

# Engaging on the framework for credentials

## 1. Why credentials are needed

**This is for comments about 'A case for change' in the framework, and 'Why we're introducing credentials' and 'Impact and issues' in the annex. We're interested in your views on:**

- **whether credentials will enable flexibility**
- **support necessary change**
- **opportunities for doctors**
- **any other thoughts on these sections.**

### **About us**

The British Pharmacological Society (BPS) is the primary UK learned society concerned with research into drugs and the way they work. The Society has around 4,000 members working in academia, industry, regulatory agencies and the health services, and many are medically qualified. The Society covers the whole spectrum of pharmacology, including laboratory, clinical, and toxicological aspects. Pharmacology is a key knowledge and skills base for developments in the pharmaceutical and biotech industries, and is therefore fundamental to a thriving UK industry and R&D. The Society publishes three scientific journals: the British Journal of Pharmacology, the British Journal of Clinical Pharmacology, and Pharmacology Research and Perspectives.

The Society is also a partner on The Clinical Pharmacology Skills Alliance (CPSA), in collaboration with the Association of the British Pharmaceutical Industry (ABPI), the Faculty of Pharmaceutical Medicine (FPM) and Health Education England (HEE). The purpose of the CPSA is to develop and support a long-term, cross-sector action plan for clinical pharmacology. Our response to this consultation outlines our view on how Clinical Pharmacology and Therapeutics could support credentialing. To discuss this submission further, please contact Lisa Hevey ([lisa.hevey@bps.ac.uk](mailto:lisa.hevey@bps.ac.uk); 020 7239 0179 or 07773 953504).

### **Credentials have the potential to enable flexibility**

In an era of outcome-based education it is essential that health-care professionals demonstrate competencies in specific knowledge, skills and attitudes essential for effective and safe practice. However, with the advancement of knowledge and shortening of some training programmes, more advanced areas of practice may not be achieved during standard training pathways.

Credentialing is clearly one way to ensure that advanced competencies can be part of the development of professionals in a quality assured way that ensures that specific areas of practice are entrusted to individuals during or after generic specialty training. As such, credentials could increase flexibility for medical doctors and could also potentially broaden the scope of practice of other healthcare professionals such as pharmacists and independent prescribers.

The NHS long term plan states that credentials will enable doctors to broaden the scope of their practice, both during and after training. Whilst it is clear how this could work with additional competence development later in training – as is the case for post-CCT fellowships – this is less clear for doctors in more junior positions. We believe that this could risk credentialing being seen as an alternative to specialty training and may create a 'sub-consultant' grade which would be

detrimental to the public perception of their care. It is therefore essential that the eligibility criteria are clearly set out.

Credentialing has important potential to support interprofessional working and skills sharing. Indeed, more broadly it could enable all clinical staff to develop new capabilities and create a more adaptable workforce. The eligibility requirements for other professionals should also be considered such that professionals have a core competence skills set through an appropriate level of qualification e.g. band 8 or consultant pharmacist before taking on expanded practice.

Further, we are encouraged by the potential of credentialing (and the flexibility it could bring) to support people to develop careers that interest them. In the modern NHS, more attention should be paid to ensure that all staff have protected time in their job plans to allow for development. This could reduce 'burn out' and increase retention and job satisfaction.

### **Credentialing has the potential to support necessary change**

Credentialing can never replace specialty training, but it offers an opportunity to amplify key skills across the workforce, support new ways of working and facilitate integrated care. We envisage credentialing working in two ways: to enable greater depth of training for specialists (e.g. a cardiologist credentialing in electrophysiology) or a greater breadth of training that amplifies key skills across the workforce (e.g. a GP/geriatrician credentialing in complex polypharmacy, or an oncologist/pharmacist credentialing in experimental medicine to support clinical trials work). We support the goals around patient safety and support for effective service delivery. We also recommend that credentialing criteria should capture other NHS priorities, such as the research agenda and support of the UK Life Sciences Industrial Strategy.

The use of medicines is central to the work of the NHS for the benefit of patients. Over 1.1 billion prescription items are dispensed in the community every year<sup>1</sup>. Although medicines have many proven benefits, 6.5% of all hospital admissions are caused by adverse drug reactions, and 237 million medication errors are made in the NHS each year<sup>2,3</sup>. A major challenge for the NHS is that of increasing numbers of older people with multiple long-term conditions, requiring prescriptions of multiple medicines. Clinical pharmacologists are experts in the safe, effective and cost-effective use of medicines. However, to have the greatest impact across the NHS, the whole workforce must be skilled in the use of medicines.

Further, development of new medicines is essential to address unmet clinical need, bringing benefit for both society and the UK economy. Supporting innovation that delivers to public needs, such as drugs and therapies for elderly patients and healthier ageing, is part of NHS England's Research Plan<sup>4</sup> and an NIHR Research Priority<sup>5</sup>. The field of drug development and clinical trials is an important part of the UK's success in health-related innovations, both in industry and in the NHS. To facilitate this, the workforce must be 'research ready', meaning healthcare professionals must be familiar with and have some exposure to the disciplines and ethics of clinical research and structured data gathering.

Personalised medicine is a key goal of NHS England, who are working with Genomics England to deliver the 100,000 genomes project and implement the use of pharmacogenomics in the NHS. This has potential to optimise the benefits of medicines and reduce adverse drug reactions. To realise this potential, the workforce must be trained to interpret and use pharmacogenomic

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<sup>1</sup> NHS Digital. (2017) Prescriptions Dispensed in the Community, Statistics for England – 2006-2016 [PAS]. Available at: <https://digital.nhs.uk/catalogue/PUB30014>

<sup>2</sup> British Pharmacological Society. (2016) Clinical Pharmacology and Therapeutics: The case for savings in the NHS. Available at: <https://www.bps.ac.uk/BPSMemberPortal/media/BPSWebsite/Assets/CPT-case-for-savings-in-the-NHS.pdf>

<sup>3</sup> Policy Research Unit in Economic Evaluation of Health & Care Interventions. (2018) Prevalence and Economic Burden of Medication Errors in the NHS in England. Available at: [www.eepru.org.uk/wp-content/uploads/2018/02/medication-error-report-revised-final.2-22022018.pdf](http://www.eepru.org.uk/wp-content/uploads/2018/02/medication-error-report-revised-final.2-22022018.pdf)

<sup>4</sup> NHS England. (2017) NHS England Research Plan. Available at: <https://www.england.nhs.uk/wp-content/uploads/2017/04/nhse-research-plan.pdf>

<sup>5</sup> National Institute for Health Research. (2015) Statement on Areas of Research Interests. Available at: <https://www.nihr.ac.uk/research-and-impact/research-priorities/areas-of-research-interests.htm>

results. It is vital that healthcare professionals are appropriately trained to manage the complex problems that emerge in clinical practice.

Therefore, we recommend exploring credentials in prescribing/complex polypharmacy, experimental medicine and pharmacogenomics. These credentials could be driven by the specialty of Clinical Pharmacology and Therapeutics, and would align to the new curriculum capabilities in practice.

### **The specialty of Clinical Pharmacology & Therapeutics is well-positioned to lead training in the use and development of medicines**

The British Pharmacological Society is a partner organisation of the Clinical Pharmacology Skills Alliance (CPSA). Other partners include the Association of the British Pharmaceutical Industry (ABPI), the Faculty of Pharmaceutical Medicine (FPM) and Health Education England (HEE). The purpose of the CPSA is to develop and support a long-term, cross-sector action plan for clinical pharmacology. Clinical Pharmacology and Therapeutics (CPT) is a small specialty, but one that is well-placed to provide leadership and amplify expertise on the use and development of medicines in the NHS, in partnership with pharmacy. We believe that credentialing would be an opportunity to cascade critical clinical pharmacology skills and support training through the workforce (e.g. pharmacists could take a credential in experimental medicine to enhance research capacity of the NHS) and enhance interprofessional working. To secure the future of this approach, it is vital to protect CPT as a specialty in parallel. The British Pharmacological Society has identified clinical pharmacology within the NHS as an area of critical skills shortages. In 2014 there were only 77 Clinical Pharmacology and Therapeutics (CPT) consultants in the UK. This compares to a Royal Colleges of Physicians (London) recommendation of a workforce of 440<sup>6</sup>. We are working with CPSA partners and NHS England to explore opportunities for increasing the consultant workforce and advancing creative opportunities such as credentialing and multi-professional working to modernise the specialty. Our vision is for a strong CPT specialty that has the capacity and opportunity to support the whole workforce to be skilled in the use of medicines and to be research ready, in partnership with pharmacy.

Clinical pharmacologists have a key role in improving the safety of medicines use across the workforce. They have jointly led the development of the Prescribing Safety Assessment, the first single, national, online assessment of prescribing competency, with the UK Medical Schools Council. Each year over 7000 final-year medical students in all 31 UK medical schools sit the Prescribing Safety Assessment<sup>7</sup>. To date, over 42,000 UK medical students have taken the assessment. All new doctors are now required to take the Prescribing Safety Assessment before they enter practice.

We are also piloting an innovative service delivery model (in a couple of locations, South London, Liverpool) that positions “medicines specialists” (i.e., experienced clinical pharmacologists and pharmacists) to provide support at the primary–secondary care interface. These specialists will review patients with the most complex polypharmacy at the request of GP/GP pharmacist teams, conduct multidisciplinary reviews with GPs/GP pharmacists of patients identified with polypharmacy using the ePACT2 polypharmacy indicators, and provide advice, training, and networking. This could be delivered through investment in new ‘Regional Medicines Specialist Centres’ jointly led by clinical pharmacologists and experienced pharmacists. Such centres could act as educational hubs for the delivery of credential training in prescribing/complex polypharmacy. We would be keen to explore this further.

Further, cost-modelling demonstrates that every £1 invested in clinical pharmacologists could save nearly £6 through more efficient use of medicines, and fewer adverse drug reactions<sup>8</sup>. Savings would be felt across the NHS, benefiting patients and the wider workforce.

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<sup>6</sup> The Royal Colleges of Physicians. (2013, update). Available from: <https://www.rcplondon.ac.uk/file/1578/download?token=TH8kJh7r>

<sup>7</sup> Maxwell SRJ, Coleman JJ, Bollington L, Taylor C, Webb DJ. (2017) Prescribing Safety Assessment 2016: Delivery of a national prescribing assessment to 7343 UK final-year medical students. *BJCP* 83(10): 2249-2258. Available from: <http://onlinelibrary.wiley.com/doi/10.1111/bcp.13319/full>

<sup>8</sup> British Pharmacological Society. (2016) Clinical Pharmacology and Therapeutics: the case for savings in the NHS. Available from: <https://www.bps.ac.uk/BPSMemberPortal/media/BPSWebsite/Assets/CPT-case-for-savings-in-the-NHS.pdf>

## Other considerations

We think it would be important to consider these issues as part of developing the credentialing model:

- There is an acute shortage of doctors in many clinical areas, but recently we have seen a particular problem in acute and general medicine with the numbers of trainees applying for specialties that include acute medicine declining rapidly. We offer caution that there may be unintended workforce implications of credentialing: e.g. if the movement of doctors into credential training increases acute rota gaps, causes people to move away from unpopular specialties, or employers require 'pay back' for having supported credentialing in a way that affects freedom of career progression. This could be managed through funding arrangements, workforce analysis as a pre-requisite for offering a credential, and risk sharing between employees and employers.
- The funding model for credentialing is unclear at present. It will be important that credentialing is seen as high value and high-quality training, so funding should be focused on the areas of greatest need and benefit. We support plans for careful implementation and, by implication, assessment of funding requirements to deliver credentials at a high level versus the resource that is available.
- Ownership of credentialing must be clear so that credentialed skills are carefully managed and consistent in their quality and assessment. In physician-related credentials, we suggest that the relevant Specialty Advisory Committee should take ownership so sub-specialty credentials are tied to curriculum development. This would enable clear support for the delivery and monitoring of credentialing.
- How will credentialing affect doctors in sub-consultant grades? We recommend consideration of an alternative recognition process similar to the CESR (Certificate of Equivalence of Specialist Registration) route. It is important that the skills of sub-consultant doctors, such as associate specialists, are recognised. This could provide security and recognition for these professionals.

Our overall view is that credentialing should be driven forward in line with strategic priorities with appropriate funding support.

## 2. Defining a credential

**This is for comments on 'Defining credentials' in the framework. We're interested in your views on:**

- **whether we have described credentials clearly**
- **if an alternative word should replace 'credentials'- and ideas welcome**
- **any other thoughts on this section.**

We agree that credentials are described clearly. We also think the term is helpful in describing substantial training, different to continuous professional development (CPD). We would also like to note that the term has gained some traction in the healthcare community and indeed is now clearly described in the NHS long term plan<sup>9</sup>, so it may be confusing to change it.

## 3. Criteria and threshold for credentials

**This is for comments on 'Identifying credentials' in the framework. We're interested in your views on:**

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<sup>9</sup> The NHS Long Term Plan (January 2019) Available from: <https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/>

- **whether we've got the criteria right**
- **anything we might need to be aware of in trying to balance the criteria correctly**
- **anything we should consider regarding the risk threshold**
- **any other thoughts on this section.**

The criteria to assess potential credentials appear rigorous and cover both patient and NHS factors.

We recommend consideration of factors that are aligned to other NHS priorities such as the research agenda and in keeping with increasing uptake of innovation. This also aligns to the UK Life Sciences Industrial Strategy and could be supported by a credential in experimental medicine.

Critically, it is important that we do not accept a lower standard of training – there is a risk of resources being spread too thinly. Credentials should be promoted and developed as high value and high quality, and focused on areas of highest need and benefit. It would be better to fund fewer credentials well than to develop too many at once.

We would welcome the opportunity to continue discussions about credentials that support skills in the use and development of medicines. In section 1, we highlighted prescribing/complex polypharmacy, experimental medicine and pharmacogenomics as critical areas for development that we would be keen to support.

#### 4. The regulatory process

**This is for comments on 'Regulating credentials' in the framework, and 'How we propose to regulate credentials' in the annex. We're interested in your views on:**

- **if approving credentials as part of the postgraduate training pathway is right**
- **if credentials should be recognised on the List of Registered Medical Practitioners**
- **any other thoughts on these sections.**

No specific comment.

#### 5. A phased approach to implementation

**This is for comments on 'Implementing credentials' in the framework, and 'Plans for implementation' in the annex. We're interested in your views on:**

- **any issues we need to consider in our plans for implementing credentials**
- **any other thoughts on these sections.**

The implementation period is timely regarding the development of new specialty curricula and IMT. This is an opportunity for development and consideration of pilots in high priority areas. Implementation should be phased slowly and outcomes carefully monitored. The medical workforce (e.g. Royal Colleges) should be involved in their implementation and assessment.

## 6. Supporting flexibility in training in other ways

**This is for comments on 'Other developments to support flexibility' in the framework. We're interested in your views on:**

- **Endorsed training modules in postgraduate curricula**
- **whether QA processes for additional skills areas adds value**
- **any other thoughts on these sections.**

We support endorsed training modules in postgraduate curricula. CPT is well-suited to this because of diverse but key areas that lends itself to module development e.g. polypharmacy, regulation, toxicology, pharmacogenomics.

Many post-CCT fellowships have been established for many years with specific outcomes and certification. If accrediting them via the GMC would not increase the cost or reduce their availability, then this would be acceptable.

## 7. Any other comments

In principle credentialing has the potential to increase flexibility and skills of the medical workforce, and that of other healthcare professions. Clinical Pharmacology & Therapeutics (CPT) has a lot to offer and we are currently working to modernise the specialty: building a core specialty attuned to the needs of the NHS, and working in partnership to amplify skills in the use and development of medicines across the workforce. We are currently undertaking this work as a partner on the Clinical Pharmacology Skills Alliance (see section 1) and credentialing offers an exciting opportunity to advance these aims. If helpful, we would be keen to discuss our work further with you and discuss how CPT may be able to help the NHS address key areas of patient safety and need. To arrange a discussion, please contact Lisa Hevey ([lisa.hevey@bps.ac.uk](mailto:lisa.hevey@bps.ac.uk); 020 7239 0179 or 07773 953504.)