Public business

Revalidation: Task and Finish Group

Purpose

To seek agreement from the Council on the establishment of a Task and Finish group.

Recommendations

The Council is asked to agree:

i. to the formation of a Task and Finish group comprising initially of members of Council with a remit and composition as outlined in sections 3.1 and 3.2.

1.0 Introduction

1.1 At the January 2011 GPhC Council workshop preliminary results were presented from four commissioned research projects funded by the Department of Health to inform the development of a revalidation model for the pharmacy profession (see Appendix 1 - copies of Executive Summaries are available on request).

In terms of further revalidation research, it was noted that a bid for additional funding into the concept of ‘verification’ of the portfolio of evidence required to show that a registrant has met the ‘revalidation standard’ was submitted to the Department of Health in December 2010. A decision on whether a grant will be awarded is expected towards the end of February.

Revalidation was also considered in the context of the current political climate and following informal discussions on the research outputs, it was suggested that next steps in developing a model of revalidation in pharmacy might be best taken forward by establishing a Task and Finish group.
2.0 **Background**

2.1 The White Paper *Trust, Assurance and Safety – The Regulation of Healthcare Professionals in the 21st Century* (February 2007), set out a range of policies, including proposals to ensure that all statutorily regulated health professionals have arrangements in place for the revalidation of their professional registration through which they can periodically demonstrate their continued fitness to practise.

Subsequently, the Department of Health established seven working groups, one of which considered and made proposals in relation to the implementation of non-medical revalidation. The Working Group had representation from the RPSGB.

2.2 The Non-Medical Revalidation Working Group’s recommendations to ministers were circulated to the regulatory bodies in August 2008 and the final report was published on 27 November 2008. The Group’s primary objective was to set out the way forward to implement the White Paper’s intention to introduce a new model of revalidation for non-medical health professions, and the report outlined 12 guiding principles to this end (see Appendix 3). The report also charged the regulatory bodies with developing models of revalidation that meet the needs of both the profession and the public. The final report defined the primary purpose of revalidation: ‘to enhance public protection by ensuring that health professionals in clinical practice are up to date and demonstrate that they continue to meet the requirements of their professional regulator. Revalidation confirms that the registrant is practising in accordance with their regulators’ standards and will identify for further investigation, and remediation, poor practice where local systems are not robust enough to do this or do not exist’.

2.3 On 3 October 2007, the RPSGB’s Council agreed the formation of a short-term revalidation advisory group (RAG), with the remit to provide recommendations to the Council on the development of revalidation in pharmacy and to facilitate communication between the Council and relevant stakeholders.

2.4 On 3 February 2009, the RPSGB’s Council agreed a report from the RAG which identified the next steps in developing the then regulator’s approach to revalidation. The report, which was submitted to the Department in Health in February 2009, concluded that following consideration of the main components of revalidation in two health professions, a process involving submission of a portfolio was likely to be most appropriate for revalidation in pharmacy. However, it exposed significant gaps in the knowledge base required to make informed choices for the implementation of revalidation in pharmacy. Draft proposals for research to address these knowledge gaps were subsequently forwarded to the Department and the Society was awarded a grant of £260,000.
to fund a full research programme in March 2009 covering three related work streams:

- Work stream 1: Risk within pharmacy practice (to inform the development of standards and processes for revalidation that are proportional to risk)
- Work stream 2: Identification and evaluation of potential sources of evidence for revalidation, including employer appraisals and CPD records
- Work stream 3: Identification and evaluation of potential structures for the delivery of revalidation within pharmacy.

2.5 In August 2009 the RPSGB set up the Revalidation Research Programme Steering Committee to assist in assuring effective research governance arrangements for the research programme. A tendering exercise was undertaken and four research projects covering the three work streams were commissioned between July 2009 and February 2010. In September 2010, following demerger of the RPSGB, the programme of research initiated by the RPSGB was transferred to the GPhC. Preliminary results are available (see Appendix 1).

2.6 Following the change in government, developments in revalidation need to be considered in the context of the current economic and political climate. Current intelligence suggests that while ministers in all four UK countries have agreed that the professional regulatory bodies should continue to gather the evidence base to assess the feasibility and proportionality of non-medical revalidation, given the pressures on the service over the coming years, they have indicated that any further measures to strengthen and assure professional standards must be proportionate and supported by robust analysis of the costs and benefits. Furthermore, the Department of Health has indicated that public funding is unlikely to be able to meet all the development and implementation costs that healthcare regulatory bodies may seek.

Non-medical regulators are also being encouraged to take account of the timetable for the medical revalidation pilots and consider any learning from those pilots where possible to inform the development of other revalidation systems.

2.7 The GPhC Council now needs to consider its approach to revalidation development, in the light of this history and in the present context. A Task and Finish group would provide a useful mechanism for doing that.

3.0 Remit and composition of the Task and Finish group

3.1 We envisage that the key role of the Task and Finish group would be to advise Council on how best to take forward GPhC policy development in this area. A
draft remit is outlined in Appendix 2.

3.2 We suggest that the group comprises four members of Council, acting for the Council as a whole and as a first step, the Council members meet as a small group to review the wider group’s remit and to report back to the Council in April with recommendations on the following:

- The wider group’s terms of reference
- The appointment of additional members to the group and the additional knowledge skills and competencies required
- What further research needs to be commissioned.

The proposal is for the group to comprise two lay and two registrant members of Council. Members interested in serving on the group would identify themselves to the Chair, who would nominate the group members, having taken any necessary soundings with colleagues, in the event of having more than four volunteers.

4.0 **Equality and diversity implications**

4.1 Revalidation processes are likely to have significant equality and diversity implications. Processes for enforcement need to be applied in ways which are fair, bearing in mind the range of work patterns, types of practice and life circumstances amongst the GPhC’s registrants. Legislation relating to equality and diversity will need to be monitored on an ongoing basis to ensure that the GPhC remains legally compliant.

5.0 **Communications implications**

5.1 Findings from the revalidation research and development programme need to be made publicly available and following consideration of the evidence base, communications will also need to be disseminated on proposed next steps.

5.2 A consultation with the public and profession will need to be undertaken to agree the revalidation standards, model and processes of revalidation within pharmacy.

6.0 **Resource implications**

6.1 Convening and servicing up to four meetings of the Task and Finish group in 2011 would have no additional resource implications and meeting costs can be met from existing budgets.
7.0 Risk implications

7.1 There is a reputational risk to the GPhC if revalidation models are introduced that are neither effective nor proportionate to risk. Risks will be mitigated by thorough analysis of the evidence from the commissioned research and of the experiences of other regulators.

7.2 Proposals for revalidation must be practical to implement and underpinned by a robust analysis of the costs and benefits. It is essential that the views of different sectors of pharmacy practice are represented on the group to identify and manage risks associated with implementation.

7.3 Revalidation in pharmacy and other health professions will be seen as a threat by some within the profession. A communications programme will be necessary to promote the formative and remedial aspects of revalidation and minimise the impact of negative opinions.

8.0 Recommendations

The Council is asked to agree:

i to the formation of a Task and Finish group comprising initially of members of Council with a remit as outlined in sections 3.1 and 3.2.

Janet Flint
Postregistration Manager
janet.flint@pharmacyregulation.org, tel 0203 365 3542

Sadia Khan
Revalidation Policy Co-ordinator
sadia.khan@pharmacyregulation.org, tel 0203 365 3543

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Appendix 1
Revalidation Research and Development Programme: Preliminary Findings

- Attitudes towards revalidation within the profession vary and some remain to be convinced that risks posed to the public are sufficient to justify interventions beyond the current regulatory approach. Key messages are to build on what is known, accepted and established and to avoid a costly, burdensome and bureaucratic scheme.

- Overall, a centralised system is favoured, with some form of ‘external verification’ of the required evidence by trained assessors who should be pharmacy professionals. Some employers could have a role in the provision of evidence for revalidation and/or verification.

- Continuing Professional Development (CPD) is favoured as a primary source of evidence for revalidation in pharmacy. The CPD ‘call and review’ process which applies to all registrants is running effectively and a revalidation process that is linked to CPD is likely to be acceptable to the profession.

- If a revalidation model is to be taken forward, there are split views on whether it should be applied to all pharmacy professionals or limited to those in clinical practice. There is, however, support for including individuals involved in wider supporting roles that can impact on patient safety.

- The research into risk assessment has identified some possible models and approaches that could be used for risk-based revalidation model, but peer review of the commissioned research on risk has highlighted the need to proceed cautiously in to this area to avoid inadvertently contravening the 2010 Equality Act.

- There is no clear consensus on the value of incorporating a designated/responsible officer-type role within pharmacy.

- There is support for development a set of generic standards that all registrants are required to meet. These could be supported by additional role or sector-specific standards.

- Most appraisal systems in pharmacy are not clinically focussed and therefore in their current form are not suitable for use as a primary source of evidence of fitness to practise.

- There are limitations in using other available sources of evidence such as reports of inspector visits, PCT monitoring visits and patient feedback questionnaires within a pharmacy model as these tend to focus on the pharmacy rather than on individuals.
Appendix 2
Remit of the Revalidation Task and Finish Group

Remit

At its inaugural meeting the group will initially comprise GPhC Council members and will be asked to review its terms of reference and to consider future composition and size with a view to reporting back to the Council in April.

It is envisaged that the remit of the group will be to

- consider the outputs of the RPSGB’s Revalidation Advisory Group report to the Department of Health in February 2009
- consider the outputs of revalidation research commissioned by the RPSGB (funded by the DH) in 2009/2010
- consider the most appropriate terminology for what we are trying to achieve
- consider revalidation in the context of the risks in pharmacy practice (what are the risks?, how great are the risks?, how the risks are currently managed?)
- consider approaches to revalidation being taken by other regulators in the context of the current political and economic climate
- make recommendations to the Council on the direction of GPhC revalidation policy.

Timescale

The first meeting will be arranged for February/March 2011 and feedback on the terms of reference, composition and size will be reported at the GPhC Council April meeting. Maximum of four meetings over a six month period in 2011 with other work undertaken virtually.
## Appendix 3

**Non-Medical Revalidation Working Group – Principles for Revalidation**  
Source: Department of Health Non-Medical Revalidation Working Group, November 2008

<table>
<thead>
<tr>
<th>Principle</th>
<th>Theme</th>
<th>Summary Description</th>
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<tbody>
<tr>
<td>Principle 1</td>
<td>Consistency</td>
<td>Models should be consistent with the Better Regulation Executive’s five principles of good regulation.</td>
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<tr>
<td>Principle 2</td>
<td>Professional Standards</td>
<td>The regulatory body for each profession should set out the contemporary professional standards, which registrants will have to meet in order to maintain registration.</td>
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<td>Principle 3</td>
<td>Remediation</td>
<td>Where revalidation processes highlight performance concerns there should be scope for remediation of the professional but measures to secure public safety must remain paramount.</td>
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<td>Principle 4</td>
<td>Patient and public involvement</td>
<td>A successful revalidation process must have the confidence of the public that it is appropriate, relevant and fit for purpose.</td>
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<tr>
<td>Principle 5</td>
<td>Continuing Professional Development (CPD)</td>
<td>This is the process by which individual registrants keep themselves up to date in order to maintain the highest standards of professional practice.</td>
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<tr>
<td>Principle 6</td>
<td>Quality Assurance</td>
<td>Quality assurance mechanisms must be built into revalidation processes.</td>
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<tr>
<td>Principle 7</td>
<td>Equality</td>
<td>Equality and diversity considerations must be evident in the development of systems and processes for revalidation.</td>
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<tr>
<td>Principle 8</td>
<td>Integration</td>
<td>Clinical governance frameworks yield information on professionals’ performance and practice. Where appropriate, effective connections need to be made between them and the system of revalidation.</td>
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<td>Principle 9</td>
<td>UK-wide</td>
<td>Revalidation arrangements should be consistent in outcome across the United Kingdom.</td>
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<td>Principle 10</td>
<td>Demonstrating Benefits</td>
<td>The structures and processes of revalidation should be effective in confirming fitness to practise.</td>
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<tr>
<td>Principle 11</td>
<td>Information</td>
<td>The nature of the information required by each regulatory body will be based on their risk profiling of their registrant groups.</td>
</tr>
<tr>
<td>Principle 12</td>
<td>Incremental Introduction</td>
<td>The introduction of revalidation should be incremental</td>
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</tbody>
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