appropriate nasal and oral suctioning techniques

8.5 manage inhalation, humidifier and nebuliser devices

8.6 manage airway and respiratory processes and equipment.

**9. Use evidence-based, best practice approaches for meeting needs for care and support with the prevention and management of infection, accurately assessing the person's capacity for independence and self-care and initiating appropriate interventions**

9.1 observe, assess and respond rapidly to potential infection risks using best practice guidelines

9.2 use standard precautions protocols

9.3 use effective aseptic, non-touch techniques

9.4 use appropriate personal protection equipment

9.5 implement isolation procedures

9.6 use evidence-based hand hygiene techniques

9.7 safely decontaminate equipment and environment

9.8 safely use and dispose of waste, laundry and sharps

9.9 safely assess and manage invasive medical devices and lines.

**10. Use evidence-based, best practice approaches for meeting needs for care and support at the end of life, accurately assessing the person's capacity for independence and self-care and initiating appropriate interventions**

10.1 observe, and assess the need for intervention for people, families and carers, identify, assess and respond appropriately to uncontrolled symptoms and signs of distress including pain, nausea, thirst, constipation, restlessness, agitation, anxiety and depression

10.2 manage and monitor effectiveness of symptom relief medication, infusion pumps and other devices

10.3 assess and review preferences and care priorities of the dying person and their family and carers

10.4 understand and apply organ and tissue donation protocols, advanced planning decisions, living wills and health and lasting powers of attorney for health

10.5 understand and apply DNACPR (do not attempt cardiopulmonary resuscitation) decisions and verification of expected death

10.6 provide care for the deceased person and the bereaved respecting cultural requirements and protocols.



Being an accountable professional	Promoting health and preventing ill health	Assessing needs and planning care	Providing and evaluating care	Leading and managing nursing care and working in teams	Improving safety and quality of care	Coordinating care	Annexe A: Communication and relationship management skills	Annexe B: Nursing procedures
-----------------------------------	--	-----------------------------------	-------------------------------	--	--------------------------------------	-------------------	--	------------------------------

## 11. Procedural competencies required for best practice, evidence-based medicines administration and optimisation

- |  |   |
|--|---|
| <p>11.1 carry out initial and continued assessments of people receiving care and their ability to self-administer their own medications</p> <p>11.2 recognise the various procedural routes under which medicines can be prescribed, supplied, dispensed and administered; and the laws, policies, regulations and guidance that underpin them</p> <p>11.3 use the principles of safe remote prescribing and directions to administer medicines</p> <p>11.4 undertake accurate drug calculations for a range of medications</p> <p>11.5 undertake accurate checks, including transcription and titration, of any direction to supply or administer a medicinal product</p> | <p>11.6 exercise professional accountability in ensuring the safe administration of medicines to those receiving care</p> <p>11.7 administer injections using intramuscular, subcutaneous, intradermal and intravenous routes and manage injection equipment</p> <p>11.8 administer medications using a range of routes</p> <p>11.9 administer and monitor medications using vascular access devices and enteral equipment</p> <p>11.10 recognise and respond to adverse or abnormal reactions to medications</p> <p>11.11 undertake safe storage, transportation and disposal of medicinal products.</p> |
|--|---|

Being an  
accountable  
professional

Promoting  
health and preventing  
ill health

Assessing  
needs and  
planning care

Providing and  
evaluating care

Leading and managing  
nursing care  
and working in teams

Improving  
safety and  
quality of care

Coordinating  
care

Annexe A:  
Communication  
and relationship  
management skills

Annexe B:  
Nursing procedures

# Glossary

**Abuse:** is something that may harm another person, or endanger their life, or violate their rights. The person responsible for the abuse may be doing this on purpose or may not realise the harm that they are doing. The type of abuse may be emotional, physical, sexual, psychological, material or financial, or may be due to neglect.

**Cognitive:** The mental processes of perception, memory, judgment, and reasoning.

**Co-morbidities:** the presence of one or more additional diseases or disorders that occur with a primary disease or disorder.

**Demography:** the study of statistics such as births, deaths, income, or the incidence of disease, which illustrate the changing structure of human populations.

**Evidence-based person-centred care/nursing care:** making sure that any care and treatment is given to people, by looking at what research has shown to be most effective. The judgment and experience of the nurse and the views of the person should also be taken into account when choosing which treatment is most likely to be successful for an individual.

**Genomics:** branch of molecular biology concerned with the structure, function, evolution, and mapping of genomes.

**Health economics:** a branch of economics concerned with issues related to efficiency, effectiveness, value and behaviour in the production and consumption of health and healthcare.

Being an accountable professional

Promoting health and preventing ill health

Assessing needs and planning care

Providing and evaluating care

Leading and managing nursing care and working in teams

Improving safety and quality of care

Coordinating care

Annexe A:  
Communication and relationship management skills

Annexe B:  
Nursing procedures

**Health literacy:** the degree to which individuals can obtain, process, and understand basic health information and services needed to make appropriate health decisions.

**Human factors:** environmental, organisational and job factors, and human and individual characteristics, which influence behaviour at work in a way which can affect health and safety.

**Interventions:** any investigations, procedures, or treatments given to a person.

**People:** individuals or groups who receive services from nurses, midwives and nursing associates, healthy and sick people, parents, children, families, carers, representatives, also including educators and students and other within and outside the learning environment.

**Person-centred:** an approach where the person is at the centre of the decision making processes and the design of their care needs, their nursing care and treatment plan.

**Self-Reflection/Reflection:** to carefully consider actions or decisions and learn from them.

**Strength-based approaches:** strength-based practice is a collaborative process between the person supported by services and those supporting them, working together to reach an outcome that draws on the person's strengths and assets.

**Vulnerable people:** those who at any age are at a higher risk of harm than others. Vulnerability might be in relation to a personal characteristic or a situation. The type of harm may be emotional, physical, sexual, psychological, material or financial, or may be due to neglect.

# The role of the Nursing and Midwifery Council

## What we do

We regulate nurses and midwives in the UK, and nursing associates in England. We exist to protect the public. We set standards of education, training, conduct and performance so that nurses, midwives and nursing associates can deliver high quality care throughout their careers.

We make sure nurses, midwives and nursing associates keep their skills and knowledge up to date and uphold our professional standards. We have clear and transparent processes to investigate professionals who fall short of our standards.

We maintain a register of nurses and midwives allowed to practise in the UK, and nursing associates allowed to practise in England.

**These standards were approved by Council at their meeting on 28 March 2018.**



Realising professionalism:  
Standards for education and training

---

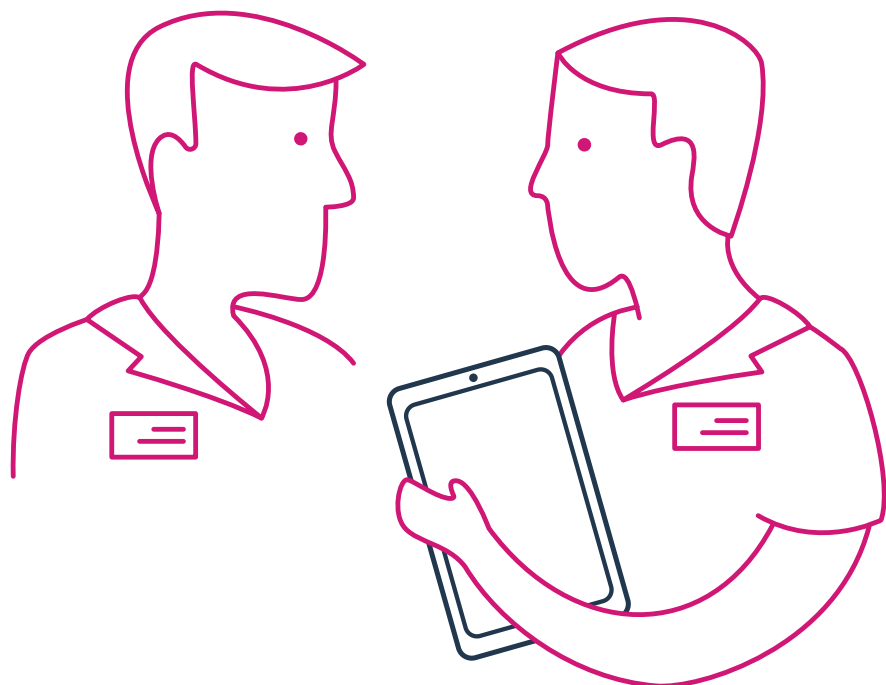
# Part 1: Standards framework for nursing and midwifery education

---

Published 17 May 2018

# About these standards

Realising professionalism: *Standards for education and training* includes the *Standards framework for nursing<sup>1</sup> and midwifery education, Standards for student supervision and assessment*, and programme standards specific to each approved programme.



Our *Standards for education and training* are set out in three parts:

## Part 1: Standards framework for nursing and midwifery education

## Part 2: Standards for student supervision and assessment

## Part 3: Programme standards

- Standards for pre-registration nursing education
- Standards for pre-registration nursing associate education
- Standards for prescribing programmes

These standards help nursing and midwifery [students](#) achieve proficiencies and programme outcomes. All nursing and midwifery professionals must practise in line with the requirements of [The Code](#), the professional standards of practice and behaviour that nurses, midwives and nursing associates are expected to uphold.

<sup>1</sup> We have used the phrase 'nursing' in this document to apply to the work of nurses and nursing associates. Nursing associates are a distinct profession with their own part of our register, but they are part of the nursing team.

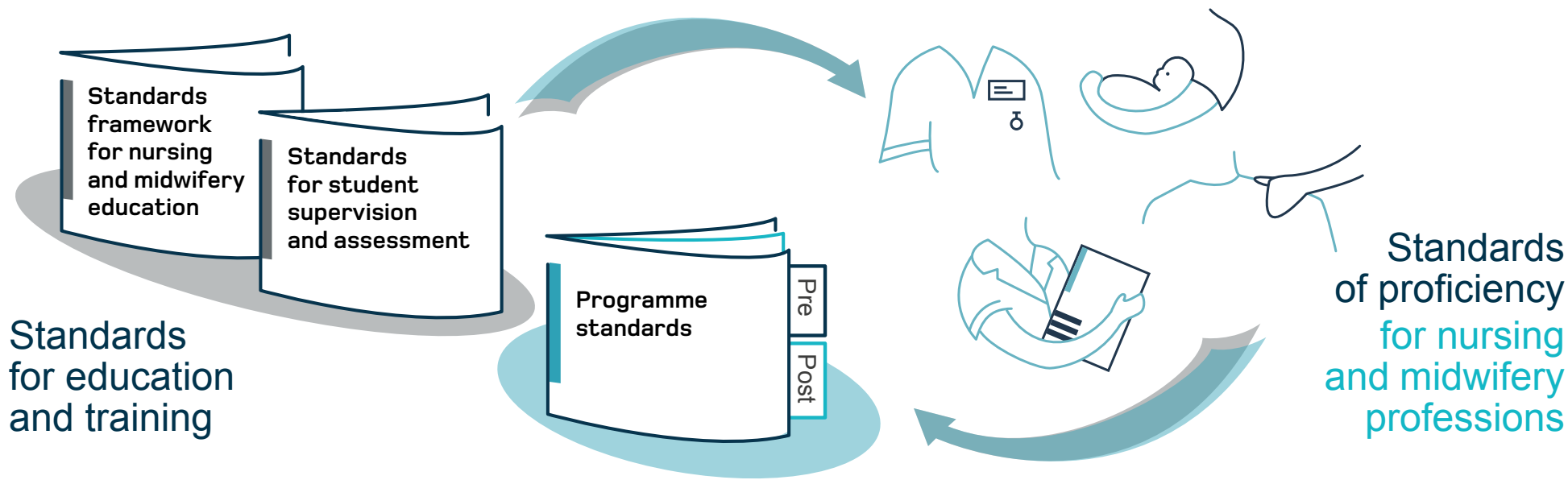
# Introduction

Our *Standards framework for nursing and midwifery education* applies to all [approved education institutions](#) (AEIs) and their [practice learning partners](#) that are running NMC approved programmes.

Article 15(1) of the Nursing and Midwifery Order 2001 ([‘the Order’](#)) requires the Council to establish standards for education and training which are necessary to achieve the standards of proficiency for admission to the register, as required by Article 5(2) of the Order. The *Standards framework for nursing and midwifery education* is established under the provision of Article 15(1) of the Order.

These standards aim to provide AEIs and practice learning partners with the flexibility to develop innovative approaches to all education for nurses, midwives and nursing associates, while being accountable for the local delivery and management of approved programmes in line with our standards. Pre-registration nursing and midwifery programmes and post-registration programmes may offer various academic and flexible routes to registration and annotation when seeking approval in line with our standards.

These standards should be read with *Part 2: Standards for student supervision and assessment* and *Part 3: Programme standards* which are standards specific for each pre-registration and post-registration educational programme. Together these are the *NMC Standards for education and training* (*‘Realising professionalism’*) for the nursing and midwifery professions. Education institutions must be approved against these standards to run any NMC approved programmes.



AEIs are responsible for working with practice learning partners to manage the quality of their educational programmes. Overall responsibility for the day-to-day management of the quality of any educational programme lies with an AEI in partnership with practice learning partners who provide opportunities for practice experience to nursing and midwifery students.

Before a programme can be run, an approval process takes place through which we check that the proposed programme meets our standards.

Public safety is central to our standards. Students will be in contact with [people](#) throughout their education and it's important that they learn in a safe and effective way.

Through our quality assurance (QA) processes we check that education programmes meet our standards and that education institutions and practice learning partners are managing risks effectively. Using internal and external intelligence we monitor risks to quality in education and training; this intelligence gathering includes analysis of system regulator reports.

Approved education providers are monitored and we have processes for collecting, analysing and responding to any risk intelligence we receive regarding educational programmes, including concerns raised with us directly by students. Approved education providers are also required to self-report any risks or concerns that could affect the quality of programme delivery and, therefore, public protection.

We strongly encourage people to take part in QA events, where they will be asked to share experiences of nurse and midwifery education and suggest improvements.

AEIs must seek permission for approval for programme endorsement for programmes approved in the UK, to be delivered in a specified location outside the UK. This must be done in line with the NMC *Quality assurance framework*.



Our *Standards framework for nursing and midwifery education* is set out under the following five headings:

## 1. Learning culture

We will only approve programmes where the learning culture is ethical, open and honest, is conducive to safe and effective learning that respects the principles of equality and diversity, and where innovation, inter-professional learning and team working are embedded

## 2. Educational governance and quality

We expect education providers to comply with all legal and regulatory requirements

## 3. Student empowerment

We want students to be empowered and provided with the learning opportunities they need to achieve the desired proficiencies and programme outcomes

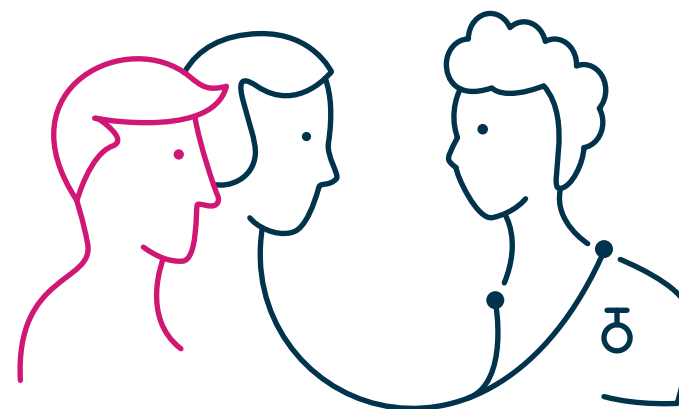
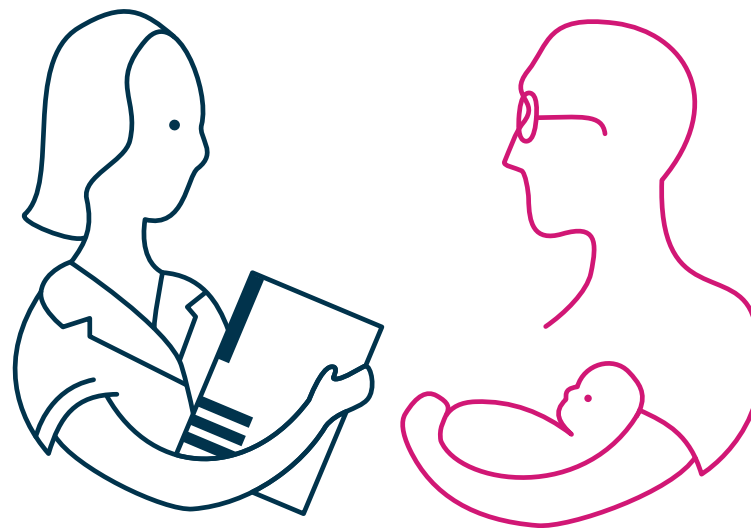
## 4. Educators and assessors

We will seek assurance that those who support, supervise and assess students are suitably qualified, prepared and skilled, and receive the necessary support for their role

## 5. Curricula and assessment

We set standards for curricula and assessment that enable students to achieve the outcomes required to practise safely and effectively in their chosen area

We use these standards to assess the safety and effectiveness of all [learning environments](#).



# 1 Learning culture

## Standards

- 1.1 The learning culture prioritises the safety of people, including carers, students and [educators](#), and enables the values of *The Code* to be upheld.
- 1.2 Education and training is valued in all learning environments.

## Requirements

### Approved education institutions, together with practice learning partners, must:

- 1.1 demonstrate that the safety of people is a primary consideration in all learning environments
- 1.2 prioritise the wellbeing of people promoting critical self-reflection and safe practice in accordance with *The Code*
- 1.3 ensure people have the opportunity to give and if required, withdraw, their informed consent to students being involved in their care
- 1.4 ensure educators and others involved in supervision, learning and assessment understand their role in preserving public safety
- 1.5 ensure students and educators understand how to raise concerns or complaints and are encouraged and supported to do so in line with local and national policies without fear of adverse consequences

- 1.6 ensure any concerns or complaints are investigated and dealt with effectively
- 1.7 ensure concerns or complaints affecting the wellbeing of people are addressed immediately and effectively
- 1.8 ensure mistakes and incidents are fully investigated and learning reflections and actions are recorded and disseminated
- 1.9 ensure students are supported and supervised in being open and honest with people in accordance with [the professional duty of candour](#)
- 1.10 ensure the learning culture is fair, impartial, transparent, fosters good relations between individuals and diverse groups, and is compliant with [equalities and human rights legislation](#)
- 1.11 promote programme improvement and advance equality of opportunity through effective use of information and data
- 1.12 ensure programmes are designed, developed, delivered, evaluated and co-produced with [service users](#) and other [stakeholders](#)
- 1.13 work with service providers to demonstrate and promote inter-professional learning and working, and
- 1.14 support opportunities for research collaboration and evidence-based improvement in education and service provision.

## 2 Educational governance and quality

### Standards

- 2.1 There are effective governance systems that ensure compliance with all legal<sup>2</sup>, regulatory, professional and educational requirements, differentiating where appropriate between the devolved legislatures of the United Kingdom, with clear lines of responsibility and accountability for meeting those requirements and responding when standards are not met, in all learning environments.
- 2.2 All learning environments optimise safety and quality, taking account of the diverse needs of, and working in partnership with, service users, students and all other stakeholders.

### Requirements

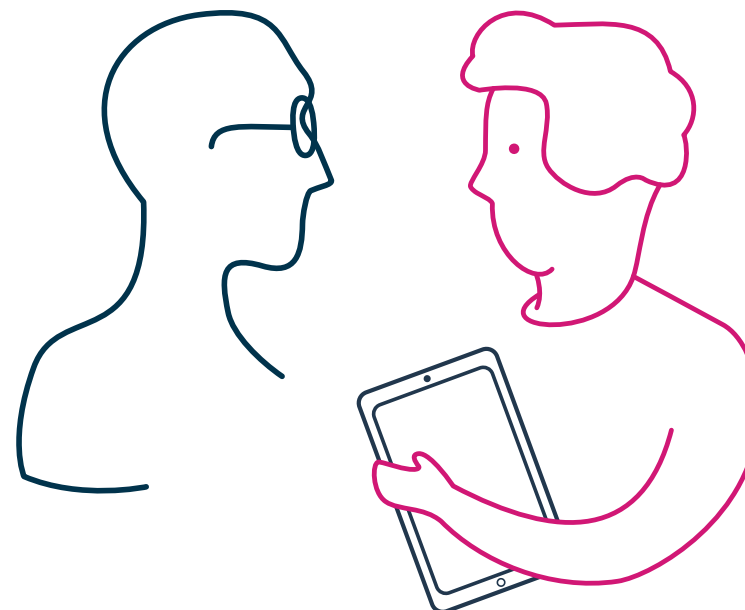
#### Approved education institutions, together with practice learning partners, must:

- 2.1 comply with all relevant legal, regulatory, professional and educational requirements
- 2.2 ensure programmes are designed to meet proficiencies and outcomes relevant to the programme

- 2.3 comply with NMC *Programme standards* specific to the programme being delivered
- 2.4 comply with NMC *Standards for student supervision and assessment*
- 2.5 adopt a partnership approach with shared responsibility for theory and practice supervision, learning and assessment, including clear lines of communication and accountability for the development, delivery, [quality assurance](#) and evaluation of their programmes
- 2.6 ensure that recruitment and selection of students is open, fair and transparent and includes measures to understand and address underrepresentation
- 2.7 ensure that service users and representatives from relevant stakeholder groups are engaged in partnership in student recruitment and selection
- 2.8 demonstrate a robust process for [recognition of prior learning](#) (RPL) and how it has been mapped to the programme learning outcomes and proficiencies
- 2.9 provide students with the information and support they require in all learning environments to enable them to understand and comply with relevant local and national governance processes and policies
- 2.10 have robust, effective, fair, impartial and lawful fitness to practise procedures to swiftly address concerns about the conduct of students that might compromise public safety and protection

<sup>2</sup> Includes, but not limited to, relevant European Union legislation and legislation passed by devolved administrations of the United Kingdom.

- 2.11 confirm that students meet the required proficiencies and programme outcomes in full, demonstrating their fitness for practice and eligibility for academic and professional award
- 2.12 provide all information and evidence required by regulators
- 2.13 regularly review all learning environments and provide assurance that they are safe and effective
- 2.14 have the capacity, facilities and resources in place to deliver safe and effective learning opportunities and practical experiences for students as required by their programme learning outcomes
- 2.15 be compliant with the NMC *Standards for education and training*<sup>3</sup> for all periods of learning undertaken outside the UK
- 2.16 improve quality, manage risk and disseminate effective practice through the proactive seeking and appropriate sharing of information and data
- 2.17 proactively identify and act on any areas for improvement, regularly measuring programme performance and outcomes against the NMC standards and requirements, and other recognised quality frameworks in education
- 2.18 appoint appropriately qualified and experienced people for programme delivery
- 2.19 identify programme leaders to confirm that all proficiencies have been met by each student by the end of their programme, and
- 2.20 ensure appropriately qualified and experienced external examiners consider and report on the quality of theory and practice learning.



<sup>3</sup>NMC *Standards for education and training*, standards established by NMC Council as necessary to achieve the standards of proficiency for admission to the register. Includes Parts 1, 2 and relevant standards in Part 3 and proficiencies.

# 3 Student empowerment

## Standards

- 3.1 Students are provided with a variety of learning opportunities and appropriate resources which enable them to achieve proficiencies and programme outcomes and be capable of demonstrating the professional behaviours in *The Code*.
- 3.2 Students are empowered and supported to become resilient, caring, reflective and lifelong learners who are capable of working in inter-professional and inter-agency teams.

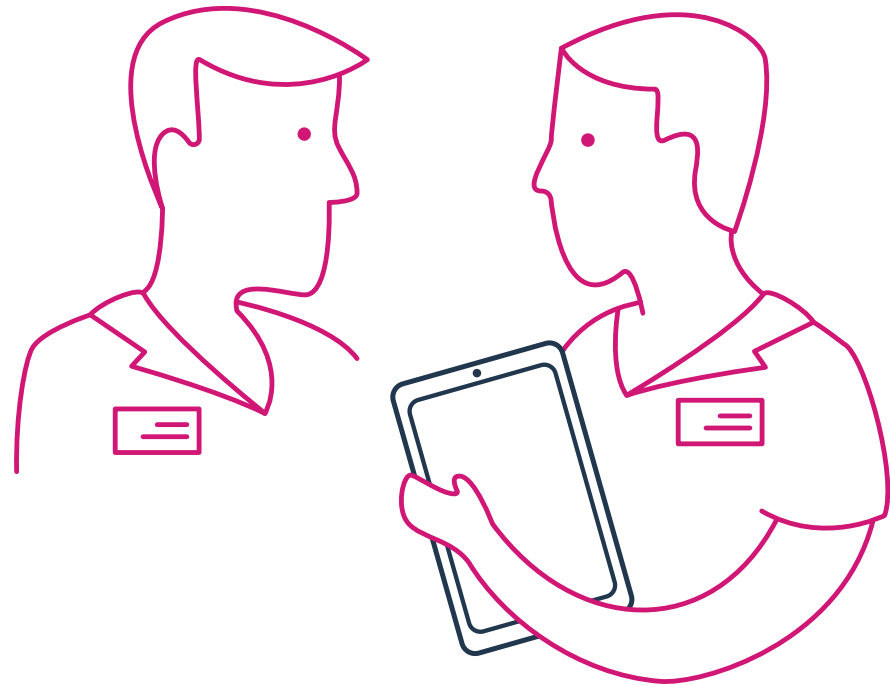
## Requirements

### Approved education institutions, together with practice learning partners, must ensure that all students:

- 3.1 have access to the resources they need to achieve the proficiencies and programme outcomes required for their professional role
- 3.2 are provided with timely and accurate information about curriculum, approaches to teaching, supervision, assessment, practice placements and other information relevant to their programme
- 3.3 have opportunities throughout their programme to work with and learn from a range of people in a variety of practice placements, preparing them to provide care to people with diverse needs

- 3.4 are enabled to learn and are assessed using a range of methods, including technology enhanced and [simulation](#)-based learning appropriate for their programme as necessary for safe and effective practice
- 3.5 are supervised and supported in practice learning in accordance with the NMC *Standards for student supervision and assessment*
- 3.6 are supervised according to their individual learning needs, proficiency and confidence
- 3.7 are allocated and can make use of [supported learning time](#) when in practice
- 3.8 are assigned and have access to a nominated practice assessor for a practice placement or a series of practice placements in addition to a nominated academic assessor for each part of the education programme, in accordance with the NMC *Standards for student supervision and assessment*
- 3.9 have the necessary support and information to manage any interruptions to the study of programmes for any reason
- 3.10 are provided with timely and accurate information regarding entry to NMC registration or annotation of their award
- 3.11 have their diverse needs respected and taken into account across all learning environments, with support and [adjustments](#) provided in accordance with equalities and human rights legislation and good practice
- 3.12 are protected from discrimination, harassment and other behaviour that undermines their performance or confidence

- 3.13 are provided with information and support which encourages them to take responsibility for their own mental and physical health and wellbeing
- 3.14 are provided with the learning and pastoral support necessary to empower them to prepare for independent, reflective professional practice
- 3.15 are well prepared for learning in theory and practice having received relevant inductions
- 3.16 have opportunities throughout their programme to collaborate and learn with and from other professionals, to learn with and from peers, and to develop supervision and leadership skills
- 3.17 receive constructive feedback throughout the programme from stakeholders with experience of the programme to promote and encourage reflective learning, and
- 3.18 have opportunities throughout their programme to give feedback on the quality of all aspects of their support and supervision in both theory and practice.



# 4 Educators and assessors

## Standard

4.1 Theory and practice learning and assessment are facilitated effectively and objectively by appropriately qualified and experienced professionals with necessary expertise for their educational and assessor roles.

## Requirements

**Approved education institutions, together with practice learning partners, must ensure that all educators and assessors:**

- 4.1 comply with all standards and requirements in the *NMC Standards for education and training*
- 4.2 act as professional role models at all times
- 4.3 receive relevant induction, ongoing support and access to education and training which includes training in equality and diversity
- 4.4 have supported time and resources to enable them to fulfil their roles in addition to their other professional responsibilities

- 4.5 respond effectively to the learning needs of individuals
- 4.6 are supportive and objective in their approach to student supervision and assessment
- 4.7 liaise and collaborate with colleagues and partner organisations in their approach to supervision and assessment
- 4.8 are expected to respond effectively to concerns and complaints about public protection and student performance in learning environments and are supported in doing so
- 4.9 receive and act upon constructive feedback from students and the people they engage with to enhance the effectiveness of their teaching, supervision and assessment
- 4.10 share effective practice and learn from others, and
- 4.11 appropriately share and use evidence to make decisions on student assessment and progression.

# 5 Curricula and assessment

## Standard

---

5.1 Curricula and assessments are designed, developed, delivered and evaluated to ensure that students achieve the proficiencies and outcomes for their approved programme.

## Requirements

---

**Approved education institutions, together with practice learning partners, must ensure:**

- 5.1 curricula fulfil NMC Programme standards, providing learning opportunities that equip students to meet the proficiencies and programme outcomes<sup>4</sup>
- 5.2 curricula remain relevant in respect of the contemporary health and social care agenda
- 5.3 curricula weigh theory and practice learning appropriately to the programme
- 5.4 curricula are developed and evaluated by suitably experienced and qualified educators and practitioners who are accountable for ensuring that the curriculum incorporates relevant programme outcomes
- 5.5 curricula are co-produced with stakeholders who have experience relevant to the programme

- 5.6 curricula provide appropriate structure and sequencing that integrates theory and practice at increasing levels of complexity
- 5.7 curricula are structured and sequenced to enable students to manage their theory and practice learning experience effectively
- 5.8 assessment is fair, reliable and valid to enable students to demonstrate they have achieved the proficiencies for their programme
- 5.9 adjustments are provided in accordance with relevant equalities and human rights legislation for assessments in theory and practice
- 5.10 students are assessed across practice settings and learning environments as required by their programme
- 5.11 assessment is mapped to the curriculum and occurs throughout the programme to determine student progression
- 5.12 practice assessment is facilitated and evidenced by observations and other appropriate methods
- 5.13 students' self-reflections contribute to, and are evidenced in, assessments
- 5.14 a range of people including service users contribute to student assessment
- 5.15 assessment of practice and theory is weighted appropriately to the programme, and
- 5.16 there is no compensation in assessments across theory and practice learning.

<sup>4</sup> Applies equally to all programmes whether delivered as full time or less than full time.



# Glossary

**Adjustments:** where a student requires reasonable adjustments related to a disability or adjustments relating to any protected characteristics as set out in equalities and human rights legislation.

**Approved education institutions (AEIs):** the status awarded to an institution, or part of an institution, or combination of institutions that works in partnership with practice placement and work placed learning providers. AEIs will have provided us with assurance that they are accountable and capable of delivering NMC approved education programmes.

**Co-produced:** when an individual influences the support and services received, or when groups of people get together to influence the way that services are designed, commissioned and delivered, acknowledging that people who use social care and health services (and their families) have knowledge and experience that can be used to help make services better. Co-production is one of the principles of the Care Act 2014.

**Educators:** in the context of the NMC *Standards for education and training* are those who deliver, support, supervise and assess theory, practice or work placed learning.

**Equalities and human rights legislation:** prohibits unlawful discrimination on the basis of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation and other characteristics. Anti-discrimination laws can be country specific and there are some legally binding international protections

**Learning environments:** includes any environment in terms of physical location where learning takes place as well as the system of shared values, beliefs and behaviours within these places.

**People:** individuals or groups who receive services from nurses, midwives and nursing associates, healthy and sick people, parents, children, families, carers, representatives, also including educators and students and others within and outside the learning environment.

**Practice learning partners:** organisations that provide practice learning necessary for supporting pre-registration and post-registration students in meeting proficiencies and programme outcomes.

**Quality assurance:** NMC processes for making sure all AEs continue to meet our requirements and their approved education programmes comply with our standards.

**Recognition of prior learning:** a process that enables previous certificated or experiential learning to be recognised and accepted as meeting some programme outcomes and requirements; this means it includes both theory and practice achievement.

**Service users:** people accessing health or social care services, and anyone supporting the needs and circumstances of these people.

**Simulation:** an artificial representation of a real world practice scenario that supports student development and assessment through experiential learning with the opportunity for repetition, feedback, evaluation and reflection. Effective simulation facilitates safety by enhancing knowledge, behaviours and skills.

**Stakeholders:** any person, group or organisation that has an interest or concern in the situation in question, and may affect or is affected by its actions, objectives or policies. In the context of the *NMC Standards for education and training* this includes students, educators, partner organisations, service users, carers, employers, other professionals, other regulators and education commissioners.

**Student:** any individual enrolled onto an NMC-approved programme at pre-registration or post-registration level, whether full time or less than full time.

**Supported learning time:** time to facilitate learning. This may include supernumerary status<sup>5</sup> that enables students to be supported in safely and effectively achieving proficiency.

<sup>5</sup> Supernumerary: see *Standards for student supervision and assessment* and specific programme standards.

# The role of the Nursing and Midwifery Council

## What we do

---

We regulate nurses, midwives and nursing associates in the UK. We exist to protect the public. We set standards of education, training, conduct and performance so that nurses, midwives and nursing associates can deliver high quality care throughout their careers.

We make sure nurses, midwives and nursing associates keep their skills and knowledge up to date and uphold our professional standards. We have clear and transparent processes to investigate nurses, midwives and nursing associates who fall short of our standards.

We maintain a register of nurses, midwives and nursing associates allowed to practise in the UK.

**These standards were approved by Council at their meeting on 28 March 2018 and have been updated to include the regulation of pre-registration nursing associate programmes on 8 October 2018.**



# REVALIDATION

**NMC** Nursing &  
Midwifery  
Council



## How to revalidate with the NMC

Requirements for renewing your registration

# CONTENTS

WHAT DOES THIS DOCUMENT DO? .....	3
WHAT IS REVALIDATION? .....	6
CHECKLIST OF REQUIREMENTS AND SUPPORTING EVIDENCE .....	9
THE REVALIDATION PROCESS .....	11
HOW TO APPROACH REVALIDATION .....	12
NON-IDENTIFIABLE INFORMATION.....	15
PRACTICE HOURS .....	18
CONTINUING PROFESSIONAL DEVELOPMENT .....	23
PRACTICE-RELATED FEEDBACK .....	25
WRITTEN REFLECTIVE ACCOUNTS .....	27
REFLECTIVE DISCUSSION.....	29
HEALTH AND CHARACTER.....	31
PROFESSIONAL INDEMNITY ARRANGEMENT.....	33
CONFIRMATION .....	35
THE APPLICATION PROCESS.....	38
VERIFICATION OF YOUR APPLICATION .....	41
REVALIDATION AND NMC FITNESS TO PRACTISE PROCESSES .....	43
CANCELLING YOUR REGISTRATION.....	45
FORMS AND TEMPLATES .....	47

**This updated document was updated in May 2019**



# WHAT DOES THIS DOCUMENT DO?

**This document is for nurses, midwives and nursing associates who are registered with the NMC. It sets out how to renew your registration with the NMC through revalidation every three years.**

The requirements for revalidation are either prescribed in the Nursing and Midwifery Order 2001 (the Order)<sup>1</sup> and the Education, Registration and Registration Appeals Rules (the Rules)<sup>2</sup>, or are standards set by the NMC for revalidation and readmission.<sup>3</sup>

## About the NMC

We're the independent regulator for nurses and midwives in the UK and nursing associates in England.

Better and safer care for people is at the heart of what we do, supporting the healthcare professionals on our register to deliver the highest standards of care.



## How to use this document

This document gives an overview of the revalidation requirements which you will have to meet every three years in order to renew your registration. It also sets out how you should collect the required information and approach the process, including suggested templates which you can use as well as mandatory forms which you must complete as part of your revalidation application.

This document includes a checklist of the revalidation requirements and the supporting evidence for each requirement.

Each requirement is presented on pages 18-37 followed by information about:

- the purpose of the requirement
- how to meet the requirement
- the recommended or mandatory approach to collecting and recording the required information, and
- how to demonstrate to us that you have met the requirement in your online application.

You should read this document in conjunction with the Code<sup>4</sup> and other guidance on our website. We have published a range of resources that you might find helpful in preparing for revalidation, including completed templates and case studies. We have also provided information for confirmers, which you should ensure that your confirmer has read, as well as information for employers, which we recommend you encourage your employer (if applicable) to read.

Please note that you must still pay your annual registration fee every year to retain your registration with the NMC.

## How the NMC will use your information

As part of the revalidation process you are required to submit information about yourself to the NMC. We will only process your personal data, as permitted by the Data Protection Act 2018 ('DPA').



Details of our data protection policy are included in our privacy notice at: [www.nmc.org.uk/privacy](http://www.nmc.org.uk/privacy)

We will use your personal data for the purposes of administering and assessing your revalidation application and any subsequent verification of that application. We may also use information obtained through the revalidation process for research, and for the purpose of maintaining and improving our internal systems and processes.

## Your responsibility

You are responsible for your revalidation application. You need to sufficiently plan to ensure, to the best of your ability, that you will meet the requirements within your three year renewal period. If you require support from us to help you revalidate, please [see our support to help you revalidate guidance sheet](#).

We expect you to complete your revalidation application on NMC online. This should not be delegated to someone else unless we have granted you an adjustment. You must provide accurate information in your online application.

You must adhere to the conditions we set out in this guidance and in the guidance we provide for confirmers and employers (if appropriate). Examples of these conditions include (but are not limited to) avoiding conflicts of interest and having your reflective discussion with a person on the NMC register.

If there are grounds for believing that you have not met these conditions, and/or that you have made a false declaration as part of your revalidation application, we will investigate and your registration could be at risk. Information supplied by you may be used to investigate any alleged breach of the Code and for the purpose of any subsequent fitness to practise proceedings.

## Equality, diversity and inclusion

We value the diversity of the people on our register, and the wider community we serve. We are dedicated to ensuring revalidation is supportive and fair.

The Equality Act 2010 ('the Act') is legislation that applies in England, Wales and Scotland.<sup>5</sup> This Act protects people from discrimination, harassment or victimisation by specifying a number of 'protected characteristics':

- age
- gender reassignment
- being married or being in a civil partnership
- being pregnant or in the maternity period
- disability<sup>6</sup>
- race, including colour, nationality, ethnic or national origin
- religion, belief, or lack of religion or belief
- sex
- sexual orientation.

We expect all employers of nurses, midwives and nursing associates to meet their legal duty in the Equality Act 2010. We expect them to support you based on your individual needs and remove any unnecessary barriers to help you meet the revalidation requirements.

We cannot change the revalidation requirements as they are competence standards that demonstrate that you can practise safely and effectively. However, we can support you to renew your registration by providing adjustments that help you revalidate. For example, we can provide you with a short extension to your application date so you have more time to meet the revalidation requirements or give you a paper application form.

You can find further information on the support we offer [on our website](#).

## How to contact the NMC

For more information please see the revalidation section of the NMC website at: [www.nmc.org.uk](http://www.nmc.org.uk). If you are unable to find the information you need and you still require further help you can email us at: [revalidation.escalation@nmc-uk.org](mailto:revalidation.escalation@nmc-uk.org).

If you wish to make a complaint or provide feedback about the standard of our service, please visit the 'Contact us' pages of our website at [www.nmc.org.uk/contact-us/complaints-about-us](http://www.nmc.org.uk/contact-us/complaints-about-us).



# WHAT IS REVALIDATION?

## Revalidation

- is the process that allows you to maintain your registration with the NMC
- demonstrates your continued ability to practise safely and effectively, and
- is a continuous process that you will engage with throughout your career.

**Revalidation is your responsibility. You are the owner of your own revalidation application. We recommend that you work towards meeting the revalidation requirements throughout the three year revalidation period so you are prepared when your application is due.**

## Revalidation is not

- an assessment of your fitness to practise
- a new way to raise fitness to practise concerns (any concerns about a nurse, midwife or nursing associate's practice should be raised through the existing fitness to practise process), nor
- an assessment against the requirements of your current/former employment.

## Purpose of revalidation

- to raise awareness of the Code and professional standards expected of you
- to provide you with the opportunity to reflect on the role of the Code in your practice as a nurse, midwife or nursing associate and demonstrate that you are 'living' these standards
- to encourage you to stay up to date in your professional practice by developing new skills and understanding the changing needs of the public and fellow healthcare professionals
- to encourage a culture of sharing, reflection and improvement
- to encourage you to engage in professional networks and discussions about your practice, and
- to strengthen public confidence in the nursing and midwifery professions.

## Revalidation and the Code

One of the main strengths of revalidation is that it reinforces the Code by asking you to use it as the reference point for all the requirements, including your written reflective accounts and reflective discussion.

This should highlight the Code's central role in the nursing and midwifery professions and encourage you to consider how it applies in your everyday practice.

The Code (paragraph 22) requires you to fulfil all registration requirements. To achieve this you must:

- meet any reasonable requests so we can oversee the registration process (22.1)
- keep to our prescribed hours of practice and carry out continuing professional development (CPD) activities (22.2), and
- keep your knowledge and skills up to date, taking part in appropriate and regular learning and professional development activities that aim to maintain and develop your competence and improve your performance (22.3).

## Revalidation and the standards of proficiency

One purpose of revalidation is to help you to maintain safe and effective practice. Revalidation does this by encouraging you to update your knowledge and develop new skills. The NMC publishes and regularly updates standards of proficiency for everyone on our register. These set out what we expect students to know, understand and be able to do to apply to join our register and to practise safely and effectively. It is important for you to become familiar with the most recent standards, identify which ones relate to your scope of practice and identify your training needs. This will help you to advance your practice and also means that you will be equipped to supervise and assess students if this is part of your role.

It is important that you speak to your employers about the types of continuous professional development that will help you achieve this.

# Overall, revalidation should lead to improved practice and therefore public protection benefits.



# CHECKLIST OF REQUIREMENTS AND SUPPORTING EVIDENCE

These are all of the requirements that you must meet in order to complete your revalidation and renew your registration every three years with the NMC.

Requirements	Supporting evidence
<p><b>450 practice hours for each registration.</b></p> <p><b>Dual registration (e.g. nurse and midwife) requires 900 practice hours<sup>7</sup></b></p>	<p>Maintain a record of practice hours you have completed, including:</p> <ul style="list-style-type: none"> <li>• dates of practice</li> <li>• the number of hours you undertook</li> <li>• name, address and postcode of the organisation</li> <li>• scope of practice (see tip box on page 22)</li> <li>• work setting (see tip box on page 22)</li> <li>• a description of the work you undertook, and</li> <li>• evidence of those practice hours should be recorded.</li> </ul> <p>See our practice hours requirements guidance sheet and suggested template at guidance and information.</p>
<p><b>35 hours of continuing professional development (of which 20 must be participatory)</b></p>	<p>Maintain accurate and verifiable records of your CPD activities, including:</p> <ul style="list-style-type: none"> <li>• the CPD method (examples of 'CPD method' are self-learning, online learning, course)</li> <li>• a brief description of the topic and how it relates to your scope of practice</li> <li>• dates the CPD activity was undertaken</li> <li>• the number of hours and participatory hours</li> <li>• identification of the part of the Code most relevant to the CPD, and</li> <li>• you should record evidence of the CPD activity. See our guidance sheet and suggested template at guidance and information</li> </ul>
<p><b>Five pieces of practice-related feedback</b></p>	<p>Notes on the content of the feedback and how you used it to improve your practice. This will be helpful for you to use when you are preparing your reflective accounts.</p> <p>Make sure your notes do not include any personal data (see the section on non-identifiable information on pages 15-17).</p>

Requirements	Supporting evidence
Five written reflective accounts	Five written reflective accounts that explain what you learnt from your CPD activity and/or feedback and/or an event or experience in your practice, how you changed or improved your work as a result, and how this is relevant to the Code. You must use the NMC form on <a href="#">page 47</a> and make sure your accounts do not include any personal data (see the section on non-identifiable information).
Reflective discussion	<p>A reflective discussion form which includes the name and NMC Pin of the NMC-registered nurse, midwife or nursing associate that you had the discussion with as well as the date you had the discussion.</p> <p>You must use the NMC form on <a href="#">page 48</a> and make sure the discussion summary section does not contain any personal data (see the section on non-identifiable information).</p>
Health and character	You must make a declaration as to your health and character as part of your online revalidation application. You can find more information in <a href="#">our guidance on health and character</a> .
Professional indemnity arrangement	<p>Evidence to demonstrate that you have an appropriate indemnity arrangement in place.</p> <p>You must tell us whether your indemnity arrangement is through your employer, membership of a professional body or through a private insurance arrangement.</p> <p>If your indemnity arrangement is provided through membership of a professional body or a private insurance arrangement, you will need to record the name of the professional body or provider.</p>
Confirmation	A confirmation form signed by your confirmer. You must use the NMC form on <a href="#">pages 49-51</a> .

# THE REVALIDATION PROCESS

## During the three years since your last renewal/you joined the register

You need to meet a range of revalidation requirements to show that you are keeping your skills and knowledge up to date and maintaining safe and effective practice

▶ See pages 18–37: for details of the requirements

## In the 12 months before your renewal date

Once you have met the requirements, you will need to discuss your revalidation with a confirmer. As part of this confirmation discussion, you will demonstrate that you have complied with all of the revalidation requirements, except having a professional indemnity arrangement and meeting the requirements of health and character.

▶ See pages 35–37: 'Confirmation'

## At least 60 days before your revalidation application date

Every three years you will be asked to apply for revalidation using NMC Online. We will notify you at least 60 days before your application is due, either by email if you have set up an NMC Online account, or by letter sent to your registered address.

▶ See pages 38–40: 'The application process'

## In the 60 days before your revalidation application date

Once you receive your notification you will need to go online and complete the application form. As part of that application, you need to declare to the NMC that you have complied with the revalidation requirements.

▶ See pages 38–40: 'The application process'

## Following submission of your revalidation application

Each year we will select a sample of revalidation applications and ask those professionals to provide us with further information so we can verify the declarations they made as part of their revalidation application. If you are selected your registration will be held effective until the verification process is complete and you can continue to practise as normal during this time. Your registration will only renew if the verification is completed successfully.

▶ See pages 41–42: 'Verification of your application'

# HOW TO APPROACH REVALIDATION

## Understand key terms

1. The registration process: Every three years from when you join (or re-join) the register you will need to renew your registration by revalidating. Every year you will also need to retain your registration by paying an annual registration fee. If you don't complete these processes on time your registration will expire.
2. Fee expiry date: The deadline for paying your annual registration fee in order to retain your registration.
3. Revalidation application date: The deadline for submitting your revalidation application. It is the first day of the month in which your registration expires, so if your renewal date is 30 April, your revalidation application date will be 1 April.
4. Renewal date: The date on which your registration will be renewed if you have successfully completed your revalidation application. It is the last day of the month in which your registration expires.

## Keep a portfolio

5. We strongly recommend that you keep evidence that you have met the revalidation requirements in a portfolio. This does not necessarily need to be an e-portfolio; please see our guidance sheet on e-portfolios at [revalidation.nmc.org.uk/download-resources/guidance-and-information](https://revalidation.nmc.org.uk/download-resources/guidance-and-information) for further information. We have provided forms you must use and templates you may like to use to record your evidence for each requirement; these are available at the end of this document and on our website at [revalidation.nmc.org.uk/download-resources/forms-and-templates](https://revalidation.nmc.org.uk/download-resources/forms-and-templates), where you will also find examples of completed forms and templates for you to refer to.
6. We expect any evidence to be kept in English, and nurses, midwives and nursing associates must submit their revalidation application, and any subsequent requested verification information in English.
7. The portfolio will be helpful for the discussion you have with your confirmer (see pages 35-37). You will also need to have this information available in case we request to see it to verify the declarations you made as part of your application (see pages 41-42).
8. You may already keep a professional portfolio. If so, you do not need to maintain a separate portfolio but you might like to add to it.



The NMC recognises the culture and linguistic needs of the Welsh speaking public (for further information please see [www.nmc.org.uk/about-us/our-equality-and-diversity-commitments/welsh-language-scheme](https://www.nmc.org.uk/about-us/our-equality-and-diversity-commitments/welsh-language-scheme)). We have published Welsh language versions of our guidance for nurses and midwives, confirmers and employers, as well as our templates and forms, on our website at [revalidation.nmc.org.uk/download-resources/guidance-and-information](https://revalidation.nmc.org.uk/download-resources/guidance-and-information).

9. You can use the checklist on page 9 to make sure that all of the information is in your portfolio before you have your confirmation discussion with your confirmer or submit your revalidation application.
10. We recommend that you keep your portfolio until after you complete your next revalidation. For example, if you revalidated in 2016, we suggest that you should keep your portfolio until after you have revalidated again in 2019.
11. Your portfolio must not record any information that might identify an individual, whether that individual is alive or deceased. This means that all information must be recorded in a way that no patient, service user, colleague or other individual can be identified from the information. The section on non-identifiable information on pages 15-17 provides guidance on how to make sure that your portfolio does not contain any information that might identify an individual.
12. During your revalidation application we will not request that you upload your evidence or submit your portfolio to the NMC. However, each year we will select a sample of revalidation applications and request further information from you to verify your revalidation application via NMC online. In some cases, we may request further evidence, so it is important that you keep all of your revalidation evidence safe.

## Conflicts of interest and perceptions of bias

13. A conflict of interest is a situation that has the potential to undermine the impartiality and objectivity of decision making within the revalidation process. Conflicts of interest can arise when an individual's judgement is influenced subjectively through association with colleagues out of loyalty to the relationship they have, rather than through an objective process.
14. Conflicts of interest can occur because of personal or commercial relationships.
15. You need to be mindful about any personal or commercial relationship between you, your confirmer and your reflective discussion partner. You may not choose a family member or person with whom you have a close personal relationship, such as a close friend to undertake either of these roles
16. You, your confirmer and reflective discussion partner will need to take responsibility for deciding whether there is any conflict of interest or perception of bias to ensure that the confirmation process and reflective discussion retains credibility and remains objective. If you think that there is a risk there might be a conflict of interest you should use a different person as your confirmer and reflective discussion partner.

## Appraisals

17. Many nurses, midwives and nursing associates have an employer. It is important for their employers to be aware of the Code and the standards expected of people on our register in their professional practice. See our Employers guide to revalidation at [revalidation.nmc.org.uk/download-resources/guidance-and-information](https://www.revalidation.nmc.org.uk/download-resources/guidance-and-information).
18. Appraisals are a way for employers to assess the performance of their employees against the requirements of their role and identify areas for improvement and development.
19. The revalidation process is designed so that it can be undertaken as part of a regular appraisal. If you are an employee who does not have a regular appraisal you could consider asking your employer to arrange an appraisal for you in advance of your revalidation application date.



20. The confirmation discussion has a different purpose from an appraisal, as it is about demonstrating to an appropriate confirmer that you have met the revalidation requirements, not the requirements of your employment (please see the section on Confirmation on pages 35-37 for more details). However, it can be incorporated into an appraisal, and we recommend that, where possible, your confirmation discussion forms part of an annual appraisal, if you have one.
21. If your line manager is also registered with the NMC, you might like to have both your reflective discussion and your confirmation discussion as part of an annual appraisal, if you have one. You might find it helpful to have a discussion with your confirmer every year as part of an annual appraisal, so that you can keep them updated on your revalidation.
22. If you are not an employee, or if you are an employee who has been unable to arrange an appraisal in advance of your revalidation application date, you will still be able to renew your registration by meeting the revalidation requirements. You are not required to arrange for another person or organisation to conduct an appraisal for the purposes of revalidation, but you will still need to arrange a reflective discussion and confirmation discussion.



# NON-IDENTIFIABLE INFORMATION

23. You are likely to process personal data as part of your day to day role. If you are employed, you are likely to be covered by your employer's registration under data protection legislation. If you are practising as an independent or self-employed nurse, midwife or nursing associate you are already likely to be registered under data protection legislation in your capacity.
24. This section sets out your obligations in relation to confidentiality and data protection in relation to meeting the revalidation requirements. It does not cover your existing obligations in relation to data protection legislation.



Personal data means data which identifies an individual.  
Section 1(1) of the Data Protection Act 1998.

## Your obligations in relation to confidentiality under the Code

25. The Code sets out the professional standards that you must uphold in order to be registered to practise in the UK. Standard 5 of the Code states:

### Respect people's right to privacy and confidentiality

- As a nurse, midwife or nursing associate you owe a duty of confidentiality to all those who are receiving care. This includes making sure that they are informed about their care and that information about them is shared appropriately.

To achieve this, you must:

- respect a person's right to privacy in all aspects of their care (5.1)
- make sure that people are informed about how and why information is used and shared by those who will be providing care (5.2)
- respect that a person's right to privacy and confidentiality continues after they have died (5.3)
- share necessary information with other health and care professionals and agencies only when the interests of patient safety and public protection override the need for confidentiality, and (5.4)
- share with people, their families and their carers, as far as the law allows, the information they want or need to know about their health, care and ongoing treatment sensitively and in a way they can understand. (5.5)

# Making sure that your evidence does not include any personal information

26. In meeting the revalidation requirements and keeping your evidence, you must not record any information that might identify an individual, whether that individual is alive or deceased. This means that all information recorded must be recorded in a way that no patient, service user, colleague or other individual can be identified from the information.
27. For example, any notes or reflections must not include:
- the name of any individual
  - the date of any incident or event referred to
  - the particular ward or place where the event occurred, or
  - descriptions of unique circumstances where an individual could be identified from the circumstances.
28. Any information extracted from employer data (such as complaints logs) must be extracted in a way that no information identifying an individual is obtained, used or recorded. For example, you must not forward work emails to your personal account, or download and take copies of employer records. You must seek consent to access or use your employer's information.

## Example scenarios

29. You will already be aware of the importance of keeping personal information confidential, and not processing personal information outside of your employment or work settings. However, we have provided some simple examples below to demonstrate how an instance of feedback could be recorded in a way that no individual can be identified.

### Scenario 1

In January 2015 Mrs Jones was in ward 8 with a broken hip. She made a complaint about lack of hydration. You want to use this feedback in one of your reflections as an example of where you put in place a new process to make sure all patients were offered water on a regular basis.

In your reflective account you could say: 'A patient with a serious injury made a complaint about lack of hydration.'

No dates, names or wards have been included in the record, and the type of injury has also been omitted, so Mrs Jones cannot be identified from this information. You can then explain what you did, what improvement you made and how this is related to the Code.

## Scenario 2

In reviewing the complaints log held by the maternity unit where you work, you noticed a complaint made by Mrs Smith in relation to a lack of continuity of care and handover between midwives at the end of a shift on 12 January 2015. You were one of the midwives involved, along with your colleague Sarah. You discussed this with your colleagues and have made improvements in the way you handover at the end of shifts. You want to use this feedback in one of your reflections.

Before writing your reflective account, you need to check with your employer that you can use information from the complaints log. In your reflective account you could say: 'A complaint was received about the lack of continuity of care and handover between myself and a colleague at the end of a shift'.

No information identifying any individual, including both Mrs Smith and your colleague, has been included in this record. You can then explain what you did, what improvement you made and how this is related to the Code.

## Storing your reflective accounts form, reflective discussion form and confirmation form

30. You are not required to submit your reflective accounts form, reflective discussion form and confirmation form to the NMC at any point in the revalidation application. There is no requirement to store them electronically or upload them into NMC Online as part of your application, or provide them if you are selected so we can verify your evidence.
31. Your 'reflective discussion form' and 'confirmation form' contain personal data about another person. This means that there are data protection implications for nurses, midwives and nursing associates completing these forms, when they are processing electronic records. There is not an exemption under Data Protection legislation which applies to personal data processed by our registrants, as part of the reflection and discussion elements of revalidation. However, the Information Commissioner's Office (ICO) have recognised that it would be highly disproportionate to expect our registrants to have to register with them as data controllers when processing electronic records, or to pay a fee. The ICO has confirmed that it does not plan to take any action against any of our registrants for failing to register with them.
32. You may choose to store your completed reflective discussion and confirmation forms in either paper or electronic format. You should still respect the fact that these forms contain personal data about your reflective discussion partner and confirmer. Please see our guidance sheet on e-portfolios for further information at [guidance and information](#).



The Information Commissioner's Office has published a guide to data protection legislation at [ico.org.uk/for-organisations/guide-to-the-general-data-protection-regulation-gdpr/](https://ico.org.uk/for-organisations/guide-to-the-general-data-protection-regulation-gdpr/)

# PRACTICE HOURS

## The requirements

33. You must have practised as a registered nurse, midwife or nursing associate for a minimum number of hours over the three year period since your registration was last renewed or you joined the register.<sup>8</sup>

Registration	Minimum total practice hours required
Nurse	450 practice hours required
Midwife	450 practice hours required
Nursing associate	450 practice hours required
Nurse and SCPHN	450 practice hours required
Midwife and SCPHN	450 practice hours required
Nurse and midwife (including Nurse/SCPHN and Midwife/SCPHN) <sup>9</sup>	900 practice hours required (to include 450 hours for nursing, 450 hours for midwifery, 450 hours for nursing associate)
Or	
Nursing associate and nurse	



A specialist community public health nurse (SCPHN) means a registered nurse, midwife or nursing associate who is also registered in the Specialist Community Public Health Nurses' part of the register.

34. If you have practised for fewer than the required number of hours in the three year period since your registration was last renewed or you joined the register, then you must successfully complete an appropriate return to practice programme approved by the NMC before the date of your application for renewal of registration.<sup>10</sup>

35. Registered nurses, midwives or nursing associates who are admitted to another part of the register since their registration was last renewed or they joined the register only need to meet the practice hours requirement for their initial registration. They will need to meet the practice hours requirements for registration in both parts in subsequent three year renewal periods.<sup>11</sup>

## The purpose of these requirements

36. The practice hours requirements are designed to help you to maintain safe and effective practice, and keep your skills up to date.

## How to meet the requirements

37. You can only count practice hours that you undertook while you were registered with the NMC. You cannot count unregistered practice or hours completed when working in an entirely different regulated profession such as a paramedic or medical doctor.
38. Practice hours should reflect your current scope of practice. You must comply with The Code: professional standards of practice and behaviour for nurses, midwives and nursing associates at all times. This includes the duty to recognise and work within the limits of your competence.
39. You must meet your practice hours in a role where you rely on your skills, knowledge and experience of being a registered nurse, midwife or nursing associate.

This includes:

- practice as a nurse, midwife, SCPHN and nursing associate, in roles that are likely to require registration
  - practice in roles where your employment contract does not expressly require you to be registered with us but you rely on your skills, knowledge and experience of being a registered nurse, midwife or nursing associate. For example, this could include roles in public health or nursing, midwifery, management, commissioning, policy and education
40. The following activities cannot be counted towards the practice hours requirement: hours undertaken in a healthcare, nursing or midwifery assistant or support worker role cannot be counted towards practice hours as a registered nurse, midwife or nursing associate.
- Hours completed when working in a separate regulated profession for example when working as a paramedic or medical doctor.
  - Nurses undertaking an 18-month midwifery programme cannot use their midwifery training hours in order to maintain their registration as a nurse. They will be able to use any practice hours undertaken as a nurse, either before or after their midwifery course, during the three-year period.
  - Hours undertaken in any healthcare, nursing or midwifery assistant or support worker roles cannot be counted towards practice hours.
41. If you are working overseas (or have worked overseas for part of your three year renewal period) as a nurse, midwife or nursing associate you can count these hours towards the practice hours requirements for revalidation. Where possible, you should always register with the appropriate regulator in the country in which you are practising.
42. If you have had a career break, you will still be able to meet the practice hours requirement if you have completed the required hours of registered practice during your three year renewal period.
43. We have produced a guidance sheet for people with multiple registrations and additional qualifications. Please see our [guidance and information](#) on our website.





Further information on working outside the UK and returning to practice can be found on our website [www.nmc.org.uk/registrations](http://www.nmc.org.uk/registrations)

44. If you have not undertaken any type of work where you relied on your skills, knowledge or experience as a registered nurse, midwife or nursing associate, or if you are unable to meet the practice hours requirement, you have two options:
- you can successfully complete an appropriate NMC-approved return to practice programme before the date of your revalidation application. These programmes are designed to allow you to renew your registration and return to practice after a break in practice. Further information about return to practice programmes is available on our website or
  - you can cancel your registration. You will continue to hold a nursing and/or midwifery qualification, but will not be registered with the NMC. You can apply for readmission to the register in future if you wish to practise as a registered nurse, midwife or nursing associate. Information on cancelling registration and seeking readmission to the register is available on our website.
45. If you do not renew your registration, you will lapse from the register. You will not be able to practise in the capacity of a registered nurse, midwife or nursing associate. You cannot rely on any hours of work you undertake when you were not registered with the NMC as part of any application for readmission to the register.

## How to record practice hours

46. We strongly recommend that you maintain a record of practice hours you have completed.
47. This will form part of the discussion you have with your confirmer, and you will also need to have this information available in case we request to see it for verification of your application. We have provided a guidance sheet on practice hours and have a suggested template to help you record your practice hours. Your records should include:
- dates of practice
  - the number of hours you undertook
  - name, address and postcode of the organisations
  - scope of practice
  - work setting
  - a description of the work you undertook, and
  - evidence of those practice hours, such as timesheets, job specifications and role profiles.
48. You do not necessarily need to record individual practice hours. You can describe your practice hours in terms of standard working days or weeks.

# What you need to tell us in your online application

49. When you apply for revalidation, you need to declare that you have met the practice hours requirement during the three year period since your last registration renewal or initial registration. You only need to tell us about the most recent hours you have undertaken to meet the minimum requirement for your registration(s). If you are currently practising in more than one setting, provide details of your main setting first.
50. You will also be asked to enter the following details:
- whether you are currently practising
  - if you are currently in practice, where you undertake that practice, including details of your scope of practice and work setting, and
  - if you are not currently in practice, where you undertook your most recent practice, including details of your scope of practice and work setting.
51. To help you prepare for your online application we have listed the scope of practice and work setting options in the tip box below. These were designed to capture the wide breadth of types of practice that people on our register can undertake, and as such they will not apply to all roles.
52. If you have completed a return to practice course or been admitted to another part of the register since you last renewed your registration or joined the register, your practice hours declaration will be as follows:
- If you have recently completed an approved return to practice course since you last renewed your registration or joined the register, you will be able to meet the practice hours requirement for that registration.
  - If you have been admitted to another part of the register since you last renewed your registration or joined the register (for example you are a nurse who has undertaken training as a midwife and gained a second registration as a midwife), you only need to meet the practice hours requirement for your initial registration. Please note that next time you apply for revalidation, if you wish to renew your registration on both parts of the register and continue practising as both a nurse and a midwife, you will need to meet the practice hours requirements for both registrations.
  - For further information about multiple registrations and additional qualifications please see our guidance sheet at [guidance and information](#).





## Scope of practice

Direct clinical care or management: adult and general care nursing; children's and neo-natal nursing; mental health nursing; learning disabilities nursing; midwifery; health visiting; occupational health; school nursing; public health; other. Commissioning, Education, Policy, Quality assurance or inspection, Research, other.

## Work setting

Ambulance service, Care home sector, Community setting (including district nursing and community psychiatric nursing), Consultancy, Cosmetic or aesthetic sector, Governing body or other leadership, GP practice or other primary care, Hospital or other secondary care, Inspectorate or regulator, Insurance or legal, Maternity unit or birth centre, Military, Occupational health, Police, Policy organisation, Prison, Private domestic setting, Public health organisation, School, Specialist or other tertiary care including hospice, Telephone or e-health advice, Trade union or professional body, University or other research facility, Voluntary or charity sector, other.



# CONTINUING PROFESSIONAL DEVELOPMENT

## The requirements

53. You must have undertaken 35 hours of continuing professional development (CPD) relevant to your scope of practice as a nurse, midwife or nursing associate, in the three year period since your registration was last renewed or you joined the register.<sup>12</sup>
54. Of those 35 hours of CPD, at least 20 must have included participatory learning.<sup>13</sup>
55. You must maintain accurate records of the CPD you have undertaken. These records must contain:
  - the CPD method
  - a description of the topic and how it related to your practice
  - the dates on which the activity was undertaken
  - the number of hours (including the number of participatory hours)
  - the identification of the part of the Code most relevant to the activity, and
  - evidence that you undertook the CPD activity.<sup>14</sup>

## The purpose of these requirements

56. As a professional, you have a duty to keep your professional knowledge and skills up to date through a continuous process of learning and reflection.
57. The CPD requirements are designed to help you to maintain safe and effective practice, to improve practice or develop new skills where a gap has been identified and to respond to changes and advances in nursing and midwifery.
58. The participatory requirement also helps to challenge professional isolation by requiring learning through engagement and communication with others.

## How to meet the requirements

59. CPD is a learning activity that you undertake separately from your normal practice. This is different from the everyday learning that all healthcare professionals will engage in as part of their ongoing practice.
60. Any learning activity you participate in should be relevant to your scope of practice as a nurse, a midwife or a nursing associate. When you plan, undertake and record your CPD you should focus on what you are learning, how it is linked to your scope of practice and how you can apply it to your practice.

61. We do not prescribe any particular type of CPD. We think that you are better placed to decide what learning activities are the most suitable and beneficial to your individual scope of practice. We have produced a guidance sheet that suggests some individual and participatory CPD activities that you can undertake, which includes many activities other than training courses (see [guidance and information](#)). It is not an exhaustive list and we have only provided it as an example.
62. We know that many organisations require their staff to undertake mandatory training. You should not include mandatory training that is not directly related to your practice (for example, fire training or health and safety training) as part of your 35 hours of CPD. However, if you undertake any mandatory training that is necessary to your scope of practice and professional development, for example, mandatory training on equality legislation if you are in a policy role, you could include that.
63. Participatory learning includes any learning activity in which you personally interact with other professionals, including professionals working outside healthcare. It can be an activity undertaken with one or more professionals or in a larger group setting. The group does not always need to be in a common physical environment, such as a study group or conference. It could be a group in a virtual environment (such as an online discussion group).
64. The NMC publishes and regularly updates standards of proficiency for everyone on our register. These set out what we expect students to know, understand and be able to apply to join our register and practise safely and effectively. When you are considering what CPD to undertake we recommend that you review the latest standards of proficiency for your part of the register and reflect on how your scope of practice relates to the standards and consider CPD activities that would help you to develop your skills. This is particularly important if you supervise and/or assess students as part of your role.

## How to record CPD

65. You must maintain accurate records of your CPD activities, and we have provided a template to help you with this. This will form part of the discussion you have with your confirmer. You will need to have this information available in case we request to see it for verification of your application. Your records should include:
- the CPD method
  - a brief description of the topic and how it relates to your practice
  - dates the CPD activity was undertaken
  - the number of hours and participatory hours
  - identification of the part of the Code most relevant to the CPD, and
  - evidence of the CPD activity.

## What you need to tell us in your online application

66. You need to declare that you have met the CPD requirement.

# PRACTICE-RELATED

# FEEDBACK

## The requirement

67. You must have obtained five pieces of practice-related feedback in the three year period since your registration was last renewed or you joined the register.<sup>15</sup>

## The purpose of this requirement

68. The practice-related feedback requirement is intended to encourage you to be more responsive to the needs of patients and service users and those who care for them. You need to seek feedback from people you work with and care for and importantly you need to use the feedback that you receive to assess and make improvements to your practice.

## How to meet the requirement

69. We recommend that you try to obtain feedback from a variety of sources, for example:

- feedback from patients, service users, carers or students as part of your day to day practice
- feedback from colleagues such as nurses, midwives, nursing associates and other healthcare professionals
- feedback from colleagues in management, on reception, in assistant positions, as well as fellow teachers, researchers, academics or policy colleagues
- complaints
- team performance reports
- serious event reviews, and
- feedback received through your annual appraisal.

70. Types of feedback:

- feedback can be about your individual practice or about your team, ward, unit or organisation's practice (you should be clear about the impact the feedback had on your practice)
- formal or informal
- written or verbal, and
- positive or constructive.

71. It's likely that you will already receive a range of feedback. In many organisations, feedback is already collected in a variety of ways. You must seek consent to access or use your employer's information. Any information must be extracted in a way that no information identifying an individual is obtained, used or recorded. For example, you must not forward work emails to your personal accounts, or download and take copies of employer records. See the section on non-identifiable information on pages 15-17 for more information.
72. Should you choose to solicit feedback directly from colleagues, patients or service users, you must make clear in your request that no information identifying individuals should be included in any feedback provided. You should also inform them how you intend to use their feedback, and reassure patients and service users that any feedback they give will not affect the care they receive.

## How to record feedback

73. We recommend that you keep a note of the content of any feedback you obtain, including how you used it to improve your practice. This will be helpful for you to use when you are preparing your reflective accounts. We have provided a template to help you record your feedback.
74. You may choose to collect more feedback but to meet the revalidation requirement you only need to note the details of five pieces of feedback.
75. In any note you keep, you must not record any information that might identify an individual, whether that individual is alive or deceased. The section on non-identifiable information on pages 15-17 provides guidance on how to make sure that your notes do not contain any information that might identify an individual.

## What you need to tell us in your online application

76. You need to declare that you have met the feedback requirement.





# WRITTEN REFLECTIVE

## ACCOUNTS

### The requirement

77. You must have prepared five written reflective accounts in the three year period since your registration was last renewed or you joined the register. Each reflective account must be recorded on the approved form and must refer to:

- an instance of your CPD and/or
- a piece of practice-related feedback you have received and/or
- an event or experience in your own professional practice and how this relates to the Code.

### The purpose of this requirement

78. We want you to engage in reflective practice so that you identify any changes or improvements you can make to your practice based on what you have learnt.

79. This requirement should also raise awareness of the Code and encourage you to consider the role of the Code in your practice and professional development.

### How to meet the requirement

80. Each reflective account can be about an instance of your CPD, feedback, an event or experience in your practice as a nurse, midwife or nursing associate, or a combination of these. Both positive and negative experiences should be reflected on. Any experience, including a conversation with a colleague, a significant clinical or professional event, or a period of time can generate meaningful reflections, insights and learning. For example, you could create a reflective account on a particular topic which may have arisen through some feedback your team received following an event, such as consent and confidentiality and identify how that relates to the Code.



## How to record your reflective accounts

81. We have provided a form that you must use to record your reflective accounts. You must explain what you learnt from the CPD activity, feedback, event or experience, how you changed or improved your practice as a result, and how this is relevant to the Code.
82. This form can be hand written, typed or, if necessary, dictated.
83. Your reflective accounts must not include any information that might identify an individual whether that individual is alive or deceased. The section on non-identifiable information on pages 15-17 provides guidance on how to make sure that your reflective accounts do not contain any information that might identify an individual.
84. You do not need to submit a copy of the reflective accounts to the NMC for the purpose of revalidation. However, you should retain these as a record to inform your reflective discussion and to show your confirmer.

## What you need to tell us in your online application

85. You need to declare that you have met the requirement for written reflective accounts.

# REFLECTIVE DISCUSSION

## The requirement

86. You must have had a reflective discussion with another NMC registrant, covering your five written reflective accounts on your CPD and/or practice-related feedback and/or an event or experience in your practice and how this relates to the Code.<sup>16</sup>
87. You must ensure that the NMC registrant with whom you had your reflective discussion signs the approved form recording their name, NMC Pin, email, professional address and postcode, as well as the date you had the discussion.<sup>17</sup>

## The purpose of this requirement

88. This requirement will encourage a culture of sharing, reflection and improvement. It does this by requiring you to discuss your professional development and improvement, and by ensuring that you do not practise in professional isolation.

## How to meet the requirement

89. You must discuss your five written reflective accounts with another person on our register as part of a reflective discussion. In the discussion you and your reflective discussion partner will be linking your reflective accounts to the Code, so it is important that both of you are familiar with, and working to, the professional standards presented in the Code.
90. The reflective discussion partner:
- must be a nurse, midwife or nursing associate with an effective registration with the NMC, by which we mean they cannot be subject to any kind of suspension, removal or striking-off order at the time of having the discussion
  - could be someone you frequently work with or someone from a professional network or learning group
  - does not need to be someone you work with on a daily basis
  - does not need to undertake the same type of practice as you, and
  - does not need to be on the same part of the register as you (so a nurse can have a reflective discussion with a midwife and vice versa).
91. If you practise in a setting with few or no nurses, midwives or nursing associates, you can reach out to peers, who are registered with the NMC, from your wider professional or specialty network in order to have your reflective discussion.
92. It is for you to decide the most appropriate person for you to have this conversation with, including whether they are senior or junior to you.



93. If your confirmer is on our register, your reflective discussion can form part of the confirmation discussion. If your confirmer is not on our register, you will need to have your reflective discussion with an NMC-registered nurse, midwife or nursing associate before your confirmation discussion with your confirmer.
94. We expect the discussion to be a face-to-face conversation in an appropriate environment. If for some reason you cannot have a face-to-face discussion, then you could arrange a video conference.
95. During your discussion you should not discuss patients, service users or colleagues in a way that could identify them unless they expressly agree. For further information on reflective discussions please [guidance and information](#).

## How to record your reflective discussion

96. We have provided an NMC form that you must use to record your discussion. You must make sure that the nurse, midwife or nursing associate with whom you had your reflective discussion signs the form and records their name, NMC Pin, email, professional address including postcode, contact number and the date you had the discussion and a summary of the discussion.<sup>18</sup> You should keep the completed and signed form.
97. The discussion summary section of the form must not include any information that might identify an individual, whether that individual is alive or deceased. The section on non-identifiable information on pages 15-17 provides guidance on how to make sure that your notes do not contain any information that might identify an individual.

## What you need to tell us in your online application

98. You need to declare that you have had a reflective discussion with another NMC-registered nurse, midwife or nursing associate.
99. You will also need to enter the name, NMC Pin, email, professional address including postcode and contact number of your reflective discussion partner, as well as the date you had the reflective discussion.

# HEALTH AND CHARACTER

## The requirements

- 100. You must provide a health and character declaration.<sup>19</sup>
- 101. You must declare if you have been convicted of any police charge, police caution, conviction or conditional discharge.<sup>20</sup>
- 102. You will be asked to declare if you have been subject to any adverse determination that your fitness to practise is impaired by a professional or regulatory body (including those responsible for regulating or licensing a health and social care profession).<sup>21</sup>

## The purpose of these requirements

- 103. These requirements will help to satisfy the Registrar that you are capable of safe and effective practice.

## How to meet the requirements

- 104. You will need to complete these declarations as part of your revalidation application.
- 105. When making these declarations please refer to our [guidance on health and character](#) for nurses, midwives and nursing associates.
- 106. Your character is important and is central to the Code because nurses, midwives and nursing associates must be honest and trustworthy. Your character is based on your conduct, behaviour and attitude. When declaring that you are of good character you should consider whether you have been involved in conduct which would breach the requirements of the Code. You can read the Code on our website: [www.nmc.org.uk/standards/code](http://www.nmc.org.uk/standards/code). See our [guidance on health and character](#) for further information.
- 107. You will also be asked to declare if you have been subject to any determination by a professional or regulatory body (including those responsible for regulating or licensing a health or social care profession) to the effect your fitness to practise is impaired.<sup>22</sup>
- 108. In accordance with the Code, we expect you to declare any police charges, cautions, convictions and conditional discharges to the NMC immediately, not wait until revalidation.<sup>23</sup> A caution or conviction includes a caution or conviction you have received in the UK for a criminal offence, as well as a conviction received elsewhere for an offence which, if committed in England and Wales, would constitute a criminal offence.<sup>24</sup> Please do not notify the NMC of motoring offences unless it led to a disqualification of driving or offences that have previously been considered by the NMC. [See our guidance on health and character](#) for further information.
- 109. We need to know that people applying to renew their registration meet our requirements for health to ensure they can practise safely and effectively.
- 110. It's important to remember that when we talk about 'good health' we mean that you are capable of safe and effective practice as a nurse, midwife or nursing associate either with or without reasonable adjustments and adjustments which your employer has made.

111. Our focus is whether you have a health condition and/or disability which may affect your practice. This is because we need to be able to assess whether it may place at risk the safety of people in your care
112. It doesn't mean the absence of a health condition and/or disability. Many people with disabilities and health conditions are able to practise with or without adjustments put in place by their employer to support them.
113. It is up to you to decide whether your health allows you to be capable of safe and effective practice. If you are satisfied with your decision then you do not need to provide us with any further information apart from your declaration (see section below).

## How to record health and character declarations

114. If your health and character enable you to practise safely and effectively in accordance with the Code, and you do not have any charges, cautions, convictions, conditional discharges or determinations to declare, you do not need to keep any information as part of this requirement. Your confirmer does not need to check that you have met this requirement.
115. If you do need to declare any charges, cautions, convictions, conditional discharges or determinations you will need to keep evidence of these to provide us with further information.



Paragraph 23.2 of the Code states that you must inform us and any employers you work for as soon as you can of any caution or charge against you, or if you have received a conditional discharge in relation to, or have been found guilty of, a criminal offence (other than a protected caution or conviction).

## What you need to tell us in your online application

116. You need to declare that your health and character enable you to practise safely and effectively in accordance with the Code. [See our guidance on health and character.](#)
117. You will be asked to declare if you have a charge, caution, conviction or conditional discharge other than those which are protected. You do not have to tell us about protected cautions and convictions. These are minor offences that will not be disclosed on a Disclosure and Barring Service (DBS) check. Listed offences are never protected and must always be declared to us. See the [full list from the DBS](#) for England, Wales and Northern Ireland. In Scotland, the checking and barring service is operated by [Disclosure Scotland](#).

# PROFESSIONAL INDEMNITY

## ARRANGEMENT

### The requirement

118. You must declare that you have, or will have when practising, appropriate cover under an indemnity arrangement.<sup>25</sup>

### The purpose of this requirement

119. By law, you must have in place an appropriate indemnity arrangement in order to practise and provide care. While the arrangement does not need to be individually held by you, it is your responsibility to ensure that appropriate cover is in place.

### How to meet the requirement

120. You will need to complete this declaration as part of your revalidation application.

121. Most employers provide appropriate indemnity cover for their employees. If you are employed you should check this with your employer(s). Further information is available from the [NHS Employer's website](#).

122. Please refer to our information on [professional indemnity arrangements](#) when making this declaration. This document defines 'appropriate cover' and sets out information for those who are employed, self-employed or undertake work in both employed and self-employed roles. It also sets out information for those who work in education, undertake voluntary work, or are having a break in their practice.

123. If it is discovered that you are practising as a nurse, midwife or nursing associate without an appropriate indemnity arrangement in place, you will be removed from the NMC register and unable to practise as a nurse, midwife or nursing associate.

## How to record your professional indemnity arrangement

124. Your declaration will be made as part of your revalidation application.
125. We strongly recommend that you retain evidence that you have an appropriate arrangement in place.
126. If your arrangement is provided through membership of a professional body or a private insurance arrangement, your declaration should be based on having an indemnity arrangement in place which provides 'appropriate cover' in relation to your individual scope of practice, as explained on [our website](#) and in the [professional indemnity arrangement guidance](#). Please note that you will need to justify decisions on cover you put in place or rely on, if we request you to do so. Your confirmer does not need to check that you have met this requirement.
127. Your confirmer does not need to check that you have met this requirement.

## What you need to tell us in your online application

128. You need to inform the NMC whether your indemnity arrangement is through your employer, membership of a professional body, or a private insurance arrangement. Alternatively, you will be able to inform us that you are not practising at this time but that you intend to have appropriate cover in place before you practise.
129. You are required to have appropriate cover in place for all of your current practice settings. If you are currently practising in more than one setting, please tell us first about your arrangement in relation to your main practice setting. Please then add other arrangements to cover all your current practice settings.
130. If your indemnity arrangement is provided through membership of a professional body or a private insurance arrangement, you will be asked to provide the name of the professional body or provider.<sup>26</sup>



# CONFIRMATION

## The process

131. We will ask you for information for the purpose of verifying the declarations you have made in your application.<sup>27</sup>
132. This will be a declaration that you have demonstrated to an appropriate confirmer that you have complied with the revalidation requirements. We have provided a form for you to use to obtain this confirmation.
133. We will ask you to provide the name, NMC Pin or other professional identification number (where relevant), email, professional address and postcode of the confirmer.

## The purpose of confirmation

134. Confirmation encompasses several benefits for you. It will provide assurance, increase support and engagement between you and your confirmer, and make you more accountable for your own practice and improvement. It should support you by increasing access to appraisals.
135. The interactive nature of the confirmation process should reduce professional isolation and encourage a culture of sharing, reflection and improvement.
136. Ultimately, the confirmation process is designed to increase professionalism by making nurses, midwives and nursing associates more accountable for their practice and improvement. This requirement also gives us an additional layer of assurance that nurses, midwives and nursing associates are complying with the revalidation requirements.
137. Confirmation is not a new way for employers to raise fitness to practise concerns. Confirmation is not about employers judging whether a nurse, midwife or nursing associate is fit to practise or an assessment against the requirements of their current or former employment. Raising a concern about a nurse, midwife or nursing associate's fitness to practise should be raised promptly through our [fitness to practise procedures](#). Information on our website about our fitness to practise processes.

## How to obtain confirmation

138. The confirmation process involves having a discussion about your revalidation with an appropriate confirmer. We recommend that you obtain confirmation through a face-to-face discussion or video conference.
139. As part of that discussion, you will demonstrate to that confirmer that you have complied with all of the revalidation requirements, except those related to a professional indemnity arrangement and health and character, as set out in this guidance.
140. We recommend that you obtain your confirmation during the final 12 months of the three year renewal period to ensure that it is recent. If you obtain confirmation earlier, we may ask you to explain why.

141. If your confirmer is a NMC-registered nurse, midwife or nursing associate, your reflective discussion can form part of the confirmation discussion. If your confirmer is not on the NMC register, you will need to have your reflective discussion with an NMC-registered nurse, midwife or nursing associate before you have your confirmation discussion with your confirmer.
142. We have provided further information about the role of confirmers in our guidance document [Information for confirmers](#), which you should ensure your confirmer has read.

## An appropriate confirmer

143. Your line manager is an appropriate confirmer, and we strongly recommend that you obtain confirmation from your line manager wherever possible. A line manager does not have to be an NMC-registered nurse, midwife or nursing associate. For example they could be a GP practice manager or care home manager at your place of work.
144. If you do not have a line manager, you will need to decide who is best placed to provide your confirmation. Wherever possible we recommend that your confirmer is an NMC-registered nurse, midwife or nursing associate. It is helpful if they have worked with you or have a similar scope of practice, but this is not essential.
145. If that is not possible, you can seek confirmation from another healthcare professional that you work with and who is regulated in the UK. For example, you could ask a doctor, dentist or a pharmacist. You will need to record their profession and professional Pin or registration number.
146. If you do not have a line manager, or access to someone on the NMC register or another healthcare professional, please check our online confirmation tool for further guidance as to who can act as a confirmer in this situation at [revalidation.nmc.org.uk/what-you-need-to-do/confirmation](https://revalidation.nmc.org.uk/what-you-need-to-do/confirmation).
147. If your confirmer is an NMC-registered nurse, nursing associate, midwife, they must have an effective registration with the NMC. We will not be able to verify your application if your confirmation was provided by a person who was subject to any kind of suspension, removal or striking-off order at the time of making the confirmation.

## Obtaining confirmation if you work wholly overseas

148. If you work wholly overseas, you can seek confirmation from your line manager where you undertake your work.
149. If you do not have a line manager, you will need to decide who is best placed to provide your confirmation. Wherever possible we recommend that your confirmer is a nurse, midwife or nursing associate regulated where you practise, or another regulated healthcare professional. Our [online confirmation](#) tool provides further guidance as to who can act as a confirmer in this situation.



## Obtaining confirmation if you have more than one line manager

150. If you have more than one employer or undertake more than one role, you only need to obtain one confirmation. You will need to decide which line manager is most appropriate to provide confirmation that you have met the revalidation requirements.
151. We recommend that you have your revalidation discussion and obtain confirmation through the line manager where you undertake the majority of your work. You may choose to have a revalidation discussion with each of your line managers, and bring the outputs of those discussions to the line manager you think is most appropriate to be your confirmer.

## Confirmation and appraisals

152. The revalidation process is designed so that it can form part of an appraisal process, and where possible we recommend that you use your annual appraisal to have your revalidation discussion and obtain confirmation.
153. If your line manager is an NMC-registered nurse or midwife, you might like to have your reflective discussion at the same time as your confirmation discussion as part of your annual appraisal.
154. However, it is not a requirement of revalidation that you obtain your confirmation as part of an appraisal.

## How to record confirmation

155. You must use the NMC form to record your confirmation. Your confirmer will need to complete and sign this form.
156. You should keep the completed and signed form.

## What you need to tell us in your online application

157. You will be asked to enter the name, NMC Pin or other professional identification number (where relevant), email, professional address including postcode and contact number of your confirmer. If your confirmer is not your line manager or an individual on the NMC register, you will also need to provide details of their profession and regulation.
158. We will also ask you whether you have a regular appraisal and whether you have a line manager who is an NMC-registered nurse, midwife or nursing associate so that we understand what level of support was available to you in completing your revalidation application.



# THE APPLICATION

## PROCESS

### Before you apply

**159. Set up an NMC Online account.**

You will need to submit your application through NMC Online. You can also check your renewal date and revalidation application date on NMC Online. We have published a step-by-step guide to registering for NMC Online at [www.nmc.org.uk/registration/nmc-online](http://www.nmc.org.uk/registration/nmc-online).



Once you have set up your online account, you will receive all subsequent notifications by email. Please add the NMC as a safe sender and check your email (including any junk email folder) regularly during the revalidation process.

**160. Keep your contact details up to date so that we can notify you when your revalidation application is due.**

The most common reason for someone failing to revalidate is a failure to keep the NMC updated on your contact details.

**161. Make sure you know when your revalidation application is due.**

You must submit your application by the date we specify. You may affect our ability to process your revalidation application if you do not submit your application by this date, and the renewal of your registration may be at risk as a result.

**162. Make sure that you have all your supporting evidence to hand when you start your online application.**

Please contact the NMC well in advance of your revalidation application date if you require an adjustment for using NMC Online (see Support to help you revalidate section below).

### The online application

163. Your online application opens 60 days before your revalidation application date.

164. During this 60 day period you will need to log into your application via NMC Online and address each of the requirements.

165. Do not submit your application until you have met all the revalidation requirements.

#### Contacting your employer or any other relevant third party

166. As part of your application process we may need to contact your employer or any other relevant third party who can verify the information that you have provided in your application.<sup>28</sup>

167. In your online application you will be asked to provide consent for this purpose.

## Equality and diversity information

168. As part of the online application process you will be asked to supply some equality and diversity information. We use this data to monitor our services so that we can support you and make sure we are treating everyone in a fair and equal way. The questions have been designed to gather data about our service users in relation to the characteristics protected by the law under the Equality Act 2010.
169. We will keep the information from this questionnaire confidential and store it in line with the Data Protection Act 2018 and the NMC's Data Protection Policy. By submitting this sensitive personal information to us, you explicitly consent to the collection and processing of your sensitive personal information in accordance with the NMC's Data Protection Policy.
170. Providing this information is optional and will not affect your revalidation application or registration renewal. If you would prefer not to disclose this information you can select the 'prefer not to say' option for any or all of the questions.



Details of our Data Protection Policy are included in our privacy notice at [www.nmc.org.uk/privacy](http://www.nmc.org.uk/privacy).

## Paying your fee

171. Alongside your revalidation application you need to pay your annual registration fee every year to maintain your registration with the NMC. Your registration will not be renewed until we have received your payment.
172. Please refer to our guidance on paying your fees at [www.nmc.org.uk/registration/staying-on-the-register/paying-your-fee](http://www.nmc.org.uk/registration/staying-on-the-register/paying-your-fee). This sets out the different ways that you can pay, including by direct debit and by debit or credit card, as well as how to pay your fee in four quarterly instalments.
173. As a registered UK tax payer you can claim tax relief on the NMC registration fees. HM Revenue and Customs (HMRC) allows individuals to claim tax relief on professional subscriptions or fees which have to be paid in order to carry out a job. The registration fee you pay to us is included in this category. Please refer to our guidance on how to claim tax relief on your fee at [www.nmc.org.uk/registration/staying-on-the-register/tax-relief](http://www.nmc.org.uk/registration/staying-on-the-register/tax-relief).

## After you have completed your application

174. After you have completed your online application you will be offered the option of printing a paper copy of your application for your records.
175. Once your application has been successfully processed and your payment has been received we will send you an email confirming that your registration has been renewed.
176. We advise you to [search the register](#) on our website at to double check your status.

## Support to help you revalidate

177. We understand that there may be circumstances that make it more difficult for you to meet the revalidation requirements. This may be as a result of a disability, an illness, pregnancy, a maternity period or any other life event that impacts on your ability to meet the revalidation requirements.
178. We can support you to meet the revalidation requirements in several ways, for example by:
- helping you to use NMC Online, or
  - providing a short extension to your application date.<sup>29</sup>

For further information on the support we can offer and how to apply for this support please see our support to help you [revalidate guidance sheet](#).

# VERIFICATION OF YOUR APPLICATION

179. Each year we will select a sample of revalidation applications and request further information so we can verify the information provided.<sup>30</sup> Such a request does not necessarily mean that there are any concerns about your application and you can continue to practise while we review the information that you provide.
180. We will contact you by email within 24 hours of you submitting your revalidation application if you have been selected to provide further information and where possible we will notify you immediately after you have submitted your application through NMC online. Please make sure to check your email during this time, including junk email folders.
181. If you are selected to provide further information, you will need to complete an online form where you will be asked to provide further information. We may also request further evidence. We will ask you to provide this information within 21 days of receiving your notice that you have been selected for verification.
182. Your registration will not lapse during the verification process, even if the process extends past your renewal date. We will hold your registration effective until the verification process is complete, and you can continue to practise as normal during this time.
183. The table below sets out the information that you will need to provide if you are selected to provide further information. You should already have this information so you should not need to seek any additional information.
184. We will contact your confirmer to request further information using the email address you provided in your application. Please contact us if your confirmer requires adjustments in the way we contact them. Please ensure that your confirmer is aware that if they do not respond to our request for verification they may put your registration at risk. We may also contact your employer and reflective discussion partner.
185. If we identify that you have not met the revalidation requirements, or you have submitted fraudulent information, your registration might be at risk. Please note that if you do not engage fully with the verification process your registration could lapse and you would have to apply for readmission.
186. The verification process will be completed within three months of your renewal date.

# Verification information

## Practice hours

You will need to provide the following information, starting with your most recent practice until you demonstrate the minimum number of practice hours during the three year revalidation period:

- dates of practice
- the number of hours you undertook
- name, address and postcode of the organisations
- scope of practice and work setting (see tip box on page 22)
- a description of the work you undertook, and
- if practising overseas, whether you are registered with the appropriate regulating body.

We may contact your employer for further information, and you may also be asked to provide further evidence of practice hours and how this relied on your knowledge, skills and experience as a nurse, midwife or nursing associate.

If you are using a completed return to practice course for your practice hours requirement, or you have been admitted to another part of the register since you last renewed your registration or joined the register, please see our guidance sheet on return to practice and new registration at [revalidation.nmc.org.uk/download-resources/guidance-and-information](https://revalidation.nmc.org.uk/download-resources/guidance-and-information) for further information.

## Continuing professional development

You will need to provide the following information:

- the CPD method
- a brief description of the topic and how it relates to your practice
- the dates the CPD activity was undertaken
- the number of hours and participatory hours, and
- identification of the part of the Code most relevant to the CPD.

You may also be asked to provide evidence of the CPD activity.

## Reflective discussion

We will not ask you to upload a copy of the signed reflective discussion form; however, we may contact your reflective discussion partner about your discussion.

## Professional indemnity arrangement

You are required to have appropriate cover in place for all of your current practice settings. If your arrangement is provided through membership of a professional body or a private insurance arrangement you will be asked to confirm a) that you have read and understood our information on professional indemnity arrangements; b) that you have in place an indemnity arrangement which provides "appropriate cover" in relation to your individual scope of practice, as explained in our guidance, [Professional indemnity arrangements](#); and c) that you understand that you will need to justify decisions on cover you put in place or rely on, if we request you to do so. If you are currently practising in more than one setting, please tell us first about your arrangement in relation to your main practice setting, followed by any other arrangements to cover all your current practice settings.

## Confirmation

We will not ask you to upload a copy of the signed confirmation form; however, we will contact your confirmer using the contact details you provided to us in your initial application so please ensure these are accurate. Please ensure that your confirmer is aware that if they do not respond to our request for verification they may put your registration at risk.

# REVALIDATION AND NMC FITNESS TO PRACTISE PROCESSES



187. If an employer, a nurse, midwife or nursing associate, or any other individual becomes aware of a serious concern about the fitness to practise of a nurse, midwife or nursing associate they should raise it promptly through our fitness to practise procedures. All nurses, midwives and nursing associates have a professional duty to raise a concern about the practice of a person on our register either through their employer or directly with us.
188. Revalidation does not create a new way of raising a fitness to practise concern about a nurse, midwife or nursing associate. You should not wait until a nurse, midwife or nursing associate's renewal is due before raising a concern.



**For more information on how to raise a fitness to practice concern see [www.nmc.org.uk/concerns-nurses-midwives/concerns-complaints-and-referrals/](http://www.nmc.org.uk/concerns-nurses-midwives/concerns-complaints-and-referrals/)**

189. The confirmation stage of revalidation is not for the confirmer to make a judgment as to whether a nurse, midwife or nursing associate is fit to practise but rather to confirm that they have met the revalidation requirements.
190. If you are subject to an NMC investigation, condition(s) of practice order or a caution, you are still required to apply to renew your registration as long as you fulfil all the requirements for renewal. However, You will remain subject to NMC fitness to practise processes and the outcome of those processes.
191. If you have been struck off the register, you are not able to revalidate because you are no longer on the register. You will need to apply for restoration to the register.



For more information on restoration please see [www.nmc.org.uk/concerns-nurses-midwives/information-under-investigation/restoration](http://www.nmc.org.uk/concerns-nurses-midwives/information-under-investigation/restoration)

192. If you are suspended from the register, you are not able to revalidate during your suspension. At the end of your suspension, if your registration is effective, you will need to comply with the revalidation requirements at the time that your registration is due to be renewed. If your registration is not effective following the end of your period of suspension, you will need to follow the readmission process.

# CANCELLING YOUR REGISTRATION

193. You may not want to retain one or all your registrations with us.

- For example you may wish to cancel all of your registrations with us if you have moved abroad, have retired from practice, changed career or wish to take a break from practice due to your current health.
- Alternatively you may wish to cancel one of your registrations if you wish to continue practising in one but not the other. For example if you are registered as both a nurse and a midwife but only wish to continue practising as a midwife you may want to cancel your nursing registration.



Please note that if you are receiving pay as a nurse, midwife or nursing associate whilst on maternity leave, sick leave or annual leave you may need to maintain your registration with us throughout this period in order to receive it. Please speak to your employer about this.

194. If you want to cancel your registration at the time of your revalidation application, you can do this online through the online revalidation application.

195. If you want to cancel your registration when you are not due to revalidate, you must submit an 'application to lapse your registration' form.

196. You will need to provide your NMC Pin, full name, contact address, the reason for cancelling and a declaration stating that you are not aware of any matter which could give rise or has given rise to a fitness to practise allegation being made against you.



Information on cancelling your NMC registration is available on our website at [www.nmc.org.uk/registration/leaving-the-register/cancelling-registration/](http://www.nmc.org.uk/registration/leaving-the-register/cancelling-registration/)

197. You will not be able to practise or present yourself as a registered nurse or midwife in the UK or nursing associate in England if you are no longer registered with the NMC. It is a criminal offence if with intent to deceive (whether expressly or by implication), you falsely represent yourself as being on the register, or on part of it, possess qualifications in nursing or midwifery or to use a title to which you are not entitled.<sup>31</sup>

198. If you choose to cancel your registration, and later wish to resume practising as a nurse or midwife in the UK, please refer to our guidance on readmission to the register at [www.nmc.org.uk/registration/returning-to-the-register](http://www.nmc.org.uk/registration/returning-to-the-register).



199. If you apply for readmission within six months of lapsing your registration when your revalidation was due, you will have to meet some of the revalidation requirements in addition to the usual readmission requirements, unless you are able to demonstrate that exceptional circumstances apply. These additional revalidation requirements are:
- 20 of your 35 CPD hours must be participatory
  - Five pieces of practice related-feedback
  - Five written reflective accounts
  - Reflective discussion
200. For further details of the revalidation readmission requirements and process please see [www.nmc.org.uk/registration/returning-to-the-register/readmission-register/details-of-the-requirements](http://www.nmc.org.uk/registration/returning-to-the-register/readmission-register/details-of-the-requirements).

## Failure to revalidate and appeals

201. If you cannot meet the revalidation requirements, you can cancel your registration with us. By cancelling your revalidation and providing us with a reason for doing so, you are showing insight and it demonstrates to us that you are managing your situation in a responsible way. You will continue to hold a nursing, midwifery or nursing associate qualification, but will not be a registered nurse, midwife or nursing associate. When you are ready to practise again, you can apply for readmission. Information on cancelling registration and seeking readmission to the register is available on our website at [www.nmc.org.uk/registration](http://www.nmc.org.uk/registration).
202. If you do not cancel your registration, but you fail to submit your revalidation application before the end of your three year renewal period, your registration will lapse (automatically expire). You will need to apply for readmission if you want to come back on to the register.
203. If your application for revalidation is refused because a decision is made that you have not met the revalidation requirements, you may appeal this decision within 28 days of the date on your decision letter.<sup>32</sup>
204. A notice of appeal should be sent to [registrationinvestigations@nmc-uk.org](mailto:registrationinvestigations@nmc-uk.org) made in writing and include:
- your name, address and NMC Pin
  - the date, nature and other relevant details of the decision against which the appeal is brought
  - a concise statement of the grounds of the appeal
  - the name and address of your representative (if any) and a statement as to whether the NMC should correspond with that representative concerning the appeal instead of you
  - a statement that the notice is a notice of appeal
  - a signature by or on behalf of you, and
  - a copy of any documents that you propose to rely on for the purposes of your appeal.<sup>33</sup>
- Please contact us if you require support or assistance in completing this notice.
205. You do not have the right of appeal if you fail to pay the registration fee or submit a revalidation application form within the required timescale and your application to renew your registration is refused as a result.<sup>34</sup>
206. If your registration is not renewed because you cancelled your registration, did not complete your revalidation application, did not submit your application in time or your application for revalidation is refused, you will not be able to practise as a registered nurse, midwife or nursing associate. It is a criminal offence if you knowingly falsely represent yourself as being on the register, or on part of it or you use a title to which you are not entitled.

# REFLECTIVE ACCOUNTS FORM

You **must** and/or an event or experience in your practice and how this relates to the Code. Please fill in a page for each of your reflective accounts, making sure you do not include any information that might identify a specific patient, service user, colleague or other individuals. Please refer to our guidance on preserving anonymity in the section on non-identifiable information in *How to revalidate with the NMC*.

## Reflective account:

What was the nature of the CPD activity and/or practice-related feedback and/or event or experience in your practice?

What did you learn from the CPD activity and/or feedback and/or event or experience in your practice?

How did you change or improve your practice as a result?

How is this relevant to the Code?

Select one or more themes: Prioritise people – Practise effectively – Preserve safety – Promote professionalism and trust

# REFLECTIVE DISCUSSION FORM

You **must** use this form to record your reflective discussion with another NMC-registered nurse, midwife or nursing associate about your five written reflective accounts. During your discussion you should not discuss patients, service users, colleagues in a way that could identify them unless they expressly agree, and in the discussion summary section below make sure you do not include any information that might identify an individual. Please refer to the section on non-identifiable information in *How to revalidate with the NMC* for further information. For more information about reflective discussion, please refer to our guidance sheet on reflective practice for revalidation.

**To be completed by the nurse, midwife or nursing associate:**

<b>Name:</b>	
<b>NMC Pin:</b>	

**To be completed by the nurse, midwife or nursing associate with whom you had the discussion:**

<b>Name:</b>	
<b>NMC Pin:</b>	
<b>Email address:</b>	
<b>Professional address including postcode:</b>	
<b>Contact number:</b>	
<b>Date of discussion:</b>	
<b>Short summary of discussion:</b>	
<p><b>I have discussed five written reflective accounts with the named nurse, midwife or nursing associate as part of a reflective discussion.</b></p> <p><b>I agree to be contacted by the NMC to provide further information if necessary for verification purposes.</b></p>	<p><b>Signature:</b></p> <hr style="border: 0.5px solid black;"/> <p><b>Date:</b></p>

# CONFIRMATION FORM

You **must** use this form to record your confirmation.

**To be completed by the nurse, midwife or nursing associate:**

<b>Name:</b>	
<b>NMC Pin:</b>	
<b>Date of last renewal of registration or joined the register:</b>	

**I have received confirmation from (select applicable):**

- A line manager who is also an NMC-registered nurse, midwife or nursing associate
- A line manager who is not an NMC-registered nurse, midwife nursing associate
- Another NMC-registered nurse, midwife or nursing associate
- A regulated healthcare professional
- An overseas regulated healthcare professional
- Other professional in accordance with the NMC's online confirmation tool

**To be completed by the confirmer:**

<b>Name:</b>	
<b>Title:</b>	
<b>Email address:</b>	
<b>Professional address including postcode:</b>	
<b>Contact number:</b>	
<b>Date of confirmation discussion:</b>	

If you are an NMC–registered nurse, midwife or nursing associate please provide:

NMC Pin:

If you are a regulated healthcare professional please provide:

Profession:

Registration number for regulatory body:

If you are an overseas regulated healthcare professional please provide:

Country of practice:

Profession:

Registration number for regulatory body:

If you are another professional please provide:

Name of regulating body:

Registration number for regulatory body:

## Confirmation checklist of revalidation requirements

### Practice hours

- You have seen written evidence that satisfies you that the nurse, midwife or nursing associate has practised the minimum number of hours required for their registration

### Continuing professional development

- You have seen written evidence that satisfies you that the nurse, midwife or nursing associate has undertaken 35 hours of CPD relevant to their practice as a nurse, midwife or nursing associate
- You have seen evidence that at least 20 of the 35 hours include participatory learning relevant to their practice as a nurse, midwife or nursing associate.
- You have seen accurate records of the CPD undertaken.

### Practice-related feedback

You are satisfied that the nurse, midwife or nursing associate has obtained five pieces of practice-related feedback.

### Written reflective accounts

You have seen five written reflective accounts on the nurse, midwife or nursing associate's CPD and/or practice-related feedback and/or an event or experience in their practice and how this relates to the Code, recorded on the NMC form.

### Reflective discussion

You have seen a completed and signed form showing that the nurse, midwife or nursing associate has discussed their reflective accounts with another NMC-registered individual (or you are an NMC-registered individual who has discussed these with the nurse, midwife or nursing associate yourself).

I confirm that I have read *Information for confirmers*, and that the above named NMC-registered nurse, midwife or nursing associate has demonstrated to me that they have met all of the NMC revalidation requirements listed above during the three years since their registration was last renewed or they joined the register as set out in *Information for confirmers*.

I agree to be contacted by the NMC to provide further information if necessary for verification purposes. I am aware that if I do not respond to a request for verification information I may put the nurse, midwife or nursing associate's registration application at risk.

Signature:

Date:

# PRACTICE HOURS LOG TEMPLATE

## Guide to completing practice hours log

To record your hours of practice as a registered nurse, midwife and nursing associate, please fill in a page for each of your periods of practice. Please enter your most recent practice first and then any other practice until you reach 450 hours. You can only count practice hours during the three year period since your last registration renewal or initial registration. You do not necessarily need to record individual practice hours. You can describe your practice hours in terms of standard working days or weeks. For example if you work full time, please just make one entry of hours. If you have worked in a range of settings please set these out individually. You may need to print additional pages to add more periods of practice. If you are both a nurse and a midwife or a nursing associate and nurse you will need to provide information to cover 450 hours of practice for each of these registrations.<sup>33</sup>

### Work setting

- Ambulance service
- Care home sector
- Community setting (including district nursing and community psychiatric nursing)
- Consultancy
- Cosmetic or aesthetic sector
- Governing body or other leadership
- GP practice or other primary care
- Hospital or other secondary care
- Inspectorate or regulator
- Insurance or legal
- Maternity unit or birth centre
- Military
- Occupational health

### Police

- Police organisation
- Prison
- Private domestic setting
- Public health organisation
- School
- Specialist or other tertiary care including hospice
- Telephone or e-health advice
- Trade union or professional body
- University or other research facility
- Voluntary or charity sector
- Other

### Scope of practice

- Direct clinical care or management
- Commissioning
- Education
- Policy
- Quality assurance or inspection
- Research
- Other

### Registration

- Nurse
- Midwife
- Nurse/SCPHN
- Midwife/SCPHN
- Nurse and Midwife (including Nurse/SCPHN and Midwife/SCPHN) Nurse and nursing associate (including Nurse/SCPHN

Dates	Name and address of organisation	Your work setting (choose from list above)	Your scope of practice (choose from list above)	Number of hours	Your registration (choose from list above)	Brief description of your work

# CONTINUING PROFESSIONAL DEVELOPMENT (CPD)

## LOG TEMPLATE

### Guide to completing CPD record log

#### Examples of learning method

- Online learning
- Course attendance
- Independent learning

#### What was the topic?

Please give a brief outline of the key points of the learning activity, how it is linked to your scope of practice, what you learnt, and how you have applied what you learnt to your practice.

#### Link to Code

Please identify the part or parts of the Code relevant to the CPD

- Prioritise people
- Practise effectively
- Preserve safety
- Promote professionalism and trust

Please provide the following information for each learning activity, until you reach 35 hours of CPD (of which 20 hours must be participatory). For examples of the types of CPD activities you could undertake, and the types of evidence you could retain, please refer to our guidance sheet at [www.revalidation.nmc.org.uk/download-resources/guidance-and-information](http://www.revalidation.nmc.org.uk/download-resources/guidance-and-information).

Dates	Method Please describe the methods you used for the activity.	Topic(s)	Link to Code	Number of hours	Number of participatory hours
	Total			Total	Total



# FEEDBACK LOG TEMPLATE

## Guide to completing a feedback log

### Examples of sources of feedback

- Patients or service users
- Colleagues – nurses, midwives, nursing associates other healthcare professionals
- Students
- Annual appraisal
- Team performance reports
- Serious event reviews

### Examples of types of feedback

- Verbal
- Letter or card
- Survey
- Report

Please provide the following information for each of your five pieces of feedback. You should not record any information that might identify an individual, whether that individual is alive or deceased. The section on non-identifiable information in How to revalidate with the NMC provides guidance on how to make sure that your notes do not contain any information that might identify an individual.

You might want to think about how your feedback relates to the Code, and how it could be used in your reflective accounts.

<b>Date</b>	<b>Source of feedback</b> Where did this feedback come from?	<b>Type of feedback</b> How was the feedback received?	<b>Content of feedback</b> What was the feedback about and how has it influenced your practice?

## ENDNOTES

- <sup>1</sup> SI 2002/253 as amended.
- <sup>2</sup> SI 2004/1767 as amended.
- <sup>3</sup> The standards for revalidation are made under Article 19(1) of the NMC Order 2001.
- <sup>4</sup> The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates, NMC, 2018.
- <sup>5</sup> The Equality Act 2010 does not apply to Northern Ireland. Where the legislation is spread across several pieces of legislation, with some differences. For example Section 75 of the Northern Ireland Act 1998 also includes consideration of 'political opinion' as a protected characteristic.
- <sup>6</sup> 'Disability' is defined in the Act as a physical or mental impairment that has a substantial or long-term negative effect on a person's ability to do normal daily activities.
- <sup>7</sup> Triple registration for nurse, midwife and nursing associate is also possible; this would require 1,350 practice hours.
- <sup>8</sup> Article 10(2)(c) of the Order, Rule 13(1)(b)(ii) of the Rules.
- <sup>9</sup> Triple registration for nurse, midwife and nursing associate is also possible; this would require 1,350 practice hours.
- <sup>10</sup> Standards set under Article 19(3) of the Order.
- <sup>11</sup> Standards set under Article 19(3) of the Order.
- <sup>12</sup> Standards set under Article 19(1) of the Order.
- <sup>13</sup> Standards set under Article 19(1) of the Order.
- <sup>14</sup> Standards set under Article 19(1) of the Order and under rule 13(1)(b)(i) of the Rules.
- <sup>15</sup> Standards set under Article 19(1) of the Order.
- <sup>16</sup> Standards set under Article 19(1) of the Order.
- <sup>17</sup> Standards set under Article 19(1) of the Order.
- <sup>18</sup> Rule 13(1)(b)(i).
- <sup>19</sup> Rule 13(1)(a) of the Rules.
- <sup>20</sup> Rule 13(1)(a) and paragraph 2 of Schedule 4 of the Rules.
- <sup>21</sup> Rule 13(1)(a) and Rules 6(6)(d) and 6(6)(e).
- <sup>22</sup> Rule 6(6)(c).
- <sup>23</sup> Rule 6(6)(c).
- <sup>24</sup> Rule 6(6)(c) of the Rules.
- <sup>25</sup> Article 10(2)(aa) of the Order and Rule 13(1)(aa) of the Rules.
- <sup>26</sup> Paragraph 1(h)(ii) of Schedule 4 of the Rules.
- <sup>27</sup> Rule 13(1)(d) of the Rules.
- <sup>28</sup> We cannot extend any application beyond three months. Rule 14(5) of the Rules.
- <sup>29</sup> Rule 13(1)(d).
- <sup>30</sup> Article 44 of the Nursing and Midwifery Order 2001.
- <sup>31</sup> Article 37(1)(a) of the Order.
- <sup>32</sup> Article 37(1)(a) of the NMC Order 2001 and the Rules 19, 20 and 21 of the Registration Rules.
- <sup>33</sup> Article 37(2) of the Order.
- <sup>34</sup> Article 44 of the Nursing and Midwifery Order 2001.





23 Portland Place, London W1B 1PZ

T +44 20 7333 9333

[www.nmc.org.uk](http://www.nmc.org.uk)

The nursing and midwifery regulator for England, Wales, Scotland and Northern Ireland

Registered charity in England and Wales (1091434) and in Scotland (SC038362)

**NMC** Nursing &  
Midwifery  
Council

<b>TYPE OF DOCUMENT</b>	<input type="checkbox"/> Trust Policy for approval by Trust Policy Committee <input type="checkbox"/> Patient based standard, guideline or policy for approval by Standards and Guidelines Committee
<b>TITLE</b>	Guidelines for implementation of supervision for registered nurses in Belfast Health & Social Care Trust
<b>Summary</b>	<p>'Supervision is defined as a process of professional support and learning, undertaken through a range of activities, which enables individual registrant nurses (R.N.s) to develop knowledge and competence, assume responsibility for their own practice and enhance service-user protection, quality and safety.' (NIPEC) 2006. In 2007, the Chief Nursing Officer (CNO) issued two standards in relation to supervision in Northern Ireland. In order to comply with the standards, all R.N.s must have an opportunity to access a minimum of two supervision opportunities per year.</p> <p>The guidelines set out the process of supervision, how the process is to be monitored and evaluated and the documentation that can be used to aid recording of supervision episodes. The roles and responsibilities of key players are described.</p>
<b>Purpose</b>	To provide registered nurses with guidance in the process of supervision, role of supervisors and supervisees and, standardised templates for recording supervision activities in order to comply with CNO standards.
<b>Operational date</b>	July 2008
<b>Review date</b>	May 2014
<b>Version Number</b>	V 4
<b>Supersedes previous</b>	All previous legacy sites documentation in relation to supervision for registered nurses
<b>Director Responsible</b>	Nicki Patterson (Acting Director of Nursing)
<b>Lead Author</b>	Audrey Dowd
<b>Lead Author, Position</b>	Senior Manager-Performance, Quality and Standards
<b>Additional Author(s)</b>	Supervision Implementation Group and Review of Supervision Documentation Sub-group
<b>Department / Service Group</b>	Central Nursing
<b>Contact details</b>	Audrey Dowd- Phone No. [REDACTED] Email- [REDACTED]

<b>Reference Number</b>	TP040/08
Supercedes	V 3

<b>Date</b>	<b>Version</b>	<b>Author</b>	<b>Comments</b>
3 <sup>rd</sup> May 2009	V 2	A. Dowd	
7 <sup>th</sup> Dec 2009	V 3	A. Dowd	Amendments to appendices
March 2011	V4	O.MacLeod	Reviewed-no amendments Review date changed

**Policy Record**

		<b>Date</b>	<b>Version</b>
Author (s)	Approval	7 <sup>th</sup> Dec 09	V 3
Director Responsible	Approval		

**Approval Process – Trust Policies**

Policy Committee	Approval		
Executive Team	Authorise		
Chief Executive	Sign Off		

**Approval Process – Clinical Standards and Guidelines**

Standards and Guidelines Committee	Approval	21/04/2011	V4
Policy Committee	Approval	16/05/2011	V4
Executive Team	Authorise	18/05/2011	V4
Appropriate Director	Sign Off	21/05/2011	V4

# **GUIDELINES FOR IMPLEMENTATION OF SUPERVISION FOR REGISTERED NURSES IN BELFAST HEALTH & SOCIAL CARE TRUST**

## Index

<b>1. Summary of Guidelines</b>		<b>1</b>
<b>2. Background</b>	<b>3</b>	
<b>3. Introduction</b>	<b>5</b>	
<b>4. Aim of Guidelines</b>	<b>6</b>	
<b>5. Definition and Scope</b>		<b>7</b>
<b>6. Purpose of Supervision Activity</b>		<b>9</b>
<b>7. Principles of Supervision</b>		<b>10</b>
<b>8. Process of Supervision</b>		<b>10</b>
- <i>Preparation of Supervisor &amp; Supervisee</i>		<b>10</b>
- <i>Contracting</i>		<b>11</b>
- <i>Frequency of Supervision</i>		<b>11</b>
- <i>Preparation for Supervision</i>		<b>11</b>
- <i>Documentation</i>		<b>12</b>
- <i>Issues of Concern</i>		<b>12</b>
- <i>Storage of records</i>		<b>12</b>
- <i>Use of Patient/ Client Records</i>		<b>12</b>
<b>9. Monitoring and Evaluation</b>		<b>13</b>
<b>10. Documentation and Recording</b>	<b>14</b>	
<b>11. Roles and Responsibilities</b>		<b>14</b>

## Appendices

<b>Appendix A - <i>Range of Activities</i></b>		<b>18</b>
<b>Appendix B - <i>Contract for Supervision</i></b>		<b>20</b>
<b>Appendix C - <i>Preparation Template for Supervision</i></b>		<b>22</b>
<b>Appendix D - <i>Supervision Record Sheet</i></b>		<b>23</b>
<b>Appendix E - Quarterly Supervision Returns by Supervisor</b>		<b>25</b>
<b>Appendix F - Quarterly Supervision Returns by Line Manager</b>		<b>26</b>



## SUPERVISION GUIDELINES

### Summary of Guidelines

**What is Supervision:** Supervision is a process of professional support and learning, undertaken through a range of activities, which enables individual registrant nurses to develop knowledge and competence, assume responsibility for their own practice and enhance service-user protection, quality and safety.'

### Objectives:

- To support and promote robust supervision activities for all nursing staff
- To ensure that supervisor(s) and supervisee(s) partake fully in the process of supervision including appropriate documentation
- To ensure the impact of supervision activity is evaluated organisationally.
- To enable nursing staff to reflect on and review their clinical practice
- To support the development of clinical skills in assessment and treatment of patients.

**Participants:** All registered nursing staff employed in the Belfast Trust including Nurse Bank staff

### Background:

In line with governance requirements, the Belfast Trust needs to be assured that nursing staff have the necessary knowledge, skills and competence to fulfil their roles in a confident and professional manner.

### Process:

These guidelines describe the process for implementation, continuing development and maintenance of a robust system of supervision in the Trust. All registered nurses must participate in a regular pattern of supervision, as directed by the Chief Nursing Officer (CNO) who issued two regional Standards for Supervision for nursing in Northern Ireland where he sets out the requirements of bi-annual mandatory clinical supervision.

Compliance with these must be reported yearly. The standards come into effect from April 1<sup>st</sup> 2008.

These guidelines set out the process of supervision, how the process is to be monitored and evaluated and the documentation that can be used to aid recording of supervision episodes. The roles and responsibilities of key players are described.

**Outcome measures:**

Nurses are encouraged to use the many opportunities within their work environments to reflect on their practice, making patient care safer and improving patient outcomes. Documentation records will be available on the Intranet for easy access. Participation in supervision will be reported to Central Nursing team for evaluation and ongoing support. Supervisor/supervisees will be supported through training and development of facilitation skills. Once established, this process will be evaluated to determine to determine impact on patient outcomes and staff.

**Conclusion:**

The importance of effective supervision has been highlighted in regional critical incident inquiries. The Quality Standards for Health and Social Care recommend that an effective system for supervision across H&SC can help organisations meet each of the clinical and social care governance standards. Supervision processes have also been recognised as a method of improving organisational recruitment and retention of nursing staff and has already an established association with job satisfaction, increased autonomy and reduced absenteeism.

## Background

The importance of effective supervision has been highlighted in regional critical incident inquiries such as the Lewis Review (2003)<sup>1</sup> Murtagh Review (2005)<sup>2</sup> and McCleery Report (2006) The Quality Standards for Health and Social Care (DHSSPS 2006)<sup>4</sup> recommend that an effective system for supervision across H&SC can help organisations meet each of the clinical and social care governance standards.

Supervision processes have also been recognised as a method of improving organisational recruitment and retention of nursing staff and have already an established association with job satisfaction, increased autonomy and reduced absenteeism<sup>5</sup>.

The NMC supports the establishment of supervision as an important part of clinical governance and in the interests of improving standards of patient care. (NMC)<sup>6</sup>

These guidelines have been produced to support the implementation, continuing development and maintenance of a robust system of supervision for registered nurses that work within Belfast Health & Social Care Trust (BHSCT). The Belfast Trust requires all registered nurses to participate in a regular pattern of supervision, as directed by the Chief Nursing Officer

<sup>1</sup> Lewis RJ, Cole D, Williamson A (2003) Review of Health and Social Services in the case of David and Samuel Briggs. Belfast, DHSSPS

<sup>2</sup> Regional Quality Improvement Authority (2005) Review of the lessons arising from the death of the Late Janine Murtagh, Belfast, RQIA

<sup>3</sup> McCleery Inquiry Panel (2006) Executive summary and recommendations from the report of the Inquiry Panel (McCleery) to the Eastern Health and Social Services Board

<sup>4</sup> Department of Health, Social Services and Public Safety (2006) The Quality Standards for Health and Social Care. Belfast, DHSSPS

<sup>5</sup> Hyrkas, K, Appelqvist-Schmidlechner, K and Haataja, R (2006). Efficacy of clinical supervision: Influence on job satisfaction, burnout and quality of care. Journal of Advanced Nursing. 55(4), 521-535

<sup>6</sup> Nursing & Midwifery Council (2002) Supporting Nurses & Midwives through lifelong learning

The Chief Nursing Officer for Northern Ireland published two standards for supervision in nursing in July 2007, which are presented below<sup>7</sup>.

The Supervision Regional Forum began work in October 2007 to give regional direction and support to the implementation of the DHSSPS Standards for Supervision in Nursing. The aim of this work was to inform a standardised approach in Northern Ireland to organisational policy, recording, documentation, learning and development activities and evaluation processes supporting supervision activity in nursing. Therefore these guidelines will be similar to those in other Health and Social Care Trusts in Northern Ireland.

### **Standard Statement 1**

Supervision will contribute to the delivery of safe and effective care when practitioners have access to appropriate systems that facilitate the development of knowledge and competence through a culture of learning by reflection.

### **Standard Statement 2**

An organisational framework supporting effective leadership and performance management will ensure that supervision will become an effective tool to improve the safety and quality of care.

---

<sup>7</sup> Chief Nursing Officer for Northern Ireland (2007). *Standards for Supervision for Nursing*. Belfast, DHSSPS

## Introduction

In recent years there has been increasing recognition of the role of supervision in health settings throughout the U.K. Supervision, when effective, remains a pivotal activity in delivering safe and effective care, is central to workforce development across professional disciplines and to the retention of skilled staff.

*‘Supervision is defined as a process of professional support and learning, undertaken through a range of activities, which enables individual registrant nurses to develop knowledge and competence, assume responsibility for their own practice and enhance service-user protection, quality and safety.’ (NIPEC, 2006, P5)<sup>8</sup>*

It is clearly recognised that the term supervision within the professional context includes a wide range of activities and approaches that have a supervision impact, such as action learning, individual and team supervision, reflective learning groups, critical companionship, professional, managerial and pure supervision. Rather than being restrictive to the use of specific models, those planning supervision are challenged to recognise the diversity of approaches required so that individual nurses not only have a choice, but can identify with a strong and supportive organisational infrastructure that advocates a shared responsibility for this work, and builds confidence in individual processes (NIPEC 2006)<sup>9</sup>

---

<sup>8</sup>Northern Ireland Practice and Education Council (2007). The Review of Clinical Supervision for Nursing in the HPSS 2006 on Behalf of the DHSSPS. Belfast, NIPEC

<sup>9</sup>Northern Ireland Practice and Education Council (2007). The Review of Clinical Supervision for Nursing in the HPSS 2006 on Behalf of the DHSSPS. Belfast, NIPEC

## **1.0 Aim of Guidelines**

1.1 The aim of these guidelines is to clearly identify the processes through which supervision activities may be integral to the organisational delivery of safe and effective care, to ensure successful implementation within the registered nursing workforce in BH&SCT.

1.2 These guidelines identify supervision for the registered nursing workforce as a key organisational objective for the Belfast Trust.

1.3 Implementation of an effective system of supervision for registered nurses will help ensure:

- Maintenance of care standards
- Public safety & protection
- Workforce competence and skill development
- Delivery of safe and effective care
- A focus on quality improvement & a mechanism for Quality Assurance
- Clinical effectiveness

1.4 senior management teams in BH&SCT must ensure that appropriate measures are in place to enable supervision activities for both clinical and non-clinical teams.

## 2.0 Definition and Scope

2.1 The Department of Health, Social Services and Public Safety (DHSSPS) adopted the following definition of supervision for nursing following the '*Review of Clinical Supervision for Nursing in the HPSS*' undertaken by NIPEC in 2006:

*'Supervision is defined as a process of professional support and learning, undertaken through a range of activities, which enables individual registrant nurses to develop knowledge and competence, assume responsibility for their own practice and enhance service-user protection, quality and safety.'* (NIPEC) 2006<sup>8</sup>

2.2 These guidelines have been produced through the work of a Regional Forum that sought to standardise the approach to professional supervision used by Health and Social Care Northern Ireland (HSCNI) organisations. It was recognised by the Regional Forum that a wide variety of diverse approaches and activities can have a supervision impact, recognised as formal or informal opportunities examples of which are given in **Appendix A, Table 1 (page 19)**

2.3 It is the intention of BH&SCT that each registered nurse will undertake a minimum of two formal supervision sessions per year. Registrants are likely to engage in other activities that can also support the supervision process. Further guidelines on the scope of such activities can be found in **Appendix A (page 18)** of this document.

2.4 It should be noted that the scope of Safeguarding Children supervision differs from supervision referred to in this policy. Safeguarding Children is separate from but complimentary to other forms of supervision. Safeguarding Children supervision provides specialist professional advice, case management and support to staff in their safeguarding children. This includes children in need of protection; children in need; looked after children and families of concern. The Safeguarding Children Supervision process includes the assessment of staff performance, professional development in relation to safeguarding children and families and quality assurance of practice to ensure compliance with best practice guidelines.

Further information is available from the DHSSPS *Safeguarding Children Supervision policy*

### **3.0 Purpose of Supervision Activity**

3.1 Supervision activities can achieve a number of purposes simultaneously. It is important for both supervisors and supervisees in BH&SCT to recognise and differentiate supervision activity from other processes such as appraisal. Whilst supervision activity informs and is informed by the Knowledge and Skills Framework annual review process, neither activity should be substituted for the other, each activity having a different purpose. Similarly, performance management issues should be dealt with as soon as the situation has been identified.

3.2 The main purposes of supervision activity are to support:

- The development of knowledge and skills within a role or clinical area, the focus being safe and effective practice and benefit to patient care
- Nurses in non-clinical roles through providing an opportunity to discuss issues pertinent to the delivery of safe and effective care and/or professional issues
- Nurses through difficult circumstances such as challenging patient caseloads or difficult interpersonal contact with other team members
- The development of competence, knowledge and skills through facilitation of personal and professional growth.



## **4.0 Principles of Supervision**

4.1 The following principles apply for registered nurses undertaking a range of supervision activities in BH&SCT

4.1.1 The BH&SCT supports and promotes robust supervision activities for all professional staff.

4.1.2 A range of supervision approaches/activities are appropriate for ensuring safe and effective care for people.

4.1.3 All supervisors and supervisees will have opportunity to undertake appropriate training that meets their assessed need, in preparation for supervision activity.

4.1.4 All supervisors and supervisees have responsibility to partake fully in the processes of supervision including completion of appropriate recording documentation.

4.1.5 The impact of supervision activity will be evaluated at organisational level to inform the BH&SCT Annual Report to the Chief Nursing Officer.

## **5.0 Process of Supervision**

5.1 A number of procedural aspects are important to ensure supervision activity takes place effectively.

### **5.2 Preparation of Supervisor & Supervisee**

The skill and competence of a supervisor is crucial to effective supervision for nursing. The skills required for supervision will build on existing communication and facilitation abilities learned through initial training and post registration professional development.

Advice and guidance regarding the learning and development framework for supervisors and supervisees may be found in the complimentary supporting document '*Supervision for Nursing: Regional Learning and Development Framework (2008)*'

### 5.3 Contracting

In setting up supervision, it is important that the purpose of the supervisory relationship is established. This is achieved through a supervision contract, which is negotiated and agreed between supervisor and supervisee(s) at the start of supervision sessions. The contract may be reviewed at any stage at the request of either supervisor or supervisee(s); however, frequent review should not be necessary. If a change of supervisor occurs, a new contract must be agreed and signed accordingly. . The supervisee should be aware that any issues discussed that might highlight unsafe practice would be acted on as per NMC Code of Conduct. Building a relationship of trust & respect between supervisor and supervisee is an important part of the process and fundamental to successful outcomes The BHSCT contract document can be found at **Appendix B (page 20)**.

5.3.1 Ratios of numbers of supervisor(s) to supervisee(s) should be such that effective supervision activity is enabled and protected. It is recommended that a ratio of 1:5 (supervisor to supervisees) and not more than 1:8.

### 5.4 Frequency of supervision

A formalised supervision session for registered nursing staff will take place at least twice yearly. Other activities engaged in throughout the year may impact on the process of supervision. Registered nurses should reflect on their own practices as they engage in ongoing learning and development activities in their work environment. This experience should be used to inform the twice-yearly supervision sessions.

Nurses can access guidance on reflection and keeping a portfolio with corresponding templates at [www.nipedef.org](http://www.nipedef.org), which can assist with this process.

### 5.5 Preparation for Supervision

In order to benefit from supervision, nurses must also spend time preparing appropriately. This will include a review of any previous supervision session with subsequent action plan and reflection on the learning activities that have been undertaken between sessions. A supervision preparation template can be found at

**Appendix C (page 22)** to help structure this process.

### 5.6 Documentation

Each formalised supervision session must have a written record signed by both supervisor and supervisee(s). The Nursing and Midwifery Council (NMC) <sup>10</sup> state that organisations employing professional staff who make such records are the legal owners of those records. Further guidelines relevant to documentation can be found in **Section 7** of this document.

### 5.7 Issues of Concern

Where an issue of unsafe, unethical or illegal practice is identified, it should be dealt with supportively via appropriate procedures. All parties must be informed of the intention to disclose, before revealing confidential information.

### 5.8 Storage of records

The BHSCT will have its own policy for the safe storage of records and in the interim, legacy site policies will continue to apply, however, each registrant should be mindful of their professional accountability with regard to the principle of confidentiality of information. Nurses should therefore take responsibility for making sure that whatever system is used is managed in such a way that it is appropriately protected to ensure the security of confidential information.

### 5.9 Use of patient records

If necessary, patient/client records may be used for the purposes of supervision activity. The NMC<sup>10</sup> states that where this happens, principles of access and confidentiality apply, namely:

- Patients'/clients' health records should only be accessed where necessary
- The patient/ client reserves the right to refuse access to their records which should be respected
- In some cases, the patient/ client may choose to limit the information accessed and registrants should respect their right to do so
- BHSCT records policy should be adhered to

---

<sup>10</sup>Nursing & Midwifery Council (2007) Record Keeping

## 6.0 Monitoring and Evaluation

6.1 Monitoring and evaluation of supervision activity are essential to ensure that resources required for supervision within an organisation can be justified. It is also necessary to monitor the benefit for individual registrants since the quality of supervision activities can influence effectiveness.

6.2 Evaluation of supervision is needed to assess how it influences care, practice standards and the service needs.

6.3 At an organisational level, monitoring will take place through quarterly governance reports or accountability reviews. The quantity and quality of supervision activity will also be included in BHSCT performance indicators for the nursing workforce.

6.4 Individual supervisors must record quarterly, the number of sessions they engage in and make these returns available to line managers for collation. **Appendix E (Page 25).** This information will in turn, be collated up by service group managers and communicated to the Associate Director of Nursing in the service group who is responsible for supervision of nursing within the organisation. This information will be tabled on a quarterly basis by the Co-Director of Nursing responsible for governance to Corporate Nursing team meetings and to the Director of Nursing's team meeting.

6.5 BHSCT may seek qualitative information periodically from individual registrants to assist in the ongoing evaluation of supervision processes.

6.6 These guidelines will be audited and reviewed every two years by BHSCT and appropriate changes made where necessary.

## **7.0 Documentation and Recording**

7.1 It is essential that written notes of individual sessions be recorded, remain confidential and record clearly any agreed action.

Individual session notes are the responsibility of the supervisee; however the supervisor should keep brief notes and maintain quarterly Record information **Appendix E (page 25)** which is submitted to the ward manager, team leader, or appropriate line manager.  
**Appendix F (page 26)**

## **8.0 Roles and Responsibilities**

8.1 In BHSCT there are a number of key players in posts with responsibility for ensuring supervision in nursing is implemented.

They are:

### **8.2 CHIEF EXECUTIVE**

The Chief Executive of BHSCT accepts responsibility and accountability for quality service provision at Trust Board level, which includes systems, such as supervision in nursing that support clinical and social care governance.

### **8.3 EXECUTIVE DIRECTOR OF NURSING**

The Executive Director of Nursing BHSCT is accountable to the Chief Executive for the implementation and maintenance of supervision in nursing.

Key responsibilities include:

- Presenting the Trust report to both the Trust Governance Committee and the Chief Nursing officer for Northern Ireland on an annual basis.
- Acting as a supervisor for co-directors and other senior professional roles when appropriate.

## **ASSOCIATE DIRECTOR of NURSING, (within Service Groups) - SUPERVISION LEAD.**

The Associate Director of Nursing is accountable to Executive Director of Nursing.

Key responsibilities include:

- Coordinating, facilitating, evaluating & maintaining a system of supervision in the nursing workforce
- Acting as a supervisor for Senior Managers, Lead Nurses, Specialist nurses & other members of the senior professional team within BHSC
- Providing information relevant to the quantity & quality of supervision within BHSC within quarterly governance reports.
- Ensuring appropriate resources are in place to enable nurses to undertake at least two formalised sessions of supervision annually

## **NURSING DEVELOPMENT LEADS**

They are accountable to the Associate Director relative to their service group.

Key Responsibilities include:

- Promoting, co-ordinating and facilitating implementation and maintenance of supervision for nurses within their individual directorates.
- Acting as a supervisor for ward managers and team leaders within their service group.
- Ensuring that Bank-only nursing staff have access to supervision in the Service Groups that they work in most often. Information on the activity will be forwarded to the Senior Manager Nursing responsible for Bank only staff.

## **WARD MANAGERS/TEAM LEADERS**

They are accountable to the Associate Director of Nursing and must submit quarterly returns received from supervisors within their team. **Appendix F (page 26).**

Key responsibilities include:

- Acting as role model
- Facilitating implementation and maintenance of supervision for nurses within their staff teams.
- Acting as a supervisor for other members of staff, either within or outside their own team.

## **ROLE OF SUPERVISORS**

They are accountable to their line managers.

Key responsibilities include:

- Development and maintenance of their own skills and competencies relative to supervision activity
- Seeking and undertaking supervision themselves,
- Arranging dates & venues in advance & communicating these to Ward Manager
- Maintaining records for both personal supervision and professional supervision of others.
- Providing at least two formal sessions of supervision annually for each supervisee, whether group or individual.
- Adhering to ground rules identified in agreed contracts and conduct supervision sessions within the principles and process identified in these guidelines.
- Informing supervisee that records are discoverable (e.g. in coroner's court).
- Providing clear, constructive feedback during sessions
- Be aware that both have a responsibility to share any information that might comprise patient/public safety or contravene NMC code of conduct.
- Be aware of BHSCT guidelines & policy

Additionally, the following criteria will apply to the role of supervisor:

Essential criteria:

- Be a registered nurse for a minimum of one year
- Have completed self-evaluation tool to identify any skills deficits

- Attended appropriate training to address these deficits
- Recognise own personal & professional needs
- Be open to constructive feedback & engage in challenge & supportive interventions

Desirable criteria:

- Have expertise in the field for which they are supervisor
- Have undertaken mentorship training
- Have undertaken facilitation-skills training

## **SUPERVISEES**

They are accountable to their line manager to engage in a minimum of two formal supervision sessions annually.

Key responsibilities include:

- Recognising own personal & professional development needs.
- Arriving promptly for arranged session.
- Engaging fully in the supervision process, adhering to ground rules identified in agreed contracts.
- Preparing for and participate in a minimum of two formal supervision sessions a year, keeping accurate records of relevant actions. Activities undertaken between sessions should be used to inform formal supervision sessions.
- Making use of reflective learning opportunities.
- Being prepared to receive constructive feedback, making changes to their practice to improve patient outcomes.



## RANGE OF ACTIVITIES

A range of activities can support supervision for registered nurses. Whichever activity is used, each registrant must ensure they have the appropriate skills, competence, knowledge & experience required to engage in the activity.

Nurses should use the many learning opportunities within their work environments to reflect on their own practice. These experiences can be used to inform formal supervision sessions.

When an informal opportunity arises during the course of any given working day, it can be difficult to find time to document the learning experiences. [www.nipecdf.org](http://www.nipecdf.org) contains a learning and development log template which can be used for recording informal experiences, providing a quick method of capturing the lived learning nurses engage in on a daily basis. To make a quick record of learning activities go to:

<http://www.nipecdf.org/portfolio/learn.asp>

Examples of activities that support supervision can be found in **Table 1**.

Many activities inform supervision processes, it should therefore, be noted that this is not a definitive list of activities, merely examples to guide professional teams. For definitions and access to a list of other activities that may be useful go to:

<http://www.nipecdf.org/learn/actList.asp>

**Examples of Activities which Support Supervision**

**Table 1**

<p><b>Reflective Practice</b></p> <p>Reflective practice is the process of thinking about your own practice and that of others in a structured way; this leads to new and better ways of working and helps you develop new levels of knowledge and competence. You will learn to think critically about your practice and about what you need to do to improve it and the care you provide. Reflection allows you to describe your experience, think about it, and evaluate the outcomes. This should help you to have new understandings and insights. Reflection is what turns experience into meaningful learning, making sense of the world around you, and to building on what is happening. You may also find it helpful to use one of the many reflective tools that have been developed.</p>	<p><b>Work Based Learning</b></p> <p>A work-based learning programme is provided by an education institution, using a negotiated, project-led approach; this is managed by you and provides the best opportunities for learning and professional development in the workplace. Work-based learning acknowledges that everyone learns in different ways. It gives you control over how and when you learn and takes learning out of the classroom into the workplace. The learning is gained through work-related projects. Work-based learning opens your eyes to the fact that you can learn from anything. Work-based learning in multi-professional teams, making full use of modern technology, can produce benefits to you, the organization and the profession. Successful completion of the programme will provide you with accredited learning and lead to an academic qualification. It is concerned with helping you to bridge the practice/theory gap.</p>	<p><b>Post Incident review</b></p> <p>This happens when an incident has occurred in the workplace that has caused you and/or other members of the healthcare team a level of distress. The incident has usually resulted in a miss or near miss, where there has or could have been damage to a patient or client. A post-incident review involves the reviewing of specific incidents, either individually or as a team, within a setting that provides emotional support to each person. The incident is analyzed with your involvement and the involvement of all team members, using reflection, self-evaluation and/or facilitated learning to establish how the incident happened and how it could be avoided in the future. If you are involved in a post-incident review it should result in good support from your team members and outcomes and actions for yourself and the team, with possible organizational implications. The final outcome must provide a clear description of risk factors and required action. You should also use the review process to identify personal action plans and required development. This is a learning event for all involved, with the objective of learning to improve practice.</p>
<p><b>Learning Sets</b></p> <p>The term refers to a group of people who meet regularly to work and learn together, using a structured format. The learning set can comprise of uni- or multi-professional groups and the focus is on self-directed learning; the participants decide the particular issues to be addressed. This provides you with a confidential forum in which to test issues that concern you, discuss new ideas and help you and the others to challenge working practices in new and creative ways. It is important to set ground rules to deal with issues such as confidentiality. Each member of the group is facilitated and supported by the others in the solving of issues and problems.</p>	<p><b>Critical Incident Review</b></p> <p>A critical incident is a significant event or experience that has occurred in your workplace and that you feel has had an impact on you or the people you work with. This could be negative or positive; it could be a personal experience or it could result from observing how other people work. You need to examine the incident through a process of reflection, using an evidence-based approach, to identify lessons to be learned. This could also take place with a group of practitioners working together. This should result in new learning for you and/or the group you are working with and result in a short action plan to bring about improvement in practice.</p>	<p><b>Peer Review</b></p> <p>This is a process, which encourages you to work with colleagues at the same level and in the same area of practice, and to evaluate each other's performance. We all have behaviours we are unaware of. Peer review gives an insight into these from the perspective of another person. This is a valuable learning activity, as it helps to develop your critical thinking and collaborative working and brings about improvements in your practice. This needs to be set up within a structured format, to ensure that you and the other peer reviewers have the required skills and are supported by experienced colleagues.</p>
<p><b>Supervised Practice for Competency Development</b></p> <p>This is a negotiated period of supervised practice, with agreed learning and competency outcomes and may be provided for you if you require to develop specific, identified competencies. It is also likely to be arranged for you if you have poor or failing clinical competence in an area of practice. This is a period of practice where you are supervised and monitored by an experienced practitioner. The length of the supervised practice and the required outcome are set before the exercise begins. You are required to work closely with your supervisor throughout the entire period of practice. You will also be assessed at the end of the supervised practice to see if you can show that you have the necessary knowledge and competence. If you have not demonstrated this, a further action plan will be drawn up.</p>	<p><b>Mentoring</b></p> <p>A mentor is someone who has skills of working with individuals who can provide guidance and support to help you achieve your potential. Your mentor may not be from your own field of practice but should be a person with mentoring experience. Mentoring is achieved through a process of relationship building between you and your mentor and takes place over a period of time. The purpose of the mentoring process is to enable you to recognise your own skills and capabilities and maximise the development opportunities available to you.</p>	<p><b>Preceptor Training</b></p> <p>This is the process by which you, as a newly registered nurse or midwife, are helped to make the transition from student to qualified and competent practitioner, through a negotiated programme of learning and support. The preceptor is a more experienced nurse/midwife who will work with you over a period of about four months to provide guidance and training. Your preceptor will also monitor your progress and performance and provide feedback to help you improve your practice and standard of care.</p>

**CONTRACT FOR SUPERVISION SESSIONS (1 OF 2)****Appendix B**

Supervision will help you reflect on your practice. This process will in turn help you to sustain your continuous development.

**Purpose of Supervision**

The purpose of supervision should be agreed between the supervisor and the supervisee. It should relate to their roles and responsibilities and can include any aspects of their personal development.

**As supervisor I take responsibility for:**

- Following the focus identified by the supervisee(s)
- Exploring the supervisee's expectations appropriately using my knowledge, skills and experience
- Allowing the supervisee to express their individuality
- A balance of challenge and support will be maintained throughout supervision.
- Facilitating reflective practice
- Evaluating the session for the supervisee(s) and supervisor
- Completing a sessional collation form
- Maintaining all records of session in a safe and confidential manner according to NMC and Trust guidelines.

**As supervisee I take responsibility for:**

- Preparing for the sessions using a formal reflective model e.g. 'Preparation template for supervision' (Appendix C) or other recognised tools
- Driving the agenda
- Bringing appropriate issues to sessions and discussing them openly
- Engaging in learning and development activities between agreed annual sessions that will inform supervision sessions
- Recording and reflecting on significant activities using 'Supervision record sheet' (Appendix D)
- Evaluating the benefit of the session
- Completing the supervision record sheet and retaining in portfolio.

**Ground rules will be agreed when developing the contract and reviewed at each session:**

Ground rules and responsibilities should be clearly defined and the contract should demonstrate the commitment to these.

**Some examples of ground rules agreed by supervisor/supervisee(s):**

- Open and honest learning
- Commitment to confidentiality except when issues breach the Code of Conduct
- Sharing best practice
- Active listening
- Ensure supervision sessions take place at the agreed time
- Evaluate the session and engage in mutual feedback

This is not an exhaustive list and consideration should be given to the needs of individuals/groups when developing a supervision contract to develop ways of working that meet everyone's agenda.

**At the end of each session we will:**

- Agree a suitable time and venue for the next session if appropriate.
- Maintain and store records as agreed in ground rules.

**CONTRACT FOR SUPERVISION SESSIONS (2 OF 2)**

**AGREEMENT**

**In addition I have:**

- Read all relative policies and guidelines
- Participated in training if required

Signature of supervisor	Signature of supervisee or group supervisees
	1.
	2.
	3.
	4.
	5.
	6.
	7.
	8.
Frequency of sessions (if applicable)	
Venue	

**Date & Time:** \_\_\_\_\_

**Clinical Area:** \_\_\_\_\_

## Preparation Template for Supervision

Name: \_\_\_\_\_

Date: \_\_\_\_\_

<b>What is the issue?</b>
<b>Why is it significant?</b>
<b>What did not go well?</b>
<b>What went well?</b>
<b>How did this make me feel?</b>
<b>What would I do differently in the future?</b>
<b>What have I learnt?</b>
<b>What actions do I need to take forward (if applicable)?</b>

(Adapted from Gibbs, 1998 & Johns, 2000)

**Supervision Record Sheet (1 of 2)**

Date: \_\_\_\_\_

Individuals Present			
Supervisor	Supervisees		
	1		5
	2		6
	3		7
	4		8

	<b>You may like to consider using the prompts below:</b>
<b>Review of action/learning points from previous session</b>	
<b>Issue(s) discussed at this supervision session</b>	What was explored during this supervision session; what was the issue/experience and or situation?
<b>What action points were agreed?</b>	By supervisee? By supervisor?



**To Be Completed By Supervisor and Returned to  
Line Manager/Designated Person within Service Group e.g. NDL**

**Quarterly Supervision Returns**

Speciality: \_\_\_\_\_

Ward/Clinical Area: \_\_\_\_\_ Service Group: \_\_\_\_\_

Supervisor: \_\_\_\_\_

**2009-2010**

Date/Dates	Name of Supervisee	First Session	Second Session	Type of Supervision	
				1-1	Group
<b>Totals</b>					



**To Be Completed By Line Manager**

**Quarterly Supervision Returns**

Service Group: \_\_\_\_\_

Associate Director of Nursing: \_\_\_\_\_

Quarter: *Please tick*    Apr-Jun     Jul-Sep     Oct-Dec     Jan-Mar

Total Number of RN's	No of RN's who have had one supervision session	No of RN's who have had two supervision sessions	Comments

**Please return to:**

**Associate Director of Nursing**

<b>TYPE OF DOCUMENT</b>	<input type="checkbox"/> Trust Policy for approval by Trust Policy Committee <input type="checkbox"/> Patient based standard, guideline or policy for approval by Standards and Guidelines Committee
<b>TITLE</b>	Guidelines for implementation of supervision for registered nurses in Belfast Health & Social Care Trust
<b>Summary</b>	<p>'Supervision is defined as a process of professional support and learning, undertaken through a range of activities, which enables individual registrant nurses (R.N.s) to develop knowledge and competence, assume responsibility for their own practice and enhance service-user protection, quality and safety.' (NIPEC) 2006. In 2007, the Chief Nursing Officer (CNO) issued two standards in relation to supervision in Northern Ireland. In order to comply with the standards, all R.N.s must have an opportunity to access a minimum of two supervision opportunities per year.</p> <p>The guidelines set out the process of supervision, how the process is to be monitored and evaluated and the documentation that can be used to aid recording of supervision episodes. The roles and responsibilities of key players are described.</p>
<b>Purpose</b>	To provide registered nurses with guidance in the process of supervision, role of supervisors and supervisees and, standardised templates for recording supervision activities in order to comply with CNO standards.
<b>Operational date</b>	December 2009
<b>Review date</b>	May 2011
<b>Version Number</b>	V 3
<b>Supersedes previous</b>	All previous legacy sites documentation in relation to supervision for registered nurses
<b>Director Responsible</b>	Nicki Patterson (Acting Director of Nursing)
<b>Lead Author</b>	Audrey Dowd
<b>Lead Author, Position</b>	Senior Manager-Performance, Quality and Standards
<b>Additional Author(s)</b>	Supervision Implementation Group and Review of Supervision Documentation Sub-group
<b>Department / Service Group</b>	Central Nursing
<b>Contact details</b>	Audrey Dowd- Phone No. [REDACTED] Email- [REDACTED]

Standards and Guidelines Committee - Guidelines for implementation of supervision for registered nurses in Belfast Health & Social Care Trust – Dec 2009

<b>Reference Number</b>	TP040/08
Supercedes	V 2

<b>Date</b>	<b>Version</b>	<b>Author</b>	<b>Comments</b>
3 <sup>rd</sup> May 2009	V 2	A. Dowd	
7 <sup>th</sup> Dec 2009	V 3	A. Dowd	Amendments to appendices

**Policy Record**

		<b>Date</b>	<b>Version</b>
Author (s)	Approval	7 <sup>th</sup> Dec 09	V 3
Director Responsible	Approval	8 <sup>th</sup> Dec 09	V3

**Approval Process – Trust Policies**

Policy Committee	Approval	10 <sup>th</sup> Aug 09	V2
Executive Team	Authorise	19 <sup>th</sup> Aug 09	V2
Chief Executive	Sign Off	21 <sup>st</sup> Aug 09	V2

**Approval Process – Clinical Standards and Guidelines**

Standards and Guidelines Committee	Approval		
Policy Committee	Approval		
Executive Team	Authorise		
Appropriate Director	Sign Off		

Standards and Guidelines Committee - Guidelines for implementation of supervision for registered nurses in Belfast Health & Social Care Trust – Dec 2009

*NH A Patten*

*William McKee*

**Director of Nursing (Acting)**

**Chief Executive**

Standards and Guidelines Committee - Guidelines for implementation of supervision for registered nurses in Belfast Health & Social Care Trust – Dec 2009

# **GUIDELINES FOR IMPLEMENTATION OF SUPERVISION FOR REGISTERED NURSES IN BELFAST HEALTH & SOCIAL CARE TRUST**

Standards and Guidelines Committee - Guidelines for implementation of supervision for registered nurses in Belfast Health & Social Care Trust – Dec 2009

## Index

<b>1. Summary of Guidelines</b>		<b>1</b>
<b>2. Background</b>	<b>3</b>	
<b>3. Introduction</b>	<b>5</b>	
<b>4. Aim of Guidelines</b>	<b>6</b>	
<b>5. Definition and Scope</b>		<b>7</b>
<b>6. Purpose of Supervision Activity</b>		<b>9</b>
<b>7. Principles of Supervision</b>		<b>10</b>
<b>8. Process of Supervision</b>		<b>10</b>
- <i>Preparation of Supervisor &amp; Supervisee</i>		<b>10</b>
- <i>Contracting</i>		<b>11</b>
- <i>Frequency of Supervision</i>		<b>11</b>
- <i>Preparation for Supervision</i>		<b>11</b>
- <i>Documentation</i>		<b>12</b>
- <i>Issues of Concern</i>		<b>12</b>
- <i>Storage of records</i>		<b>12</b>
- <i>Use of Patient/ Client Records</i>		<b>12</b>
<b>9. Monitoring and Evaluation</b>		<b>13</b>
<b>10. Documentation and Recording</b>	<b>14</b>	
<b>11. Roles and Responsibilities</b>		<b>14</b>

## Appendices

<b>Appendix A - <i>Range of Activities</i></b>		<b>18</b>
<b>Appendix B - <i>Contract for Supervision</i></b>		<b>20</b>
<b>Appendix C - <i>Preparation Template for Supervision</i></b>		<b>22</b>
<b>Appendix D - <i>Supervision Record Sheet</i></b>		<b>23</b>
<b>Appendix E - Quarterly Supervision Returns by Supervisor</b>		<b>25</b>
<b>Appendix F - Quarterly Supervision Returns by Line Manager</b>		<b>26</b>

## **SUPERVISION GUIDELINES**

### **Summary of Guidelines**

**What is Supervision:** Supervision is a process of professional support and learning, undertaken through a range of activities, which enables individual registrant nurses to develop knowledge and competence, assume responsibility for their own practice and enhance service-user protection, quality and safety.'

### **Objectives:**

- To support and promote robust supervision activities for all nursing staff
- To ensure that supervisor(s) and supervisee(s) partake fully in the process of supervision including appropriate documentation
- To ensure the impact of supervision activity is evaluated organisationally.
- To enable nursing staff to reflect on and review their clinical practice
- To support the development of clinical skills in assessment and treatment of patients.

**Participants:** All registered nursing staff employed in the Belfast Trust including Nurse Bank staff

### **Background:**

In line with governance requirements, the Belfast Trust needs to be assured that nursing staff have the necessary knowledge, skills and competence to fulfil their roles in a confident and professional manner.

### **Process:**

These guidelines describe the process for implementation, continuing development and maintenance of a robust system of supervision in the Trust. All registered nurses must participate in a regular pattern of supervision, as directed by the Chief Nursing Officer (CNO) who issued two regional Standards for Supervision for nursing in Northern Ireland where he sets out the requirements of bi-annual mandatory clinical supervision.

Compliance with these must be reported yearly. The standards come into effect from April 1<sup>st</sup> 2008.

These guidelines set out the process of supervision, how the process is to be monitored and evaluated and the documentation that can be used to aid recording of supervision episodes. The roles and responsibilities of key players are described.

**Outcome measures:**

Nurses are encouraged to use the many opportunities within their work environments to reflect on their practice, making patient care safer and improving patient outcomes.

Documentation records will be available on the Intranet for easy access. Participation in supervision will be reported to Central Nursing team for evaluation and ongoing support.

Supervisor/supervisees will be supported through training and development of facilitation skills. Once established, this process will be evaluated to determine to determine impact on patient outcomes and staff.

**Conclusion:**

The importance of effective supervision has been highlighted in regional critical incident inquiries. The Quality Standards for Health and Social Care recommend that an effective system for supervision across H&SC can help organisations meet each of the clinical and social care governance standards. Supervision processes have also been recognised as a method of improving organisational recruitment and retention of nursing staff and has already an established association with job satisfaction, increased autonomy and reduced absenteeism.



## Background

The importance of effective supervision has been highlighted in regional critical incident inquiries such as the Lewis Review (2003)<sup>1</sup> Murtagh Review (2005)<sup>2</sup> and McCleery Report (2006) The Quality Standards for Health and Social Care (DHSSPS 2006)<sup>4</sup> recommend that an effective system for supervision across H&SC can help organisations meet each of the clinical and social care governance standards.

Supervision processes have also been recognised as a method of improving organisational recruitment and retention of nursing staff and have already an established association with job satisfaction, increased autonomy and reduced absenteeism<sup>5</sup>.

The NMC supports the establishment of supervision as an important part of clinical governance and in the interests of improving standards of patient care. (NMC)<sup>6</sup>

These guidelines have been produced to support the implementation, continuing development and maintenance of a robust system of supervision for registered nurses that work within Belfast Health & Social Care Trust (BHSCT). The Belfast Trust requires all registered nurses to participate in a regular pattern of supervision, as directed by the Chief Nursing Officer

<sup>1</sup> Lewis RJ, Cole D, Williamson A (2003) Review of Health and Social Services in the case of David and Samuel Briggs. Belfast, DHSSPS

<sup>2</sup> Regional Quality Improvement Authority (2005) Review of the lessons arising from the death of the Late Janine Murtagh, Belfast, RQIA

<sup>3</sup> McCleery Inquiry Panel (2006) Executive summary and recommendations from the report of the Inquiry Panel (McCleery) to the Eastern Health and Social Services Board

<sup>4</sup> Department of Health, Social Services and Public Safety (2006) The Quality Standards for Health and Social Care. Belfast, DHSSPS

<sup>5</sup> Hyrkas, K, Appelqvist-Schmidlechner, K and Haataja, R (2006). Efficacy of clinical supervision: Influence on job satisfaction, burnout and quality of care. *Journal of Advanced Nursing*. 55(4), 521-535

<sup>6</sup> Nursing & Midwifery Council (2002) Supporting Nurses & Midwives through lifelong learning

The Chief Nursing Officer for Northern Ireland published two standards for supervision in nursing in July 2007, which are presented below<sup>7</sup>.

The Supervision Regional Forum began work in October 2007 to give regional direction and support to the implementation of the DHSSPS Standards for Supervision in Nursing. The aim of this work was to inform a standardised approach in Northern Ireland to organisational policy, recording, documentation, learning and development activities and evaluation processes supporting supervision activity in nursing. Therefore these guidelines will be similar to those in other Health and Social Care Trusts in Northern Ireland.

**Standard Statement 1**

Supervision will contribute to the delivery of safe and effective care when practitioners have access to appropriate systems that facilitate the development of knowledge and competence through a culture of learning by reflection.

**Standard Statement 2**

An organisational framework supporting effective leadership and performance management will ensure that supervision will become an effective tool to improve the safety and quality of care.

---

<sup>7</sup> Chief Nursing Officer for Northern Ireland (2007). *Standards for Supervision for Nursing*. Belfast, DHSSPS

## Introduction

In recent years there has been increasing recognition of the role of supervision in health settings throughout the U.K. Supervision, when effective, remains a pivotal activity in delivering safe and effective care, is central to workforce development across professional disciplines and to the retention of skilled staff.

*‘Supervision is defined as a process of professional support and learning, undertaken through a range of activities, which enables individual registrant nurses to develop knowledge and competence, assume responsibility for their own practice and enhance service-user protection, quality and safety.’ (NIPEC, 2006, P5)<sup>8</sup>*

It is clearly recognised that the term supervision within the professional context includes a wide range of activities and approaches that have a supervision impact, such as action learning, individual and team supervision, reflective learning groups, critical companionship, professional, managerial and pure supervision. Rather than being restrictive to the use of specific models, those planning supervision are challenged to recognise the diversity of approaches required so that individual nurses not only have a choice, but can identify with a strong and supportive organisational infrastructure that advocates a shared responsibility for this work, and builds confidence in individual processes (NIPEC 2006)<sup>9</sup>

---

<sup>8</sup>Northern Ireland Practice and Education Council (2007). The Review of Clinical Supervision for Nursing in the HPSS 2006 on Behalf of the DHSSPS. Belfast, NIPEC

<sup>9</sup>Northern Ireland Practice and Education Council (2007). The Review of Clinical Supervision for Nursing in the HPSS 2006 on Behalf of the DHSSPS. Belfast, NIPEC

## **1.0 Aim of Guidelines**

1.1 The aim of these guidelines is to clearly identify the processes through which supervision activities may be integral to the organisational delivery of safe and effective care, to ensure successful implementation within the registered nursing workforce in BH&SCT.

1.2 These guidelines identify supervision for the registered nursing workforce as a key organisational objective for the Belfast Trust.

1.3 Implementation of an effective system of supervision for registered nurses will help ensure:

- Maintenance of care standards
- Public safety & protection
- Workforce competence and skill development
- Delivery of safe and effective care
- A focus on quality improvement & a mechanism for Quality Assurance
- Clinical effectiveness

1.4 senior management teams in BH&SCT must ensure that appropriate measures are in place to enable supervision activities for both clinical and non-clinical teams.

## 2.0 Definition and Scope

2.1 The Department of Health, Social Services and Public Safety (DHSSPS) adopted the following definition of supervision for nursing following the '*Review of Clinical Supervision for Nursing in the HPSS*' undertaken by NIPEC in 2006:

*'Supervision is defined as a process of professional support and learning, undertaken through a range of activities, which enables individual registrant nurses to develop knowledge and competence, assume responsibility for their own practice and enhance service-user protection, quality and safety.'* (NIPEC) 2006.<sup>8</sup>

2.2 These guidelines have been produced through the work of a Regional Forum that sought to standardise the approach to professional supervision used by Health and Social Care Northern Ireland (HSCNI) organisations. It was recognised by the Regional Forum that a wide variety of diverse approaches and activities can have a supervision impact, recognised as formal or informal opportunities examples of which are given in **Appendix A, Table 1 (page 19)**

2.3 It is the intention of BH&SCT that each registered nurse will undertake a minimum of two formal supervision sessions per year. Registrants are likely to engage in other activities that can also support the supervision process. Further guidelines on the scope of such activities can be found in **Appendix A (page 18)** of this document.

2.4 It should be noted that the scope of Safeguarding Children supervision differs from supervision referred to in this policy. Safeguarding Children is separate from but complimentary to other forms of supervision. Safeguarding Children supervision provides specialist professional advice, case management and support to staff in their safeguarding children. This includes children in need of protection; children in need; looked after children and families of concern. The Safeguarding Children Supervision process includes the assessment of staff performance, professional development in relation to safeguarding children and families and quality assurance of practice to ensure compliance with best practice guidelines.

Further information is available from the DHSSPS *Safeguarding Children Supervision policy for Nurses (2008)*.

### **3.0 Purpose of Supervision Activity**

3.1 Supervision activities can achieve a number of purposes simultaneously. It is important for both supervisors and supervisees in BH&SCT to recognise and differentiate supervision activity from other processes such as appraisal. Whilst supervision activity informs and is informed by the Knowledge and Skills Framework annual review process, neither activity should be substituted for the other, each activity having a different purpose. Similarly, performance management issues should be dealt with as soon as the situation has been identified.

3.2 The main purposes of supervision activity are to support:

- The development of knowledge and skills within a role or clinical area, the focus being safe and effective practice and benefit to patient care
- Nurses in non-clinical roles through providing an opportunity to discuss issues pertinent to the delivery of safe and effective care and/or professional issues
- Nurses through difficult circumstances such as challenging patient caseloads or difficult interpersonal contact with other team members
- The development of competence, knowledge and skills through facilitation of personal and professional growth.

## **4.0 Principles of Supervision**

4.1 The following principles apply for registered nurses undertaking a range of supervision activities in BH&SCT

4.1.1 The BH&SCT supports and promotes robust supervision activities for all professional staff.

4.1.2 A range of supervision approaches/activities are appropriate for ensuring safe and effective care for people.

4.1.3 All supervisors and supervisees will have opportunity to undertake appropriate training that meets their assessed need, in preparation for supervision activity.

4.1.4 All supervisors and supervisees have responsibility to partake fully in the processes of supervision including completion of appropriate recording documentation.

4.1.5 The impact of supervision activity will be evaluated at organisational level to inform the BH&SCT Annual Report to the Chief Nursing Officer.

## **5.0 Process of Supervision**

5.1 A number of procedural aspects are important to ensure supervision activity takes place effectively.

### **5.2 Preparation of Supervisor & Supervisee**

The skill and competence of a supervisor is crucial to effective supervision for nursing. The skills required for supervision will build on existing communication and facilitation abilities learned through initial training and post registration professional development.

Advice and guidance regarding the learning and development framework for supervisors and supervisees may be found in the complimentary supporting document '*Supervision for Nursing: Regional Learning and Development Framework (2008)*'



### 5.3 Contracting

In setting up supervision, it is important that the purpose of the supervisory relationship is established. This is achieved through a supervision contract, which is negotiated and agreed between supervisor and supervisee(s) at the start of supervision sessions. The contract may be reviewed at any stage at the request of either supervisor or supervisee(s); however, frequent review should not be necessary. If a change of supervisor occurs, a new contract must be agreed and signed accordingly. . The supervisee should be aware that any issues discussed that might highlight unsafe practice would be acted on as per NMC Code of Conduct. Building a relationship of trust & respect between supervisor and supervisee is an important part of the process and fundamental to successful outcomes The BHSCT contract document can be found at **Appendix B (page 20)**.

5.3.1 Ratios of numbers of supervisor(s) to supervisee(s) should be such that effective supervision activity is enabled and protected. It is recommended that a ratio of 1:5 (supervisor to supervisees) and not more than 1:8.

### 5.4 Frequency of supervision

A formalised supervision session for registered nursing staff will take place at least twice yearly. Other activities engaged in throughout the year may impact on the process of supervision. Registered nurses should reflect on their own practices as they engage in ongoing learning and development activities in their work environment. This experience should be used to inform the twice-yearly supervision sessions.

Nurses can access guidance on reflection and keeping a portfolio with corresponding templates at [www.nipedef.org](http://www.nipedef.org), which can assist with this process.

### 5.5 Preparation for Supervision

In order to benefit from supervision, nurses must also spend time preparing appropriately. This will include a review of any previous supervision session with subsequent action plan and reflection on the learning activities that have been undertaken between sessions. A supervision preparation template can be found at **Appendix C (page 22)** to help structure this process.

## 5.6 Documentation

Each formalised supervision session must have a written record signed by both supervisor and supervisee(s). The Nursing and Midwifery Council (NMC)<sup>10</sup> state that organisations employing professional staff who make such records are the legal owners of those records. Further guidelines relevant to documentation can be found in **Section 7** of this document.

## 5.7 Issues of Concern

Where an issue of unsafe, unethical or illegal practice is identified, it should be dealt with supportively via appropriate procedures. All parties must be informed of the intention to disclose, before revealing confidential information.

## 5.8 Storage of records

The BHSCT will have its own policy for the safe storage of records and in the interim, legacy site policies will continue to apply, however, each registrant should be mindful of their professional accountability with regard to the principle of confidentiality of information. Nurses should therefore take responsibility for making sure that whatever system is used is managed in such a way that it is appropriately protected to ensure the security of confidential information.

## 5.9 Use of patient records

If necessary, patient/client records may be used for the purposes of supervision activity. The NMC<sup>10</sup> states that where this happens, principles of access and confidentiality apply, namely:

- Patients'/clients' health records should only be accessed where necessary
- The patient/ client reserves the right to refuse access to their records which should be respected
- In some cases, the patient/ client may choose to limit the information accessed and registrants should respect their right to do so
- BHSCT records policy should be adhered to

---

<sup>10</sup>Nursing & Midwifery Council (2007) Record Keeping

## **6.0 Monitoring and Evaluation**

6.1 Monitoring and evaluation of supervision activity are essential to ensure that resources required for supervision within an organisation can be justified. It is also necessary to monitor the benefit for individual registrants since the quality of supervision activities can influence effectiveness.

6.2 Evaluation of supervision is needed to assess how it influences care, practice standards and the service needs.

6.3 At an organisational level, monitoring will take place through quarterly governance reports or accountability reviews. The quantity and quality of supervision activity will also be included in BHSCT performance indicators for the nursing workforce.

6.4 Individual supervisors must record quarterly, the number of sessions they engage in and make these returns available to line managers for collation. **Appendix E (Page 25)**. This information will in turn, be collated up by service group managers and communicated to the Associate Director of Nursing in the service group who is responsible for supervision of nursing within the organisation. This information will be tabled on a quarterly basis by the Co-Director of Nursing responsible for governance to Corporate Nursing team meetings and to the Director of Nursing's team meeting.

6.5 BHSCT may seek qualitative information periodically from individual registrants to assist in the ongoing evaluation of supervision processes.

6.6 These guidelines will be audited and reviewed every two years by BHSCT and appropriate changes made where necessary.

## **7.0 Documentation and Recording**

7.1 It is essential that written notes of individual sessions be recorded, remain confidential and record clearly any agreed action.

Individual session notes are the responsibility of the supervisee; however the supervisor should keep brief notes and maintain quarterly Record information **Appendix E (page 25)** which is submitted to the ward manager, team leader, or appropriate line manager.  
**Appendix F (page 26)**

## **8.0 Roles and Responsibilities**

8.1 In BHSCT there are a number of key players in posts with responsibility for ensuring supervision in nursing is implemented.

They are:

### **8.2 CHIEF EXECUTIVE**

The Chief Executive of BHSCT accepts responsibility and accountability for quality service provision at Trust Board level, which includes systems, such as supervision in nursing that support clinical and social care governance.

### **8.3 EXECUTIVE DIRECTOR OF NURSING**

The Executive Director of Nursing BHSCT is accountable to the Chief Executive for the implementation and maintenance of supervision in nursing.

Key responsibilities include:

- Presenting the Trust report to both the Trust Governance Committee and the Chief Nursing officer for Northern Ireland on an annual basis.
- Acting as a supervisor for co-directors and other senior professional roles when appropriate.

## **ASSOCIATE DIRECTOR of NURSING, (within Service Groups) - SUPERVISION LEAD.**

The Associate Director of Nursing is accountable to Executive Director of Nursing.

Key responsibilities include:

- Coordinating, facilitating, evaluating & maintaining a system of supervision in the nursing workforce
- Acting as a supervisor for Senior Managers, Lead Nurses, Specialist nurses & other members of the senior professional team within BHSCCT
- Providing information relevant to the quantity & quality of supervision within BHSCCT within quarterly governance reports.
- Ensuring appropriate resources are in place to enable nurses to undertake at least two formalised sessions of supervision annually

## **NURSING DEVELOPMENT LEADS**

They are accountable to the Associate Director relative to their service group.

Key Responsibilities include:

- Promoting, co-ordinating and facilitating implementation and maintenance of supervision for nurses within their individual directorates.
- Acting as a supervisor for ward managers and team leaders within their service group.
- Ensuring that Bank-only nursing staff have access to supervision in the Service Groups that they work in most often. Information on the activity will be forwarded to the Senior Manager Nursing responsible for Bank only staff.

## **WARD MANAGERS/TEAM LEADERS**

They are accountable to the Associate Director of Nursing and must submit quarterly returns received from supervisors within their team. **Appendix F (page 26).**

Key responsibilities include:

- Acting as role model
- Facilitating implementation and maintenance of supervision for nurses within their staff teams.
- Acting as a supervisor for other members of staff, either within or outside their own team.

## **ROLE OF SUPERVISORS**

They are accountable to their line managers.

Key responsibilities include:

- Development and maintenance of their own skills and competencies relative to supervision activity
- Seeking and undertaking supervision themselves,
- Arranging dates & venues in advance & communicating these to Ward Manager
- Maintaining records for both personal supervision and professional supervision of others.
- Providing at least two formal sessions of supervision annually for each supervisee, whether group or individual.
- Adhering to ground rules identified in agreed contracts and conduct supervision sessions within the principles and process identified in these guidelines.
- Informing supervisee that records are discoverable (e.g. in coroner's court).
- Providing clear, constructive feedback during sessions
- Be aware that both have a responsibility to share any information that might comprise patient/public safety or contravene NMC code of conduct.
- Be aware of BHSCT guidelines & policy

Additionally, the following criteria will apply to the role of supervisor:

Essential criteria:

- Be a registered nurse for a minimum of one year
- Have completed self-evaluation tool to identify any skills deficits

- Attended appropriate training to address these deficits
- Recognise own personal & professional needs
- Be open to constructive feedback & engage in challenge & supportive interventions

Desirable criteria:

- Have expertise in the field for which they are supervisor
- Have undertaken mentorship training
- Have undertaken facilitation-skills training

## **SUPERVISEES**

They are accountable to their line manager to engage in a minimum of two formal supervision sessions annually.

Key responsibilities include:

- Recognising own personal & professional development needs.
- Arriving promptly for arranged session.
- Engaging fully in the supervision process, adhering to ground rules identified in agreed contracts.
- Preparing for and participate in a minimum of two formal supervision sessions a year, keeping accurate records of relevant actions. Activities undertaken between sessions should be used to inform formal supervision sessions.
- Making use of reflective learning opportunities.
- Being prepared to receive constructive feedback, making changes to their practice to improve patient outcomes.

## RANGE OF ACTIVITIES

A range of activities can support supervision for registered nurses. Whichever activity is used, each registrant must ensure they have the appropriate skills, competence, knowledge & experience required to engage in the activity.

Nurses should use the many learning opportunities within their work environments to reflect on their own practice. These experiences can be used to inform formal supervision sessions.

When an informal opportunity arises during the course of any given working day, it can be difficult to find time to document the learning experiences. [www.nipecdf.org](http://www.nipecdf.org) contains a learning and development log template which can be used for recording informal experiences, providing a quick method of capturing the lived learning nurses engage in on a daily basis. To make a quick record of learning activities go to:

<http://www.nipecdf.org/portfolio/learn.asp>

Examples of activities that support supervision can be found in **Table 1**.

Many activities inform supervision processes, it should therefore, be noted that this is not a definitive list of activities, merely examples to guide professional teams. For definitions and access to a list of other activities that may be useful go to:

<http://www.nipecdf.org/learn/actList.asp>



## Examples of Activities which Support Supervision

**Table 1**

<p style="text-align: center;"><b>Reflective Practice</b></p> <p>Reflective practice is the process of thinking about your own practice and that of others in a structured way; this leads to new and better ways of working and helps you develop new levels of knowledge and competence. You will learn to think critically about your practice and about what you need to do to improve it and the care you provide. Reflection allows you to describe your experience, think about it, and evaluate the outcomes. This should help you to have new understandings and insights. Reflection is what turns experience into meaningful learning, making sense of the world around you, and to building on what is happening. You may also find it helpful to use one of the many reflective tools that have been developed.</p>	<p style="text-align: center;"><b>Work Based Learning</b></p> <p>A work-based learning programme is provided by an education institution, using a negotiated, project-led approach; this is managed by you and provides the best opportunities for learning and professional development in the workplace. Work-based learning acknowledges that everyone learns in different ways. It gives you control over how and when you learn and takes learning out of the classroom into the workplace. The learning is gained through work-related projects. Work-based learning opens your eyes to the fact that you can learn from anything. Work-based learning in multi-professional teams, making full use of modern technology, can produce benefits to you, the organization and the profession. Successful completion of the programme will provide you with accredited learning and lead to an academic qualification. It is concerned with helping you to bridge the practice/theory gap.</p>	<p style="text-align: center;"><b>Post Incident review</b></p> <p>This happens when an incident has occurred in the workplace that has caused you and/or other members of the healthcare team a level of distress. The incident has usually resulted in a miss or near miss, where there has or could have been damage to a patient or client. A post-incident review involves the reviewing of specific incidents, either individually or as a team, within a setting that provides emotional support to each person. The incident is analyzed with your involvement and the involvement of all team members, using reflection, self-evaluation and/or facilitated learning to establish how the incident happened and how it could be avoided in the future. If you are involved in a post-incident review it should result in good support from your team members and outcomes and actions for yourself and the team, with possible organizational implications. The final outcome must provide a clear description of risk factors and required action. You should also use the review process to identify personal action plans and required development. This is a learning event for all involved, with the objective of learning to improve practice.</p>
<p style="text-align: center;"><b>Learning Sets</b></p> <p>The term refers to a group of people who meet regularly to work and learn together, using a structured format. The learning set can comprise of uni- or multi-professional groups and the focus is on self-directed learning; the participants decide the particular issues to be addressed. This provides you with a confidential forum in which to test issues that concern you, discuss new ideas and help you and the others to challenge working practices in new and creative ways. It is important to set ground rules to deal with issues such as confidentiality. Each member of the group is facilitated and supported by the others in the solving of issues and problems.</p>	<p style="text-align: center;"><b>Critical Incident Review</b></p> <p>A critical incident is a significant event or experience that has occurred in your workplace and that you feel has had an impact on you or the people you work with. This could be negative or positive; it could be a personal experience or it could result from observing how other people work. You need to examine the incident through a process of reflection, using an evidence-based approach, to identify lessons to be learned. This could also take place with a group of practitioners working together. This should result in new learning for you and/or the group you are working with and result in a short action plan to bring about improvement in practice.</p>	<p style="text-align: center;"><b>Peer Review</b></p> <p>This is a process, which encourages you to work with colleagues at the same level and in the same area of practice, and to evaluate each other's performance. We all have behaviours we are unaware of. Peer review gives an insight into these from the perspective of another person. This is a valuable learning activity, as it helps to develop your critical thinking and collaborative working and brings about improvements in your practice. This needs to be set up within a structured format, to ensure that you and the other peer reviewers have the required skills and are supported by experienced colleagues.</p>
<p style="text-align: center;"><b>Supervised Practice for Competency Development</b></p> <p>This is a negotiated period of supervised practice, with agreed learning and competency outcomes and may be provided for you if you require to develop specific, identified competencies. It is also likely to be arranged for you if you have poor or failing clinical competence in an area of practice. This is a period of practice where you are supervised and monitored by an experienced practitioner. The length of the supervised practice and the required outcome are set before the exercise begins. You are required to work closely with your supervisor throughout the entire period of practice. You will also be assessed at the end of the supervised practice to see if you can show that you have the necessary knowledge and competence. If you have not demonstrated this, a further action plan will be drawn up.</p>	<p style="text-align: center;"><b>Mentoring</b></p> <p>A mentor is someone who has skills of working with individuals who can provide guidance and support to help you achieve your potential. Your mentor may not be from your own field of practice but should be a person with mentoring experience. Mentoring is achieved through a process of relationship building between you and your mentor and takes place over a period of time. The purpose of the mentoring process is to enable you to recognise your own skills and capabilities and maximise the development opportunities available to you.</p>	<p style="text-align: center;"><b>Preceptor Training</b></p> <p>This is the process by which you, as a newly registered nurse or midwife, are helped to make the transition from student to qualified and competent practitioner, through a negotiated programme of learning and support. The preceptor is a more experienced nurse/midwife who will work with you over a period of about four months to provide guidance and training. Your preceptor will also monitor your progress and performance and provide feedback to help you improve your practice and standard of care.</p>

**CONTRACT FOR SUPERVISION SESSIONS (1 OF 2)****Appendix B**

Supervision will help you reflect on your practice. This process will in turn help you to sustain your continuous development.

**Purpose of Supervision**

The purpose of supervision should be agreed between the supervisor and the supervisee. It should relate to their roles and responsibilities and can include any aspects of their personal development.

**As supervisor I take responsibility for:**

- Following the focus identified by the supervisee(s)
- Exploring the supervisee's expectations appropriately using my knowledge, skills and experience
- Allowing the supervisee to express their individuality
- A balance of challenge and support will be maintained throughout supervision.
- Facilitating reflective practice
- Evaluating the session for the supervisee(s) and supervisor
- Completing a sessional collation form
- Maintaining all records of session in a safe and confidential manner according to NMC and Trust guidelines.

**As supervisee I take responsibility for:**

- Preparing for the sessions using a formal reflective model e.g. 'Preparation template for supervision' (Appendix C) or other recognised tools
- Driving the agenda
- Bringing appropriate issues to sessions and discussing them openly
- Engaging in learning and development activities between agreed annual sessions that will inform supervision sessions
- Recording and reflecting on significant activities using 'Supervision record sheet' (Appendix D)
- Evaluating the benefit of the session
- Completing the supervision record sheet and retaining in portfolio.

**Ground rules will be agreed when developing the contract and reviewed at each session:**

Ground rules and responsibilities should be clearly defined and the contract should demonstrate the commitment to these.

**Some examples of ground rules agreed by supervisor/supervisee(s):**

- Open and honest learning
- Commitment to confidentiality except when issues breach the Code of Conduct
- Sharing best practice
- Active listening
- Ensure supervision sessions take place at the agreed time
- Evaluate the session and engage in mutual feedback

This is not an exhaustive list and consideration should be given to the needs of individuals/groups when developing a supervision contract to develop ways of working that meet everyone's agenda.

**At the end of each session we will:**

- Agree a suitable time and venue for the next session if appropriate.
- Maintain and store records as agreed in ground rules.

**CONTRACT FOR SUPERVISION SESSIONS (2 OF 2)**

**AGREEMENT**

In addition I have:

- Read all relative policies and guidelines
- Participated in training if required

<b>Signature of supervisor</b>	<b>Signature of supervisee or group supervisees</b>
	1.
	2.
	3.
	4.
	5.
	6.
	7.
	8.
<b>Frequency of sessions (if applicable)</b>	
<b>Venue</b>	

**Date & Time:** \_\_\_\_\_

**Clinical Area:** \_\_\_\_\_

## Preparation Template for Supervision

Name: \_\_\_\_\_

Date: \_\_\_\_\_

<b>What is the issue?</b>
<b>Why is it significant?</b>
<b>What did not go well?</b>
<b>What went well?</b>
<b>How did this make me feel?</b>
<b>What would I do differently in the future?</b>
<b>What have I learnt?</b>
<b>What actions do I need to take forward (if applicable)?</b>

(Adapted from Gibbs, 1998 & Johns, 2000)

**Supervision Record Sheet (1 of 2)**

Date: \_\_\_\_\_

Individuals Present			
Supervisor	Supervisees		
	1		5
	2		6
	3		7
	4		8

	<b>You may like to consider using the prompts below:</b>
<b>Review of action/learning points from previous session</b>	
<b>Issue(s) discussed at this supervision session</b>	What was explored during this supervision session; what was the issue/experience and or situation?
<b>What action points were agreed?</b>	By supervisee? By supervisor?





**To Be Completed By Line Manager**

**Quarterly Supervision Returns**

Service Group: \_\_\_\_\_

Associate Director of Nursing: \_\_\_\_\_

Quarter: *Please tick*    Apr-Jun     Jul-Sep     Oct-Dec     Jan-Mar

Total Number of RN's	No of RN's who have had one supervision session	No of RN's who have had two supervision sessions	Comments

**Please return to:**

**Associate Director of Nursing**



<b>TYPE OF DOCUMENT</b>	<input type="checkbox"/> Trust Policy for approval by Trust Policy Committee <input type="checkbox"/> Patient based standard, guideline or policy for approval by Standards and Guidelines Committee
<b>TITLE</b>	Guidelines for implementation of supervision for registered nurses in Belfast Health & Social Care Trust
<b>Summary</b>	<p>'Supervision is defined as a process of professional support and learning, undertaken through a range of activities, which enables individual registrant nurses (R.N.s) to develop knowledge and competence, assume responsibility for their own practice and enhance service-user protection, quality and safety.' (NIPEC) 2006. In 2007, the Chief Nursing Officer (CNO) issued two standards in relation to supervision in Northern Ireland. In order to comply with the standards, all R.N.s must have an opportunity to access a minimum of two supervision opportunities per year.</p> <p>The guidelines set out the process of supervision, how the process is to be monitored and evaluated and the documentation that can be used to aid recording of supervision episodes. The roles and responsibilities of key players are described.</p>
<b>Purpose</b>	To provide registered nurses with guidance in the process of supervision, role of supervisors and supervisees and, standardised templates for recording supervision activities in order to comply with CNO standards.
<b>Operational date</b>	July 2008
<b>Review date</b>	May 2014
<b>Version Number</b>	V 4
<b>Supersedes previous</b>	All previous legacy sites documentation in relation to supervision for registered nurses
<b>Director Responsible</b>	Nicki Patterson (Acting Director of Nursing)
<b>Lead Author</b>	Audrey Dowd
<b>Lead Author, Position</b>	Senior Manager-Performance, Quality and Standards
<b>Additional Author(s)</b>	Supervision Implementation Group and Review of Supervision Documentation Sub-group
<b>Department / Service Group</b>	Central Nursing
<b>Contact details</b>	Audrey Dowd- Phone No. [REDACTED] Email- [REDACTED]

<b>Reference Number</b>	TP040/08
Supercedes	V 3

<b>Date</b>	<b>Version</b>	<b>Author</b>	<b>Comments</b>
3 <sup>rd</sup> May 2009	V 2	A. Dowd	
7 <sup>th</sup> Dec 2009	V 3	A. Dowd	Amendments to appendices
March 2011	V4	O.MacLeod	Reviewed-no amendments Review date changed

**Policy Record**

		<b>Date</b>	<b>Version</b>
Author (s)	Approval	7 <sup>th</sup> Dec 09	V 3
Director Responsible	Approval		

**Approval Process – Trust Policies**

Policy Committee	Approval		
Executive Team	Authorise		
Chief Executive	Sign Off		

**Approval Process – Clinical Standards and Guidelines**

Standards and Guidelines Committee	Approval	21/04/2011	V4
Policy Committee	Approval	16/05/2011	V4
Executive Team	Authorise	18/05/2011	V4
Appropriate Director	Sign Off	21/05/2011	V4

# **GUIDELINES FOR IMPLEMENTATION OF SUPERVISION FOR REGISTERED NURSES IN BELFAST HEALTH & SOCIAL CARE TRUST**

## Index

<b>1. Summary of Guidelines</b>		<b>1</b>
<b>2. Background</b>	<b>3</b>	
<b>3. Introduction</b>	<b>5</b>	
<b>4. Aim of Guidelines</b>	<b>6</b>	
<b>5. Definition and Scope</b>		<b>7</b>
<b>6. Purpose of Supervision Activity</b>		<b>9</b>
<b>7. Principles of Supervision</b>		<b>10</b>
<b>8. Process of Supervision</b>		<b>10</b>
- <i>Preparation of Supervisor &amp; Supervisee</i>		<b>10</b>
- <i>Contracting</i>		<b>11</b>
- <i>Frequency of Supervision</i>		<b>11</b>
- <i>Preparation for Supervision</i>		<b>11</b>
- <i>Documentation</i>		<b>12</b>
- <i>Issues of Concern</i>		<b>12</b>
- <i>Storage of records</i>		<b>12</b>
- <i>Use of Patient/ Client Records</i>		<b>12</b>
<b>9. Monitoring and Evaluation</b>		<b>13</b>
<b>10. Documentation and Recording</b>	<b>14</b>	
<b>11. Roles and Responsibilities</b>		<b>14</b>

## Appendices

<b>Appendix A - <i>Range of Activities</i></b>		<b>18</b>
<b>Appendix B - <i>Contract for Supervision</i></b>		<b>20</b>
<b>Appendix C - <i>Preparation Template for Supervision</i></b>		<b>22</b>
<b>Appendix D - <i>Supervision Record Sheet</i></b>		<b>23</b>
<b>Appendix E - <i>Quarterly Supervision Returns by Supervisor</i></b>		<b>25</b>
<b>Appendix F - <i>Quarterly Supervision Returns by Line Manager</i></b>		<b>26</b>

## SUPERVISION GUIDELINES

### Summary of Guidelines

**What is Supervision:** Supervision is a process of professional support and learning, undertaken through a range of activities, which enables individual registrant nurses to develop knowledge and competence, assume responsibility for their own practice and enhance service-user protection, quality and safety.’

### Objectives:

- To support and promote robust supervision activities for all nursing staff
- To ensure that supervisor(s) and supervisee(s) partake fully in the process of supervision including appropriate documentation
- To ensure the impact of supervision activity is evaluated organisationally.
- To enable nursing staff to reflect on and review their clinical practice
- To support the development of clinical skills in assessment and treatment of patients.

**Participants:** All registered nursing staff employed in the Belfast Trust including Nurse Bank staff

### Background:

In line with governance requirements, the Belfast Trust needs to be assured that nursing staff have the necessary knowledge, skills and competence to fulfil their roles in a confident and professional manner.

### Process:

These guidelines describe the process for implementation, continuing development and maintenance of a robust system of supervision in the Trust. All registered nurses must participate in a regular pattern of supervision, as directed by the Chief Nursing Officer (CNO) who issued two regional Standards for Supervision for nursing in Northern Ireland where he sets out the requirements of bi-annual mandatory clinical supervision.

Compliance with these must be reported yearly. The standards come into effect from April 1<sup>st</sup> 2008.

These guidelines set out the process of supervision, how the process is to be monitored and evaluated and the documentation that can be used to aid recording of supervision episodes. The roles and responsibilities of key players are described.

**Outcome measures:**

Nurses are encouraged to use the many opportunities within their work environments to reflect on their practice, making patient care safer and improving patient outcomes. Documentation records will be available on the Intranet for easy access. Participation in supervision will be reported to Central Nursing team for evaluation and ongoing support. Supervisor/supervisees will be supported through training and development of facilitation skills. Once established, this process will be evaluated to determine to determine impact on patient outcomes and staff.

**Conclusion:**

The importance of effective supervision has been highlighted in regional critical incident inquiries. The Quality Standards for Health and Social Care recommend that an effective system for supervision across H&SC can help organisations meet each of the clinical and social care governance standards. Supervision processes have also been recognised as a method of improving organisational recruitment and retention of nursing staff and has already an established association with job satisfaction, increased autonomy and reduced absenteeism.

## Background

The importance of effective supervision has been highlighted in regional critical incident inquiries such as the Lewis Review (2003)<sup>1</sup> Murtagh Review (2005)<sup>2</sup> and McCleery Report (2006) The Quality Standards for Health and Social Care (DHSSPS 2006)<sup>4</sup> recommend that an effective system for supervision across H&SC can help organisations meet each of the clinical and social care governance standards.

Supervision processes have also been recognised as a method of improving organisational recruitment and retention of nursing staff and have already an established association with job satisfaction, increased autonomy and reduced absenteeism<sup>5</sup>.

The NMC supports the establishment of supervision as an important part of clinical governance and in the interests of improving standards of patient care. (NMC)<sup>6</sup>

These guidelines have been produced to support the implementation, continuing development and maintenance of a robust system of supervision for registered nurses that work within Belfast Health & Social Care Trust (BHSCT). The Belfast Trust requires all registered nurses to participate in a regular pattern of supervision, as directed by the Chief Nursing Officer

<sup>1</sup> Lewis RJ, Cole D, Williamson A (2003) Review of Health and Social Services in the case of David and Samuel Briggs. Belfast, DHSSPS

<sup>2</sup> Regional Quality Improvement Authority (2005) Review of the lessons arising from the death of the Late Janine Murtagh, Belfast, RQIA

<sup>3</sup> McCleery Inquiry Panel (2006) Executive summary and recommendations from the report of the Inquiry Panel (McCleery) to the Eastern Health and Social Services Board

<sup>4</sup> Department of Health, Social Services and Public Safety (2006) The Quality Standards for Health and Social Care. Belfast, DHSSPS

<sup>5</sup> Hyrkas, K, Appelqvist-Schmidlechner, K and Haataja, R (2006). Efficacy of clinical supervision: Influence on job satisfaction, burnout and quality of care. Journal of Advanced Nursing. 55(4), 521-535

<sup>6</sup> Nursing & Midwifery Council (2002) Supporting Nurses & Midwives through lifelong learning

The Chief Nursing Officer for Northern Ireland published two standards for supervision in nursing in July 2007, which are presented below<sup>7</sup>.

The Supervision Regional Forum began work in October 2007 to give regional direction and support to the implementation of the DHSSPS Standards for Supervision in Nursing. The aim of this work was to inform a standardised approach in Northern Ireland to organisational policy, recording, documentation, learning and development activities and evaluation processes supporting supervision activity in nursing. Therefore these guidelines will be similar to those in other Health and Social Care Trusts in Northern Ireland.

**Standard Statement 1**

Supervision will contribute to the delivery of safe and effective care when practitioners have access to appropriate systems that facilitate the development of knowledge and competence through a culture of learning by reflection.

**Standard Statement 2**

An organisational framework supporting effective leadership and performance management will ensure that supervision will become an effective tool to improve the safety and quality of care.

---

<sup>7</sup> Chief Nursing Officer for Northern Ireland (2007). *Standards for Supervision for Nursing*. Belfast, DHSSPS



## Introduction

In recent years there has been increasing recognition of the role of supervision in health settings throughout the U.K. Supervision, when effective, remains a pivotal activity in delivering safe and effective care, is central to workforce development across professional disciplines and to the retention of skilled staff.

*‘Supervision is defined as a process of professional support and learning, undertaken through a range of activities, which enables individual registrant nurses to develop knowledge and competence, assume responsibility for their own practice and enhance service-user protection, quality and safety.’ (NIPEC, 2006, P5)<sup>8</sup>*

It is clearly recognised that the term supervision within the professional context includes a wide range of activities and approaches that have a supervision impact, such as action learning, individual and team supervision, reflective learning groups, critical companionship, professional, managerial and pure supervision. Rather than being restrictive to the use of specific models, those planning supervision are challenged to recognise the diversity of approaches required so that individual nurses not only have a choice, but can identify with a strong and supportive organisational infrastructure that advocates a shared responsibility for this work, and builds confidence in individual processes (NIPEC 2006)<sup>9</sup>

---

<sup>8</sup>Northern Ireland Practice and Education Council (2007). The Review of Clinical Supervision for Nursing in the HPSS 2006 on Behalf of the DHSSPS. Belfast, NIPEC

<sup>9</sup>Northern Ireland Practice and Education Council (2007). The Review of Clinical Supervision for Nursing in the HPSS 2006 on Behalf of the DHSSPS. Belfast, NIPEC

## **1.0 Aim of Guidelines**

1.1 The aim of these guidelines is to clearly identify the processes through which supervision activities may be integral to the organisational delivery of safe and effective care, to ensure successful implementation within the registered nursing workforce in BH&SCT.

1.2 These guidelines identify supervision for the registered nursing workforce as a key organisational objective for the Belfast Trust.

1.3 Implementation of an effective system of supervision for registered nurses will help ensure:

- Maintenance of care standards
- Public safety & protection
- Workforce competence and skill development
- Delivery of safe and effective care
- A focus on quality improvement & a mechanism for Quality Assurance
- Clinical effectiveness

1.4 senior management teams in BH&SCT must ensure that appropriate measures are in place to enable supervision activities for both clinical and non-clinical teams.

## 2.0 Definition and Scope

2.1 The Department of Health, Social Services and Public Safety (DHSSPS) adopted the following definition of supervision for nursing following the '*Review of Clinical Supervision for Nursing in the HPSS*' undertaken by NIPEC in 2006:

*'Supervision is defined as a process of professional support and learning, undertaken through a range of activities, which enables individual registrant nurses to develop knowledge and competence, assume responsibility for their own practice and enhance service-user protection, quality and safety.'* (NIPEC) 2006<sup>8</sup>

2.2 These guidelines have been produced through the work of a Regional Forum that sought to standardise the approach to professional supervision used by Health and Social Care Northern Ireland (HSCNI) organisations. It was recognised by the Regional Forum that a wide variety of diverse approaches and activities can have a supervision impact, recognised as formal or informal opportunities examples of which are given in **Appendix A, Table 1 (page 19)**

2.3 It is the intention of BH&SCT that each registered nurse will undertake a minimum of two formal supervision sessions per year. Registrants are likely to engage in other activities that can also support the supervision process. Further guidelines on the scope of such activities can be found in **Appendix A (page 18)** of this document.

2.4 It should be noted that the scope of Safeguarding Children supervision differs from supervision referred to in this policy. Safeguarding Children is separate from but complimentary to other forms of supervision. Safeguarding Children supervision provides specialist professional advice, case management and support to staff in their safeguarding children. This includes children in need of protection; children in need; looked after children and families of concern. The Safeguarding Children Supervision process includes the assessment of staff performance, professional development in relation to safeguarding children and families and quality assurance of practice to ensure compliance with best practice guidelines.

Further information is available from the DHSSPS *Safeguarding Children Supervision policy*

### **3.0 Purpose of Supervision Activity**

3.1 Supervision activities can achieve a number of purposes simultaneously. It is important for both supervisors and supervisees in BH&SCT to recognise and differentiate supervision activity from other processes such as appraisal. Whilst supervision activity informs and is informed by the Knowledge and Skills Framework annual review process, neither activity should be substituted for the other, each activity having a different purpose. Similarly, performance management issues should be dealt with as soon as the situation has been identified.

3.2 The main purposes of supervision activity are to support:

- The development of knowledge and skills within a role or clinical area, the focus being safe and effective practice and benefit to patient care
- Nurses in non-clinical roles through providing an opportunity to discuss issues pertinent to the delivery of safe and effective care and/or professional issues
- Nurses through difficult circumstances such as challenging patient caseloads or difficult interpersonal contact with other team members
- The development of competence, knowledge and skills through facilitation of personal and professional growth.

## **4.0 Principles of Supervision**

4.1 The following principles apply for registered nurses undertaking a range of supervision activities in BH&SCT

4.1.1 The BH&SCT supports and promotes robust supervision activities for all professional staff.

4.1.2 A range of supervision approaches/activities are appropriate for ensuring safe and effective care for people.

4.1.3 All supervisors and supervisees will have opportunity to undertake appropriate training that meets their assessed need, in preparation for supervision activity.

4.1.4 All supervisors and supervisees have responsibility to partake fully in the processes of supervision including completion of appropriate recording documentation.

4.1.5 The impact of supervision activity will be evaluated at organisational level to inform the BH&SCT Annual Report to the Chief Nursing Officer.

## **5.0 Process of Supervision**

5.1 A number of procedural aspects are important to ensure supervision activity takes place effectively.

### **5.2 Preparation of Supervisor & Supervisee**

The skill and competence of a supervisor is crucial to effective supervision for nursing. The skills required for supervision will build on existing communication and facilitation abilities learned through initial training and post registration professional development.

Advice and guidance regarding the learning and development framework for supervisors and supervisees may be found in the complimentary supporting document '*Supervision for Nursing: Regional Learning and Development Framework (2008)*'

### 5.3 Contracting

In setting up supervision, it is important that the purpose of the supervisory relationship is established. This is achieved through a supervision contract, which is negotiated and agreed between supervisor and supervisee(s) at the start of supervision sessions. The contract may be reviewed at any stage at the request of either supervisor or supervisee(s); however, frequent review should not be necessary. If a change of supervisor occurs, a new contract must be agreed and signed accordingly. . The supervisee should be aware that any issues discussed that might highlight unsafe practice would be acted on as per NMC Code of Conduct. Building a relationship of trust & respect between supervisor and supervisee is an important part of the process and fundamental to successful outcomes The BHSCT contract document can be found at **Appendix B (page 20)**.

5.3.1 Ratios of numbers of supervisor(s) to supervisee(s) should be such that effective supervision activity is enabled and protected. It is recommended that a ratio of 1:5 (supervisor to supervisees) and not more than 1:8.

### 5.4 Frequency of supervision

A formalised supervision session for registered nursing staff will take place at least twice yearly. Other activities engaged in throughout the year may impact on the process of supervision. Registered nurses should reflect on their own practices as they engage in ongoing learning and development activities in their work environment. This experience should be used to inform the twice-yearly supervision sessions.

Nurses can access guidance on reflection and keeping a portfolio with corresponding templates at [www.nipedef.org](http://www.nipedef.org), which can assist with this process.

### 5.5 Preparation for Supervision

In order to benefit from supervision, nurses must also spend time preparing appropriately. This will include a review of any previous supervision session with subsequent action plan and reflection on the learning activities that have been undertaken between sessions. A supervision preparation template can be found at

**Appendix C (page 22)** to help structure this process.

### 5.6 Documentation

Each formalised supervision session must have a written record signed by both supervisor and supervisee(s). The Nursing and Midwifery Council (NMC) <sup>10</sup> state that organisations employing professional staff who make such records are the legal owners of those records. Further guidelines relevant to documentation can be found in **Section 7** of this document.

### 5.7 Issues of Concern

Where an issue of unsafe, unethical or illegal practice is identified, it should be dealt with supportively via appropriate procedures. All parties must be informed of the intention to disclose, before revealing confidential information.

### 5.8 Storage of records

The BHSCT will have its own policy for the safe storage of records and in the interim, legacy site policies will continue to apply, however, each registrant should be mindful of their professional accountability with regard to the principle of confidentiality of information. Nurses should therefore take responsibility for making sure that whatever system is used is managed in such a way that it is appropriately protected to ensure the security of confidential information.

### 5.9 Use of patient records

If necessary, patient/client records may be used for the purposes of supervision activity. The NMC<sup>10</sup> states that where this happens, principles of access and confidentiality apply, namely:

- Patients'/clients' health records should only be accessed where necessary
- The patient/ client reserves the right to refuse access to their records which should be respected
- In some cases, the patient/ client may choose to limit the information accessed and registrants should respect their right to do so
- BHSCT records policy should be adhered to

---

<sup>10</sup>Nursing & Midwifery Council (2007) Record Keeping

## **6.0 Monitoring and Evaluation**

6.1 Monitoring and evaluation of supervision activity are essential to ensure that resources required for supervision within an organisation can be justified. It is also necessary to monitor the benefit for individual registrants since the quality of supervision activities can influence effectiveness.

6.2 Evaluation of supervision is needed to assess how it influences care, practice standards and the service needs.

6.3 At an organisational level, monitoring will take place through quarterly governance reports or accountability reviews. The quantity and quality of supervision activity will also be included in BHSCT performance indicators for the nursing workforce.

6.4 Individual supervisors must record quarterly, the number of sessions they engage in and make these returns available to line managers for collation. **Appendix E (Page 25).** This information will in turn, be collated up by service group managers and communicated to the Associate Director of Nursing in the service group who is responsible for supervision of nursing within the organisation. This information will be tabled on a quarterly basis by the Co-Director of Nursing responsible for governance to Corporate Nursing team meetings and to the Director of Nursing's team meeting.

6.5 BHSCT may seek qualitative information periodically from individual registrants to assist in the ongoing evaluation of supervision processes.

6.6 These guidelines will be audited and reviewed every two years by BHSCT and appropriate changes made where necessary.



## **7.0 Documentation and Recording**

7.1 It is essential that written notes of individual sessions be recorded, remain confidential and record clearly any agreed action.

Individual session notes are the responsibility of the supervisee; however the supervisor should keep brief notes and maintain quarterly Record information **Appendix E (page 25)** which is submitted to the ward manager, team leader, or appropriate line manager.  
**Appendix F (page 26)**

## **8.0 Roles and Responsibilities**

8.1 In BHSCT there are a number of key players in posts with responsibility for ensuring supervision in nursing is implemented.

They are:

### **8.2 CHIEF EXECUTIVE**

The Chief Executive of BHSCT accepts responsibility and accountability for quality service provision at Trust Board level, which includes systems, such as supervision in nursing that support clinical and social care governance.

### **8.3 EXECUTIVE DIRECTOR OF NURSING**

The Executive Director of Nursing BHSCT is accountable to the Chief Executive for the implementation and maintenance of supervision in nursing.

Key responsibilities include:

- Presenting the Trust report to both the Trust Governance Committee and the Chief Nursing officer for Northern Ireland on an annual basis.
- Acting as a supervisor for co-directors and other senior professional roles when appropriate.

## **ASSOCIATE DIRECTOR of NURSING, (within Service Groups) - SUPERVISION LEAD.**

The Associate Director of Nursing is accountable to Executive Director of Nursing.

Key responsibilities include:

- Coordinating, facilitating, evaluating & maintaining a system of supervision in the nursing workforce
- Acting as a supervisor for Senior Managers, Lead Nurses, Specialist nurses & other members of the senior professional team within BHSC
- Providing information relevant to the quantity & quality of supervision within BHSC within quarterly governance reports.
- Ensuring appropriate resources are in place to enable nurses to undertake at least two formalised sessions of supervision annually

## **NURSING DEVELOPMENT LEADS**

They are accountable to the Associate Director relative to their service group.

Key Responsibilities include:

- Promoting, co-ordinating and facilitating implementation and maintenance of supervision for nurses within their individual directorates.
- Acting as a supervisor for ward managers and team leaders within their service group.
- Ensuring that Bank-only nursing staff have access to supervision in the Service Groups that they work in most often. Information on the activity will be forwarded to the Senior Manager Nursing responsible for Bank only staff.

## **WARD MANAGERS/TEAM LEADERS**

They are accountable to the Associate Director of Nursing and must submit quarterly returns received from supervisors within their team. **Appendix F (page 26).**

Key responsibilities include:

- Acting as role model
- Facilitating implementation and maintenance of supervision for nurses within their staff teams.
- Acting as a supervisor for other members of staff, either within or outside their own team.

## **ROLE OF SUPERVISORS**

They are accountable to their line managers.

Key responsibilities include:

- Development and maintenance of their own skills and competencies relative to supervision activity
- Seeking and undertaking supervision themselves,
- Arranging dates & venues in advance & communicating these to Ward Manager
- Maintaining records for both personal supervision and professional supervision of others.
- Providing at least two formal sessions of supervision annually for each supervisee, whether group or individual.
- Adhering to ground rules identified in agreed contracts and conduct supervision sessions within the principles and process identified in these guidelines.
- Informing supervisee that records are discoverable (e.g. in coroner's court).
- Providing clear, constructive feedback during sessions
- Be aware that both have a responsibility to share any information that might comprise patient/public safety or contravene NMC code of conduct.
- Be aware of BHSCT guidelines & policy

Additionally, the following criteria will apply to the role of supervisor:

Essential criteria:

- Be a registered nurse for a minimum of one year
- Have completed self-evaluation tool to identify any skills deficits

- Attended appropriate training to address these deficits
- Recognise own personal & professional needs
- Be open to constructive feedback & engage in challenge & supportive interventions

Desirable criteria:

- Have expertise in the field for which they are supervisor
- Have undertaken mentorship training
- Have undertaken facilitation-skills training

## **SUPERVISEES**

They are accountable to their line manager to engage in a minimum of two formal supervision sessions annually.

Key responsibilities include:

- Recognising own personal & professional development needs.
- Arriving promptly for arranged session.
- Engaging fully in the supervision process, adhering to ground rules identified in agreed contracts.
- Preparing for and participate in a minimum of two formal supervision sessions a year, keeping accurate records of relevant actions. Activities undertaken between sessions should be used to inform formal supervision sessions.
- Making use of reflective learning opportunities.
- Being prepared to receive constructive feedback, making changes to their practice to improve patient outcomes.

## RANGE OF ACTIVITIES

A range of activities can support supervision for registered nurses. Whichever activity is used, each registrant must ensure they have the appropriate skills, competence, knowledge & experience required to engage in the activity.

Nurses should use the many learning opportunities within their work environments to reflect on their own practice. These experiences can be used to inform formal supervision sessions.

When an informal opportunity arises during the course of any given working day, it can be difficult to find time to document the learning experiences. [www.nipecdf.org](http://www.nipecdf.org) contains a learning and development log template which can be used for recording informal experiences, providing a quick method of capturing the lived learning nurses engage in on a daily basis. To make a quick record of learning activities go to:

<http://www.nipecdf.org/portfolio/learn.asp>

Examples of activities that support supervision can be found in **Table 1**.

Many activities inform supervision processes, it should therefore, be noted that this is not a definitive list of activities, merely examples to guide professional teams. For definitions and access to a list of other activities that may be useful go to:

<http://www.nipecdf.org/learn/actList.asp>

## Examples of Activities which Support Supervision

**Table 1**

<p style="text-align: center;"><b>Reflective Practice</b></p> <p>Reflective practice is the process of thinking about your own practice and that of others in a structured way; this leads to new and better ways of working and helps you develop new levels of knowledge and competence. You will learn to think critically about your practice and about what you need to do to improve it and the care you provide. Reflection allows you to describe your experience, think about it, and evaluate the outcomes. This should help you to have new understandings and insights. Reflection is what turns experience into meaningful learning, making sense of the world around you, and to building on what is happening. You may also find it helpful to use one of the many reflective tools that have been developed.</p>	<p style="text-align: center;"><b>Work Based Learning</b></p> <p>A work-based learning programme is provided by an education institution, using a negotiated, project-led approach; this is managed by you and provides the best opportunities for learning and professional development in the workplace. Work-based learning acknowledges that everyone learns in different ways. It gives you control over how and when you learn and takes learning out of the classroom into the workplace. The learning is gained through work-related projects. Work-based learning opens your eyes to the fact that you can learn from anything. Work-based learning in multi-professional teams, making full use of modern technology, can produce benefits to you, the organization and the profession. Successful completion of the programme will provide you with accredited learning and lead to an academic qualification. It is concerned with helping you to bridge the practice/theory gap.</p>	<p style="text-align: center;"><b>Post Incident review</b></p> <p>This happens when an incident has occurred in the workplace that has caused you and/or other members of the healthcare team a level of distress. The incident has usually resulted in a miss or near miss, where there has or could have been damage to a patient or client. A post-incident review involves the reviewing of specific incidents, either individually or as a team, within a setting that provides emotional support to each person. The incident is analyzed with your involvement and the involvement of all team members, using reflection, self-evaluation and/or facilitated learning to establish how the incident happened and how it could be avoided in the future. If you are involved in a post-incident review it should result in good support from your team members and outcomes and actions for yourself and the team, with possible organizational implications. The final outcome must provide a clear description of risk factors and required action. You should also use the review process to identify personal action plans and required development. This is a learning event for all involved, with the objective of learning to improve practice.</p>
<p style="text-align: center;"><b>Learning Sets</b></p> <p>The term refers to a group of people who meet regularly to work and learn together, using a structured format. The learning set can comprise of uni- or multi-professional groups and the focus is on self-directed learning; the participants decide the particular issues to be addressed. This provides you with a confidential forum in which to test issues that concern you, discuss new ideas and help you and the others to challenge working practices in new and creative ways. It is important to set ground rules to deal with issues such as confidentiality. Each member of the group is facilitated and supported by the others in the solving of issues and problems.</p>	<p style="text-align: center;"><b>Critical Incident Review</b></p> <p>A critical incident is a significant event or experience that has occurred in your workplace and that you feel has had an impact on you or the people you work with. This could be negative or positive; it could be a personal experience or it could result from observing how other people work. You need to examine the incident through a process of reflection, using an evidence-based approach, to identify lessons to be learned. This could also take place with a group of practitioners working together. This should result in new learning for you and/or the group you are working with and result in a short action plan to bring about improvement in practice.</p>	<p style="text-align: center;"><b>Peer Review</b></p> <p>This is a process, which encourages you to work with colleagues at the same level and in the same area of practice, and to evaluate each other's performance. We all have behaviours we are unaware of. Peer review gives an insight into these from the perspective of another person. This is a valuable learning activity, as it helps to develop your critical thinking and collaborative working and brings about improvements in your practice. This needs to be set up within a structured format, to ensure that you and the other peer reviewers have the required skills and are supported by experienced colleagues.</p>
<p style="text-align: center;"><b>Supervised Practice for Competency Development</b></p> <p>This is a negotiated period of supervised practice, with agreed learning and competency outcomes and may be provided for you if you require to develop specific, identified competencies. It is also likely to be arranged for you if you have poor or failing clinical competence in an area of practice. This is a period of practice where you are supervised and monitored by an experienced practitioner. The length of the supervised practice and the required outcome are set before the exercise begins. You are required to work closely with your supervisor throughout the entire period of practice. You will also be assessed at the end of the supervised practice to see if you can show that you have the necessary knowledge and competence. If you have not demonstrated this, a further action plan will be drawn up.</p>	<p style="text-align: center;"><b>Mentoring</b></p> <p>A mentor is someone who has skills of working with individuals who can provide guidance and support to help you achieve your potential. Your mentor may not be from your own field of practice but should be a person with mentoring experience. Mentoring is achieved through a process of relationship building between you and your mentor and takes place over a period of time. The purpose of the mentoring process is to enable you to recognise your own skills and capabilities and maximise the development opportunities available to you.</p>	<p style="text-align: center;"><b>Preceptor Training</b></p> <p>This is the process by which you, as a newly registered nurse or midwife, are helped to make the transition from student to qualified and competent practitioner, through a negotiated programme of learning and support. The preceptor is a more experienced nurse/midwife who will work with you over a period of about four months to provide guidance and training. Your preceptor will also monitor your progress and performance and provide feedback to help you improve your practice and standard of care.</p>

**CONTRACT FOR SUPERVISION SESSIONS (1 OF 2)****Appendix B**

Supervision will help you reflect on your practice. This process will in turn help you to sustain your continuous development.

**Purpose of Supervision**

The purpose of supervision should be agreed between the supervisor and the supervisee. It should relate to their roles and responsibilities and can include any aspects of their personal development.

**As supervisor I take responsibility for:**

- Following the focus identified by the supervisee(s)
- Exploring the supervisee's expectations appropriately using my knowledge, skills and experience
- Allowing the supervisee to express their individuality
- A balance of challenge and support will be maintained throughout supervision.
- Facilitating reflective practice
- Evaluating the session for the supervisee(s) and supervisor
- Completing a sessional collation form
- Maintaining all records of session in a safe and confidential manner according to NMC and Trust guidelines.

**As supervisee I take responsibility for:**

- Preparing for the sessions using a formal reflective model e.g. 'Preparation template for supervision' (Appendix C) or other recognised tools
- Driving the agenda
- Bringing appropriate issues to sessions and discussing them openly
- Engaging in learning and development activities between agreed annual sessions that will inform supervision sessions
- Recording and reflecting on significant activities using 'Supervision record sheet' (Appendix D)
- Evaluating the benefit of the session
- Completing the supervision record sheet and retaining in portfolio.

**Ground rules will be agreed when developing the contract and reviewed at each session:**

Ground rules and responsibilities should be clearly defined and the contract should demonstrate the commitment to these.

**Some examples of ground rules agreed by supervisor/supervisee(s):**

- Open and honest learning
- Commitment to confidentiality except when issues breach the Code of Conduct
- Sharing best practice
- Active listening
- Ensure supervision sessions take place at the agreed time
- Evaluate the session and engage in mutual feedback

This is not an exhaustive list and consideration should be given to the needs of individuals/groups when developing a supervision contract to develop ways of working that meet everyone's agenda.

**At the end of each session we will:**

- Agree a suitable time and venue for the next session if appropriate.
- Maintain and store records as agreed in ground rules.

**CONTRACT FOR SUPERVISION SESSIONS (2 OF 2)  
AGREEMENT**

**In addition I have:**

- Read all relative policies and guidelines
- Participated in training if required

Signature of supervisor	Signature of supervisee or group supervisees
	1.
	2.
	3.
	4.
	5.
	6.
	7.
	8.
<b>Frequency of sessions (if applicable)</b>	
<b>Venue</b>	

**Date & Time:** \_\_\_\_\_

**Clinical Area:** \_\_\_\_\_



## Preparation Template for Supervision

Name: \_\_\_\_\_

Date: \_\_\_\_\_

<b>What is the issue?</b>
<b>Why is it significant?</b>
<b>What did not go well?</b>
<b>What went well?</b>
<b>How did this make me feel?</b>
<b>What would I do differently in the future?</b>
<b>What have I learnt?</b>
<b>What actions do I need to take forward (if applicable)?</b>

(Adapted from Gibbs, 1998 & Johns, 2000)

**Supervision Record Sheet (1 of 2)**

Date: \_\_\_\_\_

Individuals Present			
Supervisor	Supervisees		
	1		5
	2		6
	3		7
	4		8

	<b>You may like to consider using the prompts below:</b>
<b>Review of action/learning points from previous session</b>	
<b>Issue(s) discussed at this supervision session</b>	What was explored during this supervision session; what was the issue/experience and or situation?
<b>What action points were agreed?</b>	By supervisee? By supervisor?



**To Be Completed By Supervisor and Returned to  
Line Manager/Designated Person within Service Group e.g. NDL**

**Quarterly Supervision Returns**

Speciality: \_\_\_\_\_

Ward/Clinical Area: \_\_\_\_\_ Service Group: \_\_\_\_\_

Supervisor: \_\_\_\_\_

**2009-2010**

Date/Dates	Name of Supervisee	First Session	Second Session	Type of Supervision	
				1-1	Group
<b>Totals</b>					

**To Be Completed By Line Manager**

**Quarterly Supervision Returns**

Service Group: \_\_\_\_\_

Associate Director of Nursing: \_\_\_\_\_

Quarter: *Please tick*    Apr-Jun     Jul-Sep     Oct-Dec     Jan-Mar

Total Number of RN's	No of RN's who have had one supervision session	No of RN's who have had two supervision sessions	Comments

**Please return to:**

**Associate Director of Nursing**

3.021

Reference No: TP 40/08

<b>Title:</b>	<b>Nursing Supervision for Registered Nurses – Facilitating Reflective Practice</b>		
<b>Author(s)</b>	Dr David Robinson, Co-Director Nursing: Governance, Standards and Performance; and BHSCT Nursing Supervision Implementation Group.		
<b>Ownership:</b>	Miss Brenda Creaney, Executive Director of Nursing & User Experience		
<b>Approval by:</b>	Standards and Guidelines Policy Committee Executive Team Meeting	<b>Approval date:</b>	31/7/2014 18/8/2014 20/8/2014
<b>Operational Date:</b>	November 2014	<b>Next Review:</b>	November 2017
<b>Version No.</b>	V5	<b>Supersedes</b>	V4-May 2011 - 2014
<b>Key words</b>	Supervision, nursing supervision, reflective practice		
<b>Links to other policies</b>	BHSCT Records Management Policy BHSCT Records Retention and Disposal Schedule Policy DHSSPSNI Good Management Good Records Guidance Safeguarding Children Supervision for Nurses and Midwives: Regional Policy and Procedure for Northern Ireland Health and Social Care Trusts, Managing Performance within BHSCT Capability Procedure - Guidance to support Nursing and Midwifery Staff		

Date	Version	Author	Comments
03/05/2009	V2	A Dowd	Reviewed – no changes
07/12/2009	V3	A Dowd	Amendments to appendices
March 2011	V4	O MacLeod	Reviewed, no amendments – review date changed
04/04/2013	V4.1	Audrey Dowd	New policy template and revision of content and appendices
09/04/2013	V4.2	Audrey Dowd	Revision of guidelines by Nursing Supervision Implementation Sub-Group (NSISG)
02/05/2013	V4.3	Audrey Dowd	Revisions by M Davison & S McVeigh
24/05/2013	V4.4	Audrey Dowd	Comments from NSISG
15/07/2013	V4.5	Audrey Dowd	Comments from NSISG
29/07/2013	V4.6	Audrey Dowd	Following discussion with M Davison & S McVeigh
05/07/2013	V4.7	Audrey Dowd	Following NSISG Meeting
14/08/2013	V4.8	Audrey Dowd	Following NSISG Meeting
23/09/2013	V4.9	Audrey Dowd	Following meeting with B Gribben/S McVeigh/ M Davison
23/10/2013	V4.10	Audrey Dowd	Following NSISG Meeting
5/12/2013	V4.11	Audrey Dowd	Following Nursing Supervision Implementation Group Meeting 5/12/13
13/05/14	V4.12	Patricia Sheppard	Review and comments from BHSCT/CEC personnel
17/07/2014	V5.0	Dr David Robinson	Review following comments received at Standards and Guidelines Committee Meeting

## 1.0 INTRODUCTION

The importance of effective supervision has been highlighted in regional critical incident inquiries such as the Lewis Review (2003), Murtagh Review (2005) and McCleery Report (2006). The Quality Standards for Health and Social Care (DHSSPS 2006) and more recently the Francis Report (2013), recommend that an effective system for supervision across Health and Social Care can help organisations meet each of the Clinical and Social Care Governance Standards.

Supervision is defined as 'a process of professional support and learning undertaken through a range of activities, which enables individual registrant nurses to develop knowledge and competence, assume responsibility for their own practice and enhance quality, safety and service-user protection' (NIPEC, 2007).

Nursing Supervision activities support registered nurses to:

- reflect on their practice and increase self-awareness
- support the delivery of safe and effective care
- encourage personal and professional growth
- reflect on their knowledge and skills
- reflect on challenging situations
- celebrate good practice.

Nursing Supervision is underpinned by reflective practice and is different from other processes such as Performance Management and Personal Contribution Framework Annual Reviews. It is recognised that there are a wide range of approaches to Nursing Supervision, examples of which can be considered under the following headings.

**Informal** At handover, a staff member discusses their new knowledge following an Infection Prevention and Control (IP&C) training session and how to apply this to their practice. Other staff can be influenced by this and also change their practice. *Informal reflective activity (informal approach to Nursing Supervision) must be formally captured and used to prepare for Nursing Supervision (formal approach to Nursing Supervision)*

**Formal** You may then want to consider this in more depth during a formal supervision session. This will enable you to explore further the implications, including the challenges to implement and sustain change in a complex health care environment. This formal supervision session is facilitated by a supervisor, either during a 1:1 or in a group session. This enables you to reflect on and evaluate practice and agree areas for development using a structured approach. This process involves the development of a contract which enables privacy and confidentiality between supervisee/s and supervisor; agreed ways of working; through skilled facilitation. You then record your personal learning for your professional portfolio as evidence of your continuous personal development and compliance with both the CNO and NMC requirements.

There are a range of recognised approaches to formal Nursing Supervision (**Appendix 1**).

### 1.1 Background

The Chief Nursing Officer (CNO) for Northern Ireland published two Standards for Supervision in Nursing in July 2007.

**Standard Statement 1**

Supervision will contribute to the delivery of safe and effective care when practitioners have access to appropriate systems that facilitate the development of knowledge and competence through a culture of learning by reflection.

**Standard Statement 2**

An organisational framework supporting effective leadership and performance management will ensure that supervision will become an effective tool to improve the safety and quality of care.

**1.2 Purpose**

The purpose of the policy is to:

- outline how the CNO Standards are implemented and monitored
- outline supervision activities for Registered Nurses
- provide Registered Nurses with guidance in the process of Nursing Supervision
- outline the role of supervisors and supervisees
- standardise the templates for recording supervision activities in order to comply with CNO Standards
- outline how Nursing Supervision session is evaluated.

**2.0 SCOPE OF THE POLICY**

This policy will apply to all Registered Nurses employed by BHSCT.

**NB** The scope of Safeguarding Children supervision differs from supervision referred to in this policy. Safeguarding Children is separate from but complementary to other forms of supervision. Further information is available from the DHSSPS Safeguarding Children Supervision Policy for Nurses (2011).

**3.0 ROLES/RESPONSIBILITIES**

The BHSCT will ensure that processes are in place to facilitate Nursing Supervision activities for all Registered Nurses. All registrants will make themselves aware of the Nursing Supervision Policy and related information.

The roles and responsibilities of key individuals are outlined in **Appendix 2**.

**4.0 KEY POLICY PRINCIPLES**

**Overarching Supervision Principles**

- 4.1.1 Registered Nurses will undertake a minimum of two, formal Nursing Supervision sessions annually, beginning each year from 01 April. 2 sessions per year
- 4.1.2 A Nursing Supervision contract will be agreed between supervisee and supervisor (**Appendix 3**). ✓
- 4.1.3 Records of the Nursing Supervision sessions (**Appendix 4**) will be completed and retained by the supervisee and supervisor. These should be maintained in either written or electronic format. ✓
- 4.1.4 Where an issue of unsafe, unethical or illegal practice is identified, it will be dealt with outside of supervision but supportively via appropriate BHSCT procedures and as per NMC Code. NS ✓



**4.2 Supervisors will:**

- 4.2.1 Be working as a Registered Nurse for a minimum of one year.
- 4.2.2 Complete the Nursing Supervision Self-Evaluation Tool (**Appendix 5**). Areas for development can be addressed through a variety of approaches e.g. attendance at a one-day workshop 'How to become an Effective Supervisor' at Clinical Education Centre (CEC), through Facilitation and Leadership module which can be accredited through 'Developing Practice in Healthcare Pathway' with University of Ulster Jordanstown or through experiential learning.
- 4.2.3 Ensure that they have availed of two Nursing Supervision sessions themselves as per CNO Standards.
- 4.2.4 Retain all Nursing Supervision records for a period of 5 years in the location of work; thereafter transfer to Human Resources personnel file of the supervisor, as per BHSC Records Retention and Disposal Schedule Policy (references L2, L27 & P42). Where the supervisor is no longer an employee of the Trust, all supervision records are relocated to the main Human Resources personnel file of the supervisor.
- 4.2.5 Update supervisor record on HRPTS or provide information to the appropriate person to enable episode to be recorded.
- 4.2.6 Provide evidence of actively undertaking the role of a Nursing Supervisor to their Line Manager e.g. at time of Personal Development Review (PDR).
- 4.2.7 Demonstrate continuous professional development and continue to meet the competencies required as a Nursing supervisor. Nursing Supervisors will review 'Self Evaluation Tool' on a three yearly basis, utilising feedback from supervisees and their own supervisor to demonstrate competence and address any areas for development.

**4.3 Supervisees will:**

- 4.3.1 Identify a supervisor in partnership with their Line Manager.
- 4.3.2 Arrange Nursing Supervision sessions at least twice yearly with their identified supervisor.
- 4.3.3 Prepare for their Nursing Supervision session by completing a reflection on their practice using a reflective tool (**Appendix 6**).
- 4.3.4 Maintain a record of each Nursing Supervision session. This may be within their professional portfolios (**Appendix 4**).

**4.4 Record Keeping:**

- 4.4.1 Registered Nurses should be mindful that all records are discoverable and of their professional accountability with regard to the principle of confidentiality, ensuring information is appropriately protected as per BHSC Records Management Policy. <http://intranet.belfasttrust.local/policies/Documents/Records%20Management%20Policy.pdf> and DHSSPSNI Good Management Good Records [www.dhsspsni.gov.uk/gmgr](http://www.dhsspsni.gov.uk/gmgr).
- 4.4.2 Patient/client records will only be accessed where necessary and completely anonymised. Where this happens, ethical principles and confidentiality apply.

## 5.0 IMPLEMENTATION OF POLICY

### 5.1 **Dissemination**

This policy will be disseminated through Trust Directorate structures.

### 5.2 **Resources**

Supervisors who have identified learning and development needs will attend appropriate learning opportunities to prepare them for their role.

All Registered Nurses will themselves require a minimum of two supervision sessions each year in order to undertake Nursing Supervision.

A 'Frequently Asked Questions' leaflet has been developed to support nurses (**Appendix 7**).

## 6.0 MONITORING

Monitoring of this policy will be through:

- Support, Improvement and Accountability Framework (SIAF) by local ward/department/areas.
- Returns on compliance with CNO Standards, from Directorates (generated from HRPTS) are submitted to Central Nursing & Midwifery Team to inform below reports:
  - i. Accountability Review Performance Report (six monthly), where performance/achievements are measured against Directorate Management Plans.
  - ii. Annual Assurance Report which is submitted to the Executive Director of Nursing and Chief Nursing Officer.

## 7.0 EVIDENCE BASE / REFERENCES

BHSCT Records Management Policy

<http://intranet.belfasttrust.local/policies/Documents/Records%20Management%20Policy.pdf>

Bond M and Holland S (1998), Skills of Clinical Supervision for Nurses. A Practical Guide for Supervisees, Clinical Supervisors and Managers. Open University Press, Buckingham, UK.

Butterworth T. and Faugier J (1992), Clinical supervision and mentorship in nursing. London, Chapman and Hall.

DHSSPSNI Good Management Good Records [www.dhsspsni.gov.uk/gmgr](http://www.dhsspsni.gov.uk/gmgr)

Department of Health (DH) (2010) Preceptorship framework for newly registered Nurses, Midwives and Allied Health Professionals. London: DH.

DHSSPSNI (2011), Safeguarding Children Supervision Policy for Nurses.

DHSSPSNI (2007), Standards for Supervision for Nursing, Chief Nursing Officer for Northern Ireland.

DHSSPSNI (2006), The Quality Standards for Health and Social Care.

Francis R QC (2013), The Mid Staffordshire NHS Foundation Trust Public Inquiry.

Gibbs G (1988), Learning by Doing: A Guide to Teaching and Learning Methods. Oxford. Oxford Further Education Unit.

Johns C (2000), Becoming a Reflective Practitioner: a Reflective and Holistic Approach to Clinical Nursing, Practice Development and Clinical Supervision. Oxford: Blackwell Science.

Health Service Executive (2010), Enhancing Care for Older People A Guide to Practice Development Processes to Support and Enhance Care in Residential Settings for Older People.

Kadushin A (1992), Supervision in social work, Columbia University Press, New York.

Kavanagh DJ, Spence SH, Wilson J & Crow N (2002), Achieving effective supervision. Drug and Alcohol Review, 21, 247-252.

Lewis RJ, Cole D, Williamson A (2003), Review of Health and Social Services in the case of David and Samuel Briggs, DHSSPS.  
 McCleery Inquiry Panel (2006), Executive summary and recommendations from the report of the Inquiry Panel (McCleery) to the Eastern Health and Social Services Board.  
 Mezirow J (1991), Transformative Dimensions of Adult Learning. California. Jossey-Bass Publishers.  
 Northern Ireland Practice and Education Council (2007), The Review of Clinical Supervision for Nursing in the HPSS 2006 on behalf of the DHSSPS.  
 Nursing and Midwifery Council (2009). Record Keeping: Guidance for nurses and midwives.  
 Nursing and Midwifery Council (2008), The code: Standards of conduct, performance and ethics for nurses and midwives.  
 Raelin J A (2008), Work-Based Learning (New and Revised edition). Jossey-Bass, San Francisco, CA.  
 Rogers (2012), Coaching Skills – A Handbook, 3<sup>rd</sup> Edition, McGaw.  
 Rolfe G, Freshwater D and Jasper M (2001), Critical Reflection for Nursing and the Helping Professionals a User's Guide. Hampshire. Palgrave MacMillan  
 Regional Quality Improvement Authority (2005), Review of the lessons arising from the death of the Late Janine Murtagh.  
 Seagraves L, Osbourne N, Neal P, Dockrell, R, Hartshorn, C. and Boyd, A (1996), Learning in Smaller Communities (LISC) Final Report. Educational Policy and Development: University of Stirling, in Rounce K. and Workman B (2005) Work-based learning in healthcare: application and innovations Kingsham Press: Chichester.  
 Titchen A (2001), Critical Companionship: part 1 Nursing Standard, 18 (9), 33 – 40.  
 Wright H (1989), Group work: Perspectives and Practice, London: Scutari Press.

**8.0 CONSULTATION PROCESS**

Co-Directors of Nursing  
 Associate Directors of Nursing or Deputy Associate Directors  
 Service Managers  
 Nursing Development Leads

**9.0 APPENDICES / ATTACHMENTS**

Appendix 1	Examples of Recognised Approaches to Informal & Formal Supervision
Appendix 2	Roles and Responsibilities
Appendix 3	Example Contract for Supervision Sessions
Appendix 4	Example Supervision Record Sheet
Appendix 5	Self-Evaluation Tool
Appendix 6	Preparation for Supervision Sheet
Appendix 7	Frequently Asked Questions Leaflet

**10.0 EQUALITY STATEMENT**

In line with duties under the equality legislation (Section 75 of the Northern Ireland Act 1998), Targeting Social Need Initiative, Disability discrimination and the Human Rights Act 1998, an initial screening exercise to ascertain if this policy should be subject to a full impact assessment has been carried out.

The outcome of the Equality screening for this policy is:

- Major impact
- Minor impact
- No impact.

**SIGNATORIES**

David S. Rol...

Name  
Title

Date: November 2014

Sandra McCreary

Name  
Title

Date: November 2014

2

0

# Your guide to the CPD standards

## Introduction

We are the Health Professions Council, and we were created to protect the public. To do this, we keep a register of health professionals who meet our standards for their training, professional skills, behaviour and health.

We now also set standards for continuing professional development (CPD), and all health professionals registered with us must undertake CPD in order to remain registered. This leaflet has been written for health professionals registered with us, and is a quick guide to your responsibilities regarding CPD. It also tells you how and where you can get more information.

## What is CPD?

Our definition of CPD is,

*“a range of learning activities through which health professionals maintain and develop throughout their career to ensure that they retain their capacity to practice safely, effectively and legally within their evolving scope of practice.”<sup>1</sup>*

## A new responsibility

Before 2005, we made no requirements as to your CPD. You may have been required to undertake CPD as part of your membership of your professional body, or by your employer, or another organisation. You may not have been *required* to undertake CPD by any individual or organisation, but you may have been undertaking it anyway as part of your professional development. But before 2005, any CPD that you did was not linked to your registration with us.

Now that the Council has agreed our CPD standards, CPD is an important part of your continuing registration, and your continuing ability to use your professional title. Our standards now mean that all health professionals must continue to develop their knowledge and skills while they are registered.

## Our CPD standards

These are the standards which your CPD should meet, in order for you to remain registered with us.

A registrant must:

1. maintain a continuous, up-to-date and accurate record of their CPD activities;
2. demonstrate that their CPD activities are a mixture of learning activities relevant to current and future practice;
3. seek to ensure that their CPD has contributed to the quality of their practice and service delivery;
4. seek to ensure that their CPD benefits the service user;
5. present a written profile containing evidence of their CPD on request.

<sup>1</sup> This definition was written as part of the Allied Health Professions project, ‘Demonstrating competence through CPD’, 2002.

Date	Ver.	Dept/Cmte	Doc Type	Title	Status	Int. Aud.
2005-11-22	a	POL	PUB	CPD registrants guide	Draft DD: None	Public RD: None

In brief, this means:

1. Keep a personal record of your CPD, in whatever format is most convenient for you.
2. Make sure your CPD is a mixture of different kinds of activities – not just one kind of learning – and that it's relevant to your practice. It could be relevant to your current role, or to a planned future role.
3. You should aim for your CPD to improve the quality of your practice. It may not actually improve your practice, due to factors beyond your control. But improvements in your practice should be part of how you plan your CPD, and select your CPD activities.
4. You should aim for your CPD to benefit the service user. As above, you may not be able to ensure that this happens, but benefits to service users should be part of your planning and review. Depending on where and how you practice, service users might include, for example, patients, clients, users, your team, and /or students.
5. If you're audited, you need to send us in a profile about how the CPD you have done meets these standards.

### ***Our standards mean that...***

... you can make your own decisions about the kinds of CPD that are relevant to your role, and to your practice. CPD activity could include, for example, secondment, in-service training, critical incident analysis, mentoring, or reading or reviewing journal articles.

Please see the end of this leaflet for a fuller list of suggested CPD activities.

... you could decide that you could meet our requirements by participating in a scheme run by your professional body, or your employer. You might supplement this with other activities if necessary, or alternatively, you could structure your own CPD activities, around your personal development plan for example. Our standards give you the flexibility to plan your own CPD in a way that suits your practice, your learning needs, your preferences, and the time and resources available to you.

... your development is now formally recognised as an important part of your registration. This gives an opportunity for campaigning for greater support and recognition of your CPD activities, from your employers and other organisations.

### ***A flexible approach***

Our flexible approach means that your CPD can take account of how you work, whether part-time or full-time, whether in the NHS or in private practice, whether in a clinical setting or in management, education or research (or anywhere else). Our standards mean that you can plan your CPD activity to take account of your changing needs. You just need to make sure that your CPD meets our standards.

### ***Renewing your registration***

When you renew your registration, you need to sign to confirm that you have met our CPD standards. From 2008, when a profession renews, we will audit a small random

Date	Ver.	Dept/Cmte	Doc Type	Title	Status	Int. Aud.
2005-11-22	a	POL	PUB	CPD registrants guide	Draft DD: None	Public RD: None

sample to ensure that the standards are met. If you are audited, we will write to you and ask you to send in information showing how your last two years of CPD have met our standards. We will send you a form to complete, where you can write about how you meet the standards. This form is called the 'profile'.

### **Key dates**

**July 2005** – CPD standards approved by Council.

**July 2006** – Registrants need to begin recording their CPD.

**July 2008** – First CPD audits begin.

The dates of the first audit for all 13 professions are given below, listed in date order.

Chiropodists and podiatrists	July 2008
Operating department practitioners	October 2008
Orthoptists	August 2009
Paramedics	August 2009
Clinical scientists	September 2009
Prosthetists and orthotists	September 2009
Speech and language therapists	September 2009
Occupational therapists	October 2009
Biomedical scientists	November 2009
Radiographers	February 2010
Physiotherapists	April 2010
Art therapists	May 2010
Dietitians	May 2010

After these dates, we plan to audit each profession every two years, each time that the profession renews its registration. We plan to audit 5% of the first two professions, and then, depending on the results, go on and audit 2.5% of each profession that renews its registration.

### **Finding out more**

We have published example profiles on our website: [www.hpc-uk.org](http://www.hpc-uk.org)

These profiles, which were put together in partnership with professional bodies, are intended to show how health professionals can demonstrate that their CPD activities have met our standards, and how they can write a statement that shows this.

For more information about the CPD audit, you can also see our document 'Continuing professional development and your registration'. This is a longer document, with more detail about CPD, and about the audit process. You can download this document from our website, or request a copy from the address on the back of this leaflet.

Date	Ver.	Dept/Cmte	Doc Type	Title	Status	Int. Aud.
2005-11-22	a	POL	PUB	CPD registrants guide	Draft	Public
					DD: None	RD: None

## Appendix 1: Examples of types of CPD activity

(this is not an exhaustive list, but we have provided it to give you an idea of the kinds of activity that might make up your CPD)

Work based learning	Professional activity	Formal / educational	Self-directed learning	Other
<ul style="list-style-type: none"> <li>• Learning by doing</li> <li>• Case studies</li> <li>• Reflective practice</li> <li>• Clinical audit</li> <li>• Coaching from others</li> <li>• Discussion with colleagues</li> <li>• Peer review</li> <li>• Gaining and learning from experience</li> <li>• Involvement in wider work of employer e.g. representative on a committee</li> <li>• Shadowing</li> <li>• Secondments</li> <li>• Job rotation</li> <li>• Journal club</li> <li>• In-service training</li> <li>• Supervision of staff/students</li> <li>• Visits to other departments and reporting back</li> <li>• Role expansion</li> <li>• Significant event analysis</li> <li>• Completion of self-assessment questionnaires</li> <li>• Project work/management</li> </ul>	<ul style="list-style-type: none"> <li>• Involvement in a professional body</li> <li>• Member of specialist interest group</li> <li>• Lecturing/teaching</li> <li>• Mentoring</li> <li>• Examiner</li> <li>• Tutor</li> <li>• Branch meetings</li> <li>• Organising journal clubs or other specialist groups</li> <li>• Maintaining and/or developing specialist skills e.g. musical ability</li> <li>• Expert witness</li> <li>• Member of other professional bodies/groups</li> <li>• Presentation at conferences</li> <li>• Organiser of accredited courses</li> <li>• Research supervision</li> <li>• National assessor</li> <li>• Appointment to a promoted post</li> </ul>	<ul style="list-style-type: none"> <li>• Courses</li> <li>• Further education</li> <li>• Undertaking research</li> <li>• Attendance at conferences</li> <li>• Submission of articles/paper</li> <li>• Seminars</li> <li>• Distance learning</li> <li>• Courses accredited by professional body</li> <li>• Planning or running a course</li> </ul>	<ul style="list-style-type: none"> <li>• Reading journals/articles</li> <li>• Review of books/articles</li> <li>• Updating knowledge via www/TV/press</li> <li>• Progress files</li> </ul>	<ul style="list-style-type: none"> <li>• Public service</li> <li>• Voluntary work</li> <li>• Courses</li> </ul>

Int. Aud.  
Public  
RD: None

Status  
Draft  
DD: None

Title  
CPD registrants guide

Doc Type  
PUB

Dept/Cmte  
POL

Ver.  
a

Date  
2005-11-22



# Continuing professional development and your registration

## Contents

<b>Introduction.....</b>	<b>3</b>
About this document .....	3
CPD and HPC registration: a summary.....	3
<b>CPD and your registration.....</b>	<b>4</b>
The Health Professions Council.....	4
Professions .....	4
A new responsibility.....	4
Background .....	5
Our CPD standards.....	5
Your responsibility .....	5
The role of your employer .....	5
CPD and fitness to practise.....	6
CPD and competence.....	6
If a profile is fraudulent .....	6
CPD, your practice, and your ongoing competence.....	6
Key dates .....	7
Audit dates .....	7
<b>Doing your CPD .....</b>	<b>8</b>
What is CPD?.....	8
CPD Standards .....	8
The standards in detail.....	8
Standard 1 .....	8
Standard 2 .....	9
Standard 3 .....	10
Standard 4 .....	10
Standard 5 .....	11
CPD activities .....	11
Based on learning outcomes .....	12
Some examples of CPD activity .....	13
Registrant in clinical practice.....	13
Registrant working in education .....	13
Registrant working in management.....	13
Registrant engaged in research.....	13
A flexible process.....	13
CPD schemes .....	14
Your scope of practice.....	14
The NHS Knowledge and Skills Framework .....	15
CPD and clinical governance.....	15
Returning to practice .....	16
<b>The audit process .....</b>	<b>17</b>
In brief .....	17

Two years' registration.....	18
Sampling of CPD profiles.....	18
Auditing.....	18
When your profile has been received by us.....	19
Profile meets the standards.....	19
Further information needed.....	19
Profile does not meet the standards.....	19
The CPD assessors.....	20
Assessment criteria.....	21
Assessing the profile.....	23
Assessment outcomes.....	23
The appeal process.....	23
Coming back onto the Register.....	24
Deferral.....	24
Keeping us up to date.....	25
Communicating with employers.....	25
<b>Putting together your profile.....</b>	<b>26</b>
The purpose of each part of the profile.....	26
Writing your summary of practice history.....	26
Writing your statement.....	27
Using your personal development plan.....	27
Using the standards.....	28
Using 'prompt questions'.....	28
Your supporting evidence.....	31
Examples of evidence of CPD.....	31
Copies of documents.....	32
Proportionality of evidence.....	32
Confidentiality and anonymity.....	32
Example profiles.....	33
Disabled registrants.....	33
Your writing style.....	33
Our standards for communication in English.....	34
<b>Glossary.....</b>	<b>35</b>
<b>Appendix 1: Examples of types of CPD activity.....</b>	<b>37</b>
<b>Appendix 2: Examples of evidence.....</b>	<b>38</b>

## Introduction

### ***About this document***

This document has been written for the health professionals on our Register who are selected to be the subject of a continuing professional development (CPD) audit.

Throughout the document, 'we' refers to us, the Health Professions Council, and 'you' refers to a health professional registered with us.

However, you may also find this document useful if you are:

- a registrant who is not the subject of an audit, but you wish to find out more about CPD and the audit process;
- a student or other potential registrant, and you want to find out more detailed information about CPD and the audit process;
- a manager, considering the CPD needs of your team, and how you can support them in their CPD;
- a CPD co-ordinator, union learning representative, or from a professional body, and you want to support registrants in their CPD;
- an employer of registrants, and you want to find out more background information about registrants' CPD responsibilities; or
- an individual or organisation considering offering CPD activities to registrants.

We have also written a short guide for registrants called 'Your guide to the CPD standards'. This contains a quick summary of the main points, and may be useful if you think that this document contains too much detail for you at this stage.

We will keep this document under review, and will update it if necessary.

### ***CPD and HPC registration: a summary***

You are now required to undertake continuing professional development in order to remain registered with us. We have set standards which your CPD must meet.

We will audit registrants' CPD randomly, and will link the audit process to the renewal of registration. Every time you renew your registration, you will need to sign to confirm that you have met these standards. From 2008, whenever a profession renews its registration, we will randomly audit a proportion of health professionals from that profession, who will be asked to send in evidence to show how their CPD meets the standards.

For further updates on the process and detailed timings for audits, please see our website where this information will be published once it is available:  
[www.hpc-uk.org](http://www.hpc-uk.org)

## CPD and your registration

### ***The Health Professions Council***

We are the Health Professions Council, and we were created to protect the public. To do this, we keep a register of health professionals who meet our standards for their training, professional skills, behaviour and health.

We now also set standards for continuing professional development (CPD), and all health professionals registered with us must undertake CPD in order to remain registered.

### ***Professions***

These are the 13 professions that we currently regulate.

- arts therapists;
- biomedical scientists;
- chiropodists/podiatrists;
- clinical scientists;
- dietitians;
- occupational therapists;
- operating department practitioners;
- orthoptists;
- paramedics;
- physiotherapists;
- prosthetists & orthotists;
- radiographers; and
- speech and language therapists.

We may regulate other professions in the future; please see our website for an up to date list. Each of these professions has a protected title, and anyone who uses one of these titles must register with us. Anyone who uses a protected title who is not on our Register may be prosecuted and fined up to £5000.

### ***A new responsibility***

Before 2005, we made no requirements as to your CPD. You may have been required to undertake CPD as part of your membership of your professional body, or by your employer, or another organisation. You may not have been *required* to undertake CPD by any individual or organisation, but you may have been undertaking it anyway as part of your professional development. But before 2005, any CPD that you did was not linked to your registration with us.

Now that the Council has agreed our CPD standards, CPD is an important part of your continuing registration, and your continuing ability to use your professional title. Our standards now mean that all health professionals must continue to develop their knowledge and skills while they are registered.

## ***Background***

Before we issue standards or guidance, we consult on our proposals. We do this because it is required by the Health Professions Order 2001, but also because we believe it is important that we listen to, and take account of the views of our stakeholders.

In 2004, we presented our ideas about how we would link CPD with renewing registration. We published a document on our website, sent it out to all registrants, and held 46 meetings in 22 locations all over the UK. At each meeting, we presented our ideas, and then received questions and comments from those attending. Over 6,500 registrants attended these meetings, and we benefited from a wide range of views and comments.

We then published a summary of the responses received from the consultation, and the decisions we had taken as a result. One of our decisions was that we needed to publish more information for registrants about CPD, particularly about the audit process. This is why we have put together this document.

## ***Our CPD standards***

A registrant must:

1. maintain a continuous, up-to-date and accurate record of their CPD activities;
2. demonstrate that their CPD activities are a mixture of learning activities relevant to current or future practice;
3. seek to ensure that their CPD has contributed to the quality of their practice and service delivery;
4. seek to ensure that their CPD benefits the service user; and
5. present a written profile containing evidence of their CPD upon request.

## ***Your responsibility***

We register individuals, and we take action if individuals do not meet our standards. This means that, just as you are responsible for making sure that you meet our standards of conduct, performance and ethics, you are also now responsible for making sure that you meet our standards for CPD. This is part of your responsibility as a registered health professional.

## ***The role of your employer***

Our role is determined by our legislation: the Health Professions Order 2001. That legislation gives us the legal power to, for example, protect professional titles. It does not give us any legal power to require employers to dedicate particular amounts of time or resources to CPD. We were asked many times during the CPD consultation in 2004 whether we could require employers to give their staff a certain amount of time for CPD, but this is not possible.

We do believe that responsible employers will want to encourage the development of their staff, however we cannot require them to do this, or 'police' the role of employers in facilitating CPD. We believe that there are substantial potential benefits to employers in supporting CPD: benefits in service provision, and recruitment and retention, for example.

We also believe, now that CPD is required in order to remain registered, organisations like professional bodies (supported by information from us where appropriate) will be able to bring more pressure on employers and other organisations, to ensure that your CPD is recognised, and given a higher priority than may have been the case in the past.

## ***CPD and fitness to practise***

### **CPD and competence**

In terms of our processes, and your registration, there is not an automatic link between your CPD and your competence. This is because it would be possible (although unlikely) for a competent professional to undertake no CPD, and yet still meet our standards for their professional skills and knowledge. Equally, it is also possible that a registrant who was not competent might complete a large amount of CPD activities, but nevertheless not be fit to practise.

In our legislation, we have a separate process for dealing with issues of lack of competence, under our fitness to practise procedures, and this is not linked to our powers to require health professionals to do CPD. (You can find out more about our fitness to practise processes on our website, [www.hpc-uk.org](http://www.hpc-uk.org))

Regarding CPD, our legislation says that we can "...establish the standards to be met in relation to ... CPD" (2001 Order, Article 19(4)); and, "...grant the application for renewal if the applicant satisfies the Education and Training Committee that he has met any prescribed requirements for CPD within the prescribed time" (2001 Order, Article 10(2)(b)).

This means that we can set standards for CPD, and we can link these standards to renewing registration. We can also take registrants off the Register if they have not met our CPD standards (although there is a right to appeal).

### **If a profile is fraudulent**

We recognise that the vast majority of health professionals will complete their CPD profiles honestly, accurately, and in good faith. Normally there is no link between CPD and our fitness to practise process. However, if a registrant made a false declaration, or falsified a CPD record, then this would be dealt with by our fitness to practise process. This could lead to the registrant being struck off the Register. Anyone who is struck off the Register cannot apply to be re-registered for at least five years.

### **CPD, your practice, and your ongoing competence**

All of the above describes how competence and CPD are related in *our* legislation, and *our* processes. We do recognise that for individual professionals, there is likely to be a link between their continuing competence and their continuing development. When considering your CPD, and planning your learning activities, you may consider your ongoing competence as an important objective, or context, for your CPD. But you should be assured that we do not assess your competence or make assumptions about your fitness to practise based on the CPD activities that you undertake.

## **Key dates**

This is a list of key dates which describe how CPD is now linked with your registration.

**July 2003** – We began operating under our rules and the Health Professions Order.

**September – December 2004** – Our consultation on CPD.

**July 2005** – CPD standards approved by Council.

**July 2006** – Registrants need to begin recording their CPD.

**July 2008** – The first CPD audits begin

## **Audit dates**

The dates of the first audit for all 13 professions are given below, listed in date order. These are the deadline dates for renewal of registration for these professions. If you are selected for audit, we will write to you before this date, asking for a profile of the CPD you have done over the previous two years.

Chiropodists and podiatrists	July 2008
Operating department practitioners	October 2008
Orthoptists	August 2009
Paramedics	August 2009
Clinical scientists	September 2009
Prosthetists and orthotists	September 2009
Speech and language therapists	September 2009
Occupational therapists	October 2009
Biomedical scientists	November 2009
Radiographers	February 2010
Physiotherapists	April 2010
Art therapists	May 2010
Dietitians	May 2010

After this, audits will take place every two years, whenever a profession renews its registration.

## Doing your CPD

### ***What is CPD?***

Our definition of CPD is,

*“a range of learning activities through which health professionals maintain and develop throughout their career to ensure that they retain their capacity to practice safely, effectively and legally within their evolving scope of practice.”<sup>1</sup>*

### ***CPD Standards***

A registrant must:

1. maintain a continuous, up-to-date and accurate record of their CPD activities;
2. demonstrate that their CPD activities are a mixture of learning activities relevant to current or future practice;
3. seek to ensure that their CPD has contributed to the quality of their practice and service delivery;
4. seek to ensure that their CPD benefits the service user; and
5. present a written profile containing evidence of their CPD upon request.

In order to meet our standards, you need to take your own, professional decisions about the kinds of CPD activity you need to undertake in order to develop and enhance your practice.

### ***The standards in detail***

In this section, we go through our standards one by one, to explain what is meant by each of them in detail. Where we think it would be helpful, we have pulled out phrases or words from the standard, and explained what this means.

#### **Standard 1**

**A registrant must maintain a continuous, up-to-date and accurate record of their CPD activities.**

You can keep a record of your activities in whatever way is most convenient for you. You might choose to keep a hard copy portfolio of evidence, perhaps using a format provided by your professional body or your employer. You could keep this record online, or electronically, or in any other way that you find useful. All that we require is as follows:

#### **Your record must be, ‘*continuous*’**

This means that you should keep your record updated regularly during your two year renewal period.

#### **Your record must also be ‘*up-to-date*’**

Because our CPD audit is linked to the registration renewal cycle, this means that your profile will normally concentrate on your CPD activities from the previous two years. However, some of your CPD activities may be ongoing from before this, and

---

<sup>1</sup> This definition was written as part of the Allied Health Professions Project, ‘Demonstrating competence through CPD’.



others may carry on after the two year period. But normally, you would focus on this two year period, which is what is meant by ‘up to date’.

**Finally, your record must be, ‘accurate’**

This means that your CPD record should be a true reflection of the activities that you have undertaken.

Your CPD record (you might call this your ‘portfolio’) is your own personal and complete record of your activities, and we will not ask to see it.

If you are audited, we will ask you to complete a CPD ‘profile’. This is a form that we will provide you with, on which you write a statement which tells us how your CPD has met our standards. When you send this to us, you will also select and send in supporting evidence, which you will draw from your personal, complete record.

The simplest way to demonstrate to the CPD assessors that you have kept a record of your CPD is to send us, as part of your evidence, a summary of all of your CPD activities. This could be in any format you choose, but we suggest that it might be a simple table which includes the date and ‘type’ of each activity.

**Standard 2**

**A registrant must demonstrate that their CPD activities are a mixture of learning activities relevant to current or future practice.**

**Your CPD should include ‘a mixture of learning activities’**

We do not require you to undertake a certain ‘amount’ of CPD, for example a number of hours or days. This is because we believe that different people will be able to dedicate different amounts of time to CPD, and also because the time spent in doing an activity does not necessarily reflect the learning that you gain from it.

This standard requires that your CPD must include a mixture of learning activities: in other words, that you include different types of learning activity in your profile. See page 31 for a list of suggested learning activities.

A CPD profile which relied on only one type of activity (eg: only peer review, or only mentoring) would not meet this standard.

Although we expect that most people’s profiles will contain a good mixture of different types of learning activity, we do recognise that there might be good reasons for you concentrating on a limited number of different types. You might do most of your learning through one or two types of activity, because you have found that this way of learning suits you, or because it is most easily available in your area, or because this kind of learning activity involves a considerable dedication of your time.

As long as you can explain in your profile how you planned your CPD, how you decided what activities to do, and how your CPD meets our standards, it’s likely that your profile would be assessed as meeting the standards.

**Your CPD should be ‘relevant to current or future practice’**

Your CPD should be relevant to the way that you practice your profession. This means that the CPD you undertake may be very different from that which your colleagues undertake in different contexts, even though you are from the same profession.

If you are managing a team, for example, your CPD may be entirely based around your skills in appraising your team, supporting their development, and financial planning, and may not include any clinical element.

Equally, if you are planning to move from one area to another, your CPD may be a mixture of that which is relevant to your current job, and activities which are helping to prepare you for your move to a different area of practice. Alternatively, you may choose to concentrate most or all of your CPD on the new area you intend to move into.

The purpose of this wording is to ensure that your CPD activities, and your learning and development, are relevant to the way that you practise, or the way that you intend to practise.

### **Standard 3**

**A registrant must seek to ensure that their CPD has contributed to the quality of their practice and service delivery.**

**You should ‘*seek to ensure*’...**

This standard contains the phrase ‘*seek to ensure*’ because sometimes ‘ensuring’ that your CPD contributes to the quality of your practice may be outside your control. You may undertake activities that you anticipate will improve your practice, but on reflection are not as effective as you expected, or circumstances could change. You need then to consider what actions you could take, and explain why. Doing this will still meet this standard, because you have *tried* to make your CPD contribute to the quality of your practice.

**‘*CPD has contributed to the quality of... practice and service delivery*’**

This means that you should aim for your CPD to improve the way that you practice. Your learning activities should lead to you making changes to how you practice, which improve the way that your service is delivered. Alternatively, your learning activities may mean that you continue to practise as you did before, but you are more confident that you are practising effectively.

Improving the quality of your practice and service delivery does not necessarily involve fundamental change to how you work; you may meet this standard by showing how your practice has developed as your skills develop through your learning. In meeting this standard you should be able to show that your CPD activities are part of your practice, contribute to your practice, and are not separate from it.

### **Standard 4**

**A registrant must seek to ensure that their CPD benefits the service user.**

**You should ‘*seek to ensure*’...**

Like Standard 3, this standard also contains the wording *'seek to ensure'* because you may intend that your CPD should benefit your service users, but this may not occur, due to factors which are beyond your control. As above, you may implement changes which you believe will benefit your service users, but on reflection find that they have not, and you need to further review your CPD and your practice. This will still meet this standard, because you have *tried* to make your CPD benefit the service user.

Both standard 3 and standard 4 require that the quality of your practice, and the benefits to your service users are the drivers for your CPD, and an important part of the context to how you make decisions about your learning activities.

#### ***'service user'***

Your service users will vary, depending on how and where you practise. For many health professionals, 'service users' will be patients. However, if you work in education, your service users may be your students, or perhaps the team of educationalists that you manage. Similarly, if you work in management, your service users may be your team, or other teams that you are part of. If you work in research, your service users may be the people who use your research work. We intend 'service user' in this context to have a broad meaning of anyone who is affected by your practice.

#### ***'benefits'***

When we say benefits, we mean that it has a positive effect on the service that you provide. This part of the standard exists to ensure that your CPD activities, as well as being a developmental, learning process for you, are related to the people who use your services, and have a beneficial impact on how you work with or for them.

We realise that it can be difficult to provide evidence that there has been service user benefit. But this standard asks you to think about how your service users might benefit when you are choosing your CPD activities, and then if you are audited, to show if or how you believe that this has occurred.

## **Standard 5**

### **A registrant must present a written profile containing evidence of their CPD upon request.**

This standard means that if you are selected for audit, you must send in a profile about how you meet the standards, by the deadline. This effectively means that you do not have to think about meeting this standard unless you are audited.

For more information about how your profile meets the standards, please see our Assessment Criteria on page 21, and the section of this document, 'Putting together your profile' on page 26.

### ***CPD activities***

We believe that CPD takes many forms, and that we should not prescribe the way that health professionals should learn. We also believe that health professionals may be engaged in activities through which they learn, and which develop their practice, but they may not call these activities 'CPD'. Our standards and our process take account of a wide variety of types of activity which can contribute to your development.

CPD activities could include:

- **work-based learning**, for example, reflective practice, clinical audit, significant event analysis, user feedback, membership of a committee, journal club;
- **professional activity**, for example, membership of a specialist interest group, mentoring, teaching, expert witness, presentation at conferences;
- **formal/educational**, for example, courses, undertaking research, distance learning, planning or running a course;
- **self-directed learning**, for example, reading journals/articles, reviewing books/articles, updating knowledge via WWW/TV/press; and
- **other activities**, for example, public service.

A fuller list of suggested learning activities is at the back of this document.

CPD has sometimes been thought of as being exclusively formal education, for example attending a course. Our standards and the process that we propose take account of the fact that a course may not be the most useful kind of CPD for all registrants, and indeed that some registrants may not have access to courses.

Registrants in rural or remote areas, for example, may find it difficult to gain access to some forms of CPD, but our standards mean that these registrants can undertake other types of CPD that are more useful and accessible to them.

Similarly, registrants who are practising outside the UK may be learning and developing through the experience that they gain of another healthcare delivery system or another culture, and this may form part of their CPD. Registrants who work as locums or who are peripatetic may be learning and developing as they gain experience of a variety of different employers. Our standards recognise that there are a huge variety of ways that registrants may undertake CPD, and do not force registrants to learn in one particular way.

### ***Based on learning outcomes***

Our CPD process is outcomes based, and not based upon a certain number of hours or points or days. You will need to make a professional decision about the kinds of activities that would be most appropriate for you to undertake, in order to ensure that you meet the standards.

Different registrants will have varying development needs, and their CPD activities may be very different. The way in which you take part in CPD and the range of your CPD activities will depend on:

- experiences and opportunities for CPD in your work;
- your profession and speciality within it;
- your personal learning needs;
- your preferred learning style;
- the relevance of the CPD activities to your practice; and
- the context of your practice.

### ***Some examples of CPD activity***

The examples below show how different registrants may choose to undertake different types of activity, depending on how or where they work. Your practice might cover more than one of these areas.

#### **Registrant in clinical practice**

- attendance at a short course on new legislation impacting on practice;
- critical appraisal of a journal article with a group of peers; or
- in-service presentation to colleagues on a new technique.

#### **Registrant working in education**

- membership of a Learning & Teaching Committee;
- reviewer for a professional journal; or
- studying for a formal teaching award.

#### **Registrant working in management**

- membership of a national occupational group for managers;
- undertaking study of management modules; or
- supporting the development and implementation of national or local policy.

#### **Registrant engaged in research**

- conference presentation;
- membership of Local Ethics Research Committee; or
- referee of articles for scientific journal.

When setting our standards for CPD, we realise that registrants are already undertaking a wide range of CPD activities, and that these activities are an integral part of their professional life. Our standards are not intended to make ‘extra’ requirements of health professionals registered with us: our standards recognise and legitimise those learning activities which professionals are already undertaking.

### ***A flexible process***

Following the responses to a consultation we undertook in 2002, we decided that our approach to CPD should not be based simply on the number of hours undertaken each year. For this reason, we have not published a required number of hours, and we do not suggest how many hours you should complete. Our standards are concerned with quality, development and with outcomes, not with the time that you spend on your CPD.

In setting our standards, we wanted to take account of the diversity of professionals on our Register, and the different ways in which they may undertake CPD.

We wanted the CPD that you undertake to be based upon on-going learning and development, with a focus on your learning achievements and how these enhance service delivery, either directly or indirectly.

This means that you can take your own decisions about the kinds of activities that are relevant to your role, and to your practice. We are not going to ‘approve’ certain CPD

schemes, or certain CPD courses or activities, because we believe that you are best able to make a decision about the CPD which is most relevant to you. If we accredited or approved only certain ways of doing CPD, then you might not be able to complete other activities, which you might find more useful in terms of their benefit to your practice and to your service users.

### ***CPD schemes***

Our standards mean that you could meet our requirements by participating in a scheme run by your professional body, or your employer, or any other organisation. If you are part of a CPD scheme, and you feel that this scheme is useful to you, that it is relevant to your practice, and that it helps you to develop, and that the structure that the scheme offers means you can meet our standards, then continuing to participate in this scheme would be a perfectly acceptable way of meeting our requirements. If you were audited, you would draw on the different activities that you had completed as part of the scheme in writing your profile.

We consider that most CPD schemes offered by other organisations will provide registrants with a way of meeting our standards, and a useful way of structuring their activities and development. However, it is important to remember that, as we do not approve or endorse any CPD schemes, you should make your own professional decision whether you are content that participating in any scheme will enable you to meet our standards. You are still responsible for your CPD, even if you are part of a formal CPD scheme.

Alternatively, you could structure your own CPD activities without using a formal scheme. You could plan your learning around your personal development plan, for example. This may be particularly relevant if you are working in a very specialised area, and feel that CPD offered by organisations is not relevant to your practice. Our standards give you the flexibility to plan your own CPD in a way that suits your practice, your learning needs, your preferences, and the time and resources available to you.

### ***Your scope of practice***

When you are planning or completing your CPD, you will need to ensure that it is relevant to your scope of practice. Similarly, as a condition of your registration with us, you need to make sure you keep to your 'scope of practice'.

Your scope of practice is the area (or areas) of your profession in which you have the knowledge, skills and experience to practise safely and effectively, in a way that meets our standards and does not present any risk to the public or to yourself.

When you come onto our Register for the first time, you must meet the whole of the Standards of Proficiency for your profession.

After you have been registered with us, we recognise that your scope of practice may change so that you can no longer demonstrate that you meet the whole of the Standards of Proficiency for your profession. This may be because of specialisation in your job, a move into management, education or research, or it may be because your fitness to practise in certain areas has become impaired. A changing scope of practice is not necessarily a cause for us to take action or a cause for concern.

**Example**

A speech and language therapist's first job after graduating was one where she worked entirely with children. She worked in this area for nearly ten years, building up considerable expertise.

When the opportunity came to manage a team of speech and language therapists that worked with a variety of different patients, clients and users, she felt that her skills in these areas needed refreshing. With the support of her new employer, she attended training, and completed private study, to update her skills and ensure that she could safely extend her scope of practice, to effectively practise in her new role. These activities all formed part of her CPD for that two-year period.

The example above shows how your CPD can prepare you for a changing scope in practice, whereas most registrants' CPD will reflect their current scope of practice.

Your scope of practice may change over time, and you should be aware of your scope of practice and ensure that you only practise within it. It is closely linked to your 'fitness to practise', but the two are not the same.

***The NHS Knowledge and Skills Framework***

Although the majority of our registrants are employed by the NHS, it is very important that our systems and processes take account of the fact that many are not. Our CPD standards are therefore not explicitly linked with Agenda for Change, which was implemented in October 2004. They are also not explicitly linked to the NHS Knowledge and Skills framework (KSF). This is because we are a UK-wide health regulator, and we regulate health professionals wherever they practise.

However, our CPD rules and standards complement other frameworks, whether profession-specific, local, or employer-based. For example, 'Lifelong learning' is an important part of the Knowledge and Skills Framework, which has clear similarities with CPD. The purpose of the Knowledge and Skills Framework is to develop services, to develop individuals, and to improve patient care. This is exactly in line with our CPD standards; if you are employed in the NHS, you can base your CPD on the learning needs that are identified in your development review and still meet our CPD standards. Our standards enable you to do this, but they also do not exclude health professionals who do not work in the NHS.

You can download information about the KSF from the Department of Health website, [www.dh.gov.uk](http://www.dh.gov.uk) A document showing the links between KSF Dimensions and the HPC examples of CPD activity can be found on the NHS Employers website.

***CPD and clinical governance***

Clinical governance is, "a framework through which NHS organisations are accountable for continually improving the quality of their services and safeguarding

high standards of care by creating an environment in which excellence in clinical care will flourish."<sup>2</sup>

Central to good clinical governance is the continuous improvement of service and care, which particularly links it to CPD standard 3, which requires that you aim for your CPD to contribute to the quality of your practice. Equally, it is vital to clinical governance that health professionals are continuing to develop their professional skills and knowledge. Our CPD requirements are complementary to clinical governance, which includes the development of individuals, services, and clinical care.

### ***Returning to practice***

We recognise that many health professionals will take a break from their practice, which may occur for many reasons, which may include parental leave, extended travel, caring responsibilities or illness.

From July 2006, we are putting into place a new return to practise process, which will apply to health professionals who want to start practising again after a break of more than two years. We will require health professionals in this situation to complete a period of updating, depending on how long they have been out of practice. More information about this process, and about the period of updating is available on our website.

If you are out of practice for more than two years, then we recommend that you should come off our Register. While you are not registered with us, and are not practising, you may be undertaking activities which you feel contribute to your ongoing CPD. These might be some form of ongoing contact with your profession, they might be activities related to another job, or they might be activities from your personal life that contribute to your learning and development. If you wish, you can keep a record of these, in case you come back onto the Register and want to use this information in the future as part of your professional CPD. **However, while you are not registered with us, you are not required to undertake CPD.**

If you wish to come back onto the Register, you will need to meet our return to practice requirements before you apply for readmission. Please see our website for more information about these requirements.

If you are out of practice for less than two years, you may choose to remain on the Register. You might do this if, for example, you wish to remain registered so that you can quickly return to work after a shorter break, or if you are not sure how long your break in practice will be because of ongoing illness. If you are selected for audit during this period, you can ask us to defer your CPD audit. Please see the section on deferral for more information.

---

<sup>2</sup> Scally, G, Donaldson, L (1998) Looking forward: clinical governance and the drive for quality improvement in the new NHS. *British Medical Journal*, 317, p61-65

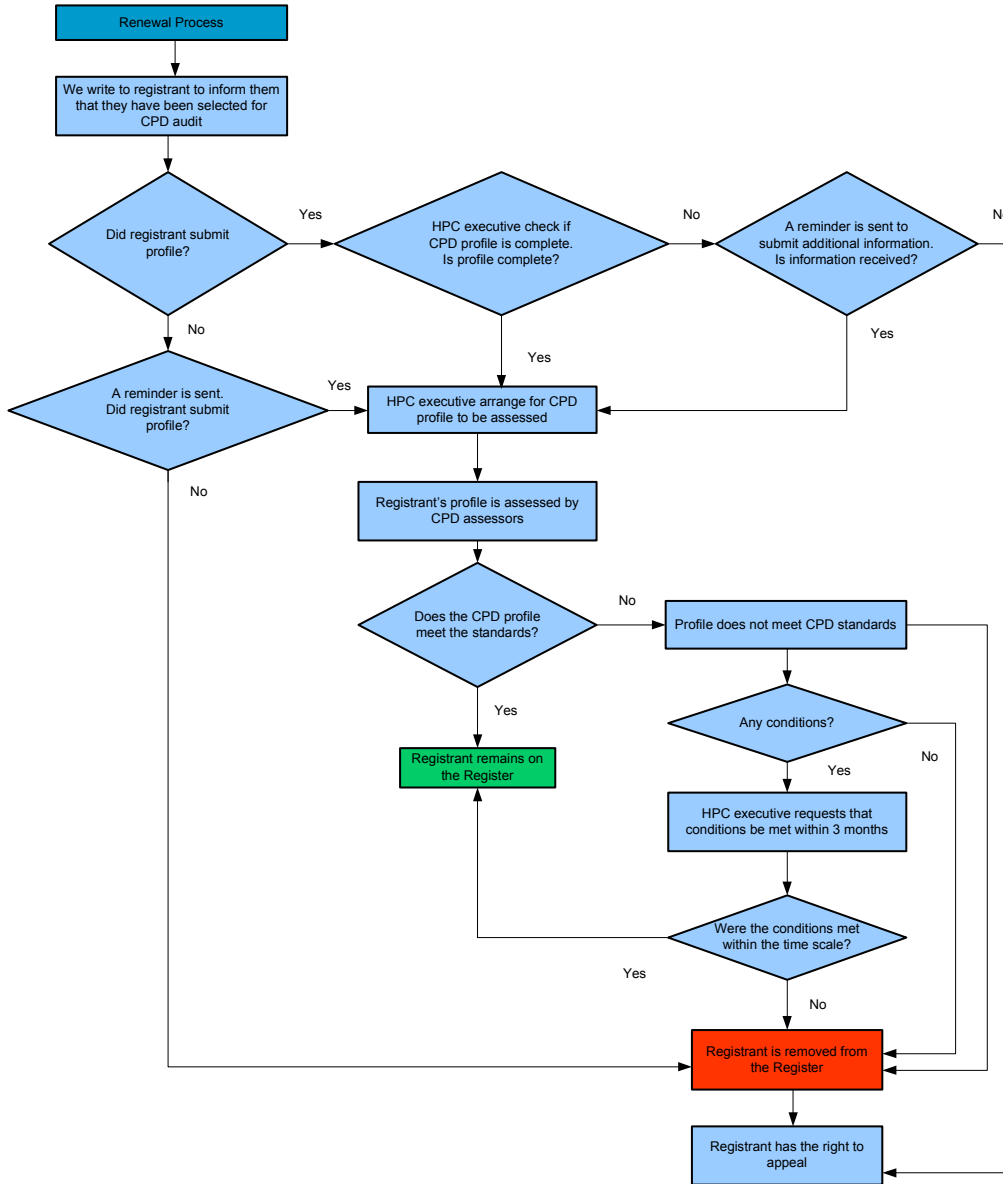


# The audit process

## In brief

Every time you renew your registration, you will sign your renewal form to confirm that you have met our standards for your CPD.

From 2008, each time a profession renews its registration, we will take a sample of registrants at random from that profession. These registrants will be asked to send in a 'profile' of evidence to show how they meet our standards. These profiles will be assessed against the standards by CPD assessors. The flow chart below shows how the process will work.



### ***Two years' registration***

We have decided that only registrants who have been on the Register for more than two years will be audited. This means that if you have come onto the Register during the two year registration cycle that is coming to an end, then you will not be selected for audit. We have made this decision because although we believe that all registrants should undertake CPD throughout their careers, we also believe that registrants should be allowed at least two years on the Register to build up evidence of their activities before they are audited.

This means that if you are a recent graduate, and you renew your registration for the first time, you will not be selected for audit. Similarly, if you have had a break in your practice, and you have just come back onto the Register, then the first time you renew your registration, you will not be selected for audit.

### ***Sampling of CPD profiles***

We propose to audit a sample of registrants' CPD each year, rather than checking each and every registrant. We believe that this is safe to do because we trust that, as professionals, registrants will take responsibility for meeting the Standards of CPD.

By auditing a sample of registrants, rather than all registrants, we will keep the costs of assessment down and achieve better value for registrants' money.

When the first audits take place in 2008, we will audit 5% of the first two professions, which are operating department practitioners, and chiropodists and podiatrists. Depending on the results of these audits, we then propose to audit 2.5% of the professions that we are auditing in 2009 and 2010, and thereafter.

Samples of this size will allow us to be confident that we have a good picture of whether registrants are generally meeting our standards or not, while keeping costs down to manageable levels. Statistical theory says that the larger the population we are checking, the smaller the proportion we need to sample to be confident that we have got an accurate picture of compliance.

The levels of 5% and 2.5% have been chosen to provide us with confidence about compliance for the numbers of health professionals on our register. We have taken expert advice on sample sizes in determining these proportions. We will use different-sized samples if we find that the proportions we currently propose using are not working adequately in some way. If we change our sample size, we will publish this information on our website, and will inform key stakeholders, such as professional bodies.

### ***Auditing***

If you are selected for audit, we will contact you to inform you. We will ask you to send in a profile demonstrating that your CPD meets our standards by your renewal deadline date. We will also send you a reminder letter.

If, by the renewal deadline date, we have not received your CPD profile, then your registration will not be renewed.

## **When your profile has been received by us**

We will then ask CPD assessors to evaluate your profile. At least one of these assessors will be from the same part of the Register as you.

The CPD assessors will assess your profile against our standards using the assessment criteria which are set out below. They will then let us know whether, in their professional opinion, your CPD meets our standards.

While your profile is being assessed, and during any appeal that takes place, you will remain on the Register, and can continue to practise.

There are three possible outcomes at this point:

### **Profile meets the standards**

We will write to you and let you know. You will remain on the Register.

### **Further information needed**

We will write to you and let you know what further information the assessors have asked for, and what more they need to know in order to make a decision about whether you meet the standards. You will remain on the Register while you send more information to the assessors.

### **Profile does not meet the standards**

If the CPD assessors decide that your profile does not meet our standards, they will then decide whether to offer you an additional three months in which to meet our CPD standards. Alternatively, they can recommend that your registration should lapse, and you will no longer be registered.

The assessors will make the decision on whether to offer you a further three months, looking at your profile, and bearing in mind:

- whether you appear to have undertaken and completed your CPD profile in good faith;
- whether you have met any or some of the standards; and / or
- whether it would be possible for you to undertake CPD in three months that would then show that you met the standards.

If you meet several of the standards, then it may be appropriate for the assessors to recommend that you are given three months to meet the remaining standards. If you have not met any of them, the assessor may consider that it is very unlikely that you would be able to meet the standards in three months, and that this would not be helpful to you. Likewise, if your CPD profile suggests that you are not committed to CPD, then the assessor may consider that it is not reasonable to recommend a further three months, and therefore that you should no longer be registered.

If you are given a further three months to meet conditions regarding your CPD, we will write to you and give you the assessors' feedback and their decision. (You will still remain on the Register during this three months.) We will then ask you to send in a further profile, which will be assessed to ensure it meets our standards before your

registration is renewed. If, at the end of this process, your profile does not meet our standards, you will be removed from the Register.

If you are not given a further three months with conditions, then you will be taken off the HPC Register. Whatever decision the assessors reach, we will write to you and inform you of the decision, and the reasons for that decision. If you do not agree, you will be able to appeal. More information about the appeal process comes further on in this document.

### ***The CPD assessors***

The CPD assessors have a vital role in ensuring that the CPD audit process runs smoothly. CPD assessors will be a new type of 'partner' for us. Other types of partners that we already have include registration assessors, who look at applications from people who trained outside the UK, and panel members, who consider allegations at fitness to practise hearings.

We will recruit and train our CPD assessors in the same way as our other partners: ensuring that we advertise openly for the roles, by short-listing based on a person specification, and interviewing to ensure we have an appropriate number of CPD assessors, drawn from a range of professional backgrounds. We will then train CPD assessors to ensure that they carry out their jobs fairly. (We will post information about how to become a CPD assessor on our website when we begin recruiting.)

Once CPD audits are underway, we will keep the performance of CPD assessors under review through our Partners appraisal system, and we will look at the results of the audits and act on these results where necessary, in order to ensure consistency of decision-making, as far as possible.

**Assessment criteria**

<b>Standard</b>	<b>Standard not met</b>	<b>Standard partly met</b>	<b>Standard met</b>
<p><i>A registrant must:</i></p> <p>1. maintain a continuous, up-to-date and accurate record of their CPD activities;</p>	<p>No evidence that registrant has kept a record of their CPD.</p>	<p>Some evidence of a record of CPD, eg: registrant has described keeping a record of CPD.</p>	<p>Evidence that registrant has maintained a record of their CPD activities: as part of their supporting evidence, registrant has sent in a brief summary of all CPD activities undertaken.</p>
<p><i>A registrant must:</i></p> <p>2. demonstrate that their CPD activities are a mixture of learning activities relevant to current or future practice;</p>	<p>Registrant has undertaken no activities. OR Registrant's CPD consists of only one type of learning activity. OR Registrant's CPD appears to have no relevance to current or future practice, as laid out in the summary of practice.</p>	<p>Registrant has undertaken two types of learning activities, but offers no explanation for concentrating on these. OR Some evidence that learning is relevant to current or future practice, but this is not made explicit.</p>	<p>Registrant's CPD includes three or more types of learning activity. OR Registrant's CPD includes two types of learning activity, and registrant's profile has explained why they have chosen to use only these types of learning activity. AND Evidence that learning activities are relevant to current practice or future practice. The link is clear in the personal statement.</p>
<p><i>A registrant must:</i></p> <p>3. seek to ensure that their CPD has contributed to the quality of their practice and service delivery;</p>	<p>No evidence that CPD activities have improved the quality of registrant's practice, or that registrant has aimed for CPD to improve the quality of their practice.</p>	<p>Some suggestion that CPD has improved the registrant's practice: improvement is implied, can be inferred from information given, or improvement in practice is stated but no evidence is given to support this.</p>	<p>Personal statement shows that CPD activities have improved the quality of the registrant's practice. Statements are backed up with evidence. OR Registrant has shown how they believed that their CPD might improve the quality of their practice, and planned for this, but in fact this has not been the case. Registrant shows that they have considered why this has occurred, and what their next steps are in order that</p>

			<p>their CPD will improve the quality of their practice in the future..</p>
<p><i>A registrant must:</i> 4. seek to ensure that their CPD benefits the service user;</p>	<p>No information that explains any benefit to service users from CPD activities.</p>	<p>Limited information about how CPD activities have benefited the service user. OR Benefit to service user is stated but no evidence or explanation is given to support this.</p>	<p>Registrant has shown (through evidence or through explanation) how their CPD activities have benefited the service user, either directly or indirectly. OR Registrant has shown how they believed that their CPD might benefit the service user, but in fact this has not been the case. Registrant shows that they have considered why this occurred, and what their next steps are in order that their CPD will benefit the service user in the future.</p>
<p><i>A registrant must:</i> 5. present a written profile containing evidence of their CPD upon request.</p>	<p>No profile submitted by deadline.</p>	<p>Incomplete profile submitted by deadline (‘evidence to follow’, for example.)</p>	<p>Profile submitted by deadline.</p>
<p><b>Outcome:</b></p>	<p>Assessor would recommend that the profile is sent back to the registrant, and that registrant is informed that their profile does not meet the standard. Assessor would decide whether to recommend that the registrant is allowed 3 months to show that they meet the CPD standards.</p>	<p>Assessor would recommend that the profile is sent back to the registrant asking for more information.</p>	<p>Assessor would recommend that the registrant is informed that their profile meets the standard.</p>

## ***Assessing the profile***

CPD assessors will assess your profile, and will make a decision against each of the standards. In order for your registration to be renewed, the assessors must be assured that you meet each of the standards.

## **Assessment outcomes**

Outcomes are suggested in the table above, depending on whether you meet, partly meet, or do not meet the standards.

If the extent to which you meet the standards varies from standard to standard, then the CPD assessors will look at your profile on its individual merits to make a decision, which they will justify, bearing the following in mind:

- Normally, if the CPD assessors decide that you meet most of the standards, but you only ‘partially meet’ one or more standard, then we will ask you for more information, so that the CPD Assessors can reach their decision.
- Normally, if the CPD assessors decide that any one or more of the standards are ‘not met’ then we will write to you, to inform you that your profile does not meet the standards.

However, we will ask the CPD assessors to look at each profile individually, to make sensible and reasoned decisions in the case of, for example, for example, a profile where the majority of standards are met, but one is only partially met, or where every standard is nearly met. The CPD assessors will make a decision based on the information that you have provided, and will take into account how you have met the other standards, in making their decision.

## ***The appeal process***

If we consider that your profile does not meet our CPD standards, and your registration is not renewed, you can appeal against this decision.

We want to operate an appeals process which is transparent, and fair, and which gives you the opportunity to tell us why you feel that the decision not to renew your registration was unfair. While you make an appeal against our decision, you will remain on the Register.

In order to appeal, you must write to us within 28 days of the date of the decision letter. Your letter needs to tell us that you wish to appeal, and tell us why you feel that the decision not to renew your registration was wrong.

We will arrange an appeal hearing; at this hearing, a registration appeal panel will look at your appeal and consider the information they are given about your registration renewal. You have the choice to attend, or to ask the panel to look at your appeal on documentation alone. You can also have a representative attend the hearing with you.

The panel may decide to:

- allow the appeal, and therefore allow you to remain on the Register;
- dismiss the appeal, meaning that the original decision to take you off the Register will be upheld; or
- ask that your profile be re-assessed.

If you do not agree with the decision made by the panel, you have a further right to appeal, to the County Court in England and Wales or Northern Ireland, or to a local Sheriff in Scotland.

More detailed information about how to make an appeal can be found in our document ‘Making a registration appeal’. This is published on our website. The rules that govern registration appeals are also available on our website.

### ***Coming back onto the Register***

If you are taken off the Register because you haven’t met our CPD standards, then we will write to you and inform you of this. When we write to you, we will tell you what you need to do before you can be re-registered. We will put in place a process which, as far as possible, recognises the need to be fair to those registrants who have met our CPD standards, and also is fair to registrants who have come off the Register, but who wish to undertake CPD that meets our standards in the future. As well as sending this information to you if you come off the Register, information about how this will work will be posted on our website.

### ***Deferral***

We recognise that some registrants, due to unavoidable circumstances, may need to defer their CPD audit. Registrants may need to defer their audit because they cannot complete their profile due to illness, or family circumstances. The deferral process will offer registrants who cannot complete their profiles due to circumstances beyond their control the opportunity to remain registered.

If your audit is deferred, you will automatically be selected for audit when your profession next renews, two years later. We will put in place a deferral process which will mean that if you are selected for audit, you can if necessary write to us and request a deferral. We will need supporting evidence your application for deferral, and we will look at your situation to see whether it would be fair to you, and to the other registrants who have to complete their profiles that year, to defer your audit for two years.

We will put in place a system which ensures, as far as possible, that we are fair to registrants who cannot complete their profiles, while still maintaining our standards, and being fair to those registrants who do complete the audit process. Information about deferral of your CPD audit will be published on our website and in hard copy before the first audits take place in 2008.

If you need to apply for deferral more than once, we will scrutinise your application for deferral very carefully and will be looking for clear evidence that deferral is absolutely necessary and that to require a CPD profile from you at this time would be clearly unfair.



***Keeping us up to date***

Our CPD audit process will work by us writing to you to tell you that you have been selected for audit, and writing to you to inform you of the result of that audit. This means it is now more important than ever that you keep us informed about your address.

We can store your work address and your home address on our system. We can change your details so that the general geographical area of your work address is displayed on our online register, but your correspondence is sent to your home address, or vice versa.

To update your details, please contact the UK Registration department on 0845 3004 472 (lo-call rate) or 020 7840 9802.

If we do not have your most recent details, then we will not be able to contact you so that you can renew your registration. Please make sure that you keep us informed, so that we can keep you informed about your registration.

***Communicating with employers***

We know that the time and resources for CPD that registrants are given by their employers is an important issue. One way that we have tackled this is by ensuring that our CPD standards are flexible enough to allow health professionals to design their own CPD, even if they are self-employed, or have little or no formal support for their CPD activities.

However, we also recognise that it is very important that employers of our registrants are informed about the new responsibilities of their staff. We will begin working on a communications campaign in 2006 with employers, and information about CPD will form an important part of our ongoing communications. We believe that recognition of registrants' CPD, and support for their CPD activities is a complex issue that will need a long-term approach. But we are committed to giving stakeholders, including employers, information about what we do, and how it affects them. For more information about how we inform employers about CPD, please see our website where we will publish this information.

## Putting together your profile

If you are selected for audit, we will provide you with a form to complete.

The main parts of your profile will be:

- a summary of practice history for the last two years (maximum 500 words);
- a statement of how Standards of CPD have been met (maximum 1500 words); and
- evidence to support your statement.

### ***The purpose of each part of the profile***

Each of the three categories above will help the CPD assessors to see how or if you meet our standards.

The **summary of your practice history** should help to show the assessors how your activities are linked to your practice. This part of the profile should help to show how you meet **standard 2**, which says that your activities must be *‘relevant to current or future practice’*.

Your **statement** of how our standards have been met should clearly show how you believe you meet each of our standards, and should refer to the **evidence** that you send in to support your statement. The statement will explain how you meet **standards 1 - 4**. (Sending in your completed profile to us means that you will meet standard 5.)

The **evidence** you select will back up the assertions you make in your profile. It should show that you have undertaken the activities you refer to, and should also show benefit to the quality of your practice, and some benefit to the service user. It backs up how you meet **standards 1 – 4**. Your evidence should include a summary of all your CPD activities, and this will show that you meet **standard 1**. The CPD assessors should be able to see how your CPD activities meet **Standard 2** (ie are relevant to your practice, and a *‘mixture of learning activities’*).

### ***Writing your summary of practice history***

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

You could base this part of your profile on your job description (or KSF post outline, for NHS posts), if appropriate.

When you have written your statement about how you meet the standards, you may find it helpful to go back over your summary of practice history, to make sure that it’s clear to the assessor how your CPD activities are relevant to your future or current practice.

## **Writing your statement**

In this section, we ask you to write a statement about how your CPD activities have met the standards that we set.

Our CPD Standards make different requirements of you. Standard 1 requires you to keep up to date continuous records of your CPD activities. Standard 2 requires that this includes a mixture of activities, relevant to how you practise, or how you intend to practise. Standards 3 and 4 require you to write about the impact of your CPD on the quality of your practice/service and its benefits to service users. Standard 5 asks you to submit a profile if you are selected for audit.

When you write your statement, we therefore expect that you will spend more time and more of your total statement in considering how you meet standards 3 and 4.

Below, we have suggested how you might want to approach writing your statement.

## **Using your personal development plan**

We know that not all registrants have a personal development plan (PDP): you may be self-employed, or your employer may not work in this way. But if you do have a PDP, you may find it useful to write your personal statement using this as a starting point. Even if you do not already have a PDP, you may find it useful to develop your own, and to use this approach.

You could start by thinking about Standard 3 and how it relates to your PDP.

Most PDPs involve identifying:

- learning need;
- learning activity;
- type of evidence; and
- what you learnt.

You could write a statement on how you have updated your knowledge and skills over the last two years, and what learning needs you have met. You may find it helpful to identify 3-6 key areas, aims, targets or learning objectives that you have made during the past 2 years and that have contributed to the quality of your practice.

These areas will have been identified through your personal development plan, your individual performance review, peer review or service/workplace review or audits. If you have a PDP, audit, significant event analysis, service review or peer review, you can submit these as part of your evidence.

You can then write about each of these areas, drawing on CPD activities that have supported them, and writing about what you learnt, how this has benefited your practice, and how it has benefited your service users.

If you run your own private practice, and you have a business development plan or a similar document, then you may find this a useful starting point.

## Using the standards

Alternatively, if you do not have a PDP, or if you would prefer another approach, you could start with our standards, and using the information below, write about how you have met each of them. If you decide to do this, you may find it helpful to read through the ‘prompt questions’ below.

You could split your statement into sections, and dedicate each section to one standard.

## Using ‘prompt questions’

Here, we have provided a number of questions which should help you to think about structuring your profile to show that you meet our CPD standards.<sup>3</sup>

Under each standard we have identified some key questions. These are first, in bold, and these are the most important questions that you should make sure your profile answers. These are questions that the CPD assessors will want to see are answered by your profile.

We have also provided supplementary questions. You do not need to answer all of the supplementary questions or to follow them verbatim. But you can select the ones that seem most useful, and use them to help you write your statement, if you find this helpful.

We have suggested here that you may find it useful to look at standards 3 & 4 together.

### Standard 1

**A registrant must maintain a continuous, up-to-date and accurate record of their CPD activity**

#### Key question:

- **Have you included in your evidence a summary sheet of all your CPD activities?**

#### Supplementary questions:

- How have you maintained an up-to-date and accurate record of your CPD activity?
- What method did you employ to record your CPD e.g. monthly portfolio update?
- Who (if anyone) approved your CPD plan?

<sup>3</sup> These prompt questions are based on work done by the Allied Health Professions Project, Demonstrating Competence Through CPD.

**Standard 2**

**A registrant must identify that their CPD activities are a mixture of learning activities relevant to current or future practice.**

**Key questions:**

- **How are your learning activities a ‘mixture’? What different types of learning activity have you undertaken?**
- **How is your CPD relevant to your practice?**

Supplementary questions:

How do you identify your learning needs? For example:

- What structures do you use to help you identify your learning needs (e.g. appraisal, peer review, clinical supervision, mentorship schemes, personal development plan)?
- How do you gain the views and advice of others to help you identify your learning needs?
- How do you decide on what CPD activity to do?
- How do you ensure an appropriate mix of CPD activity to meet your needs?

In what ways has the mixture of learning activities you have used for your CPD been relevant to your current or future practice?

- What parts of your role are affected by your CPD?
- What different learning activities have you used for your CPD?
- How has each learning activity related to your current / future practice e.g. practice improvement, enhanced patient care, etc?

**Standards 3 & 4**

**A registrant must seek to ensure that their CPD has contributed to the quality of their practice and service delivery.**

**A registrant must seek to ensure that their CPD benefits the service user.**

**Key questions:**

- **How have you updated your knowledge and skills over the past two years? How has the way that you practice improved?**
- **How has your learning benefited your service users?**

Supplementary questions:

- How does your learning relate to your ability to practise safely, effectively and legally?
- How does your professional development relate to your evolving scope of practice?
- What aspects of your work have changed as a result of your development (eg, clinical areas, service delivery, research practice)?

How does your professional development relate to your evolving scope of practice?

For example:

- How have you kept up-to-date within your current role?

- If there have been changes to your role, how did you prepare for these?
- How have you responded to these changes?
- What advice have you sought when faced with an experience or situation that is outside of your current scope of practice?
- What support mechanisms do you use and how have they helped you?
- How does your involvement with relevant groups support your development?
- How do you think your scope of practice may change in the future?
- What new learning needs have you identified and how do you plan to meet these?

Has your learning assisted you in:

- Extending your scope of practice?
- Learning new therapy techniques?
- Learning new teaching/ management/research skills?
- Addressing ethical issues with patients/colleagues?
- Learning about new legislation?
- Improving your communication skills? ( e.g. developing new information leaflets/ organising information sessions for carers, or thinking about how you give explanations to patients)

What are the main areas in which your learning has enhanced what you offer to clients/users/patients? How has your learning enhanced your contribution to service delivery?

How does your learning relate to your ability to practise safely, effectively and legally? For example:

- How have you responded to changes in practice (e.g. new legislation)?
- How is your work informed by codes or standards of practice?
- What dilemmas have you been faced with and how have you dealt with these?
- What have you learnt from positive and adverse incidents?
- How has this learning informed your practice?
- What support mechanisms do you use to seek advice and what action have you taken afterwards?
- How has the evidence base informed your practice?

What aspects of your work have changed as a result of your development? For example:

- How have you kept up-to-date within your current role?
- What areas of practice do you feel more confident in?
- What new avenues/sources of support do you use?
- Have you taken on new responsibilities as a result of your learning?

### **Standard 5**

**A registrant must present a written profile containing evidence of their CPD upon request.**

In writing your profile (if you are audited), and submitting it within the timeframe required, you show that you meet this standard.

For more information about writing your statement, please see the section of this document **the standards in detail** on page 8, and also our **assessment criteria**, on page 21.

### ***Your supporting evidence***

You do not need to send in your entire record of all the CPD you have done. In fact, we strongly encourage you *not* to send this to us. You can send us a summary of all your activities, in order to show that you have met standard 1, but it is likely that this summary will only be a sheet or two with a very brief list of activities and dates.

If you are selected for audit, you need to look through your entire CPD record and consider which activities best show how you have met the standards. This should be a mixture of activities that are directly linked to your current or future practice, and you should consider how you can present evidence of how these activities have improved your practice, and benefited your service users. In all cases, evidence of how you have planned your CPD, what activities you have undertaken, and learned from, how you then applied this learning to your practice, and the effects that this had on how you practice and the effects on your service users, will all be helpful to the assessors.

When you put together your profile, you also need to send in supporting information and evidence to back up the assertions that you make in your personal statement. This requires you to make decisions about the information that you send to us.

### **Examples of evidence of CPD**

- A personal development plan could help to demonstrate that you take a structured approach to your learning and ongoing development (CPD Standards 1 & 5).
- Peer review and your subsequent learning could provide evidence of feedback and how you have responded to this (CPD Standards 3 & 4).
- A business plan may identify learning needs and subsequent action plan related to this (CPD Standards 1, 2 & 5).
- Reflection on practice and discussion in supervision or with a mentor could identify benefits to the service user and provide evidence of feedback and how you have acted on this (CPD Standards 3 & 4).
- Dissemination of research findings, discussion and feedback could benefit the service user and provide feedback (CPD Standards 4 & 5).

A more extensive list of the different types of supporting information that you could send to us is suggested at the back of this document, in Appendix 2.

We are aware that it can be difficult to provide evidence for some of the standards. When you are describing, for example, how your CPD has benefited the quality of your practice, or benefited your service users, you may need to describe in your personal statement how you *believe* that this has happened. You may be able to back up this assertion with evidence of, for example, an altered way of working which you believe has enhanced the quality of your practice. You may have evidence of a meeting with your manager where you discussed implementing new skills you had learnt, or you may have evidence of how you personally planned to make changes to systems or practices. If your personal CPD record includes a place where you write a statement after your CPD about how you will use the knowledge you have gained,

then this statement (which you might call a ‘reflective statement’) could be useful evidence. These types of evidence are evidence of the *effects* of your activities, and this, alongside the evidence of the CPD activities themselves, will help to show the assessors how you meet our standards.

**Copies of documents**

As far as we can, we will put in place systems to keep your information safe. However, when items are sent through the post, there is always the possibility that they may be lost. Likewise, although we work hard to process and file your information, it is possible that we may lose a small number of profiles. We therefore ask you to make sure you only send us a copy of your supporting information, and that you do not send us any original documents.

The assessors may ask to see original documents if they have a particular query about a piece of evidence, and if this is the case, we will contact you to let you know, and to discuss the best way of doing this. But unless this happens, please do not send us any original or irreplaceable documentation.

**Proportionality of evidence**

In your personal CPD record you may have a large quantity of evidence relating to certain activities. However, you do not need to send all of this information to us. You need to look at the information you have, decide which activities show how you meet our standards, and then decide what evidence of those activities to send to us. You should refer to the assessment criteria to ensure that you have provided information to show how you meet each of the standards.

We do not have detailed guidelines concerning how much information to send us, since each CPD record will be unique. But you should bear in mind that the CPD assessors will need to see enough information to assure themselves that the CPD activity has taken place, and also information relating to any outcomes you describe.

**Confidentiality and anonymity**

It is your responsibility, in all aspects of your practice, to maintain patient confidentiality. This is part of your responsibility under our Standards of conduct, performance and ethics.

Some of the information that you wish to send us may contain details of your patients, clients or users. If this is the case, please remove any details that could allow us to identify the people concerned. We expect that your supporting evidence will normally take the form of documents, and so in order to maintain confidentiality you could, for example, strike through any personal details in black before making a copy of the documents.

This issue becomes more complex if you are submitting information in other formats, for example an audio cassette, or a video tape, or photographs. In the case of photographs, you may be able to scan these, and then to mask over faces in order that the patients, clients or users cannot be identified.



If this is not possible with photographs, or if you wish to submit tapes/ videos / DVDs, etc. where confidentiality is not possible, then you should make sure that, before you send the information to us, you have informed consent to do so from your patients, clients or users, or other people who could be identified from your evidence. Even if you have already gained consent from the people concerned in order to make the recording in the first place, you would also need express consent from them in order to send that material to us. We do not need evidence of the consent as part of your CPD profile, since you must keep to our standards of confidentiality and consent whether you are audited or not. (Please see our standards of conduct, performance and ethics for more information.) However, we may ask you for evidence of obtaining consent if we need to.

Please be aware that we cannot accept evidence unless you have gained appropriate consent from the people involved, or maintained their anonymity to remove the need for consent.

**Example profiles**

You can find example CPD profiles on our website, or you can contact us to ask for a hard copy. We asked the professional bodies for each of the professions that we regulate to submit example profiles, giving examples of how registrants’ activities would meet our standards, in a variety of contexts, and we are very grateful to the professional bodies for working on this project.

**Disabled registrants**

If you are a disabled registrant who is selected for audit, we will assess your profile fairly. You do not have to inform us about your disability in your profile, as it may not be relevant to your CPD activities.

However, it is possible that you feel your impairment is relevant to your CPD. For example, part of your development might be in developing further reasonable adjustments to your practice with your employer, reviewing those adjustments, and improving them. In this case, you can mention your impairment on your profile if you wish. This information will be seen by the CPD assessors who assess your form, and the members of staff who process it, but we will not share the information with anyone else, and we will keep this information securely and confidentially.

If you need any information from us in alternative formats, for example in Braille or large print, please let us know. Similarly, if you would like to submit your profile in an alternative format, we will be happy to accept it. Please just let us know in advance that you intend to do this so that we can make any arrangements that we need to.

When you are putting together your profile, you can do so using any reasonable adjustments that are useful to you. For example, if you normally take notes in your practice by dictating to an assistant, you could compile your profile in the same way. If you have any questions about the way that you wish to compile your profile, please contact us to find out how we can assist you.

**Your writing style**

The way you write does not form part of the assessment criteria for the CPD audit, but

Date	Ver.	Dept/Cmte	Doc Type	Title	Status	Int. Aud.
2005-11-22	a	POL	PUB	Continuing professional development and your registration	Draft DD: None	Public RD: None

it will still greatly assist the CPD assessors if your writing is clear and logically presented so they can easily understand your profile and how you meet each of our standards. This does not mean that you need to be able to write in a particular style: you might present your profile clearly in note format, for example.

The CPD audit process is not an academic assessment of how clearly or how well you can write. When a CPD assessor looks at your profile, he or she will be focusing on your CPD activities and whether they meet our standards. Your fluency, spelling, grammar, and command of English are relevant, but only in the way that they enable the assessors to see how you clearly and legibly communicate what you have done, how you have done it, and how the activities meet the CPD Standards.

### **Our standards for communication in English**

In addition, as part of your registration with us, we require that you are able to communicate in English to the standards equivalent to level 7 of the International English Language Testing System, with no element below level 6.5 (There is a higher standard for Speech and Language Therapists, of level 8, with no element below 7.5.) This is not part of our CPD requirements, but part of our Standards of Proficiency which every registrant must meet. If English is your first language, then you will already meet this standard. If English is not your first language, then you will normally have passed this test or an equivalent test when you applied to us for registration.<sup>4</sup>

It is possible that a submission to us might raise serious concerns with the CPD assessors, not about your CPD activity, but about your ability to meet our standards for your communication in English. If this were the case, then we would have to decide whether to take action through our fitness to practise process in order to protect the public. However, we consider that this is very unlikely to happen, and would not affect those registrants whose first language is English. In particular, if you are dyslexic, you should be assured that the purpose of this standard is to ensure that registered health professionals can communicate effectively, in order to practise safely and effectively, and it is not intended to bar people with dyslexia from being registered.

---

<sup>4</sup> Under Community law, EEA applicants exercising mutual recognition rights cannot be language tested on entry to the register but they do have to meet the language proficiency standard when they practice.

## Glossary

Audit	A CPD audit is the process where we randomly select a percentage of registrants who are renewing their registration, and ask them to send in a profile showing how their CPD meets our standards.
Appeal	If you come off the Register because your profile does not meet our CPD standards, you can appeal against this decision. When you appeal, we will look at the decision again, with any extra information you send us, and decide whether to change the decision made.
Clinical governance	"A framework through which NHS organisations are accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish." (Sally, G, Donaldson, L (1998) Looking forward: clinical governance and the drive for quality improvement in the new NHS. British Medical Journal, 317, p61-65)
Competence	Your competence is your ongoing ability to meet our standards for your professional knowledge, understanding and skills, so that you can practise safely and effectively.
Continuing professional development (CPD)	A range of learning activities through which health professionals maintain and develop throughout their career to ensure that they retain their capacity to practice safely, effectively and legally within their evolving scope of practice.
CPD assessor	An HPC partner, whose role is to assess CPD profiles against the CPD standards.
Deferral	The process by which a registrant who is unable to complete their profile puts off their CPD audit for two years.
Fitness to Practise	If someone is fit to practise, this means that they have the health and character, as well as the necessary skills and knowledge to practise their profession safely and effectively.
Health Professions Council	The statutory UK regulator for thirteen health professions, set up to set standards, and protect the public.
Health Professions Order	The legislation which created the Health Professions Council, and which gives it legal powers.
Hearing	Proceedings at which someone's fitness to practise is considered, or an HPC decision is appealed.
Lapsed (registration)	The term used to describe what happens to registration when a health professional does not renew their registration, and they are then no longer on the register.
Partner	Partners work as agents of the HPC. They provide the expertise the HPC needs for its decision making, and ensure

	that we have good professional, and lay (public) input into what we do. Partners include registration assessors, who assess applications from health professionals who trained outside the UK, panel members, who sit at hearings to decide on registrants' fitness to practise, and CPD assessors, who assess CPD profiles.
Portfolio	This name is sometimes used for a registrant's personal and complete record of their CPD activity. This can be kept in whatever format is most useful for the registrant, and will not be looked at or inspected by HPC.
Professional body	Each of the professions regulated by the HPC has a professional body, membership of which is voluntary. Professional bodies may deal with supporting their members, promoting the profession, developing best practice, and continuing education.
Profile	The information that a registrant who has been selected for audit sends to the HPC to show that they meet the standards for CPD.
Protected title	A title like 'physiotherapist', 'chiropracist' or 'dietitian' which can only be used by someone on the HPC Register. Anyone who is not registered with HPC who uses a protected title may be prosecuted and fined £5,000. For a full list of protected titles, please see our website <a href="http://www.hpc-uk.org">www.hpc-uk.org</a>
Register	A published list of health professionals who meet the HPC's standards. This is available online at <a href="http://www.hpc-uk.org">www.hpc-uk.org</a>
Renewal	The name of the process where professionals on the HPC Register pay their registration fees, and sign their professional declaration, so that their registration continues for another two year period. Each profession regulated by HPC renews its registration once every two years. Our CPD audit process is linked to registration renewal.
Revalidation	The process whereby a registered professional is assessed, regularly to ensure that they are fit to practise. (This is not the same as CPD, which is concerned with ongoing development and learning.)
Returners to practice	Health professionals who have been out of practice for a period of time, who wish to re-join their profession.
Scope of practice	The term used for the area of someone's profession in which they have the knowledge, skills and experience to practise safely and effectively, in a way that meets our standards and does not present any risk to the public or to the health professional.
Struck off	When a health professional is removed from the Register as the result of a fitness to practise hearing.

## Appendix 1: Examples of types of CPD activity<sup>5</sup>

(This is not an exhaustive list, but we have provided it to give you an ideas of the kinds of activity that might make up your CPD.)

Work based learning	Professional activity
<ul style="list-style-type: none"> <li>• Learning by doing</li> <li>• Case studies</li> <li>• Reflective practice</li> <li>• Clinical audit</li> <li>• Coaching from others</li> <li>• Discussion with colleagues</li> <li>• Peer review</li> <li>• Gaining and learning from experience</li> <li>• Involvement in wider work of employer e.g. representative on a committee</li> <li>• Shadowing</li> <li>• Secondments</li> <li>• Job rotation</li> <li>• Journal club</li> <li>• In-service training</li> <li>• Supervision of staff/students</li> <li>• Visits to other departments and reporting back</li> <li>• Role expansion</li> <li>• Significant event analysis</li> <li>• Completion of self-assessment questionnaires</li> <li>• Project work/management</li> <li>• Evidence from learning activities undertaken as part of your progression on the NHS Knowledge and Skills framework</li> </ul>	<ul style="list-style-type: none"> <li>• Involvement in a professional body</li> <li>• Member of specialist interest group</li> <li>• Lecturing/teaching</li> <li>• Mentoring</li> <li>• Examiner</li> <li>• Tutor</li> <li>• Branch meetings</li> <li>• Organising journal clubs or other specialist groups</li> <li>• Maintaining and/or developing specialist skills e.g. musical skills</li> <li>• Expert witness</li> <li>• Member of other professional bodies/groups</li> <li>• Presentation at conferences</li> <li>• Organiser of accredited courses</li> <li>• Research supervision</li> <li>• National assessor</li> <li>• Appointment to a promoted post</li> </ul>

Formal / educational	Self-directed learning	Other
<ul style="list-style-type: none"> <li>• Courses</li> <li>• Further education</li> <li>• Undertaking research</li> <li>• Attendance at conferences</li> <li>• Submission of articles/paper</li> <li>• Seminars</li> <li>• Distance learning</li> <li>• Courses accredited by professional body</li> <li>• Planning or running a course</li> </ul>	<ul style="list-style-type: none"> <li>• Reading journals/articles</li> <li>• Review of books/articles</li> <li>• Updating knowledge via www/TV/press</li> <li>• Progress files</li> </ul>	<ul style="list-style-type: none"> <li>• Public service</li> <li>• Voluntary work</li> <li>• Courses</li> </ul>

<sup>5</sup> This appendix is based on work done by the Allied Health Professions Project on Demonstrating Competence through CPD.

## Appendix 2: Examples of evidence<sup>6</sup>

(This is not an exhaustive list, but has been provided to encourage you to think about how you can provide evidence of your CPD)

<b>Things you may have produced</b>	<b>Materials demonstrating reflection and evaluation of learning and practice</b>	<b>Materials acquired from others</b>
<ul style="list-style-type: none"> <li>• Information leaflets</li> <li>• Case studies</li> <li>• Critical literature reviews</li> <li>• Adapted user/student notes</li> <li>• Policy or position statements</li> <li>• Discussion documents</li> <li>• Procedural documents</li> <li>• Documents relating to national or local processes (e.g. schemes for peer review, mentorship or clinical supervision)</li> <li>• Recent job applications</li> <li>• Reports (e.g. on project work, clinical audit, reviews of activity)</li> <li>• Business plans</li> <li>• Protocols</li> <li>• Guidance materials (e.g. for service users, colleagues or students)</li> <li>• Clinical audit tools</li> <li>• Clinical guidelines</li> <li>• Course assignments</li> <li>• Action plans</li> <li>• Course programme documents</li> <li>• Presentations</li> <li>• Articles produced for publication</li> <li>• Questionnaires</li> <li>• Research papers/proposals/funding applications/ethical approval applications</li> <li>• Induction materials for new members of staff</li> <li>• Learning contracts</li> <li>• Contributions to work of a professional body</li> <li>• Contributions to work of a special interest group</li> </ul>	<ul style="list-style-type: none"> <li>• Profiles drawn from learning portfolios</li> <li>• Adapted documentation arising from appraisal, clinical supervision, job evaluation, compliance with locally implemented competence frameworks.</li> <li>• Documentation from compliance with local or national CPD schemes</li> <li>• Evaluation of courses/conferences attended</li> <li>• Personal development plans</li> <li>• Documented and approved claims for academic credit for prior or experiential learning</li> </ul>	<ul style="list-style-type: none"> <li>• Testimonies</li> <li>• Letters from users, carers, students or colleagues</li> <li>• Course certificates</li> </ul>

<sup>6</sup> This appendix is based on work done by the Allied Health Professions Project on Demonstrating Competence through CPD.

---

Information for registrants

# Continuing professional development and your registration

# Contents

## **Introduction 2**

About this document 2

CPD and HCPC registration: A summary of CPD and the audit process 2

## **CPD and your registration 3**

About us 3

Registered professions 3

A new responsibility 3

Background 3

Our standards for CPD 4

Your responsibility 4

The role of your employer 4

CPD and fitness to practise 4

– CPD and competence 4

– If a CPD profile is fraudulent 4

– CPD, your practice, and your ongoing competence 5

Audit dates 5

## **Undertaking CPD 6**

What is CPD? 6

Standards of CPD 6

The standards in detail 6

– Standard 1 6

– Standard 2 7

– Standard 3 7

– Standard 4 8

– Standard 5 8

CPD activities 8

Based on learning outcomes 9

Some examples of CPD activity 9

– Registrant working in clinical or frontline practice 9

– Registrant working in education 9

– Registrant working in management 9

– Registrant involved in research 10

A flexible process 10

CPD schemes 10

Your scope of practice 10



Example	11
The NHS Knowledge and Skills Framework	11
CPD and clinical governance	11
Returners to practice	12
<b>The audit process</b>	<b>13</b>
In brief	13
Two years' registration	13
Sampling registrants	13
Auditing	13
When we have received your profile	13
CPD assessors	14
Assessment criteria	15
Assessing the profile	18
Assessment outcomes	18
The appeal process	18
Coming back onto the Register	18
Deferral	19
Keeping us up-to-date	19
Communicating with employers	19
<b>Putting your CPD profile together</b>	<b>20</b>
The purpose of each part of the profile	20
Writing the summary of your practice history	20
Writing your statement	20
Using your personal development plan	20
Using the standards	21
Your supporting evidence	22
Examples of evidence of CPD	22
Copies of documents	23
Amount of evidence needed	23
Confidentiality	23
Example profiles	24
Disabled registrants	24
Your writing style	24
Our standards for communicating in English	24
<b>Glossary</b>	<b>25</b>
<b>Appendix 1: examples of CPD activities</b>	<b>27</b>

# Introduction

## About this document

We, the Health and Care Professions Council (HCPC), have written this document for registrants who are chosen to have a continuing professional development (CPD) audit.

Throughout this document:

- ‘we’ refers to us, the Health and Care Professions Council;
- ‘you’ refers to a health and care professional on our Register;
- health and care professionals on our Register are known as ‘registrants’; and
- CPD means continuing professional development.

People who might find this document useful are:

- a registrant who is being audited;
- a registrant who is not being audited but who wants to find out more about CPD;
- a student who wants to find out more about CPD;
- a manager thinking about the CPD needs of their team and how they can help them with their CPD;
- a CPD coordinator, union representative or a representative from a professional body who wants to support registrants with their CPD;
- an employer of registrants who wants to find out more about their CPD responsibilities; or
- a person or organisation thinking about offering CPD activities to registrants.

We have also written a short guide called Your guide to our standards for continuing professional development. This contains a quick summary of the main points in this document, and may be useful if you think that

this document contains too much detail for you at this stage.

We will review this document and update it if necessary.

## CPD and HCPC registration: A summary of CPD and the audit process

You must undertake CPD to stay registered with us. We have set standards which your CPD must meet. Every time you renew your registration, you will need to confirm that you have met these standards. From 2008, whenever a profession renews its registration, we will randomly audit (check) the CPD of a proportion of registrants from that profession. The registrants randomly chosen have to send in evidence to show how their CPD meets the standards.

# CPD and your registration

## About us

We are the Health and Care Professions Council. We were created to protect the public. To do this, we keep a register of health and care professionals who meet our standards for their training, professional skills, behaviour and health.

We now also set standards for CPD. All registrants must undertake CPD to stay registered.

## Registered professions

We currently regulate the following professions.

- Arts therapists
- Biomedical scientists
- Chiropodists / podiatrists
- Clinical scientists
- Dietitians
- Hearing aid dispensers
- Occupational therapists
- Operating department practitioners
- Orthoptists
- Paramedics
- Physiotherapists
- Practitioner psychologists
- Prosthetists / orthotists
- Radiographers
- Social workers in England
- Speech and language therapists

All of the professions have at least one professional title which is protected by law, including those shown above. This means, for example, that anyone using the titles 'physiotherapist' or 'dietitian' must be registered with us. It is a criminal offence for someone to claim that they are registered with

us when they are not, or to use a protected title that they are not entitled to use. We will prosecute people who commit these crimes.

## A new responsibility

Before 2005, you may have needed to undertake CPD as part of your membership of your professional body, or as part of your job. You may not have needed to undertake CPD, but you may have been undertaking it anyway as part of your professional development. But before 2005, any CPD that you did was not linked to your registration with us.

Now that we have agreed our standards for CPD, CPD is an important part of your continuing registration. Our standards now mean that all registrants must continue to develop their knowledge and skills while they are registered.

## Background

Under the Health and Social Work Professions Order 2001, we must consult registrants, employers, professional bodies and others with an interest in how we work before we issue standards or guidance.

In 2004, we consulted on our ideas of how we would link CPD with registration. We published a document on our website, sent it out to all registrants, and held 46 meetings in 22 locations all over the UK. At each meeting, we presented our ideas and then answered any questions we were asked. Over 6,500 registrants attended the meetings and we benefited from a wide range of views and comments.

We published a summary of the responses we received from our consultation, and the decisions we had taken as a result. One of our decisions was that we needed to publish more information about CPD, particularly about the audit process. This is why we have put together this document.

## CPD and your registration

### Our standards for CPD

Our standards say that registrants must:

1. maintain a continuous, up-to-date and accurate record of their CPD activities;
2. demonstrate that their CPD activities are a mixture of learning activities relevant to current or future practice;
3. seek to ensure that their CPD has contributed to the quality of their practice and service delivery;
4. seek to ensure that their CPD benefits the service user; and
5. upon request, present a written profile (which must be their own work and supported by evidence) explaining how they have met the standards for CPD.

### Your responsibility

As a registrant, you have always been responsible for making sure you meet our standards of conduct, performance and ethics. You are now also responsible for making sure that you meet our standards for CPD.

### The role of your employer

During our consultation on CPD in 2004, many people asked whether we could make sure employers gave their staff a certain amount of time for CPD. Unfortunately the Health and Social Work Professions Order 2001 does not allow us to do this.

We believe that responsible employers will want to encourage the development of their staff. We believe that employers will benefit a great deal from supporting CPD.

We also believe that now registrants must undertake CPD to stay registered, organisations such as professional bodies (supported by information from us) will be able to put more pressure on employers and other

organisations to make sure your CPD is recognised and given a higher priority than it was given in the past.

### CPD and fitness to practise

#### CPD and competence

There is no automatic link between your CPD and your competence. This is because it would be possible (although unlikely) for a competent professional not to undertake any CPD and yet still meet our standards for their skills and knowledge. Equally, it would be possible for a registrant who was not competent to complete a lot of CPD activities but still not be fit to practise.

We have a separate process (our fitness to practise procedures) for dealing with lack of competence, and this is not linked to our powers to make sure registrants undertake CPD. (You can find out more about our fitness to practise procedures on our website at [www.hcpc-uk.org](http://www.hcpc-uk.org).)

The Health and Social Work Professions Order 2001 says that we can set standards for CPD, and we can link these standards to renewing registration. We can also take registrants off our Register if they have not met our standards for CPD (although there is a right to appeal).

#### If a CPD profile is fraudulent

Most registrants will fill in their CPD profiles honestly and accurately. As we have already said, there is not usually any link between CPD and our fitness to practise procedures. However, if a registrant provides false or misleading information in their CPD profile, we would deal with them under our fitness to practise procedures. This could lead to them being struck off the Register so that they can no longer practise. Someone who is struck off our Register cannot apply to be registered again for five years.

## CPD and your registration

**CPD, your practice, and your ongoing competence**

Above we have described how competence and CPD are not directly linked under the Health and Social Work Professions Order 2001. However, for individual professionals, there is likely to be a link between competence and CPD. When considering your CPD, and planning your CPD activities, you may consider your ongoing competence as important for your CPD. But you can be sure that we do not assess your competence, or make assumptions about your fitness to practise, based on your CPD activities.

**Audit dates**

The table to the right gives the dates of forthcoming CPD audits. After this, audits will take place every two years. If you are chosen for audit we will write to you asking you to submit a CPD profile which shows how the CPD you have undertaken over the last two years meets the standards for CPD.

Profession	Renewal notices / CPD notifications sent out	Registration end date
Physiotherapists	February 2014	30 April 2014
Arts therapists	March 2014	31 May 2014
Dietitians	April 2014	30 June 2014
Chiropodists / podiatrists	May 2014	31 July 2014
Hearing aid dispensers	May 2014	31 July 2014
Operating department practitioners	September 2014	30 November 2014
Social workers in England	September 2014	30 November 2014
Practitioner psychologists	March 2015	31 May 2015
Orthoptists	June 2015	31 August 2015
Paramedics	June 2015	31 August 2015
Clinical scientists	July 2015	30 September 2015
Prosthetists / orthotists	July 2015	30 September 2015
Speech and language therapists	July 2015	30 September 2015
Occupational therapists	August 2015	31 October 2015
Biomedical scientists	September 2015	30 November 2015
Radiographers	December 2015	29 February 2016

# Undertaking CPD

## What is CPD?

We define CPD as ‘a range of learning activities through which health professionals maintain and develop throughout their career to ensure that they retain their capacity to practise safely, effectively and legally within their evolving scope of practice’. (This definition is taken from the Allied Health Professions project, ‘Demonstrating competence through CPD’, 2002.)

Put simply, CPD is the way registrants continue to learn and develop throughout their careers so they keep their skills and knowledge up-to-date and are able to work safely, legally and effectively.

## Standards of CPD

A registrant must:

1. maintain a continuous, up-to-date and accurate record of their CPD activities;
2. demonstrate that their CPD activities are a mixture of learning activities relevant to current or future practice;
3. seek to ensure that their CPD has contributed to the quality of their practice and service delivery;
4. seek to ensure that their CPD benefits the service user; and
5. upon request, present a written profile (which must be their own work and supported by evidence) explaining how they have met the standards for CPD.

To meet our standards, you need to make your own professional decisions about the kinds of CPD activity you need to undertake to develop and improve your skills and knowledge.

## The standards in detail

In this section, we look in detail at each of our standards.

### **Standard 1 – A registrant must maintain a continuous, up-to-date and accurate record of their CPD activities.**

You can keep a record of your activities in whatever way is most convenient for you. You might choose to keep a binder or folder of papers, perhaps using a format provided by your professional body or your employer, or you could keep this record on computer.

Your record must be continuous. This means that you should regularly add to your record.

Your record must also be up-to-date. Your profile will normally concentrate on the CPD you have undertaken in the previous two years. Some of your CPD activities may have started before this, and others may carry on after the two-year period. However, you would normally focus on this two-year period.

Finally, your record should be a true reflection of the activities that you have undertaken.

Your CPD record is your own personal and complete record of your activities, and we will not ask to see it.

If you are audited, we will ask you to fill in a CPD profile. This is a form that we will provide you with. In it you must write a statement which tells us how your CPD has met our standards. When you send this to us, you must also send in supporting evidence from your personal CPD record.

The simplest way to prove that you have kept a record of your CPD is to send us, as part of your evidence, a summary of all of your CPD activities. This could be in any format you choose, but we suggest that it might be a simple table which includes the date and ‘type’ of each activity.



## Undertaking CPD

### **Standard 2 – A registrant must demonstrate that their CPD activities are a mixture of learning activities relevant to current or future practice.**

Your CPD should include ‘a mixture of learning activities’.

We do not need you to undertake a certain amount of CPD (for example, to do a number of hours or days). This is because we believe that different people will be able to dedicate different amounts of time to CPD, and also because the time spent on an activity does not necessarily reflect the learning gained from it.

Under this standard, your CPD must include a mixture of learning activities – so you should include different types of learning activity in your CPD record. See page 27 for a list of suggested learning activities.

If you filled in a CPD profile with details of only one type of activity (for example, only peer reviews or only mentoring), this would not meet this standard.

Although we expect most people’s CPD profiles to contain a good mixture of learning activities, we realise that there might be good reasons for you concentrating on a limited number of different types. For example, you might do most of your learning through just a few types of activity because:

- you have found that certain ways of learning suit you;
- a particular type of learning is most easily available in your area; or
- a particular kind of learning activity takes up a lot of your time.

As long as your CPD profile explains how:

- you planned your CPD;
- you decided what activities to do; and
- your CPD meets our standards;

it is likely that your profile will meet this standard for CPD.

Your CPD should be ‘relevant to your current or future practice’.

Your CPD should be relevant to the way you work. This means that your CPD may be very different from that which your colleagues undertake, even though you are from the same profession.

For example, if you are managing a team, your CPD may be based around your skills in appraising your team, supporting their development, and financial planning.

Equally, if you are planning to move from one type of work to another, your CPD may be a mixture of what is relevant in your current job, and activities which are helping to prepare you for your future role. Or, you may choose to concentrate most or all of your CPD on the new area of work you will be moving into.

### **Standard 3 – A registrant must seek to ensure that their CPD has contributed to the quality of their practice and service delivery.**

You should aim for your CPD to improve the way you work. Your learning activities should lead to you making changes to how you work, which improve the way you provide your service. Alternatively, your learning activities may mean that you continue to work as you did before, but you are more confident that you are working effectively.

You do not necessarily have to make drastic changes to how you work to improve the quality of your work and the way you provide your service. You may meet this standard by showing how your work has developed as your skills increase through your learning. In meeting this standard, you should be able to show that your CPD activities are part of your work, contribute to your work, and are not separate from it.

## Undertaking CPD

This standard contains the phrase ‘seek to ensure’ because making sure your CPD contributes to the quality of your work may be outside your control. For example, you could undertake activities that you think will improve your work but are not as effective as you expected. In situations like this, you need to consider and explain what further actions you could take. By doing this you will still meet this standard because you have tried to make your CPD contribute to the quality of your work.

### **Standard 4 – A registrant must seek to ensure that their CPD benefits the service user.**

Like standard 3, this standard says that you should ‘seek to ensure’ (try to make sure) because you may intend for your CPD to benefit service users, but this may not happen because of factors beyond your control. You will meet this standard as long as you have tried to make your CPD benefit service users.

Standards 3 and 4 both mean that your CPD should be driven by the quality of your work and the benefits to service users.

Who your service users are will depend on how and where you work. For many registrants, service users will be patients. However, if you work in education, your service users may be your students or the team of lecturers you manage. Similarly, if you work in management, your service users may be your team, or other teams that you are part of. If you work in research, your service users may be the people who use your research. So in this standard, ‘service user’ means anyone who is affected by your work.

We realise that it can be difficult to provide evidence that your CPD has benefited service users. For this standard, when you are choosing your CPD activities, you need to think about how your service users might benefit. If you are audited, you will need to explain how you think this has happened.

### **Standard 5 – A registrant must, upon request, present a written profile (which must be their own work and supported by evidence) explaining how they have met the standards for CPD.**

If you are chosen for audit, we will send you a CPD profile. Under this standard, you must fill the profile in, with details of how you have met the standards for CPD. You must return the profile to us, with evidence to support it, by the deadline we set. You do not have to think about meeting this standard unless you are audited.

The HCPC has no objection to registrants using templates or exemplar documents to assist them in preparing their CPD profiles, but the use of standard documents or text from profiles prepared by other registrants or third parties is inappropriate, as a CPD profile should be both a registrant's own work and a true reflection of their own CPD activity.

More information on filling in a CPD profile is given from page 20.

### **CPD activities**

We believe that CPD takes many forms, and that we should not set down exactly how registrants should learn. We also believe that registrants may already be taking part in activities they learn through, and which develop their work, but they may not call these activities CPD. We take account of many types of activity which can contribute to your development.

CPD activities could include the following.

- **Work-based learning** (for example, reflecting on experiences, considering feedback from service users, being a member of a committee and so on)
- **Professional activity** (for example, being a member of a specialist interest group, mentoring or teaching others, being an expert witness, giving presentations at conferences and so on)



## Undertaking CPD

- **Formal education** (for example, going on courses, doing research, distance learning, planning or running a course and so on)
- **Self-directed learning** (for example, reading articles, reviewing books and articles, updating your knowledge through the internet and so on)
- **Other activities** (for example, public service)

There is a fuller list of suggested learning activities on page 27 of this document.

Many people think of CPD as only being formal education (for example, going on a course). Our standards take account of the fact that a course may not be the most useful kind of CPD for all registrants, and some registrants may not have access to courses. For example, registrants in rural or remote areas may find it difficult to get access to formal courses, but our standards mean that they can undertake other types of CPD that are more useful and accessible to them.

Similarly, registrants working outside the UK may be learning and developing through the experience they gain of another health and social care system or another culture, and this may form part of their CPD. Registrants who work as locums or work in more than one place may be learning and developing as they gain experience of a variety of different employers. Our standards recognise that there are a number of ways that registrants can undertake CPD, and we do not force registrants to learn in one particular way.

### Based on learning outcomes

Our CPD process is based on the outcomes of your learning and not on a certain number of hours or points or days. You will need to make professional decisions about the kinds of activity that will be most appropriate for you.

Different registrants will have different development needs, and their CPD activities may be very different. The way you take part in CPD and the range of your CPD activities will depend on:

- the opportunities for CPD in your work;
- your profession and speciality within it;
- your personal learning needs;
- your preferred style of learning;
- how relevant particular activities are to your work; and
- the context of your work.

### Some examples of CPD activity

The examples below show how different registrants may choose to undertake different types of activity, depending on how or where they work. Your work might cover more than one of these areas.

#### Registrant working in clinical or frontline practice

- Attending a short course on new laws affecting your work.
- Appraising an article with a group of colleagues.
- Giving colleagues a presentation on a new technique.

#### Registrant working in education

- Being a member of a learning and teaching committee.
- Doing a review for a professional journal.
- Studying for a formal teaching award.

#### Registrant working in management

- Being a member of an occupational group for managers.
- Studying management modules.

## Undertaking CPD

- Supporting the development and introduction of a national or local policy.

### Registrant involved in research

- Giving a presentation at a conference.
- Being a member of a local ethics research committee.
- Considering articles for journals.

When setting our standards for CPD, we realise that registrants are already undertaking a wide range of CPD activities as part of their professional life. Our standards are not designed to increase the workload of registrants, but to recognise the activities they are already undertaking.

### A flexible process

After considering all the feedback we received, we decided that our approach to CPD should not be based simply on the number of hours undertaken each year. For this reason, we have not set a number of hours, and we do not suggest how many hours you should complete. Our standards are concerned with quality and with outcomes, not with the time that you spend on your CPD.

When setting our standards, we wanted to take account of the range of registrants registered with us, and the different ways they can undertake CPD.

We do not ‘approve’ certain CPD activities because we believe that you are in the best position to decide what type of CPD activity is most relevant to you. If we approve only certain CPD activities, you might not be able to complete other activities which could benefit your work and service users more.

### CPD schemes

Our standards mean that you could meet our requirements by taking part in a scheme run by your professional body, your employer, or any

other organisation. If you are part of a CPD scheme that:

- is useful to you;
- is relevant to your practice;
- helps you to develop; and
- has a structure that means you can meet our standards;

taking part in this scheme would be a perfectly acceptable way of meeting our standards. If you were audited, when filling in your CPD profile you would draw on the different activities that you had completed as part of the scheme.

Most CPD schemes offered by other organisations will give you the opportunity to meet our standards, and offer a useful way of structuring your activities and development. However, as we do not approve any CPD schemes, you must decide whether you are content that taking part in any scheme will make sure you meet our standards. You are still responsible for your CPD, even if you are part of a formal CPD scheme.

Alternatively, you could structure your own CPD activities without using a formal scheme. For example, you could plan your learning around your personal development plan. This may be particularly relevant if you are working in a very specialised area and feel that the CPD schemes offered by organisations are not relevant to your work. Our standards give you the flexibility to plan your own CPD in a way that suits your work, your learning needs, your preferences, and the time and resources available to you.

### Your scope of practice

When you are planning or undertaking your CPD you will need to make sure that it is relevant to your work. Similarly, to stay registered with us, you need to make sure you keep to your ‘scope of practice’.

## Undertaking CPD

Your 'scope of practice' is the area (or areas) of your profession in which you have the knowledge, skills and experience to practise lawfully, safely and effectively, in a way that meets our standards and does not present any risk to the public or to yourself.

When you are registered for the first time, this means that you meet all of our standards of proficiency for your profession. The standards of proficiency are the minimum standards for the safe and effective practice of each of the professions we regulate.

After you have been registered with us, we recognise that your scope of practice may change so that you can no longer meet all of the standards of proficiency for your profession. This may be because of specialisation in your job, a move into management, education or research, or it may be because your fitness to practise in certain areas has become 'impaired' (affected in some way). As long as you make sure that you are capable of practising safely and effectively within your scope of practice, and do not practise in areas where you are not able to do so, a changing scope of practice will not normally cause us concern.

### Example

A speech and language therapist's first job after graduating was one where she worked entirely with children. She worked in this area for nearly ten years, building up considerable expertise.

When the opportunity came to manage a team of speech and language therapists who worked with a variety of different patients, clients and users, she felt that her skills in these areas needed refreshing. With the support of her new employer, she attended training and completed private study to update her skills and make sure that she could safely extend her scope of practice, to effectively practise in her new role. These activities formed part of her CPD for that two-year period.

This shows how your CPD can prepare you for a changing scope of practice. Other registrants' CPD will reflect their current scope of practice.

Your scope of practice may change over time, and you should be aware of your scope of practice and make sure that you only practise within it. It is closely linked to your fitness to practise, but the two are not the same.

### The NHS Knowledge and Skills Framework

Although many registrants are employed by the NHS, it is very important that our systems and processes take account of the fact that many are not. So our standards for CPD are not linked with 'Agenda for Change' (which was introduced in October 2004). They are also not linked to the NHS 'Knowledge and Skills Framework'.

However, our standards for CPD work well with other frameworks. For example, 'Lifelong learning' is an important part of the Knowledge and Skills Framework and is similar in some ways to CPD. The purpose of the Knowledge and Skills Framework is to develop services, to develop people, and to improve patient care. This is exactly in line with our standards for CPD. If you are employed in the NHS, you can base your CPD on the learning needs that are identified in your development review and still meet our CPD standards. Our standards allow you to do this, but they are also suitable for registrants who do not work in the NHS.

You can download information about the Knowledge and Skills Framework from the Department of Health website at [www.dh.gov.uk](http://www.dh.gov.uk)

### CPD and clinical governance

We define clinical governance as 'a framework through which NHS organisations are accountable for continually improving the quality of their services and safeguarding high

## Undertaking CPD

standards of care by creating an environment in which excellence in clinical care will flourish'. (This definition is taken from 'Looking forward: clinical governance and the drive for quality improvement in the new NHS', G Scally and L Donaldson, British Medical Journal, issue 317, pages 61 to 65.)

An important part of good clinical governance is continuous improvement in services and care. This links to standard 3, which says that you should aim for your CPD to contribute to the quality of your work. For good clinical governance it is also vital that registrants continue to develop their professional skills and knowledge. So our CPD requirements work with clinical governance, which includes developing people, services, and improving care.

### Returners to practice

Many registrants will take a break from their work. This could be for many reasons, including maternity leave, going travelling, being a carer or being ill.

In July 2006 we put a new 'returners to practice' process into place. The process applies to professionals who want to start working again after taking a break of more than two years. Professionals in this situation need to complete a period of updating, depending on how long it has been since they last worked in their profession. More information about this process, and about the period of updating, is available on our website and in our Returning to practice publication.

If you stop working for more than two years, you should come off our Register. While you are not working and are not registered with us, you may be undertaking activities which you feel contribute to your CPD. These might be some form of contact with your profession, activities related to another job, or activities from your personal life that contribute to your

learning and development. You can keep a record of these in case you become registered again and want to use this information in the future as part of your CPD. However, while you are not registered with us, you do not have to undertake CPD.

If you want to be registered again, you will need to go through our 'returners to practice' process first. Please see our website for more information about this process.

If you stop working in the profession for less than two years, you may choose to stay on the Register. You might do this if, for example, you want to stay registered so that you can quickly return to work, or if you are not sure how long your break will be because it is due to illness. If you are chosen to be audited during this period, you can ask us to defer your CPD audit. Please see page 19 for more information.

# The audit process

## In brief

Every time you renew your registration, you are confirming that you have met our standards for CPD.

From 2008, each time a profession renews its registration, we will ask a random sample of registrants to fill in a CPD profile and return it with evidence of how they have met our standards. We will assess these profiles.

## Two years' registration

We will only audit registrants who have been registered for more than two years. We have made this decision because, although we believe that all registrants should undertake CPD throughout their careers, we also believe that registrants should be allowed at least two years on the Register to build up evidence of their CPD activities before they are audited.

This means that if you are a recent graduate, and you renew your registration for the first time, you will not be chosen for audit. Similarly, if you have had a break from work, and you have just come back onto the Register, you will not be chosen for audit the first time you renew your registration.

## Sampling registrants

Each year we propose to audit a sample of registrants' CPD, rather than checking each and every registrant. We believe that this is safe to do because we trust that registrants will take responsibility for meeting the standards of CPD.

By auditing a sample of registrants rather than all those registered with us, we will keep the audit costs down and provide better value for money for those who pay registration fees.

When the first audits took place in 2008, we audited five per cent of the first two professions to be audited (chiropractors / podiatrists and operating department practitioners). Following the positive results

of these audits, we reduced the sample size to 2.5 per cent. This percentage will be subject to review in the future.

Samples of this size will give us confidence that we have a good picture of whether registrants in general are meeting our standards or not, while keeping costs down to manageable levels. Statistics show that the larger the population we are checking, the smaller the percentage we need to sample to be confident that we have got an accurate picture.

We have chosen the levels of 5 per cent and 2.5 per cent after taking account of the number of registrants on our Register and taking expert advice on sample sizes. We will use different-sized samples if we find that the proposed percentages are not working well enough in some way. If we change our sample size, we will publish this information on our website.

## Auditing

If you are chosen for audit, we will send you a CPD profile to fill in and return by your renewal deadline date. We will also send you a reminder letter. If we do not receive your CPD profile, your registration will not be renewed.

## When we have received your profile

We will ask CPD assessors to assess your CPD profile. At least one of these assessors will be from the same profession as you.

The CPD assessors will assess your CPD profile against our standards using the assessment criteria set out in the table on pages 15, 16 and 17. They will then let us know whether, in their professional opinion, your CPD meets our standards.

While your profile is being assessed, and during any appeal that takes place, you will stay on the Register and can continue to work.



## The audit process

There are three possible outcomes at this point.

- Your profile meets the standards – you will stay on the Register. We will write to you and let you know.
- More information is needed – we will write to you and let you know what information the assessors need to decide whether you meet the standards of CPD. You will stay on the Register while you send more information to the assessors.
- Your profile does not meet the standards – the CPD assessors will then decide whether to offer you an extra three months to meet our standards of CPD or to recommend that your registration should end.

The CPD assessors will decide whether to offer you an extra three months by considering whether:

- you appear to have filled in your CPD profile honestly and accurately;
- you have met any or some of the standards; and
- within the three months, it would be possible for you to undertake CPD which would meet our standards.

If you meet several of the standards, the assessors may recommend that you are given three months to meet the remaining standards. If you have not met any of the standards, the assessors may think it is very unlikely that you would be able to meet the standards in three months, and so would recommend that your registration ends. Likewise, if your CPD profile suggests that you are not committed to CPD, the assessors may think that it is not reasonable to recommend a further three months, and will recommend instead that you should no longer be registered.

If you are given a further three months to meet our standards of CPD, we will tell you that we

will not renew your registration. (You will stay on our Register during this three months.) We will then ask you to send in a further CPD profile. If that CPD profile does not meet our standards, you will be taken off the Register.

If you are not given a further three months to meet the necessary standards, we will take you off our Register. Whatever decision the assessors reach, we will write to you with the decision, and the reasons for it. If you do not agree, you can appeal. More information about the appeal process is given on page 18 of this document.

### CPD assessors

CPD assessors play a vital role in making sure the audit process runs smoothly. They are one type of what we call ‘partners’. Other types of partner that we currently use include registration assessors, who make decisions about applications from people who trained outside the UK, and panel members who consider concerns raised about registrants.

When recruiting our CPD assessors we:

- make sure we advertise openly for the roles;
- produce a shortlist of those who have the necessary skills, knowledge and experience; and
- interview all those shortlisted to make sure we have an appropriate number of CPD assessors drawn from a range of professional backgrounds.

We then train the CPD assessors to make sure they carry out their jobs fairly. (Information about how to become a CPD assessor is on our website.)

We review the performance of CPD assessors to make sure decisions are being made consistently as far as possible.

**Assessment criteria**

<p>1. A registrant must maintain a continuous, up-to-date and accurate record of their CPD activities.</p>	<p>The registrant has not provided evidence that they have kept a record of their CPD.</p>	<p>There is some evidence that the registrant has kept a record of their CPD. For example, they have described keeping a record.</p>	<p>There is evidence that the registrant has maintained a record of their CPD activities, and as part of their supporting evidence they have sent in a brief summary of all the CPD activities they have undertaken.</p>
<p>2. A registrant must demonstrate that their CPD activities are a mixture of learning activities relevant to current or future practice.</p>	<p>The registrant has not undertaken any CPD activities. Or The registrant's CPD consists of only one type of CPD activity. Or The registrant's CPD is not relevant to their current or future practice, as described in the 'summary of practice'.</p>	<p>The registrant has undertaken two types of CPD activity, but they have not explained why they have concentrated just on those. Or There is some evidence that the registrant's CPD is relevant to current or future work, but this is not made clear.</p>	<p>The registrant's CPD includes three or more types of CPD activity. Or The registrant's CPD includes two types of CPD activity and their CPD profile has explained why they have chosen to concentrate only on those types of activity. And There is evidence that the registrant's CPD activities are relevant to their current or future practice and the link is clear in the personal statement.</p>

The audit process

<p>3. A registrant must seek to ensure that their CPD has contributed to the quality of their practice and service delivery.</p>	<p>There is no evidence that the registrant's CPD activities have improved the quality of their work, or that they have aimed for their CPD to improve the quality of their work.</p>	<p>There is some suggestion that the registrant's CPD has improved their work – improvement is hinted at in the information they have provided but they have not given any evidence to support this.</p>	<p>The registrant's personal statement shows that their CPD activities have improved the quality of their work and this is backed up with evidence. Or The registrant has shown how they believed that their CPD might improve the quality of their work, and had planned for this, but this had not been the case. The registrant's statement must show that they have considered why this has happened, and what they will do next to make sure their CPD will improve the quality of their work in the future.</p>
<p>4. A registrant must seek to ensure that their CPD benefits the service user.</p>	<p>The registrant has not provided any information which explains any benefit to service users.</p>	<p>There is limited information about how the registrant's CPD activities have benefited service users. Or The registrant has stated a benefit to service users but not given any evidence or explanation to support this.</p>	<p>The registrant has shown (through evidence provided or an explanation given) how their CPD activities have benefited service users, either directly or indirectly. Or The registrant has shown how they believed their CPD would</p>



The audit process

<p>benefit service users, but this has not been the case. The profile must show that they have considered why this has happened and what they will do next to make sure their CPD will benefit service users in the future.</p>			<p>5. A registrant must, upon request, present a written profile (which must be their own work and supported by evidence) explaining how they have met the standards for CPD.</p>
<p>The registrant must send in their profile by the deadline.                  Note: You may use templates or exemplar documents to assist you in preparing your CPD profile. However, the use of standard documents or text from profiles prepared by other registrants or third parties is inappropriate. Your CPD profile should be both your own work and a true reflection of your own CPD activity.</p>	<p>The registrant has provided a profile by the deadline but it was incomplete (for example, they said that evidence was to follow).</p>	<p>The registrant did not return their profile by the deadline.</p>	

## The audit process

### Assessing the profile

Our CPD assessors will assess your CPD profile and will make a decision against each of the standards. The assessors must be certain that you meet each of the standards.

### Assessment outcomes

The table on pages 15, 16, and 17 shows the possible outcomes after we have assessed your profile. This depends on whether you meet, partly meet or do not meet the standards.

The extent to which you meet the standards may vary from standard to standard. For example, you might meet some standards while only partly meeting others. The CPD assessors will look at your CPD profile as a whole to make a decision, which they will justify.

The CPD assessors will bear the following in mind.

- If the CPD assessors decide that you meet most of the standards, but you only partly meet some, we will normally ask you for more information so that the CPD assessors can make a decision.
- If the CPD assessors decide that you have not met one or more of the standards, we will normally write to you to explain that your CPD profile does not meet the standards.

We ask the CPD assessors to look at each CPD profile individually and to make sensible and reasoned decisions in the case of, for example, a CPD profile where most of the standards are met but one is only partly met, or where every standard is almost met. In each case, the CPD assessors will make a decision based on the information you have provided.

### The appeal process

If we think that your CPD profile does not meet our standards, and we decide that we will take you off our Register, you can appeal against this decision.

We want to run an appeals process which is fair and easy to understand, and which gives you the opportunity to tell us why you think the decision to remove you from the Register was unfair. You will stay on our Register while you are making your appeal.

If you want to appeal, you must write to us within 28 days of the date of the letter giving our decision. Your letter needs to tell us that you want to appeal and why you think our decision was wrong.

We will arrange an appeal hearing. At this hearing, a panel will look at your appeal and consider the information they are given. You can go to the appeal or ask the panel to consider the matter just by looking at the relevant paperwork. If you decide to go to the appeal, you can have a representative with you.

The panel may decide to:

- agree with you and allow you to stay on our Register;
- dismiss the appeal, so our original decision to take you off our Register will still apply; or
- ask us to assess your CPD profile again.

If you do not agree with the panel's decision, you can refer the matter to a county court in England, Wales or Northern Ireland, or to a local sheriff court in Scotland.

More detailed information about how to appeal is given in our document 'Making a registration appeal'. This is published on our website. The rules on appeals are also on our website.

### Coming back onto the Register

If we take you off our Register because you have not met our standards for CPD, we will write to you and tell you this. When we write to you, we will tell you what you need to do before you can be registered again. We have designed a process which, as far as possible:

## The audit process

- recognises the need to be fair to those who have met our standards; and
- is also fair to registrants we have taken off our Register but who wish to undertake CPD that meets our standards in the future.

We will send details of this process to you if you come off the Register.

### Deferral

We recognise that, due to unavoidable circumstances, some registrants may need to defer (put off) their audit. This may be because they cannot fill in their CPD profile as a result of illness, family circumstances or maternity leave. 'Deferral' offers those who cannot complete their CPD profiles due to circumstances beyond their control the opportunity to stay registered.

Our deferral process means that if you are chosen for audit, you can write to us and ask for a deferral. We will need evidence of the reason why you cannot fill in your CPD profile, and we will look at your situation to see whether it would be fair to you, and to the other registrants who have to fill in their profiles that year, to defer your audit. If your audit is deferred, you will automatically be chosen for audit two years later when your profession is due for renewal again.

Our deferral process makes sure, as far as possible, that although we are fair to those who cannot fill in their CPD profiles, we are still maintaining our standards and being fair to those who are audited.

If you need to apply for deferral more than once, we will check your application for deferral very carefully and will be looking for clear evidence that a deferral is absolutely necessary.

### Keeping us up-to-date

As we will write to you to tell you that you have been chosen for audit, and write to you to tell you the result of that audit, it is very important that you keep us informed if you change address.

Our online Register shows your name, registration number and the general area you work or live in. We can store your work address and your home address on our system. We can change your details so that the general area of your work address is displayed on our online Register, but we write to you at your home address. Or, we could show your home address on our online Register but write to you at your work address.

To update your details, please call our Registration Department on +44 (0)845 300 4472.

If we do not have your most recent details, we will not be able to contact you and you will not be able to renew your registration.

### Communicating with employers

We know that the time and resources employers provide for CPD is an important issue. One way that we have tackled this is by making sure our standards for CPD are flexible enough to allow registrants to design their own CPD, even if they are self-employed or have little or no formal support for their CPD activities.

We also recognise that it is very important that employers of registrants are told about their employees' responsibilities. For this reason, we hold regular events for employers throughout the UK which provide information about CPD. To find out more about how we communicate with employers about CPD, please see our website.

# Putting your CPD profile together

If you are chosen for audit, we will send you a form (the CPD profile) to fill in.

The main parts of your CPD profile will be:

- a summary of your practice history for the last two years (up to 500 words);
- a statement of how you have met our standards of CPD (up to 1,500 words); and
- evidence to support your statement.

## The purpose of each part of the profile

The **summary of your practice history** should help to show the CPD assessors how your CPD activities are linked to your work. This part of the CPD profile should help you to show how your activities are ‘relevant to your current or future work.’

Your **statement** of how you have met our standards should clearly show how you believe you meet each of our standards, and should refer to all the CPD activities you have undertaken and the **evidence** you are sending in to support your statement.

The **evidence** you send in will back up the statements you make in your CPD profile. It should show that you have undertaken the CPD activities you have referred to, and should also show how they have improved the quality of your work and benefited service users. Your evidence should include a summary of all your CPD activities. This will show that you meet standard 1. The CPD assessors should also be able to see how your CPD activities are a mixture of learning activities and are relevant to your work (and therefore meet standard 2).

## Writing the summary of your practice history

Your summary should describe your role and the type of work you do. The summary should include your main responsibilities, identify the

specialist areas you work in and identify the people you communicate and work with most.

You could base this part of your CPD profile on your job description if appropriate.

When you have written your statement about how you meet our standards for CPD (see the following explanation), you may find it helpful to go back over your summary of work, to make sure that it clearly explains how your CPD activities are relevant to your future or current work.

## Writing your statement

When you write your statement, we expect you to concentrate most on how you meet standards 3 and 4 – how your CPD activities improve the quality of your work and the benefits to service users.

Below, we have suggested how you might want to approach writing your statement.

## Using your personal development plan

We know that not all registrants have a personal development plan – you may be self-employed, or your employer may not work in this way. But if you do have a personal development plan, you may find it useful to use this as a starting point for writing your statement. If you do not already have a personal development plan, you may find it useful to develop one and to use this approach.

Most personal development plans involve identifying:

- learning needs;
- learning activities;
- types of evidence; and
- what you have learnt.

You could write a statement on how you have updated your knowledge and skills over the

## Putting your CPD profile together

last two years, and what learning needs you have met. You may find it helpful to identify three to six points that have contributed to the quality of your work.

These areas will have been identified through your personal development plan or a review of your role or performance. If you have a personal development plan, you can provide this as part of your evidence.

If you run your own private practice, and you have a business development plan or a similar document, then you may find this a useful starting point for writing your own statement.

### Using the standards

If you do not have a personal development plan, or if you would prefer to use another approach to write your statement, you could start with our standards. Using the information we have provided about our standards for CPD, write about how you have met each one. You could split your statement into sections, and dedicate each section to one of our standards.

Here, we have provided a number of questions which should help you to think about structuring your statement. (These prompt questions are based on work done by the Allied Health Professions' project 'Demonstrating competence through CPD'.)

Under each standard we have identified some main questions. These are the most important questions that your CPD profile should answer.

We have also provided extra questions. You do not need to answer all of these or to follow them exactly. But you can choose the ones that seem most useful, and use them to help you write your statement.

**To meet standard 1 – Registrants must maintain a continuous up-to-date and accurate record of their CPD activities**

Main question:

- Does your evidence include a summary sheet of all your CPD activities?

Extra questions:

- How have you kept an up-to-date and accurate record of your CPD activities?
- How did you record your CPD activities?
- Who (if anyone) approved your plan for undertaking CPD activities?

**To meet standard 2 – Registrants must demonstrate that their CPD activities are a mixture of learning activities relevant to current or future practice**

Main questions:

- What different types of learning activity have you undertaken?
- How is your CPD relevant to your work?
- What parts of your role are affected by your CPD?

Extra questions:

- How did you identify your learning needs?
- How did you decide on what CPD activities to undertake?
- How did you make sure your mix of CPD activities is appropriate to meet your needs?
- How has the mixture of learning activities been relevant to your current or future work?

**To meet Standards 3 and 4 – Registrants must seek to ensure that their CPD has contributed to the quality of their practice and service delivery and seek to ensure that their CPD benefits the service user**

## Putting your CPD profile together

Main questions:

- How have you updated your knowledge and skills over the past two years?
- How has this learning affected how you work?
- How has your learning benefited your service users?

Extra questions:

- How does your learning relate to your ability to work safely, effectively and legally?
- How does your professional development relate to your changing work?
- What aspects of your work have changed as a result of your CPD?

**To meet standard 5 – you must, upon request, present a written profile (which must be your own work and supported by evidence) explaining how you have met the standards for CPD.**

By filling in your CPD profile (if you are audited) and sending it to us on time, you are showing that you meet this standard.

The HCPC has no objection to registrants using templates or exemplar documents to assist them in preparing their CPD profiles, but the use of standard documents or text from profiles prepared by other registrants or third parties is inappropriate, as a CPD profile should be both a registrant's own work and a true reflection of their own CPD activity.

### Your supporting evidence

You do not need to send in the full record of all your CPD activities. In fact, we strongly encourage you not to send this to us. You can send us a summary of all your activities, but this summary should be only a sheet or two with a very brief list of activities and dates.

If you are chosen for audit, you need to look through your entire record of CPD activities and consider which activities best show how you have met our standards. This should be a mixture of activities that are directly linked to your current or future work, and you should consider how you can provide evidence of how these activities have improved your work, and benefited service users. In all cases, evidence of how you have planned your CPD, what activities you have undertaken, and the effects that this had on how you work and the effects on your service users, will all be helpful to the assessors.

When you put together your profile, you also need to send in evidence to back up your personal statement.

### Examples of evidence of CPD

- Your personal development plan (if you have one) could help to show that you take a structured approach to your learning and ongoing development.
- Paperwork from reviews of your role and performance provides evidence of feedback you have received and how you have responded to this.
- A business plan may identify learning needs and any action plan related to this.
- Reflections on your work, experiences and discussions with a mentor could identify benefits to the service users and provide evidence of feedback and how you have acted on this.

A more extensive list of the different types of evidence you could send to us is suggested in appendix 2 at the back of this document.

We know that it can be difficult to provide evidence for some of our standards. For example, when you are describing how your CPD has benefited the quality of your work, or benefited service users, your personal



## Putting your CPD profile together

statement may need to describe how you believe that this has happened. You may be able to back this up with evidence of, for example, an altered way of working which you think has improved the quality of your work. You may have evidence of a meeting with your manager where you discussed using new skills you had learnt, or you may have evidence of how you personally planned to make changes to systems or practices. If your record of CPD activities includes a place where you write about how you will use the knowledge you have gained, then this could be useful evidence. These types of evidence are evidence of the effects of your activities. This, alongside the evidence of your CPD activities themselves, will help to show the CPD assessors how you meet our standards.

### Copies of documents

As far as we can, we will put in place systems to keep your information safe. However, when you send items through the post, there is always the possibility that they may be lost. For this reason you should only send us copies of your supporting documents. Do not send us any original documents.

The CPD assessors may sometimes ask to see original documents. If this is the case, we will contact you to let you know, and to discuss the best way of you providing those documents.

### Amount of evidence needed

In your personal record of CPD activities you may have a large amount of evidence relating to certain activities. However, you do not need to send us all of this information. You need to look at the information you have, decide which activities show how you meet our standards, and then decide what evidence to send to us. You should refer to the assessment criteria on pages 15, 16 and 17 to make sure you have provided relevant supporting information to show how you meet each of the standards.

We do not have detailed guidelines on how much information you should send us. But you should bear in mind that the CPD assessors will need to see enough information to be sure that the CPD activity has taken place.

### Confidentiality

In all aspects of your work you must maintain patient confidentiality. This is part of your responsibility under our standards of conduct, performance and ethics.

Some of the information you want to send us may contain service users' details. If this is the case, please remove any details that could allow us to identify the service users. Your supporting evidence will normally be in the form of documents, so to maintain confidentiality you could, for example, cover any personal details before making a copy of the documents.

The issue of confidentiality becomes more complex if you are providing information in other formats (for example, an audio tape, DVD or photograph). In the case of photographs, you may be able to scan these and then mask over faces so service users cannot be identified.

If this is not possible with photographs, or if you wish to provide tapes, videos, DVDs and so on where confidentiality is not possible, make sure that, before you send the information to us, you have permission to do so from your service users or other people who could be identified from your evidence. Even if the people concerned have already given you permission to make the recording, you would also need permission to send that material to us. We do not need the consent as part of your CPD profile. (Please see our standards of conduct, performance and ethics for more information.) However, we may ask you for evidence that you got permission.

## Example profiles

You can find example CPD profiles on our website, or you can contact us to ask for copies. We asked the professional bodies for each of the professions we regulate to provide example CPD profiles. We are very grateful to the professional bodies who did this for us.

## Disabled registrants

If you are disabled, we will assess your CPD profile fairly. You do not have to tell us about your disability in your CPD profile if it is not relevant to your CPD activities.

However, if you think your disability is relevant to your CPD (for example, if part of your development is making reasonable adjustments to your work with your employer, reviewing those adjustments, and improving them) you can mention your disability in your CPD profile. This information will be seen by the CPD assessors, and the members of staff who process your profile. We will not share the information with anyone else, and we will keep this information securely and confidentially.

If you need any information from us in alternative formats (for example, in Braille or large print), please let us know. Similarly, if you would like to provide your CPD profile in an alternative format, we will be happy to accept it. Just let us know that you intend to do this so that we can make any necessary arrangements.

When you are putting your CPD profile together, you can use any reasonable adjustments that are useful to you. For example, if you normally take notes at work by dictating to an assistant, you could put your CPD profile together in the same way. If you have any questions about how you want to put your CPD profile together, please contact us.

## Your writing style

The audit process is not an assessment of how clearly or how well you can write. When a CPD assessor looks at your CPD profile, he or she will be focusing on your CPD activities and whether they meet our standards. However, it will still greatly help the CPD assessors if your writing is clear so they can easily understand the information and how you meet each of our standards. This does not mean that you need to be able to write in a particular style.

## Our standards for communicating in English

To be registered with us, you must be able to communicate in English to the standards equivalent to level 7 of the International English Language Testing System. (There is a higher standard of level 8 for speech and language therapists.) This is not part of our CPD requirements. If English is your first language, you will already meet this standard. If English is not your first language, you will normally have passed this test, or an equivalent test, when you applied for registration or started working in the profession here in the UK.

It is possible that your CPD profile could raise serious concerns not about your CPD activities, but about your ability to meet our standards for communicating in English. If this is the case, we would decide whether or not to take action through our fitness to practise process in order to protect the public. However, this is very unlikely to happen, and would not affect registrants whose first language is English. Also, if you are dyslexic, you should know that the purpose of this standard is to make sure registrants can communicate effectively, in order to work safely and effectively. It is not intended to prevent people with dyslexia from being registered.



# Glossary

<b>Audit</b>	A CPD audit is the process where we ask a random percentage of registrants who are renewing their registration to send in a profile showing how their CPD meets our standards.	<b>Deferral</b>	The process by which a registrant who cannot complete their profile puts off their CPD audit for two years.
<b>Appeal</b>	If you come off the Register because your profile does not meet our CPD standards, you can appeal against this decision. When you appeal, we will look at the decision again, with any extra information you send us, and decide whether to change our decision.	<b>Fitness to practise</b>	If someone is fit to practise, this means that they have the health and character, as well as the necessary skills and knowledge, to work in their profession safely and effectively.
<b>Clinical governance</b>	A framework through which NHS organisations must continually improve the quality of their services, and maintain high standards of care, by creating an environment in which care will flourish.	<b>Health and Care Professions Council</b>	A UK regulator for 16 health and care professions, set up to set standards, and protect the public.
<b>Competence</b>	Your competence is your ability to meet our standards for your professional knowledge, understanding and skills, so that you can work safely and effectively.	<b>Health and Social Work Professions Order 2001</b>	The law which created us and which gives us legal powers.
<b>Continuing professional development (CPD)</b>	A range of learning activities through which registrants maintain and develop throughout their career to make sure that they continue to be able to work safely, effectively and legally within their changing scope of practice.	<b>Hearing</b>	Proceedings at which someone's fitness to practise is considered, or our decision is appealed against.
<b>CPD assessor</b>	A partner of ours, whose role it is to assess CPD profiles against the CPD standards.	<b>Lapsed (registration)</b>	When a registrant does not renew their registration, and they are then no longer on the Register, their registration is said to have lapsed.
		<b>Partner</b>	Partners work as agents of ours. They provide the expertise we need to make decisions, and make sure we have good professional and public input into what we do. Partners include registration assessors (who assess applications from health and care professionals who trained outside the UK), panel members (who sit at hearings to decide on registrants' fitness to practise) and CPD assessors (who assess CPD profiles).

<b>Portfolio</b>	This name is sometimes used for a registrant's personal and complete record of their CPD activity. This can be kept in whatever format is most useful for the registrant, and will not be looked at or inspected by us.	<b>Revalidation</b>	fees, and make a professional declaration, so that their registration continues for another two-year period. Each profession regulated by us renews its registration once every two years. Our CPD audit process is linked to registration renewal.
<b>Professional body</b>	Each of the professions regulated by us has a professional body, membership of which is voluntary. Professional bodies may deal with supporting their members, promoting the profession, developing best practice, and continuing education.	<b>Returners to practice</b>	The process whereby a registered professional is regularly assessed to make sure that they are fit to practise. (This is not the same as CPD, which is concerned with ongoing development and learning.)
<b>Profile</b>	The information that a registrant being audited sends to us to show that they meet the standards for CPD.	<b>Scope of practice</b>	Health and care professionals who have been out of practice for a period of time and who want to re-join their profession.
<b>Protected title</b>	A title like 'physiotherapist', 'chiropracist' or 'dietitian' which can only be used by someone on our Register. Anyone who is not registered with us who uses a protected title may be prosecuted and fined £5,000. For a full list of protected titles, please see our website at <a href="http://www.hcpc-uk.org">www.hcpc-uk.org</a>	<b>Struck off</b>	The term used for the area of someone's profession in which they have the knowledge, skills and experience to work safely and effectively, in a way that meets our standards and does not present any risk to the public or to the registrant.
<b>Register</b>	A published list of registrants who meet our standards. This is available online at <a href="http://www.hcpc-uk.org">www.hcpc-uk.org</a>		When a registrant is removed from our Register as the result of a fitness to practise hearing.
<b>Renewal</b>	The name of the process where professionals on our Register pay their registration		

# Appendix 1: examples of CPD activities

This list should give you an idea of the kinds of activity that might make up your CPD. It is based on work done by the Allied Health Professions' project 'Demonstrating competence through CPD'.

## Work-based learning

- Learning by doing
- Case studies
- Reflective practice
- Audit of service users
- Coaching from others
- Discussions with colleagues
- Peer review
- Gaining and learning from experience
- Involvement in the wider work of your employer (for example, being a representative on a committee)
- Work shadowing
- Secondments
- Job rotation
- Journal club
- In-service training
- Supervising staff or students
- Visiting to other departments and reporting back
- Expanding your role
- Significant analysis of events
- Filling in self-assessment questionnaires
- Project work
- Evidence from learning activities undertaken as part of your progression on the NHS Knowledge and Skills framework

## Professional activities

- Involvement in a professional body
- Membership of a specialist interest group
- Lecturing or teaching
- Mentoring
- Being an examiner
- Being a tutor
- Branch meetings
- Organising journal clubs or other specialist groups
- Maintaining or developing specialist skills (for example, musical skills)
- Being an expert witness
- Membership of other professional bodies or groups
- Giving presentations at conferences
- Organising of accredited courses
- Supervising research
- Being a national assessor
- Being promoted

## Formal / educational

- Courses
- Further education
- Research
- Attending conferences
- Writing articles or papers
- Going to seminars
- Distance learning
- Going on courses accredited by a professional body
- Planning or running a course

Appendix 1: examples of CPD activities

**Self-directed learning**

- Reading journals or articles
- Reviewing books or articles
- Updating your knowledge through the internet or TV
- Keeping a file of your progress

**Other**

- Public service
- Voluntary work

## Appendix 2: examples of evidence

This list should encourage you to think about how you can provide evidence of your CPD. It is based on work done by the Allied Health Professions' project 'Demonstrating competence through CPD'.

### Materials you may have produced

- Information leaflets
- Case studies
- Critical reviews
- Adapted students' notes
- Policies or position statements
- Discussion documents
- Procedural documents
- Documents about national or local processes
- Recent job applications
- Reports (for example, on project work, clinical audits reviews and so on)
- Business plans
- Procedures
- Guidance materials
- Guidelines for dealing with service users
- Course assignments
- Action plans
- Course programme documents
- Presentations you have given
- Articles for journals
- Questionnaires
- Research papers, proposals, funding applications,
- Induction materials for new members of staff
- Learning contracts
- Contributions to the work of a professional body
- Contributions to the work of a special-interest group

### Materials showing you have reflected on and evaluated your learning and work

- Adapted documents arising from appraisals, supervision reviews and so on
- Documents about following local or national schemes relating to CPD
- Evaluations of courses or conferences attended
- Personal development plans
- Approved claims for credit for previous learning or experience

### Materials you have got from others

- Testimonies
- Letters from service users, carers, students or colleagues
- Course certificates

Park House  
184 Kennington Park Road  
London SE11 4BU

tel +44 (0)845 300 6184  
fax +44 (0)20 7820 9684  
[www.hcpc-uk.org](http://www.hcpc-uk.org)

**This document is available in  
alternative formats and Welsh  
on request.  
Call +44 (0)20 7840 9806  
or email [publications@hcpc-uk.org](mailto:publications@hcpc-uk.org)**



MIX  
Paper from  
responsible sources  
FSC® C105395

© Health and Care Professions Council 2012  
Publication code: 20060602cPOLPUB  
(updated March 2014)

This publication is produced using trees from sustainable forests and recycled fibre.



---

Information for registrants

# Continuing professional development and your registration

# Contents

## **Section 1 – Introduction 3**

About this document 3

About us 3

## **Section 2 – Summary 4**

CPD and registration 4

Meeting the CPD standards 4

If you are audited 4

## **Section 3 – About the CPD standards 5**

What is CPD? 5

CPD standards 5

A flexible approach based on outcomes 5

The role of employers 5

CPD and fitness to practise 6

## **Section 4 – Meeting the standards 7**

The standards in more detail 7

CPD schemes 9

## **Section 5 – The audit process 11**

The audit process in summary 11

The audit process in more detail 12

## **Section 6 – Putting your CPD profile together 15**

The profile in summary 15

Writing your statement 15

Supporting evidence 15

## **Section 7 – More information 17**

### **Glossary 18**

### **Appendix 1: Examples of CPD activities 19**

### **Appendix 2: Examples of evidence 20**

### **Appendix 3: Assessment criteria 21**



# Introduction

## About this document

We have written this document to provide information and guidance to registrants about our requirements for continuing professional development (CPD).

All registrants must meet our standards for continuing professional development. We carry out audits every time a profession renews its registration to make sure that our standards are being met.

## How this document is structured

- Section one provides information about the HCPC.
- Section two provides a summary of our requirements for registrants.
- Section three explains more about the CPD standards and why we have them.
- Section four explains how you can meet the CPD standards.
- Section five explains what happens if you are audited.
- Section six provides guidance about completing a CPD profile.
- Section seven gives contact details for more information.

## Language

Throughout this document:

- ‘health and care professional’ or ‘registrant’ refers to a professional on our Register;
- ‘service user’ refers to anyone who uses or is affected by a registrant’s practice;
- ‘the standards’ refers to the CPD standards;
- ‘we’ or ‘us’ refers to the Health and Care Professions Council (HCPC); and
- ‘you’ or ‘your’ refers to a registrant.

## About us

We are a regulator and were set up to protect the public. To do this, we keep a register of professionals who meet our standards for their professional skills and behaviour. Individuals on our register are called ‘registrants’.

We currently regulate 15 professions:

- Arts therapists
- Biomedical scientists
- Chiropodists / podiatrists
- Clinical scientists
- Dietitians
- Hearing aid dispensers
- Occupational therapists
- Operating department practitioners
- Orthoptists
- Paramedics
- Physiotherapists
- Practitioner psychologists
- Prosthetists / orthotists
- Radiographers
- Speech and language therapist

## Section 2 – Summary

This section summarises our requirements for registrants.

### CPD and registration

- CPD is the way in which you continue to learn and develop throughout your career so you keep your skills and knowledge up to date and are able to practise safely and effectively.
- CPD is not only formal courses but any activity from which you learn and develop.
- CPD is a requirement of your registration, so you need to meet our CPD standards to stay registered.
- Complete a CPD profile explaining how you have met the CPD standards and send it to us by the deadline.
- Provide supporting evidence with your CPD profile to show us that you have carried out CPD which meets the standards. Don't forget to include a dated list of all the activities you have carried out since you last renewed your registration. Explain any gaps in your CPD of three or more consecutive months.

### Meeting the CPD standards

You need to do the following.

- Carry out regular CPD and keep a record of what you do in the way that is most convenient for you.
- Carry out different kinds of learning activities.
- Think about how your CPD might improve your practice and benefit your service users.
- Take part in an audit if we ask you to. We audit a random sample of each profession at every renewal.

### If you are audited

You will only form part of the sample picked for audit if you have been registered for two years or more. If you are picked for audit, you need to do the following.

- Renew your registration by completing the professional declarations and paying the registration fee (as you normally would).

# Section 3 – About the CPD standards

This section provides more information about the CPD standards and why we have them.

## What is CPD?

CPD is the way in which registrants continue to learn and develop throughout their careers so they keep their skills and knowledge up to date and are able to practise safely and effectively.

CPD is not just formal courses. A CPD activity is any activity from which you learn and develop. This might include the following.

- **Work-based learning.** For example, reflecting on experiences at work, considering feedback from service users or being a member of a committee.
- **Professional activity.** For example, being involved in a professional body or giving a presentation at a conference.
- **Formal education.** For example, going on formal courses or carrying out research.
- **Self-directed learning.** For example, reading articles or books.

We have provided a longer list of possible CPD activities in appendix 1. It is not a full list and there may be other activities not listed that still help you to learn and develop and which can be part of your CPD.

## CPD standards

CPD is linked to registration, so you need to meet our CPD standards to stay registered. There are five CPD standards.

A registrant must:

1. maintain a continuous, up-to-date and accurate record of their CPD activities;
2. demonstrate that their CPD activities are a mixture of learning activities relevant to current or future practice;

3. seek to ensure that their CPD has contributed to the quality of their practice and service delivery;
4. seek to ensure that their CPD benefits the service user; and
5. upon request, present a written profile (which must be their own work and supported by evidence) explaining how they have met the Standards for CPD.

In section four we explain what you need to do to meet each standard.

## A flexible approach based on outcomes

We have developed our approach to CPD to be flexible enough to take account of the range of different health and care professionals registered with us, different working roles and learning needs and variation in registrants' access to certain types of CPD.

We do not set a number of hours or points that you have to complete and we do not 'approve' or 'endorse' any CPD activities. Instead we want you to identify your development needs and choose appropriate activities to help you meet them. We are much more interested in the outcomes of your learning and how this has benefited your practice and the service users you work with.

This means that you can plan your CPD based on the kinds of activities that are most relevant to you and your practice.

## The role of employers

We regulate individual health and care professionals and do not have any role in regulating employers. So, the CPD standards are a personal responsibility that all registrants have to meet to stay registered with us.

However, responsible employers will want to encourage the learning and development of their employees to make sure employees stay

### Section 3 – About the CPD standards

on the Register. We communicate regularly with employers to make sure that they are aware of the standards and what they mean for their employees.

#### **CPD and fitness to practise**

CPD is linked to registration and we can remove you from the Register if you do not meet our CPD standards.

We have a separate process (our fitness to practise process) for dealing with concerns about the conduct and competence of our registrants.

Although there is no direct link to the fitness to practise process, our standards for CPD are all about making sure you continue to learn and develop so that you can stay fit to practise and improve your practice for the benefit of your service users.

# Section 4 – Meeting the standards

This section provides more information about how you can meet the standards. There is more information about the audits in section five.

## The standards in more detail

We have taken each standard below and explained what it means.

### **Standard 1: A registrant must maintain a continuous, up-to-date and accurate record of their CPD activities**

#### **What the standard means**

- You need to carry out regular CPD activities – you can find examples of these in appendix 1.
- You need to keep a record of what you do in whatever way is most convenient for you.
- You need to add to your record on an ongoing basis. If you are audited, we will be interested in what you have done over the previous two years (the length of each registration cycle).
- Your record needs to be a true reflection of the activities that you have carried out.

#### **Keeping your record**

We do not ask for a set format for recording your CPD. You might choose to keep a binder or folder including documents such as certificates and notes that you have kept relating to your CPD, or you might keep this record electronically. You might follow a format provided by your professional body or by your employer. Please make sure that you can access your record – for example, in case you leave your employer.

This is your personal record. We will not ask to see a complete copy, but if you were audited, we would ask you to give us details of the activities you have completed over the previous two years and send us

some supporting evidence. So keeping a good record will mean that you can do this easily. You can find examples of the types of evidence you might want to keep in appendix 2.

### **Standard 2: A registrant must demonstrate that their CPD activities are a mixture of learning activities relevant to current or future practice**

#### **What the standard means**

- Your CPD must include a mixture of different types of learning.
- Your CPD must relate to your registration and practice as a health and care professional.

#### **Mixture of activities**

Your CPD must include a mixture of different types of learning. This means that you need to carry out at least two different types of learning activity. In practice, most registrants will carry out many different types of learning while registered with us. We have provided a longer list of possible CPD activities in appendix 1.

If you were audited and had only carried out one type of learning – for example, if you had only read professional journals but had not carried out any other kind of learning – you would not meet this standard.

#### **Your practice**

Your CPD must be relevant to your current or future practice. This means that your CPD should be related in some way to your registration as a health and care professional.

Your CPD will be relevant to your practice so will be individual to you. For example, if you are managing a team, some of your CPD might be based around your skills as a manager. If you work in private practice, some of your CPD might be about the skills you need to run a successful practice.

## Section 4 – Meeting the standards

Your CPD can also support your career development. So some or all of your CPD might be about preparing you for a future role.

If you have an annotation on the Register (for example, in prescribing), we would particularly encourage you to consider whether you need to complete some CPD activities to keep up to date in this area of practice.

You are able to make your own decisions about the CPD that is most beneficial to you, your practice and your future career ambitions.

### Interactive activities

There is some developing evidence that suggests that the most effective learning activities are often those that are ‘interactive’ and which encourage ‘self-reflection’. For example, ‘peer discussion’ is a term used to describe opportunities to discuss practice issues with groups of professional colleagues. Although this is not a specific requirement, we would encourage you to look for opportunities to learn and reflect on your practice with others.

### Standard 3: A registrant must seek to ensure that their CPD has contributed to the quality of their practice and service delivery

#### What the Standard means

- You should aim for your CPD to improve the way you work.
- If you were audited, we would ask you to tell us about some of the activities you have carried out, what you learnt and how this has improved your practice.

#### Quality of practice and service delivery

Your CPD should lead to you making changes to how you work which improves the service that you provide.

You do not necessarily have to make drastic changes to how you work. Some CPD activities might mean that you continue to

work as you did before, but that you are more confident that you are working effectively. Others might help you gain new or improved skills or help you to make changes to working practices.

### ‘Seek to ensure’

We use the term ‘seek to ensure’ in standard 3 because there may be some instances where the CPD activity you carried out to improve your practice is not as effective as you thought it would be. You cannot always anticipate the actual benefits of CPD activity. The important thing is to consider why the activity was not as helpful as you thought it would be, and how you might do things differently in future. As long as you can explain this if asked, you will still meet this standard.

### Standard 4: A registrant must seek to ensure that their CPD benefits the service user

#### What the standard means

- You should aim for your CPD to benefit your service users.
- If you were audited, we would ask you to tell us about some of the activities you have carried out, what you learnt and how this has benefited your service users.

#### Benefits the service user

For the purposes of this standard, we define a ‘service user’ as anyone who uses your services or is affected by your work.

Who your service users are will depend on how and where you work. For example:

- if you are in ‘front line’ or laboratory-based practice, your service users might include patients, clients, carers, other professionals and others you provide services to;

## Section 4 – Meeting the standards

- if you work in education, your service users might include your students; and
- if you are a manager, your service users might include the team that you manage.

The above is not a full list, so you will need to think about who your service users are.

Your CPD should lead to benefits for your service users. These benefits do not need to be radical and in many cases may simply be a result of improvements you have made to your practice. For example, a CPD activity has improved your practice because you have gained new skills, and as a result you are able to provide a better service to your service users. This standard is asking you to think about how your CPD has benefited those who you work with and who are affected by your practice.

### ‘Seek to ensure’

We use the phrase ‘seek to ensure’ in standard 4 because you might carry out a CPD activity to provide benefits to service users, but find that it is not as helpful as you had expected. As long as you think about why the activity was not useful and what you might do in future instead, and can explain this if asked, you will still meet this standard.

### Third-party feedback

Asking for, receiving and reflecting on feedback from service users and peers can help improve practice and help to identify future learning needs.

Although this is not a specific requirement, we would encourage you to ask for and reflect on feedback from service users and others if you are able to. This feedback can also be a useful piece of evidence to support the fact that you have met standard four (see section six).

## **Standard 5: A registrant must, upon request, present a written profile (which must be their own work and supported by evidence) explaining how they have met the Standards for CPD**

### **What the standard means**

- You only need to meet this standard if you are one of the registrants picked as part of a random sample for audit.
- You need to take part in the audit by sending us a CPD profile containing information and evidence about how you have met the standards.
- The CPD profile must be your own work.

We explain more about taking part in an audit and completing a CPD profile in sections five and six.

### **Your own work**

If you are audited, the CPD profile must be your own work. A profile which was written by someone else, or included text from profiles produced by others, would not meet this standard.

If we suspect that a CPD profile is not your own work but, for example, includes plagiarised material, we would stop the assessment process and investigate this under our fitness to practise process.

This does not mean that you cannot ask a colleague for help and we would encourage you to discuss your CPD audit with your colleagues if you feel you need help.

### **CPD schemes**

As our standards are based on outcomes, there are lots of different ways in which you might meet them.

You could meet our requirements by choosing to take part in a scheme run by your professional body, your employer or any other



Section 4 – Meeting the standards

organisation. Most CPD schemes will give you the opportunity to meet our standards and offer a useful way of structuring and recording your CPD activities.

As we do not approve any CPD schemes, you still need to make sure that you are content that taking part in a scheme will allow you to meet our standards. If you were audited, you would draw on the different activities that you had completed as part of the scheme to demonstrate how you have met our standards.

Our CPD standards are also complementary to CPD frameworks which are sometimes published by service providers or by professional bodies and which link learning and development to career development and progression.

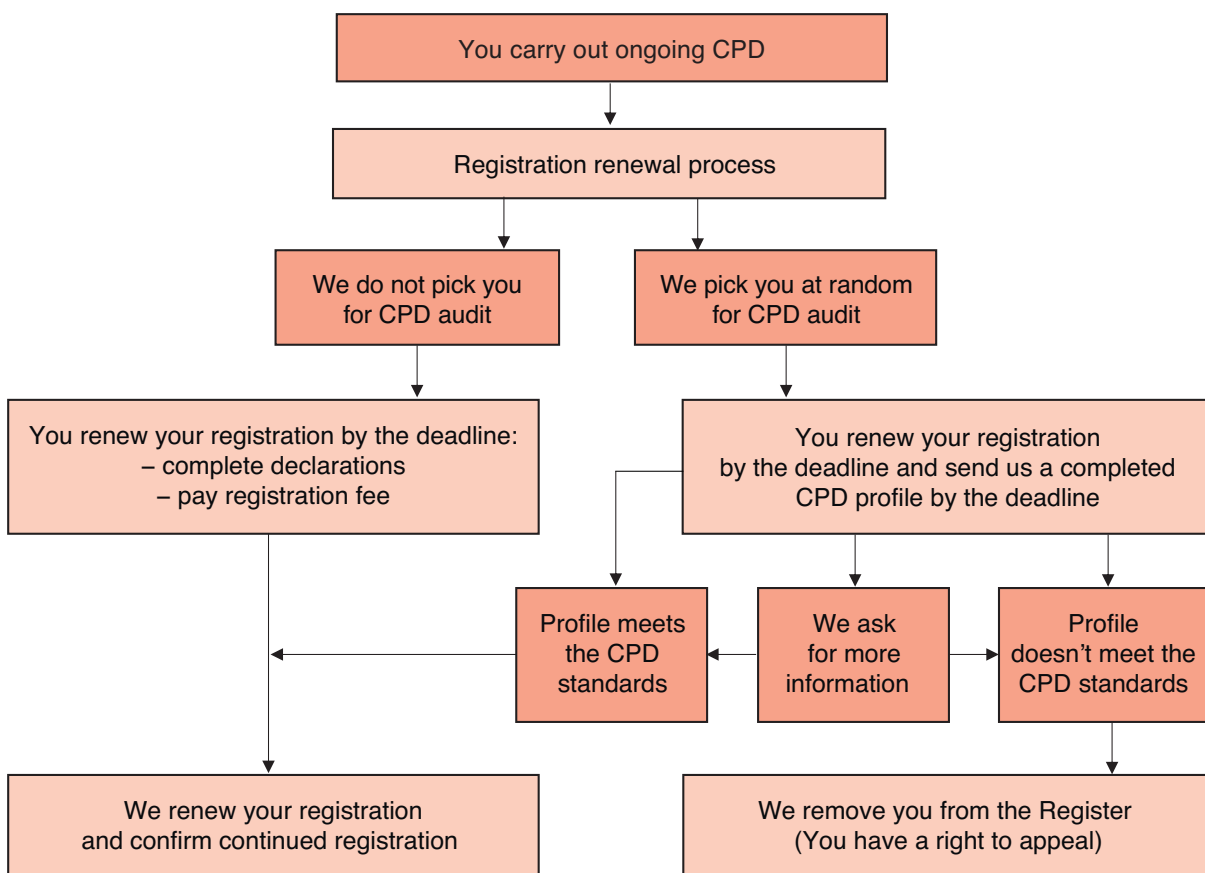


# Section 5 – The audit process

This section explains more about the audit process. If we pick you as part of the random sample for audit, we will send you information about exactly what you need to do.

## The audit process in summary

The following is a simple summary of the audit process.



## Section 5 – The audit process

### The audit process in more detail

#### Selection for audit

Each profession renews its registration every two years. When you renew your registration, we ask you to complete a declaration to confirm that you have met our standards, including the standards for CPD.

We audit a random sample of 2.5 per cent of registrants in each profession at every renewal and ask these individuals to send us information and evidence that they have met the CPD standards. We review this percentage regularly and we may change it in the future.

We will only audit registrants who have been registered for two years or more. This means that if you are a recent graduate, we will not choose you for audit when you renew your registration for the first time. Similarly, if you have had a break in registration and have just come back onto the Register, we will not choose you the first time you renew your registration.

The audit selection is computer-generated at random. As CPD is an ongoing requirement while you are registered, it is possible that you could be picked for audit on multiple occasions.

#### Completing the audit

If you are picked as part of the random sample for audit, we will send you information about completing your CPD profile. You will need to complete and send us your profile by your renewal deadline date. If circumstances mean that you cannot take part in an audit, you can make a request to defer your audit (see page 14).

You will have approximately three months in which to complete and send us your profile. We will also remind you approximately one month before the deadline. You can find examples of completed CPD profiles on our website.

If you do not send us a CPD profile or any information we ask for as part of the audit process, we may remove you from the Register. You would be able to appeal this decision (please see page 13).

You also need to renew your registration as you normally would – by completing the renewal declarations and paying the registration fee. If you do not renew your registration, we will remove you from the Register.

We may not be able to assess your profile by the end of your registration cycle. If that happens and you have completed your renewal, we will renew your registration in the normal way so that you can continue to practise. We will then continue to assess your profile.

#### When we have received your profile

When we receive your completed profile, we will check that it is complete (for example, that you have included some evidence). If something is missing, we will ask you for the missing information.

We will ask CPD assessors to assess your CPD profile against the standards. CPD assessors are registrants we appoint and train to assess profiles, and at least one of them will be from the same profession as you. In appendix 3, we have broken down each standard into ‘assessment criteria’ so you can see what meeting and not meeting a standard might look like.

While we are assessing your profile (and if you were to appeal against any decision) you will continue to stay registered and can continue to practise.

#### Assessment outcomes

Once we have assessed your profile, there are three possible outcomes.

- **Your profile meets the standards.**  
We will contact you and let you know.

## Section 5 – The audit process

- **We ask you for more information.**  
We will contact you and let you know what information we need to decide whether you meet the CPD standards.
- **Your profile does not meet the standards.**

If your profile does not meet the standards, the CPD assessors will then decide whether or not to offer you extra time (up to an extra three months) to meet the standards. We will normally ask you for more information before we make this decision.

The CPD assessors will decide whether to offer you extra time by considering whether:

- you have made a reasonable attempt to provide a complete CPD profile;
- you have met some of the standards; and
- with extra time it would be possible for you to meet the standards.

You are very likely to be offered extra time if it is clear to the assessors that you are committed to CPD but for whatever reason have struggled to meet some of the CPD standards fully.

If we give you extra time to meet the standards, we will contact you to tell you what we need you to do and by when. This might include, for example, carrying out further CPD or completing a new profile. You will need to send us the information we ask for which we will then assess.

If you do not meet the standards, we will remove you from the Register. Whatever decision we reach, we will let you know our decision and the reasons for it.

### Making an appeal

If we decide that your CPD profile does not meet our standards, or you have not taken part in or completed the audit process, and we decide to remove you from the Register, you can appeal against this decision. You will

be able to tell us why you think this decision is wrong.

We will let you know exactly what you need to do and by when. If you make an appeal, you will stay on the Register until a decision has been made. Your appeal will be considered by an appeal panel. You can choose to go to an appeal hearing or ask for your appeal to be considered on the documents that you send to the panel.

The appeal panel can decide to:

- agree with you and allow you to stay registered;
- dismiss the appeal, so our original decision to take you off the Register stands; or
- ask us to assess your CPD profile again.

If you do not agree with the panel's decision, you can appeal to the County Court in England, Wales or Northern Ireland or to a local Sheriff Court in Scotland.

### Coming back onto the Register

If we decide that your CPD profile does not meet our standards, or you have not taken part in or completed the audit process, and we remove you from the Register, you will be able to apply to us to be registered again in the future.

To come back onto the Register, you will need to apply for 'readmission'. We will ask you for more information about why you previously came off of the Register and about the CPD you plan to carry out if you are registered again. We will then consider this information before making a final decision about your application. If we re-register you, we will include you in the next CPD audit for your profession.

You can find more information about applying for readmission on our website.

## Section 5 – The audit process

### **Deferral**

If we pick you as part of the random sample for audit, but you cannot take part because of your circumstances, you can ask us to defer your audit. This might be because of a serious illness, a bereavement or maternity leave.

We will ask you to send us evidence of why you cannot take part. We will want to make sure that deferring your audit will be fair to you and to the other registrants who have been audited. If your audit is deferred, you will be automatically picked for audit when your profession next renews its registration.

It is your choice about whether to apply for deferral. For example, you may feel that you are able to take part in an audit even if you have been on maternity leave or sick leave for a significant part of the two-year registration cycle. If this is the case, you could choose to take part in the audit and make your circumstances clear in your profile

# Section 6 – Putting your CPD profile together

This section provides a brief summary of what we will need from you if we pick you as part of the random sample for audit.

If we do pick you for audit, we will give you more information about what we need you to do, how and by when. This information includes information about the reasonable adjustments we can put in place if you are disabled.

You can find out more in ‘How to complete your Continuing Professional Development profile’ available on our website. You can also find sample CPD profiles for each profession which show you different ways of completing your profile and meeting the standards.

## The profile in summary

The profile has four parts.

- **Summary of your practice history (up to 500 words).** In this section, we ask you to describe your current role and the type of work you do. We ask for this information so that we can assess whether your CPD is relevant to your current or future practice (standard two).
- **A statement of how you have met the standards (up to 1,500 words).** In this section, we ask you to draw on the CPD activities you have carried out to show us how you meet the standards.
- **A dated list of the CPD activities you have carried out since you last renewed your registration.**
- **Supporting evidence.** We ask you to give us evidence which shows that the CPD activities you have written about in the profile have taken place.

## Writing your statement

In your statement, you will be concentrating most on telling us how you meet standards three and four – how your CPD activities

improve the quality of your work and benefit service users.

One way to complete your statement is to choose four to six CPD activities you have carried out and for each one describe:

- what the activity was;
- what you learnt; and
- how you think the activity improved the quality of your work and benefited your service users.

You can choose to tell us about the activities which you think benefited you the most and for which you have some supporting evidence. Writing your statement in this way can be a clear and simple way of showing us how you have met the standards.

However, there is more than one way of completing your statement so this is only a suggestion. Other ways might include using your professional development plan or similar (if you have one) or structuring your statement around each of the CPD standards.

## Supporting evidence

You need to send us the following evidence.

- **A dated list of all the CPD activities you have carried out in the last two years** (since you last renewed your registration). This shows us that you have carried out CPD and kept a record (standard one).

Your dated list might be something you produce as a result of the audit, looking at your personal CPD record, or might be something you can produce automatically if you are using an electronic record-keeping system.

Your CPD record must be ‘continuous’ (standard one) but we recognise that CPD activities may not be evenly spaced out during your registration cycle. If you have a gap in your CPD activities of three or more

## Section 6 – Putting your CPD profile together

consecutive months, please explain why in your statement. Some activities may take place over a period of time rather than on a specific date. If this is the case, you should state the start and end date in your list of activities.

- **Evidence which shows that the CPD you have written about in the profile has taken place.** You might also provide evidence (if available) of the benefits of your CPD to your practice and service users.

We will look for evidence that the activities you have written about in your statement have taken place. So for example, if you have told us about five activities in your statement, we would expect to see five pieces of supporting evidence.

Appendix 2 at the back of this document provides a list of the different types of evidence you might send us. This could include evidence such as course certificates, as well as evidence you have produced yourself, for example, notes from reading professional journals.

You can also send us evidence of the benefits of your CPD. For example, you may have evidence of a meeting with your manager where you discussed using new skills you had learnt, or you may have evidence of how you personally planned to make changes to systems and practices. But we recognise that for some activities, evidence like this might not be possible. So you should make sure that you explain clearly in your statement what you learnt from an activity and what you think the benefits were and why.

## Section 7 – More information

Our website: [www.hcpc-uk.org/registrants/cpd](http://www.hcpc-uk.org/registrants/cpd) contains more information, including:

- guidance on putting a CPD profile together;
- sample CPD profiles;
- the HCPC biennial CPD audit reports; and
- CPD frequently asked questions.

If you have any questions about this document, please contact us. You can contact us at:

Registration Department  
Health and Care Professions Council  
Park House  
184 Kennington Park Road  
London  
SE11 4BU

Phone: +44 (0)300 500 4472

Email: [registration@hcpc-uk.org](mailto:registration@hcpc-uk.org)

# Glossary

<b>Appeal</b>	If you do not meet the CPD standards, or you have not taken part in or completed the audit process, and we tell you that we will remove you from the Register, you can ask us to reconsider the decision by making an appeal.	<b>Professional body</b>	Each of the professions we regulate has at least one professional body. Professional bodies may support their members, promote the profession and develop best practice.
<b>Audit</b>	A CPD audit is the process where we ask a sample of registrants who are renewing their registration to send in a profile showing how their CPD meets our standards.	<b>Profile</b>	If you are audited, this is the information you send to us to show how you meet the standards for CPD.
<b>Continuing professional development (CPD)</b>	CPD is the way in which you continue to learn and develop throughout your career so you keep your skills and knowledge up to date and are able to practise safely and effectively.	<b>Readmission</b>	The process by which someone who was registered in the past can apply to be registered again.
<b>CPD assessor</b>	A registrant we have appointed to assess CPD profiles against the CPD standards.	<b>Registrant</b>	A health and care professional who is registered by us.
<b>Deferral</b>	If you cannot complete your profile, deferral is the process where you are allowed to put off your CPD audit until your profession next renews its registration.	<b>Renewal</b>	The process by which professionals on our Register make a professional declaration and pay their registration fees, so that they can continue to be registered. Each profession renews its registration every two years.
<b>Fitness to practise</b>	When we say that a registrant is 'fit to practise', we mean that they have the skills, knowledge and character to practise their profession safely and effectively.  Fitness to practise is also the name of the process we follow when we consider concerns about the practice or behaviour of a registrant.	<b>Service user</b>	For the purposes of the standards for CPD, a service user is someone who uses or is affected by a registrant's practice.



# Appendix 1: Examples of CPD activities

This list should give you an idea of the kinds of activities that might make up your CPD. (This list has been adapted from work done by the Allied Health Professions' project 'Demonstrating competence through CPD' (2003).)

## Work-based learning

- Learning by doing
- Case studies
- Reflective practice
- Audit of service users
- Coaching from others
- Discussions with colleagues
- Peer review
- Gaining and learning from experience
- Involvement in the wider, profession-related work of your employer (for example, being a representative on a committee)
- Work shadowing
- Secondments
- Job rotation
- Journal club
- In-service training
- Supervising staff or students
- Expanding your role
- Significant analysis of events
- Filling in self-assessment questionnaires
- Project work

## Professional activities

- Involvement in a professional body, specialist-interest group or other groups
- Lecturing or teaching
- Mentoring

- Being an examiner
- Being a tutor
- Organising journal clubs or other specialist groups
- Maintaining or developing specialist skills (for example, musical skills)
- Being an expert witness
- Giving presentations at conferences
- Organising accredited courses
- Supervising research or students
- Being a national assessor

## Formal and educational

- Courses
- Further education
- Research
- Attending conferences
- Writing articles or papers
- Going to seminars
- Distance or online learning
- Going on courses accredited by a professional body
- Planning or running a course

## Self-directed learning

- Reading journals or articles
- Reviewing books or articles
- Updating your knowledge through the internet or TV
- Keeping a file of your progress

## Other

- Relevant public service or voluntary work

# Appendix 2: Examples of evidence

This list should give you an idea of the kinds of evidence of your CPD you could provide. (This list has been adapted from work done by the Allied Health Professions' project 'Demonstrating competence through CPD' (2003).)

## Materials you may have produced

- Information leaflets
- Case studies
- Critical reviews
- Policies or position statements
- Documents about national or local processes
- Reports (for example, on project work or audits or reviews)
- Business plans
- Procedures
- Guidance materials
- Guidelines for dealing with service users
- Course assignments
- Action plans
- Course programme documents
- Presentations you have given
- Articles for journals
- Questionnaires
- Research papers, proposals, funding applications
- Induction materials for new members of staff
- Learning contracts
- Contributions to the work of a professional body
- Contributions to the work of a special-interest group

## Materials showing you have reflected on and evaluated your learning and work

- Adapted documents arising from appraisals, supervision reviews and so on
- Documents about following local or national schemes relating to CPD
- Evaluations of courses or conferences you have been to
- Personal development plans
- Approved claims for credit for previous learning or experience

## Materials you have got from others

- Testimonials
- Letters from service users, carers, students or colleagues
- Course certificates

# Appendix 3: Assessment criteria

## Assessment criteria

Standard	Standard not met	Standard partly met	Standard met
1. A registrant must maintain a continuous, up-to-date and accurate record of their CPD activities.	You have not provided evidence that you have kept a record of your CPD.	There is some evidence that you have kept a record – for example, you have described keeping a record.	There is evidence that you have kept a record of your CPD activities. You have included a dated list of all the CPD activities you have carried out. If there is a gap of three or more months, you have explained why.
2. A registrant must demonstrate that their CPD activities are a mixture of learning activities relevant to current or future practice.	You have not carried out any CPD activities. Or Your CPD consists of only one type of learning activity. Or Your CPD is not relevant to your current or future practice.	There is some evidence that your CPD is relevant to current or future work, but this is not made clear.	Your CPD includes at least two types of learning activity. And Your CPD activities are relevant to your current or future practice.

Appendix 3: Assessment criteria

**Assessment criteria**

Standard	Standard not met	Standard partly met	Standard met
<p>3. A registrant must seek to ensure that their CPD has contributed to the quality of their practice and service delivery.</p>	<p>You have not provided any information which shows that you have thought about how your CPD activities might have improved the quality of your work.</p>	<p>There is some suggestion that your CPD has improved your work but this is not clear.</p>	<p>Your personal statement explains how your CPD activities have improved the quality of your work. Or You have explained how you believed that your CPD would improve the quality of your work but this has not been the case. You have explained why this was and what you will do in the future.</p>
<p>4. A registrant must seek to ensure that their CPD benefits the service user.</p>	<p>You have not provided any information which explains any benefit to service users.</p>	<p>There is limited information or explanation about how your CPD activities have benefited service users.</p>	<p>Your personal statement explains how your CPD activities have benefited your service users. Or You have explained how you believed that your CPD would benefit your service users but this has not been the case. You have explained why this was and what you will do in the future.</p>

Appendix 3: Assessment criteria

**Assessment criteria**

Standard	Standard not met	Standard partly met	Standard met
<p>5. A registrant must, upon request, present a written profile (which must be their own work and supported by evidence) explaining how they have met the Standards for CPD.</p>	<p>You did not complete a profile and send it to us by the deadline.</p>	<p>You have provided a profile but it is incomplete (for example, the evidence is missing).</p>	<p>You have sent in a completed profile by the deadline.</p>

Park House  
184 Kennington Park Road  
London SE11 4BU

tel +44 (0)300 500 6184  
fax +44 (0)20 7820 9684  
www.hcpc-uk.org

**To request this document in Welsh  
or an alternative format,  
email [publications@hcpc-uk.org](mailto:publications@hcpc-uk.org)**



**RECYCLED**  
Paper made from  
recycled material  
FSC® C012830

© Health and Care Professions Council 2017  
Publication code: 20060602cPOLPUB (updated June 2017)  
This publication is produced using trees from sustainable forests.



---

Your duties as an education provider

# Standards of education and training

# Contents

**Introduction 1**

**Level of qualification for entry to  
the Register 2**

**Programme admissions 4**

**Programme governance, management  
and leadership 5**

**Programme design and delivery 7**

**Practice-based learning 8**

**Assessment 9**



# Introduction

This document sets out the standards of education and training (SETs). These are the standards against which we assess education and training programmes.

A programme which meets the SETs allows a learner who successfully completes that programme to meet the standards of proficiency for their profession. They are then eligible to apply to the Health and Care Professions Council (HCPC) for registration.

We conduct approval visits to education providers to assess their programmes against the SETs. If a programme meets the SETs we will normally grant open-ended approval, subject to ongoing monitoring.

Annual monitoring is a documentary process used to determine whether a programme continues to meet the SETs. If any changes are made which significantly affect a programme, we consider these through our major change process to make sure that the SETs continue to be met.

We have produced detailed guidance on the SETs, which is intended to give more information about the meaning and intention of the standards and what our expectations will be when we assess and monitor education and training programmes against them. This guidance can be found on our website.

We have also produced supplementary information documents for education providers when preparing for an approval visit, completing annual monitoring submissions, or making significant changes to programmes. These documents, which can also be found on our website, give more information about the processes we use to assess and monitor programmes against the SETs.

# Level of qualification for entry to the Register

- 1.1 The Council normally expects that the threshold entry routes to the Register will be the following.

Bachelor degree with honours for:

- biomedical scientists (with the Certificate of Competence awarded by the Institute of Biomedical Science, or equivalent);
- chiropodists / podiatrists;
- dietitians;
- occupational therapists;
- orthoptists;
- paramedics;
- physiotherapists;
- prosthetists / orthotists;
- radiographers; and
- speech and language therapists.

Diploma of Higher Education for operating department practitioners.

Foundation degree for hearing aid dispensers.

Masters degree for:

- arts therapists;
- clinical scientists (with the Certificate of Attainment awarded by the Association of Clinical Scientists, or equivalent);
- forensic psychologists (with the award of the British Psychological Society qualification in forensic psychology, or equivalent);
- health psychologists (with the award of the British Psychological Society qualification in health psychology, or equivalent);

- occupational psychologists (with the award of the British Psychological Society qualification in occupational psychology, or equivalent); and
- sport and exercise psychologists (with the award of the British Psychological Society qualification in sport and exercise psychology, or equivalent);

Professional doctorate for clinical psychologists.

Professional doctorate, or equivalent for:

- counselling psychologists; and
- educational psychologists.

# Programme admissions

- 2.1 The admissions process must give both the applicant and the education provider the information they require to make an informed choice about whether to take up or make an offer of a place on a programme.
- 2.2 The selection and entry criteria must include appropriate academic and professional entry standards.
- 2.3 The admissions process must ensure that applicants have a good command of English.
- 2.4 The admissions process must assess the suitability of applicants, including criminal conviction checks.
- 2.5 The admissions process must ensure that applicants are aware of and comply with any health requirements.
- 2.6 There must be an appropriate and effective process for assessing applicants' prior learning and experience.
- 2.7 The education provider must ensure that there are equality and diversity policies in relation to applicants and that they are implemented and monitored.

# Programme governance, management and leadership

- 3.1 The programme must be sustainable and fit for purpose.
- 3.2 The programme must be effectively managed.
- 3.3 The education provider must ensure that the person holding overall professional responsibility for the programme is appropriately qualified and experienced and, unless other arrangements are appropriate, on the relevant part of the Register.
- 3.4 The programme must have regular and effective monitoring and evaluation systems in place.
- 3.5 There must be regular and effective collaboration between the education provider and practice education providers.
- 3.6 There must be an effective process in place to ensure the availability and capacity of practice-based learning for all learners.
- 3.7 Service users and carers must be involved in the programme.
- 3.8 Learners must be involved in the programme.
- 3.9 There must be an adequate number of appropriately qualified and experienced staff in place to deliver an effective programme.
- 3.10 Subject areas must be delivered by educators with relevant specialist knowledge and expertise.
- 3.11 An effective programme must be in place to ensure the continuing professional and academic development of educators, appropriate to their role in the programme.
- 3.12 The resources to support learning in all settings must be effective and appropriate to the delivery of the programme, and must be accessible to all learners and educators.
- 3.13 There must be effective and accessible arrangements in place to support the wellbeing and learning needs of learners in all settings.
- 3.14 The programme must implement and monitor equality and diversity policies in relation to learners.

- 3.15 There must be a thorough and effective process in place for receiving and responding to learner complaints.
- 3.16 There must be thorough and effective processes in place for ensuring the ongoing suitability of learners' conduct, character and health.
- 3.17 There must be an effective process in place to support and enable learners to raise concerns about the safety and wellbeing of service users.
- 3.18 The education provider must ensure learners, educators and others are aware that only successful completion of an approved programme leads to eligibility for admission to the Register.

# Programme design and delivery

- 4.1 The learning outcomes must ensure that learners meet the standards of proficiency for the relevant part of the Register.
- 4.2 The learning outcomes must ensure that learners understand and are able to meet the expectations of professional behaviour, including the standards of conduct, performance and ethics.
- 4.3 The programme must reflect the philosophy, core values, skills and knowledge base as articulated in any relevant curriculum guidance.
- 4.4 The curriculum must remain relevant to current practice.
- 4.5 Integration of theory and practice must be central to the programme.
- 4.6 The learning and teaching methods used must be appropriate to the effective delivery of the learning outcomes.
- 4.7 The delivery of the programme must support and develop autonomous and reflective thinking.
- 4.8 The delivery of the programme must support and develop evidence-based practice.
- 4.9 The programme must ensure that learners are able to learn with, and from, professionals and learners in other relevant professions.
- 4.10 The programme must include effective processes for obtaining appropriate consent from service users and learners.
- 4.11 The education provider must identify and communicate to learners the parts of the programme where attendance is mandatory, and must have associated monitoring processes in place.

# Practice-based learning

- 5.1 Practice-based learning must be integral to the programme.
- 5.2 The structure, duration and range of practice-based learning must support the achievement of the learning outcomes and the standards of proficiency.
- 5.3 The education provider must maintain a thorough and effective system for approving and ensuring the quality of practice-based learning.
- 5.4 Practice-based learning must take place in an environment that is safe and supportive for learners and service users.
- 5.5 There must be an adequate number of appropriately qualified and experienced staff involved in practice-based learning.
- 5.6 Practice educators must have relevant knowledge, skills and experience to support safe and effective learning and, unless other arrangements are appropriate, must be on the relevant part of the Register.
- 5.7 Practice educators must undertake regular training which is appropriate to their role, learners' needs and the delivery of the learning outcomes of the programme.
- 5.8 Learners and practice educators must have the information they need in a timely manner in order to be prepared for practice-based learning.



# Assessment

- 6.1 The assessment strategy and design must ensure that those who successfully complete the programme meet the standards of proficiency for the relevant part of the Register.
- 6.2 Assessment throughout the programme must ensure that learners demonstrate they are able to meet the expectations of professional behaviour, including the standards of conduct, performance and ethics.
- 6.3 Assessments must provide an objective, fair and reliable measure of learners' progression and achievement.
- 6.4 Assessment policies must clearly specify requirements for progression and achievement within the programme.
- 6.5 The assessment methods used must be appropriate to, and effective at, measuring the learning outcomes.
- 6.6 There must be an effective process in place for learners to make academic appeals.
- 6.7 The education provider must ensure that at least one external examiner for the programme is appropriately qualified and experienced and, unless other arrangements are appropriate, on the relevant part of the Register.

# Notes

Standards of education and training 11

# Notes



Park House  
184 Kennington Park Road  
London SE11 4BU

tel +44 (0)300 500 6184  
fax +44 (0)20 7820 9684  
www.hcpc-uk.org

**To request this document in Welsh  
or an alternative format,  
email [publications@hcpc-uk.org](mailto:publications@hcpc-uk.org)**



**RECYCLED**

Paper made from  
recycled material

**FSC® C012830**

© Health and Care Professions Council 2017

Publication code: 20120801POLSETS (amended June 2017)

This publication is produced using trees from sustainable forests.



Department of  
**Health, Social Services  
and Public Safety**

[www.dhsspsni.gov.uk](http://www.dhsspsni.gov.uk)

## Improving Health and Well-being Through Positive Partnerships

### A Strategy for the Allied Health Professions in Northern Ireland 2012 - 2017





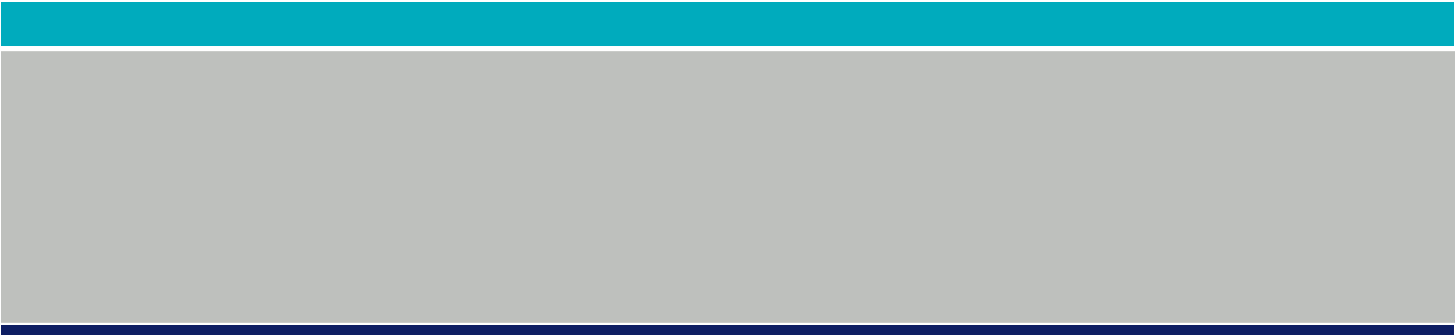




# Contents

	Page Number
<b>A Message from the Minister</b>	<b>1</b>
<b>Foreword by the Lead Allied Health Professions Officer</b>	<b>3</b>
<b>Executive Summary</b>	<b>5</b>
<b>Introduction</b>	<b>10</b>
Role of the AHPs	10
Care Context	15
Aim and Scope	17
Strategy Vision and Values	18
Strategy Format	20
Policy Context	21
<b>Strategic Theme 1 Promoting Person-centred Practice and Care</b>	<b>23</b>
<b>Strategic Theme 2 Delivering Safe and Effective Practice and Care</b>	<b>32</b>
<b>Strategic Theme 3 Maximising Resources for Success</b>	<b>38</b>
<b>Strategic Theme 4 Supporting and Developing the AHP Workforce</b>	<b>46</b>
<b>Where do we go from here?</b>	<b>54</b>
<b>Appendix 1 AHP Disciplines within the Scope of the Strategy</b>	<b>56</b>
<b>Appendix 2 Summary of Action Points</b>	<b>59</b>
<b>Appendix 3 Membership of the Steering Group</b>	<b>69</b>
<b>Abbreviations and Glossary of Terms</b>	<b>71</b>
<b>Bibliography</b>	<b>76</b>
<b>References</b>	<b>78</b>







## A Message from the Minister

I am pleased to publish this document 'Improving Health and Well-being through Positive Partnerships: A Strategy for the Allied Health Professions in Northern Ireland'.

AHPs make a difference to people's lives, whether it be giving our children the best start in life, preventing diseases through health promotion or supporting through rehabilitation and re-ablement those, who through illness or disability, are unable to look after themselves as they would wish. Placing the service user at the heart of the design and delivery of AHP practice and care is crucial to achieving the vision and values in this strategy and to ensuring the best possible outcomes for them.

The diversity and wide-ranging nature of the AHP disciplines and their practices creates additional challenges for the planning, design and delivery of AHP practices to ensure individuals have access to the right person in the right place at the right time. This strategy outlines how we can achieve this by making best use of our AHP workforce.

Whilst we face challenges in the immediate future on the financial front, the examples in this strategy demonstrate how AHPs have met, and can continue to meet, my key objectives by delivering prevention and early intervention measures, helping avoid unnecessary hospital attendances and admissions, driving up the quality of services, improving outcomes and enhancing patient experience.

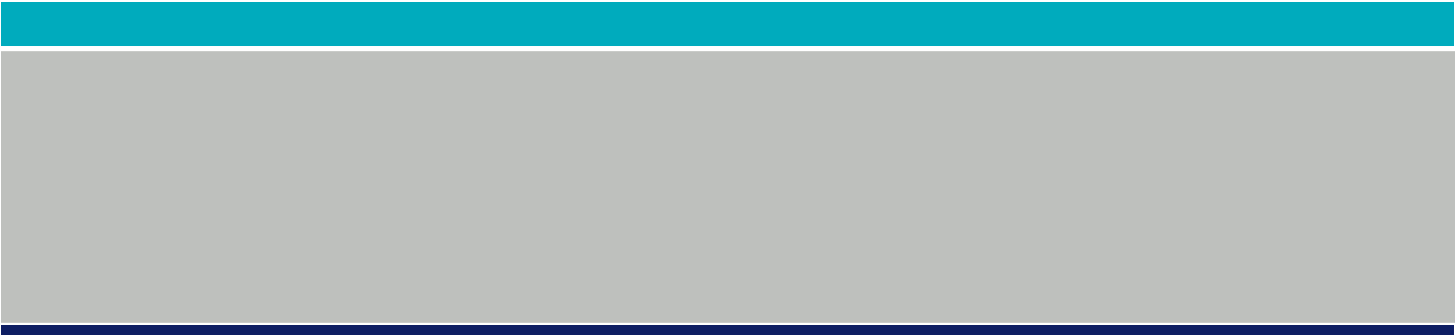
The increasing demand for AHP services requires that those in leadership roles ensure the skills are in place to enable the AHP workforce to meet the challenges of implementing new models of practice and care.

I am confident that through positive partnerships we can all maximise outcomes for patients and their carers using AHP resources to enhance people's lives and deliver services that are safe, timely, effective and focused on the needs of the population.

**Edwin Poots, MLA**

Minister of Health, Social Services and Public Safety







## Foreword by the Lead Allied Health Professions Officer

The Allied Health Professions (AHP) in Northern Ireland consist of 12 distinct and unique disciplines. AHPs play key roles and add critical value across the full spectrum of primary and secondary prevention, diagnosis, treatment and care.

As Lead AHP Officer I wish to acknowledge the valuable contribution of all those who contributed to the development of this Strategy be that as Steering Group Members or those who engaged in workshops, meetings or focus groups. In particular we must also remember our late colleague Patricia Blackburn for her specific contribution to this Strategy.

**'Improving Health and Well-being Through Positive Partnerships'** sets out a high level road map for the development of the AHP workforce and to support the commissioning and delivery of AHP practices to enhance the health and social well-being of the population in Northern Ireland. Key to the success of this Strategy will be positive partnerships with service users and carers, other health professionals, commissioners, education and other agencies.

The Strategy is based around four Strategic Themes which, whilst generic and wide-ranging in nature, when taken together set out an overall approach for the development of AHP services and workforce to achieve the Strategy's vision. Key areas within specific themes e.g. leadership and education, span all four themes whilst being described in detail under the most relevant theme.

New models of practice and care across all sectors provide challenges for everyone including AHPs. To meet these challenges this requires continued innovation and modernisation in how AHP practices are commissioned, designed and delivered.

I am confident that as AHPs we are ready to make our contribution to these challenges through positive partnerships and this Strategy will support us in achieving this.

*Pauline Mulholland*

**Pauline Mulholland**  
Lead AHP Officer, DHSSPS







## Executive Summary

The purpose of the Strategy is to provide a framework to guide the Department of Health, Social Services and Public Safety (DHSSPS), the Health and Social Care Board (HSCB), the Public Health Agency (PHA) and Health and Social Care Trusts in designing, delivering, reviewing and integrating models of care, as well as providing opportunities for learning and development that will help Allied Health Professionals (AHPs) and therapy support workers deliver high quality outcomes for service users.

This Strategy has been written for the AHP workforce, irrespective of the discipline or care sector within which individuals work. Its aim is to provide a high level road map for the AHPs for the next 5 years. It focuses on the roles and responsibilities of the AHP workforce at all levels and how these can be developed to enhance the planning and delivery of AHP practices that support the health and social well-being of the population of Northern Ireland. Twelve professions are covered by this Strategy<sup>i</sup>:

- Art Therapists
- Dietitians
- Drama Therapists
- Music Therapists
- Occupational Therapists
- Orthoptists
- Orthotists
- Physiotherapists
- Podiatrists
- Prosthetists
- Radiographers – Diagnostic and Therapeutic
- Speech and Language Therapists



<sup>i</sup> Further details of the AHP disciplines covered in the Strategy can be found at Appendix 1.

## Executive Summary

Given the diversity of the AHP disciplines and the wide-ranging nature of AHP practices, the Strategy does not seek to address in detail what services are provided to service users or how they are delivered. Instead it focuses on the approach to care outlining how, by implementing key actions at strategic, organisational and individual levels, the AHP workforce can meet the challenges of planning and delivering high quality services that are person-centred, safe, fit for purpose and provide good value for money.

The AHP workforce has an increasingly crucial part to play in optimising and supporting the health and well-being of our population through:

- undertaking roles in health promotion, health improvement, diagnosis, early detection and early intervention;
- supporting service users to avoid illnesses and complications; enhancing rehabilitation and re-ablement to maximise independence;
- supporting people of all ages to manage long term conditions;
- contributing to physical and sensory disability services, mental health and learning disability services and palliative and end of life care; and
- providing essential support to children and young people living with complex disabilities, their families and carers.

This Strategy reflects the value that is added by AHPs in optimising the health and social well-being of service users and highlights the importance of appropriately facilitating their involvement (either uni-professionally or inter-professionally) in the design, delivery, review and integration of models of care.

The Strategy has been written primarily for AHPs working in the statutory sector, however the principles, values and good practice outlined throughout this Strategy will also be applicable to AHPs not employed directly by Health and Social Care (HSC), including those working in the voluntary, community and independent sectors and in education. For such individuals the Strategy,





including the key actions at organisational and individual levels, should be read in the context of their own organisation and circumstances.

The Strategy sets out a vision for the development of the AHP workforce which is: *that by continuing to work in partnership with colleagues, other professionals, other agencies and, most importantly, service users of all ages, families and carers; AHPs will actively enhance people's lives through the planning and delivery of high quality and innovative diagnostic, treatment and rehabilitation services and practices that are safe, timely, effective and focused on the service user.*

This vision is underpinned by a series of core values which together support the delivery of the best possible outcomes for service users, their families and carers. The vision and values are applicable regardless of the care setting within which therapists and therapy support staff work.

The Strategy is based around 4 Strategic Themes which reflect and support the Strategy's vision and values. These themes are:

- Promoting person-centred practice and care;
- Delivering safe and effective practice and care;
- Maximising resources for success; and
- Supporting and developing the AHP workforce.



By their nature these are broad themes that are applicable to each of the 12 AHP disciplines covered by this Strategy. A number of key areas have been identified within each strategic theme together with associated key actions through which the strategic themes can be delivered. Each key action has been assigned to one of three levels of responsibility – Strategic, Organisational or Individual. A summary of the key actions is set out in Appendix 2 of the Strategy.

Strategic Theme 1 – “**Promoting Person-centred Practice and Care**” – places the service user at the heart of the design and delivery of AHP services and highlights the importance of personal and public involvement in developing AHP practices that take due cognisance of the needs of service users. This section also highlights the need for the AHP workforce to work in partnership with



## Executive Summary

service users, their families, carers, HSC colleagues, other professionals and organisations, as well as the wider community, to design and develop practices and relationships that are fit for purpose and enhance the service user's experience and outcomes. This strategic theme also acknowledges the role of AHPs in supporting people to manage their own health and well-being.

Strategic Theme 2 – “**Delivering Safe and Effective Practice and Care**” – outlines the importance of effective governance and accountability arrangements to achieve and assure safe and effective care. All AHPs who work within HSC, as well as those in the independent, voluntary and community sectors have an individual responsibility to ensure the delivery of high quality care that is safe, effective and focused on the service user, and to promote excellence and continuous improvement. This section outlines how effective risk assessment and clear accountability processes can support the delivery of quality care.

In Strategic Theme 3 – “**Maximising Resources for Success**” – the importance of innovation and modernisation in how AHP practices are designed and delivered is explored. Innovation and modernisation includes examining existing models of care to identify what is essential, what can be delivered more effectively and what is no longer sustainable, appropriate or necessary based on new evidence and best practice. This means considering how and what AHP services can best be developed and improved to deliver optimum outcomes that are focused on the assessed and agreed needs of service users. The crucial role of AHP leadership in driving forward innovation and modernisation is also considered.

The development of the AHP workforce is explored in Strategic Theme 4 – “**Supporting and Developing the AHP Workforce**”. This section highlights the importance of a motivated, influential, patient-focused, appropriately trained, highly skilled and flexible AHP workforce. It considers how workforce planning, learning and development can support the development of an AHP workforce that is responsive to current and future demand in terms of number and composition, as well as ensuring that therapists and therapy support workers have the knowledge, skills and competencies to deliver high quality services that are fit for purpose and meet service needs.



The concluding section - “**Where Do We Go From Here?**” - outlines how the Strategy will be taken forward and implemented across the AHP workforce. It proposes the establishment of a Regional Implementation Steering Group with a remit to ensure that the actions set out within the Strategy are progressed.

A key role of the Regional Implementation Steering Group will be to develop a Regional AHP Strategy Implementation Plan within an agreed timeframe for approval by a DHSSPS Implementation Board. The Implementation Plan will include detailed actions at an operational level, together with appropriate milestones, targets and associated timescales. The Implementation Plan will also detail the monitoring and accountability arrangements for taking forward the approach and key actions set out in the Strategy.



# Introduction

## Role of AHPs

1. Allied Health Professionals (AHPs) are a diverse group of clinicians working in a range of disciplines to deliver treatment and care to service users<sup>ii</sup> across a wide range of services in a variety of different settings and across all age groups. AHPs play key roles and add critical value across the full spectrum of primary and secondary prevention, diagnosis, treatment and care. At March 2011 there were 4,022 therapists and therapy support staff working in the Health and Social Care (HSC) workforce in Northern Ireland (3,391 WTE).
2. As specialist clinicians and clinical leaders, AHPs are vital to the delivery of high quality, people focussed services. In addition to their core clinical roles of early detection, assessment, diagnosis, treatment, discharge and rehabilitation, AHPs help people to navigate the journey out of hospital and back to home, to return to work and to participate in community life. AHPs also have an essential role in addressing health inequalities through designing and communicating important public health promotion and prevention messages to service users, carers and other partners working both with individuals and the wider community in doing so.
3. Through both leading and working within multi-disciplinary teams, AHPs have a unique contribution to make to the health and well-being of children and adults in Northern Ireland. This includes early intervention and prevention of disease and disability; applying diagnostic skills and expertise to promote early detection of disease or disability which in turn informs appropriate response and treatment; enhancing independence by helping and empowering people to maintain their functionality and supporting self management for people with long term conditions; and providing service users and their carers with strategies that can help them adapt to and manage disability.

10

ii Throughout this Strategy the use of “service user” should also be taken to mean “people”, “patient” or “client”. It may also include family and carers where appropriate.



4. Twelve professions are covered by this Strategy:

Art Therapists  
 Dietitians  
 Drama Therapists  
 Music Therapists  
 Occupational Therapists  
 Orthoptists  
 Orthotists  
 Physiotherapists  
 Podiatrists  
 Prosthetists  
 Radiographers – Diagnostic and Therapeutic  
 Speech and Language Therapists

- **Art Therapists**

Provide a psychotherapeutic intervention which enables service users to effect change and growth by the use of art materials to gain insight and promote the resolution of difficulties.

- **Dietitians**

Assess, diagnose and treat diet and nutrition problems at an individual and wider public health level. Dietitians translate public health and scientific research on food, health and disease into practical guidance to enable people to make appropriate lifestyle and food choices.

- **Drama Therapists**

Encourage service users to experience their physicality, to develop an ability to express the whole range of their emotions and to increase their insight and knowledge of themselves and others.

- **Music Therapists**

Use music, with an individual or group of service users, to improve functioning and develop potential in a number of skill areas impaired by disability, illness or trauma. These areas include communication, physical, emotional, mental, social and cognitive skills. Music therapy aims to



# Introduction

achieve a better quality of life for clients through prevention, rehabilitation or treatment.

- **Occupational Therapists**  
Promote health and well-being through occupation. The primary goal of occupational therapy is to enable service users to participate in the activities of everyday life. Occupational therapists achieve this outcome by working with service users and communities to enhance their ability to engage in the occupations they want to, need to, or are expected to do; or by modifying the occupation or the environment to better support their occupational engagement.
- **Orthoptists**  
Diagnose and treat eye movement disorders and defects of binocular vision.
- **Orthotists**  
Design and fit orthoses (callipers, braces etc.) which provide support to part of a patient's body, to compensate for paralysed muscles, provide relief from pain or prevent physical deformities from progressing.
- **Physiotherapists**  
Physiotherapists use a holistic approach in the preventative, diagnostic and therapeutic management of disorders of movement or optimisation of function, to enhance the health and well-being of the community from an individual or population perspective. Physiotherapy practice has the exercise of clinical judgement and informed interpretation, underpinned by best available evidence, at its core. It encompasses a diversity of clinical specialities to meet the unique needs of service user groups with varying health status.
- **Podiatrists**  
Assess the vascular, neurological and orthopaedic status of the service users lower limbs to, diagnose and treat diseases and conditions affecting the feet. Podiatrists focus on relieving symptoms and maintaining functional independence.



- **Prosthetists**

Provide care and advice on rehabilitation for service users who have lost or who were born without a limb, fitting the best possible artificial replacement.

- **Radiographers – Diagnostic and Therapeutic**

Diagnostic Radiographers employ a range of imaging techniques to produce high quality images of injury or disease, often interpreting the images so that correct treatment can be provided. They undertake diagnostic work and independent reporting as part of a multi-disciplinary team and are a key part of the delivery of acute as well as community-based services. Early diagnosis is a vital step in care pathways and the delivery of any subsequent treatment.

Therapeutic radiographers are the only health professionals qualified to plan and deliver radiotherapy in the treatment of cancer. They manage the care pathway through the many radiotherapy processes, providing care and support for service users throughout their treatment.

- **Speech and Language Therapists**

Speech and Language Therapists (SLTs) are concerned with the management of speech, language, communication and swallowing in children and adults. SLTs contribute to the delivery of specialist, targeted and universal services to service users and their families. They reduce long term demands on services by addressing immediate needs that arise from circumstances as well as needs that arise from underlying impairment. SLTs also provide training for the wider workforce.

5. AHPs are graduates who are statutorily regulated by the Health Professions Council (HPC) which holds an individual register for each of the allied health professions. They are autonomous practitioners from the point of registration. Therapy support workers play an important role in supporting AHPs to deliver front-line services and care for services users.



## Introduction

6. References to the AHP “workforce” within this Strategy should be taken to include therapists and therapy support workers in the HSC as well as those employed by the voluntary, community, education and independent sectors.
7. AHPs are an integral part of an increasingly corporate approach to the planning and delivery of health and social care, often working as leaders or members of multi-disciplinary teams with other professionals to provide high quality, integrated services within the primary, community and secondary care sectors. They also interact with a wide range of other services and agencies within and outside the Health and Social Care sector, providing professional expertise and advice to ensure that service users receive timely and accurate support as part of an integrated and co-ordinated approach to service provision.
8. Increasing demand for the skills and expertise of AHPs across care pathways - from health prevention and promotion, detection and diagnosis through to rehabilitation and re-ablement - requires that robust AHP leadership and influence are employed in the analysis and implementation of best practice, utilising skill and grade mix. This will ensure having AHPs with the right skills in the right place at the right time, for the benefit of all those who use their services. The services provided by the AHP workforce must take cognisance of the views and where appropriate be influenced by service users, who should be at the centre of all care planning discussions. The AHP leadership should constantly review the roles and responsibilities of the workforce to ensure that the services and care they provide, often on a clinically prioritised basis, are responsive to need and provide positive outcomes for service users.
9. In reading this Strategy, reference should be made to the definitions of the responsibilities of AHP roles as outlined in the Glossary.





## Care Context

10. AHPs and therapy support workers work within a constantly changing environment both in terms of how health and social care is provided and in the nature of the population for which services are designed and delivered.
11. In addition to the demands arising from demographic changes as the proportion of older people increases, the impact of lifestyle factors, such as smoking, poor diet and lack of exercise, is also leading to increased pressure on our health and social care services as lifestyles become less healthy, leading both directly and indirectly to health problems.
12. As children and young people are living longer with complex disabilities and chronic conditions, AHPs have an essential role to play in supporting them and their families and carers. AHPs are also increasingly focusing on supporting people of all ages and their carers in managing long term conditions as well as contributing to physical and sensory disability services, mental health and learning disability services and palliative and end of life care.
13. While the size of our population is estimated to increase over the next ten years, of greater significance to the demand for health and social care is that the average age of our population will continue to increase at a faster rate. Specifically estimates are that between 2008 and 2020:
  - The Northern Ireland population will increase by 142,000 people (8%).
  - The number of people over 75 years will increase by 40%.
14. As people get older they are more likely to develop one or more long term (or chronic) condition. As a result their need for health and social care interventions increases, placing pressure on health and social care services.
15. People's expectations are also changing and increasingly they tell us they want health and social care services with a focus on personal choice and well-being. Service users are becoming more active partners in making



# Introduction

decisions about how their health and social care is designed and delivered, with greater engagement between health and social care professionals and individuals to improve the quality and experience of care. Increasingly, service users are also taking more responsibility for their own health and the health of their family, as well as understanding the impact of their behaviours on health and well-being, especially in terms of rising rates of long term conditions.

16. The changing context of health and social care also impacts directly on how and what AHP services are delivered. Increasingly AHPs work with other health and social care professionals in areas of population health such as health promotion, health improvement and early intervention; in diagnostics and early detection, and in providing advice and support to service users to avoid illnesses and complications developing, enhance rehabilitation and reduce avoidable hospital admissions.
17. Within the context of this changing environment it is important that people receive treatment and care that are appropriate to them delivered in the right place, at the right time, by the right people. In recent years the policy of DHSSPS has been to promote the provision of a wider range of services in the community and facilitate the shift away from dependence on hospital services, with service users, their families, carers and local communities having better access to local primary care services closer to their own homes. The role of many AHPs has changed to reflect this with more services provided by AHPs as part of multi-disciplinary teams working in the community. In some instances however, for example diagnostic radiographers, their roles will continue to be mainly hospital based.
18. At a time of increasing financial pressures, meeting service user expectations and needs will require examination of the models of care delivered to identify, across the whole HSC system, where services can be improved and modernised and how they can provide added value to the public purse - for example through interventions to improve the recovery of stroke survivors or those with musculoskeletal disorders.



19. The Strategy seeks to ensure that existing HSC resources are allocated effectively and efficiently in order to maximise the outcomes for service users. This means considering what is and what is not sustainable as well as how productivity and efficiency can be improved and innovation harnessed without compromising quality and safety. Addressing these challenges will require a phased change in how care is commissioned, planned and delivered, with greater emphasis addressing health inequalities through prevention and health improvement activities and interventions.

## Aim and Scope of the Strategy

20. The Strategy has been written primarily for AHPs working in the statutory sector, however the principles, values and good practice outlined throughout this Strategy will also be applicable to AHPs not employed directly by the HSC, including those working in the voluntary, community and independent sectors and in education. In particular the principles of good governance underpinning the Strategy should be integral to the commissioning of services which are provided by AHPs working outside the statutory sector in order to ensure the delivery of safe and effective practice and care.
21. The Strategy provides a high level road map to guide the AHP workforce at all levels over the next 5 years. The breadth of its remit means that the Strategy focuses on the general roles and responsibilities of the AHP workforce and how these can be developed to enhance the planning and delivery of AHP practices that support the health and social well-being of the population of Northern Ireland. The Strategy also highlights the importance of ensuring the development of a skilled and competent workforce to meet service demand and equipped to provide innovative services across all care pathways.
22. Given the diversity of the range of AHP disciplines and the wide-ranging nature of AHP practices, the Strategy does not address the detail of services provided to service users or how they are delivered. Nor does the



# Introduction

Strategy provide a specific road map for the development of each of the 12 professions included within it. Instead it outlines an approach to the planning and delivery of practices that will support the AHP workforce in meeting the challenges of providing innovative services that are person-centred, effective, fit for purpose and provide good value for money. Examples of good practice which demonstrate the added value and positive outcomes which innovative AHP services provide are included throughout the document.

23. The purpose of the Strategy is to provide a framework to guide DHSSPS, the Health and Social Care Board, the Public Health Agency and Health and Social Care Trusts in designing, delivering, reviewing and integrating models of care, as well as providing opportunities for learning and development that will help AHPs and therapy support workers deliver high quality outcomes for service users.
24. The Strategy is the culmination of a process of consultation with key stakeholders through a series of engagement workshops, meetings and focus groups and is based on the principle that the contribution of every member of the AHP workforce is valued and that each has a part to play in ensuring the delivery of high quality care that is safe, effective and focused on service users.

## Strategy Vision and Values

25. The Strategy sets out a vision for the AHP workforce to maximise the health and social well-being of service users. In addition, it sets out a series of values to guide the actions of AHPs and therapy support workers in the delivery of treatment and care to service users, families, carers and local communities.



## Our Vision

26. Our vision *“is that by continuing to work in partnership with colleagues, other professionals, other agencies and, most importantly, service users of all ages, families and carers; AHPs will actively enhance people’s lives through the planning and delivery of high quality and innovative diagnostic, treatment and rehabilitation services and practices that are safe, timely, effective and focused on the service user.”*

## Our Values

27. Our vision will be underpinned by a set of core values which reflect the contribution that AHP services and practices make to enhance the experience of service users, and ensure the best possible outcomes and quality of life for them, their families and carers. These core values are common to all areas where AHPs are employed be that health and social care, education, voluntary and community or independent practice. These values are:

- Service users as partners;
- Supportive and integrated teamwork;
- Safe, effective and person-centred practice;
- Positive leadership and innovation; and
- Excellence in our practice through continued learning and development.



28. The vision and values set out above will support the reform and modernisation of AHP services through new ways of working and managing resources. They are applicable regardless of the care setting within which individual AHPs work and seek to ensure that through continuing self development and innovation, AHPs are equipped to meet the needs of individuals and communities in a changing society.



29. While the varying uni-professional AHP core standards, accountability and leadership structures are acknowledged, it is anticipated that every member of the AHP workforce should demonstrate these values in the way

# Introduction

in which they interact with service users, their families and carers and with colleagues. These values are reflected throughout this Strategy.

## Strategy Format

30. The structure of the Strategy has been developed around four Strategic Themes. By their nature these themes are generic and wide-ranging to encompass the different disciplines that make up the AHP workforce. It is important that the strategic themes are not considered in isolation - taken together they set out an overall approach to AHP services and the development of the AHP workforce that will support the achievement of the Strategy's vision. They are:

- Promoting person-centred practice and care;
- Delivering safe and effective practice and care;
- Maximising resources for success; and
- Supporting and developing the AHP workforce.

31. A number of Key Areas have been identified within each theme. These outline core components that together make up the theme. Included within them are a series of Actions through which the strategic themes can be delivered. These Actions have been assigned to each of three levels to ensure that there is alignment between the different levels of responsibility and clarity about how they relate to one another. These levels are:

Strategic:	DHSSPS, Public Health Agency and Health and Social Care Board;
Organisational:	HSC Trust and other service providers;
Individual:	Allied Health Professionals and therapy support workers.

32. At the Strategic level the Public Health Agency, as part of its role, provides professional advice on AHP services (in collaboration with AHP uni-professional leadership as necessary and appropriate) to the Health and Social Care Board to assist the Board in developing its commissioning strategies for services.



33. Individuals have been identified at Strategic and Organisational levels to have lead responsibility and accountability for taking forward the key actions. In doing so, it is expected that these individuals will work with and through Trust AHP Leads and uni-professional Heads of Service as appropriate.
34. At Strategic and Organisational levels the detail of accountability in the key actions relates primarily to statutory organisations and will not be directly applicable to smaller organisations.
35. At individual level, the principles of the key actions will apply irrespective of where AHPs work – be that statutory, voluntary, community, education or independent sector.

## Policy Context

36. This document has been written primarily for members of the AHP workforce at all levels and across all care sectors. It provides a strategic overview of how AHP services should be commissioned, planned and delivered, addressing major themes such as person-centred care, accountability, innovation and staff development. To this end it focuses on the approach to health promotion, early detection, diagnosis, treatment and care, rather than the operational detail of AHP services.
37. The Strategy has been developed within the context of existing legislation, guidance, policy, strategies and service frameworks in Northern Ireland, including the Department's primary care strategic framework "*Caring for People Beyond Tomorrow*" (2005)<sup>1</sup>. This has been a driver for the shift in care that has seen health and social care delivery increasingly move out of the hospital sector and into a community setting.
38. The need for the commissioning, planning and delivery of care to be focused on and responsive to service users is at the core of this Strategy. The Strategy has therefore been informed by and reflects:



## Introduction

- Circular HSC (SQSD) 29/07 “*Guidance on Strengthening Personal and Public Involvement in Health and Social Care*”<sup>2</sup>;
  - “*Improving the Patient and Client Experience*” (2008)<sup>3</sup>;
  - “*A Partnership for Care – NI Strategy for Nursing and Midwifery 2010-2015*” (2010)<sup>4</sup>;
  - “*Living Matters:Dying Matters a Palliative and End of Life Care Strategy for Adults in Northern Ireland*” (2010); and
  - “*Quality 2020 - A 10 Year Quality Strategy for Health and Social Care in Northern Ireland*” (2011)<sup>5</sup>.
39. In addition, account has also been taken of the Department’s draft Policy Framework “*Living with Long Term Conditions*” (issued for consultation February 2011) and the draft Physical and Sensory Disability Strategy (issued for consultation December 2010).





## Strategic Theme 1 - Promoting Person-centred Practice and Care

Placing the service user at the heart of the design and delivery of AHP practice and care is crucial to achieving the vision and values set out in this Strategy and to ensuring the best possible outcomes for service users.

Person-centred practice and care means working in partnership with service users, their families, carers and communities to design and develop practices, treatment and care that are fit for purpose and responsive to need.

Increasingly, person-centred practice and care are focused on supporting people to take responsibility for their own health and social well-being, including health promotion and prevention of ill health. The AHP workforce, working in partnership with individual service users as well as professional colleagues and partners, plays a key role in supporting people, such as those with long term conditions, to manage their own conditions and to enhance their health and social well-being, independence and quality of life.

*“Improving the Patient and Client Experience”* (2008) complements a person-centred approach to practice and care by defining a series of 5 standards that patients and clients can expect from HSC services and which should underpin the commissioning and delivery of care. The 5 standards are Respect; Attitude; Behaviour; Communication; and Privacy and dignity. These standards, which apply across the HSC workforce, should be central to the planning and delivery of services provided by the AHP workforce.

Increasingly care pathways cross boundaries that reach beyond traditional health care services. AHPs should continue to work across boundaries with a range of stakeholders including other services and organisations to ensure seamless practices and care that optimise resources and service user outcomes.



## Strategic Theme 1 - Promoting Person-centred Practice and Care

Promoting person-centred care requires a focus on four key areas:

- Ensuring personal and public involvement
- Improving the service user experience
- Promoting and supporting self management
- Working in partnership

### Exemplars

#### Colinglen schools

A nationally recognised partnership model between health and education led by Speech and Language Therapists for Primary 1 children in the Colinglen area of Belfast has resulted in:

- Improved identification of children with speech, language and communication difficulties
- Improved support with goals of therapy linked to class targets
- Increased knowledge, skills and confidence of teaching staff in identifying and supporting children in the classroom
- Increased access to services with a 2 week wait for assessment and 50-70% increased uptake of the service compared to local community clinics
- 59% of those accessing the service were discharged with age appropriate speech and language skills

*"The liaison between the SLT and school staff was imperative and valuable. It has provided me with the ability to support pupils who are having speech and language difficulties when the SLT is not here"*  
(Teacher)



### Condition Management Programme

Multi-agency Condition Management Programmes (CMP) are designed and delivered by a range of professionals including Occupational Therapists, Physiotherapists and Dietitians. Via this multi-disciplinary programme the cycle of poor health, unemployment, welfare dependency and social exclusion is broken by supporting individuals to self manage their health conditions and improve their potential for employment.

Last year one Trust in Northern Ireland had 560 referrals to CMP. 17% of those who completed the programme are now in paid employment saving an estimated £3.5 million to the Northern Ireland economy.

### Music Therapy in Children and Adolescent Mental Health Services (CAHMS)

Within CAHMS services attendance rates at clinics are traditionally low. Music Therapy in two Trusts in Northern Ireland has clearly demonstrated its 'added value' achieving attendance rates of 90% and meeting patients' expectations.

Outcomes for children and young people include:

- building concentration
- helping with aggression and anger
- improving low self- esteem
- addressing difficult behaviour at home and in school

*"My son was sent to see if it would help him work out his anger and aggression. He loved music therapy. He couldn't wait for the next session. It was great to have that half hour for someone to work one to one with him... Music therapy made him feel special and from that point it helped."*



# Strategic Theme 1 - Promoting Person-centred Practice and Care

## Ensuring Personal and Public Involvement (PPI)

Effective service user and public involvement is central to the delivery of high quality health and social care services which are safe, effective and focused on the service user. The DHSSPS Personal and Public Involvement Policy (2007)<sup>6</sup> seeks to improve the quality of HSC services through pro-actively engaging and working with individuals, organisations and communities in informing and influencing the commissioning, design and delivery of health and social care services to ensure high quality outcomes for service users and the best use of resources.

PPI seeks to empower the general population, communities and voluntary groups to give them more confidence and opportunities to influence the delivery of health and social care services in ways that are relevant and meaningful to them. At an individual level, PPI means engaging with and listening to service users and carers, drawing upon their knowledge, personal experiences and expertise to improve practices and ensuring they are actively involved in decisions about their care and treatment.

### At a Strategic Level

---

#### Action 1

Secure the effective engagement of service users and the public in shaping health policy and participating in decisions about the planning, commissioning and delivery of health and social care services.

Led by: The Lead AHP Officer (DHSSPS) to support the Director of Nursing and AHPs in the Public Health Agency (PHA) and the Assistant Director for AHPs and PPI (PHA).



## At an Organisational Level

---

### Action 2

Ensure that the principles of personal and public involvement are continuously embedded within AHP practice.

Led by: The Accountable Executive Director<sup>iii</sup> in conjunction with Trust AHP Leads and Professional Heads of Service.

## At an Individual Level

---

### Action 3

The AHP workforce will engage effectively with service users and as appropriate their carers, as partners in identifying and assessing needs and in the planning and delivery of their practice and care.

## Improving the Service User Experience

*“Improving the Patient and Client Experience”* sets out standards and guidance for all health and social care staff. The standards are based around 5 themes aimed at improving how care is provided to patients, clients and, where appropriate, carers. The standards are focused on Respect; Attitude; Behaviour; Communication; and Privacy and dignity. *“Improving the Patient and Client Experience”* recognises that patients and clients have a right to experience respectful and professional care in a considerate, supportive and collaborative environment where their privacy is protected and dignity maintained. The standards set out in *“Improving the Patient and Client Experience”* should be promoted and implemented into practice across the AHP workforce.



iii The Accountable Executive Director is the Director at Trust Board level who has governance responsibility for AHP services within their Trust.

# Strategic Theme 1 - Promoting Person-centred Practice and Care

## At a Strategic Level

---

### Action 4

Support the DHSSPS and PHA to oversee the regional implementation and monitoring of “*Improving the Patient Client Experience*” standards.

Led by: The Lead AHP Officer (DHSSPS) and the Assistant Director for AHPs and PPI (PHA).

## At an Organisational Level

---

### Action 5

Ensure appropriate actions are in place within AHP practice to support the delivery of the “*Improving the Patient and Client Experience*” standards.

Led by: The Accountable Executive Director in conjunction with Trust AHP Leads and Professional Heads of Service.

## At an Individual Level

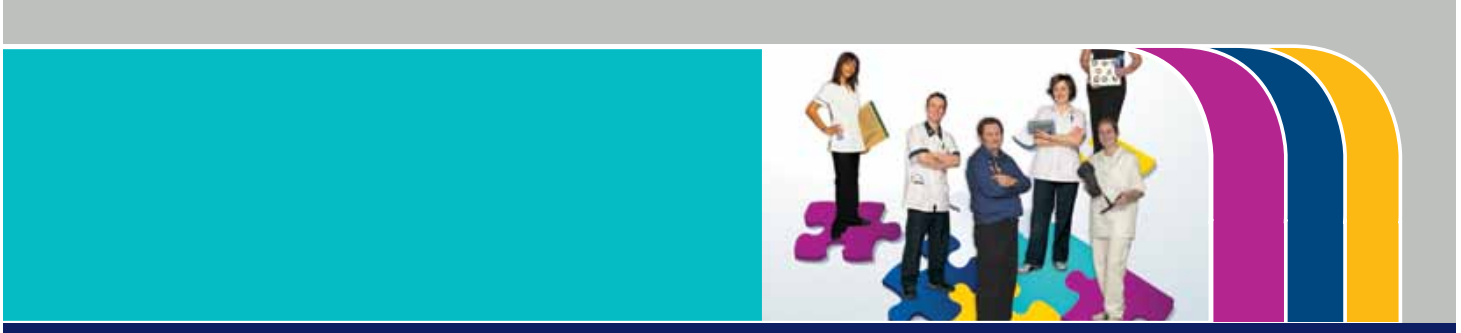
---

### Action 6

The AHP workforce will continue to work with colleagues to deliver services which improve the outcomes for, and experience of, service users in line with the “*Improving the Patient and Client Experience*” standards.

## Promoting and Supporting Self Management

Self management provides people with the knowledge and skills they need to take control of and manage their own health with appropriate levels of support, and to be active partners in decision-making about their treatment and care. A key role of the AHP workforce is to work in partnership with service users to maximise health, independence and social well-being through promoting and



supporting self management and helping to prevent other related conditions or complications.

Advances in how long term, or chronic, conditions are managed have led to changes in the planning and delivery of AHP interventions and practices to support people in self management.

**At a Strategic Level**

---

**Action 7**

Ensure that supporting self management becomes integrated within the development of policy and standards and the commissioning and design of AHP practice.

Led by: The Lead AHP Officer (DHSSPS) in conjunction with the Director of Nursing and AHPs (PHA) and the Assistant Director for AHPs and PPI (PHA).

**At an Organisational Level**

---

**Action 8**

Ensure that the AHP workforce promotes and supports self management as an integral element of their practice.

Led by: The Accountable Executive Director in conjunction with Trust AHP Leads and Professional Heads of Service.

**At an Individual Level**

---

**Action 9**

The AHP workforce will engage and work with people as partners to support them to self manage their own health and well-being.



# Strategic Theme 1 - Promoting Person-centred Practice and Care

## Working in Partnership

In improving the service user experience and supporting people to self manage their conditions, AHPs work in partnership with service users, their families and carers to ensure the best possible outcomes for health and well-being. In addition to working with individual service users, AHPs also interface with a range of statutory, voluntary, community and independent services and organisations, including housing, education, community and voluntary sector services, prisons and the youth justice system.

Service users often have complex needs which cannot be addressed by a single health care professional. The benefits of multi-disciplinary team working in population health promotion and prevention, early detection, diagnosis, treatment and ongoing care are well recognised. AHPs have a key role to play working in partnership with colleagues as leaders and members of multi-disciplinary and multi-agency teams. They provide professional expertise, advice and support as part of an integrated approach to the planning and delivery of health and social care.

AHP interventions should dovetail with and complement other interventions to deliver what service users require. Establishing and maintaining effective communication, collaborative working, and teamwork are critical to building relationships that deliver co-ordinated and integrated care for the benefit of service users.

### At a Strategic Level

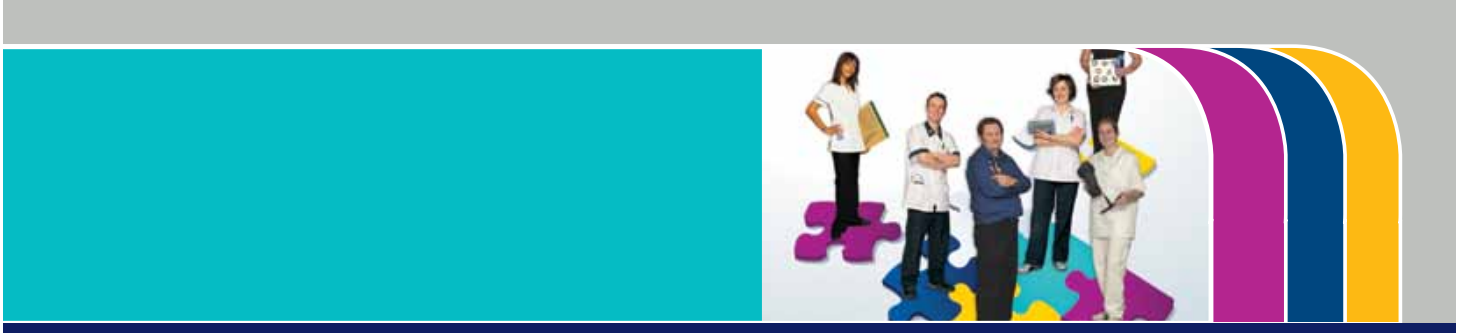
---

#### Action 10

Develop and further promote partnership working arrangements across relevant Government Departments and other key stakeholders to enhance the health and social well-being of service users.

Led by: The Lead AHP Officer (DHSSPS).





**Action 11**

Promote and support effective partnership working within AHP services and across other agencies and organisations.

Led by: The Director of Nursing and AHPs (PHA) in conjunction with the Assistant Director of AHPs and PPI (PHA).

**At an Organisational Level**

---

**Action 12**

Engage with relevant stakeholders to ensure effective policy development and inter-agency working with other statutory, independent, voluntary and community sector organisations.

Led by: The Accountable Executive Director in conjunction with Trust AHP Leads and Professional Heads of Service.

**Action 13**

Ensure that any barriers to good partnership working, both within and outside the organisation, are identified and addressed.

Led by: The Accountable Executive Director, in conjunction with Trust AHP Leads and Professional Heads of Service.

**At an Individual Level**

---

**Action 14**

The AHP workforce, with appropriate professional support, will work effectively in multi-disciplinary and multi-agency teams to deliver co-ordinated and integrated practices and care.



## Strategic Theme 2 - Delivering Safe and Effective Practice and Care

Safe and effective practice and care is the responsibility of all staff and should be at the heart of all AHP services. Good governance and accountability arrangements, alongside continuing education, research and service development, are essential to achieve and ensure this.

The DHSSPS Framework Document<sup>7</sup> describes the roles and functions of the various HSC bodies, the parameters within which each body must operate and the necessary governance and accountability arrangements to support the effective delivery of health and social care in Northern Ireland.

Quality and professional standards for health and social care are set out in "*Supporting Good Governance and Best Practice in the HPSS*"<sup>8</sup>. This identifies the standards that the public, service users, families and carers can expect - and the standards the statutory sector is required to meet - in the planning, commissioning, delivery and review of health and social care services. These standards contribute to the implementation of clinical and social care governance and are used by organisations, service users, carers and the wider public to assess the quality of care provision. "*Quality 2020*" the Department's 10 year Strategy to Protect and Improve Quality in Health and Social Care in Northern Ireland builds on this foundation.

Effective governance frameworks (including risk assessment, risk management and clear accountability arrangements) should be embedded across all levels and be central to the planning and delivery of safe and effective practice and care.

AHPs who work in the health and social care system, as well as those in the independent, education, voluntary and community sectors play a key role in assessing, managing and reducing risks. They have an individual responsibility to ensure the delivery of high quality practices and care that are safe, effective and focused on the service user and to promote excellence and continuous improvement in the services provided. This should be supported by appropriate



training and education and demonstrated by the establishment of clinical audit and evidence-based quality outcomes for practices and care.

AHP registrants must seek to ensure that their Continuing Professional Development (CPD) contributes to the quality of their practice and service delivery and that ultimately it benefits the service user<sup>9</sup>.

Delivering safe and effective care requires a focus on two key areas

- Risk assessment and management
- Clear governance and accountability frameworks

## Exemplars

### Home Enteral Feeding Co-ordinators

Dietitians as Home Enteral Tube Feeding (HETF) Co-ordinators have improved the quality of care for patients across Southern HSCT. Working across the primary and secondary care interface they reduced risk of medical crises and emergency callouts through extended scope practice. They act as a single point of contact for patients, families/ carers, other professionals and external agencies to support people with feeding tubes at home.

In one year alone they avoided 149 A&E attendances saving in excess of £74,500.



## Strategic Theme 2 - Delivering Safe and Effective Practice and Care

### A&E Super Hand Clinic

In South Eastern HSCT Occupational Therapy input to hand clinics provides early and comprehensive specialist treatment to reduce risk of complications from hand injuries. Development and centralisation of this specialist service on a single Trust site has achieved the following outcomes for service users and services:

- Reduced need for referral to fracture clinics
- Reduced need for referral to plastic surgery trauma clinics
- Access to extended scope expertise of Occupational Therapists in diagnostics and reading x-rays
- Increased productivity
- More timely access to treatment

### Risk Assessment and Management

The AHP workforce, collectively and as individuals, is accountable for the identification, assessment and management of risk in order to support safe and effective practices and care. This requires AHPs to use their specialist skills and competencies to take a pro-active and anticipatory approach to risk assessment and risk management which also includes positive risk taking and enablement. This means prioritising those clinical activities that target effective risk management and in doing so minimising risk for service users, families, carers, colleagues and the organisation.

The planning, commissioning and delivery of AHP practices should be driven by an emphasis on quality, which includes the safety of service users. Adopting a culture of sharing the learning where complaints, serious adverse incidents and "near misses" do occur, and taking appropriate action to ensure that lessons learned are applied, should result in measurable improvements in the quality of care.



### At a Strategic Level

---

#### Action 15

Contribute to the development of policy to support good practice and ensure that effective risk assessment and management processes for AHP practices are in place and that lessons are learned and applied from complaints, adverse incidents, “near misses” and reviews.

Led by: The Lead AHP Officer (DHSSPS) and the Director of Nursing and AHPs (PHA) in conjunction with the Assistant Director for AHPs and PPI (PHA).

### At an Organisational Level

---

#### Action 16

Provide an assurance to HSC Trust Board that effective risk assessment and management processes for AHP practices are in place and implemented and that lessons are learned and applied from complaints, serious adverse incidents, “near misses” and reviews.

Led by: The Accountable Executive Director in conjunction with Trust AHP Leads and Professional Heads of Service.

### At an Individual Level

---

#### Action 17

The AHP workforce will be supported to continue to work to recognised standards, guidelines, policies and procedures for the identification, assessment and management of risk for service users. This will include uni-disciplinary and collaborative approaches appropriate to their scope of practice.



## Strategic Theme 2 - Delivering Safe and Effective Practice and Care

### Clear Governance and Accountability Frameworks

AHPs are autonomous practitioners who practice across the full spectrum of health and social care both as individuals and as members of multi-disciplinary teams. The decisions made and the practices delivered by the AHP workforce directly impact on the health and social well-being and quality of life of service users.

It is essential that effective accountability arrangements are in place, regionally and at local level, to ensure good governance and the delivery of high quality practices and care that are safe, effective and focused on the service user. Appropriate and effective supervision and support, together with clarity of roles and responsibilities, can provide a structured framework to support good governance. This is particularly so where the scope of AHP roles and responsibilities are being extended.

Where AHPs interface with other agencies and service providers, these relationships and interactions must also be clearly defined so that responsibility and accountability of AHP roles are clear.

#### At a Strategic Level

---

##### **Action 18**

Establish a Regional Accountability Framework for AHPs.

Led by: The Lead AHP Officer (DHSSPS) in partnership with relevant stakeholders.

##### **Action 19**

Establish a mechanism that provides leadership, support and guidance for AHP governance and accountability arrangements.

Led by: The Director of Nursing and AHPs (PHA) in conjunction with the Assistant Director for AHPs and PPI (PHA).



### At an Organisational Level

---

#### Action 20

Develop, support and monitor AHP workforce compliance with agreed accountability and governance frameworks.

Led by: The Accountable Executive Director in conjunction with Trust AHP Leads and Professional Heads of Service.

### At an Individual Level

---

#### Action 21

The AHP workforce will be supported to use relevant standards, guidelines, protocols and procedures and to report and escalate issues of concern regarding poor practice or poor performance of others in line with organisational, professional body and regulatory guidance.



## Strategic Theme 3 - Maximising Resources for Success

The context within which AHP practices are commissioned, designed and delivered is dynamic and increasingly challenging. Demographic changes, including the increasing prevalence of long term conditions, are leading to greater levels of demand, which inevitably places pressure on financial and other resources as well as having implications for areas such as access to services. Within this context it is essential that all resources are deployed as effectively, efficiently and economically as possible, whilst ensuring that service users continue to receive high quality care that is safe, effective and focused on their needs.

New models of practice and care in the primary, community and secondary care sectors provide a challenge for AHPs. To meet such challenges requires continued innovation and modernisation in how AHP practices are commissioned, designed and delivered. This will necessitate examining existing services and models of care across the whole HSC system to identify what is essential, what can be delivered more effectively and what is no longer appropriate or necessary based on new evidence and best practice. It means optimising and ensuring the most effective and efficient use of resources, including the AHP workforce itself as well as extending the use of technology, aids and equipment that support health promotion, early detection, diagnosis, treatment and rehabilitation. It also means considering the sustainability of AHP services over the longer term and determining how the services AHPs provide can best be developed and improved to deliver outcomes that are focused on the needs of service users, their families and carers irrespective of where services are provided.

Innovation and modernisation will vary across the AHP disciplines however it should be guided and informed by evidence-based best practice which is identified, promoted and communicated. Existing service design and delivery models should be benchmarked against this to inform service development and improvement that ensures the optimum use of resources and the provision of practices and care that are fit for purpose.





Key to successful innovation and modernisation will be capitalising on the knowledge, expertise and professional experience of the AHP workforce and communicating and sharing good practice, particularly in areas such as public health, diagnostics and re-ablement. All appropriate steps should be taken to maximise how the research, knowledge and skills of the AHP workforce are utilised to deliver safe and effective practices and care to meet the changing needs of the population of Northern Ireland, for example, through deploying extended scope practitioners.

Maximising resources for success requires a focus on two key areas:

- Innovation and service modernisation
- Effective leadership

## Exemplar

### “Living your life to the full” A Southern HSCT Re-ablement initiative

Re-ablement is a new exciting, innovative model of care for older people targeted at maximising their independence; choice and control by ***helping people do things for themselves, rather than doing things to or doing things for people.***

Led by Occupational Therapists this service aims to help motivate and support people to regain the ability to live as independently as possible reducing their need for support in the future.

Over a 6 month period 134 referrals were received by the service each week with an average of 50% being discharged without needing other services.

Traditionally these individuals collectively would have commenced services estimated to cost more than £500,000 per year.



## Strategic Theme 3 - Maximising Resources for Success

### Self Referral

Self referral to Physiotherapy initiatives for people with Musculoskeletal Disorders (MSD) can

- Stop people going off work
- Get people back to work
- Facilitate managed return to work
- Reduced GP visits releasing capacity for other priorities

Cost savings from self referral have been realised across the UK

Cambridge	– 75% of self referrals did not require a GP prescription saving £12,000 per GP practice per year
NHS Scotland	– identified cost benefits of £2.5 million per year
Northern Ireland	– 2008 Audit Office report confirmed 80% of Civil Servants avoided sickness absence
	– 80% had sickness absence reduced by an average of 6 weeks

### Orthoptic and optometry service redesign

A joint orthoptic and refraction clinic led by orthoptists from NHSTC was recognised as Leading Innovation in the 2011 National Advancing Healthcare Awards. This one stop clinic has allowed children to begin treatment immediately with numerous benefits including:

- Single assessment appointment
- Shared care plan and records thus reducing paperwork and avoiding duplication
- Reduced waiting times for refraction clinics
- Fewer appointments for children to attend
- Consistent advice to children and parents
- Administration costs halved
- Enhanced multi-disciplinary working and practice evaluation
- Improved staff morale



### Fractures Reporting

Advanced Practitioner Diagnostic Radiographers in South Tyneside have modernised their hip fracture services through redesign of the care pathway with significant outcomes for service users including:

- Diagnostic Radiographers reporting x-rays
- Managing bed admissions procedures
- 97% of patients admitted to hospital bed within 1 hour of arrival at A&E
- Release of Orthopaedic and A&E Medical staff time

## Innovation and Service Modernisation

Innovation and modernisation means commissioning, designing and delivering AHP services that ensure the right things are done by the right person, in the right place and at the right time. This requires being positive about change through examining existing models of care holistically to identify how practices can be improved and resources deployed more effectively to ensure capacity building and the longer term sustainability of services. The focus of this should be to ensure that services are in place that are more accessible, flexible and responsive to the needs of service users and which facilitate the achievement of key targets and standards.

Modernising services necessitates identifying quality outcomes for service users and taking a whole systems approach to considering where new or evolving services can be extended or further developed. Utilising research, knowledge, evidence, best practice and the unique skills of AHPs to change and improve ways of working for the benefit of service users is essential.

The AHP workforce, working in partnership with professional colleagues and service users, is best placed to make improvements in practices and procedures to ensure the best possible outcomes. A key element of this will be the promotion of research and identifying evidence-based best practice.



## Strategic Theme 3 - Maximising Resources for Success

Examples of how to maximise resources may include working in partnership with colleagues to develop integrated working practices; identifying how multi-disciplinary and multi-agency team working can be improved; extending information and communication systems to share good practice; identifying how new and extended AHP roles can be utilised to improve service design and optimise patient outcomes and utilising technology to support improved outcomes for service users. The knowledge and skills of the AHP workforce can also be used in health promotion and prevention as well as to facilitate earlier diagnosis and interventions, self referrals and effective discharge arrangements.

The development of innovative AHP practices depends on workforce capacity and capability. AHPs should have access to continuing professional development, including opportunities to lead and participate in audit and research projects and education and training that will support the development and improvement of new and existing skills and expertise which will enable staff to be innovative in the development and delivery of high quality, person-centred services. Ensuring that skilled and competent staff are in place is an essential part of maximising resources and this is explored further in Theme 4 - *“Supporting and Developing the AHP Workforce”*.

### At a Strategic Level

---

#### Action 22

Contribute to, and lead as required, the development of policy and strategies to promote the commissioning, design and delivery of evidence based best practice and service improvement.

Led by: The Lead AHP Officer (DHSSPS).



**Action 23**

Ensure effective service design and delivery models are commissioned and in place which allow for more innovation in the provision of accessible, flexible and responsive services to ensure improved clinical outcomes, user satisfaction and value for money.

Led by: The Director of Nursing and AHPs (PHA) in conjunction with the Assistant Director of AHPs and PPI (PHA).

**At an Organisational Level**

---

**Action 24**

Ensure that services are in line with strategic policy and principles, are accessible, flexible and responsive to the needs of service users and carers, and make the most effective use of the AHP workforce.

Led by: The Accountable Executive Director in conjunction with Trust AHP Leads and Professional Heads of Service.

**Action 25**

Work with HSCB/PHA to ensure identification and implementation of effective service design and delivery models which allow for more innovation in the provision of accessible, flexible and responsive services to maximise performance and ensure improved clinical outcomes, user satisfaction and value for money.

Led by: The Accountable Executive Director in conjunction with Trust AHP Leads and Professional Heads of Service.



## At an Individual Level

---

### Action 26

The AHP workforce, in conjunction with Professional Heads of Service, will continue to review their practice and consider innovative ways in which the services they deliver can be modernised and improved to the benefit of service users and carers.

## Effective Leadership

Positive and effective professional and clinical leadership is vital to achieve the vision for AHP services set out in this Strategy. Effective leaders identify priorities; challenge assumptions; facilitate change; drive the creativity for service re-design and modernisation; motivate and support people to achieve their best; and develop and nurture partnership working.

Effective professional and clinical leadership at all levels, and in particular at strategic level, is an essential resource for ensuring the current delivery and future development of quality AHP services that are focused on achieving optimum outcomes for service users. Developing and supporting the AHP leaders of the future is crucial and this is explored in more detail in Theme 4 "*Supporting and Developing the AHP Workforce*".

## At a Strategic Level

---

### Action 27

Provide effective professional leadership for the AHP workforce, working in partnership with relevant groups and other key stakeholders.

Led by: The Lead AHP Officer (DHSSPS) and the Assistant Director of AHPs and PPI (PHA).



### At an Organisational Level

---

#### Action 28

Provide effective professional leadership and act as positive role models for staff by demonstrating commitment to the innovation and modernisation of AHP practices, the development of staff and the delivery of high quality care that is safe, effective and focused on best outcomes for service users.

Led by: The Accountable Executive Director in conjunction with Trust AHP Leads and Professional Heads of Service.

### At an Individual Level

---

#### Action 29

The AHP workforce will take personal ownership of, and demonstrate a high level of commitment to, the delivery of high quality, innovative practices and care leading to improved clinical outcomes, service user satisfaction and value for money.



## Strategic Theme 4 – Supporting and Developing the AHP Workforce

A responsive and skilled workforce means that the right people are in the right place with the right skills, at the right time to deliver the right outcome. It is essential to have a motivated, patient-focused, appropriately trained, highly skilled and flexible AHP workforce to meet service needs into the future. A strategic and forward looking approach to workforce planning, including continuing professional development, extended roles and changing work practices, will help facilitate this.

The increasing demand for AHP services requires that those in leadership roles for AHPs should ensure that the skills and grade mix are in place that will enable the workforce to meet assessed demand and service users' needs. Workforce planning should not only take into account existing models of service delivery but should also address essential future skill mix that will support the strategic shift in how and where care is delivered; moving away from the hospital sector to delivering a wider range of more responsive, accessible, timely and integrated services, including prevention and anticipatory management, in the community. Effective workforce planning needs to be supported by appropriate learning and development to ensure the availability of a skilled and adaptable AHP workforce. This will support AHPs to progress in their careers, deliver a quality service and acquire the range of skills needed for delivery of services into the future.

This Strategy encourages, through research, education and learning, the development of the AHP workforce. This is particularly important in the context of the diversity of emerging needs arising from demographic change, the reform and modernisation of services and increasing service user expectations. The development of the AHP workforce should also recognise the need to provide a supportive environment within which AHPs work.





Supporting and developing the AHP workforce requires a focus on three key areas:

- Workforce planning
- Learning and development
- Workforce development

## Exemplars

### Supplementary prescribing

Investment in learning and development of Physiotherapists, Podiatrists and Radiographers as supplementary prescribers provides service users with quicker and more efficient access to medicines.

An audit evaluating more than 1000 non medical prescribing episodes by Podiatrists and Physiotherapists in North West England identified that for those seen by an AHP:

- 20% avoided a GP clinic appointment
- 11% avoided the need for a GP home visit
- 15% avoided both new and unnecessary follow up by a consultant led hospital clinic
- 8% avoided hospital admissions

[North West Allied Health Professional Non Medical Prescribing Audit 2010].



## Strategic Theme 4 – Supporting and Developing the AHP Workforce

### **Skill Mix In Podiatry Services**

Podiatry Support Workers in Northern Ireland have successfully completed the Society of Chiropractors and Podiatrists competency programme. Outcomes for podiatry services include;

- Delegation of non-professional tasks e.g. decontamination of equipment
- Professional time optimised and used more effectively
- More timely access to podiatry for patients through more efficient management of waiting lists

In 2010/2011 use of a Podiatry Support worker released 1.0 wte Podiatrist to manage more complex cases and achieved cost savings of £5,500 per year.

### **Dietetic Support Worker**

Southern HSCT invested in the learning and development of Dietetic Support Workers (DSW) through the development of a training and competency framework manual which:

- Identifies key areas for in house nutrition training
- Is formally linked to QCF Level 3 Allied Health Professional Support Qualification
- Provides assurance that DSWs have the level of nutrition knowledge and skills to be competent to perform delegated tasks

Trained DSWs now manage a caseload of routine non-complex review patients safely and effectively, releasing professional dietetic staff thus maximising resources.



## Workforce Planning

Good workforce planning means taking account of current, short term and future demand and making plans to ensure this can be met in terms of both the number of staff and their skills and competencies to meet service need. Workforce reviews will seek to inform the effective management of supply and demand across the professions, including support staff.

It is also important that workforce planning takes account of the changing work practices and skills required within the workplace and the wider context of health and social care reform. In particular, both undergraduate and post graduate training and clinical placements should be regularly reviewed to ensure they equip AHPs to meet the increasing demands for AHP services and for innovation in how these are commissioned, designed and delivered to maximise resources. The challenge of growing and sustaining the workforce requires creative and flexible responses from all the professions<sup>10</sup>.

### At a Strategic Level

#### Action 30

Continue to ensure that a strategic approach is taken to regional workforce planning to meet identified service needs and take into account the workforce implications of the modernisation of HSC services.

Led by: The Lead AHP Officer (DHSSPS).

#### Action 31

Carry out, influence and contribute to workforce reviews for individual Allied Health Professions and for multi-disciplinary and multi-professional programmes of care as appropriate.

Led by: The Lead AHP Officer (DHSSPS) in conjunction with the Director of Nursing and AHPs (PHA), the Assistant Director for AHPs and PPI (PHA), Trust AHP Leads and Professional Heads of Service.



## Strategic Theme 4 – Supporting and Developing the AHP Workforce

### At an Organisational Level

---

#### Action 32

Ensure appropriate input to organisation level workforce planning, as well as representation and participation to inform regional workforce planning.

Led by: The Accountable Executive Director in conjunction with Trust AHP Leads and Professional Heads of Service.

### At an Individual Level

---

#### Action 33

The AHP workforce will use their experience and specialist expertise to inform workforce planning.

## Learning and Development

Learning and development underpins the establishment of a skilled, competent and adaptable workforce. All AHPs must be registered with the Health Professions Council (HPC) in order to practise and must continue to meet the standards they have been set by the Council in order to maintain registration. Included in these is the maintenance of competency to practise through continuing professional development, applicable to all AHPs irrespective of the care sector or setting within which they practice.

Resources are provided by the DHSSPS and employers to support the commitment to learning and development, including shared learning opportunities with other health and social care professionals. A Workforce Learning Strategy<sup>11</sup> has been developed to help maximise the return on this investment.



**At a Strategic Level**

**Action 34**

Inform and support the learning and development of AHPs.

Led by: The Lead AHP Officer (DHSSPS) in conjunction with the Director of Nursing and AHPs (PHA), the Assistant Director for AHPs and PPI (PHA), Trust AHP Leads and Professional Heads of Service.

**At an Organisational Level**

**Action 35**

Support the commitment to the learning and development of the AHP workforce through mentorship and ensuring that staff are supported in the acquisition of new skills and competencies as necessary to respond to emerging needs of the service.

Led by: The Accountable Executive Director in conjunction with Trust AHP Leads and Professional Heads of Service.

**At an Individual Level**

**Action 36**

AHPs, in conjunction with their Professional Heads of Service and managers as appropriate, are responsible for their continued professional development and meeting the requirements for their ongoing professional registration.



**Workforce Development**

Ensuring the AHP workforce has the skills and competencies to meet emerging needs and challenges within health and social care is essential for continued high quality service delivery, particularly so as AHPs have become more involved in public health initiatives and programmes. Valuing staff and committing to their development is vital for staff retention and motivation. High skills standards and

## Strategic Theme 4 – Supporting and Developing the AHP Workforce

staff involvement in service development help ensure that services are designed and delivered based on the most up to date knowledge and best practice.

An ongoing commitment to workforce development is needed to ensure that the range of knowledge and skills required to meet service demands into the future is available, from AHP support staff through to advanced consultant practitioners and those who provide leadership for the AHP workforce at strategic and organisational levels. This ensures support is provided to Therapy Support Workers for skills acquisition relevant to QCF level. Trusts and other organisations should identify workforce development needs and ensure that these are addressed through the commissioning of appropriate training and development.

For their part, individual AHPs and therapy support workers will be expected to build on their core competencies, adding additional knowledge and skills through lifelong learning to enable them to provide new and improved services to service users and carers.

### At a Strategic Level

---

#### Action 37

Advise DHSSPS of workforce developments in consultation with relevant groups and other key stakeholders and commission appropriate training and development which aligns with service needs.

Led by: The Lead AHP Officer (DHSSPS) in conjunction with the Director of Nursing and AHPs (PHA), the Assistant Director for AHPs and PPI (PHA), Trust AHP Leads and Professional Heads of Service.



**At an Organisational Level**

---

**Action 38**

Ensure that appropriate induction, perceptorship and supervision are in place to support transitions along the career pathway.

Led by: The Accountable Executive Director in conjunction with Trust AHP Leads and Professional Heads of Service.

**Action 39**

Inform and influence the commissioning of appropriate training and development to align with service needs.

Led by: The Accountable Executive Director, Trust AHP Leads and Professional Heads of Service.

**At an Individual Level**

---

**Action 40**

Action: The AHP workforce, in conjunction with Professional Heads of Service and their managers as appropriate, will identify their training and development needs and build on their core competencies, adding additional knowledge and skills through life-long learning and accepting responsibility for improving their own practice through continuing professional development.



## Where do we go from here?

This document sets out the strategic direction for the AHP workforce, irrespective of the care setting or sector within which individual AHPs or therapy support staff work. Each of its strategic themes has identified key areas and actions through which, together, we will achieve our vision of working in partnership with service users to actively enhance people's lives through the delivery of high quality and innovative diagnostic, treatment and rehabilitation services and practices that are safe, timely, effective and focused on the service user.

The implementation of the Strategy will be taken forward by a Regional Implementation Steering Group which will be established within 3 months of publication of this Strategy. The Regional Implementation Steering Group will include key stakeholders, including service users, and will have a remit to ensure that the approach and actions set out within the Strategy are progressed. Terms of Reference for the Regional Implementation Steering Group will be developed and agreed by the Department and the Implementation Steering Group. The PHA and HSCB will provide the leadership to the Implementation Steering Group to ensure effective implementation of the Strategy. This may also include considering how the strategic direction and roles for the individual disciplines within the AHP workforce can be developed over the Strategy period.

The PHA/HSCB will be required to provide regular reports to the Department of progress against the Strategy's key actions, including a formal report at least annually.

A key role of the Regional Implementation Steering Group will be to develop a Regional AHP Strategy Implementation Plan within an agreed timeframe for approval by a DHSSPS Implementation Board. The Implementation Plan will include detailed actions at an operational level, together with appropriate milestones, targets and associated timescales. It will detail monitoring and accountability arrangements for taking forward the approach and key actions set out in this Strategy for ensuring the future development of the AHP workforce and the services it provides.





DHSSPS through the HSCB and PHA will support and monitor the progress of this Strategy and its implementation within the HSC, whilst HSC Trusts will be instrumental in ensuring that the Strategy and its action points are taken forward at an operational level. It will be the responsibility of all members of the AHP workforce however, wherever they work, to embrace the actions expressed in this Strategy as part of their everyday practice.

This Strategy will be reviewed at the end of the five year period to measure progress and to set the future direction of travel.



## Appendix 1

# AHP Disciplines Covered in the Strategy

- **Art Therapists**  
Provide a psychotherapeutic intervention which enables clients to effect change and growth by the use of art materials to gain insight and promote the resolution of difficulties.
- **Dietitians**  
Assess, diagnose and treat diet and nutrition problems at an individual and wider public health level. Dietitians translate public health and scientific research on food, health and disease into practical guidance to enable people to make appropriate lifestyle and food choices.
- **Drama Therapists**  
Encourage clients to experience their physicality, to develop an ability to express the whole range of their emotions and to increase their insight and knowledge of themselves and others.
- **Music Therapists**  
Use music, with an individual client or group of clients, to improve functioning and develop potential in a number of skill areas impaired by disability, illness or trauma. These areas include communication, physical, emotional, mental, social and cognitive skills. Music therapy aims to achieve a better quality of life for clients through prevention, rehabilitation or treatment.
- **Occupational Therapists**  
Promote health and well-being through occupation. The primary goal of occupational therapy is to enable people to participate in the activities of everyday life. Occupational therapists achieve this outcome by working with people and communities to enhance their ability to engage in the occupations they want to, need to, or are expected to do; or by modifying



the occupation or the environment to better support their occupational engagement.

- **Orthoptists**  
Diagnose and treat eye movement disorders and defects of binocular vision.
- **Orthotists**  
Design and fit orthoses (callipers, braces etc.) which provide support to part of a patient's body, to compensate for paralysed muscles, provide relief from pain or prevent physical deformities from progressing.
- **Physiotherapists**  
Physiotherapists use a holistic approach in the preventative, diagnostic and therapeutic management of disorders of movement or optimisation of function, to enhance the health and well-being of the community from an individual or population perspective. Physiotherapy practice has the exercise of clinical judgement and informed interpretation, underpinned by best available evidence, at its core. It encompasses a diversity of clinical specialities to meet the unique needs of patient groups with varying health status.
- **Podiatrists**  
Assess the vascular, neurological and orthopaedic status of the patient's lower limbs to diagnose and treat diseases and conditions affecting the feet. Podiatrists focus on relieving symptoms and maintaining functional independence.
- **Prosthetists**  
Provide care and advice on rehabilitation for patients who have lost or who were born without a limb, fitting the best possible artificial replacement.
- **Radiographers – Diagnostic and Therapeutic**  
Diagnostic Radiographers employ a range of imaging techniques to produce high quality images of injury or disease, often interpreting the images so that correct treatment can be provided. They undertake diagnostic work

## Appendix 1

# AHP Disciplines Covered in the Strategy

and independent reporting as part of a multi-disciplinary team and are a key part of the delivery of acute as well as community-based services. Early diagnosis is a vital step in care pathways and the delivery of any subsequent treatment.

Therapeutic radiographers are the only health professionals qualified to plan and deliver radiotherapy in the treatment of cancer. They manage the patient pathway through the many radiotherapy processes, providing care and support for patients throughout their treatment.

- **Speech and Language Therapists**

Speech and Language Therapists (SLTs) are concerned with the management of speech, language, communication and swallowing in children and adults. SLTs contribute to the delivery of specialist, targeted and universal services to service users and their families. They reduce long term demands on services by addressing immediate needs that arise from circumstances as well as needs that arise from underlying impairment. SLTs also provide training for the wider workforce.



## Appendix 2 Summary of Action Points

Action	Led By
1. Secure the effective engagement of service users and the public in shaping health policy and participating in decisions about the planning, commissioning and delivery of health and social care services.	Strategic The Lead AHP Officer (DHSSPS) to support the Director of Nursing and AHPs in the PHA and the Assistant Director for AHPs and PPI (PHA)
2. Ensure that the principles of personal and public involvement are continuously embedded within AHP practice.	Organisational The Accountable Executive Director in conjunction with Trust AHP Leads and Professional Heads of Service
3. The AHP workforce will engage effectively with service users as partners in the planning and delivery of their practice and care	Individual
4. Support the DHSSPS and PHA to oversee the regional implementation and monitoring of "Improving the Patient Client Experience" standards.	Strategic The Lead AHP Officer (DHSSPS) and the Assistant Director for AHPs and PPI (PHA)
5. Ensure appropriate actions are in place within AHP practice to ensure the delivery of the "Improving the Patient and Client Experience" standards.	Organisational The Accountable Executive Director in conjunction with Trust AHP Leads and Professional Heads of Service

## Appendix 2 Summary of Action Points

Action	Led By
6. The AHP workforce will continue to work with colleagues to deliver services which improve the outcomes for, and experience of, service users in line with the “ <i>Improving the Patient and Client Experience</i> ” standards.	Individual
7. Ensure that supporting self management becomes integrated within the development of policy and standards and the commissioning and design of AHP practice.	Strategic The Lead AHP Officer (DHSSPS) in conjunction with the Director of Nursing and AHPs (PHA) and the Assistant Director for AHPs and PPI (PHA)
8. Ensure that the AHP workforce promotes and supports self management as an integral element of their practice.	Organisational The Accountable Executive Director in conjunction with Trust AHP Leads and Professional Heads of Service
9. The AHP workforce will engage and work with people as partners to support them to self manage their own health and well-being.	Individual
10. Develop and further promote partnership working arrangements across relevant Government Departments and other key stakeholders to enhance the health and social well-being of service users.	Strategic The Lead AHP Officer (DHSSPS)



Action	Led By
11. Promote and support effective partnership working within AHP services and across other agencies and organisations.	Strategic The Director of Nursing and AHPs (PHA) in conjunction with the Assistant Director of AHPs and PPI (PHA)
12. Engage with relevant stakeholders to ensure effective policy development and inter-agency working with other statutory, independent, and voluntary and community sector organisations.	Organisational The Accountable Executive Director in conjunction with Trust AHP Leads and Professional Heads of Service
13. Ensure that any barriers to good partnership working, both within and outside the organisation, are identified and addressed.	Organisational The Accountable Executive Director in conjunction with Trust AHP Leads and Professional Heads of Service.
14. The AHP workforce, with appropriate professional support, will work effectively in multi-disciplinary and multi-agency teams to deliver co-ordinated and integrated practices and care.	Individual

## Appendix 2 Summary of Action Points

Action	Led By
15. Contribute to the development of policy to support good practice and ensure that effective risk assessment and management processes for AHP practices are in place and that lessons are learned and applied from complaints, adverse incidents, “near misses” and reviews.	Strategic The Lead AHP Officer (DHSSPS) and the Director of Nursing and AHPs (PHA) in conjunction with the Assistant Director for AHPs and PPI (PHA)
16. Provide an assurance to HSC Trust Board that effective risk assessment and management processes for AHP practices are in place and implemented and that lessons are learned and applied from complaints, serious adverse incidents, “near misses” and reviews.	Organisational The Accountable Executive Director in conjunction with Trust AHP Leads and Professional Heads of Service
17. The AHP workforce will be supported to continue to work to recognised standards, guidelines, policies and procedures for the identification, assessment and management of risk for service users. This will include uni-disciplinary and collaborative approaches appropriate to their scope of practice.	Individual
18. Establish a regional accountability framework for AHPs.	Strategic The Lead AHP Officer (DHSSPS) in partnership with relevant stakeholders





Action	Led By
19. Establish a mechanism that provides leadership, support and guidance for AHP governance and accountability arrangements.	Strategic The Director of Nursing and AHPs (PHA), in conjunction with the Assistant Director for AHPs and PPI (PHA)
20. Develop, support and monitor AHP workforce compliance with agreed accountability and governance frameworks.	Organisational The Accountable Executive Director in conjunction with Trust AHP Leads and Professional Heads of Service
21. The AHP workforce will be supported to use relevant standards, guidelines, protocols and procedures and to report and escalate issues of concern regarding poor practice or poor performance of others in line with organisational, professional body and regulatory guidance.	Individual

## Appendix 2 Summary of Action Points

Action	Led By
22. Contribute to, and lead as required, the development of policy and strategies to promote the commissioning, design and delivery of evidence-based best practice and service improvement.	Strategic The Lead AHP Officer (DHSSPS)
23. Ensure effective service design and delivery models are commissioned and in place which allow for more innovation in the provision of accessible, flexible and responsive services to ensure improved clinical outcomes, user satisfaction and value for money.	Strategic The Director of Nursing and AHPs (PHA) in conjunction with the Assistant Director of AHPs and PPI (PHA)
24. Ensure that services are in line with strategic policy and principles, are accessible, flexible and responsive to the needs of service users and carers, and make the most effective use of the AHP workforce.	Organisational The Accountable Executive Director in conjunction with Trust AHP Leads and Professional Heads of Service
25. Work with HSCB/PHA to ensure identification and implementation of effective service design and delivery models which allow for more innovation in the provision of accessible, flexible and responsive services to maximise performance and ensure improved clinical outcomes, user satisfaction and value for money.	Organisational The Accountable Executive Director in conjunction with Trust AHP Leads and Professional Heads of Service



Action	Led By
<p>26. The AHP workforce, in conjunction with Professional Heads of Service, will continue to review their practice and consider innovative ways in which the services they deliver can be modernised and improved to the benefit of service users and carers.</p>	<p>Individual</p>
<p>27. Provide effective professional leadership for the AHP workforce, working in partnership with relevant groups and other key stakeholders.</p>	<p>Strategic The Lead AHP Officer (DHSSPS) and the Assistant Director of AHPs and PPI (PHA)</p>
<p>28. Provide effective professional leadership and act as positive role models for staff by demonstrating commitment to the innovation and modernisation of AHP practices, the development of staff and the delivery of high quality care that is safe, effective and focused on best outcomes for service users.</p>	<p>Organisational The Accountable Executive Director in conjunction with Trust AHP Leads and Professional Heads of Service</p>
<p>29. The AHP workforce will take personal ownership of, and demonstrate a high level of commitment to, the delivery of high quality, innovative practices and care leading to improved clinical outcomes, service user satisfaction and value for money.</p>	<p>Individual</p>

## Appendix 2 Summary of Action Points

Action	Led By
30. Continue to ensure that a strategic approach is taken to regional workforce planning to meet identified service needs and take into account the workforce implications of the modernisation of HSC services.	Strategic The Lead AHP Officer (DHSSPS)
31. Carry out, influence and contribute to workforce reviews for individual Allied Health Professions and for multi-disciplinary and multi-professional programmes of care as appropriate.	Strategic The Lead AHP Professional Officer (DHSSPS) in conjunction with the Director of Nursing and AHPs (PHA), the Assistant Director for AHPs and PPI (PHA), Trust AHP Leads and Professional Heads of Service
32. Ensure appropriate input to organisation level workforce planning, as well as representation and participation to inform regional workforce planning.	Organisational The Accountable Executive Director in conjunction with Trust AHP Leads and Professional Heads of Service
33. The AHP workforce will use their experience and specialist expertise to inform workforce planning.	Individual
34. Inform and support the commitment to the learning and development of AHPs.	Strategic The Lead AHP Officer (DHSSPS) in conjunction with the Director of Nursing and AHPs (PHA), the Assistant Director for AHPs and PPI (PHA), Trust AHP Leads and Professional Heads of Service



Action	Led By
<p>35. Support the commitment to the learning and development of the AHP workforce through mentorship and ensuring that staff are supported in the acquisition of new skills and competencies as necessary to respond to emerging needs of the service.</p>	<p>Organisational The Accountable Executive Director in conjunction with Trust AHP Leads and Professional Heads of Service</p>
<p>36. AHPs, in conjunction with their Professional Heads of Service and managers as appropriate, are responsible for their continued professional development and meeting the requirements for their ongoing professional registration.</p>	<p>Individual</p>
<p>37. Advise DHSSPS of workforce developments in consultation with relevant groups and other key stakeholders and commission appropriate training and development which aligns with service needs.</p>	<p>Strategic The Lead AHP Officer (DHSSPS) in conjunction with the Director of Nursing and AHPs (PHA), the Assistant Director for AHPs and PPI (PHA), Trust AHP Leads and Professional Heads of Service</p>
<p>38. Ensure that appropriate induction, mentorship and supervision are in place to support transitions along the career pathway.</p>	<p>Organisational The Accountable Executive Director in conjunction with Trust AHP Leads and Professional Heads of Service</p>

## Appendix 2 Summary of Action Points

Action	Led By
39. Inform and influence the commissioning of appropriate training and development to align with service needs.	Organisational The Accountable Executive Director, Trust AHP Leads and Professional Heads of Service
40. The AHP workforce, in conjunction with Professional Heads of Service and their managers as appropriate, will identify their training and development needs and build on their core competencies, adding additional knowledge and skills through life-long learning and accepting responsibility for improving their own practice through continuing professional development.	Individual



## Appendix 3

### Membership of the AHP Steering Group

Martin Bradley (Chair) (until retirement June 2011)	Chief Nursing Officer	DHSSPS
Angela McLernon (Chair) (wef July 2011)	Acting Chief Nursing Officer	DHSSPS
Jacqueline Magee	Service User Facilitator	HSC Board
Michelle Tennyson	Assistant Director of AHPs and Personal Public Involvement	Public Health Agency
Margaret Moorehead	Assistant Director of AHPs	SEHSCT
Paula Cahalan	AHP Services Manager	BHSCT
Denise Killough (wef June 2011)	Acting AHP Services Manager	BHSCT
Carmel Harney	Assistant Director AHP Governance, Workforce Development and Training	SHSCT
Paul Rafferty	Head of AHP Services	WHSCT
Elizabeth McKnight	AHP Professional Body Representative	AHP Federation NI
Hazel Winning	Chair of Health Professionals Forum	NHSCT
Pauline Mulholland (wef January 2011)	Lead AHP Officer	DHSSPS
Gillian Seeds	Primary Care Development Unit	DHSSPS
Michael Sweeney	Physical and Sensory Disability Unit	DHSSPS

## Appendix 3 Membership of the AHP Steering Group

Sandra O'Hare	Nursing, Midwifery and AHP Directorate	DHSSPS
Anne Mills	Nursing Officer	DHSSPS
Joyce Cairns	Human Resources Directorate	DHSSPS
Karen Dawson	Primary Care Development Unit	DHSSPS
Mark Anderson	Nursing, Midwifery and AHP Directorate	DHSSPS





## Abbreviations and Glossary of Terms

Accountability Framework	Identifies systems of control within an organisation including professional management structures and practices, reporting arrangements, and risk management processes.
Accountable Executive Director	The Accountable Executive Director is the Director at HSC Trust Board level who has governance responsibility for AHP services within their Trust.
Allied Health Professions Federation (AHPF)	<p>The Allied Health Professions Federation (AHPF) is a UK-wide organisation which provides collective leadership and representation on common issues that impact on its member professions and their service users.</p> <p>The AHPFNI is a regional umbrella organisation which works in partnership with key decision makers and stakeholders in health, social care and education to promote better understanding of the unique contribution of the allied health professions.</p> <p>The AHPFNI represents the interests of 11 AHP professional bodies throughout Northern Ireland.</p>
Assistant Director with responsibility for Allied Health Professions and Patient and Public Involvement (PHA)	The Assistant Director for AHPs and PPI (PHA) is responsible (through the Director of Nursing and Allied Health Professions) for AHP leadership and professional inputs both within the Public Health Agency and Health and Social Care Board as well as leadership more broadly across the Health and Social Care system. The key areas through which this is achieved are in setting direction, service delivery and service development.

## Abbreviations and Glossary of Terms

Continuing Professional Development (CPD)	A structured approach to skills enhancement through which professionals maintain, improve and broaden their knowledge, skills and professional competence.
Corporate Governance	Corporate governance in healthcare is defined as “the systems and processes by which health bodies lead, direct and control their functions, in order to achieve organisational objectives, and by which they relate to their partners and the wider community” (Audit Commission definition).
Department of Health, Social Services and Public Safety (DHSSPS)	The Department has three main business responsibilities: <b>Health and Social Care (HSC)</b> - including policy and legislation for hospitals, family practitioner services and community health and personal social services; <b>Public Health</b> - policy, legislation and administrative action to promote and protect the health and well-being of the population; and <b>Public Safety</b> - policy and legislation for fire and rescue services.
Director of Nursing and Allied Health Professions (PHA)	The Director of Nursing and Allied Health Professions (PHA) has overall responsibility for nursing, midwives and allied health professionals in the HSC in addition to service and public health issues and the Local Supervising Midwifery Authority.
Health Professions Council (HPC)	A regulatory body established to protect the public. The HPC maintains a register of health professionals who meet specified standards in place for their training, professional skills, behaviour and health.



Health and Social Care (HSC)	Hospital services, family and community health services and personal social services.
Health and Social Care Board (HSCB)	The Health and Social Care Board has 3 main functions: <ul style="list-style-type: none"> <li>• To commission a comprehensive range of modern and effective health and social services;</li> <li>• To work with the Health and Social Care Trusts that directly provide services to people to ensure that these meet their needs;</li> <li>• To deploy and manage its annual funding to ensure that all services are safe and sustainable.</li> </ul>
Lead Allied Health Professions Officer	This is the lead officer in DHSSPS who provides advice to the Minister in relation to AHP issues and leads the professions in Northern Ireland.
Multi-disciplinary Team (MDT)	A group of people from different disciplines who work together to provide and/or improve care for service users. The composition of the multi-disciplinary team will include people from both health care and non-healthcare disciplines.
Personal and Public Involvement	Involving and empowering people and communities to influence the planning, commissioning and delivery of services in ways that are relevant and meaningful to them. It includes involving individuals in planning and decision making about their specific care or treatment.
Public Health Agency (PHA)	The PHA was set up to focus on public health and well-being. It brings together a wide range of public health functions under one organisation. Main areas of responsibility are:

## Abbreviations and Glossary of Terms

	<ul style="list-style-type: none"> <li>• health and social well-being improvement</li> <li>• health protection</li> <li>• public health support to commissioning and policy development</li> <li>• HSC research and development.</li> </ul>
Primary care	Family and community health services and major components of social care which are delivered outside the hospital setting and which an individual can access on their own behalf. Primary care will usually be the person's first contact point with the HSC e.g. GP, Community Nurse, dentist.
Professional Head of Service	The term Professional Head of Service in this strategy refers to the most senior uni-professional AHP in the HSC who has professional accountability and governance responsibility for their specific profession.
Secondary care	Care that is usually provided in a hospital or a particular specialised centre. Secondary care may be accessed by a person directly but is usually as a result of referral from primary care.
Self management	Empowering people to take control of and manage their own health and well-being and providing them with the knowledge skills and support they need to be able to do so.
Serious adverse incidents & near misses	Any event or circumstance arising during the course of business of an HSC organisation/Special Agency or commissioned service that led, could have led, to serious unintended harm, loss or damage.



<p>Trust AHP Lead</p>	<p>Trust AHP Lead in this strategy refers to the most senior AHP in HSC Trusts who has a collective responsibility for AHP professional and/or operational service delivery.</p>
<p>Therapy Support Worker</p>	<p>Part of the AHP workforce, therapy support workers provide support and assistance to Allied Health Professionals in the delivery of patient care.</p>

## Bibliography

*A Fitter Future for All: An Obesity Prevention Framework for Northern Ireland 2011-2021*, DHSSPS consultation document issued November 2010  
<http://www.dhsspsni.gov.uk/consultations>

*A Healthier Future, a Twenty Year Vision for Health and Well-being in Northern Ireland, 2005 – 2025*, DHSSPS 2004  
<http://www.dhsspsni.gov.uk/healthyfuture-main.pdf>

*A Partnership for Care – Northern Ireland Strategy for Nursing and Midwifery 2010-2015*, DHSSPS 2010  
[http://www.dhsspsni.gov.uk/8615\\_-\\_a7\\_booklet\\_web.pdf](http://www.dhsspsni.gov.uk/8615_-_a7_booklet_web.pdf)

*A Workforce Learning Strategy for the Northern Ireland Health and Social Care Services 2009-2014*, DHSSPS April 2009  
<http://www.dhsspsni.gov.uk/workforce-learning-strategy-apr-2009.pdf>

*Audit of Allied Health Professionals – Speech and Language Therapy Services*  
 DHSSPS – PricewaterhouseCoopers, July 2008  
<http://dhsspsextra.intranet.nigov.net/vfm-speech.pdf>

*Audit of Allied Health Professionals – Occupational Therapy Services* DHSSPS – PricewaterhouseCoopers, July 2008  
[http://dhsspsextra.intranet.nigov.net/vfm-occ\\_therapy.pdf](http://dhsspsextra.intranet.nigov.net/vfm-occ_therapy.pdf)

*Audit of Allied Health Professionals – Physiotherapy Services* DHSSPS – PricewaterhouseCoopers, July 2008  
<http://dhsspsextra.intranet.nigov.net/vfm-physio.pdf>

*Building on Success - future direction for the Allied Health Professions in Scotland*, NHS Scotland/Scottish Executive, 2002  
<http://www.scotland.gov.uk/publications/2002/06/14963/7817>



*Caring for People Beyond Tomorrow – A Strategic Framework for the Development of Primary Health and Social Care*, DHSSPS, 2005  
<http://dhsspsni.gov.uk/primarycare05.pdf>

*Framing the Contribution of Allied Health Professionals – delivering high quality healthcare*. Department of Health, London, October 2008  
[http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/documents/digitalasset/dh\\_089514.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_089514.pdf)

*From Strength to Strength – celebrating 10 years of the Allied Health Professions in Scotland*, NHS Scotland/Scottish Government, 2011  
<http://www.scotland.gov.uk/Publications/2011/03/11104802/0>

*Improving the Patient and Client Experience*, DHSSPS, NIPEC and RCN 2008  
[http://www.dhsspsni.gov.uk/improving\\_the\\_patient\\_and\\_client\\_experience.pdf](http://www.dhsspsni.gov.uk/improving_the_patient_and_client_experience.pdf)

*Living with Long Term Conditions – A Policy Framework*, DHSSPS Consultation Document February 2011  
<http://www.dhsspsni.gov.uk/consultations>

*Long Term Conditions - Working Together*, Long Term Conditions Alliance/DHSSPS, October 2008, Conference Summary  
<http://www.ltcani.org.uk/resources/LTC-conference-08-report.pdf>

*Public Health Agency Annual Report 2009/10*, 2010  
[http://www.publichealth.hscni.net/sites/default/files/PHA%20Annual%20Report%202009-2010\\_1.pdf](http://www.publichealth.hscni.net/sites/default/files/PHA%20Annual%20Report%202009-2010_1.pdf)

*Quality 2020 – A 10 Year Quality Strategy for Health and Social Care in Northern Ireland*, DHSSPS 2011  
<http://www.dhsspsni.gov.uk/quality2020.pdf>

*Report to the National Allied Health Profession Advisory Board on the outcomes of the Modernising Allied Health Professional Careers Programme*, Dept of Health February 2011  
<http://www.dh.gov.uk/publications>

## References

- 1 Department of Health, Social Services and Public Safety "*Caring for People Beyond Tomorrow – A Strategic Framework for the development of primary health and social care for individuals, families and communities in Northern Ireland*" 2005 DHSSPS Belfast
- 2 Department of Health, Social Services and Public Safety Circular HSC (SQSD) 29/07 "*Guidance on Strengthening Personal and Public Involvement in Health and Social Care*" 2007 DHSSPS Belfast
- 3 Department of Health, Social Services and Public Safety "*Improving the Patient and Client Experience*" 2008 DHSSPS/NI Practice and Education Council/Royal College of Nursing Belfast
- 4 Department of Health, Social Services and Public Safety "*A Partnership for Care – Northern Ireland Strategy for Nursing and Midwifery 2010-2015*" 2010 DHSSPS Belfast
- 5 Department of Health, Social Services and Public Safety "*Quality 2020 – a 10 Year Quality Strategy for NI*" 2011 DHSSPS Belfast
- 6 Department of Health, Social Services and Public Safety Circular HSC (SQSD) 29/07 "*Guidance on Strengthening Personal and Public Involvement in Health and Social Care*" 2007 DHSSPS Belfast
- 7 Department of Health, Social Services and Public Safety Framework Document 2011 DHSSPS Belfast
- 8 "*Supporting Good Governance and Best Practice in the HPSS*" 2006 DHSSPS Belfast
- 9 Health Professions Council "*Continuing Professional Development and your Registration*", 2005 London(reprinted 2011 with revisions)





- <sup>10</sup> *“Modernising AHP Careers – A competence based framework”* 2008  
Department of Health London
  
- <sup>11</sup> Department of Health, Social Services and Public Safety *“A Workforce Learning Strategy for the Northern Ireland Health and Social Care Services 2009-2014”* 2009 DHSSPS Belfast









Produced by:  
Department of Health, Social Services and Public Safety

Castle Buildings  
Belfast, BT4 3SQ  
**Telephone:** (028) 9052 0626  
**Textphone:** (028) 9052 7668  
**[www.dhsspsni.gov.uk](http://www.dhsspsni.gov.uk)**

February 2012  
Ref: 45 /2011

2014

# Regional Supervision Policy for Allied Health Professionals

Working for a Healthier People



Department of Health, Social Services and  
Public Safety (Northern Ireland)

Policy Title:	<b>Regional Supervision Policy for Allied Health Professions</b>
Policy Reference Number:	<b>AHP Policy 1/14</b>
Implementation Date:	<b>2 April 2014</b>
Review Date:	<b>2 April 2016</b>
Responsible Officer:	<b>Lead Allied Health Professions Officer DHSSPSNI</b>
Co-Authors;	<b>Paul Rafferty Head of AHP Services, WHST</b>  <b>Carmel Harney Assistant Director for AHP Governance, Workforce Development &amp; Training – SHSCT</b>  <b>Fiona Hodkinson AHP Project Officer DHSSPSNI</b>  <b>Regional AHP Leads Forum</b>



<b>Contents</b>	<b>Page</b>
<b>Foreword by Minister</b>	5
<b>Foreword by Lead Allied Health Professions Officer</b>	6
<b>1. Introduction / Background</b>	7
<b>2. Purpose and Aims of This Policy</b>	9
<b>3. AHP Supervision</b> 3.1 Purpose of AHP Supervision 3.2 Core Values and Principles 3.3 Non-Professional Roles That Require the Post Holder to be Registered as AHP 3.4 Frequency of Supervision	9
<b>4. Supervision Processes</b> 4.1 Training 4.2 Receiving Supervision 4.3 Providing Supervision 4.4 Professional Heads of Service	11
<b>5. Components of Supervision</b> 5.1 Clinical Supervision 5.2 Professional Supervision 5.3 Managerial Supervision 5.4 Operational Supervision	14
<b>6. Interpersonal Relationship Within the Supervision Context</b>	16
<b>7. Recording Supervision</b> 7.1 Confidentiality 7.2 Use of Patient / Client Records 7.3 Storage of Records 7.4 Supervision Implementation Plans	17
<b>8. Monitoring and Evaluation</b>	18
<b>9. Professional Governance Frameworks for the Allied Health Professions</b>	19
<b>10. Review</b>	19
<b>Appendices</b>	20

<ul style="list-style-type: none"><li>• Appendix A – Ground Rules</li><li>• Appendix B – AHP Professions</li><li>• Appendix C – Professional Bodies</li><li>• Health and Care Professions Council</li><li>• Linkage to DHSSPS Strategic Documents</li><li>• Reviews / Reports Referenced</li></ul>	
--	--

## ***FOREWORD by Minister***

Health and Social Care in Northern Ireland is entering a period of unprecedented change and Allied Health Professionals need to be at the forefront of that change.

The collective expertise of Allied Health Professions-(AHPs) makes a significant contribution to improving the health & wellbeing of people in Northern Ireland. They have established a reputation as health professionals firmly committed to building and maintaining relationships with patients and their families.

AHPs have an important role to play in delivering on the aims of Transforming Your Care in the future by developing innovative and creative solutions to health challenges.

The importance of effective governance and accountability arrangements to achieve and assure safe and effective care is paramount. Access to regular supervision is an essential component of good quality therapy services AHPs have demonstrated their commitment to service improvement and high quality patient care by developing services that are responsive to the needs of people who use them and their families. I am confident therefore that this Policy on Supervision will further enhance that commitment.

Healthcare professionals must work to the highest standards. It is my view that in order to maintain those standards, professionals should have access to a formal process of regular Supervision

High quality supervision is one of the most important drivers in ensuring positive outcomes for people who use AHP services. It also has a crucial role to play in the development, retention and motivation of the workforce.

Good quality supervision underpins high quality safe practice.

This Policy Document sets out a formal process for how that should be achieved in the workplace and will be a vital tool in maintaining the highest standards of care for all. It has been designed to enable organisations, supervisors and those receiving supervision to make the most of the opportunities that supervision offers.

Linked to this I expect those who commission and regulate AHP services will look for and require evidence of effective supervision provided to the standards outlined in this document.

## **Foreword: by Lead Allied Health Professions Officer**

The Allied Health Professions (AHPs) in Northern Ireland consist of 12 distinct and unique disciplines. AHPs play key roles and add critical value across the full range of primary and secondary prevention, diagnosis, treatment and care.

The DHSSPS Strategy 'Improving Health and Well-being Through Positive Partnerships' sets out a high level road map for the development of the AHP workforce and to support the commissioning and delivery of AHP practices to enhance the health and social well-being of the population in Northern Ireland.

Within the AHP Strategy one of the key actions details the development of policy to support good practice and ensure that effective risk management processes for AHP practices are in place.

In this context, a key factor in delivering quality AHP services is assurance of professional support and supervision.

This Policy Document sets out a formal process for how that should be achieved in the workplace.

This policy sets clear direction for AHP staff, their professional leads and line managers to ensure processes and systems are in place to support professional supervision.

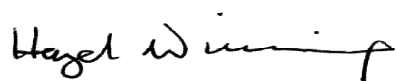
It has been designed to enable organisations, supervisors and those receiving supervision to make the most of the opportunities that supervision offers.

In light of recent publications and reports and strong direction from the HCPC Regulatory Body and the range of AHP Professional Bodies it is crucial that robust governance arrangements including supervision are in place to ensure the safe delivery of high quality care for service users and staff.

As Lead AHP Officer I wish to acknowledge the valuable contribution and dedication of those who contributed to the development of this policy.

I am delighted with the timely publication of this policy a single set of core values and principles to support AHP professional supervision.

### **AHP lead officer signature**



## 1. Introduction/Background

This document outlines the Allied Health Professions Policy on supervision and support for AHP staff working in Health and Social Care Trusts in Northern Ireland.

HSC Trusts employ approximately 4,500 Allied Health Professionals plus their support staff and their contribution is essential to providing safe, effective, modern and high quality services across Health and Social Care.

Allied Health Professionals must be registered with the Health and Care Professions Council (HCPC) in order to practice within the statutory or independent sector employment in the UK.

Consistent with arrangements for other regulated professions, the HCPC is a UK wide statutory regulatory body, which places responsibilities on both the employer, and employee that must be fulfilled to safeguard public protection.

The importance of effective supervision has been highlighted in many recent regional critical incident inquiries such as the, ***Lewis Review (2003)***, ***Murtagh Review (2005)*** and ***McCleery Report (2006)*** and the more recent Robert Francis QC ***Mid Staffordshire NHS Foundation Trust Public Enquiry (2013)*** and ***Winterbourne View report (2012)***.

The recent publication of the Francis Report has re-emphasised the importance of ***Quality 2020***. Many of the themes identified during consultation for Quality 2020 resonate with issues brought forward by Robert Francis QC.

Three elements encompass Quality 2020

- **Safety**-avoiding and preventing harm to patients and clients from the care, treatment and support that are intended to help them;
- **Effectiveness** –the degree to which each patient receives the right care, at the right time in the right place, with the best outcomes:

- **Patient and client focused**-all patients and clients are entitled to be treated with dignity and respect and should be fully involved in decisions affecting their treatment care and support.

The guiding principle of Quality 2020 is to protect and improve the quality of services. The strategy set out in this document is designed to provide a clear direction over the next 10 years to plan for the future while ensuring this principle is preserved, whatever the challenges we may encounter.

The ***Quality Standards for Health and Social Care (DHSSPS 2006)***

recommend that an effective system for supervision across H&SC can help organisations meet each of the clinical and social care governance standards.

In 2012 the Minister for Health Edwin Poots MLA also published the document '***Improving Health and Well-being through Positive Partnerships: A Strategy for the Allied Health Professions in Northern Ireland.***

This strategy focuses on the roles and responsibilities of the AHP workforce at all levels and how these can be developed to enhance the delivery of AHP services that support the health and wellbeing of the population of Northern Ireland.

Within the AHP Strategy one of the key actions details the development of policy to support good practice and ensure that effective risk management processes for AHP practices are in place, that lessons from complaints, adverse incidents, near misses and reviews are learned and applied.

In the context of ***Transforming Your Care A Review of Health and Social Care in Northern Ireland 2011***, the 'shift left' agenda seeks where possible to provide patients with more of their health needs in the home or in a community setting. This requires staff to take on new roles and models of service. This requires robust governance arrangements to be in place to support staff in the delivery of safe effective care.

## 2. Purpose and Aims of this Policy

In this context, a key factor in delivering a quality AHP service is assurance of professional performance supervision and appraisal.

This policy sets policy direction for AHP staff, their professional leads and line managers to ensure processes and systems are in place to support professional supervision.

There is a strong consensus within the Allied Health Professions (referred to hereafter as AHPs) that all practitioners, irrespective of their level of experience, should have access to and be prepared to 'make constructive use of supervision process to support ***lifelong- learning, professional regulation and clinical governance***'. Indeed, many of the Professional Bodies of the professions covered by this Policy state that access to regular Supervision should be available for all staff.

To satisfy the Health Professions Council standards for registration, AHPs can demonstrate competence through Continuing Professional Development which may include evidence of supervision activity.

Supervision refers to: '*a formal/informal arrangement, which enables a therapist to discuss his or her work performance in a safe environment with someone who is experienced and qualified.*'

Appraisal is: '*A process for assessing the performance of staff and their requirements for training and development*' (MHSC 2005).

A responsive and skilled workforce means that the right people are in the right place with the right skills, at the right time to deliver the right outcome. It is essential to have a highly motivated, patient focused, appropriately trained, highly skilled and flexible AHP workforce to meet service needs into the future.

Appropriate supervision and appraisal and a strategic and forward looking approach to service delivery and workforce planning, extended roles and changing work practices, including continuing professional development, will help facilitate this.

## 3. AHP Supervision

### 3.1 Purpose of AHP Supervision

The main purpose of AHP supervision is to: -

- Support the development of knowledge and skills within a role or clinical area, the focus being safe and effective practice and benefit to service users and carers.

- Support AHP's in non-clinical roles(AHP team leads etc) through providing an opportunity to discuss issues pertinent to the delivery of safe and effective care and/or professional issues.
- Support AHP's through difficult circumstances such as challenging and complex client caseloads or difficult interpersonal contact with other team members.
- Support the development of competence, knowledge and skills through facilitation of personal and professional growth with reference to the KSF and where possible using the KSF development review process.
- Support reflective practice and clinical reasoning taking account of professional standards, the legislative context and eligibility criteria for service delivery.

### 3.2 Core Values and Principles

The following are the core values which underpin the supervision policy document.

- Supervision must ensure the effective management of practice by developing and supporting staff and promoting staff engagement within the organisation.
- The quality of supervision has a direct bearing on the quality of service delivery and outcomes.
- All staff members, irrespective of their role, have the right to receive high quality supervision.
- The supervisory process will promote and protect the best interests of staff & service users irrespective of differing political opinions, race, religious or cultural views, age, marital status, sexual orientation or disability.
- All staff members bear responsibility for the quality of their own work and are required to prepare for and make a positive contribution to the supervisory process. They are not passive recipients.
- Supervision should be available to all AHP staff in four areas of professional activity: **Clinical, Professional, Managerial, and Operational**, on an interpersonal and supportive basis.
- Trusts have a responsibility to promote good supervision by implementing this policy and ensuring training is provided for both supervisors and supervisees.

### 3.3 Non- professional Roles that require the post holder to be registered as AHP

Staff who work within non professional roles that require the post holder to be registered as an AHP with HCPC as one of the criteria for the post (and do not have professional duties) do NOT require professional supervision from core services.



In order to retain registration and ensure their CPD requirements are met they must evidence CPD activity to reflect the duties of their post. This group of staff access general management supervision and support.

### 3.4 Frequency of Supervision

**Formal supervision** should be available on a regular basis. In line with professional standards, each Professional Head of Service Lead will decide on the frequency of supervision (not less than 4 times per year) that is required for staff within their service/ Trust.

**Informal supervision** should be provided on an ongoing basis as required. Informal supervision can be carried out on a daily basis where help is sought regarding Clinical, Professional, Managerial and Operational issues from Peers and Managers.

The main form of supervision will be in the form of formal one to one supervision but professional managers may deploy team or group supervision techniques where appropriate. It is likely that a combination of both types of supervision will be used.

Professional Heads of Service must ensure all AHP staff has access to professional supervision relevant to their grade, competency and experience regardless of where they work within the Trust services /structures.

Time allocated per supervision session should be adequate to address the aims and objectives of the specific session.

Other activities AHPs engage in throughout the year may impact on the process of supervision.

Registered AHPs should reflect on their own practices as they engage in ongoing learning and development activities in their working environment. This experience should be used to inform the supervision sessions.

AHP's can access guidance on reflection and keeping a portfolio at [www.hcpc-uk.org](http://www.hcpc-uk.org) which can assist with this process.

## 4. SUPERVISION PROCESSES

### 4.1 Training

The provision of supervision carries training implications for all practising AHPs.

Supervisors and supervisees must be trained to carry out their roles within the supervision process and profession specific induction of all staff must include the supervision policy and procedures. Supervisors

will attend designated training in supervision within an agreed timescale of taking up their first supervisory/management post.

Refresher training will be available to supervisors to consolidate skills and is discussed within the supervisor's annual appraisal.

Where supervision training is not yet complete, AHPs new to the supervisory role should sit in for a number of sessions with an experienced supervisor to gain some experience of the process as deemed appropriate and with consent of all involved. Time should be made available for supervisors to attend appropriate introductory and advanced training courses.

The skills and competence of a supervisor is crucial to the effective supervision of AHPs. The skills required for supervision will build on existing communication and facilitation abilities learned through initial training, post-registration professional development and experiential learning.

#### **4.2 Receiving Supervision**

All AHP staff should be in receipt of regular supervision either formally or informally. Formal supervision should be available to all AHP staff in four areas of professional activity:

- **Clinical,**
- **Professional**
- **Managerial and**
- **Operational.**

Although the four types of supervision may be provided to an individual AHP staff member by the same supervisor from within their profession, within the Integrated Team Structures this will not be the case for many staff.

Where managerial/operational supervision is carried out by a supervisor from a different professional background there will be a need for the professional line manager to undertake clinical and professional supervision separately to ensure that sufficient time is afforded to all functions of supervision and that all four types are fully addressed.

The professional and operational managers should ensure that there is an appropriate balance in terms of the time given to each form of supervision and will need to share information and work in partnership to achieve this.

Joint supervision sessions with the Operational Manager, Professional Manager and the supervisee may be an efficient way of agreeing overlap areas and the supervision agreement. These processes will be agreed with the professional and operational line managers.

The principal method of supervision within the Trust is **one-to-one** supervision – where one worker is given the responsibility to work with another worker to meet certain organisational, professional and personal objectives. Supervision as defined in this policy should operate at all professional levels in the organisation up to Professional Head of Service.

However, in some instances as advised by the Professional Head of Service it may be necessary and appropriate to use other methods of supervision. These include **group supervision, team supervision** and **mentoring** by senior practitioners or the use of other expertise and skills.

The guiding principle, irrespective of which methods are used, is that the professional and operational line managers are jointly responsible for ensuring that all four functions of supervision are addressed.

It is recognised that all AHP's engage in the process of informal supervision and whilst acknowledging the importance, and indeed necessity of this activity, this should not in any way replace the formal supervisory requirement.

#### **4.3 Providing Supervision**

All qualified AHP staff may regularly be expected or asked to provide supervision to a range of grades of staff within their own discipline. Supervision must be arranged and conducted in such a way as to permit proper reflection and discussion and is not subject to cancellation and is only postponed in exceptional circumstances. Any postponed session is reconvened at the earliest opportunity.

Since supervision is a planned purposeful activity the following activities must be addressed.

Both supervisor and supervisee must prepare for supervision by:

- Agreed items for discussion are drawn up at the start of each supervision meeting with contribution from both supervisor and supervisee.
- Decisions made at previous supervision meetings are reviewed to ensure agreed actions have been taken.

#### **4.4 Professional Heads of service**

AHP Professional Heads of Service have overall responsibility to ensure all professional staff within the Trust across services have access to appropriate supervision.

The AHP Professional Heads of Service are accountable to the Chief Executive for safe professional practice of their staff/service.

In order to support their own professional practice/supervision requirements this is gained through attendance at Regional Managers groups, liaison/involvement with their Professional Body, attendance at Trust AHP Forums, involvement through the Trust AHP Lead with the Regional AHP Forum at the PHA, and regional AHP workstreams, linking ultimately to the Lead AHP Officer at the DHSSPS.

## **5. Components of Supervision**

### **5.1 Clinical Supervision**

The fundamental aim of clinical supervision is to promote best clinical practice through the process of reflection, discussion and review of all aspects of the clinical task and client/therapist relationship.

For the purpose of this policy clinical supervision is defined as *'supervision that relates to all clinical activity; the processes involved in case management, assessment, clinical reasoning, formulation, therapeutic intervention, decision making, consultation, consideration of legislative context and statutory functions, case evaluation/case review status and other wider and more systemic clinical activities.'*

In the case of clinical supervision the AHP staff providing supervision should be working within the same area of specialty and should preferably be from within the same organisation.

If no suitably qualified member of AHP staff within the same specialism is available to provide clinical supervision within the organisation then it may be necessary to seek and to ensure supervision is provided, preferably by a suitably qualified Allied Health Professional from within the same specialism, outside the organisation. This will be particularly pertinent for those staff in extended/new roles and regional posts.

In instances where no such suitable qualified AHP staff are available to provide supervision either within or external to the organisation, the practitioner should seek competent supervision from another AHP staff member or recognised and accredited Professional, in agreement with his or her Professional Head or Service.

The professional line managers will agree streamlined approaches to the supervision of AHP staff in rotational posts/split posts to avoid the need for multiple supervisors and ensure clarity of approach.

In keeping with the professional body guidelines and agreement from professional Head of Service, Specialist AHP Practitioners should ensure their supervisory requirements are met using the following:

- Attendance at Special Interest Groups
- Regional Forums
- Peer Support
- Peer Supervision

The nature of some of the above activities is such that the time requirement for supervision may not necessarily be met as planned but will be met through longer sessions held less regularly throughout the year.

AHP staff not directly employed by HSC, but contracted to provide a service into HSC, need to ensure they engage in professional clinical supervision from the same professional specialism. This will help ensure clinicians develop professionally in the skills applicable to their job roles.

## 5.2 Professional Supervision

All AHPs should have access to a Professional Line Manager of the same profession for issues relating to the following:

- Scope of practice
- Continued Professional Development
- Their role as one of the AHP professionals as defined in their job description
- Professional Guidelines
- Ethical obligations
- Other broader Professional issues

Within supervision, the supervisor ensures that the Continuing Professional Development functions (including the post registration training and learning requirement (PRTL) set down by HCPC) are met by:

- Helping staff to develop their professional competence.
- Enabling staff to meet their post qualifying and training requirements related to their ongoing registration with HCPC.
- Helping staff to initiate fresh ways of working in response to changing needs.
- Enabling staff to relate theory and research to practice.
- Assessing training and development needs.
- Developing skills and knowledge.
- Helping workers to reflect on their work and interaction with service users mindful of equality and human rights legislation.
- Providing feedback on performance.
- Discussing knowledge and skills gained in training events and identifying opportunities to integrate these into the supervisee's work.

### 5.3 Managerial Supervision

Within supervision, the supervisor ensures that the management (competent, accountable performance) function is met by ensuring that:

- Trust/Professional policies and procedures are understood and adhered to.
- The supervisee's workload is managed and priorities are set.
- The quality of the supervisee's performance is measured.
- Statutory responsibilities are addressed.
- Work is allocated according to the experience and skill of the practitioner and the team business plan in keeping with profession specific guidelines.
- Case recording, including daily records meet Trust/Professional standards.
- Case files are audited as per Trust requirements.
- Intervention plans are devised, implemented, reviewed and recorded on the case file.
- Any advice/consultation on case work given **outside formal supervision** by the professional line manager or other manager should be recorded by the supervisee on the patient case file.
- The needs and desirable outcomes of service users are understood; and that risks are identified and countered.
- Appraisals take place, that supervisees have opportunities to meet objectives set in these and that the objectives are reviewed on a regular basis.

### 5.4 Operational Supervision

Within Supervision, the supervisor ensures the **engagement** (of the individual with the organisation) by:

- Communicating effectively with staff about organisational changes and initiatives.
- Briefing management about resource deficits.
- Representing staff needs to management.
- Seeking policy clarification.
- Consulting with staff and feeding back to management on how organisational policies/practice is perceived.
- Negotiating on differences which may arise between supervisors and other professionals, teams or service.

## 6. Interpersonal Relationship within the Supervision Context

It is important that there is recognition for AHP staff as practitioners to be aware of how working with varying client groups can impact upon staff and to be mindful of the implications of this for their work as clinicians. In light of the above AHP clinicians should have access to ways and means that allow them to reflect upon and to process such issues.

Within Supervision, the supervisor where appropriate ensures that staff are supported by signposting them to get guidance to address any issues such as: work related stress, personal issues or team dynamics and relationships.

There may be times when personal experiences and issues cannot be dealt with appropriately within the existing clinical or other supervisory relationships. In such instances there may be a need for some additional personal supervision. Where this is considered necessary the AHP concerned should discuss their need with their Line Manager or Professional Head of Service.

## **7. Recording Supervision**

All supervision sessions should be recorded promptly, competently and stored properly, using the relevant proforma.

- All records relating to cases (whether individual or joint supervision or unplanned discussions) are recorded on the relevant proforma, signed by the supervisor and placed on the supervisee's supervision file by the former. This record would normally only be read by more senior management for the purposes of auditing the quality of work and supervision.
- All supervision records should be either typed or written legibly in clear print.

The date and time of each supervision session should be recorded along with a brief outline of areas discussed.

Both supervisor and supervisee:

- Should agree and sign the supervision records. Where clinical supervision involves the discussion of specific clinical cases a brief summary of the issues discussed and any recommendations or actions agreed, should be included in the case file by the clinician bringing the case to supervision using the appropriate proforma.
- Both supervisor and supervisee should record time involved in informal/unplanned supervision along with a brief summary of the content of this, on the supervision record.
- If any functions of supervision are undertaken by a third party, the operational line manager should ensure effective communication and organises relevant tripartite meetings as appropriate.
- Professional Senior management should conduct regular audit of supervision practice.

It is essential that written notes of individual sessions are taken, remain confidential and record clearly any agreed actions.

### **7.1. Confidentiality**

Supervision sessions are, in general confidential exchanges between supervisor and supervisee. However, the supervision record is an organisational document which may be seen by others if required. The record may also be used where there are situations like grievances or disciplinary proceedings, without the consent of the parties involved. The supervision agreement process should clarify the constraints upon confidentiality and where records are kept in electronic format security access levels will need to be agreed.

**All parties must be informed of the intention to disclose, before revealing confidential information.**

### **7.2. Use of Patient/Client Records**

Where supervision is focused on case discussions/review or application of clinical reasoning patient/client records may be used to support this activity. This will be particularly relevant to new graduates and to aid complex case discussions. Where this happens, the staff code of ethics and confidentiality will apply.

Organisations employing professional staff members who make such records are the legal owners of those records.

### **7.3. Storage of Records**

Each HSC Trust has its own policy for the safe storage of records. However, each registrant / staff member should be mindful of his/her professional accountability with regard to the principle of confidentiality of information

### **7.4. Supervision Implementation Plans**

Each Professional Head of Service will have an agreed implementation plan for their service which will be agreed and shared with operational line managers if AHP staff members have separate professional and operational line managers.

## **8. Monitoring and Evaluation**

Following any regional policy a monitoring process will be developed to provide assurances that implementation has been completed. Ongoing monitoring and evaluation of supervision activity is also essential to ensure that Supervision Policies and Procedures are meeting service need and that they are meeting all four functions of Supervision. It is also



necessary to monitor the benefit to individual registrants /staff, clients and the organisation, since the quality of supervision activities can influence effectiveness, reduce risk and promote safe and effective care.

Individual supervisors must comply with information gathering regarding the number of sessions they engage in and make this data available to professional line managers for collation. This information will, in turn, be provided by AHP Heads of Service and communicated to the Trust Lead AHP.

Reporting arrangements and timeframes will be in line with DHSSPS accountability arrangements and the HSCB/PHA led by the Director of Nursing and AHPs (PHA) in conjunction with the Assistant Director for AHPs and PPI (PHA) from the Trust Executive Director with responsibility for AHPs.

## **9. Professional Governance Frameworks for the Allied Health Professions**

Part of the overarching HSC Framework (2011) details the Professional Assurance Framework the statutory requirements placed upon the Health and Social Care (HSC) by the Health and Social Care (Reform) Act (NI) 2009 for Allied Health Professions (AHPs).

The document clearly articulates processes alongside professional roles and responsibilities in existing structures.

The Professional Assurance Framework ensures an assurance to the DHSSPS through the HSC Trust Board that effective processes for AHP practice are in place and implemented to develop support and monitor workforce compliance with agreed accountability and governance frameworks.

This includes implantation of this Regional Supervision Policy for AHPs underpinned by legislation and range of other DHSSPS policies and standards, along with professional standards developed by the professional and regulatory Bodies for AHPs.

While ultimate accountability rests with the Minister through DHSSPS, accountability to the Lead AHP Officer (DHSSPS) will be led by the Director of Nursing and AHPs (PHA) in conjunction with the Assistant Director for AHPs and PPI(PHA) from the accountable Trust Executive Director in conjunction with Trust AHP Leads and professional AHP Heads of Service.

## **10. Review**

Given the importance of supervision to the clinical and governance tasks, the Supervision Policy should be reviewed every two years and amended in accordance with clinical governance standards and relevant Professional Guidelines.

# Appendices

## Appendix A

### A) GROUND RULES – 1:1 SUPERVISION

**Prior to supervision session the SUPERVISEE will have:** -

- Read all relevant/associated policies, procedures and guidance
- Prepared for the session and will have considered and identified practice areas for open discussion
- Undertaken relevant action(s) as agreed at previous supervision session(s)

**Prior to supervision session the SUPERVISOR will have:** -

- Prepared for the session and will have considered and identified practice areas for open discussion with an agenda.
- Undertaken relevant action(s) as agreed at previous supervision session(s)

**During each supervision session both SUPERVISOR and SUPERVISEE will:** -

- Maintain mutual respect
- Have an attitude of open learning
- Maintain strict confidentiality
- Be open to constructive feedback
- Engage in reflective practice
- Deal appropriately with areas of disagreement according to the ground rules
- Where a situation arises of the intention to disclose revealing confidential information all parties must be informed
- Explore the supervisee's expectations appropriately using appropriate knowledge, skills and experience

**At the end of the supervision session both SUPERVISOR and SUPERVISEE will:** -

- Agree a suitable time and venue for the next session

**After the session the SUPERVISEE will:** -

- Engage in learning and development activities that will
  - (a) inform subsequent supervision sessions
  - (b) form part of a CPD portfolio and
  - (c) act as the basis for an analysis of future learning need that will feed into the KSF development review process as appropriate.
- Record and reflect on significant activities
- Evaluate the perceived benefit of the session
- Maintain and store records in line with Trust policy

**After the session the SUPERVISOR will: -**

- Maintain and store records in line with Trust policy
- Provide the supervisee with a copy of the session if not already provided
- Reflect benefit of the session to the supervisee

## **b) GROUND RULES – GROUP SUPERVISION**

**Prior to supervision session the SUPERVISEES will have: -**

- Read all relevant/associated policies, procedures and guidance
- Prepared for the session, considered any identified practice areas for open discussion
- Undertaken relevant action(s) as agreed at previous supervision session(s)

**During each supervision session both SUPERVISOR and SUPERVISEES will: -**

- Be sensitive and supportive to the needs of individuals and the overall dynamics within the group
- Maintain strict confidentiality by not disclosing or discussing information provided by any other members of a group
- Listen to and allow other members of the group to speak and maintain mutual respect
- Have an attitude of open learning
- Be open to constructive feedback
- Engage in reflective practice
- Deal appropriately with areas of disagreement according to the ground rules
- Ensure that identified unsafe, unethical or illegal practice is dealt with supportively via appropriate procedures
- All parties must be informed of the intention to disclose, before revealing confidential information.

**At the end of the supervision session both SUPERVISOR and SUPERVISEES will: -**

- Agree a suitable time and venue for the next session

**After the session the SUPERVISEES will: -**

- Engage in learning and development activities for subsequent supervision sessions
- Record and reflect on significant activities
- Evaluate the perceived benefit of the session
- Maintain and store records in line with Trust policy

**After the session the SUPERVISOR will: -**

- Maintain and store records in line with Trust policy
- Provide the supervisees with a copy of the session if not already provided
- Reflect benefit of the session to the supervisees

## **Appendix B**

### **AHP Professions**

Allied Health Professions work with all age groups and are highly trained and skilled in health promotion, assessing, diagnosing, treating and rehabilitating people with health and social care needs. They work independently and in teams in a range of settings including hospital, community, education, housing, independent and voluntary sectors. Their interventions are central to promoting and maintaining health and well-being, maintaining safety and independence, preventing inappropriate hospital admission and assisting safe and effective hospital discharge.

The twelve AHP professions include:

- Art therapists
- Dietitians
- Drama therapists
- music therapists
- Occupational Therapists
- Orthoptists
- Orthotists
- Physiotherapists
- Podiatrists
- Prosthetists
- Radiographers- diagnostic and therapeutic
- Speech and language therapists

## **Appendix C**

### **Professional Bodies**

<a href="http://www.scpod.org">www.scpod.org</a>	-The society of Chiropodists & Podiatrists
<a href="http://www.sor.org">www.sor.org</a>	-The Society & College of Radiographers
<a href="http://www.rcslt.org">www.rcslt.org</a>	-The Royal College of Speech & Language Therapists
<a href="http://www.csp.org.uk">www.csp.org.uk</a>	-The Chartered Society of Physiotherapy
<a href="http://www.orthoptics.org.uk">www.orthoptics.org.uk</a>	-The British & Irish Orthoptic Society
<a href="http://www.bapo.com">www.bapo.com</a>	-The British Association of Prothetists & Orthostists
<a href="http://www.cot.co.uk">www.cot.co.uk</a>	-The British Association of Occupational Therapists
<a href="http://www.bda.uk.com">www.bda.uk.com</a>	-The British Dietetic Association
<a href="http://www.baat.org">www.baat.org</a>	-The British Association of Art Therapists
<a href="http://www.badth.org.uk">www.badth.org.uk</a>	-The British Association of Drama Therapists
<a href="http://www.bamt.org">www.bamt.org</a>	-The British Association for Music Therapy

## Appendix D

### Health and Care Professions Council

The Health and Care Professions Council (HCPC) was created by legislation: Health Professions Order 2001 and established as an independent UK wide statutory health regulator that works to protect the health and well-being of people using the services of the health professionals.

#### Aims:

- maintaining and publishing a public register of properly qualified members of the professions;
- approving and upholding high standards of education and training, and continuing good practice;
- investigating complaints and taking appropriate action;
- working in partnership with the public, and a range of other groups including professional bodies; and
- Promoting awareness and understanding of the aims of the Council.
- Our procedures and processes have been developed in full consultation with the public, health and social care professionals and other key stakeholders.
- Our strategic intent document contains more information about our aims and vision:

Web site: [www.hcpc-uk.org](http://www.hcpc-uk.org)

The HCPC set standards of professional training, performance and conduct for AHP professions. The Professionals who meet the HCPC Standards are placed on a register and action is taken if they do not meet the required standard for professional skills, behaviour and a health .Each profession has a 'protected title'. Anyone who uses one of these titles must be registered with HCPC.

## **Appendix E**

### **Linkage to DHSSPS Strategic Documents**

There is a shared vision across all Northern Ireland Government Departments.

For DHSSPS this is about working across government to:-

- Improve health and well being outcomes;
- Minimize health inequalities;
- Deliver services of the highest quality; and
- Provide a good patient experience when HSC services are used.

### **Strategic Documents**

**This is a range of current documents that impact on AHP Services**

Public Health Strategy (2012-2022)

A Fitter Future for All - A Framework for Preventing and Addressing Overweight and Obesity in Northern Ireland (2012-2022);

Healthy Child, Healthy Future (2010);

Children's Service Framework

RQIA Review on Children on Adult Wards

Physical and Sensory Disability Strategy and Action Plan (2012);

Childcare Strategy

Mental Health and Well-being Promotion

Living with Long-Term Conditions - a Policy Framework (2012);

Healthy Futures (2010);

Bamford Action Plan (2009-2011)

Review of Child and Adolescent Mental Health Services (2011)

Promoting Good Nutrition (2011)

The Chronically Sick and Disabled Persons (NI) Act 1978

The Disabled Persons (NI) Act 1989

The Human Rights Act 1998

The European Union Employment Directive 2000 / 78 / E

## **Appendix F**

### **Reviews/ Reports Referenced**

**Lewis Review** – The review of Health and Social Services in the Case of David & Samuel Briggs (The Lewis Review)

**Murtagh Review** – Review of the Lessons Arising from the death of the Late Janine Murtagh

**McCleery Report** – Executive summary and recommendations from the report of the inquiry panel (McCleery) to the Eastern Health and Social Services Board.

**Mid Staffordshire NHS Foundation Trust Public Enquiry**

**Quality Standards for Health and Social Care DHSSPS 2006**

**Improving Health & Well Being Through Positive Partnerships: A Strategy for the Allied Health Professions in Northern Ireland.**

**Transforming Your Care: A Review of Health and Social Care in Northern Ireland**



