PDA Feedback Paper on some of the issues raised by the proposed reform of the Initial Education and Training of Pharmacists, as outlined in a meeting with the GPhC in October 2020.

The PDA welcomes the acknowledgment that the IETP needs a radical overhaul to make it fit for purpose.

The recent past has seen a change in expectation of the roles and thus the services that pharmacists will provide within community pharmacy, GP practices, hospitals, and other settings such as care homes.

Clearly, a structural shift in both the initial education and the post-registration lifetime continuing development process is needed to prepare pharmacists to undertake these roles.

The Covid-19 pandemic exposed the deficiencies within the existing IETP to the extent that pre-registration students have been allowed to only enter a provisional register until such time that they pass a registration exam.

The GPhC accredits the education providers and the pre-registration tutors and is also responsible for the registration exam. However, it is clear that the whole process has become reliant on the final registration exam as a quality assurance gateway to the register.

This absolute reliance on a registration exam as the gateway to the register clearly would not be needed if sufficiently robust quality assurance measures were in place during the whole student journey from point of selection (i.e. UCAS stage) to the final sign off at the end point of registration; this sign off needs to be robust and rounded and fit for purpose.

The reform process must address the significant existing differences in the ethnic distribution of pharmacy students and the disproportional proportion of BAME pharmacists that get the poorest placements which then impacts them for the rest of their careers. A rotational programme giving proper exposure to all sectors and co-ordinated by the NHS will have far greater potential to remove this existing and well documented structural inequality.

In medical education, doctors become doctors at the end of their formal education period and enter a 2-year foundation period. There is no reason why pharmacists should not follow a similar pathway, ideally also co-ordinated by the deaneries.

There are many options which may work. However, the path to choosing the best one (or more) options should be based on evidence and preparedness. Rushing through changes

without having the supporting infrastructure in place may embed or even worsen the deficiencies that have led to these proposed reforms.

The lessons from the GPhC stance on the 2020 pre-registration exam and the implicit recognition of the lack of preparedness of pre-registration students to enter the register without first passing a registration exam must be learnt and not repeated.

There is a real risk that these major reforms will create a culture of tick-box use producing "has met .." or "shows .. "or "does .." without fundamentally assessing whether that requirement has actually been met. This has huge patient safety implications.

An integral part of the reforms must be the embedding of equality issues within the whole process that the GPhC oversees and removing the current attainment gap present at institutions that provide the MPharm.

This will become the bedrock of how students, irrespective of background can become pharmacists that can contribute fully to their profession as patient facing practitioners and as academics who teach future generations of pharmacists.

A: Overarching embedding of equality within every aspect of the proposed GPhC reforms

Overall, pharmacy seems a very diverse profession. However, within this superficial diversity there are embedded a whole series of structural barriers which have prevented BAME pharmacists from fulfilling their potential. The huge attainment disparity at point of graduation given that this disparity did not exist at point of entrance clearly shows that something is terribly wrong with the 4-year pharmacy student journey.

The problem is not the student. The problem is the institution. It is not a student deficit – it's an institution deficit. This is not merely wordplay – it is a suggestion for a constructive approach.

There is substantial evidence that the gap cannot be simply explained away by demographics, age, entry grades etc. It is not any one issue but a series of interconnected and structural issues which is causing this gap. We detail some measures that may help with reducing this, but the biggest factor is leadership, motivation, and a sense of doing the right thing. Without this change in mindset change will not occur.

A.1 Data collection is a pre-requisite for identifying systemic problems. Transparency and openness are key drivers to drive fairness and equity. The GPhC MUST ensure to gain accreditation comprehensive diversity data is collected and published. This may include:

i/ Diversity data at point of application
ii/ Diversity data at point of offer (including clearing) including grades data iii/ Diversity data at end of each year (pass rates, grading etc)
iv/ Diversity data of all staff (at all levels)
v/ Diversity data at point of graduation and any GPhC subsequent assessment

A.2 At point of entry, all students start with equal potential, however there is a huge final degree grade gap between students of differing ethnicities. At some institutions, the MPharm attainment gap is as large as 37%, i.e. the proportion of white ethnic students achieving a first or upper second is 37% higher than an ethnic student.

This is a structural issue which must be addressed as part of the accreditation process and universities must have specific measures in place to reduce and eliminate this gap to be accredited. Some Universities have shown true leadership and have already engaged with this curriculum design process to reduce the attainment gap.

A.3 Students will aspire and be motivated to become what they see. Therefore, it is critical that staffing reflects the diversity of the student intakes. There MUST be mandatory training of every faculty member on diversity issues as part of the MPharm accreditation process.

A.4 University departments offering the MPharm must have measures in place that ensure that the support networks and inclusiveness in projects, placements and experiences are bias-free.

A.5 Assessment methodology must ensure that it eliminates risk of unconscious bias. Students at point of entry all have the same potential yet the outcome at graduation shows huge disparity. Therefore, assessment methodology must be fit for purpose.

A.6 The fitness to practice process for students needs to be cognisant of diversity and any panels must reflect the diversity of the student cohort.

A.7 Students MUST be integral to the process of reform that embeds equality into the reformed MPharm and what will support their learning. Students must be co- authors of the reform process.

A.8 There must be a structured approach to ensuring equality into PhD programmes linked to the pharmacy school, this would act as slow burner to the next generation of BAME pharmacy faculty members.

A.9 Any foundation training and associated assessments MUST focus on eliminating the processes that are herding BAME students into poor training placements. A rotational programme may be the simplest way to eliminate any inherent bias.

Key areas that the proposed reforms must consider:

The following points cover key areas of concern and as such is not a comprehensive coverage of each detail of the proposals.

1. **The selection process – control at point of entry.**

    1.1. The starting point for any reform must be a robust process at the point of entrance for the MPharm degree.
    1.2. Offers made to students must reflect the advertised UCAS grades and the values of their future profession.
    1.3. If alternative entry points are available (for example the 5 year MPharm with foundation programme) the year 1 endpoint of foundation and entry to the MPharm must reflect the same entry standards as of that of the standard 4 year MPharm entry point standard.
    1.4. Entry via clearing must be monitored.
    1.5. A standardised admission test applicable to all accredited MPharm courses should be considered to reduce the subsequent variation in pass rates (as can be seen from the pre-registration exams where there is a wide and consistent variation between institutions). Medical schools in the UK use a standardised admission test as part of the admissions process.

    The PDA recognises that the GPhC may not wish to be as proscriptive as this and might favour instead looking at HEI processes for combining monitoring and support of students.

Key Questions:

How will the GPhC gain assurance that HEIs have appropriate monitoring and support measures in place to:

- **allow students from all ethnic backgrounds to achieve their full potential?**
- **identify those students for whom it becomes apparent that pharmacy will not be a viable career at a suitably early stage, allowing them to explore other more appropriate career paths?**
- **Address and prevent disparities in awards made to white and non-white students?**

2. Length of MPharm and potential diminution of science content

2.1 The MPharm is based on a fundamental understanding of science. Experiments, lab work and core understanding of pharmacology, microbiology a whole diverse range of topics underpin the MPharm. Any reform which increases the clinical aspects of the MPharm must not result in the diminution of the existing science-based approach that underpins the degree.

2.2. The MPharm could reform from a 4+1 but we must look at all future options focusing on substance rather than nomenclature.

The options of a 4+1 or a 4+2 must not be taken off the table where:

- 4+1 = modified MPharm (i.e. greater experiential component) degree with a 1 year clinical rotational foundation (where the student is a NHS employee) leading to registration as a ***non-autonomous IP*** (in effect can only make changes after consulting an autonomous prescriber).
- 4+2 = modified MPharm (i.e. greater experiential component) degree followed by 2 years NHS employment spent as: 1-year foundation (GP/Hospital/Community – 4/4/4) rotational followed by 1 year in depth supervised practice enabling registration as **non-autonomous IP**. (in effect can only make changes after consulting an autonomous prescriber).

In both above cases, the reforms kick-start the IP process for all new registrants and then it is left to the motivation of the individual how far he/she wishes to progress along the full IP route.

The year 1-4 curriculum will require significant modification to allow both the increase in experiential clinical placements and learning to support IP at the end of year 5 (in the current proposal) and maintain the important scientific content which confers a unique combination of prescribing and pharmaceutical skills upon pharmacists. This is a huge undertaking.

Key Questions:

What work is underway to ensure that:

- **Variation between HEIs in quality of the new courses is kept to a minimum?**
- **Variation between HEIs in the mode of introduction of iterative changes during the transition period and beyond is kept to a minimum?**
- **Current regulation only allows a 5-year remit for GPhC. Is any effort being put into lobbying to extend this to 6 years in recognition of the need to ensure patient safety whilst making this fundamental change to pharmacist training?**
- **Adequate support is given to those undergraduates who commenced their learning in the current system, but who will emerge at least partially under the new system?**

3. Experiential Learning reforms.

3.1. There is significant variation in the amount of experiential learning provided within the existing accredited courses. One recent paper evidenced the variation exposure of 50 hours during a 4-year MPharm to 500+ hours. This unacceptable discrepancy must be eradicated in any reformed IETP.

3.2. There must be an element of minimum standards for experiential learning including:

- Quantity or hours for each year
- Robust quality framework for evaluation of that learning
- The learning to be in a variety of settings

3.2. There must be a sequential and specified year on year building of these learning experiences. Quality monitoring for each stage must be built into the process.

3.3. This experiential learning component must be subject to sign-off after each stage and should be used as independent quality assurance process toenter any future foundation programme.

3.4. The experiential learning programme must be adequately funded, and the learning must incorporate a variety of methods including simulated learning, group learning, and individual placements. It must not rely solely on any one method.

3.6 The placements must be in all settings. However, it must be recognised that certain settings (such as GP surgeries or hospital placements) will need significant additional resourcing.

Key Questions:

- **How will HEIs collaborate to modify or align their courses to reduce unacceptable variation in course experiential content?**
- **What plans are in place to generate, train and support the significantly increased number of educational supervisors required to provide clinical placements throughout years 1-4?**
- **What plans are in place to address the significant variation in quality of supervision in community pharmacy settings for undergraduate placements?**
- **How will the GPhC ensure that Course Providers allocate sufficient funding to enable these changes to occur?**
- **How will the GPhC allocate the increased accreditation costs to the HEIs rather than burdening current registrants?**

4. Role of Deaneries and Universities and Tutors

4.1 Universities have noted significant concerns about arranging sufficient placements and in the monitoring of placements.

4.2 Tutors need to be supported and trained. Tutor support has repeatedly been shown to impact on the quality of the training experience for students. Coaching and mentoring should be embedded.

4.3. Training sites must be suitable and fit for purpose and allow for multi- disciplinary working.

4.4 The role of Deaneries to facilitate and accredit suitable training sites should be explored.

4.5 An extended role tutor role should be considered within Universities. This person could provide mentorship, oversee the co-ordination of the training programmes, and provide overarching support to groups of students.

Key Questions:

- **What plans are proposed for setting up a suitable accreditation process for training sites?**
- **Will the medical Deanery model form the blueprint for IETP?**

5. A continuum in the education process – UCAS to registration

5.1 The structure of the journey from application to study pharmacy (exam needed) to registration and beyond into early years practice must be a continuum rather than fragmented and disjointed.

5.2 The journey must be consistent across all providers so that students at point of registration can practice anywhere within the UK.

5.3 A clear endpoint and sign-off and "handover" of students from University to their next developmental stage must be in place.

5.4. Systems must be in place to remove the current disparity in outcomes faced by students
The variation in outcomes between schools
The ethnic variation in pass rates
The imbalances in placements offered to students

5.5 A period of supervised working for all new registrants with clear mechanisms in place where greater support levels are identified as being needed.

5.6 It must be clear whether the end point at registration is an examination to enter the register or a sign off by the University to enter the register.

5.7 There must be some form of mandated supervised practice requirement for a specified period before an IP qualified pharmacist can work autonomously. This is akin to a doctor qualifying from medical school, is called a doctor and practises as a doctor, but is still undertaking a foundation level of supervision for all activities (including prescribing).

These are overarching issues that the proposed reforms need to consider. However, we have sector specific and qualification specific concerns which may have serious patient safety impact.

In particular, the proposal that every pharmacist will be qualified as an IP at the end of Year5 is simply not tenable given the level of supervision, mentoring and support that is required.

We have substantial experience of supporting pharmacists, many of whom have been in practise for a number of years, who have all needed that extra support whilst undertaking the IP qualification and in the early stages of their prescribing career. We have also come across significant harm being caused to patients when stringent protocols were either absent or not followed and newly qualified IPs with minimal general practice experience were encouraged or required to undertake activities outside their competence. Newly registered and qualified IPs embarking upon their first “proper job” at the age of 22 or 23 may find it very difficult to assertively decline requests from their new employers and this poses a real risk to patients.

It is essential, for public safety that there is a requirement for suitable post IP qualification experience before unsupervised prescribing takes place.

Key Question:

- **What measures will be put in place to ensure that newly qualified PIPs receive the early stages support and supervision they require to become competent and confident prescribers?**

Pharmacy in General Practice

- General practice training for doctors takes place in SEB approved training practices – Pharmacist training in the new model should emulate the medical model.

- Basic human development studies have clearly shown that the human brain does not fully mature until age 25. Indeed, GPs are not fully qualified until 27 at the earliest, so how can a prescribing pharmacist be fully trained by age of 22?

- The medical degree requires an additional 3y of specific training before autonomous GP prescribing is allowed, even after an UG course loaded with on the job experiential hospital tuition, followed by a 2-year foundation period.

- Nurse prescribers often prescribe within very clearly defined limits as clinical nurse specialists.

- There seems to be a lack of appreciation in some quarters of the nature of prescribing responsibility pharmacists in general practice are being expected/pressurised to undertake. Increasingly, pharmacists are expected to pick up prescribing from GPs across the full range of therapeutics – this generalist role is hugely challenging (which at present takes an additional 3 years of training for GPs).

- It is challenging to find mentors and tutors to support those undertaking IP courses. Given the volumes of students (i.e. all students) that are proposed it may prove to be impossible to find sufficient levels of mentoring or supervisory support within GP practices.

- Our data from member queries showing what can go wrong when pharmacists end up operating outside their scope of competence in general practice.

Key Question:

- **Is any consideration being given to requiring sector-specific ongoing training requirements for newly qualified IPs? (This would allow for increased supervisory requirements within the general practice arena whilst recognising that prescribing within the hospital sector has long-standing built-in supervisory and training frameworks.)**

Community Pharmacy Practice

- Quality of training support: the huge variation in the quality of current pre- registration placements in community pharmacy is well known – what will be done to ensure that this variation does not carry through into the new programme?

- Without overhaul of community pharmacy in line with our proposals (a second pharmacist, high street clinic model rather than retail including hugely increased support and clinical supervision) what prescribing role is envisaged for the pharmacists going straight into community pharmacy?

- In many cases the workload is such that pharmacists do not have time to take their legally mandated breaks, let alone add prescribing on top of dispensary duties, CPCS, flu vaccinations, COVID vaccinations etc.

- Clear evidence from Oriel pre-reg placement service that community pharmacy is already the least popular choice for students especially due to poor quality of support provided to students. This should be an area of significant concern.

- If the education reforms are not accompanied by contractual reforms of the community pharmacy contracts then what is the purpose of training pharmacists to prescribe without the suitable infrastructure to support this prescribing within the community setting? This poses a significant threat to workforce planning and service provision in this sector.

Key Questions:

- **What will be done to ensure robust regulation of community pharmacies to ensure the required standards are maintained enabling excellent learning opportunities and experience for pre-registration graduates in all providers?**
- **What plans are underway to lobby Government to support the required changes in community pharmacy practice which would make the sector an attractive prospect for PIPs?**

Finance

The PDA believes that these are the key areas where substantial investment will be required to ensure the success of the revamped IETP:

- Provision of sufficient training placements for undergraduates with suitably trained and supported educational supervisors at training sites.
- Support for HIEs to review and overhaul current UG courses.
- Training and support for educational supervisors in training placements in recognition of both an increased throughput of trainees and the increased requirements for the support provided.
- Radical remodelling of community pharmacy service provision to allow for additional pharmacist resource and a move to greater pharmaceutical care provision allowing community pharmacy PIPs to utilise their skills and enhance patient care.

Key Question:

- **How will the GPhC finance the extra costs associated with the detailed scrutiny required to quality assure the reformed MPharm?**

Conclusion

The reform of IETP provides an exciting opportunity to ensure that the initial education and training of pharmacists provides them will the skills and expertise to take their rightful place in healthcare multi-disciplinary teams across all sectors. However, this undertaking is not without significant risks and the PDA would like to see the changes approached in a measured way which identifies and recognises those things which need changing but does not bend to external pressures for the provision of pharmacist IPs in the shortest time possible. This precipitous approach will not only increase the risk of damage to the careers of young pharmacists, but more importantly, to the safety of patients which could ultimately result in long-term damage to the reputation of the profession