

**Professional recognition and professional advancement:  
For our practitioners, for our profession and for our patients.**

**Joint Partners Credentialing Task group (JPCT)**

**A Report for the Royal Pharmaceutical Society and the wider Profession  
Evidence-based recommendations: credentialing of practitioners**



**February 2013**

**This work was partly funded by:** United Kingdom Clinical Pharmacy Association (UKCPA)

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This report will focus on:

- Professional Assessment and credentialing within a professional recognition programme.
- Evidence-based recommendations, for a credentialing and professional recognition programme for practitioners.
- Recommendations regarding the development of the RPS Faculty\* for advancing professional practice.

\*The RPS Faculty: The Royal Pharmaceutical Society has indicated that a primary aim of a Faculty will be to develop support and processes for identifying professional development needs and career maps to advance professional practice. The RPS Faculty will help individuals identify levels of practice, developmental aims to routes to achieve these practice-based aims. [RPS Press Release January 2013]

## Foreword



I am delighted to present the final report from the Joint Partners Credentialing Taskgroup team. The Taskgroup has been working on the evidence gathering and report since April 2012 and it has been a pleasure to be able to steer and Chair the JPCT team.

This Report sets out the evidence gathered from 25 advanced specialist and generalist expert pharmacy groups in UK (all Partner organisations of the RPS) together with structured expert opinion and consensus formation. A literature review of professional recognition and credentialing practice from other professions and other countries is also part of the report.

“Professional recognition and professional advancement: For our practitioners, for our profession and for our patients” is a document which sets out seven high level recommendations for the RPS during the Faculty development process but which also looks beyond this initial formation towards embedding full Royal College status and function. These recommendations are fully endorsed by the RPS Partners and carry an expert practice weighting which we hope will provide an imperative and clarity as the RPS continues with this significant development for our profession.

It is not an understatement to say that we have been privileged to have conducted this work and sincerely hope that it proves useful and impactful for the RPS and the profession as a greater whole.

Yours sincerely,

A handwritten signature in black ink that reads "Geoff Saunders." The signature is written in a cursive, flowing style.

Geoffrey Saunders, FRPharmS  
Chair of the JPCT

## Executive Summary

For healthcare professionals, the capacity to deliver improvements in therapeutic outcomes, patients' quality of life, scientific advancement and public health imperatives is dependent on a foundation of *competence* and *capability*, enhanced by developing expertise in their specialist knowledge and skills. Likewise, a competent and capable workforce is an essential pre-requisite for all healthcare professions and pharmacy is no exception. Professional recognition for pharmacists and pharmaceutical scientists (which embraces the concept of credentialing) for advancing practice should deliver this, supporting practitioner development and progression through excellent quality assured training and recognising personal development.

The aims of the Joint Partners Credentialing Taskgroup (JPCT) project were to:

- i. Provide expert opinion and evidence for professional recognition across all areas of practice;
- ii. Develop a set of principles for professional recognition for advanced levels of practice;
- iii. Identify a set of appropriate tools and modalities for professional recognition processes;
- iv. Provide a set of evidence based recommendations for professional credentialing of practitioners to inform the development of the RPS Faculty.

The methods of analysis for the project included a literature search, a survey of specialist/partner groups and structured interviews with expert practitioners and senior managers.

### Part I

A literature review was conducted to assess information about credentialing nationally and internationally. It provided an overview of the current practice and policy trends in pharmacy, in addition to other healthcare professions. The literature provides the background, context and imperative for a credentialing or professional recognition programme.

### Part II

For the survey, twenty-five responses from practitioner groups were submitted and analysed; the outcomes related to the specialists/partner groups specialism focus, advanced practice development and subsequent professional recognition. The majority of the respondent groups were practicing in patient facing settings (including primary care), often working with higher-risk patients in acute sector care and also in long term, chronic or ambulatory patients. All have a clear focus on patient care outcomes. For the non-patient facing respondent groups, a primary focus in pharmacy science is seen as a crucial driver for their practice.

The respondent groups were clear that it is possible to identify 'levels of performance' according to practice, which would be an essential facilitating process of any professional recognition (credentialing) programme.

1. There was general agreement on the principles of professional recognition and credentialing across all 25 respondent specialist groups surveyed.
2. Tools considered as being appropriate for credentialing purposes were: structured Portfolio review based on the Advanced to Consultant Level Framework (ACLF); structured oral assessment by an Expert Panel of peers; Multiple Source Feedback methods (MSF) such as Peer Review/360° feedback; Directly Observed Practice (DOP) and structured Case-based evaluation methods.
3. There were no clear preferential differences between the professional recognition (credentialing) assessment tools prioritised by clinical and non-clinical groups; it therefore seems possible that specialist groups can adapt generic tools according to their areas of expertise.

The Groups surveyed were strongly supportive about the use of practitioner development frameworks, in particular the ACLF, as core component of professional recognition processes; none of the clinical and non-clinical groups suggested otherwise. However, Groups and expert opinion were also clear that most gains will accrue for practitioners when the ACLF is used in conjunction with specialist professional curricula.

Ensuring access to contemporary professional curricula will be a key part of any RPS Faculty offering in relation to professional recognition and tools to support the use of the ACLF in developing a portfolio of practice.

The evidence from the specialist and practitioner Groups and expert opinion gathered in this report suggests strongly that a Portfolio approach to professional recognition is a principal strategy. The components of a professional development Faculty Portfolio should include, at the core:

- Reference and mapping of evidence to the ACLF, with reference to the relevant professional curricula;
- Evidence of multiple-source feedback (MSF) or 360° type appraisal documentation (for example 'Peer Assessment Tool' schemes such as used in other professions);
- Evidence of practice development through the use of complex/extended intervention reports, clinical exercise (CEX) or case-based discussion (CbD) reports;
- Evidence of Directly Observed Practice (DOP) is recommended by some of the clinical specialist groups, including the UKCPA Community Pharmacy Group.

### **Part III**

In order to provide descriptive overview for the survey findings, nineteen semi-structured interviews were conducted with expert practitioners and senior pharmacy managers across acute and community sectors of practice. A thematic analysis was performed, and 15 themes were identified and grouped into 3 main clusters (professional recognition: "For the Practitioner"; "For Practice" and "For the Profession"). The interview questions were structured to seek the relevance of a professional recognition programme, how such a programme could be developed and what impact/benefit it might have.

Outcomes suggested strongly that expert practitioners and senior managers have similar generalist views on the overall themes, with the exception of expert practitioners who tended to have more focus on personal practice development challenges (e.g. structured use of ACLF) compared with senior managers who tended to have more of a focus on the overall 'status' and capability of the workforce as a whole (e.g. use of quality assured Post-nominals for describing the workforce).

One of the principal outcomes is that practitioner development frameworks are viewed as 'extremely useful' by all constituencies, in order to recognise both development needs and current level of practice and capabilities of the practitioner. They are seen as providing a structure for evidence of what has been achieved and which areas need a focus for advancement; the contribution to the development of the practitioner, improved performance and ultimately better outcomes for patients was not contested.

Interviewees stated that it should be the role of professional leadership bodies to develop a professional recognition/credentialing programme, working together with peer groups. Additionally, professional leadership bodies should provide an infrastructure to enable advanced support for practitioners and their practice development.

A core theme of professional recognition, which was supported by all specialist groups and experts interviewed, was the notion of Peer Review. All Groups were of the opinion that Peer Review panels need to be established for the purposes of professional recognition and that membership of these Peer Review panels should be seen as important and high value for the practitioners.

## Recommendations

The JPCT group recommends that the RPS should:

- I. Develop professional recognition programmes using tools and methods that are already used across the profession (such as the ACLF<sup>1</sup>) with appropriate adaptation for the different specialities and using Partner-endorsed *Professional Curricula*.
- II. Start immediate work on developing Faculty systems for member support in practice development. In particular the JPCT recommend the development of an online ACLF e-portfolio tool and supportive guidance in appropriate evidence to demonstrate ACLF criteria, and the use of existing tools to support Directly Observed Practice (such as the Medication Review Consultation Framework [MRCF]) in addition to the development of online clinical intervention monitoring tools to support Case-based Discussion and Extended Intervention logs records for practitioners.
- III. Establish networks that will support the development of advanced practitioners and advancement in care, in particular to assist with Multiple Source Feedback (MSF) development and mentoring of exchange networks, in addition to providing mentor support for conducting Clinical Exercise (CEX) and Case-based Discussion (CbD) type exercises for those practitioners working in more isolated environments; the Local Practice Fora would be ideally suited as a structure for this activity.
- IV. Direct the Principles of Assessment to be based on portfolio review (to assess breadth of practice), a form of MSF (for example, 360° degree, or peer and self assessment in order to assess working relationships) and a form of expert assessment based on the area of practice and commensurate with the service risk to patients (as identified by the specialist and expert groups). However, any MSF tool used for credentialing should be aimed at being above and beyond those required for routine employment purposes and must be clearly evaluative and developmental (for example mini-PAT<sup>2</sup>).
- V. Promote and advocate engagement with Faculty Peer Review panels as a career highlight for practitioners (as members of the panels) and as a fundamental professional responsibility for specialist and expert Partner Groups.
- VI. Establish Governance processes for the Faculty and Peer Review panels as a key imperative for both the RPS and for RPS Partner Groups. The JPCT further recommends, on the basis of the expert opinions gathered, that initial Transitional Recognition Panels should be established at the earliest opportunity to address recognition of prior experience and expertise in order to initially populate the Faculty (an APEL<sup>3</sup> type process in the first phase of Faculty operations). This once-only process should be conducted via an appropriate credentialing scheme for this single intention, under a Faculty governance framework.
- VII. Recognise the sense of urgency in the evidence gathered. The RPS should immediately commence a formal appointment process for the Transitional Recognition Panels, the principal Faculty governance panels and infrastructure committees. The Transitional Recognition Panels should start work to establish working practices, assessment standards and assessment guidance for professional recognition levels within the RPS Faculty, and before the formal establishment of the RPS Faculty.

Overall there was strong agreement between the survey outcomes and the individual interviews. The JPCT, as a collection of expert and specialist groups (including primary and general practice care) strongly recommend that the RPS develops a Faculty programme for professional recognition urgently, taking account of the above recommendations for the future of the profession and the advancement of pharmaceutical health care.

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<sup>1</sup> CoDEG 2009

<sup>2</sup> Patel *et al*, 2009, 2011; Davies *et al*, 2013

<sup>3</sup> Accreditation of Prior Experiential Learning

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## 1. Project Outline

### 1.1 Aims and objectives

Professional recognition can aid practitioners to have realistic career goals and the opportunity to plan their development. In addition to the subsequent educational and training support required to achieve these professional goals, there is the benefit of enhanced career recruitment, retention, motivation and development in a changing healthcare landscape. Practitioners, as a peer community, can have an opportunity to steward the definitions, the experiential components, the professional curricula and support networks that collectively make up practitioner development strategies. Moreover, science and the profession as a whole will have tools and evidence to add credibility to evolving new roles and practice. There is also evidence to suggest that 'credentialed' or (in the US, "board certified") practitioners deliver improved quality of care, clinical outcomes and better patient safety as compared with non-credentialed practitioners (Galt 2004; Giberson *et al* 2011; CCP 2010).

There are also benefits for employers, including commissioners of clinical services, in being able to more accurately match candidates with staff positions and health care needs provision - so long as the workforce is flexible and adaptable. Workforce development can be taken towards a more useful policy driven mapping and planning activity.

And for patients - they will have assurances of quality of practitioner services. A recent literature review into credentialing in medical careers indicated that credentialed individuals deliver improved quality of care and clinical outcomes and better patient safety (Giberson *et al* 2011; DoH 2010).

The partners groups, which constitute the Joint Partners Credentialing Taskgroup, have developed a co-terminus set of principles with clinical and non-clinical partner groups.

The aims of the Joint Partners Credentialing Task Group (JPCT) were to:

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The outcomes of the work developed by the JPCT were based on gathering of examples of best practice and evidence for a formal, nationally applicable professional recognition or credentialing model. The work captured the policy views of the RPS Partner Groups as well as the expertise and evidence residing within the partner groups. The report aims to provide an overview based on evidence and expert opinions of professional recognition, and to provide a set of clear and consensus driven recommendations for next stage development of a formal professional recognition programme.



## 1.2 Methodology

### Context for the work

Following a Partners meeting held at the Royal Pharmaceutical Society in January 2012, key stakeholders were subsequently identified to be part of the Joint Partners Credentialing Task Group (JPCT), in order to examine the current status of formal and informal professional recognition activities in the UK. Invitations were sent and by early April a representative group had been identified. Mr Geoff Saunders (Faculty of Cancer Pharmacy) accepted the invitation to chair the JPCT group. Terms of Reference for the project were also developed and agreed by the JPCT members (appended).

The outline of the project was agreed and divided in three stages, a literature review, a survey conducted to the specialists/partners groups and structured interviews to expert practitioners and senior managers.

### Part I

The initial stage comprised a literature review to assess information about credentialing nationally and internationally. It provided an overview of the current practice and policy trends in pharmacy as well as other healthcare professionals, in particular the medics.

### Part II

The second stage focussed on developing a survey to the specialists/partners groups to gather evidence about current practice. An original survey was created based on the current evidence available, an Internet address was provided to the respondents as well as a word document. The questions addressed the current practice, the tools being used for informal/formal profession recognition at advance levels of practice as well as providing principles of credentialing to be commented. Definitions of the tools were provided in the survey to facilitate comprehension (Annex I).

### Part III

The third stage of the project consisted in conducted structured interviews to expert practitioners and senior managers. The group identified and agreed the interviewees, an initial email was send with all the information about the project as well as the outline of the questions that would be asked. The interviews were conducted over the phone and in person, the replies were directly typed and not voice recorded.

Support documents were developed by the group, such as: a briefing document containing the background, drivers and outline of the project; a cover letter to facilitate the understanding of the aims and objective of the JPCT group in addition to explaining the credentialing survey for participating specialist groups and after to expert professionals; and a glossary (glossary included in annex II).

Descriptive analysis was conducted on the data retrieved from the surveys and a thematic analysis was conducted on the interview evidence. The results from phase 2 and 3 are triangulated to inform the outcomes and recommendations of the JPCT (Annex III for abbreviated questions).

## 2. Part I | Background to the project

### 2.1 Vision for Pharmacy

Pharmacists practise in community pharmacies, in hospitals, health centres and General Practitioner (GP) surgeries, in universities, laboratories, regulatory agencies and in the pharmaceutical industry. Pharmacists who practise in a healthcare environment are a source of safe and convenient healthcare advice, medicines provision and support that is trusted by the public. Pharmacists are also working in roles in industry that place them at the cutting edge of drug discovery, and the clinical, technological, financial and ethical dimensions of modern healthcare (Hawthorne and Anderson 2009).

According to 'Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century', a UK Government policy paper, the pharmacy profession has an opportunity to enter a new area, where pharmacists can apply their greater knowledge and expertise towards a direct patient care approach. A staged development was proposed that encouraged the practice of pharmacy to be more clinical and adapted to the needs of patients, for example, including independent prescribing (DoH 2007).

It outlines the role that pharmacists can play and the future potential for pharmacy to contribute more actively and valuably in public health, management of minor ailments, general medicines management, dealing effectively with more complex and specialist patients, and prescribing and consultant level practice. The reform will benefit patients and will drive the pharmacy profession forward to ensure the use of the latest pharmaceutical advances in practice and ensure patients receive the best care related to medicines wherever they live.

As a White Paper for England, it draws on the established policy of developing and recognising consultant pharmacists and pharmacists with special interests, and captures the momentum that has been building within the National Health System with the establishment of approved NHS Consultant Pharmacists' posts. The Pharmacy White Paper also states that to a certain extent, opportunities to take forward these roles are dependent on optimal performance (DoH 2008a).

#### International perspectives

The American College of Clinical Pharmacy (ACCP) also recently published a White Paper for Clinical Pharmacist Competencies. The ACCP's vision for the pharmacy profession is that 'pharmacists will be recognised and valued as the preeminent healthcare professionals responsible for the use of medicines in the prevention and treatment of disease'. Their vision expressed by the Joint Commission of Pharmacy Practitioners also calls for future pharmacists to be responsible for the rational use of medication (ACCP 2008).

To achieve such vision the profession must ensure that there will be an adequate supply of appropriately educated and skilled pharmacists practising as both clinically-oriented pharmacy generalists and specialists. Among the strategies that will be used is to define and promote the core competencies of a clinically-oriented pharmacy practitioner.

Changes and advances in health care delivery systems and medicines technology will require periodic re-evaluation and modification of therapeutic knowledge areas, hence the need of a practitioner to develop the required competencies, capabilities, methods and processes for self-assessment of professional competence which can be used as a guide to continuous professional development (DoH 2007).

The Pharmaceutical Society of New Zealand (PSNZ) in 2004 published a document entitled "Ten-Year Vision for pharmacists in New Zealand, Focus on the Future". It illustrates the key role pharmacists need to have to improve patient care and health outcomes, and make the best use of health funding. It draws on the views of individual pharmacists, health sector funders and other key healthcare practitioners. The Ten-year vision consists of 24 statements covering 12 key areas of the profession, including the work of all pharmacists regardless of their setting.

These areas acknowledge practitioners who work in primary health organisations, at the primary/secondary interface, in secondary care, health sector planning and funding, and information services to academic and education roles. In terms of education, this particular vision states that pharmacists will have a wide range of continuing professional education and training options available enabling a high percentage of pharmacists to achieve suitable accreditation levels leading them to practise and provide a wider range of medicine management services (PSNZ 2004).

The International Pharmaceutical Federation (FIP) is the global federation of national associations of pharmacists and pharmaceutical scientists in official partnership with the World Health Organisation (WHO) and represents and serves three million practitioners and scientists around the world. The development of FIP Education initiatives within pharmacy practice and pharmaceutical sciences has led to the growth of new branches of FIP in areas such as pharmacy education and human resources for health (FIP 2008).

At a global level, countries are at different stages when it comes to quality and education, and even within countries there may be differences in the degree to which change has been, or will be, affected. Cultural, historical, and political factors also impact on this change. The education of practitioners and regulation of pharmacy practice have to consider these developments. Hence, several countries have introduced models to develop advance practice using capability frameworks, which can inform/support the development of a credentialing model or professional recognition programme for the pharmacy profession in Great Britain (Bruno *et al* 2010; Coombes *et al* 2010; Donegan 2011; Meštrović *et al* 2012; Rutter *et al* 2012; Coombes *et al* 2012; O’Leary *et al* 2012).

Medicines are becoming more complex, more accessible, and used in more diverse and ageing patients. Patient safety issues and accountability for the outcomes of therapy have become a main focus of attention. Patients, consumers and governments alike are demanding higher standards and seeking assurance of quality. Countries are looking to improve the services and standards for healthcare delivery and the importance in the quantity and quality of healthcare professionals, and this includes the current systems to assure the quality of education and training and the ongoing competence and capability of practitioners (Rouse 2004).

## 2.2 New roles and services

The enhanced roles of pharmacists, which have been developing over the past 15 years, have necessitated a move from a product to a patient focus; this has in turn warranted a greater focus on education and training and new modalities for practitioner development and advancement. It is being made clear in many policy statements that patient centred skills should be placed at the centre of education and training in order to address health services delivery. By extension, the use of modern framework and competency approaches will directly feed into these policy initiatives (DoH 2007; DoH 2008a,b; DoH 2012).

A further paradigm shift occurred, driven by the work of Hepler and Strand in 1990. The concept of Pharmaceutical Care introduced a focus on patient-centred, outcomes driven and of quality of life service delivery philosophy. For practitioners, Pharmaceutical Care implies assuming the responsibility – and accountability – for the outcomes of medicine related therapy. Since then there have been collaborations between FIP and WHO, which reinforce and support this paradigm change, such as ‘Developing Pharmacy Practice - Focus on Patient Care’ (Hepler and Strand 1990; WHO/FIP 2006).

Pharmacists are now service providers, from primary prevention of diseases to therapeutic outcome monitoring. The role of the pharmacist includes providing accurate and relevant information about health. The modern definition of pharmacist is a provider of patient care. Pharmacists are important stakeholders in promoting wellness, preventing disease and contributing to disease management, working in close collaboration with other healthcare professionals, to ensure that patients obtain the best possible results from their medicines (FIP Vision 2020).

As experts in medicines, obtaining the best possible outcomes for the patients through maximising the value of medicines, is the ultimate aim. Medicines optimisation has become a vital agenda focussed on the outcomes, on patients and led by pharmacists. Is an approach that seeks to maximise the beneficial clinical outcomes for patients from medicines with an emphasis on safety, governance, professional collaboration and patient engagement (UKMi 2012).

A recent report from RPS gathers all the evidence that currently exist in practice, supporting practitioners and pharmacy teams with the appropriate information (RPS 2012). In this time of change and difficulties, the NHS outcomes framework 2011/12 outlines two major shifts for the health services, one directly related to medicines optimisation: “(...) a relentless focus on delivering the outcomes that matter most to people.” (NHS 2010).

The overall implication is that continued education, advancement and progression is a necessary aspect of professional development in order to meet these care responsibilities and a credentialing process, with support from all the stakeholders including the practitioner networks, is a key infrastructure element for the near future.

### 2.3 Terminology around professional recognition

Any process of recognition is based on an objective evaluation of a practitioner’s current training, experience, competence and capability to provide specified healthcare services or perform particular procedures. It differs from the term ‘accreditation’ in that it is an evaluation of an individual rather than of a course or learning material. The words “credential” and “credentialing” derive from the Latin verb *credere*, meaning “to trust” (CCP 2010).

There have been evolving efforts, nationally and internationally, to codify competencies and standards of practice as well as the processes by which quality and accountability can be ensured during training. Credentialing can be useful for the support and progression through training, to support revalidation, as well as to demonstrate achievement of competence and capability in areas of practice, which are not currently recognised (DoH 2010).

Credentialing is a process that identifies when a defined set of knowledge, skills and experiences has been met at a defined standard of practice, and where an individual is able to demonstrate this against a consistent method of evaluation. It is a process used by many organisations and agencies nationally and internationally to assure that practitioners who practice beyond their registration qualifications meet all the necessary requirements to deliver services relating to their roles and responsibilities.

Credentials should comprise a collection of capabilities, which might be equivalent to the outcome of several years of professional development. As services change and develop, the expertise required to deliver the services will change, and credentialing is a process that can assure that this is done to a nationally agreed professional standard, best defined by the peer group (CCP 2010).

Several professions, including healthcare professionals, have established methods to recognise the acquisition of advanced competencies (knowledge, skills, and experiences) set against career pathways, where career progression is aligned with the ability to deal safely with increasingly complex cases and situations in a safe and appropriate way.

Pharmacy needs a career map, supported by professional development frameworks, that assist with knowledge, skills and expertise transfer from sector to sector; to build specialist practice with an understanding of the generalist knowledge that ensures pharmacists contribute the most effective way for medicines optimisation and pharmaceutical care. There is a clear need for a robust yet simple professional recognition programme that helps pharmacists to identify what they need to know and do at different levels of practice; a consequence of this is being able to access the knowledge, skills and experiences in order to develop their practice accordingly.

## 2.4 Literature and Policy Conclusions

For the pharmacy health care professional, the interest in credentialing and professional recognition has increased in the recent years due to several factors, such as the increasing complexity of health care, new patient facing roles and a growing trend toward a speciality area in practice combined with the need of being capable of providing complex care. Another important contributing factor is the need to assure the public, employers, stakeholders and other health care providers that practitioners are competent and capable regardless where they are in their careers or their practice setting (CCP 2010; DoH 2008c; MEE 2012).

According to the Centre for Workforce Intelligence in their Pharmacy Workforce Report 2012, the next steps for the profession are for pharmacy providers and professional bodies to work together to promote best practice and new ways of working to deliver pharmacy enhanced services as well as to develop new models of services (CfWI 2012).

*“Appropriate education and training is required to prepare the pharmacist for collaborative practice a form of credentialing should be undertaken incorporating a competence assessment leading to a record of the accreditation of the individual.”*

*FIP 2009, FIP Reference Paper Collaborative Practice*

A form of professional recognition for advance practice would be beneficial to stakeholders, such as pharmacists, employers, but most importantly the patients and the public. It reassures the patient and health care managers that the pharmacy practitioners in the health service satisfy the Kennedy principle that “a patient is entitled to be cared for by health care professionals with relevant and up-to-date skills and expertise.” (BRII 2001; Bates *et al* 2004). Professional recognition in pharmacy has already been shown, in principle, to be a feasible and useful process for pharmacists and employers, providing a valid assessment of competent performance (Costa *et al* 2012; McKenzie *et al* 2011; Coombes *et al* 2011; Obiols Albinana *et al* 2005).

Credentialing for the individual or profession recognition for the profession, should also take into account that the workforce needs to be flexible and able to adapt to the many changes facing it in healthcare (Duggan 2011). It concerns what practitioners have done and what they are capable of doing, with the ultimate outcome – improving patient care.

### 3. Outcomes

#### Governance of JCPT Working Methods

The JPCT steering group had eight conference calls during the course of the project, chaired by Mr Geoff Saunders. Documents were prepared previously as agreed in the conference calls and discussed during meetings, following a consensus protocol. All the phases of the project were agreed by the group as well as the content of the several documents produced, including the survey and interview questions.

#### 3.1 Part II | Survey Analysis

The survey was conducted between July and August 2012 of the Specialist and Partner groups; the Chairs, General Secretaries or Professional Secretaries were contacted via email with information from the JPCT group. A briefing document, cover letter and a glossary were attached in addition to a word version of the document to facilitate discussion within the groups. Several reminders were sent to increase the response rate.

The Specialist and Partner groups were able to reply via an online survey or in a word version previously attached in email communications. After data cleaning, replies from 25 specialists groups were analysed. The list below shows which groups provided data. The UKCPA leadership development group stated that the questions in the survey would not be applicable to their group, therefore unable to provide an answer.

#### Respondent groups

Ambulance Pharmacists Network  
British Oncology Pharmacy Association (BOPA) and Faculty of Cancer Care  
British Pharmaceutical Nutrition Group (BPNG)  
Care of the Elderly Group  
College of Mental Health Pharmacy (CMHP)  
Community Pharmacy Group (UKCPA)  
Critical Care Group  
Education and Training Group  
Gastroenterology/Hepatology  
GHP/UKCPA IT Interest Group  
Haemostasis, Anticoagulation and Thrombosis (HAT) Group  
Medicines safety & quality Group  
Neonatal & Paediatric Pharmacists Group  
NHS Pharmaceutical QA Committee  
NHS Pharmacy Education and Development Group  
Pain Management Group  
Palliative Care Pharmacists Network  
Primary and Community Care Pharmacy Network (PCCPN)  
Respiratory Group  
Surgery and Theatres  
UK HIV Pharmacy Association  
UK Medicines Information  
UK Ophthalmic Pharmacy Group (UKOPG)  
UK Renal Pharmacy Group  
Women's Health Pharmacist's Group

### 3.1.1 Overview of the data

From the 25 replies, 72% were answered in the capacity of the Chair of the groups/partners. The replies provided were validated with the respective groups/partner in 76% of the cases.

The membership of the groups is distributed as follows:

- 60% described as patient facing
- 16% non-patient facing
- 20% described as both
- 4% stated other

For the patient facing groups (80% of the sample) the service delivery target is distributed as follows (more than one category could be chosen):

- 60% Generally high-risk patients
- 68% Long term/chronic/ambulatory patients
- 72% Acute sector care
- 32% Generally community facing

For the non-patient groups (36% of the sample) the service delivery is distributed as follows (more than one category could be chosen):

- 40% Driven by information provision
- 84% Driven by medicines science
- 72% Driven by regulatory/quality processes

In 75% of replies it was stated that they can identify specific 'levels of performance', which would adequately describe the differences between novice, intermediate and expert practice.

The groups stated that Advance Levels of Practice could be achieved:

- 9% - within 3 years from registration
- 65% - within 4-6 years from registration
- 26% - only after 6 years from registration

In 20% of the cases it was stated that the respective group has previously conducted credentialing type of activities.

### 3.1.2 Assessment tools

Figure 1 shows the frequencies of credentialing tools; groups were asked to indicate which of the listed tools they would consider to be appropriate for credentialing purposes (unlimited choice). The denominator is the total of all choices made by the groups (100%). The patient-facing, clinical groups were filtered and a similar frequencies analysis applied for comparison.

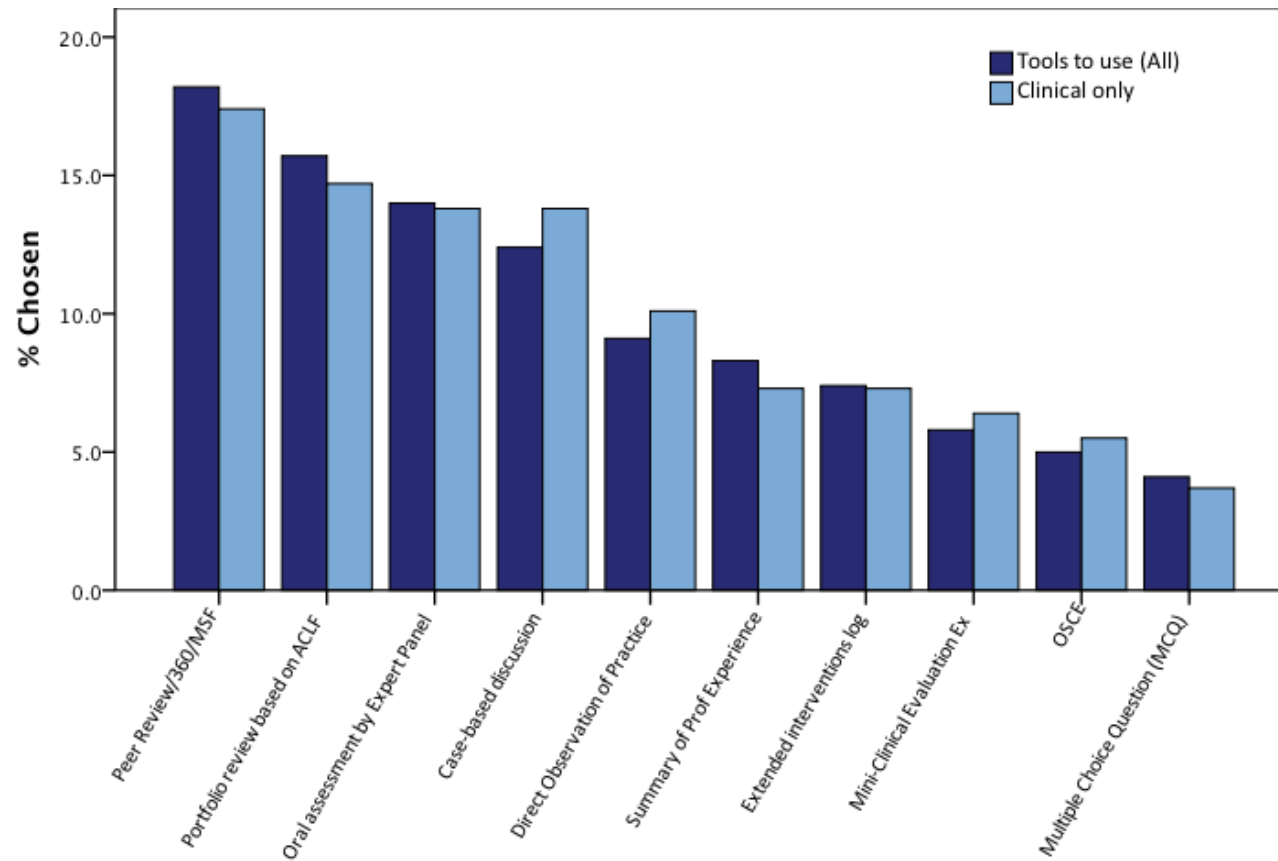


Figure 1: Frequencies of appropriateness of tools



For those assessment tools that have a large knowledge component or high intensity (eg. OSCEs, DOP) the frequency table (table 1) for positive choice against Partner group is as follows:

*DOP = Direct observation of Practice*

*OSCE = Objective structured clinical examination*

*CbD = case-based discussion*

*MCQ = multiple choice question exam*

**Table 1: Assessment choice by Partner and Specialist group.**

Group and assessment choice	Risk factor of patient group served	DOP	CbD	OSCE	MCQ
Palliative Care Pharmacists Network	Generally high-risk	Y	Y	Y	
Critical Care Group	Generally high-risk	Y	Y	Y	
Haemostasis, Anticoagulation and Thrombosis (HAT) Group	Generally high-risk	Y	Y	Y	
Education and Training Group		Y		Y	
Surgery and Theatres	Generally high-risk	Y	Y		
UK Ophthalmic Pharmacy Group (UKOPG)		Y	Y		
UK Medicines Information	Generally high-risk	Y	Y		
British Pharmaceutical Nutrition Group (BPNG)	Generally high-risk	Y	Y		Y
UK HIV Pharmacy Association	Generally high-risk	Y	Y		
Community Pharmacy Group (UKCPA)		Y	Y		Y
Neonatal & Paediatric Pharmacists Group	Generally high-risk	Y	Y		Y
Care of the Elderly Group	Generally high-risk			Y	
Women's Health Pharmacist's Group	Generally high-risk		Y	Y	Y
Pain Management Group			Y		
Gastroenterology/Hepatology			Y		
NHS Pharmaceutical QA Committee					Y
GHP/UKCPA IT Interest Group					
Ambulance Pharmacists Network					
British Oncology Pharmacy Association and FCP	Generally high-risk				
Respiratory Group	Generally high-risk		Y		
NHS Pharmacy Education & Development					
Medicines safety & quality Group					
Primary & Community Care Network (PCCPN)					
UK Renal Pharmacy Group	Generally high-risk		Y		
College of Mental Health Pharmacy (CMHP)					

This table shows a general tendency for clinical groups with higher-risk patients to favour knowledge-based assessment for level of practice, with case-based discussion evidence and direct observation of practice evidence as the majority.

Figure 2 shows the ranked frequencies applied to those tools considered being the three most important for credentialing purposes. The denominator is cases (ie. groups) and represents the most highly ranked of the credentialing tools in the opinion of the groups. The clinical groups were again filtered and compared with the sample as a whole.

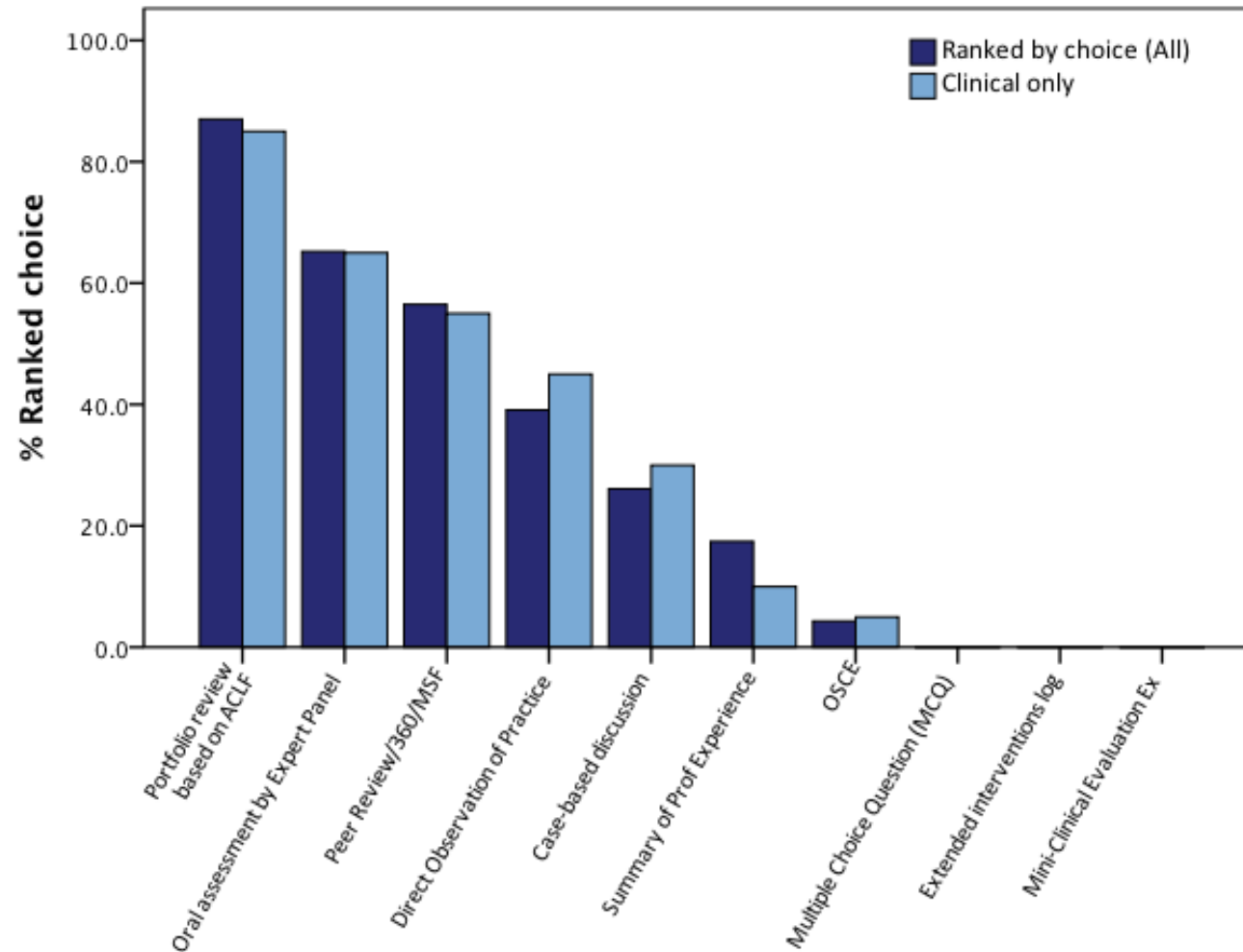


Figure 2: Ranked choices from groups

Taking Figure 2 and looking at the knowledge-based or high intensive assessments (as above) as a frequency of the top three choices of Partner groups reveals (table 2):

*DOP = Direct observation of Practice*

*OSCE = Objective structured clinical examination*

*CbD = case-based discussion*

*MCQ = multiple choice question exam*

**Table 2: Top three assessment choices by partner/specialist group.**

Group and assessment choice	Risk factor of patient group served	DOP	CbD	OSCE	MCQ
Palliative Care Pharmacists Network	Generally high-risk	Y			
Critical Care Group	Generally high-risk	Y			
Haemostasis, Anticoagulation Thrombosis (HAT) Group	Generally high-risk	Y			
Education and Training Group		Y			
Surgery and Theatres	Generally high-risk	Y	Y		
UK Medicines Information	Generally high-risk	Y	Y		
Community Pharmacy Group (UKCPA)		Y			
Neonatal & Paediatric Pharmacists Group	Generally high-risk	Y			
Respiratory Group	Generally high-risk	Y			
Care of the Elderly Group	Generally high-risk			Y	
UK Ophthalmic Pharmacy Group (UKOPG)			Y		
British Pharmaceutical Nutrition Group (BPNG)	Generally high-risk		Y		
UK HIV Pharmacy Association	Generally high-risk				
Women's Health Pharmacist's Group	Generally high-risk				
Pain Management Group			Y		
Gastroenterology/Hepatology					
NHS Pharmaceutical QA Committee					
GHP/UKCPA IT Interest Group					
Ambulance Pharmacists Network					
British Oncology Pharmacy Association and FCP	Generally high-risk				
NHS Pharmacy Education and Development Group					
Medicines safety & quality Group					
Primary & Community Care Pharmacy Network (PCCPN)					
UK Renal Pharmacy Group	Generally high-risk		Y		
College of Mental Health Pharmacy (CMHP)					

When providing a priority listing of assessments considered suitable for assessment in a credentialing system, direct knowledge-based assessments become a minority choice. Directly observed practice is equivocal between direct-patient facing clinical groups, with roughly half in favour as a priority. MCQ examination was not prioritised by any group.

### 3.1.3 A set of principles for Professional Recognition/Credentialing

From the survey results, there was strong agreement on a set of principles. The Groups and Partners had good and clear consensus on all the developed principles of professional recognition.

The commentary derived from the practitioner groups was most often around the language being used and editorial comments concerning implementation and perceived barriers to accepting the full implications of a national, principled, professional peer recognition process.

To illustrate the commentary provided, editorial comments are paraphrased *in italics* below:

#### Principles of credentialing

*"This will be good for the profession but needs to be done in such a way that patients see the benefits and they also see differences between practitioners. As a 'high level principle', a good system will provide assurance to the perception of standards and areas of practice."*

#### In the context of the profession as a whole:

- a. The idea of professional recognition is based on developing aspirational standards of practice and quality assured professional development of health professionals.

*"Aspirational" can have different notions for individuals; for majority this may mean "unobtainable", apart from a very few. We agree in principle but would comment that some may interpret this as a basis for elitism and also may discourage many from aspiring to the best of their abilities if role models seem too far removed from practice."*

- b. A good system of professional recognition will provide global evidence that patient safety – in the context of health service delivery is being addressed.
- c. A good system will enhance the global quality of pharmaceutical care provision, by using benchmark indicators (or core competencies, or key performance indicators, or standards of care expected of a practitioner at a defined level of practice).

*"This latter might depend on the practitioner. Many do not like to be benchmarked as this is seen as professionally 'threatening' and some firmly believe they do not need any further measurement post-registration (this attitude has been evidenced in senior pharmacists at relatively high levels in the context of teaching prescribing)."*

#### In the context of the individual practitioner:

- d. Having an agreed process for professional recognition should primarily support practitioner progression (through training) and secondarily support any professional revalidation processes.
- e. A good system will provide evidence of the individual performance characteristics for any practitioner at a defined level of practice (in any speciality within a profession) and should be able to demonstrate achievement of defined capabilities.

*"This is a two stage principle and needs looking at carefully. Demonstration of capabilities should be tied to demonstrable effect on patient outcome, and this is where the difficulty lies. How can we, as practitioners, develop a system of measurement and tools which clearly measure our effectiveness and benefit to patient care?"*

- f. A good system should incentivise the professional development of practitioners for reasons of professional altruism rather than direct regulation.

*“This is in agreement, but may be difficult to implement when there are competing interests; altruism is rare in today’s NHS and society at large. Great differences are observed in practitioner expertise and professionalism; perhaps this needs to be more realistic here and attuned to the diversity of human nature/motivations.”*

- g. A good system will signpost opportunities for continued advancement of the individual and open up new practice and scientific development opportunities for professionals.
- h. A good system will encourage the engagement of practitioners in “Communities of Practice” and encourage effective networking between peers.

*“How would [the JPCT] ensure that all employers sign up to this and allow development to take place? We all feel that we could develop further and faster given the opportunity without all the other tasks. Will this allow opportunities for career progression within the profession? There are a large group of pharmacists that just want to be really good clinical pharmacists; post-nominals could potentially isolate them.”*

*“Many senior pharmacists are now being encouraged towards more management types of roles due to the changing NHS environment - should we include management qualifications in the list? Could review in light of plain English and too much jargon.”*

### **3.1.4 Outcomes from the survey**

From the survey results it is possible to state categorically that the replies submitted were representative of the views and expert opinions of each specialist Group on behalf of their members. To reinforce the credibility of the responses provided, the majority of the groups (and all of the larger groups) validated the responses within the committee structure and expert panels of the groups, representing a general consensus viewpoint.

Regarding practice setting, 80% of the respondent Groups and Partners represented patient facing roles (including primary care), variously described by the Groups as delivering patient care to high-risk patients, long term, chronic, ambulatory patients in both acute sector and community-based care settings. For the non-patient facing Groups and Partners the delivery of service was described as being additionally driven by medicines science. Therefore the responses to the survey represent both the viewpoints of practice and science capacities, and can be generalisable for the profession as a whole.

The Groups and Partners all stated that identification of levels of performance was possible, describing the differences between novice, intermediate and expert practice within their areas of practice. Hence being able to develop a set of professional recognition criteria, against which practitioners could be measured, was considered feasible.

Almost all the specialist Groups and Partners believe that advance practice can be achieved within a minimum of 6 years from the registration point, allowing practitioners to develop and improve their capabilities as well as allowing time to develop their own areas of interest.

A small minority of 20% of the specialist groups/partners stated they had previously conducted credentialing/type activities for their members. Making the case for an overarching professional recognition/credentialing programme to be created, facilitating the groups/partners to develop activities according to their membership needs.

One major outcome from the results is illustrated in the figures 1 and 2 - the groups/partners were asked to identify professional recognition assessment tools considered important or most suitable for their specialism; the results show no statistical significance in the tools chosen by the clinical and non-clinical groups. This strongly suggests that the assessment tools can be adapted according to each area of specialism. The three most frequently cited tools across the groups are a structured portfolio review based on the ACLF clusters; an oral assessment with an expert panel; and a MSF type evaluation such as peer review/360° appraisals. Knowledge-based/oriented and more intensive assessments featured as choice for many of the groups, particularly directly-observed practice, OSCE and case-based discussion evidence. There were no associations with type of assessment or patient-risk or speciality. However, when asked to prioritise meaningful and relevant assessments, these knowledge-based tools became a minority. There is case for providing evidence of competence and capability using DOPS and CbD for some Partner groups; it could be argued that these types of assessment could be incorporated into portfolio evidence or presented to peer assessment panels. No group selected OSCE or MCQs as high priority choices.

The principles of credentialing (annex IV) were agreed by all the 25 specialist Groups and Partners. The comments submitted in survey had focus on implementation and the process of professional recognition. One important comment suggested that for a professional recognition programme to be effective it should be done in a way that patients and the public are able to see the benefit and be able to acknowledge differences between practitioners.

## 3.2 Part III | Interview Analysis

The interviews were conducted between October and September 2012. The interviewees previously agreed by the JPCT steering group were contacted via email and provided with appropriate information. A briefing document, cover letter and a glossary were attached in addition to a document containing the outline of the questions to facilitate comprehension. Several reminders were sent to increase the response rate.

In total, 19 structured interviews were conducted with 11 expert practitioners and 8 senior pharmacy managers from both acute and community sectors. A thematic analysis was conducted and 15 themes were identified which were subsequently grouped into 3 principal clusters.

Seven interview questions (with options) were posed having a focus on the relevance of credentialing or professional recognition likely to be in general; how to develop such process; what impact might it have on the different stakeholders as well as for the profession and how patients could benefit from such a professional recognition programme.

### 3.2.1 Overview of the results by cluster and theme

#### 1. For the profession:

- (12) Competency frameworks are extremely useful
- (9) RPS engagement
- (8) Competent workforce | Building capability throughout careers
- (6) Royal College | Post nominal title
- (5) Engagement with all stakeholders

#### 2. For the practitioner:

- (52) Recognise the level you work at | Skills you have | Evidence
- (16) Credentialing or profession recognition provides aspirational goals
- (16) Peer support and networks
- (14) Confidence in the practitioners
- (9) Mentoring and feedback

#### 3. For practice:

- (21) Patient care outcomes | Expected level of care
- (16) Standards of practice
- (10) Right pharmacist for the right patient/practice
- (10) Medical Model
- (7) ACLF is a generalisable and useful tool

#### Assessment tools preferred:

- (18) Portfolio
- (14) 360°
- (12) Viva Voice (Expert panel)
- (9) Cbd and CEX
- (4) Observations (ward or workplace)
- (3) OSCEs
- (2) MCQs and Appraisals

The themes derived from the replies from the interviewees, with the same common denominator. The clusters were formed to facilitate comprehension of the results, as the same quote could be placed in different themes.

### 3.2.2 Cluster 1 'for the profession'

This theme gathers evidence of the impact, implications and opportunities for the pharmacy profession as a whole that a professional recognition or credentialing programme would likely to have. This cluster comprises the themes of:

- *'Competency frameworks are extremely useful'* – derived from quotes expressing that a capability framework enables practitioners to meet the needs of the patient and be evaluated for the capabilities they possess. Frameworks provide a pragmatic assessment of practitioner competence against agreed behaviours, in addition to identifying competencies for improvement. They can also allow flexibility to move from one area to another, with supporting evidence of the practitioner achievements.

- *‘RPS Engagement’* – several quotes mentioned the fact that for a credentialing model to be able to strive and advance the profession it needs the engagement of the professional body. In order to achieve an external recognised set of criteria (agreed by all stakeholders) to advance practice, the process needs to be conducted through a professional body.
- *‘Competent workforce | Building capability throughout careers’* – this theme derived from quotes expressing that a workforce needs to be competent and accountable for, it needs to provide the services according to the needs of the patients. Pharmacists need to be capable according to the services they provide. It should recognise the pharmacist as a competent healthcare professional, improving the professional profile as well. However it needs to be in conjunction with the workforce plan, acknowledging the roles that are required and what can be expected.
- *‘Royal College / Post-nominal title’* – several senior managers mentioned the need for the process to have a royal college ‘status’, to be able to provide further opportunity for practice or academic development. It was also mentioned that rather than the term ‘advanced practitioner’, a faculty membership (post-nominal) involving a statement of completion, needs to be promoted.
- *‘Engagement with all stakeholders’* – derived from quotes that state the necessity for all the stakeholders to collaborate to develop a robust system, in order to have a meaningful impact on the profession.

To illustrate the themes above described as they are more related to profession, comments are paraphrased *in italics* below:

#### **RPS engagement**

*“Again the whole thing becomes a lot easier, if people achieve this external recognise criteria for advance practice. Interesting to have the relationship between regulator and professional body. To what extent the regulator can recognise what the professional body is doing.”*

**SPM6**

*“It will have an impact. But it is important that is not a big stick to beat people with. Constructive criticism rather than disciplinary concepts. Professional body rather than a regulator tool. RPS rather than GPhC.”*

**EP5**

#### **Royal College | Post nominal title**

*“Depends on what the GPhC chooses to do with revalidation, maybe a relatively basis of practice. Common dominator. Royal college status, maybe a different set of criteria revalidation set for you. Revalidation will be the basis as they need to be across the profession. Low for the higher level of practice.”*

**SPM3**

*“This provides an opportunity for either honorary academic titles or progression to consultant level or an alternative. (perhaps a registrar level for pharmacist) Opportunity to locate people in the career structure, against the ACLF tool e.g.”*

**EP10**

#### **Competency frameworks are extremely useful**

*“Yes, I think assessing people against a competency framework is extremely useful tool. Credential and recognised it will improve the ability to market in the specialist areas of practice. NHS healthcare will be commission within the CCG with a different tariff, pharmacists’ contribution. Having credential practitioner will make it easier to place them in the specifications. Medical model. It is also important for the profession, which can then act as mentor and roles models. Having a framework enables post-graduate registration to the focus, which meets the need of the patient and able to be evaluated. I see it as a future of post-grad registration.”*

**EP6**



*"I think is essential for Hospital pharmacists maybe not so sure for Community. Reassuring for the public; Career pathway; For individual it gives you kudos. Reassurance for you and your Trust a competency framework can provide the evidence. Pragmatic assessment of your competency – real life."*

SPM2

### 3.2.3 Cluster 2 'for the practitioner'

This theme gathers the evidence of the impact, implications and opportunities for the individual practitioner, of a professional recognition or credentialing programme, on the individual practitioner. This cluster comprises the themes of:

- *'Recognise the level you work at; skills that you have; evidence that you have'* – this was the most common expressed opinion; that a professional recognition programme would provide the practitioner and the employer with an appreciation of what level the practitioner is at. It provides evidence of the work done at a specific point in time as well as the evidence of what skills are possessed. It encourages practitioners to showcase their skills and expertise by ascertaining the level at which they operate.
- *'Credentialing or professional recognition provide aspirational goals'* – this theme derived from quotes stating that if a robust system is in place it will be able to identify areas of weakness and strengths, to inspire development to the next level. It will provide goals to work towards for the individual practitioner.
- *'Peer support and networks'* – several interviewees agreed that, if such a system could be in place, it would provide the opportunity to create support networks. It would provide peer support, shared best practices as well as share expert information.
- *'Confidence in the practitioner'* – this was derived from quotes stating that the practitioner would have more confidence in their knowledge and their level of practice. A credentialing system would build confidence in the practitioner around the patient, therefore giving the patient the confidence in what the practitioner it is doing, and building confidence on the practitioner caring.
- *'Mentoring and feedback'* – this theme quotes states the opportunities for mentoring and supporting practitioners to improve their practice based on the feedback provided by their peers. It is also important to have as mentors and role models as the practitioner progresses in the profession. Mentoring supports opportunities to grow new roles.

### 3.2.4 Cluster 3 'for practice'

This theme gathers evidence of the impact, implications and opportunities for practice, a professional recognition or credentialing programme, would likely to have. This cluster comprises the themes of:

- *'Patient care outcomes; expected level of care'* – for this theme several quotes stating that through professional recognition the patient has the right to receive the highest level of care depending on their needs. In addition, the public has the right to expect different levels of service, receiving the expected and/or appropriate level of care.
- *'Standards of practice'* – for this theme, interviewees had the opinion that by having a set of standards it would provide the evidence for level of practice. The standards should be developed based on the best practice available. This would standardise the expectation of working levels by being measured against defined criteria. It would allow for recognition of a highly skilled workforce and would also enhance service delivery to patients.
- *'Right pharmacist for the right patient/practice'* – this was derived from several quotes using these exact words. Expert practitioners and senior managers suggested it would improve recognition of specialist practice, therefore improving care having. It also reassures the health service commissioners that the patient has the best quality of care with an added value.

- *'Medical Model'* – the medical model was widely mentioned for several reasons. The recognition that the medical model has different sets of skills to provide for different clinical situations. According to one particular interviewee the profession needs to embrace and recognise the difference in skills and knowledge that practitioners develop according to their area of expertise. It should also take into account the assessment tools being used by other professions, such as assessment of knowledge (OSCEs and MCQs) and practice assessment (portfolio or viva). It was noted that credentialing should avoid over-specialisation leading to the fragmentation of the profession and hence leading to practice being conducted in *silos*.
- *'ACLF is a generalisable and useful tool'* – several expert practitioners, some of them with experience in the ACLF tool mentioned the easy adaptation of the clusters to other specialities. Practitioners are able to produce the portfolio themselves and the structure of the framework provides generality across different areas.

During the interviews several assessment tools were mentioned, these being portfolio reviews, MSF techniques such as 360° appraisals and *viva voce* with an expert peer panels as the most relevant for practice. The findings from the interviews corroborate with the findings from the survey, leading JPCT to conclude they are principally important for the development of a robust system of professional recognition or credentialing.

At the end of each interview, interviewees had the opportunity to state any final remarks or reflections they would like to share. There was emphasis of the importance of this project for future practice and for practitioner development and that all the evidence and best practices should be taken into consideration. Credentialing or professional recognition of pharmacists should also inform the patient, public and government the role of the pharmacist in the health care team, enhancing expertise in medicines. There was strong opinion that work on formation of a royal college-type Faculty structure should be an imperative and steps should be taken to accelerate progress on this infrastructure.

To illustrate the statements a few comments are paraphrased *in italics* below:

#### **ACLF is a generalisable and useful tool**

*"The majority of the assessment that the Critical Care Group did was equal to the Care of elderly. Important finding the assessment were relevant to all of the area. Only specifics; CbD study pre-prepared could be perhaps in a real life situation. Add an actor or role-play; Portfolio critical with evidence, practitioner is going along the career pathway with evidence. Get them to tell their histories; Portfolio plus CbD; 360° is important as well. Correlate well with portfolio. ACLF triangulate with 360°; 360° junior pharmacists, more on ward. Not sure if 360° are able to triangulate the ACLF is more about expert practice. Applies more on advance level people rather than the consultant level; 360° person for each of the cluster. If we want to triangulate with the other clusters."*

EP8

*"ACLF – it was endorsed by the independent review. I am confident that we are doing it well. Credentialing is more to do with Advanced level practice. Evidence – portfolio interview "*

SPM6

#### **Final Reflections**

*"The process give me reinsurance of what the level you are and it provides you a time scale of the learning gaps that you are/identified."*

EP7

*"Great that we are working together. Use the current models around there."*

SPM2

*"In general is a very good idea, give pharmacists more confidence about myself. Peer-reviewed. People want to practice at the best level."*

SPM4

*"Embrace the common grounds, which is about patient care. End in mind is the patient."*

SPM7

*"Unless it has engagement with RPS, GPhC, governments and patient group the work would invaluable. This project should be part of a wider mission to educate government, patient and public about what pharmacists do."*

EP10

*"We have to do this. We do this or we die as a profession."*

EP11

### 3.3 Conclusion

The JPCT group has gathered evidence that provides a snapshot of the current practice, the assessment tools currently being used and other considerations critical for the development of a professional recognition programme, and as well as an overview of the impact, implications and opportunities such a programme would provide.

When comparing and contrasting the results from the survey and the interviews, commonalities are clear: a national credentialing process or a professional recognition programme is an opportunity for significant progression of the profession, for professional practice and for individual pharmacists. Levels of performance can be identified and a set of criteria, such as practice standards or behaviours, can be mapped to a common capability framework.

If a robust system is put in place, with engagement of all stakeholders and led by the professional leadership body, expert opinion suggests this will have an impact on the perspectives of patients, public and government regarding the role of the pharmacist and as well as its place in the delivery of excellent pharmaceutical health care. Improving patient outcomes, through recognition of medicines expertise, will subsequently improve the overall quality of pharmaceutical care delivery.

The use of the ACLF as a basis for the development of a professional recognition programme is strongly recommended, with the necessary adaptations according to speciality needs. It is recognised in both evidence sets presented here that the ACLF is a valid and useful tool for practitioner development and a valid method of mapping capability when used in conjunction with other work-based tools. For employers, it provides evidence reassuring them of the level of competence and capability of the practitioner workforce; for patients and the public it allows them to receive the best possible care according to their needs from a professionally recognised health care practitioner.

The professional recognition assessment tools most widely cited from expert opinion, across the survey and the interviews, are:

- Portfolio review (allowing the practitioner to generate evidence of their competence), ideally based on the ACLF framework;
- An oral assessment by an expert panel or board (viva voice);
- MSF such as Peer review, 360° appraisal or similar methods.
- It was also noted that a knowledge and skills assessment, Objective Structured Clinical Examinations (OSCEs) and Multiple Choice Question exam could be incorporated for some specialities. However, with prioritisation, these knowledge-based assessments became lower ranked choices, although some clinical groups indicated a preference for direct observation of practice to be incorporated into professional recognition processes.

Ensuring that all pharmacists who practice within a specialist area, or a defined advanced generalist area, have experienced a process of evaluation and are credentialed as highly capable by a peer group of experts is one of the aspirational goals facing the profession. Hence a professional recognition programme is needed to support and facilitate the process, and this should be progressed quickly.

Enhancement and excellence in patient care is the ultimate aim of a professional recognition programme; by developing a robust system and evaluating practice with evidence-driven processes, the JPCT believe this will improve standards and outcomes of pharmaceutical service delivery.

## 4. Recommendations

The JPCT group would like to recommend for the RPS to take into consideration the evidence gathered in this report for the development of a professional recognition programme, situated within a royal college type faculty structure.

The evidence illustrates that practitioners want to be recognised for the level they have and be further supported to achieve better performance through structured practitioner development methods.

The JPCT group recommends that the RPS should:

- I. Develop professional recognition programmes using tools and methods that are already used across the profession (such as the ACLF<sup>4</sup>), with appropriate adaptation for the different specialities and using Partner-endorsed *Professional Curricula*.
- II. Start immediate work on developing Faculty systems for member support in practice development. In particular the JPCT recommend the development of:
  - a. An online ACLF tool, and subsequent use of existing frameworks to support Directly Observed Practice and consultation skills (such as the MRCF<sup>5</sup>).
  - b. Online monitoring tools to support Case-based Discussion and Extended Intervention logs records for practitioners.
- III. Establish networks that will support the development of advancement in care, in particular to assist with MSF development and mentoring exchange networks, in addition to providing mentor support for conducting Clinical evaluation and Case-based type exercises for those practitioners working in more isolated environments; the Local Practice Fora would be ideally suited for this activity.
- VIII. Direct the principles of assessment to be based on portfolio review (to assess breadth of practice), a form of peer feedback (360° degree, peer/self assessment - to assess working relationships) and a form of expert assessment based on the area of practice and commensurate risk to patients. However, any MSF tool used for professional recognition should be aimed at being above and beyond those required for routine employment purposes and must be clearly evaluative and developmental (for example mini-PAT<sup>6</sup>).
- IV. Promote and advocate engagement with Faculty Peer Review panels as a career highlight for expert practitioners and as a fundamental professional responsibility for the RPS Partner Groups.
- V. Establish the governance processes of the Faculty Peer Review panels as a key imperative for the Faculty and for RPS Partner Groups. The JPCT further recommends that initial Transitional Recognition Panels should be established at the earliest opportunity to address recognition of prior experience and expertise in the profession in order to progress initial population of the Faculty; an APEL type process would be recommended for the start up period of the Faculty.
- VI. In order to establish working practices, assessment standards and assessment guidance for professional recognition levels within the RPS Faculty, and before the formal establishment of the RPS Faculty, the RPS should now start a formal appointment process for the Transitional Recognition Panels, the principal Faculty governance panels and committees.

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<sup>4</sup> CoDEG 2009

<sup>5</sup> Abdel-Tawab *et al* 2005; CoDEG 2007; Abdel-Tawab *et al* 2011

<sup>6</sup> Patel *et al*, 2009, 2011; Davies *et al*, 2013.

Overall there was strong agreement between the survey outcomes and the individual interviews. The JPCT, as a collection of expert and specialist groups (including primary and general practice care) strongly recommend that the RPS Faculty develops a programme for professional recognition urgently, taking account of the above recommendations for the future of the profession and the advancement of pharmaceutical health care.

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Internal documents provided by the partner/specialist groups were also consulted.

## Annex I | Definitions of the tools

**Case-based discussion or similar:** A retrospective evaluation of input into patient care e.g. an intervention. A one to one format, whereby an Assessor can explore a number of themes. Can be encompassed into peer review meetings and training sessions. More in-depth than a miniCEX takes 30/40 min.

**Direct Observation of Practice Skills (DOPS):** A similar method to the miniCEX, but designed specifically for the assessment of practical skills and activities in real time. Needs a trained Observer/Assessor. The aim is to demonstrate competence in a range of defined practical activities.

**Extended interventions log:** records of actions taken by a pharmacist to improve patient care & outcome, and including those that have prevented patient harm. It comprises a summative record of significant interventions made.

**Mini-Clinical Evaluation Exercise (miniCEX) or similar:** A prospective observation (by practitioner) of a patient contact e.g. drug history taking, medication counselling. Takes 15/20 min including feedback.

**Mini-Peer Assessment (mini-PAT):** is normally a questionnaire, which provides feedback from a range of co-workers (sometimes described as a 360° assessment). Assessors are nominated within supervising pharmacists, senior medical and nursing colleagues to complete the paper/online questionnaire.

**Multiple Choice Question (MCQ) exam:** An MCQ exam will assess specific knowledge – e.g. pharmacology, pharmacokinetics – in addition to assessing information that all pharmacy practitioners should know – e.g. legal aspects associated with pharmacy.

**Multiple Source Feedback (MSF):** MSF, also known as 360° feedback, can be defined as a process by which multiple individuals, representing discrete informant groups, provide feedback to the practitioner. The concept is based on the premise that practitioners' roles in multidisciplinary teams are fundamental and central to the provision of good patient care. MSF assumes that practitioners can be individually assessed in a meaningful way across a number of competencies by a multidisciplinary team.

**Objective Structured Clinical Examinations (OSCEs):** Have the aim of assessing practitioners' skills and application of knowledge in simulated settings.

**Oral assessment by Expert Panel or Board:** A face to face oral (viva voce) assessment by an accredited/Quality Assured Panel of Experts within the subject field of experience.

**Portfolio review:** is based on the Advance to Consultant Level Framework (ACLF) Evidence gathering in a portfolio, which demonstrates practitioner competence to practice pharmacy as advance level pharmacist. The portfolio may contain a number of elements.



## Annex II | Glossary of Terms | Version July 2012

This document is a joint publication. It aims to set out a common lexicon for practitioner development and professional recognition concepts. It is to help practitioners and specialists groups to develop a common understanding of the terminology being used by the group. The document is a work in process as concepts and definitions often evolve in accordance with policy development.

### Term: **Accreditation**

#### Definition:

The term 'accreditation' can be used in two ways:

1. Independent kite marking for materials, courses and education that is recognised by regulators or other QA bodies;
2. Endorsement from a recognised and respected body of educational materials or courses developed by independent providers, to demonstrate to users that it is of high quality.

### Term: **Advanced & Consultant Level Framework (ACLF)**

#### Definition:

The ACLF is a professional development framework for pharmacy practitioners working at more advanced or complex levels of practice. It was used as a framework guide for the creation of NHS Consultant pharmacists via the Department of Health.

It was developed by the Competency Development and Evaluation Group (CoDEG) in 2004 and has been extensively piloted and validated in different specialties of pharmacy, at all levels of practice, and in hospital, community and primary care sectors. CoDEG have also produced a development framework for early years and more inexperienced pharmacists, called the General Level Framework (GLF see [below](#)). The ACLF was designed by practitioners, for practitioners, using a grounded approach and evidence from other professions and literature.

The ACLF is often used as an enabling framework to 'host' specialist curriculum (see [Professional curricula](#) below). The ACLF is not intended to be adapted for each pharmacy speciality, and does not constitute a "curriculum" for specialties.

This is a generic framework that has been used across the profession for specialist and advanced practice, as well as externally for generic leadership competencies across professions. It consists of 6 clusters; Expert Professional Practice, Building Working Relationships, Management, Leadership, Education and Training and Research and Evaluation. It is structured in 3 levels: Foundation (i.e. an 'advance practice' foundation level which applies post completion of the GLF) Excellence and Mastery (which applies to 'consultant level' practice).

### Term: **Capability**

#### Definition:

Extent of a practitioner's ability; a measure of the ability of a practitioner to achieve his/her professional objectives, especially in relation to an overall mission or task definition. The term could also be applied to a developmental framework, which supports both broad scope and higher skills development within a practitioner role, and which may not always be constrained by the requirements of a specific job or role. ["capability framework"; "practitioner development framework"]. It can be linked to competency development, although this is more usually seen as one component of the formative part of the developmental pathway.

### Term: **Career structure/Pathway**

#### Definition:

Planned set of differentiated steps, posts or jobs through which one can progress professionally within a specific position or across positions over time.

<b>Term:</b>	<b>Competence</b>
<b>Definition:</b>	Full repertoire of competencies.  See <a href="#">Competencies</a>
<b>Term:</b>	<b>Competencies</b>
<b>Definition:</b>	Knowledge, skills, behaviours and attitudes that an individual accumulates, develops, and acquires through education, training, and work experience.
<b>Term:</b>	<b>Competency framework</b>
<b>Definition:</b>	A complete collection of competencies that are thought to be essential to performance.
<b>Term:</b>	<b>Continuing Education (CE)</b>
<b>Definition:</b>	A structured process of education designed or intended to support the continuous development of pharmacists to maintain and enhance their professional competence.
<b>Term:</b>	<b>Continuing Professional Development (CPD)</b>
<b>Definition:</b>	The responsibility of individual pharmacists for systematic maintenance, development and broadening of knowledge, skills and attitudes, to ensure continuing competence as a professional throughout their careers.
<b>Term:</b>	<b>Credentialing</b>
<b>Definition:</b>	A process that evaluates and documents evidence of professional or educational capabilities and qualifications (examples may include both formal and informal qualifications and capabilities: university degree, diploma, and certification; quality assured evidence of capability; professional examinations; membership criteria for learned societies or associations; etc).  See <a href="#">Professional recognition</a>
<b>Term:</b>	<b>Education and training</b>
<b>Definition:</b>	The process by which an individual is equipped with the knowledge, skills and attitudes needed to produce the kind of performance necessary to achieve health services objectives.
<b>Term:</b>	<b>Evidence-Based practice</b>
<b>Definition:</b>	Using good quality evidence to make sound clinical decisions.
<b>Term:</b>	<b>General Level Framework (GLF)</b>
<b>Definition:</b>	The GLF is a development and support framework for pharmacists in their early years of practice or for use in routine performance management.  It was developed by the Competency Development and Evaluation Group (CoDEG) in 2004 and has been extensively piloted and validated in different specialties of pharmacy, at all levels of practice, and in hospital, community and primary care sectors. There is an extensive bibliography available at <a href="http://www.codeg.org">www.codeg.org</a> .

<b>Term:</b>	<b>Innovation</b>
<b>Definition:</b>	The translation of ideas into new or improved services, processes, or systems.
<b>Term:</b>	<b>Performance</b>
<b>Definition:</b>	An effective and persistent observable behaviour. What an individual actually does as opposed to what they can do.
<b>Term:</b>	<b>Performance management</b>
<b>Definition:</b>	Process of optimising productivity and quality of work of the workforce.
<b>Term:</b>	<b>Professional curricula</b>
<b>Definition:</b>	<p>A curriculum encompasses the purposes, knowledge, evaluations, skills and experiences needed to define subject specific practice in any particular area.</p> <p>Several specialist pharmacy groups, for example the UKCPA Critical Care Group and the UK Renal Pharmacy Group, have developed specialist curricula.</p> <p>The <a href="#">ACLF</a> is often used as a framework to ‘host’ any particular curricula and provide a means to identify the different knowledge, skills and experiences required at advancing levels of practice and in different competency areas.</p> <p>This allows practitioners to easily identify what is required to advance in their area of practice. In summary, the ACLF will provide a framework for evidence gathering to show or support practice development for a practitioner; the professional curriculum will define the ‘syllabus’ or subject knowledge that underpins practice performance. There may be different curricula for different subject areas; and the ACLF is an overarching competence framework for all practitioners in all sectors.</p> <p>The ACLF can also be used to validate the curricula – to ensure that it applies to the different levels of practice - Foundation/Excellence/Mastery – and by extension, is applicable to all NHS Bands or other such employee structures.</p> <p>Many specialist curricula have ‘core’ content which is common to other specialisms (so called “subject adjacencies”), which highlights the ability for advanced practitioners to work in different therapeutic areas without having to re-train “from scratch” within a new specialism.</p>
<b>Term:</b>	<b>Professional recognition</b>
<b>Definition:</b>	<p>Also sometimes termed “credentialing”, this is a quality assured process, which recognises a practitioner’s attainment of the required knowledge and skills at a particular level of practice. Crucially, this is a process conducted through professional peer review, and is not connected with a regulatory function. It exists for the purposes of validation of practice by peers, and demonstrates a recognition of practice which has value and merit for the general public and other members of the profession or professional colleagues.</p> <p>Some countries have more developed credentialing system (for example, north America) and this concept, in pharmacy, is gaining credibility among the healthcare community. In medicine, it is a well developed concept, conducted through Royal medical colleges and other medical professional bodies. It is seen as a crucial element of career progression and development.</p>

**Term:** Revalidation

**Definition:** A process for practitioners to assurance continuing fitness to practice, aimed at supporting and enhancing professional practice.

**References for the definitions in the glossary obtained and adapted from the following sources:**

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**Joint Partners Credentialing Taskforce Group**

British Oncology Pharmacy Association (BOPA)  
College of Mental Health Pharmacy (CMHP)  
Faculty of Cancer Pharmacists (FCP)  
HIV Pharmacists Association (HIVPA)  
Independent sector employers  
Neonatal and Paediatric Pharmacy Group (NPPG)  
Pharmacy Quality Assurance/Specialist Technical Services (Tech Services)  
Radiopharmacists Group (PG)  
Renal Pharmacy Group (RPG)  
Royal Pharmaceutical Society (RPS)  
United Kingdom Clinical Pharmacy Association (UCKPA)

### Annex III | Abbreviated survey and interview questions

- Group's MEMBERSHIP: Patient facing; Non patient facing; Other.
- For generally "patient facing" groups, service delivery target: Generally high-risk patients; Long term/chronic/ambulatory patients; Acute sector care; Generally community facing.
- For generally "non patient facing" groups, service delivery: Driven by information provision; Driven by medicines science; Driven by regulatory/quality processes.
- Can the group identify specific 'levels of performance', which would adequately describe the differences between novice, intermediate and expert practice within your specialism, independently of other specialisms?
- Has the Group previously (or currently) conducted credentialing/type activities for members?
- Which of the tools, in the specialism/group, would be of use in identifying expert practice or advanced performance in practitioners.
- From the identical listing, choose the 3 most important tools for recognising advanced/expert practice suitable for the specialism or Group.
- Please briefly explain the reasons for choosing the three most important tools for advance/expert practice recognition.
- Principles of credentialing: Commentary asked.
- How relevant is professional recognition or credentialing likely to be?
- In order to develop a credentialing framework, what should be taken into account?
- If pharmacy develops a robust system for professional recognition or credentialing, what impact would you expect it to have?
- How might patients benefit from professional recognition or credentialing of pharmacists?

## **Annex IV | A set of principles for Professional Recognition/Credentialing**

### **Principles of credentialing**

#### **In the context of the profession as a whole:**

- a. The idea of professional recognition is based on developing aspirational standards of practice and quality assured professional development of health professionals.
- b. A good system of professional recognition will provide global evidence that patient safety – in the context of health service delivery is being addressed.
- c. A good system will enhance the global quality of pharmaceutical care provision, by using benchmark indicators (or core competencies, or key performance indicators, or standards of care expected of a practitioner at a defined level of practice).

#### **In the context of the individual practitioner:**

- d. Having an agreed process for professional recognition should primarily support practitioner progression (through training) and secondarily support any professional revalidation processes.
- e. A good system will provide evidence of the individual performance characteristics for any practitioner at a defined level of practice (in any speciality within a profession) and should be able to demonstrate achievement of defined capabilities.
- f. A good system should incentivise the professional development of practitioners for reasons of professional altruism rather than direct regulation.
- g. A good system will signpost opportunities for continued advancement of the individual and open up new practice and scientific development opportunities for professionals.
- h. A good system will encourage the engagement of practitioners in “Communities of Practice” and encourage effective networking between peers.