Pharmacy Schools Council response to the General Pharmaceutical Council discussion paper on supervising pharmacist independent prescribers in training, January 2017

We set out three core reasons for changing the current supervision requirements for PIPs in training: a. It is right in principle to extend supervision rights to experienced non-medical independent prescribers.

b. It makes sense to be supervised by other PIPs – people who are already working in that role.

c. Supervision capacity needs to increase to allow pharmacist independent prescribing courses to grow to meet service demands.

1. Do you think current supervision requirements should be changed for these reasons?

Yes

Please explain your reasons for this

Permitting suitably experienced Pharmacist Independent Prescribers (PIPs) to undertake this role would be extremely valuable. Increasing supervision capacity is necessary and appropriate; currently, obtaining a suitable prescriber to become a DMP who is both motivated and has the right skill set is a common challenge for all aspiring non-medical prescribers. Often, those who do volunteer to become a DMP underestimate the time commitment and course providers need to provide significant resources to oversee DMPs supervising pharmacists. The law already permits pharmacists to become fully independent prescribers and there is no compelling reason for the role of the DMP / supervisor to be retained solely by another professional group.

Specific comments on each core reason have been summarised below:

Core reason (a)

PhSC supports the principle to extend supervision rights to PIPs. All pharmacists are trained to Masters level (level 7) before professional registration is allowed. The education and training that pharmacists receive gives them an in depth knowledge on the development, use, side effects, etc. of a wide range of medicines. This knowledge puts them in a unique position with regards to the prescribing of medicines. This knowledge should be harnessed not only to support trainee pharmacist independent prescribers (TIP) but all prescribers to meet the continuing demands of the NHS. Patient safety in respect of medicines use is best served by the pharmacy profession. This could potentially also be extended to other experienced non-medical prescribers, provided they have the appropriate knowledge,

skills and experience. Further work needs to look at how to assess what would qualify an individual as an "experienced" non-medical independent prescribers, particularly for professions other than pharmacy. This should include, but is not exclusive to, training level, knowledge of medicines, pharmaceutical sciences, length of time prescribing, competency in training.

Core reason (b)

There is already provision allowed for trainees to spend time with other PIPs. Anecdotal feedback from students has shown that students highly value the time spent with a pharmacist prescriber. The multi-disciplinary healthcare profession approach adds to the richness of the learning experience and should be encouraged.

Core reason (c)

Higher Education Institutes have been increasing their resources and capacity to provide training for more pharmacists wishing to gain the prescribing qualification. This is being driven by an increased demand by the NHS for other healthcare professionals to take on roles that have traditionally been met by others e.g. pharmacists working in emergency and urgent care settings. Increased multidisciplinary team working requires a core set of skills for all healthcare professionals of which prescribing is one. It therefore follows that supervision capacity needs to increase. This is necessary to maintain the quality of the learning experience and to avoid supervisors having to 'spread themselves thin'.

2. Do you agree that supervision rights should be extended to experienced pharmacist independent prescribers?

Yes

Please add your comments here:

As stated in 1a we support the principle to extend supervision rights to pharmacist independent prescribers. Modern healthcare is increasingly delivered in a multidisciplinary manner and as prescribing skills are generic, then there is no reason a suitably qualified PIP cannot be the supervisory practitioner for another profession.

All pharmacists are trained to Masters level (level 7) before professional registration is allowed. The education and training they receive over this 5-year period gives them a broad and in-depth knowledge on the development, science, pharmacodynamics, selection, use, side effects, etc. of a wide range of medicines that is incomparable to other health care profession's training on this subject, including medical education. This knowledge puts the pharmacist in a unique position with regards to the prescribing of medicines. This should be harnessed not only to support trainee pharmacist independent prescribers but all prescribers to meet the continuing demands of the NHS.

A caveat to this is that the supervising pharmacist must recognise that their own skills in diagnosis and clinical assessment will not be as broad as that of a medic and it may be appropriate for the supervising pharmacist to direct their trainee to others to enhance the learning opportunities. Conversely the medic's knowledge of drug metabolism, pharmacology, medicine selection, medicine optimisation, the spectrum of medicines available etc. will not be as good as the pharmacist. A multidisciplinary

approach to supporting trainee PIPs would be recommended, with overall supervision by an experienced PIP or DMP.

As mentioned previously, consideration should also be given to the definition of an 'experienced' PIP: for example, numbers of years having the annotation would not be sufficient.

3. Do you agree that supervision rights should be extended to other experienced independent prescribers?

Yes

Please add your comments here:

Prescribing is no longer the sole domain of the medical profession; prescribing skills are generic and are not profession specific. It therefore follows that other experienced IPs should be able to supervise others. However, anyone who takes on a supervisory role should have appropriate training for the role and should be educated to the appropriate level of education. For example, level of qualifications and level of access to prescribing formulary. Further consideration should be given to the merits and practicalities of inter-professional supervision.

We are proposing that four measures should be put in place if supervision rights are extended:

a. Supervisors must have worked in the area in which a PIP in training wishes to learn to prescribe before becoming their supervisor.

b. Supervisors must be trained for the role before they begin.

c. Supervisors must be mentored for a period of time once supervising.

d. Course providers must support supervisors throughout their time as supervisors linked to an accredited course.

4a. Do you agree that they are the right measures?

No

4b. Should there be any other measures? If 'Yes', please explain what they should be.

Yes

Please add your comments here:

Firstly, there are several matters to highlight in relation to the measures proposed above:

Measure a.

Prescribing is a generic skill and therefore the supervisor does not have to have worked in the prescribing area in which a PIP in training wishes to learn to prescribe before becoming their supervisor. Whilst it is usual for the medical supervisor to be working in the same area this is not essential. A secondary care pharmacist looking to become a prescriber in General Practice may well

benefit from being supervised by a community pharmacist who also works in an urgent care setting for example. Appropriate experience in teaching and mentoring may be more relevant.

If measure a. were to be included, further definition would need to be given as to 'worked in the area'; whether this would need to be for a certain amount of time or to a certain level of competency, and whether this relates to the type of practice or speciality, etc.

Measure b.

Many experienced PIPs who are looking to take on a supervisory role will have already had relevant training. For example these PIPs may have teaching and learning roles in their Trust, experience as clinical coordinators supporting junior pharmacists on Diploma courses, Pre-Reg tutor roles, RPS Faculty mentor etc. These teaching / mentoring skills should be recognised as being transferable skills. In addition, as experienced prescribers they will already be familiar with the IP course learning outcomes and the prescribing competency framework and therefore to put in additional training requirements would be an unnecessary hurdle requiring time and resources that may prevent the increase in number of supervisors. HEI course providers will need to be assured of the supervisor's competence to perform the role, as is the current position with DMPs. It would be important for HEIs to continue to offer support to the supervisors.

Measure c.

Mandating mentoring of supervisors would be burdensome and create an additional level of bureaucracy which would be counterproductive to the need to expand the potential pool of supervisors. It is already recognised that a lack of DMPs is restricting the growth of future PIPs, therefore finding suitable mentors may simply be transferring the issue to a different group. A form of peer mentoring and creating support networks or forums may be a more suitable way forward.

It must be recognised that there are pharmacist prescribers who already have suitable tutoring skills. Employers and organisations have a duty to support their employees. HEIs should continue to be available to offer support to both their students and supervisors as is currently the position for TIPs and DMPs.

Measure d.

Course providers currently have an obligation to support mentors of TIPs. There is no reason to change this or to add to this. This should be left to the discretion of the HEI and be part of the accreditation process by the GPhC. A range of support should be offered e.g. face to face contact, handbooks, webinars etc.

Further suggested measures and considerations and summarised below:

PhSC fully supports the role of experienced PIPs acting as supervisors for trainee PIPs. However, the role of the prescriber includes the need to make diagnostic decisions. Even experienced PIPs may have limited training in diagnosis. We would therefore make a recommendation that a pharmacist supervisor should recommend to their trainee that part of their learning in practice time should be spent

with a medic. Equally as so much of prescribing depends today on the enhanced science and often personalised knowledge of the medicine, it should be recommended that all prescribers, medics included, spend time with a pharmacist. Other multidisciplinary training opportunities should also be explored. This will help to promote the role of the pharmacist as a prescriber in a multi-disciplinary team and will help to develop transferable skills that can be utilised to meet the changing needs of the NHS. In the same vein, and to pool resources, trainee medics could spend time with a supervising pharmacist prescriber.

It should also be recognised that there only around 6% of pharmacists who currently have the prescribing annotation. Many of these are not actively prescribing and many may not be in a position to supervise a trainee. This would leave a small pool of pharmacists who could act as supervisors. Thus it will be important to continue to endeavour to increase the number of pharmacists training to gain a prescribing annotation.

The standards expected of 'new' prescribing supervisors should be no more onerous than those expected of existing DMPs. A process of peer-review could be considered in order to ensure supervisors are adequately skilled for the task.

Consideration should also be given to supervisor revalidation and whether this might be needed after a certain period of time. Furthermore, how to share information between employers on the training and mentoring of supervisors.

5. Are there any equality, diversity or inclusion issues you think have been raised by our proposals?

No