Get ready for revalidation in pharmacy

A process for periodic revalidation in pharmacy should be ready for phased implementation by the General Pharmaceutical Council in 2012. In this article, Andreas Hasman, policy co-ordinator at the Royal Pharmaceutical Society, describes the background to this development.

Often described as a regular “MOT” for health professionals, revalidation has so far attracted surprisingly little attention in pharmacy. That is about to change, however, because the concept is taking centre stage in ongoing reforms of professional regulation in the UK. Revalidation holds promise, in fact, to be the biggest innovation in the regulation of the profession for a generation. When the General Pharmaceutical Council is established in 2010, it is likely to introduce, within a couple of years, a system for periodic assessment of registrants’ fitness to practise.

Scandals

In other professions, notably medicine, revalidation has featured prominently in the debate about regulation for more than a decade. Following the emergence of high-profile scandals involving poor medical practice in the late 1990s, the General Medical Council pledged in 2000 to introduce a five-yearly process to ensure that doctors on the medical register remain competent, up to date and fit to practise. These plans were significantly delayed, however, following the public inquiry into the Harold Shipman murders.

The inquiry found that the proposed revalidation process, based largely on employees’ appraisals, would be inadequate in protecting the public against poorly performing doctors. Medical revalidation was, nevertheless, back on the agenda in February 2007, when the Government accepted proposals from its chief medical officer to introduce a mandatory licence to practise for all practising doctors, which would require renewal or revalidation every five years. According to current plans, the process for medical revalidation will be based on an assessment of a folder of information about the individual, which includes the outcome of a strengthened system of standard-based annual appraisal, feedback from patients and colleagues, and evidence from practice.

The development of plans for revalidation in medicine was accompanied by an acknowledgement of the risks to patient safety in healthcare practice go beyond the practice of medicine, not all pharmacy registrants have access to appraisal of sufficiently high quality. It is likely, therefore, that additional sources of evidence will be needed. Ideally this additional evidence would be generated through routine practice with a minimum of additional effort required by registrants and the regulator.

A decision will also be made on the nature of the assessment process for revalidation. One possibility is for this process to consist of a number of consecutive assessments, so that if there is an initial failure to meet the standard for revalidation, there would be an additional in-depth assessment.

Repeated failure to demonstrate fitness to practise could lead to removal from the register but the model under consideration includes provision for remediation leading to supervision after every stage.

In terms of the delivery of revalidation, initial considerations have centred on either a centralised model, which entails objective assessment by assessors who have no prior knowledge of the individual registrant, or a decentralised model, in which assessment for revalidation is undertaken at a local level by someone who is familiar with the practice of the individual and its context.

In due course, the regulator may choose to run centralised and decentralised processes in parallel to meet the differentiated needs of different groups of registrants (eg, pharmacists employed in the NHS and self-employed pharmacists in the community).

To inform future revalidation policy development in pharmacy, the Society has commissioned a number of research projects. These will explore the options for use of evidence for revalidation with a particular focus on CPD, employer’s appraisals and other evidence relevant to the revalidation process. The research will also deliver a risk assessment of pharmacy practice. This is required to ensure that the frequency and intensity of the eventual revalidation process are proportionate to the risks of practice. A third project, due to be commissioned at a later date, will provide information to support the choice of a centralised or decentralised revalidation process. The revalidation research will be completed in 2010.

Next steps

In parallel with the revalidation research, the GPhC will be responsible for setting standards against which assessment will be carried out. One aim could be for the revalidation standards to be joined up with standards of proficiency required for initial registration as a pharmacist or pharmacy technician and the standards that underpin the CPD required by employers. Once proposals for the standards and process of revalidation have been specified, the GPhC will need to consult the pharmacy professions and other stakeholders on the revalidation proposals before final implementation. It is expected that a process for periodic revalidation in pharmacy will be ready for phased implementation in 2012.