1ST MEETING ON FORMING A COMMON TRAINING FRAMEWORK FOR HOSPITAL PHARMACY SPECIALISATION IN EUROPE

10th November 2014, Novotel Airport Hotel, Brussels, Belgium

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1 Participants

Professor Ian Bates (Chair) **(IB)**

Dr Roberto Frontini (EAHP President) **(RF)**

Prof Dr Kees Neef (EAHP Director of Education, Science and Research) **(KN)**

Joan Peppard (EAHP President-Elect) **(JP)**

Juraj Sykora (EAHP Director of Professional Development) **(JS)**

Eduardo Echarri Arrieta (Spain) **(EEA)**

Miguel Ángel Calleja Hernández (Spain) **(MACH)**

Jos Kosterink (Netherlands) **(JK)**

Toine Egberts (Netherlands) **(TE)**

Aida Batista (Portugal) **(AB)**

Andreia Bruno (Portugal) **(ABr)**

Claudine Ligneel (Belgium) **(CL)**

Fons Verbruggen (Belgium) **(FV)**

Paolo Serra (Italy) **(PS)**

Santolo Cozzolino (Italy) **(SC)**

Carlo Polidori (Italy) **(CP)**

Guillaume Hache (France) **(GH)**

Jacqueline Surugue (France) **(JSu)**

Aurelie Guerin (FNSIP observer) **(AG)**

Jennie De Greef (EAHP Chief Operating Officer) **(JDG)**

Richard Price (EAHP Policy and Advocacy Officer) **(RP)**

David Preece (EAHP Research Assistant) **(DP)**

Presenters:

Sophie Weisswange, European Commission **(SW)**

Dirk Bochar, Secretary General, Fédération Européenne d'Associations Nationales d'Ingénieurs (FEANI), **(DB)**

2 Introductions

Professor Ian Bates welcomed all to the meeting and gave an introduction to the stated purposes of the meeting, including agreeing a process and method for forming a common training framework for hospital pharmacy specialisation in Europe. Accordingly, he saw the day as a potentially significant one in the development and shaping of the international pharmacy profession. Prof Bates emphasised that there was therefore an important collective responsibility for participants to communicate the proceedings and outcomes of the meetings back to their respective organisations and members, and to strive towards a consensus of agreement on next steps by the end of the day. He then asked participants to introduce themselves to one another by way of a short ‘tour-de-table’.

Following this Sophie Weisswange from the European Commission was invited to present to the meeting about the operation of the Common Training Framework.

3 Presentation from Sophie Weisswange, European Commission

Ms Weisswange explained that the newly revised Professional Qualifications Directive offered two new possibilities for qualification recognition under the term "common training principles": the common training framework, and the common training test. To be formed it required professional associations and/or member state Governments from at least 1/3 of EU countries to put the suggestion forward. The framework should apply to "regulated" professions, be described in terms of 'knowledge, skills and competencies', and relate to the European Qualifications Framework (EQF).

The EQF was established as a common reference framework for comparing education and training systems in the EU in 2008. The EQF was 8 defined levels and Ms Weisswange supposed that hospital pharmacy specialisation might fall into level 7 in terms of the description of learning outcomes.

Ms Weisswange advised that one of the sensible approaches to take at the beginning of a journey towards achieving qualification recognition between countries is to conduct a rigorous mapping exercise in order to more accurately identify what all the obstacles to achieving qualification recognition are likely to be.

On receipt of a proposal for a common training framework to be established (sent either by professional associations OR competent authorities OR national governments) the Commission will, if after successful meeting of criteria, prepare a delegated act to establish the framework.

Ms Weisswange reminded that one of the criteria for the common training framework is that it has been prepared according to a transparent due process. She therefore recommended wide involvement in its creation. The involvement of competent authorities for qualification recognition is especially important – it is unlikely that a proposal for a common training framework will be successful without this wide support. National level contact points for professional qualification recognition could provide a starting point for contact.

Once the Commission has compiled and published a proposal to form a common training framework there is then a deadline for Member States to seek exemption. This exemption might be sought, for example, on the basis that the framework "*would adversely impact the provision of education*".

The final stage of the process is the adoption by the Commission of an Implementing Act listing the titles and qualifications benefitting from the common training framework.

Ms Weisswange warned that the process of agreeing competencies of a profession between countries can be difficult as well embedded national systems can be reluctant to make significant changes that may be required.

An approach that could be helpful in the recommended mapping exercise is working on a European job profile for the hospital pharmacists, and matching the names and titles in use e.g. a job profile mapping exercise as well as a competency mapping exercise. The International Standard Classification of Occupations (ISCO) framework might be helpful in this regard.

The Commission are also in the process of developing a database of regulated professions around Europe that was likely to include hospital pharmacy and include some information on required skills and knowledge, and other components of labour market information.

In summarising his understanding, IB could see the need for a mapping exercise of hospital pharmacy across Europe that includes a) scope of practice b) training requirements and c) how competencies are assessed. This should probably also include who the awarding institutions are (e.g. is it the University, the professional association, other?), access arrangements to the profession and relevant legal references.

JS asked for clarification of the interpretation of 'regulated' in terms of the Commission's understanding of 'regulated profession'[1]. RP also asked for clarification on the matter. SW read the lengthy definition given in legislation but clarified that it could be taken to mean a profession that has some standing in law.

RF asked for confirmation that the common training framework did not require qualifications to be of the same length of duration. SW confirmed this was not necessary, competency agreement was more important. This would be illustrated, for example, by following the EQF's learning-outcome based approach.

JS asked why the process of competence agreement between countries could be so difficult. SW responded that it may often largely be an issue of lack of trust between systems. JS asked at what level competency agreement should be targeted i.e. best practice, or minimum requirements. SW replied that most competency agreements are termed as "minimum requirements", but it may be sensible to think in terms of an "upper average". Striving for an agreement based on the highest requirements increases the difficulty in achieving successful agreement.

4 Presentation from Dirk Bochar, Secretary General of FEANI

Presentation **here**.

Dirk Bochar presented briefly on the history of FEANI, the only European organisation to represent all engineers (as opposed to segments of the profession, such as civil engineers or mechanical engineers). Its 5 areas of strategic focus are: education and CPD; labour mobility; standards; societal issues; and, cultural matters in global fora. It represents through its membership around 350 professional associations.

Engineering card for professional qualification recognition

A key recent development in its work on labour mobility was the issuing of European engineering cards which demonstrated an individual's credentials in 3 particular areas: education; experience; and, CPD/further education. 5 factors are considered important to its success: completeness of the information; standardised formats; reliability; flexibility; and, validity.

The card links, in its interpretation of education, to the European Qualifications Framework. It is partly overseen by national competent authorities for engineering qualification recognition and others who meet 3 to 4 times a year to give consideration to all matters relating to the card.

The card is partly funded through the individuals who apply to make use of the system. It is a private product independent of Governments and the European Commission. Still relatively new (launched 2 years ago), 9 countries are making full use of the system, including Germany, the Netherlands, the Czech Republic and Poland. Being new, the card continues to evolve as well.

Reflecting on the process EAHP is launching, DB counselled that these kind of developments can take substantial time. For example, the engineering card was between 5 to 10 years in development depending on how one judges the start date.

The FEANI index

DB then outlined FEANI's creation and maintenance of the 'FEANI Index' – a reference source for the provision of quality education in engineering around Europe. The index lists the institutions of engineering higher education in European countries represented within FEANI, and their engineering programmes, which are all recognized by FEANI as fulfilling the mandatory education requirements for the EUR ING title.

The need for the Index was made apparent by the varying ways in which engineering is taught, recognised and regulated across Europe, with notable differences between north and south. The

[1] The definition given within the Professional Qualifications Directive for 'regulated profession' is: *"a professional activity or group of professional activities, access to which, the pursuit of which, or one of the modes of pursuit of which is subject, directly or indirectly, by virtue of legislative, regulatory or administrative provisions, to the possession of specific professional qualifications; in particular, the use of a professional title limited by legislative, regulatory or administrative provisions to holders of a given professional qualification constitutes a mode of pursuit"*

Index is underlined by the EUR-ACE accreditation system that provides a set of standards that identifies high quality engineering degree programmes.

The EUR-ING Title

The European Engineer (*Eur-Ing*.) is an international professional qualification for engineers used in over 32 European countries – a kind of common platform. With at least 10 countries signed up, it overcomes some of the difficulties experienced in respect of the variation in how engineering education is provided. While some countries have 3 years batchelor degree followed by 4 years experience before you can become an engineer, other countries have 5 years education followed by 2 years experience. EUR ING will recognise both – as long as the 7 years are met. EUR-ING is a lifetime engineering title, recognised by the European Commission since 1994.

Asked by IB what FEANI's opinion of the common training framework was, DB said that through the EUR-ING title, the FEANI index, the EUR-ACE accreditation system and the professional card, FEANI did not see a need to go through the difficult requirements of the common training framework. FEANI had met their wishes for mobility and standardisation through non-Commission tools, giving them ultimately greater flexibility and control. SW added that there could be issues for engineers in fully meeting the common training framework's "regulated profession" requirements in all countries. From DB's perspective, as long as the employer was recognising the qualification from another country, this was the most important thing. If FEANI's own initiatives could facilitate this, there was less requirement to go through European Commission legal tools.

Concluding the morning session with open questions to the two speakers, JS asked whether part of the evidence that would need to be presented to the European Commission included evidence of individuals being denied the opportunity to work in other countries because of lack of qualification recognition tools. SW confirmed this would be helpful evidence.

JSu asked whether the Commission would fund any activity to help EAHP form a common training framework for hospital pharmacy specialisation. The meeting discussed 200,000 euros DG SANCO was making available to support the creation of a CTF for healthcare assistants.

IB thanked both speakers for their presentations, attendance and willingness to take questions, and the meeting showed its appreciation. The meeting broke for coffee at 10.30 and returned at 11.00.

5 Presentations from participating countries about their specialisations

Spain

The first national presentation was from the Spanish delegation, given by Eduardo Echarri Arrieta (EEA). Presentation here.

Key points from the presentation included:

- The specialisation programme in Spain, in its present day recognisable form, began in the early 1980s with developments at regular intervals, including its extension to a 4 year programme in 1999.
- The programme is a mandatory requirement for practice as a pharmacist in Spanish hospitals.
- A selection process for candidates is undertaken every year (c.136 individuals), and the programme is overseen by a national committee. The Committee includes representation from the education system (2), SEFH (2), student representatives, guild representatives and others.
- The programme can be split into 12 principal areas of knowledge, amenable to definition with the EQF 'knowledge, skills and attitudes' categorisation. In all, the programme has 106 teaching units.

IB asked at what stage individuals began undertaking the programme. EAS considered that 99% of individuals embarking on the programme will have become registered pharmacists the year previously. IB asked if Faculties of Pharmacy are involved. EAS said the programme is primarily driven by the health ministry. JS asked how the programme was funded. EAS responded that funding is largely derived from the regions. Sometimes there is a debate with the regions about the allocation numbers as the salary of the participating individuals is met through this funding mechanism and HPs are in the same salary bracket as doctors.

Italy

The second national presentation was from the Italian delegation, given by Paolo Serra. Presentation here.

Key points from this presentation included:

- The Italian hospital pharmacy specialisation has been of 4 years duration since 2009 and has been mandatory since 1997. The original specialisation commenced in 1976 however, making it one of the most established programmes in Europe.
- The programme is distributed nationally through 22 Schools, with c.150 pharmacists taken into the programme each year.
- The programme content is largely set out in a 2006 decree, and includes important areas of knowledge such as biology, evidence-based medicine, informatics, medical devices, and internal medicine. This is underpinned in a national manual for the programme, overseen by a national observatory.
- There is around 1 tutor for 3 trainees and there progress is documented in an online database.

The presentation by PS was supplemented by a presentation by Carlo Polidori of the University of Camerino, to give a perspective from the education provider, outlining the year by year education provision. Presentation here.

IB asked about the demographic of individuals commencing the programme. This was described as being pharmacy graduates in the 28-34 age bracket. Much of the funding expectation came from the individuals (and may in practice be the parents).

France

The third national presentation was from the French delegation, given by Guillaume Hache. Presentation here.

Key points from this presentation included:

- The specialisation programme is based on a residency programme and is underpinned by a 2008 legal decree. A job is not guaranteed by the programme however.
- Around 300 hospital pharmacists are produced by the programme each year and it is governed according to 7 regions.
- The programme is founded on a cooperation between hospitals (employers) and Universities, with hospitals considered to be chiefly responsible for the individual attaining relevant skills and the Universities delivering the knowledge components. Accordingly, both the Ministry of Health and Ministry of Education take interests in the programme. Teacher-practitioners are also key in delivery of the programme.
- Other features include the ability to incorporate experience gained abroad, and having an equal career status to the medical profession at completion

Netherlands

The fourth national presentation was from the Netherlands delegation, given by Jos Kosterink. Presentation here.

Key points from this presentation included:

- Commencement of the first form of specialisation in the Netherlands might be traced to 1962 when the inaugural 2 year training programme was introduced, which became 3 years in 1986 and by 1999 was established in law.
- A system of colleges of specialisation in pharmacy can define the scope, competencies and titles of certain pharmacy specialities, with a certain level of oversight from the Ministry of Health and by professionals themselves. An annual fee is payable to the colleges, though it is often refunded by the employer. This parallels to medical specialty arrangements.
- The hospital pharmacy training programme is entitled ELOZ which was commenced in 2004 and revised in 2009 as ELOZ II (e.g. additional elements of medication safety added etc). ELOZ III is planned for 2015, when it is expected new components related to individual pharmaceutical care will be added.

- The first year of the programme is of an orientation nature, with the following years being focused on broadening and deepening knowledge. Much of the programme is delivered locally with an emphasis on learning on the job.
- 5 years after completion of the programme, a re-registration process is expected to be completed.
- There are around 30-40 places on the programme each year, with candidates typically drawn from those already working as pharmacists within hospitals. The places are funded by the Ministry of Health, with selection made at a local level.

Belgium

The fifth national presentation was from the Belgium delegation, given by Claudine Ligneel. Claudine explained that the presentation would focus on the Flemish experience as representatives from Wallonia were unavailable. Presentation here.

Key points from this presentation included:

- Specialisation in Belgium has existed since the 1970s, originally organised by Universities. The Masters programme is now under the supervision of a national accreditation council (15 members) following a 2012 royal decree. The accreditation council also accredit the internship supervisors and internship sites.
- Around 50 students per year enter into the programme, which is made according to a calculation
- The first year of the programme has a strong lecture component (40 ECTS, c.30 hours lectures) with the second and third years more practice based (3,500 hours of practical training). 2nd and 3rd year students received some limited remuneration by the Government.
- A masters thesis is expected by the end of the programme and should result in a publication or Journal article. Candidates are also expected to maintain an internship diary.
- The first accreditation is for 5 years, with extensions thereafter required every 5 years continually.
- Arrangements with the Government have been made to give financial support for 0.25 FTE placement students per 200 beds, motivated in large part by the desire to achieve extended delivery of clinical pharmacy services.

Portugal

The sixth national presentation was from the Portugal delegation, given by Aida Batista. Presentation here.

Key points from this presentation included:

- Specialisation in Portugal has been a requirement for hospital pharmacists since 1991, made up of a 3-year programme.
- However two systems are now in operation – one overseen since 1998 by the Ordem dos Farmacêuticos (open to all pharmacists, 5 years), and the 3-year 1991 specialisation by the Government (selective intake). Some hospital pharmacists, such as AB, are therefore “twice specialists” having conducted both programmes
- The Ministry and Order continue to work towards an agreement to better deal with this scenario of duplication. Repeated changes in Government have been unhelpful in this regard.
- Key aspects of the specialisation include drug management, production and compounding, quality assurance, clinical pharmacy activities, drug information, pharmacovigilance and nuclear pharmacy.

The meeting broke for lunch at 1300 and returned at 1400.

6 Post-morning reflections

In a change to the agenda, IB suggested the meeting hold some discussion in plenary before breaking into workshop groups, as lunchtime conversation with participants had indicated a desire for this.

IB indicated his opinion that from the morning presentations he believed that whilst the meeting had heard about 6 quite different national systems with their own unique histories, they shared a

common goal – to improve the workforce for the purpose of improving pharmaceutical care. With this in mind, a form of harmonisation, or common understanding between the programmes and qualifications ought to be achievable, if not necessarily simple in the method for achieving this. IB encouraged meeting participants to share views and opinion.

FV could see a difficulty in terms of the manner in which specialisation programmes are delivered across countries in the sense that some are under academic supervision and others are not. He recognised however, that beyond this, parallels and commonality between the programmes, in terms of what is delivered (i.e. competent hospital pharmacists), could be drawn. Language is another matter that cannot be ignored in terms of labour mobility. Individuals need to be able to speak the language of the patient in order to carry out clinical pharmacy services. RF reminded there was reasonable evidence of increasing movement of patients across borders allied to a more mobile workforce. In this sense, the need for healthcare professionals with multiple languages may increase.

TE believed that one ought to consider the rights of patients in this matter. In a sense, patients in Europe should have a right to expect pharmaceutical care from highly trained and expert pharmacists in the hospital setting. The achievement of a common training framework could be an important means to achieve this. IB sympathised, and imagined that if patients were asked whether they wanted the guarantee of hospital pharmacists with education levels to underpin specialised knowledge, the answer would be yes.

JS raised some concerns he felt following the morning session, including the feasibility of achieving a common training framework given the legal interpretation issues of “regulated profession” that the European Commission speaker had mentioned. He also wondered how small countries could deliver education systems to match the CTF standards given the small student populations that would be involved.

JSu recommended maintaining an ambitious vision of what should be achieved, but taking realistic small steps in order to get there. JK considered that there was a balance to be struck in this as well, as taking too small steps might stagnate progress.

IB thought one approach that could be taken to heighten understanding of the relative similarities and differences between systems could be to think conceptually of what the ‘capabilities’ of individuals are after completing the respective specialisation programmes – what can the individual DO? In probability, each country could likely indicate this in a very simple form i.e. in a single side of paper.

The meeting then broke into 3 discussion groups to consider a reduced number of workshop questions than circulated prior to the meeting.

7 Workshop conclusions

The participants of the 3 working groups are available here.

Workshop Group 1

TE presented the conclusions of Working Group 1. They had conceptualised matters of hospital pharmacy education in Europe in terms of a cake with 3 layers that needed to be distinctly understood:

Layer 1 – the Pharmacy MPharm to enter the pharmacy profession

Layer 2 – the hospital pharmacy specialisation to underpin professionalism in pharmacy in the hospital sector

Layer 3 – Additional specialties in narrower areas (e.g. paediatrics, oncology etc)

IB appreciated the metaphor especially considering that whilst one might think of establishing a common recipe, countries could follow the recipe in different ways, or add some different ingredients.

Among the challenges and obstacles that may need to be overcome include the financial needs of building and maintaining a European system. Inter-professional barriers may possibly arise as well. IB believed there were grounds for optimism that such barriers could be breaking down, partly as a result of changes made in under-graduate education (more collaboration at an early stage).

Workshop Group 2

RF reported back from workshop group 2. Identified obstacles to creating a common training framework included the difficulty of changing education (and indeed health) systems if this was required. The scenario can already be seen to exist in the example of one country requiring

knowledge in the use of medical devices as something quite fundamental to practice as a hospital pharmacist, whilst in other countries such competence is close to unnecessary.

The Group also considered that the quality assurance mechanisms underpinning a common training framework would be of high importance to engender trust. Consideration should therefore be given to creating agreed criteria and arrangements for quality assuring the provision of hospital pharmacy education recognised within the CTF. IB saw this issue as compounded by the fact that no over-arching European pharmacy education or quality assurance bodies are currently in existence. JS speculated that some form of European Board or Committee might need to be established to this end. IB could also see the need for continual vigilance for changes in practice knowledge requirements. For example, where HIV used to be a highly specialised pursuit, now, with co-morbidity so prevalent, it is established as an area of knowledge all HPs should have.

Workshop Group 3

ABr reported the conclusions of the third workshop group. Amongst the obstacles identified were language, legal definitions and the need to engender political goodwill for the project. Other obstacles might be the fear of impacts to individual job security from increased European labour mobility within the hospital pharmacy profession. Another obstacle could be the lack of clarity for some stakeholders about what the end product of the project will look like. Difference in nomenclature across countries could also present difficulties e.g. “hospital pharmacist” and “clinical pharmacist”. The Group also identified the need to give an early emphasis on the quality assurance aspects of any common training framework.

A working group should therefore be formed following the meeting, with a clear timetable for reporting at regular intervals, which might include the EAHP Congress in March 2015 and the EAHP General Assembly in June 2015.

8 Discussion on next steps

IB opened the discussion to a concluding session to settle the next steps of activity.

RF suggested that consideration be made to including the Czech Republic within the early steering group of countries commencing the first stages of the project. JSu proposed investigation of EU funding opportunities be one of the next steps.

JS recommended work be conducted to translate the relevant curriculum and other key documents associated with each hospital pharmacy specialisation programme to aid common understanding.

JK and ABr both emphasised the need for a rigorous mapping comparison of the hospital pharmacy specialisation programmes in Europe. ABr also predicted there would be quite a range of supporting evidence and other tasks and projects that would be needed to bring the hoped for common training framework into reality.

JDG advised the construction of a small Steering Group with technical working groups operating underneath this. IB supported this suggestion, believing that much of the work of the group could be conducted by virtual methods. However, due to the nature of the work, the members would need to have the correct expert credentials and understanding of both the technical and wider matters. Therefore, a specification for the persons to serve might usefully be drawn up. “Expert volunteers” were required, supported by the EAHP secretariat.

ABr related her experience of serving on the technical working group of a World Health Organisation initiative. This involved over 50 healthcare professionals from around the world, including 3 from pharmacy. To make the work manageable, the group divided into smaller task-related groups. It may be sensible therefore to convene a first group to define all the projects and tasks to be completed, and then delegate these to subsequent groups for completion, made up of the right persons for the task in hand.

To close the meeting IB asked each of the participants to give their final remarks and reflections.

- RP was pleased that a sense of direction was emerging from the meeting enabling the secretariat to move forward with activities secure in the knowledge they represented the will of the participating members.
- JK said he was looking forward to playing a part in the project and would be in a position to give ongoing service and assistance to the project.
- FV considered strong central coordination would be important to the project. He would be willing to give assistance to the project going forward.
- CL saw the project having important humanitarian implications for Europe in terms of achieving higher standards of care across Europe and was happy to be involved.
- JDG was keen that a strong set of deadlines be constructed following the meeting and the 24th March 2015 could be an important moment to report back the early stages of work commenced to EAHP members.
- DP was grateful for the additional levels of detail being added by the day's presentation to the overall understanding of the project and looked forward to playing his part in supporting the project within the secretariat.
- KN was pleased to get confirmation from the European Commission that differing durations of specialisation programmes across Europe need not form an obstacle to forming a common training framework as long as the knowledge, skills and attitudes could be agreed. He saw potential roles for interested members of the Scientific Committee in the project. He would be happy to continue to serve the project.
- JP could see the project might be a long journey but the end result should be worthwhile. The mapping exercise in the next stage would be key to adding clarity. Specialisation should be understood as a fast route to expertise.
- JS concurred with JP's sentiments about not underestimating the scale of the challenge.
- JSu saw the achievement of a common meaning of specialisation as a worthy undertaking.
- GH shared his enthusiasm, as a young pharmacist, to see the project achieved and realised in his professional lifetime.
- AG thanked the meeting for the opportunity to observe and would be happy to contribute in any way she could to the project.
- EEA could see the need to plan for expansion of the project beyond the existing countries in the room, and hoped good progress could be made. He would be happy to serve the project.
- CP found the day's meeting insightful and educational and would be willing to make further contribution to the project.
- SC felt the day had been important and imagined the project could rely on good support from SIFO. He would continue to contribute to the project for as long SIFO requested him to.
- AB agreed that the project was of a large scale but the European Summit on Hospital Pharmacy demonstrated that EAHP and its members could take on such major projects successfully. She was happy to offer her services to the project.
- ABr had found the meeting enlightening and would be happy to serve the project.

Before bringing the meeting to a close, IB reiterated the importance of participants taking the news from the meeting back to their countries to help ensure dissemination of future activities.

IB thanked everybody for the work conducted prior to the meeting, including the compilation of well-constructed and comprehensive presentations. He wished all safe journeys home.

The meeting closed at 1700.

9 Agreed Next Steps and Timetable of Actions

ITEM OF ACTIVITY	RESPONSIBILITY	TIMESCALES
1. CONSTRUCT A FORMAL STEERING COMMITTEE TO OVERSEE THE PROJECT, DEFINE ITEMS OF WORK, AND SCRUTINISE THE OUTPUTS OF WORKING GROUPS	EAHP SECRETARIAT TO LEAD THIS ACTIVITY UNDER SUPERVISION OF EAHP BOARD	MEMBERSHIP OF STEERING COMMITTEE TO BE DEFINED AND COMPLETED **BEFORE THE END OF THE CALENDAR YEAR**
2. COMMENCE RIGOROUS MAPPING EXERCISE OF CURRENT HOSPITAL PHARMACY SPECIALISATION PROGRAMMES IN EUROPE	RESPONSIBILITY OF NEW STEERING COMMITTEE TO OVERSEE THE CONDUCT OF THIS TASK. EAHP SECRETARIAT TO SUPPORT.	FOLLOWING CONSTRUCTION OF THE NEW STEERING COMMITTEE, THIS, AND OTHER TASKS (E.G. ACCREDITATION MATTERS, ADDITIONAL COUNTRY INPUT, FUNDING), TO BE DELEGATED TO APPROPRIATE WORKING GROUPS. WORKING GROUP TO BE ESTABLISHED AND PURSUING ITS TASK **BY TIME OF EAHP CONGRESS (MARCH 2015)**
3. REGULAR REPORTING AND PROVISION OF RELEVANT INFORMATION TO THOSE WITH RESPONSIBILITY FOR OVERSEEING THE PROJECT (E.G. FUNDING OPPORTUNITIES, LESSONS FROM OTHER PROFESSIONS, NEWS FROM COMMISSION)	EAHP SECRETARIAT (POLICY AND ADVOCACY OFFICER AND RESEARCH ASSISTANT)	CONTINUAL (REPORTS TO PROVIDED AT LEAST EVERY TWO MONTHS TO THE STEERING COMMITTEE)
4. REPORT BACK TO ALL RELEVANT STAKEHOLDERS INCLUDING EAHP MEMBERS	**ALL** PARTICIPANTS AT MEETING TO REPORT BACK TO THEIR ASSOCIATIONS EAHP SECRETARIAT TO OVERSEE COMMUNICATIONS TO ALL EAHP MEMBERS	**BEFORE THE END OF THE CALENDAR YEAR** FURTHER REPORT AT 2015 EAHP CONGRESS (MARCH)