The policy background

Question 1: In this discussion paper we have summarised governments' policies for pharmacy in the future. We think these policies will mean changes to initial education and training standards for the pharmacy team. Do you think our description of these policies and their impact on pharmacy, and on members of the pharmacy team, is accurate?

The government's policies and the impacts are described well; however, there are a number of aspects that should be clarified here. These policies clearly have important implications for the pharmacy team, but it seems that further analysis is needed before any major changes are imposed on the MPharm model. We need to establish how far the new MPharm, as established by the 2011 GPhC standards, meets future challenges, and investigate the specific ways in which it needs to change. Employers have widely declared that they hope to recruit large numbers of additional pharmacists over the next five years in order to help to fill the gap left by GP shortages in practices and to fill national pilots for pharmacists to work in emergency care departments. The recent report 'The future of primary care: Creating teams for tomorrow' by the Primary Care Workforce Commission, foresees a positive and expanding role for Pharmacists and argues that the number of pre-registration pharmacy placements needs to be increased in order to meet the enhanced role for pharmacists. (http://offlinehbpl.hbpl.co.uk/NewsAttachments/PGH/The-future-of-primary-care.pdf). These forecasts of the need for an expanding pharmacy workforce should also be a focus for the new standards and highlights the need for the creation of a framework which is affordable. This also indicates that employers already recognise the skills, abilities and value of qualified pharmacists.

The current MPharm has seen significant improvements that will only be visible in the graduates of 2014/15 at the earliest, who have experienced a considerably increased level of clinical exposure throughout their education. Much of this exposure has been introduced early on within MPharm courses – a strategy which stems from the evidence base that suggests early clinical exposure is particularly valuable. This could prove to be more innovative than proposals which incorporate clinical placements into year four of the programme. Although we agree that bringing the placement year further under HEI control may benefit the course outcomes, 'integration' needs to be clearly defined before it can be supported. It needs to be clarified whether this refers to further integrated clinical exposure or to a science-practice integration. This will require an evidence based approach and sufficient time for analysis.

In terms of pharmacists taking a leading role in prescribing, the positive results from the Prescribing Safety Assessment pilot illustrate that students may already be very capable, even without major changes to the education system. Although it is agreed that further development of the curriculum in this area would be useful (please see response to question four).

While it is agreed that the patient-facing aspect of a pharmacist role is very important, given that a majority of graduates are employed in community pharmacies and hospitals, the description of the policy impacts seem to lack acknowledgement of the importance of other, less patient-focused roles and of the future supply chain roles that the pharmacist must lead. In addition, many graduates are employed within industry, education and research, regulation, etc. Therefore it is important that pharmacy retains a broad science-base, with a need for pharmacists to understand the science involved in drug discovery and medicines development. Missing from this document is a definition of the unique skills of pharmacists as the experts in medicines within multidisciplinary healthcare teams. Furthermore it is important that research skills (both in science and social science) are a key component of prequalification education, as it will be a future expectation that all pharmacists are engaged in research.

The 'pharmacy team' used here needs to be defined in more detail, as this could encompass a wider range of roles than MCAs and dispensing assistants.

There is a concern that the document may place too high expectations on undergraduate education, without recognising the role of postgraduate courses. It is important to note that medical graduates are not immediately expected to be experts in all roles and specialities, nor are doctors finishing their F2 medical placements. Whilst pharmacy schools are currently able to produce highly qualified MPharm graduates, it is unrealistic to suggest that graduates should be able to move into all of the roles pharmacists undertake as soon as they finish their pre-registration year.

To a large extent, the new MPharm model may already be considered fit-for-purpose to rise to the challenge of government policies for the future of pharmacy and stakeholder needs. However we agree that there is need for improvement of the pre-registration year in order to meet policy objectives. There needs to be a clearer definition of the educational aims and requirements for year 5. It is recognised that there are issues of quality assurance of placements, in particular those based in community pharmacies. Although bringing placements further under HEI auspices may lead to integration of the pre-registration placement(s) and the first four years of study, further investigation is needed as to whether this is indeed the right way forward, and if so, what this would look like. All of the potential options need to be fully evaluated before moving forward; students, the NHS, other stakeholders should not be affected by further changes unless they prove to have an evidenced advantage.

The pharmacy team

Question 2: Based on the future policies we have described and the conclusions we have drawn, do you agree that the initial education and training standards for all members of the pharmacy team should cover a common set of skills and abilities:
1 professionalism
2 good communication skills
3 effective working in multi-professional teams?

These criteria offer a good starting point for a common basic skill set for the pharmacy team, however, some further refinement to these would be useful. For example, to expand on criteria one, there is evidence to suggest that early clinical exposure is important in creating professionalism. It will be important to clearly define what professionalism means and how it can be measured. Professionalism is not only about values and behaviours, but clearly also critical evaluation, decision making, and moral reasoning.

All three core skills can be seen in the previous standards and are already present within the current MPharm curriculums. Communication is already a major focus and it should be clear that this needs to be underpinned by a strong knowledge base and problem solving abilities. All students already experience inter-professional learning within their undergraduate degree, working with medical and other healthcare students throughout the programme. Multi-professional teams may not be essential to *all* aspects of the pharmacy profession**.** Community pharmacists are on the whole, quite isolated and therefore do not generally work in multi-professional teams. This will be important to consider in terms of the value of the range of placements. The corporate community pharmacy environment does not necessarily encourage independent critical thinking, which is a key aspect of professionalism.

Question 3: What else should be common to all roles?

While there are common skills and abilities, this should not take priority over the knowledge and expertise in the subject matter; without this a pharmacist cannot be professional. As mentioned, the new standards should place a greater emphasis on the science knowledge as the basis for pharmacists as medicine experts. An ability to understand the science behind medicines, their effects and safe use is a major part of the work of a pharmacy team. Although this will vary from role to role in terms of the level of expertise, there will need to be some understanding across the team. Regulations should support this knowledge base; otherwise pharmacists may lose their unique position within the health landscape as the experts in medicines.

Critical thinking skills and evidence based effective decision making will be important in all roles, including the ability to decide when and where to refer a patient. Pharmacists need to know how to access reliable medicines related information and critically appraise that information. Research skills should also be included as a focus here; using evidence and applying findings from the literature to solve problems. The Pharmacist's role in the drug development team should also be a key consideration here.

Pharmacists

Question 4: Accepting that pharmacist education is, and must continue to be, broad-based and built on a solid science base, we think that three areas should be developed in the initial education and training standards for pharmacists:
1 clinical diagnosis and decision-making, building towards prescribing being a core skill rather than an extra area of competence
2 interpersonal and communication skills, especially communicating with patients
3 multi-professional team working

Do you agree?

These areas are indeed important to the training of the pharmacy team and these areas should be developed within initial education and training standards. This is not to say, however, that MPharm courses are not already meeting these challenges. The document states that 'existing MPharm degrees do include some first-hand experience of patient-centred care and inter-professional learning. But we do not believe there is enough of either for the degree to play its part in delivering pharmacists fit for the roles described above.' This has not been supported by evidence, and can be challenged by the significant changes seen within MPharm courses (please also see answer to question 1). Despite a lack of direct funding related to clinical and inter-professional learning, schools have launched completely revised programmes. These courses are yet to produce graduates, and therefore the results of these changes cannot yet be seen. Qualitative evidence in terms of feedback from placement providers suggests that these new courses have provided a significant uplift in the clinical and professional competence of pharmacy undergraduates. Evaluation of these changes need to be undertaken before we move forward with further changes, in order to investigate whether the current direction of change is the best possible option, and whether a more complex, resource and cost intensive integrated process is truly necessary.

It is generally agreed that prescribing should be a core skill in undergraduate training; however it may be that the final stages of training to be a fully independent prescriber are something that needs to be developed during postgraduate training. It is important not to generalise about all aspects of diagnosis; this is a doctor's role; a pharmacist is the medicines expert. This needs to be specified clearly in the new standards and an important part of this will be setting out the parameters of a pharmacist's role.

The Prescribing Safety Assessment pilot results and the qualitative evidence on the benefits of the changes to MPharm programmes so far, suggest that there are simple ways of achieving patient focus and interaction without complex change and disruption to other core components of training. This would include enhanced quality assurance for the pre-registration year and HEI led clinical placements during the four year MPharm. While we agree funding should not be a driver of change to the standards, it is important not to rush into costly restructuring before the more economically viable options are proved to be subordinate. It will be important not to disrupt the high level clinical science training that is internationally appealing.

Multi-professional team work is indeed important to many aspects of a pharmacist's role, however it could be suggested that the full development of professional skills and multi-professional working can only occur after graduation: the degree needs to ensure that it covers the basic scientific understanding that underpins every aspect of the career. Improvement of the curriculum is important, but there will need to be some prioritisation, it will not be possible to continually add to undergraduate education.

Question 5: Are there other areas that should be developed?

The emphasis on developing the communication and patient skills of a pharmacist are important, however there seems to be a lack of emphasis on further strengthening of the pharmacist's key expertise: understanding medicines and their applications. The science base is recognised but this should have a greater focus in the new standards. Science underlies every clinical decision that is made, and is central to a pharmacist's role in industry and academic research. The pharmacy team must lead on expertise on medicines; their design, need, development, application, prescription and monitoring. Aspects of leadership and business management may also be useful to develop within the standards, if not already covered within professionalism. When to refer should also be an important aspect here and the ability and confidence of students to apply clinical knowledge is key.

Critical analysis, evidence based decision making and research skills should be emphasised in the new standards; these are core competencies that help give pharmacists credibility within the healthcare professions and enables them to carry out evidence based practice.

Pharmacy technicians

Question 6: Other than the common set of skills and abilities described in question 2, what skills or abilities are fundamental to being a pharmacy technician and should be included in standards for initial education and training?

This role is very varied and technicians working in the hospital sector can have very senior roles. There needs to be a clearer definition of a technician's role.

Pharmacy support staff

Question 7: Other than the common set of skills and abilities described in question 2, what skills or abilities must be covered by the initial education and training of medicines counter assistants?

MCAs need a basic understanding of medicines, and the knowledge required for the safe storage and supply of over the counter medicines. Customer service skills are also important. The MCA role should however, focus on the preparation of medicine to allow pharmacists to be the first point of contact. Again, initial education and training should include a focus on when to refer a patient.

Question 8: Other than the common set of skills and abilities described in question 2, what skills or abilities must be covered by the initial education and training of dispensing assistants?

The role of the dispensing assistant needs to be more clearly defined.

Barriers

Question 9: What barriers might affect the implementation of revised initial education and training standards, either for the team as a whole or members of it?

As previously mentioned, while it is agreed that funding should not be the primary focus for change, it should be considered in setting the parameters and realities of what can be achieved within undergraduate education. It will be impossible to separate the need for greater funding from calls for more intense, integrated clinical training in a multi-professional format. Many schools already supplement funding with international student fees in order to provide this. HEIs believe they have the capacity to reach the optimum policy goals for the training of pharmacists, and to quality assure all clinical placements, but only with greater resources. Inflexibility of standards and reforms would be a major impediment to change. Innovation in providing experience must not be compromised by standardization of process. There needs to be recognition of the range of views and a deep analysis of the current MPharm model.

It is clear that Conservative government policy precludes any form of cap on student numbers; however there are concerns over the growing pressure on funding for placements. This issue needs to be carefully considered within the review of standards and a solution will need to be achievable which meets all stakeholder requirements. A further issue here may be the loss of international student funding; if plans move forward with an integrated five year course with registration at the point of graduation, certain markets such as Canada, where students return home for the registration year, may be lost. It should also be recognised that the proposed change in standards will result in a much greater cost to the student as it will lead to a loss of year's salary in their fifth year.

The roles within the community compared to hospitals remain very different for pharmacists; these should be recognised and included in the review process. Emphasis of initial education and training should be on developing common, core competencies and promoting generalist (rather than sector specific) pharmacy skills. A barrier to the intended outcomes may be that initial education cannot fit all roles for a pharmacist at the point of graduation. A major challenge will also be ensuring that the standards work across all the different countries of the UK. The changes to the training of pharmacists should not occur in isolation from other healthcare professions who will need to be engaged in the process

Pharmacy schools are producing graduates with wide ranging clinical skills, a major issue is that they are then unable to use them in the community environment – where a majority of pharmacists work. Contract and funding changes are needed within community pharmacies to allow pharmacists to move away from dispensing roles. This is also an issue within the education process due to the quality of clinical placements within community pharmacies; students are not able to fully practise their clinical skills and therefore the impact of the training changes is weakened. IT in community pharmacies also needs to be developed to allow pharmacists to have access to medical records. Pharmacists can only be taught clinical decision-making based on having the appropriate information. It must also be recognised that there is the community role in the high street and the community role within the GP surgery and walk in centres, one does not threaten the other and different skills will develop and apply.